Financial Report

Fiscal Year **2018**

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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 2018 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:

MANAGEMENT'S DISCUSSION & ANALYSIS

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

FINANCIAL SECTION

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

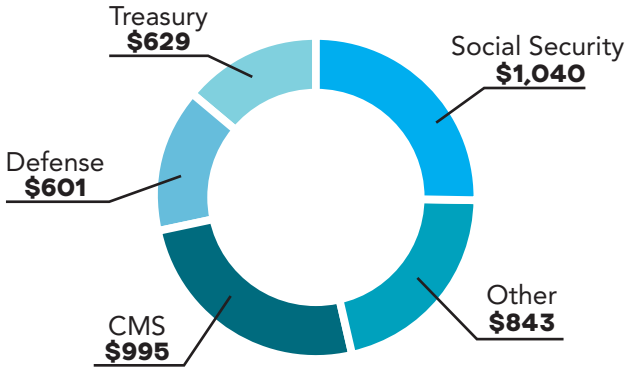
OTHER INFORMATION

This section includes the Summary of the Federal Managers' Financial Integrity Act Report and the Office of Management and Budget (OMB) Circular A-123—Management Responsibility for Enterprise Risk Management and Internal Control.

2018 FEDERAL OUTLAYS

CMS has outlays of approximately $995 billion (net of offsetting receipts and Payments of the Health Care Trust Funds) in fiscal year (FY) 2018, approximately 16 percent of total Federal outlays.

CMS employs approximately 6,200 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 (U.S.).

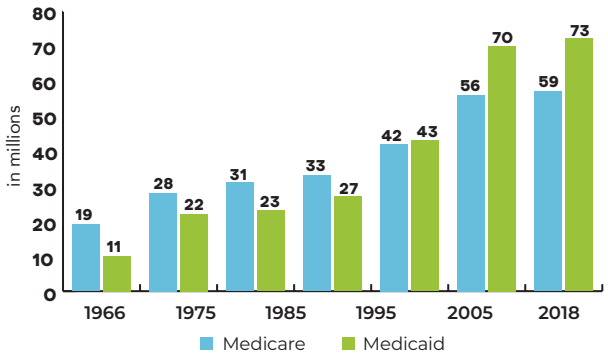


$ in billions

Source: U.S. Treasury

2018 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 59 million beneficiaries. Medicaid enrollment has increased from 11 million beneficiaries in 1966 to about 73 million beneficiaries.



A MESSAGE FROM THE ADMINISTRATOR

SEEMA VERMA

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2018 Agency Financial Report. In FY 2018, CMS made tremendous progress in accomplishing its vision of moving toward a sustainable health care system that provides better care, smarter spending, and increased access to coverage for the more than 140 million Americans we serve, including many of our most vulnerable citizens. During the past year, CMS has focused its resources on: reducing regulatory burden on health care providers in an effort to improve patient care and to empower patients and doctors to make decisions about their health care; ushering in a new era of state flexibility and local leadership; supporting innovative approaches to improve quality, accessibility, and affordability; and improving the CMS customer experience.

We traveled across the country to visit health care facilities and spoke directly with health care providers, beneficiaries, and staff of Medicaid state agencies. Through this outreach, CMS is now better enabled to anticipate their needs to better serve them. The finalization of a number of rules that directly reduce regulatory burden has allowed providers more time to spend with patients to support better health outcomes, improve the beneficiary experience, and has provided states the flexibility to drive reforms based on the unique needs of their populations. The use of Medicaid demonstration projects and state innovation waivers allows states to design innovative ways to better serve the nation's more than 65 million Medicaid recipients.

CMS's launch of several new ground-breaking initiatives this year was aimed at improving health care quality, accessibility, affordability, and improving the customer experience. In health care, interoperability, which is the ability of different systems to communicate quickly and effectively, means sharing patient data quickly and seamlessly across diverse settings - including hospitals, pharmacies, health care providers' offices, and labs - with complete reliability and security. Our MyHealthEdata initiative aims to empower patients around a common goal – giving every American control of his or her medical data. MyHealthEData will help to break down the barriers that prevent patients from having electronic access and true control of their own health records from the device or application of their choice. Patients will be able to choose the provider that best meets their needs and then give that provider secure access to their data, leading to greater competition and reducing costs.

Last March, CMS announced Blue Button 2.0, a developer-friendly Application Programming Interface (API) that allows Medicare beneficiaries to connect their claims data to third-party applications, services, and research programs. We asked the developer community to develop apps that will improve quality of life and increase positive health care outcomes for people with Medicare. We're also looking for ways to use open APIs to support data sharing with providers participating in our payment models, and encouraging insurers to make their claims data available for use in apps like those our developer partners are creating.

Our multi-year effort to remove Social Security numbers from Medicare cards is helping people to protect their personal identities and prevent fraud. This spring, we successfully began mailing the new cards to new Medicare enrollees and current beneficiaries and remain committed to getting the cards to all people with Medicare by April 2019.

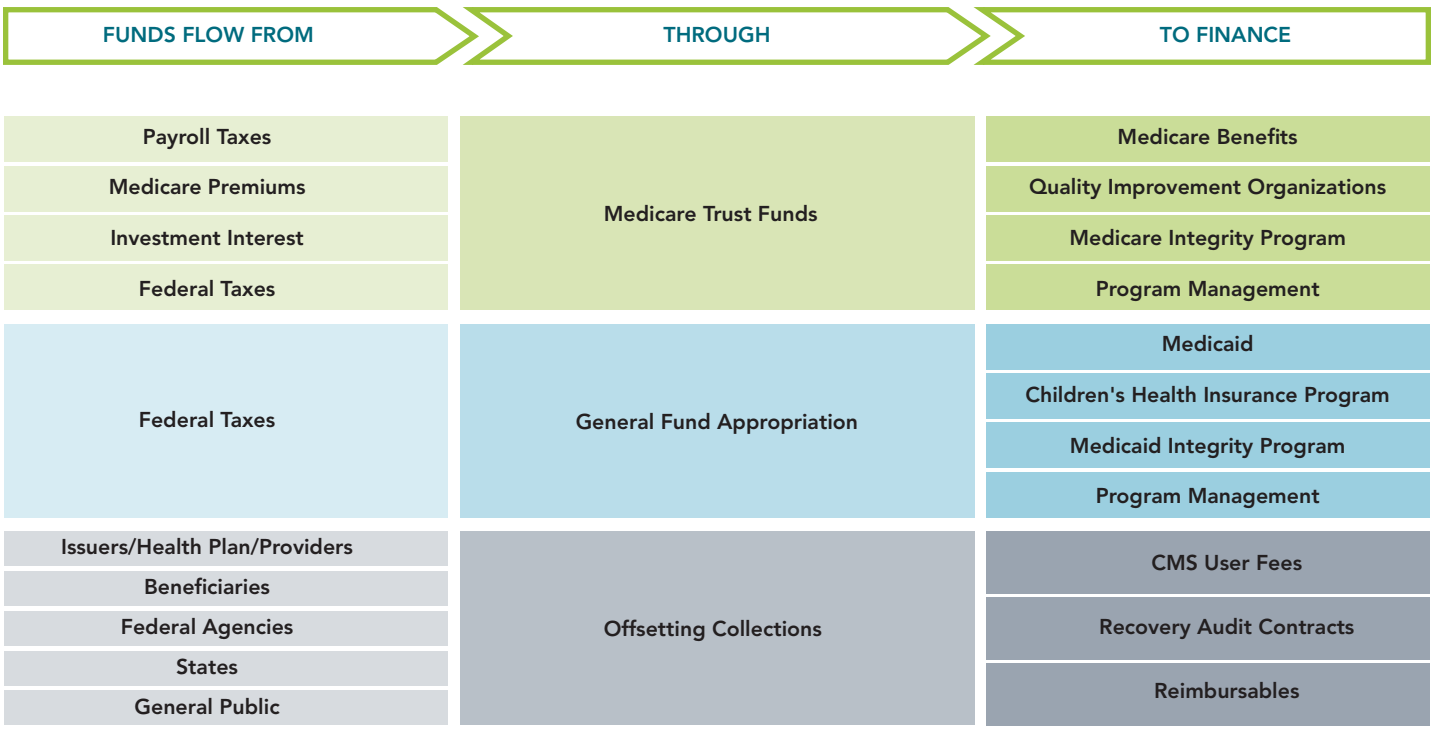
This past year, CMS has demonstrated great progress in improving health care. It's exciting to see all the ways in which CMS is working to develop and implement innovative ideas to modernize, advance, and drive change across the health care system. However, our work is not done. We are inspired every day to keep going by working together with our partners to design a health care system that delivers quality care and real value to every American.

Thank you for your continued support and interest in CMS's programs and initiatives.

Seema Verma

SEEMA VERMA
CMS ADMINISTRATOR
NOVEMBER 2018

FINANCING OF CMS PROGRAMS & OPERATIONS



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MANAGEMENT'S DISCUSSION & ANALYSIS

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Overview of Social Insurance Data

OUR ORGANIZATION

CMS, an operating division of the Department of Health and Human Services (HHS), employs approximately 6,200 federal employees in Maryland, Washington, DC, and 10 regional offices 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.

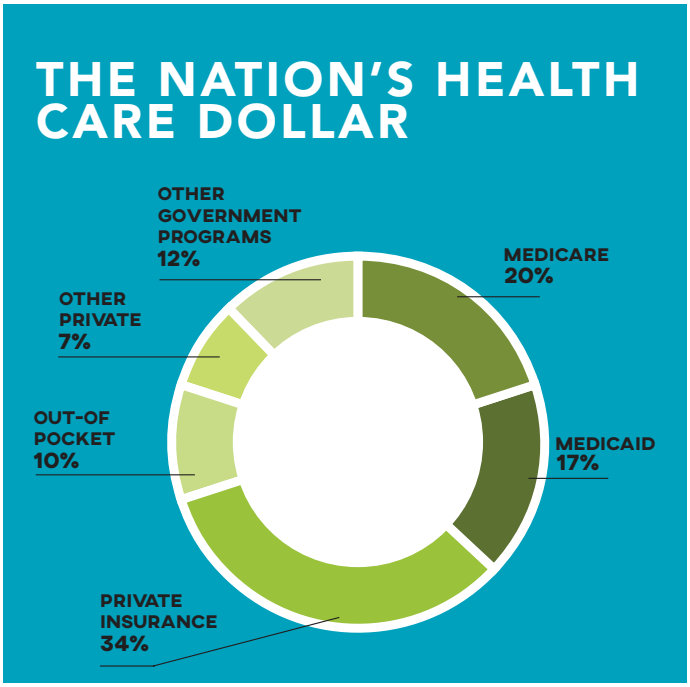
CMS's employees write policies and regulations that establish program eligibility and benefit coverage; set payment rates; safeguard the fiscal integrity of the programs it administers from fraud, waste, and abuse; and develop quality measurement systems to monitor quality, performance, and compliance. In addition, CMS's staff provides technical assistance to Congress, the Executive branch, universities, and other private sector researchers.

CMS also contracts with third parties to operate many of its important activities. Each state administers the Medicaid program and the Children's Health Insurance Program (CHIP). States also inspect 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.

OVERVIEW

CMS administers Medicare, Medicaid, CHIP, and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) program. The passage of the *Patient Protection and Affordable Care Act* (PPACA) led to the expansion of CMS's role in the health care arena beyond our traditional role of administering the Medicare, Medicaid, and CHIP Programs. 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 2018 projections, Medicare and Medicaid (including state funding) represent 37 cents of every dollar spent on health care in the United States—or looked at from three different perspectives: 54 cents of every dollar spent on nursing homes, 44 cents of every dollar received by U.S. hospitals, and 34 cents of every dollar spent on physician services.



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 people with disabilities and people with end-stage renal disease (ESRD). The Medicare program was further expanded in 2003 with the *Medicare Modernization Act* (MMA), which included a prescription drug benefit for all Americans with Medicare beginning January 1, 2006.

Medicare processes over one billion fee-for-service (FFS) claims a year, and accounts for approximately 15 percent of the federal budget. Medicare is a combination of four programs: Hospital Insurance (Part A), Supplementary Medical Insurance (Part B), Medicare Advantage (MA, also known as Part C), and Medicare Prescription Drug Benefit (Part D). Since 1966, Medicare enrollment has increased from 19 million to over 59 million beneficiaries.

Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is provided to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most people entitled to Social Security or

Railroad Retirement benefits. Most people do not pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. The HI program pays for hospital, skilled nursing facility (SNF), home health (HH), 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.

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, people with disabilities, and people with ESRD who are entitled to Part A benefits. Medicare Part B helps cover doctors' services and outpatient care. The SMI program pays for physician, outpatient hospital, some home health care, laboratory tests, durable medical equipment, designated therapy, some outpatient prescription drugs, and other services not covered by HI, such as some of the services of physical and occupational therapists. Part B helps pay for these covered services and supplies when they are medically necessary. The SMI coverage is optional, and beneficiaries are subject to monthly premium payments.

Medicare Advantage

The *Balanced Budget Act of 1997* (BBA) established the Medicare + Choice program, now known as the Medicare Advantage Program or Medicare Part C 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 Medicare Advantage (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 health care plans that contract with CMS instead of receiving services under traditional FFS arrangements offered under original Medicare. Many MA plans offer additional services such as prescription drugs, vision, and dental benefits, and also may cover some or all of an enrollee's out of pocket costs. MA plans assume full financial risk for care provided to their Medicare enrollees. Beneficiaries can also enroll in cost plans where they can receive services through the cost plan's network or Original Medicare.

Medicare Prescription Drug Benefit

The Medicare Prescription Drug Benefit, also known as Medicare Part D, is an optional prescription drug benefit created by the MMA for individuals who are entitled to benefits under Part A or enrolled in Part B. Effective January 1, 2006, eligible individuals have the opportunity to enroll in either a stand-alone prescription drug plan to supplement their traditional Medicare coverage, or in a MA prescription drug plan, which integrates basic medical coverage with added prescription drug coverage. Beneficiaries who qualify for both Medicare and Medicaid (full-benefit dual-eligible beneficiaries) are automatically enrolled in the Part D program; assistance with premiums and cost sharing is available to full benefit dual-eligible beneficiaries and other qualified low-income beneficiaries.

Medicaid

Enacted in 1965 as Title XIX of the *Social Security Act*, Medicaid is administered by CMS in partnership with the states. Although the Federal Government establishes certain parameters for all states to follow, each state administers its Medicaid program differently, resulting in variations in Medicaid coverage across the country. States have flexibility in determining Medicaid benefit packages within federal guidelines, and are required to cover certain mandatory benefits. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community based services (HCBS) and children in state-funded foster care, who are not otherwise eligible. The Medicaid program is jointly funded by states and the Federal Government, as CMS provides matching payments to the states and territories for Medicaid program expenditures and related administrative costs. Medicaid provides access to comprehensive health coverage that may not be affordable otherwise for millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is the primary source of health care for more than 73 million beneficiaries–22 percent of the U.S. population. Over 11.2 million people are dually eligible, that is, covered by both Medicare and Medicaid.

CHIP

CHIP was created through the BBA and provides health coverage to low-income uninsured children and pregnant women whose income is too high to qualify for Medicaid. Title XXI of the *Social Security Act* outlines the program's structure, and establishes a partnership between the federal and state governments. CHIP is administered by states, according to federal requirements. CMS works closely with the states, Congress, and other federal agencies

to administer CHIP. CMS ensures that state programs meet statutory requirements that are designed to ensure meaningful coverage and provides extensive guidance and technical assistance so states can further develop their CHIP state plans and use federal funds to provide health care coverage to as many children as possible. CHIP funds cover the cost of health care services, reasonable costs for administration, and outreach services to enroll children. States are given broad flexibility in designing their programs such as choosing to provide benchmark coverage, benchmark-equivalent coverage, or Secretary-approved coverage. In addition, states can create or expand their own separate CHIP programs, expand Medicaid, or combine both approaches. Important cost-sharing protections in CHIP safeguard families from incurring unaffordable out-of-pocket expenses. In FY 2018, more than 10 million children were enrolled in CHIP for at least one month during the year.

CLIA

CLIA legislation expanded the 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 261,117 facilities.

The CLIA program is 100 percent user-fee financed and is jointly administered by three HHS components: CMS, Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA). CMS manages the overall CLIA program, including its regulatory and financial aspects. This includes enrollment, regulation and policy development; approval of accrediting organizations and exempt states; proficiency testing and certification of providers; and enforcement. The CDC provides research and technical support, and coordination of the Clinical Laboratory Improvement Advisory Committee, while the FDA performs test categorization.

Health Insurance Exchanges

CMS is charged with implementing many of the provisions of the *PPACA* that relate to private health insurance. CMS works to hold health insurance companies accountable for compliance with new market reforms, increase industry transparency, and build health insurance Exchanges where health insurance issuers 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 health insurance issuers from denying coverage for pre-existing conditions, prohibiting annual and lifetime dollar limits on essential health benefits, and ensuring that health insurance issuers are complying with rating requirements. CMS also implements a process for states or CMS to review rates of non-grandfathered health insurance products in the individual (including student health plans) and small group markets to determine compliance with federal health insurance rating rules and whether proposed rate increases are unreasonable. CMS is also responsible for enforcing compliance with a federal minimum medical loss ratio requiring that health insurance issuers spend a predetermined portion of premium revenues on clinical services and quality improvement, or rebate the excess premium to policyholders. This mechanism helps ensure that consumers receive a good value for their premium dollar and to make health insurance markets more transparent.

Permanent Risk Adjustment Transfers

The risk adjustment program provides payments to health insurance issuers that attract high risk enrollees, such as those with chronic conditions, reduces the incentives for issuers to avoid those enrollees, and lessens the potential influence of risk selection on the premiums that plans charge. The risk adjustment program is designed to support plans offering a wide range of benefits that are available to consumers.

PERFORMANCE MANAGEMENT

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's programmatic objectives to the public and 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.

The *Government Performance and Results Act of 1993* (GPRA) mandates that Cabinet-level Agencies have strategic plans, annual performance goals, and annual performance reports that make them accountable stewards of public programs.

HHS released its new Strategic Plan (2018-2022) in March 2018, as required by the *GPRA Modernization Act of 2010*, and key CMS performance measures are featured in the **HHS Annual Performance Plan and Report**. Consistent with GPRA principles, the CMS GPRA performance goals reinforce the mission, goals, and objectives of the Administration's new Strategic Plan. We look forward to the challenges represented by our performance goals and we are optimistic about our ability to meet them.

Our FY 2018 performance measures track progress in our major program areas, including through measuring error rates. In addition, we measure quality improvement initiatives geared toward older adults, children, and people with disabilities, as they are served by the Medicare, Medicaid, CHIP, and the QIO programs. Detailed information and available results about CMS performance measures are included in the **CMS Budget**. Progress on our measures will be reported through the FY 2020 President's Budget process.

CMS STRATEGIC GOALS

This is a critical time for health care in our Nation, and our agency has a responsibility to make health care accessible and affordable for all Americans. We continue to accomplish this by meeting our strategic goals of empowering patients and doctors to make decisions about their health care; ushering in a new era of state flexibility and local leadership; supporting innovative approaches to improving quality, accessibility, and affordability; and improving the CMS customer experience. These goals cut across the programs and support functions throughout the agency to improve the quality and affordability of care. Taken together, these strategic goals will help ensure that we always put people first in everything we do at CMS – including our health care system.

Empowering Patients and Doctors to Make Decisions about Their Health Care

When people are in charge of their health care, outcomes are better. Our goal is to empower people to take ownership of their health care by ensuring that they have the information they need to make informed choices. We continue to bring our dedication, creativity, and compassion to all the work and initiatives, some of which are briefly described below.

Medicare's Blue Button 2.0

CMS launched Blue Button 2.0 in 2018 to empower patients by giving them control of their health care data and allowing it to follow them through their health care journey. Medicare first launched Blue Button in 2010 to give patients access to their claims data in a downloadable PDF file. Now, with Blue Button 2.0, beneficiaries authorize CMS to share their Medicare claims data with applications designed to help them manage their health or with their doctors to improve clinical decision-making. CMS has recruited more than 400 organizations – including some of the most notable names in technological innovation – to join CMS's Medicare Blue Button 2.0 developer preview program. This program allows developers to build and test innovative apps to connect to Blue Button 2.0.

Health Care Price Transparency

To empower patients to become active health care consumers, CMS is seeking to increase price transparency for health care services through the use of online posting of standard charges through the Healthcare Common Procedure Coding System (HCPCS) and through the gathering stakeholder input. Under the current law, online posting of standard charges requires hospitals to establish and make public a listing of standard charges. CMS is currently updating its guidelines to specifically require hospitals to post this information. In addition, CMS developed and posted on its website a software tool and an associated manual to provide an informational crosswalk between the hospital inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS) for select surgical Medicare Severity Diagnosis Related Groups. This tool will allow for better payment comparisons between the IPPS and OPPS for these services and empower patients with better pricing information.

In addition, CMS is gathering input from the public through various means, including a Request for Information in five 2019 proposed payment rules and listening sessions. Stakeholder input will be used to design consumer-centered initiatives to improve access to and use of pricing information for health care items and services by fee-for-service Medicare beneficiaries and Medicare-enrolled providers and suppliers.

Site Neutral Payments

Within traditional fee-for-service Medicare, a covered health care service can be paid different rates depending on where the service is provided. CMS is moving toward site neutral payments for services, regardless of the type of office or clinic in which the visit occurs. The proposed changes would help ensure that seniors have access to the care they need at the site of care that they choose. If finalized, this proposal will lower patients' copayments for services provided at an off-campus hospital outpatient department. Additionally, CMS is proposing to give patients more options on where to obtain care by proposing to expand the number of procedures payable at ASCs to include additional procedures that can safely be performed at ASCs.

CMS Public Reporting Programs

The CMS public reporting programs, such as the Compare websites (e.g. Hospital Compare, Home Health Compare), offer consumers and providers vehicles to compare costs, review treatment outcomes, and assess patient satisfaction. By providing access to comparative information on health care quality, efficiency, and other areas of interest, public reporting makes health care costs and quality information more transparent to consumers and providers, enabling them to make better choices and health care decisions. CMS successfully launched Hospice Compare and Long Term Care Hospital (LTCH) Compare and Inpatient Rehabilitation Facility (IRF) Compare in December 2016. In addition, CMS released to Skilled Nursing Facilities (SNF) their Quality Reporting Program (QRP) public reporting preview reports in anticipation of the October 2018 inaugural launch of the public reporting of SNF QRP data on Nursing Home Compare.

In April 2018, CMS announced an overhaul of the Medicare and Medicaid EHR Incentive Programs and the Merit-based Incentive Payment System (MIPS). This effort will advance care information performance categories to focus on interoperability, improve flexibility, relieve burden and place emphasis on measures that require the electronic exchange of health information between providers and patients. To better reflect this focus, CMS is renaming the following:

1. The EHR Incentive Programs to the Promoting Interoperability Programs for eligible hospitals, Critical Access Hospitals (CAHs), and Medicaid providers; and

2. The MIPS Advancing Care Information performance category to the Promoting Interoperability performance category for MIPS eligible clinicians.

CMS is finalizing several policies to reduce burden on providers while aiming to increase interoperability. The implementation of these policies will advance interoperability and support the access, exchange, and use of electronic health information.

Consumer Assessment of Health Care Providers and Systems

Through the Consumer Assessment of Health care Providers and Systems Surveys, CMS asks patients (or in some cases their families) about their experiences with their health care providers and health plans, including hospitals, home health care agencies, doctors and drug plans. The surveys focus on matters that patients themselves say are important to them and for which patients are the best and/or only source of information. CMS publicly reports the results of its patient experience surveys, and some surveys affect payment to providers.

Connected Care

Connected Care is an educational initiative implemented to raise awareness of the benefits of chronic care management (CCM) services for Medicare beneficiaries with multiple chronic conditions, and to provide health care professionals with support to implement CCM programs. Connected Care is a nationwide effort within Medicare FFS that includes a focus on racial and ethnic minorities, as well as rural populations who tend to have higher rates of chronic disease. CMS developed new resources for patient education and a toolkit for health care professionals with detailed information about CCM, a partner toolkit that includes downloadable resources, and suggested activities to get involved in the Connected Care initiative.

Coverage to Care

From Coverage to Care (C2C) is a CMS initiative designed to help educate consumers about their health care coverage and to connect them with primary care and preventive services. In FY 2018, C2C partnered with the Substance Abuse and Mental Health Services Administration to develop A Roadmap to Behavioral Health, which is a companion guide to the Roadmap to Better Care and a Healthier You. It offers important information about mental health and substance use disorder services; how to find a behavioral health provider; key behavioral health terms; and how to get care. C2C also translated the guide into Spanish to help meet the needs of those impacted by hurricanes Irma, Harvey, and Maria. C2C depends on collaboration with community groups, consumers, and providers, and empowers stakeholders by providing digital and print resources and messages to use

to enable a patient-centered approach for accessibility and affordability. Through federal partners, state organizations, and individual community organizations, C2C furthered its partnerships efforts through 20 webinars educating 1,500 partners who then re-share resources and messages. As a result, nearly four million C2C resources have been shared across the United States.

The Next Generation Accountable Care Organization Model

The Next Generation Accountable Care Organization Model (NGACO) offers an opportunity in accountable care—one that sets prospective financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care. Accountable Care Organizations are patient-centered organizations where the patients and providers are true partners in care decisions. Medicare beneficiaries have better control over their health care, and providers have better information about their patients' medical history, as well as better relationships with patients' other providers. As of September 2018, there are 51 model participants located in multiple states across the country.

Ushering in a New Era of State Flexibility and Local Leadership

States have the freedom to design Medicaid programs that allow them to meet the unique needs of their citizens. CMS ensures that states and local communities have the flexibility they need to design innovative, fiscally responsible programs for all of their populations. Our initiatives continue to provide the states the freedoms needed to develop programs that meet the needs of their citizens.

State Innovation Waivers

Section 1332 of the *PPACA* permits a state to apply for a State Innovation Waiver (section 1332 waiver) to pursue innovative strategies for providing its residents with access to high quality, affordable health coverage. CMS is using section 1332 waivers to help states who want to pursue solutions to help lower costs and increase coverage choices for Americans struggling with unaffordable premiums and reduced competition in the insurance market, brought on by the *PPACA*. CMS also published a checklist to provide guidance to states as they develop and complete applications for section 1332 waivers, including high risk pools/ state-operated reinsurance programs. Under a section 1332 waiver, a state may receive pass-through funding associated with the resulting reductions in federal spending to use towards the state program. Thus far, seven states have received section 1332 waivers.

Medicaid and CHIP State Plan Amendments

CMS approved the first state plan amendment proposal to allow the State of Oklahoma to negotiate supplemental rebate agreements involving value-based purchasing arrangements with drug manufacturers. These agreements could produce extra rebates for the state if clinical outcomes are not achieved. The state plan amendment proposal submitted by Oklahoma permits the state to enter into tailored agreements with manufacturers on a voluntary basis. The state and each manufacturer can now jointly agree on benchmarks based on health outcomes and the specific populations for which these outcomes-based benchmarks will be measured and the evaluated.

Transformed-Medicaid Statistical Information System (T-MSIS)

For several years CMS has worked to transfer the Medicaid and CHIP data enterprise to ensure proper oversight and financial management of the programs. As of June 2018, CMS completed implementation of the Transformed-Medicaid Statistical Information System (T-MSIS) with 50 states, the District of Columbia, and Puerto Rico submitting information, representing nearly all of the Medicaid and CHIP population. T-MSIS modernizes and enhances the way states submit operational data about beneficiaries, providers, health plans, claims, and encounters. This data is currently available for various key internal stakeholders and will be publicly available in the future to provide state profiles and analytic files for public researchers. CMS will also continue working with all states to assess and improve T-MSIS state data quality to support national and state level program analysis with timely, accurate, and complete data for policymaking and research.

Connecting Kids to Coverage Outreach and Enrollment Grants and National Campaign

CMS has made available $162 million in awards to states, providers, and community-based organizations to design locally-tailored initiatives to identify and enroll uninsured children in Medicaid and CHIP. Funds also support efforts to retain eligible children enrolled in these programs. CMS is currently funding 39 grantees with awards totaling up to $32 million. CMS will be releasing a new Notice of Funding Opportunity announcement in the coming months to continue this support to local organizations, providers, states, and other eligible entities by providing up to $48 million in new awards. In addition, CMS also operates Connecting Kids to Coverage National Campaign which provides outreach training and support for grantees and other national and local partners who are working to help enroll eligible children in Medicaid and CHIP at the local level. To support the efforts of local partner organizations, the Campaign conducts outreach and enrollment training webinars, customizable print materials, social media graphics, and other resources.

Section 1115 Demonstrations – Opioid/ Substance Use Disorders

CMS issued a new policy on State Medicaid Director Letter (SMDL) on November 1, 2017 to support section 1115(a) demonstration projects that increase access to treatment for opioid use disorder (OUD) and other substance use disorders (SUD). This new policy offers a more flexible, streamlined approach to accelerate states' ability to respond to the national opioid crisis while enhancing states' monitoring and reporting of the impact of any changes implemented through these demonstrations. Under this updated policy, states are able to pay for a fuller continuum of care to treat SUD, including critical treatment in residential treatment facilities that Medicaid is unable to pay for without a section 1115 demonstration. The new policy will also encourage states to strengthen quality of care assurances. In addition, through enhanced reporting and evaluation requirements, this initiative will increase our understanding of what treatment delivery methods are the most effective in addressing our nation's opioid crisis. As of July

31, 2018, CMS approved 10 substance use disorder demonstrations under the new SMDL. CMS is also piloting new monitoring and evaluation tools under these priority policy areas to strengthen accountability to states.

State Innovation Models Initiative

The State Innovation Models (SIM) provided almost one billion dollars in funding to 34 states, three territories and the District of Columbia (representing over 60 percent of the U.S. population) to test the ability of state governments to use their policy and regulatory levers to accelerate health care payment and delivery system transformation. Through two rounds of SIM, states have designed and implemented models with the goal of improving health system performance, increasing quality of care and decreasing costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries- and for all residents of participating states.

Accountable Health Communities Model

The Accountable Health Communities Model has funded 32 cooperative agreements with local and community-based entities and organizations such as county governments, hospitals, universities, and health departments, among others, representing rural and urban communities across 193 counties in 23 states. With the Accountable Health Communities Model, CMS is testing whether increased awareness and access to services addressing health-related social needs will impact total health care costs and improve health and quality of care for Medicare and Medicaid beneficiaries in targeted communities by empowering local leaders to strengthen the links between clinical and community-based resources.

Maryland Total Cost of Care Model

CMS and the State of Maryland are partnering to test the Maryland Total Cost of Care (TCOC) Model, the first model that holds a state fully at risk for the total cost of care for Medicare beneficiaries. The TCOC Model builds on the Maryland All-Payer Model, which set a limit on per capita hospital expenditures in the state. The Maryland TCOC Model creates new opportunities for a range of non-hospital health care providers to participate in this test to limit Medicare spending across an entire state, and it sets Maryland on course to save Medicare over $1 billion by the end of 2023.

Medicare-Medicaid Financial Alignment Initiative

Through the Medicare-Medicaid Financial Alignment Initiative and related work, CMS is partnering with 11 states to test models of integrating primary, acute, and behavioral health care and long-term services and support for individuals dually eligible for Medicare and Medicaid. The Financial Alignment Initiative includes a capitated model and a managed fee-for-service model. Although the approaches differ in each demonstration, beneficiaries in every version of the model receive their full array of Medicare and Medicaid benefits, with added care coordination, beneficiary protections, and access to additional or enhanced services.

Medicaid Integrity Institute

As part of our efforts to increase state flexibility and local leadership, CMS is focused on developing methods to better quantify the effectiveness of program integrity activities and improving dissemination of state program integrity promising practices. In FY 2018, Medicaid Integrity Institute (MII) course development continues to emphasize content that is responsive to state program integrity needs, highlights emerging trends and strategies, and features states' effective practices. CMS supports states in their efforts to combat Medicaid provider fraud, waste, and abuse. MII includes functionally-diverse state Medicaid-related participants to encourage cross-functional partnerships that will achieve program integrity outcomes. In the spring of 2018, CMS held educational webinars for Medicaid state program integrity personnel, featuring topics like prior authorization, and third party liability. CMS also established voluntary state technical assistance and data compare services to provide more resources to states who want to rely on CMS data and information.

Supporting Innovative Approaches to Improving Quality, Accessibility, and Affordability

CMS uses data-driven insight to develop new ways to provide cost-effective care that improves patient outcomes. There are countless opportunities at CMS to support and drive innovation and enhance our technology to prevent fraud, waste and abuse. Some of CMS's innovative initiatives are described below.

Improving Language Access

CMS released a "Guide to Developing a Language Access Plan," a tool that helps identify ways providers can assess their programs and develop language access plans to ensure persons with limited English proficiency have meaningful access to their programs. In addition, the guide provides background information on the legislation and regulations that cover meaningful access for individuals with limited English proficiency. The guide also provides information on the various types of language access services, easy-to-use instructions for conducting a needs assessment, and discusses key elements of a language access plan, such as notices, training, and evaluation.

Medicare Shared Savings Program – "Pathways to Success"

CMS issued a proposed rule in August 2018 which provided a new direction for the Medicare Shared Savings Program, also known as the Shared Savings Program and "Pathways to Success." Under this proposed rule, Accountable Care Organizations (ACOs) transition to two-sided models in which they may share in savings and are accountable for repaying shared losses. The proposed rule increases savings and mitigates losses for the trust funds, and increases program integrity, reduces gaming opportunities, and promotes regulatory flexibility and free-market principles. If finalized, the rule strengthens beneficiary engagement, ensures rigorous benchmarking, and improves the quality of care for patients, with an emphasis on combatting opioid addiction and expanding the use of interoperable electronic health record technology among ACO providers and suppliers. The proposed policies also provide additional tools and flexibilities for ACOs established by the *Bipartisan Budget Act of 2018*, specifically new beneficiary incentives, tele-health services, choice of beneficiary assignment and voluntary alignment refinements.

CMS Rural Health Strategy

CMS released the agency's first Rural Health Strategy, which is intended to provide a proactive approach on health care issues and to ensure that individuals who live in rural America have access to high quality, affordable health care. The strategy was developed based on feedback obtained during listening sessions held across rural America. The Rural Health Strategy includes five objectives that seek to apply a rural lens to the agency's work, and to leverage existing partnerships to achieve the goals of the Rural Health Strategy.

State Data Resource Center

The State Data Resource Center (SDRC) provides assistance to states on using and accessing Medicare data, along with hosting webinars and bi-monthly Medicare Data Workgroup calls. To date, 47 states plus the District of Columbia have contacted CMS to obtain Medicare Parts A, B, and D data to support care coordination, program integrity, and quality measures for individuals dually eligible for Medicare and Medicaid. In FY 2018, 45 states plus the District of Columbia participated in SDRC programs and 28 states plus the District of Columbia are actively receiving data.

Integrated Care Resource Center

The Integrated Care Resource Center (ICRC) serves as a technical resource center for states that are interested in integrating services and financing for individuals dually eligible for Medicare and Medicaid. ICRC assists states with program design, stakeholder engagement, data analysis, and other functions. The ICRC worked with 45 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, through direct technical assistance, small group learning events, and national webinars to facilitate the sharing of best practices. These resources are available to all states.

Comprehensive Primary Care Plus Model

Comprehensive Primary Care Plus Model (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the U.S. There are 2,900 primary care practices currently participating and 61 aligned payer partners in 18 regions. When designing the CPC+, CMS built upon the lessons learned from participants and stakeholders involved in the Comprehensive Primary Care initiative and feedback from the 2015 request for information on Advanced Primary Care Initiatives. While developing CPC+, CMS also conducted structured interviews with over 15 payment policy and primary care delivery experts, including representatives from academia, national and local payers, think tanks, and physician organizations.

Bundled Payments for Care Improvement Advanced

Payment models that provide a single bundled payment to health care providers can motivate health care providers to furnish services efficiently, to better coordinate care, and to improve the quality of care. The Bundled Payments for Care Improvement Advanced

(BPCI Advanced) model is testing a new iteration of bundled payments for 32 Clinical Episodes and is aiming to align incentives among participating health care providers for reducing expenditures and improving quality of care for Medicare beneficiaries. Health care providers receiving a bundled payment may either realize a gain or loss, based on how successfully they manage resources and total costs throughout each episode of care. A bundled payment also creates an incentive for providers and suppliers to coordinate and deliver care more efficiently because a single bundled payment will often cover services furnished by various health care providers in multiple care delivery settings.

Medicaid Innovation Accelerator Program

The Medicaid Innovation Accelerator Program (IAP) continues to work with Medicaid State Agencies by providing targeted technical assistance to support states' ongoing delivery system reform efforts. To date, IAP has reached all 50 states and the District of Columbia through national webinars. Through direct technical support, IAP has worked with 40 states, the District of Columbia, and three territories.[1] During 2018, IAP continued to provide direct technical support to state Medicaid agencies related to its program and functional priority areas: (1) promoting community integration through long-term services and supports, including building State Medicaid-Housing Agency Partnerships; (2) reducing substance use disorders, (3) analyzing data, and (4) designing and implementing value-based payments broadly and for home and community-based services, maternal and infant health services, and children's oral health. In addition, IAP is developing technical resources for state Medicaid agencies that can be used to support their reform goals. Examples of these technical resources include, T-MSIS based data analytic tools, a resource document that outlines how states can use their Medicaid data to identify adults with serious mental illness; and a tool to help states design medication assisted treatment payment rates.

Section 1115 Demonstrations – Budget Neutrality

CMS recently released a Budget Neutrality (BN) State Medicaid Director's Letter (SMDL). The SMDL describes and formalizes current approaches to the calculation of budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Social Security Act. BN is a required component for the 1115(a) demonstration approval to strengthen the integrity of BN reviews. CMS is also preparing to release a budget neutrality workbook and will track the receipt and review of these workbooks which are due on a quarterly basis from states with 1115 demonstrations in the Medicaid 1115 IT system, Performance Metrics Database and Analytics.

National Quality Measurement Programs

As part of our national quality measurement programs for Medicaid and CHIP, CMS is working with state agency and federal partners to promote uniform reporting of quality measures across all Medicaid and CHIP programs. CMS has identified core sets of health care access and quality measures to assess the quality of health care provided to children and adults enrolled in Medicaid and CHIP. The goals of this effort are to encourage reporting by states on a uniform set of measures and support states in using these measures to drive quality improvement in the health care provided to the children and adults enrolled in Medicaid and CHIP. Improving quality measure reporting will give states the information they need to focus efforts and develop initiatives tailored to their populations. With better data, states develop a better understanding of their beneficiaries' health and can determine how best to design and implement population health improvement initiatives at the state level.

Using Data for Quality Improvement

CMS is helping state Medicaid and CHIP agencies engage in innovative approaches to improving quality, accessibility, and affordability to their programs. Through the Adult and Child Core Set measures programs, CMS helps states identify their strengths in care delivery and health outcomes based on reporting performance, as well as those areas of particular challenge. Using these data-driven insights, CMS assists states in their quality improvement efforts through one-on-one technical assistance. CMS offered states capacity building trainings to learn quality improvement techniques while engaging in a state-specific quality improvement activity. Additionally, CMS supports state sharing and diffusion activities to promote successful state initiatives that result in improved performance.

Health Improvement Initiatives

CMS has Medicaid and CHIP health improvement initiatives in several specific areas, including maternal and infant health, oral health, and prevention.

1 A list of states that participate in IAP's direct technical support opportunities are on each program and functional area webpage on the Medicaid IAP website here: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/index.html

Maternal and Infant Health

Medicaid covers nearly 50 percent of U.S. births.[2] Medicaid coverage helps keep pregnant women healthy and ensures that infants get a good start in life. The Maternal and Infant Health Initiative (MIHI) is a collaboration between CMS, states, and providers. MIHI builds on strategies identified by maternal and infant health experts and other stakeholders to drive improvements in maternal health and birth outcomes through improving the care provided postpartum and between pregnancies. Twenty nine states have participated in MIHI activities to date. The initiative is comprised of four key components: (1) Collaborating with states to improve access to quality health care for women of reproductive age, (2) Strengthening technical assistance to promote policies that enhance provider service delivery, (3) Expanding beneficiary engagement in their care through enhanced outreach, and (4) Partnering with other federal agencies, including the Centers for Disease Control and Prevention, Office of Population Affairs, and the Health Resources and Services Administration. MIHI activities include convening an Action Learning Series to help states test changes designed to improve the visit rate and content of postpartum care among Medicaid and CHIP enrollees; developing state capacity to link state Medicaid claims, vital records, and other data in order to monitor key maternal and infant health indicators; MIHI provides support to states for the collection and reporting of data on access to effective methods of contraception to measure progress on the second goal of the MIHI. The effort also provides technical support to five state Medicaid agencies to select, design, and test value-based payment approaches to sustain local care delivery models that demonstrate improvement in maternal and infant health outcomes.

Oral Health

Tooth decay continues to be one of the most prevalent chronic diseases of childhood, despite the abundance of scientific evidence demonstrating that it can be prevented. CMS is committed to improving access to dental and oral health services for children enrolled in Medicaid and CHIP. Together, CMS and states have made considerable progress in this area as the percentage of Medicaid-enrolled children ages 1-20 who receive preventive dental care continues to increase nationwide.[3] To ensure continued progress, we are working closely with states through our Oral Health Initiative 2.0, through which we identify opportunities across CMS to engage with states through existing levers such as section 1115 demonstration renewals and State Plan Amendment review and approval, and providing technical support to promote oral health's importance within broader Medicaid and CHIP program objectives.

We are also supporting three state Medicaid agencies to pilot value-based payment initiatives in oral health through CMS's Medicaid IAP, including developing and scaling up financial strategies to support local programs to reduce the need for young children to receive dental care in hospital operating rooms, by providing targeted, intensive preventive care.

Prevention

CMS's Medicaid Prevention Learning Network provides individualized technical assistance and encourages state-to-state learning to assist states improve the quality of, access to, and utilization of preventive services. As part of this initiative, CMS has held several affinity groups focusing on specific prevention areas or system delivery models, including school-based health services, tobacco cessation, diabetes prevention and management, and human immunodeficiency virus (HIV) care. Each affinity group provides states with a forum to discuss their successes and challenges, and to learn from peers, other stakeholders, and experts in these critical topic areas identified by states. The groups focus on sharing examples of innovative approaches to improving quality of care, access and affordability.

Improving Medicare Post-Acute Care Transformation Act of 2014

CMS continues its work in meeting the requirements of the Improving *Medicare Post-Acute Care Transformation Act of 2014* (IMPACT Act). The IMPACT Act requires CMS to modify the post-acute care patient assessment data. Post-acute care providers will submit standardized

2 https://www.medicaid.gov/medicaid/quality-of-care/downloads/secretarys-report-perinatal-excerpt.pdf

3 CMS-416 Annual Participation Report for FFY 2016, https://www.medicaid.gov/medicaid/benefits/downloads/epsdt/fy-2016-data.zip

data in specified categories that are comparable and exchangeable across providers. These efforts support the "collect once, use multiple times" mission to reduce reporting burden and improve patient care services and quality of care. Such standardized patient assessment data are intended to inform payment models based on patient characteristics rather than setting of care, as well as to enable post-acute care engagement in interoperable information exchange to foster safe care transitions. Further, such data is to be used to calculate measures that compare care across post- acute care providers on specific quality domains as required in the Act.

Quality Reporting Programs and Provider Performance

Hospice Quality Reporting programs, LTCH, IRF, HH and SNF also require providers to submit data on specified quality measures aimed at addressing both provider-specific and cross-setting quality issues and gaps. As with the Physician and Hospital programs, post-acute care quality reporting programs require that data on quality measures be made public to support consumer choice, as well as enable providers the opportunity to ensure high quality care. For all five post-acute care programs, CMS provides free and on-demand confidential reports to inform providers on data that they can use in real-time for their continuous improvement. A provider's annual payment update will be reduced by two percent if it fails to report the data as required.

Data Element Library

To further post-acute care engagement in data exchange, CMS implemented the CMS Data Element Library (DEL). The DEL is intended to serve as a free resource with the goal of fostering the adoption of electronic health records and information exchange in post-acute care. Within the DEL, discrete standardized patient assessment data elements are mapped to their associated national health information technology standards and vocabularies.

Improving the CMS Customer Experience

Transforming to a patient-first perspective is not just about who we serve, but how we serve all of our customers. We have a direct role in how effectively services are rendered to our internal and external customers, including our beneficiaries, providers, states, and stakeholders.

Patients over Paperwork

Through the "Patients over Paperwork" initiative, CMS established an internal process to evaluate and streamline regulations and sub-regulatory guidance with a goal to reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience. CMS is removing regulatory obstacles that hinder a provider's ability to spend time with patients. CMS will cut down on burden across Medicare by incorporating burden reduction policies in every Medicare FFS Payment Rule and related sub-regulatory instructions.

The CMS-wide Patients over Paperwork Initiative is all about reducing unnecessary administrative burden, allowing providers to spend more time providing quality care to beneficiaries. While largely a regulation and sub-regulation reform effort, CMS also reduces burden by increasing efficiencies and improving customer experience. Getting customer input is critical to this work. As part of this initiative, CMS issued Requests for Information (RFI) to solicit comments on burden reduction, flexibilities, and efficiencies through the annual rulemaking process for nine Medicare FFS payment rules. CMS identified 2,830 comment letters as containing RFI-relevant content/burden language. Comments were received from seven main stakeholder categories: Beneficiary/ Consumer Group, Clinician/Individual Provider, Institutional Provider, Government Entity, Health Plan, Supply Chain, and Other.

CMS also established customer-centered workgroups focusing on nursing homes, beneficiaries, clinicians and hospitals. These workgroups gather insights from clinical and administrative leaders and front-line staff through numerous interviews, listening sessions and in-person visits to provider facilities. We are using the workgroups to understand and learn from our customers' experience, internalize it, and remember their perspectives as we work on our reform efforts.

Provider Enrollment, Chain, and Ownership System

CMS is improving the Provider Enrollment, Chain, and Ownership System (PECOS) to be more intuitive and user-friendly. This effort reduces both provider and state burden by streamlining data entry and increasing access to information. CMS is redesigning the current system with a focus on improving operational efficiency, strengthening program integrity, and transitioning the system from a single-purpose product to an enterprise resource that is a platform for enrollments across Medicare, Medicaid, ACOs, and emerging provider programs.

New Medicare Cards

CMS began mailing new Medicare cards to beneficiaries in April 2018 and will meet the statutory deadline for replacing all Medicare cards by April 2019. The new Medicare cards will no longer contain a beneficiary's Social Security Number (SSN), but rather a unique, randomly-assigned number. CMS is taking this step to protect people with Medicare from fraudulent use of SSNs, which can lead to identity theft and illegal use of Medicare benefits. The new numbers will protect the identities of Medicare beneficiaries, reduce fraud, and offer better safeguards of important health and financial information.

Reducing Administrative Burden on Hospitals

CMS finalized a variety of changes to reduce the number of hours providers spend on paperwork so that hospitals can spend more time providing care to their patients while maintaining patient protections and program integrity. CMS finalized the following proposals to:

1. Remove the requirement that Part A certification statements detail where in the medical record the required information can be found;

2. Reduce the number of denied claims for clerical errors in documenting physician admission orders by removing the requirement that a written inpatient admission order be present in the medical record as a specific condition of Medicare Part A payment;

3. Provide more flexibility for new urban teaching hospitals to enter into Medicare Graduate Medical Education affiliation agreements, which will allow hospitals to share full time equivalent cap slots to accommodate the cross training of residents;

4. Reduce documentation requirements by allowing hospitals to use average hourly wage data from the current year's IPPS final rule, which is available on the CMS website. This would allow hospitals to demonstrate they are the only hospital in their Metropolitan Statistical Area for the purpose of meeting an exemption from certain wage index geographic reclassification requirements beginning in FY 2021;

5. Revise the regulations to allow certain hospitals which are excluded from the IPPS (for example, LTCHs) to operate IPPS-excluded units (so long as such an arrangement would be allowed under the applicable hospital conditions of participation); and

6. Revise the regulations for IPPS-excluded hospitals to allow that a satellite of a unit of the hospital would not have to comply with the separateness and control requirements, as long as the satellite of the unit is not co-located with an IPPS hospital.

Streamlining Evaluation and Management (E/M) Payment and Reducing Clinician Burden

CMS and the Office of the National Coordinator for Health Information Technology have heard from stakeholders that E/M coding documentation requirements have resulted in unintended consequences by making medical records a collection of predefined templates and boilerplate text for billing purposes. In many cases, stakeholders have said that E/M coding documentation reflects very little about the patients' actual medical care or story. To support efficient care and in response to stakeholder concerns, CMS has proposed changes that would help to free electronic health records to be powerful tools. This would give physicians more time to spend with their patients, especially those with complex needs, rather than on paperwork. Specifically, these proposed changes would simplify, streamline and offer flexibility in documentation requirements for certain E/M visits, which make up about 20 percent of allowed charges under the Physician Fee Schedule and consume much of clinicians' time. In addition, based on stakeholder input CMS is proposing to reduce unnecessary physician supervision of radiologist assistants for diagnostic tests; and remove burdensome and overly complex functional status reporting requirements for outpatient therapy.

Advancing Virtual Care

Getting to the doctor can be a challenge for some beneficiaries, whether they live in rural or urban areas. Using innovative technology that enables remote services would expand access to care and create opportunities for patients to access personalized care management, as well as connect with their physicians quickly. If finalized, provisions in the proposed 2019 Physician Fee Schedule would support access to care using telecommunications technology by paying clinicians for virtual check-ins; brief, non-face-to-face appointments via communications technology; paying clinicians for evaluation of patient-submitted photos; and expanding Medicare-covered tele-health services to include prolonged preventive services.

Fraud Prevention System

CMS launched the enhanced version of the Fraud Prevention System (FPS) 2.0, which modernized the

system and user interface, improving development time and performance measurement and expanding CMS's program integrity capabilities. CMS will continue to enhance FPS capabilities with better reporting, visualization (such as social networking and services rendered in proximity of beneficiary), and expanding the user base (e.g., MACs). FPS's range of benefits includes a more efficient and operational IT infrastructure, improved cost recovery from administrative actions, and improved prevention and detection of fraud, waste, and abuse in Medicare program spending.

2018 Health Insurance Exchange Open Enrollment Season

CMS introduced a new streamlined and simplified direct enrollment process for consumers signing up for individual market coverage through Exchanges that use HealthCare.gov. The direct enrollment process offers the consumer easier access to health care comparisons and shopping experiences for coverage offered through HealthCare.gov.

Compared to prior years, this year's open enrollment was the agency's most cost effective and successful experience for HealthCare.gov consumers to date. Nearly three quarters of consumers who enrolled through the Exchanges actively shopped for a policy versus letting their policy automatically renew. Among all consumers with a plan selection, 27 percent were new enrollees and 47 percent actively enrolled and returned to select a plan. These consumers were able to easily shop for and pick a plan with little interruption throughout the entire enrollment period. HealthCare.gov used only 22.5 hours of regular maintenance time, the lowest ever. Data from the Federal Health Insurance Exchange Call Center shows that the consumer satisfaction rate reached an all-time high of 90 percent, this is up from 85 percent last year.

Medicare Pharmaceutical and Technology Ombudsman

Stakeholder engagement and customer service are key to the success of the Medicare program. CMS has designated a new Ombudsman to help support customer service and innovation in the Medicare program. In collaboration with the other CMS ombudspersons, as well as subject-matter experts throughout the agency, the Medicare Pharmaceutical and Technology Ombudsman will help support customer service and innovation in the Medicare Program by receiving and looking into concerns and questions from manufacturers and other industry stakeholders, as well as by helping stakeholders navigate Medicare programs as needed. The Ombudsman hears feedback from stakeholders about their experiences and will share it with CMS policy makers, helping to promote transparency and predictability of the processes.

Transforming Clinical Practice Initiative

The Transforming Clinical Practice Initiative (TCPI) was designed to support and accelerate health care transformation by providing direct technical assistance and sharing of lessons learned with providers, states, and other external stakeholders and customers. More specifically, TCPI aims to support a collection of practices to become alternative payment models.

Preventing Improper Billing of Medicare Cost Sharing to Qualified Medicare Beneficiaries

By law, Medicare providers may not bill Qualified Medicare Beneficiaries (QMBs) for Medicare Parts A and B cost sharing amounts. CMS began implementing key changes aimed at empowering beneficiaries as well as providers and suppliers with information that will better facilitate provider and supplier adherence to QMB billing requirements and better inform beneficiaries of their obligations. Medicare providers and suppliers could begin to use CMS's HIPAA Eligibility Transaction System to verify a beneficiary's QMB status and exemption from cost sharing charges. The Medicare Summary Notice, the document sent to beneficiaries detailing their claims from the past quarter, identifies when a beneficiary is enrolled in the QMB program and accurately reflecting that the beneficiary's cost sharing is $0. Additionally, providers and suppliers who serve beneficiaries enrolled in Original Medicare are now able to readily identify beneficiaries' QMB status and billing prohibitions from the Medicare Provider Remittance Advice, the statement the MACs send to providers after processing their claims.

Medicaid State Plan Amendments and 1915 Waivers

To better serve our Medicaid and CHIP state partners, CMS initiated an effort to streamline the Medicaid and CHIP State Plan Amendments (SPA) and section 1915 waiver review and approval processes. In collaboration with states, we identified the issues impacting SPA and 1915 waiver processing and jointly developed a number of process improvement strategies. The improvements modify current processes to promote

greater accountability and efficiency, resulting in quicker and less burdensome adjudications for states. CMS also established a joint federal-state workgroup to inform this initiative and ensure that improving the customer experience remains at the forefront of this effort. The concerted effort by both states and CMS on process improvement and the implementation of the new strategies are beginning to result in more efficient and timely processing of SPA and 1915 waiver actions.

Post-Acute Care Quality Reporting Programs

CMS offers free, in-person training on the patient assessment instruments that post-acute care providers must use to submit data to CMS. We also provide free data-submission software for providers. CMS data submission software design process utilized a user-centered design approach and included interviewing facility staff to enhance the new system and the data needs of providers. Additionally, CMS ensures that there are substantial outreach and educational activities for these quality reporting programs. CMS has held several outreach events in the past year to reach numerous stakeholders, and we have grown our list serve outreach to subscribers to increase providers' and stakeholders' engagement and access to information updates. CMS ensures the development measures include opportunities for public input; 24/7 comment access is available through email and help desks, where we provide immediate responses. CMS's ongoing webinars on post-acute care quality reporting programs and our efforts to implement the IMPACT Act have resulted in evaluation ranking in the mid-80s to mid-90s.

Quality Payment Program

The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. Under the Quality Payment Program, eligible clinicians can participate via two tracks: Advanced Alternative Payment Models or the Merit-based Incentive Payment System.

Under the Quality Payment Program, CMS has worked to reduce administrative burden on clinicians by ensuring meaningful measurement occurs, and ensuring that clinicians have the time and ability to put their patients' needs and outcomes first. Additionally, as an agency priority, we are committed to furthering clinicians' access to all health information on their patients via interoperability. Through partnering with the United States Digital Services, we have developed the program policies and data submission feature

through a human-centered design approach to ensure that we are meeting the needs of users to successfully report with the least amount of burden possible.

Measures Management System

The Measures Management System (MMS) is a standardized system for developing and maintaining the quality measures used in its various initiatives and programs to ensure transparency for CMS stakeholders through the standardization of processes and engagement throughout the measure lifecycle. CMS continues to make stakeholder education and outreach a priority through public webinars (over 1,000 attendees), monthly newsletters distributed to 65,000+ subscribers, and additional resources on the redesigned MMS website. In November 2017, the MMS launched the CMS Measures Inventory Tool (CMIT) to showcase quality measures used throughout CMS quality programs from concept to implementation for stakeholders to easily access and query and the inventory has grown to 31 programs and 2200 measures. Through these efforts, CMS provides stakeholders with the opportunity and means to directly get involved in quality measurement across the agency. Since the site went live, the number of visitors is up almost 50 percent, and the amount of time people spend on the site and return to the site is also up almost 50 percent.

Program Integrity

CMS is committed to the prevention of fraud, waste, and abuse in its programs. CMS's program integrity strategy strikes an important balance by preventing and addressing potentially fraudulent and improper payments while reducing the administrative burden on legitimate providers and suppliers. CMS uses a multifaceted approach, including provider enrollment and screening standards, enforcement authorities, and advanced data analytics such as predictive modeling. More importantly, CMS is moving away from the "pay-and-chase" method of recovery after claims are paid by proactively preventing potentially fraudulent and improper payments before they are made. Program integrity efforts must put patients and access to care first.

OVERVIEW OF FINANCIAL DATA

Sound financial management is an integral part of CMS's efforts to deliver services and administer our programs. 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.

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 Officers 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 CMS management. 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, 2018 and 2017, 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 $467.3 billion. The bulk of these assets is in Investments totaling $303.3 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 of $135.7 billion, most of which is for Medicaid, CHIP, and Payments to Health Care trust funds. Liabilities of $123.5 billion consist primarily of the Entitlement Benefits Due and Payable of $99.1 billion. CMS's Net Position totals $343.8 billion and reflects primarily the Cumulative Results of Operations for the Medicare trust funds and the unexpended balances for Medicaid and CHIP.

Consolidated Statements of Net Cost

The Consolidated Statements of Net Cost present the actual net cost of CMS's operations by program for the years ended September 30, 2018 and 2017. The three major programs that CMS administers are: Medicare, Medicaid, and CHIP. The majority of CMS's expenses are in these programs. Both

Medicare and Medicaid program integrity, fraud and abuse funding are included under the HI trust fund. The costs related to the Program Management appropriation are cost-allocated to Medicare, Other Health and Medicaid. The net cost of operations under "Other Activities" include: State Grants and Demonstrations, Other Health, and Other. A Consolidating Statement of Net Cost is provided to show the Medicare funds as Dedicated Collection versus Other Fund components of net cost as additional information. In FY 2018, our total Net Cost of Operations was $1,009.1 billion encompassing program/activity costs of $1,107.1 billion and operating costs of $8.5 billion.

Consolidated Statements of Changes in Net Position

The Consolidated Statements of Changes in Net Position present the change in net position (i.e., difference between assets and liabilities) for the years ended September 30, 2018 and 2017. Changes in CMS's net position result from changes that occur within the Cumulative Results of Operations and Unexpended Appropriations. Funds From Dedicated Collections are shown in a separate column from Other Funds.

The bulk of the change pertains to Appropriations Used of $742.1 billion, which represents the Medicaid and CHIP appropriations, transfers from Payments to the Health Care Trust Funds to HI and SMI, and State Grants and Demonstrations and general fund-financed Program Management appropriations. 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 and Self Employment Contributions Act for the HI trust fund, and totaled $264.6 billion.

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, 2018 and 2017. An additional Schedule of Budgetary Resources is provided as Required Supplementary Information (RSI) to present budgetary information by program. 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 $1,591.3 billion. Obligations of $1,526.9 billion leave unobligated balances of $64.4 billion. Total outlays, net of collections, were $1,461.7 billion. When offset by $467 billion relating to collection of premiums and general fund transfers from the Payments to the Health Care Trust Funds, as well as refunds of MAC overpayments, the net outlays were $994.7 billion.

OVERVIEW OF SOCIAL INSURANCE DATA

Statement of Social Insurance

The Statement of Social Insurance (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 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 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

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) decreased from $(3.5) trillion, determined as of January 1, 2017, to $(4.7) trillion, determined as of January 1, 2018.

Including the combined HI and SMI trust fund assets increases the present value, as of January 1, 2018, the future cash flow for all current and future participants was $(4.4) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI trust fund assets, is $(11.6) 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 77 percent at the beginning of FY 2014 to 66 percent at the beginning of FY 2018.

TRUST FUND RATIO

Beginning of Fiscal Year [4]

	2014	2015	2016	2017	2018
HI	**77%**	**73%**	**67%**	**66%**	**66%**

4 Assets at the beginning of the year to expenditures during the year.

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 2018 Trustees Report indicate that the HI trust fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2018 Trustees Report, the HI trust fund ratio is estimated to decline steadily until the fund is depleted in calendar year 2026. Assets at the end of calendar year 2017 were $202 billion and are expected to decrease steadily until depleted in 2026.

Long-Term Financing

The short-range outlook for the HI trust fund has deteriorated compared to what was projected last year. The trust fund ratio declines until the fund is depleted in 2026, three years earlier than the date projected last year. HI financing is not projected to be sustainable over the long term with the projected tax rates and expenditure levels. Program cost is expected to exceed total income in all years. 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 91 percent in 2026 to 78 percent in 2042 and then to increase to about 85 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 3.1 in 2017 to about 2.1 by 2092. 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 $4.5 trillion, which is 0.8 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. For more information, please refer to the Required Supplementary Information: Social Insurance disclosures required by the Federal Accounting Standards Advisory Board.

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, the appropriation for Part D has generally been set such that amounts can be transferred to the Part D account on an as-needed basis; under this process, there is no need to maintain a contingency reserve. In September 2015, a new policy was implemented to transfer amounts from the Treasury into the account 5 business days before the benefit payments to the plans. As a result, the Trustees expect the Part D account to include a more substantial balance at the end of most months to reflect the new policy.

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 $(33.0) trillion.

Even though from a program perspective, the unfunded liability is $0, there is concern over the rapid increase in cost of the SMI program as a percent of GDP. In 2017, SMI expenditures were 2.1 percent of GDP. By 2092, SMI expenditures are projected to grow to 3.9 percent of the GDP.

The following table presents key amounts from our basic financial statements for fiscal year 2016 through 2018.

TABLE OF KEY MEASURES [5]

Dollars in billions

	2018	2017	2016
Net Position (end of fiscal year)			
Assets	**$467.3**	**$444.2**	**$446.0**
Less Total Liabilities	**$123.5**	**$137. 5**	**$137.3**
Net Position (assets net of liabilities)	**$343.8**	**$306.7**	**$308.7**
Costs (end of fiscal year)			
Net Costs	**$1,009.1**	**$963.3**	**$953.1**
Total Financing Sources	**$1,017.7**	**$984.6**	**$960.1**
Net Change in Cumulative Results of Operations	**$8.6**	**$21.3**	**$7.0**
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 (as of 1/1/2018)	**($4,708)**	**$(3,532)**	**$(3,822)**
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 (as of 1/1/2017)	**($3,532)**	**$(3,822)**	**$(3,187)**
Change in present value	**$(1,176)**	**$290**	**$(636)**

5 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.

STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS

The Statement of Changes in Social Insurance Amounts 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 cash flow represents a positive change (improving financing), while a decrease in the present value of net cash flow represents a negative change (worsening financing).

The present value as of January 1, 2018 decreased by $168 billion due to advancing the valuation date by one year and including the additional year 2092, by $921 billion due to changes in the projection base, and by $535 billion due to changes in legislation. However, the present value increased due to changes in demographic assumptions, and economic and health care assumptions, by $434 billion and $14 billion, respectively.

Required Supplementary Information

As required by Statement of Federal Financial Accounting Standards (SFFAS) 17, Accounting for Social Insurance (as amended by SFFAS 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 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

Limitations of the Financial Statements

The principal financial statements are prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. § 3515(b). The statements are prepared from the books and records of CMS in accordance with Federal General Accepted Accounting Principles and the formats prescribed by OMB. Reports used to monitor and control budgetary resources are prepared from the same books and records. The financial statements should be read with the realization that they are for a component of the U.S. Government.

FINANCIAL SECTION

A Message from the Chief Financial Officer //

Financial Statements // Notes to the Financial Statements //

Required Supplementary Information // Supplementary Information //

Audit Reports

A MESSAGE FROM THE CHIEF FINANCIAL OFFICER

JENNIFER MAIN

I am honored to present the fiscal year (FY) 2018 Centers for Medicare & Medicaid Services (CMS) Agency Financial Report (AFR), which marks the 20th consecutive year of receiving unmodified opinions on the audit of our annual financial statements. We provide reasonable assurance that the financial information contained in this AFR is complete, reliable and accurate. The auditors' issuance of an unmodified opinion on four of our six principal financial statements represents CMS's achievement of financial management excellence by demonstrating that our financial statements are fairly presented, our internal controls are operating effectively, and CMS's programs are fiscally sound. This 20 year milestone allows us to pause for reflection on these past achievements, while looking forward to continued dedication to the highest financial management standards.

Our auditors are still not able to express an opinion on the sustainability financial statements, which are comprised of the Statement of Social Insurance (SOSI) and the Statement of Changes in Social Insurance Amounts, due to the uncertainty in the long-range assumptions applied in our projection models. However, we remain confident that our SOSI projections are sound and have provided the necessary disclosures regarding the uncertainty around the projections presented in these statements. We remain committed to partnering with our auditors to create a strategy that will give them the ability to express an opinion on these statements in the future.

As good stewards of taxpayer dollars entrusted to us, our goals are to ensure the sustainability of our Medicare trust funds by providing transparency in our spending; increasing program savings; reducing improper payments; and preventing fraud, waste, and abuse. The achievement of these goals is paramount in ensuring the fiscal integrity of our programs.

During fiscal year 2018, CMS continued reporting standardized spending information on USASpending.gov in compliance with the Digital Accountability and Transparency Act (DATA Act) of 2014. This reporting provides consistency and complete transparency around how taxpayers' dollars are spent. CMS's administrative budget investment strategy has supported continued investments in high priority activities with a focus on high quality service

for our customers. This has allowed us to improve the experience providers, patients, caregivers, and the states have with CMS in a way that we can anticipate their needs to better serve them.

CMS remains steadfast in our commitment to reduce payment errors by focusing on identifying, reporting, and implementing actions to reduce payment error vulnerabilities. The agency is continually working to reduce its improper payments by making sure we are paying the right provider the right amount for services covered under our programs. As a result of implementing corrective actions to address improper payments, CMS achieved, for the first time in improper payment reporting history, reductions in all five of our high risk programs (Medicare Fee-For-Service (FFS), Medicare Advantage, Prescription Drug, Medicaid, and the Children's Health Insurance Program). This year CMS is also reporting the lowest Medicare FFS improper payment rate since 2010.

CMS is dedicated to modernizing our programs and strengthening the integrity and sustainability of Medicare and Medicaid by investing in activities to prevent fraud, waste, and abuse. With the launch of the enhanced Fraud Prevention System, CMS has improved the prevention and detection of fraud, waste, and abuse in Medicare program spending. The resources we have expended fighting fraud, waste, and abuse in the last three years have proven to be an excellent investment of our resources, as CMS recovers more than $4 for every $1 spent on health care-related fraud and abuse investigations. In June 2018, HHS/CMS, in partnership with various law enforcement agencies across the government, announced the largest ever health care fraud enforcement action involving approximately $2 billion in false billings.

As we head into FY 2019, I want to thank the entire CMS community for their excellent work and dedication in achieving financial management excellence. We look forward to continuing our important work in strengthening and modernizing the nation's health care system.

JENNIFER MAIN
CMS CHIEF FINANCIAL OFFICER
NOVEMBER 2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

NOV - 6 2018

TO: Seema Verma, M.P.H.
Administrator
Centers for Medicare & Medicaid Services

FROM: Gloria L. Jarmon
Deputy Inspector General for Audit Services

SUBJECT: Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2018 (A-17-18-53000)

This memorandum transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2018 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, 2018 and 2017, 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, 2018, 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 19-01, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Ernst & Young found that the FY 2018 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. Ernst & Young was unable to obtain sufficient audit evidence for the particular amounts presented in the statements of social insurance as of January 1, 2018, 2017, 2016, 2015, and 2014, and the related statements of changes in social insurance amounts for the periods ended January 1, 2018 and 2017. As a result, 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*, Ernst & Young identified significant deficiencies in CMS's financial reporting processes and information systems controls:

- *Financial Reporting Processes*—Ernst & Young noted that CMS continues its efforts to enhance internal controls as part of the financial reporting processes. Weaknesses in oversight of the Medicaid program included the development of robust analytical procedures and the establishment of benchmarks to monitor and identify risks associated with the Medicaid program, and the development of a process to perform a detailed claims-level look-back analysis related to the Entitlement Benefits Due and Payable accrual to determine the reasonableness of the various State calculations of the incurred but not reported liability.

  EY also identified weaknesses in the following processes: two formula errors in the spreadsheets that are used in the preparation of the statement of social insurance, one of which was significant, and the recording of Medicare Administrative Contractor (MAC) account balances using a manually prepared journal voucher. The recording of MAC account balances should be configured as a routine, systemic set of entries to properly categorize the information within the financial statements. These deficiencies collectively represent a significant deficiency in internal control.

- *Information Systems Controls*—Ernst & Young noted that deficiencies continue to be identified in implementing and monitoring access controls and segregation of duties with CMS's information systems. CMS continues to encounter challenges in monitoring its own and its contractor's adherence to CMS's established information systems control standards and processes. 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 Medicaid program did not meet its error rate target (7.93 percent) because the reported error rate was 9.79 percent. CHIP reported an error rate of 8.57 percent, which did not meet its targeted reduction rate of 8.20 percent for FY 2018. In addition, CMS was not in compliance with section 6411 of the Affordable Care Act because 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 19-01.

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," "Required Supplementary Information," "Supplementary Information," and "Other 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 Carrie A. Hug, Assistant Inspector General for Audit Services, at (202) 619-3972 or through e-mail at Carrie.Hug@oig.hhs.gov. Please refer to report number A-17-18-53000.

Attachment

cc:
Jennifer Moughalian
Acting Assistant Secretary for Financial Resources
and Acting Chief Financial Officer

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

Jennifer Main
Director Office of Financial Management
and Chief Financial Officer

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Report of Independent Auditors

The Administrator and Chief Financial Officer
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, 2018 and 2017, 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 also engaged to audit the sustainability financial statements, which comprise the statements of social insurance as of January 1, 2018, 2017, 2016, 2015, and 2014, the related statements of changes in social insurance amounts for the periods ended January 1, 2018 and 2017, and the related notes to the sustainability 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, 2018, 2017, 2016, 2015, and 2014, the related statements of changes in social insurance amounts for the periods ended January 1, 2018 and 2017, 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 (OMB) Bulletin No. 19-01, *Audit Requirements for Federal Financial Statements*. Those standards and OMB Bulletin No. 19-01 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, 2018 and 2017, 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 12 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. The sustainability financial statements are intended to aid users in assessing whether future resources will likely be sufficient to sustain public services and to meet obligations as they come due. The statements of social insurance and changes in social insurance amounts are based on income and benefit formulas in current law and assume that scheduled benefits will continue after any related trust funds are exhausted. The sustainability financial statements are not forecasts or predictions. The sustainability financial statements are not intended to imply that current policy or law is sustainable. 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

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the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA).

As further described in Note 13 to the financial statements, with respect to the estimates for the social insurance program presented as of January 1, 2018, 2017, 2016, 2015, and 2014, 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 13, 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 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 a change in the health care delivery system or level of update by subsequent legislation, beneficiaries' access to Medicare-participating providers and quality care may become significant issues in the long term under current law. Overriding the price updates in current law, as lawmakers repeatedly did 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. 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, 2018, 2017, 2016, 2015, and 2014, and the related statements of changes in social insurance amounts for the periods ended January 1, 2018 and 2017.

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, 2018, 2017, 2016, 2015, and 2014, and the related changes in the social insurance program for the periods ended January 1, 2018 and 2017.

Opinion

In our opinion, the consolidated balance sheets, consolidated statements of net cost and changes in net position, and combined statements of budgetary resources referred to above present fairly, in all material respects, the financial position of CMS as of September 30, 2018 and 2017, 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.

Other Matters

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.

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Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 6, 2018, on our consideration of CMS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of those reports is solely 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 effectiveness of CMS' 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 6, 2018

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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
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. 19-01, *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, 2018 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, 2018, and the related statement of changes in social insurance amounts for the period ended January 1, 2018, and have issued our report thereon dated November 6, 2018. 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, 2018 and the related statement of changes in social insurance amounts for the period ended January 1, 2018.

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, contracts and grant agreements, 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. 19-01. 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 disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 19-01, 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 2012 (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 improper payment error rates for each of its high-risk programs, or components of such programs, it is not in full compliance with the Acts. While the Medicaid and CHIP error rates were less than the statutorily required maximum of 10 percent, the Medicaid and CHIP programs did not meet their one year target reduction rate. In addition, CMS was not in full compliance with Section 6411 of the Affordable Care Act as CMS had not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in their letter dated November 6, 2018. 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 6, 2018

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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
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 statement audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 19-01, *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, 2018 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, 2018, and the related statement of changes in social insurance amounts for the period ended January 1, 2018, and have issued our report thereon dated November 6, 2018. 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, 2018 and the related statement of changes in social insurance amounts for the period ended January 1, 2018.

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 CMS' internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 19-01. 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.

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

As CMS continues its efforts to enhance internal controls, the following areas identified in the current year audit merit continued focus as part of the financial reporting processes significant deficiency.

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.

As of June 2018, CMS completed implementation of the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS modernizes and enhances the way states submit operational data about beneficiaries, providers, health plans, claims and encounters. Although operational data is currently available, CMS must continue to work with states to assess and improve T-MSIS state data quality to support national and state level program analysis with timely, accurate, and complete data for policymaking and research. At this time the information contained within T-MSIS requires additional verification before it would be considered reliable. CMS should continue to enhance the usefulness of T-MSIS data so they will be able to perform robust analytical procedures and develop benchmarks to monitor and identify risks associated with the Medicaid program. Examples of risks to monitor could include outliers and unusual or unexpected results that demonstrate abnormalities in state-related Medicaid expenditures and/or allow CMS to assess the reliability of the T-MSIS data. Given that CMS does not currently maintain reliable historical claims level detail for Medicaid, data analyses have been limited. At this time, CMS is unable to perform a claims-level detailed look-back analysis for the Medicaid Entitlement Benefits Due and Payable (EBDP) to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability. The Medicaid EBDP is a significant liability on the FY 2018 financial statements and is subject to volatility based on the complexity and judgement required in establishing this estimate. From time to time, claim processing cycle changes, such as a claims inventory buildup, may arise. As such, the lack of detailed claims data limits the ability to detect this type of situation on a timely basis or consider the potential volatility from this occurrence. With the implementation of T-MSIS, CMS now has access to data on which to base a claims-level detailed look-back analysis for Medicaid EBDP; however CMS must continue to evaluate and improve the quality and completeness of data reported by the states in T-MSIS. Until further analysis is developed and performed to verify the reliability of T-MSIS data, there remains a risk that potential updates to CMS' analysis will not be reflected in CMS' financial statements in a timely manner.

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Oversight of Third-Party Contractors

CMS relies heavily on third-party contractors as it outsources substantially all of 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. The contracts between CMS and its Medicare Fee-for-Service contractors include provisions that require the Medicare Administrative Contractors (MACs) to develop policies and procedures that satisfy the 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. The MACs' account balances are recorded at Central Office through the manual journal voucher process and should be configured as routine systematic entries within the system to properly categorize the information within the financial statements and reduce risk of manual error, as required by OMB Circular A-136, *Financial Reporting Requirements*.

Statements of Social Insurance

The Statements of Social Insurance (SOSI) for CMS presents a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from, or on behalf of, those same individuals. The SOSI models are complex, 75-year projections that contain a high degree of estimation. The models and their results are heavily reviewed by actuaries and others within CMS. The veracity of the underlying data remains critical to the accuracy of the model, and as a result the reviews of the underlying data is robust, in line with CMS' policies and procedures. As part of this review, the input into the spreadsheet is checked against the original data sources to ensure that no input errors have been made. In addition, output data, including those that are generated from updating and running any macro in the spreadsheet, are checked by the reviewer. These checks include a comparison to the results from the year before, and testing of the formulas that are part of the spreadsheet or macro, to ensure that the projection output from the program is as expected and reasonable. During our procedures, two formula errors were identified, one of which was significant, that were not detected by the organization's monitoring and review function, and accordingly, the related control was not functioning as designed.

Improper Payments

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 improper payment error rates in the

high-risk CMS programs of Medicare Fee-for-Service (FFS), Medicare Advantage, Medicare Prescription Drugs, Medicaid and CHIP.

CMS builds in time to their processes 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 improper payment 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. Allowing the maximum amount of time for this development causes the processes to be completed very near the required annual reporting deadline. During the current year, CMS made improvements to the process with the overall goal of reducing the improper payment error rates, which resulted in declines in the Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, and CHIP rates. CMS continues to further explore additional opportunities to continue to reduce improper payments.

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:

- Continue to enhance the data analyses on Medicaid claims level data to develop robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the Medicaid program.

- 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 $34.1 billion accrual.

- Consider whether there are portions of the manual journal voucher process to record MAC data at Central Office that should be configured as routine systematic entries within the system.

- Continue to adhere to established policies and procedures to ensure that the SOSI model methodology and related calculation and estimates are reviewed at a level of sufficient precision.

- Consider additional opportunities to further reduce improper payments which are consistent with the organization's objectives of improving payment accuracy levels.

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.

To manage the operational and financial risk presented by these information systems, CMS established a formal monitoring process of their contractors that is detailed in their 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 Medicare Fee-for-Service (FFS) shared systems and CMS Central Office systems that affect Medicare FFS, Medicare Advantage, Medicare Prescription Drug, Medicaid and CHIP programs and also are incorporated by reference in CMS' agreements with its contractors. The contractors supporting the administration of the Medicare FFS computerized systems and related beneficiary, provider, payment and financial management data processes include, but are not limited to, MACs, Single Testing Contractor (STC), Shared Systems Maintainers (SSMs) and Virtual Data Centers (VDCs).

For the Medicare FFS shared systems, CMS has contracted with SSMs to provide application software development, documentation, testing and training support for the majority of the systems used to process Medicare FFS 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 FFS 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 and oversees the change initiation and provides final release approval for the updates to the shared systems. Integration testing is performed in the testing environment 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 production environment of the shared systems for the individual MACs mostly through the quarterly release process.

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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 continues to encounter challenges to monitor their own and contractors' adherence to their established information systems control standards and processes. For example, most of CMS' business functions, including the operation of computer systems and configuration management, are performed by contractors. In many cases, the implementation of the information systems security standards is dependent upon a contractor's interpretation and implementation of CMS security and configuration management policies. Further, the oversight of the information systems control standards and processes is performed by multiple business units within the CMS Central Office, such as the Office of Information Technology (OIT), Office of Financial Management (OFM), and the Center for Medicare (CM). The multiple business units involved in oversight activities heighten CMS' inability to enforce enterprise-wide risk management strategy, and overall integrity of its Medicare systems and other enterprise-wide systems.

Deficiencies continued to be identified, similar to previous years, in the contractors' implementation and CMS' monitoring of compliance with CMS' information systems control standards and processes which included:

- CMS' risk management strategy is decentralized and lacks an enterprise viewpoint, which has resulted in several control deficiencies in areas where business units share responsibility for oversight. Governance challenges were identified for shared system configuration management, integration of access control software systems for Central Office systems, and monitoring of direct data access at one VDC. Further, risk management procedures have not been adequately tailored to manage specific risks based on the role of critical IT systems within the CMS environment.

- Several vulnerabilities related to system configurations were identified with the Central Office information systems. The remediation, mitigation of risks, or monitoring of these vulnerabilities was not performed or not performed timely.

- Central Office and Medicare FFS contractors' information security and configuration management-related findings identified by internal and external audits remained unresolved during the fiscal year. This includes the findings that sufficient security controls have not been implemented to ensure the resiliency of Medicare enrollment data.

- CMS' process requiring interconnection security agreements (ISAs) to establish the security requirements for the integration of its information systems for its major applications has not been followed consistently to include all of the standard content.

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Without the sufficient and consistent oversight by CMS Central Office to monitor and enforce compliance with its established information security and configuration management policies and procedures including IT operational controls such as contingency and disaster recovery planning, and heightened attention to remediating all deficiencies, Medicare systems and other enterprise-wide systems may be susceptible to error, fraud, and/or security vulnerabilities that may impact claims processing, financial reporting and ultimately on-going operation of IT systems supporting the CMS business processes.

Controls over System Access and Segregation of Duties

CMS has a large number of users required to have access to CMS systems to process claims and to support beneficiaries in a timely and effective manner. As such, properly implemented system access controls including user and system account management, monitoring of system access, and appropriate segregation of duties are critical to preventing and detecting unauthorized usage of CMS information resources, including program and data files. Without maintaining an appropriate level of access controls and segregation of duties within CMS systems, the integrity of CMS' information resources could be compromised.

Deficiencies continued to be identified in the implementation and monitoring of access controls as well as segregation of duties with CMS information systems which included:

- Procedures for the removal of users who no longer required access were not consistently followed.
- Integration of user populations in the CMS enterprise identity management system and key financial systems and infrastructure components was not complete.
- Oversight of periodic access reviews for key applications and system parameters were not performed as required or not adequately performed.
- Segregation of duty requirements for those users conducting user access reviews and privileged application functions were not consistently implemented.
- Monitoring of privileged access for key applications and underlying IT infrastructure was not performed or evidence of such monitoring activity was not retained.

Appropriate consideration of the design of controls over access, monitoring of access, and segregating access with incompatible duties is essential to provide a suitable framework for subsequent implementation and operation of the controls. Without adequate controls over managing access to critical systems and segregation of duties, the risk of errors, fraud or other illegal acts is increased.

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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 IT systems and data at both the Central Office and the CMS Medicare FFS contractors. Such an approach will require continued and active communication and integration of efforts by the OFM, OIT and CM.

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

- Enhanced risk management policies, procedures, and practices that focus on the role of the IT system within the enterprise and a clear definition of responsibilities associated with the oversight and implementation of controls to address identified risks.
- Continued implementation of configuration and vulnerability management activities at the Central Office and Medicare FFS contractors in accordance with CMS' policies and guidance.
- Maintain a complete and current inventory of interfaces and consistently complete system interconnection documents for all of CMS' significant systems.
- Remediation of findings identified in audits and tests performed on CMS and its Medicare contractors' IT operations.

Specific to the implementation of access controls and segregation of duties, we recommend that CMS ensure that:

- Relevant CMS guidance is followed for the removal of users to all systems.
- Access to all systems is periodically assessed such that access remains appropriate and is aligned with the identity management systems.
- Privileged access for key applications and the underlying IT infrastructure is monitored to detect and correct unauthorized access or activities, and evidence of such monitoring activities is retained.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in the accompanying letter dated November 6, 2018. 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 effectiveness of 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 6, 2018

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

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

Dear Sir:

We would like to thank your office for the professional and cooperative manner in which your staff conducted the audit of the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2018 annual financial statements. We are pleased to receive an unmodified audit opinion on our annual financial statements: Consolidated Balance Sheet, Consolidated Statements of Net Cost and Changes in Net Position, and the Combined Statement of Budgetary Resources for the 20th consecutive year.

As in previous years, you were not able to express an opinion on the sustainability financial statements, the Statement of Social Insurance (SOSI) and the Statement of Changes in Social Insurance Amounts (SCSIA). Although CMS remains confident that our SOSI model projections are fairly presented in accordance with current law, we are fully committed to partnering with you to find a solution to report the SOSI projections that will support your ability to opine on these statements in future.

The audit also identified no material weaknesses in our internal controls; however, significant deficiencies were noted in our financial reporting processes and information systems controls. CMS has already begun remediation efforts to resolve the weaknesses identified. CMS recognizes that the complexity of our programs can be challenging and may require multi-year efforts to remediate those issues. In the coming months, CMS looks forward to working with you to implement many of the recommendations noted in your audit report.

Once again, I thank your auditors for the efficiency and ease at which your staff completed the audit and commend your team's professionalism displayed throughout the entire audit process.

Sincerely,

Jennifer Main
Chief Financial Officer
November 6, 2018

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CONSOLIDATED BALANCE SHEETS

as of September 30, 2018 and September 30, 2017

(in millions)

	FY 2018 Consolidated Totals	FY 2017 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury *(Note 2)*	$135,672	$108,676
Investments *(Note 3)*	303,253	271,845
Accounts Receivable, Net *(Note 4)*	612	584
Other Assets *(Note 5)*	25	25
TOTAL INTRAGOVERNMENTAL ASSETS	439,562	381,130
Accounts Receivable, Net *(Note 4)*	26,035	31,814
General Property, Plant and Equipment, Net	1,318	1,224
Other Assets *(Note 5)*	452	30,010
TOTAL ASSETS	$467,367	$444,178
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$1,405	$534
Other Intragovernmental Liabilities	5,550	7,325
TOTAL INTRAGOVERNMENTAL LIABILITIES	6,955	7,859
Accounts Payable	167	181
Entitlement Benefits Due and Payable *(Note 6)*	99,148	108,347
Contingencies *(Note 7)*	7,118	13,121
Other Liabilities	10,148	7,977
TOTAL LIABILITIES *(Note 8)*	$123,536	$137,485
NET POSITION		
Unexpended Appropriations–Dedicated Collections *(Note 10)*	$22,934	$17,287
Unexpended Appropriations–Other Funds	65,147	42,242
Cumulative Results of Operations–Dedicated Collections *(Note 10)*	256,977	251,620
Cumulative Results of Operations–Other Funds	(1,227)	(4,456)
TOTAL NET POSITION - DEDICATED COLLECTIONS *(Note 10)*	279,911	268,907
TOTAL NET POSITION - OTHER FUNDS	63,920	37,786
TOTAL NET POSITION	$343,831	$306,693
TOTAL LIABILITIES AND NET POSITION	$467,367	$444,178

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST

for the years ended September 30, 2018 and September 30, 2017

(in millions)

	FY 2018 Consolidated Totals	FY 2017 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare (Dedicated Collections)	**$616,831**	**$567,129**
Medicaid	**383,730**	**372,986**
CHIP	**17,329**	**16,633**
Net Cost: GPRA Programs	**$1,017,890**	**$956,748**
Other Activities		
State Grants and Demonstrations	**$500**	**$556**
Other Health	**3,343**	**1,316**
Other	**(12,658)**	**4,712**
Net Cost: Other Activities	**(8,815)**	**6,584**
NET COST OF OPERATIONS *(Notes 9 and 15)*	**$1,009,075**	**$963,332**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2018

(IN MILLIONS)

	Consolidated Dedicated Collections	Consolidated Other Funds	FY 2018 Consolidated Total
UNEXPENDED APPROPRIATIONS			
Beginning Balances	**$17,287**	**$42,242**	**$59,529**
Budgetary Financing Sources:			
Appropriations Received	**376,964**	**517,077**	**894,041**
Appropriations Transferred-in/out		**(4,384)**	**(4,384)**
Other Adjustments	**(34,640)**	**(84,373)**	**(119,013)**
Appropriations Used	**(336,677)**	**(405,415)**	**(742,092)**
Total Budgetary Financing Sources	**5,647**	**22,905**	**28,552**
Total Unexpended Appropriations	**$22,934**	**$65,147**	**$88,081**
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	**$251,620**	**$(4,456)**	**$247,164**
Budgetary Financing Sources:			
Appropriations Used	**336,677**	**405,415**	**742,092**
Nonexchange Revenue:			
FICA and SECA Taxes	**264,566**		**264,566**
Interest on Investments	**9,677**	**27**	**9,704**
Other Nonexchange Revenue	**4,641**		**4,641**
Transfers-in/out Without Reimbursement	**(5,180)**	**1,760**	**(3,420)**
Other Financing Sources (Nonexchange):			
Transfers-in/out Without Reimbursement			
Imputed Financing	**54**	**24**	**78**
Other			
Total Financing Sources	**610,435**	**407,226**	**1,017,661**
Net Cost of Operations	**605,078**	**403,997**	**1,009,075**
Net Change	**5,357**	**3,229**	**8,586**
CUMULATIVE RESULTS OF OPERATIONS	**$256,977**	**$(1,227)**	**$255,750**
NET POSITION	**$279,911**	**$63,920**	**$343,831**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2017

(IN MILLIONS)

	Consolidated Dedicated Collections	Consolidated Other Funds	FY 2017 Consolidated Total
UNEXPENDED APPROPRIATIONS			
Beginning Balances	**$36,012**	**$46,847**	**$82,859**
Budgetary Financing Sources:			
Appropriations Received	**348,468**	**481,724**	**830,192**
Appropriations Transferred-in/out		**(4,344)**	**(4,344)**
Other Adjustments	**(41,645)**	**(94,617)**	**(136,262)**
Appropriations Used	**(325,548)**	**(387,368)**	**(712,916)**
Total Budgetary Financing Sources	**(18,725)**	**(4,605)**	**(23,330)**
Total Unexpended Appropriations	**$17,287**	**$42,242**	**$59,529**
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	**$227,156**	**$(1,266)**	**$225,890**
Budgetary Financing Sources:			
Appropriations Used	**325,548**	**387,368**	**712,916**
Nonexchange Revenue:			
FICA and SECA Taxes	**259,740**		**259,740**
Interest on Investments	**9,761**	**6**	**9,767**
Other Nonexchange Revenue	**4,634**		**4,634**
Transfers-in/out Without Reimbursement	**(4,934)**	**2,451**	**(2,483)**
Other Financing Sources (Nonexchange):			
Transfers-in/out Without Reimbursement		**2**	**2**
Imputed Financing	**29**	**18**	**47**
Other		**(17)**	**(17)**
Total Financing Sources	**594,778**	**389,828**	**984,606**
Net Cost of Operations	**570,314**	**393,018**	**963,332**
Net Change	**24,464**	**(3,190)**	**21,274**
CUMULATIVE RESULTS OF OPERATIONS	**$251,620**	**$(4,456)**	**$247,164**
NET POSITION	**$268,907**	**$37,786**	**$306,693**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES

for the years ended September 30, 2018 and September 30, 2017

(in millions)

	FY 2018 Combined Totals Budgetary	FY 2017 Combined Totals Budgetary
Budgetary Resources:		
Unobligated balance from prior year budget authority, net (discretionary and mandatory)	$85,963	$64,588
Appropriations (discretionary and mandatory)	1,504,939	1,456,777
Borrowing authority (discretionary and mandatory)	(127)	3,872
Spending authority from offsetting collections (discretionary and mandatory)	564	2,858
TOTAL BUDGETARY RESOURCES	$1,591,339	$1,528,095
Status of Budgetary Resources:		
New Obligations and upward adjustments *(Note 11)*	$1,526,914	$1,502,109
Unobligated balance, end of year		
Apportioned, unexpired accounts	34,639	10,346
Exempt from Apportionment, unexpired accounts		(12,301)
Unapportioned, unexpired accounts	7,963	6,162
Unexpired unobligated balance, end of year	42,602	4,207
Expired unobligated balance, end of year	21,823	21,779
Unobligated balance, end of year (total)	64,425	25,986
TOTAL BUDGETARY RESOURCES	$1,591,339	$1,528,095
Outlays, net		
Outlays, net (discretionary and mandatory)	1,461,724	1,438,373
Distributed offsetting receipts	(467,019)	(444,507)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	$994,705	$993,866

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2018 and Prior Base Years

(in billions)

	Estimates from Prior Years (unaudited)				
	2018 (unaudited)	2017	2016	2015	2014
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 12 and 13)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$11,323	$10,679	$10,294	$9,134	$8,398
SMI Part B	24,143	21,641	19,386	17,027	17,127
SMI Part D	7,176	6,929	7,659	6,424	5,928
Have attained eligibility age (age 65 or over)					
HI	525	492	455	382	332
SMI Part B	4,725	4,122	3,660	3,300	2,873
SMI Part D	1,015	958	952	887	775
Those expected to become participants					
HI	10,959	10,567	9,952	8,386	7,812
SMI Part B	5,586	5,019	4,437	3,668	4,311
SMI Part D	2,932	2,869	3,602	2,845	2,609
All current and future participants					
HI	22,807	21,738	20,701	17,902	16,542
SMI Part B	34,453	30,783	27,484	23,995	24,311
SMI Part D	11,124	10,756	12,213	10,156	9,312
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 12 and 13)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	18,604	17,193	16,800	14,494	14,117
SMI Part B	23,832	21,392	19,178	16,818	17,003
SMI Part D	7,176	6,929	7,659	6,424	5,928
Have attained eligibility age (age 65 and over)					
HI	5,027	4,539	4,285	3,803	3,484
SMI Part B	5,180	4,531	4,026	3,637	3,171
SMI Part D	1,015	958	952	887	775
Those expected to become participants					
HI	3,884	3,539	3,437	2,791	2,764
SMI Part B	5,442	4,860	4,281	3,540	4,137
SMI Part D	2,932	2,869	3,602	2,845	2,609
All current and future participants:					
HI	27,515	25,270	24,523	21,089	20,365
SMI Part B	34,453	30,783	27,484	23,995	24,311
SMI Part D	11,124	10,756	12,213	10,156	9,312
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 12 and 13)					
HI	(4,708)	(3,532)	(3,822)	(3,187)	(3,823)
SMI Part B					
SMI Part D					
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 12 and 13)					
HI	$(4,708)	$(3,532)	$(3,822)	$(3,187)	$(3,823)
SMI Part B					
SMI Part D					
Trust Fund assets at start of period					
HI	202	199	194	197	205
SMI Part B	80	88	68	68	74
SMI Part D	8	8	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 12 and 13)					
HI	(4,506)	(3,333)	(3,628)	(2,990)	(3,618)
SMI Part B	80	88	68	68	74
SMI Part D	8	8	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, 2018 and Prior Base Years

(in billions)

		Estimates from Prior Years (unaudited)			
	2018 (unaudited)	2017	2016	2015	2014
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)	$6,266	$5,572	$5,067	$4,569	$3,980
Expenditures	11,222	10,027	9,263	8,328	7,430
Income less expenditures	(4,957)	(4,455)	(4,196)	(3,759)	(3,450)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	42,643	39,250	37,339	32,585	31,453
Expenditures	49,612	45,514	43,637	37,736	37,048
Income less expenditures	(6,970)	(6,264)	(6,298)	(5,151)	(5,595)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(11,926)	(10,719)	(10,493)	(8,909)	(9,045)
Combined Medicare Trust Fund assets at start of period	290	295	263	266	280
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(11,637)	(10,425)	(10,230)	(8,643)	(8,764)
Future Participants: *Actuarial present value for the 75-year projection period:*					
Income (excluding interest)	19,477	18,456	17,992	14,898	14,732
Expenditures	12,258	11,268	11,320	9,176	9,510
Income less expenditures	7,219	7,187	6,672	5,722	5,222
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(4,708)	(3,532)	(3,822)	(3,187)	(3,823)
Combined Medicare Trust Fund assets at start of period	290	295	263	266	280
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$(4,418)	$(3,237)	$(3,559)	$(2,921)	$(3,542)

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, 2017 to January 1, 2018

(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 14)*					
As of January 1, 2017	$63,277	$66,809	$(3,532)	$295	$(3,237)
Reasons for change					
Change in the valuation period	2,355	2,523	(168)		(168)
Change in projection base	(502)	419	(921)	(5)	(926)
Changes in the demographic assumptions	(551)	(985)	434		434
Changes in economic and health care assumptions	3,176	3,162	14		14
Changes in law	629	1,165	(535)		(535)
Net changes	5,107	6,283	(1,176)	(5)	(1,181)
As of January 1, 2018	$68,385	$73,092	$(4,708)	$290	$(4,418)
HI: Part A *(Note 14)*					
As of January 1, 2017	$21,738	$25,270	$(3,532)	$199	$(3,333)
Reasons for change					
Change in the valuation period	747	915	(168)	11	(157)
Change in projection base	(612)	309	(921)	(8)	(929)
Changes in the demographic assumptions	(214)	(648)	434		434
Changes in economic and health care assumptions	1,223	1,208	14		14
Changes in law	(74)	461	(535)		(535)
Net changes	1,069	2,245	(1,176)	3	(1,173)
As of January 1, 2018	$22,807	$27,515	$(4,708)	$202	$(4,506)
SMI: Part B *(Note 14)*					
As of January 1, 2017	$30,783	$30,783		$88	$88
Reasons for change					
Change in the valuation period	1,154	1,154		(10)	(10)
Change in projection base	197	197		2	2
Changes in the demographic assumptions	(358)	(358)			
Changes in economic and health care assumptions	2,087	2,087			
Changes in law	591	591			
Net changes	3,670	3,670		(8)	(8)
As of January 1, 2018	$34,453	$34,453		$80	$80
SMI: Part D *(Note 14)*					
As of January 1, 2017	$10,756	$10,756		$8	$8
Reasons for change					
Change in the valuation period	455	455		(1)	(1)
Change in projection base	(87)	(87)		1	1
Changes in the demographic assumptions	21	21			
Changes in economic and health care assumptions	(133)	(133)			
Changes in law	113	113			
Net changes	368	368			
As of January 1, 2018	$11,124	$11,124		$8	$8

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, 2016 to January 1, 2017

(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 14)*					
As of January 1, 2016	$60,398	$64,220	$(3,822)	$263	$(3,559)
Reasons for change					
Change in the valuation period	2,481	2,669	(187)	24	(163)
Change in projection base	(136)	(479)	342	8	350
Changes in the demographic assumptions	(122)	(20)	(102)		(102)
Changes in economic and health care assumptions	617	384	233		233
Changes in law	40	36	4		4
Net changes	2,880	2,590	290	31	321
As of January 1, 2017	$63,277	$66,809	$(3,532)	$295	$(3,237)
HI: Part A *(Note 14)*					
As of January 1, 2016	$20,701	$24,523	$(3,822)	$194	$(3,628)
Reasons for change					
Change in the valuation period	792	979	(187)	1	(186)
Change in projection base	133	(209)	342	4	346
Changes in the demographic assumptions	(152)	(50)	(102)		(102)
Changes in economic and health care assumptions	265	32	233		233
Changes in law		(4)	4		4
Net changes	1,037	748	290	5	295
As of January 1, 2017	$21,738	$25,270	$(3,532)	$199	$(3,333)
SMI: Part B *(Note 14)*					
As of January 1, 2016	$27,484	$27,484		$68	$68
Reasons for change					
Change in the valuation period	1,115	1,115		17	17
Change in projection base	281	281		3	3
Changes in the demographic assumptions	7	7			
Changes in economic and health care assumptions	1,856	1,856			
Changes in law	40	40			
Net changes	3,299	3,299		20	20
As of January 1, 2017	$30,783	$30,783		$88	$88
SMI: Part D *(Note 14)*					
As of January 1, 2016	$12,213	$12,213		$1	$1
Reasons for change					
Change in the valuation period	575	575		5	5
Change in projection base	(550)	(550)		1	1
Changes in the demographic assumptions	22	22			
Changes in economic and health care assumptions	(1,504)	(1,504)			
Changes in law					
Net changes	(1,457)	(1,457)		6	6
As of January 1, 2017	$10,756	$10,756		$8	$8

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

Basis of Accounting and Presentation

The financial statements were prepared from CMS's 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). In accordance with Statement of Federal Financial Accounting Standards (SFFAS) 47, Reporting Entity, CMS has included all consolidation entities for which it is accountable in this general purpose federal financial report.

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's 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

Financial statements prepared in accordance with GAAP are based on a selection of accounting policies and the application of significant accounting estimates. Some estimates require management to make significant assumptions. 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 Advance Premium Tax Credit, and Basic Health Program payments; these payments are not included in CMS's 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. Benefit payments made by the Medicare contractors for Medicare Part A 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 U.S. Government (General Fund) 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.

Medicare Supplementary Medical Insurance Trust Fund – Part B

Section 1841 of the Social Security Act established the Supplementary Medical Insurance (SMI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part B 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 the method to fully compensate the trust fund 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. Medicare also 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 Patient Protection and Affordable Care Act (PPACA) provides that beneficiary cost sharing in the Part D coverage gap is reduced for brand-name and generic drugs by 7 percentage points per year until coinsurance is 25 percent by 2019. 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. 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. 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.

Payments to the Health Care Trust Funds Appropriation

The Social Security Act provides for payments to the HI and SMI trust funds for SMI (e.g., appropriated funds to provide for Federal matching of SMI premium collections) and HI (e.g., for the Uninsured and Federal Uninsured Payments). The Act also 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 the General Fund to the SMI trust fund; this occurs via the Payments to the Health Care Trust Funds account. The Act also 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 the Payments to the Health Care Trust Funds account to cover CMS's 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 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 is administered via grant awards, which limit the funds that can be drawn by the States to cover current expenses. 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 PPACA expanded eligibility (based upon a state's choice) for Medicaid to certain low-income adults with the Federal government paying 100% of claims for those newly eligible under Medicaid expansion for the first three years, phasing down to 90% in calendar year (CY) 2020 and beyond (the rate for CY 2018 is 94% and for CY 2019 is 93%).

CHIP

CHIP is administered via grant awards, which limit the funds that can be drawn by the States to cover current expenses.

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

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 PPACA, several new grants were included in the account and the availability of funds for other grants was extended.

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, Exchange, and Other User Fees

This account operates as a revolving fund without fiscal year restriction. Medicare Advantage plans are required 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 PPACA requires the collection of a user fee from each issuer offering coverage through a Federally-facilitated Exchange 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 PPACA 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.

Investments consist of trust fund (Dedicated collections) investments which are investments (plus the accrued interest on investments) held by Treasury. 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. Additionally, investments consist of the CHIP Child Enrollment Contingency Fund investments (net of any accrued amortized or unrealized discounts) also held by Treasury (see Note 3).

Unexpended Appropriations include the portion of CMS's 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.

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. The MMA 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.

Medicare Premiums Collected are used to help finance benefits and administrative expenses. Premiums collected are for Part A, Part B, 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 Collected 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 account.

- **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.

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.

The PPACA

The PPACA 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). One of the main programs under CCIIO is the Health Insurance Exchanges (the "Exchanges"). A brief description of the remaining programs is presented below. There were two additional programs - Transitional Reinsurance and Risk Corridors – that are no longer in operation.

Health Insurance Exchanges

Grants have been provided to the States to establish Health Insurance Exchanges. 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 through December 31, 2014, after which time no further grants could be made. All Exchanges were launched on October 1, 2013.

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 Exchanges. 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.

Changes, Reclassifications and Adjustments

Effective FY 2018, the following changes were made: (1) the Statement of Changes in Net Position (SCNP) has changed to move Unexpended Appropriations and the associated details to the beginning of the statement and (2) the Statement of Budgetary Resources (SBR) has changed to condense the information presented. Changes have been made to the supplementary SCNP and SBR to reflect these changes for both the current and prior year for comparability. These changes, as well as various changes to the footnotes and any needed reclassifications, have been made in order to comply with OMB's Circular A-136.

NOTE 2:

FUND BALANCE WITH TREASURY

(Dollars in Millions)

	FY 2018	FY 2017
Status of Fund Balances with Treasury:		
Unobligated Balance:		
Available	**$34,639**	**$(1,955)**
Unavailable	**29,786**	**27,941**
Obligated Balance not yet Disbursed	**137,140**	**143,493**
Non-Budgetary FBWT	**(65,893)**	**(60,803)**
Total Status of Fund Balances with Treasury	**$135,672**	**$108,676**

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities. The Unobligated Balance Available includes $14,734 million ($11,216 million in FY 2017), which is restricted for future use and is not apportioned for current use for PPACA, CHIP, Program Management, and State Grants and Demonstrations.

NOTE 3:

INVESTMENTS

(Dollars in Millions)

FY 2018 **Medicare Investments** ***(Dedicated Collections)***	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2019	2 7/8%	$14,087
Bonds	June 2019 to June 2028	1 7/8 - 5 1/8%	188,718
Accrued Interest			1,682
Total HI TF Investments			**$204,487**
SMI TF			
Certificates	June 2019	2 7/8 - 3%	$23,511
Bonds	June 2020 to June 2033	1 7/8 - 5%	74,687
Accrued Interest			568
Total SMI TF Investments			**$98,766**
Total Medicare Investments			**$303,253**

FY 2017 **Medicare Investments** ***(Dedicated Collections)***	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2018	2 1/8%	$4,706
Bonds	June 2018 to June 2027	1 7/8 - 5 1/8%	193,129
Accrued Interest			1,780
Total HI TF Investments			**$199,615**
SMI TF			
Certificates	June 2018	2 1/4%	$298
Bonds	June 2019 to June 2032	1 7/8 - 5%	70,291
Accrued Interest			498
Total SMI TF Investments			**$71,087**
Total Medicare Investments			**$270,702**

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:

CMS INVESTMENT SUMMARY

(Dollars in Millions)

FY 2018	Medicare (Dedicated Collections)			Non-Dedicated Collections	Consolidated Total
	HI TF	SMI TF	Total	CHIP	
Certificates	$14,087	$23,511	$37,598		$37,598
Bonds	188,718	74,687	263,405		263,405
Treasury Bills					0
Accrued Interest	1,682	568	2,250		2,250
Total Investments	**$204,487**	**$98,766**	**$303,253**	**$0**	**$303,253**

FY 2017	Medicare (Dedicated Collections)			Non-Dedicated Collections	Consolidated Total
	HI TF	SMI TF	Total	CHIP	
Certificates	$4,706	$298	$5,004		$5,004
Bonds	193,129	70,291	263,420		263,420
Treasury Bills				$1,143	1,143
Accrued Interest	1,780	498	2,278		2,278
Total Investments	**$199,615**	**$71,087**	**$270,702**	**$1,143**	**$271,845**

NOTE 4:

ACCOUNTS RECEIVABLE, NET

(Dollars in Millions)

FY 2018	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$612		$612		$612
Total Intragovernmental	$612		$612		$612
With the Public					
Entity					
Medicare FFS	$7,917		$7,917	$(3,281)	$4,636
Medicare Advantage/Prescription Drug Program	13,122		13,122	(5)	13,117
Medicaid	5,101		5,101	(957)	4,144
Other	4,424		4,424	(323)	4,101
Non-Entity	4	$65	69	(32)	37
Total With the Public	$30,568	$65	$30,633	$(4,598)	$26,035

FY 2017	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$584		$584		$584
Total Intragovernmental	$584		$584		$584
With the Public					
Entity					
Medicare FFS	$7,484		$7,484	$(2,520)	$4,964
Medicare Advantage/Prescription Drug Program	15,708		15,708		15,708
Medicaid	7,029		7,029	(993)	6,036
Other	5,384		5,384	(318)	5,066
Non-Entity	6	$66	72	(32)	40
Total With the Public	$35,611	$66	$35,677	$(3,863)	$31,814

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 [restitutions balances for FY 2018 are $2 billion (gross) and $65 million (net)], the recognition of Medicare secondary payer (MSP) accounts receivable, and Exchange 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 Exchange activities.

NOTE 5:

OTHER ASSETS

(Dollars in Millions)

As of September 30, 2018, CMS has $477 million ($30,035 million in FY 2017) in other assets, mainly for COOP loans and advances to others. In 2017, there were advance payments mainly for the Prescription Drug and Medicare Advantage benefit payments of $29,233 million that occurred on September 29, 2017 instead of October 1, 2017. There were no prepayments made in 2018 for FY 2019 that would result in a similar advance in the consolidated balance sheets as of September 30, 2018.

NOTE 6:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(Dollars in Millions)

	FY 2018	FY 2017
Medicare FFS	$51,031	$48,029
Medicare Advantage/Prescription Drug Program	11,165	12,596
Medicaid	35,570	34,070
CHIP	1,377	1,345
Other	5	12,307
TOTALS	$99,148	$108,347

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, 2018 and 2017 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 2018. 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, 2018.

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 Exchange activities. The PPACA provided for a temporary Risk Corridors program that was administered by CMS. The Risk Corridors program is no longer in operation. As of September 30, 2018, due to changes in assumptions, no accruals have been recorded related to Risk Corridor activities.

NOTE 7:

CONTINGENCIES

(Dollars in Millions)

The contingencies balance as of September 30, 2018 is $7,118 million ($13,121 million in FY 2017), which includes $6,277 million for Medicaid ($12,195 million in FY 2017) for audit and program disallowances and reimbursement of state plan amendments. Additionally, 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. Additionally, CMS may owe amounts to providers for previous years' disputed cost report and claims adjustments. 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.

NOTE 8:

LIABILITIES NOT COVERED BY BUDGETARY RESOURCES

(Dollars in Millions)

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.

Additionally, the Balanced Budget Act of 2015 (Section 601) authorized a transfer from the general fund to SMI, to temporarily replace the reduction in Part B premiums for calendar years 2016 and 2017. Section 601 created an "additional premium" charged alongside the normal Part B monthly premiums, which will be used to pay back the general fund transfer without interest. These repayments are transferred quarterly. As of September 30, 2018, $5,024 million ($6,396 million in FY 2017) is still owed.

Starting January 1, 2014, the PPACA provides for a permanent Risk Adjustment program and a temporary transitional Reinsurance program administered by CMS. With these programs, amounts may be owed to or due from private health insurers who participate in the Exchange that began on January 1, 2014, as well as the broader individual and small group markets. The Reinsurance program is no longer in operation and there are no accruals that have been recorded for this program as of September 30, 2018. The Risk Adjustment program will be administered in a budget neutral manner in any calendar year and collections will not be due and payments will not be made until the year following the calendar year for which the program operates. As of September 30, 2018, accruals were recorded to cover future payments, collections, sequestration, and appeals that are still due for/pertain to program years 2015 and 2016 for the Risk Adjustment program and are reflected on the Other line below.

FY 2018 Intragovernmental	Medicare (Dedicated Collections)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Other	$1	$1			$1	$38	$41		$41
Total Intragovernmental	1	1			1	38	41		41
Federal Employee and Veterans' Benefits	3	7			3		13		13
Other	16	24	$2		6,945	6	6,993		6,993
Contingencies	841		6,277				7,118		7,118
Total Liabilities Not Covered by Budgetary Resources	861	32	6,279		6,949	44	14,165		14,165
Total Liabilities Covered by Budgetary Resources	71,226	73,429	35,611	$1,379	2,979	65	184,689	$(76,060)	108,629
Total Liabilities Not Requiring Budgetary Resources	80	599				63	742		742
TOTAL LIABILITIES	$72,167	$74,060	$41,890	$1,379	$9,928	$172	$199,596	$(76,060)	$123,536

FY 2017 Intragovernmental	Medicare (Dedicated Collections)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Other	$1	$1			$16	$56	$74	$(15)	$59
Total Intragovernmental	1	1			16	56	74	(15)	59
Federal Employee and Veterans' Benefits	3	6	$1		3		13		13
Other	16	22	2		5,999	4	6,043		6,043
Contingencies	926		12,195				13,121		13,121
Total Liabilities Not Covered by Budgetary Resources	946	29	12,198		6,018	60	19,251	(15)	19,236
Total Liabilities Covered by Budgetary Resources	68,741	73,979	34,084	$1,346	2,457	12,356	192,963	(75,331)	117,632
Total Liabilities Not Requiring Budgetary Resources	83	475				59	617		617
TOTAL LIABILITIES	$69,770	$74,483	$46,282	$1,346	$8,475	$12,475	$212,831	$(75,346)	$137,485

NOTE 9:

NET COST OF OPERATIONS

(Dollars in Millions)

	Medicare (Dedicated Collections)			Health				
FY 2018	**HI TF**	**SMI TF**	**Total**	**Medicaid**	**CHIP**	**Other Health**	**Other**	**Consolidated Total**
PROGRAM/ACTIVITY COSTS								
Medicare								
Fee for Service	$210,541	$211,827	$422,368					$422,368
Medicare Advantage/ Managed Care	92,182	117,727	$209,909					209,909
Prescription Drug (Part D)		78,976	$78,976					78,976
Medicaid/CHIP/State Grants & Demos			$0	$383,619	$17,315		$491	401,425
Other Health						$6,685		6,685
Other			$0				(12,276)	(12,276)
Total Program/Activity Costs	$302,723	$408,530	$711,253	$383,619	$17,315	$6,685	$(11,785)	$1,107,087
OPERATING COSTS								
Medicare Integrity Program	$1,254		$1,254					$1,254
Quality Improvement Organizations	638	$295	$933					933
Bad Debt Expense and Writeoffs/ Reimbursable Expenses	549	164	$713	$(36)		$(6)	$1	672
Administrative Expenses	923	1,923	$2,846	151	$15	807	$1,465	5,284
Depreciation and Amortization/Imputed Cost Subsidies	100	54	$154	4		55	122	335
Total Operating Costs	3,464	2,436	5,900	119	15	856	1,588	8,478
TOTAL COSTS	$306,187	$410,966	$717,153	$383,738	$17,330	$7,541	$(10,197)	$1,115,565
Less: Exchange Revenues:								
Medicare Premiums	$3,983	$96,204	$100,187					$100,187
Other Exchange Revenues	45	90	$135	$8	$1	$4,198	$1,961	6,303
Total Exchange Revenues	4,028	96,294	100,322	8	1	4,198	1,961	106,490
TOTAL NET COST OF OPERATIONS	$302,159	$314,672	$616,831	$383,730	$17,329	$3,343	$(12,158)	$1,009,075

NOTE 9:

NET COST OF OPERATIONS *(CONTINUED)*

(Dollars in Millions)

FY 2017	Medicare (Dedicated Collections)			Health				
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	Consolidated Total
PROGRAM/ACTIVITY COSTS								
Medicare								
Fee for Service	$194,575	$187,001	$381,576					$381,576
Medicare Advantage/ Managed Care	93,060	113,275	206,335					206,335
Prescription Drug (Part D)		63,967	63,967					63,967
Medicaid/CHIP/State Grants & Demos				$373,059	$16,621		$539	390,219
Other Health						$6,642		6,642
Other							4,489	4,489
Total Program/Activity Costs	$287,635	$364,243	$651,878	$373,059	$16,621	$6,642	$5,028	$1,053,228
OPERATING COSTS								
Medicare Integrity Program	$1,282		$1,282					$1,282
Quality Improvement Organizations	584	$286	870					870
Bad Debt Expense and Writeoffs	149	(460)	(311)	$(193)		$295		(209)
Reimbursable Expenses	37	79	116	6	$1	32		155
Administrative Expenses	1,135	1,883	3,018	134	13	744	$1,713	5,622
Depreciation and Amortization	13	27	40	2		16	158	216
Imputed Cost Subsidies	13	16	29	1		13	4	47
Total Operating Costs	3,213	1,831	5,044	(50)	14	1,100	1,875	7,983
TOTAL COSTS	$290,848	$366,074	$656,922	$373,009	$16,635	$7,742	$6,903	$1,061,211
Less: Exchange Revenues:								
Medicare Premiums	$4,014	$85,392	$89,406					$89,406
Other Exchange Revenues	131	256	387	$23	$2	$6,426	$1,635	8,473
Total Exchange Revenues	4,145	85,648	89,793	23	2	6,426	1,635	97,879
TOTAL NET COST OF OPERATIONS	$286,703	$280,426	$567,129	$372,986	$16,633	$1,316	$5,268	$963,332

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 $2,334 million ($2,031 million in FY 2017) paid to Medicare contractors to carry out their responsibilities as CMS's 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 2018 Part D expense of $78,976 million ($63,967 million in FY 2017) is net of State reimbursements of $11,785 million ($11,227 million in FY 2017). The gross expense would have been $90,761 million ($75,194 million in FY 2017).

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, 2018				
ASSETS				
Fund Balance with Treasury	$27,389	$7,203		$34,592
Investments	303,253			303,253
Other Assets	90,933	6,530	$(74,037)	23,426
TOTAL ASSETS	$421,575	$13,733	$(74,037)	$361,271
LIABILITIES				
Entitlement Benefits Due and Payable	$62,196	$3		$62,199
Other Liabilities	84,031	9,167	$(74,037)	19,161
TOTAL LIABILITIES	$146,227	$9,170	$(74,037)	$81,360
Unexpended Appropriations	$22,855	$79		$22,934
Cumulative Results of Operations	252,493	4,484		256,977
TOTAL LIABILITIES AND NET POSITION	$421,575	$13,733	$(74,037)	$361,271
Statement of Net Cost for the year ended September 30, 2018				
Benefit Expense	$711,253	$(12,276)		$698,977
Operating Costs	5,900	6,614		12,514
Total Costs	717,153	(5,662)		711,491
Less Exchange Revenues	100,322	6,091		106,413
Net Cost of Operations	616,831	(11,753)		605,078
Statement of Changes in Net Position for the year ended September 30, 2018				
Net Position, Beginning of Period	$276,993	$(8,086)		$268,907
Taxes and Other Nonexchange Revenue	278,884			278,884
Other Financing Sources	336,302	896		337,198
Less Net Cost of Operations	616,831	(11,753)		605,078
Change in Net Position	(1,645)	12,649		11,004
NET POSITION, END OF PERIOD	$275,348	$4,563		$279,911

NOTE 10:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare	Other Non-Medicare	Eliminations	Total Dedicated Collections
Balance Sheet as of September 30, 2017				
ASSETS				
Fund Balance with Treasury	$28,284	$4,539		$32,823
Investments	270,702			270,702
Other Assets	122,260	6,835	$(72,739)	56,356
TOTAL ASSETS	**$421,246**	**$11,374**	**$(72,739)**	**$359,881**
LIABILITIES				
Entitlement Benefits Due and Payable	$60,625	$12,303		$72,928
Other Liabilities	83,628	7,157	$(72,739)	18,046
TOTAL LIABILITIES	**$144,253**	**$19,460**	**$(72,739)**	**$90,974**
Unexpended Appropriations	$17,287			$17,287
Cumulative Results of Operations	259,706	$(8,086)		251,620
Total Net Position	**276,993**	**(8,086)**		**268,907**
TOTAL LIABILITIES AND NET POSITION	**$421,246**	**$11,374**	**$(72,739)**	**$359,881**
Statement of Net Cost for the year ended September 30, 2017				
Benefit Expense	$651,878	$4,489		$656,367
Operating Costs	5,044	6,553		11,597
Total Costs	656,922	11,042		667,964
Less Exchange Revenues	89,793	7,857		97,650
Net Cost of Operations	**$567,129**	**$3,185**		**$570,314**
Statement of Changes in Net Position for the year ended September 30, 2017				
Net Position, Beginning of Period	$268,602	$(5,434)		$263,168
Taxes and Other Nonexchange Revenue	274,135			274,135
Other Financing Sources	301,385	533		301,918
Less Net Cost of Operations	567,129	3,185		570,314
Change in Net Position	**8,391**	**(2,652)**		**5,739**
NET POSITION, END OF PERIOD	**$276,993**	**$(8,086)**		**$268,907**

NOTE 11:

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 2018	Direct	Reimbursable	Combined Totals
Category A (Distributed by Quarter)	$21,505	$190	$21,695
Category B (Restricted and Distributed by Activity)	768,823	1,404	770,227
Exempt from Apportionment	734,992		734,992
Total	$1,525,320	$1,594	$1,526,914

FY 2017	Direct	Reimbursable	Combined Totals
Category A (Distributed by Quarter)	$20,390	$439	$20,829
Category B (Restricted and Distributed by Activity)	747,775	1,257	749,032
Exempt from Apportionment	732,248		732,248
Total	$1,500,413	$1,696	$1,502,109

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 $230,855 million ($207,353 million in FY 2017) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2018 and FY 2017 (in millions):

	FY 2018 Combined Balance	FY 2017 Combined Balance
TRUST FUND BALANCE, BEGINNING	$207,353	$201,562
Receipts	653,853	621,222
Less Obligations	630,351	615,431
Excess (Shortage) of Receipts Over Obligations	23,502	5,791
TRUST FUND BALANCE, ENDING	$230,855	$207,353

EXEMPT FROM APPORTIONMENT

This amount includes the FY 2018 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 2016

CMS reconciled the amounts of the FY 2017 column of the SBR to the actual amounts for FY 2017 from the Appendix in the FY 2018 President's Budget for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections). The Budget with the actual amounts for the current year (FY 2018) will be available at a later date at https://www.whitehouse.gov/omb/budget/.

FY 2017	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Net Outlays
Combined Statement of Budgetary Resources	$1,528,095	$1,502,109	$444,507	$1,438,373
Expired Accounts	(23,934)			
Other	3,892	3,888	(53)	4,291
President's Budget (2017 Actual)	**$1,508,053**	**$1,505,997**	**$444,454**	**$1,442,664**

For the budgetary resources reconciliation, the amount used from the President's Budget was the total budgetary resources available for obligation. The Expired accounts line included expired authority, recoveries and other amounts included in the Combined Statement of Budgetary Resources (SBR) that are not included in the President's Budget. The Other line contained in the SBR and also not in the President's Budget for budgetary resources, obligations incurred and net outlays are CMS amounts reported on CDC and OS statements and GTAS adjustments.

UNDELIVERED ORDERS AT THE END OF THE PERIOD

The amount of budgetary resources obligated for undelivered orders totaled $34,497 million for Budgetary ($62,751 million FY17). There were no undelivered order amounts for Non-Budgetary at September 30, 2018 ($5 million FY 2017).

	FY 2018		FY 2017	
	Federal	Non-Federal	Federal	Non-Federal
Undelivered orders (unpaid)	$389	$33,852	$323	$32,876
Undelivered orders (paid)	27	229	31	29,526
Total	$416	$34,081	$354	$62,402

NOTE 12:

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 in the 2018 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and healthcare-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 completed review occurred with the 2016-2017 Technical Review Panel.

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 June 5, 2018, 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 and 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, premiums paid by, or on behalf of, aged uninsured beneficiaries, 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.

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 June 5, 2018, 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 healthcare-specific assumptions, including changes in per beneficiary health care costs, 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 2018 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2018. 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. Similar detailed information 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 2018

					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	
2018	1.81	1,678,000	776.4	1.59	3.82	2.23	2.7	1.4	5.3	0.5	0.1
2020	1.84	1,498,000	762.4	1.95	4.55	2.60	2.6	3.3	4.7	6.0	0.8
2030	2.00	1,321,000	697.7	1.28	3.88	2.60	2.1	4.4	5.3	5.3	2.7
2040	2.00	1,272,000	641.1	1.22	3.82	2.60	2.1	4.6	4.2	4.7	2.7
2050	2.00	1,247,000	591.5	1.23	3.83	2.60	2.1	3.8	3.8	4.7	2.7
2060	2.00	1,233,000	547.9	1.22	3.82	2.60	2.1	3.6	3.7	4.5	2.7
2070	2.00	1,225,000	509.4	1.15	3.75	2.60	2.1	3.8	3.6	4.4	2.7
2080	2.00	1,221,000	475.2	1.13	3.73	2.60	2.1	3.9	3.7	4.4	2.7
2090	2.00	1,218,000	444.7	1.15	3.75	2.60	2.1	3.4	3.5	4.3	2.7

[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, 2010, 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 SOSI 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. Table 2 below summarizes these ultimate values assumed for the current year and the prior 4 years, based on the intermediate assumptions of the respective Medicare Trustees Reports.

TABLE 2:
SIGNIFICANT ULTIMATE ASSUMPTIONS USED FOR THE STATEMENT OF SOCIAL INSURANCE, FY 2018–2014

					Annual percentage change in:						
									Per beneficiary cost[8]		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI B	SMI D	Real-interest rate[9]
FY 2018	2.0	1,218,000	444.7	1.15	3.75	2.60	2.1	3.4	3.5	4.3	2.7
FY 2017	2.0	1,227,000	438.7	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7
FY 2016	2.0	1,228,000	435.1	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7
FY 2015	2.0	1,060,000	458.4	1.13	3.83	2.70	2.1	3.8	4.1	4.4	2.9
FY 2014	2.0	1,055,000	419.8	1.13	3.93	2.80	2.1	3.8	3.8	4.5	2.9

[1] Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 12th year of the projection period.

[2] Includes legal immigration, net of emigration, as well as other, non-legal, immigration. (Beginning with FY 2018 legal immigration is referred to as lawful permanent resident (LPR) immigration, and other, non-legal, immigration is referred to as other-than-LPR immigration.) The ultimate level of net legal immigration is 788,000 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 for FY 2014 and FY 2015 and is the value assumed in the year 2090 for FYs 2016-2018.

[3] The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FY 2014 and FY 2015 and is the value assumed in the year 2090 for FYs 2016-2018

[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 for FY 2014 and FY 2015 and is the value assumed in the year 2090 for FYs 2016-2018

[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 for FY 2014 and FY 2015 and is the value assumed in the year 2090 for FYs 2016-2018

[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. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FY 2014 and FY 2015 and is the value assumed in the year 2090 for FYs 2016-2018.

[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 pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. Since the annual rate of growth declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FY 2014 and FY 2015 and is the value assumed in the year 2090 for FYs 2016-2018.

[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 13:

ALTERNATIVE SOSI PROJECTIONS (UNAUDITED)

The Medicare Board of Trustees, in its annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results.

The Trustees assume 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 private nonfarm business multifactor productivity and the specified physician updates put in place by MACRA—will occur as current law requires. In order for this outcome to be achievable, health care providers would have to realize productivity improvements at a faster rate than experienced historically. For those providers affected by the productivity adjustments and the specified updates to physician payments, sustaining the 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 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.

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 gap will continue to widen throughout the projection, and the Trustees estimated that physician payment rates under current law will be lower than they would have been under the sustainable growth rate (SGR) formula by 2048. Absent a change in the delivery system or level of update by subsequent legislation, access to Medicare-participating physicians may become a significant issue in the long term under current law. Overriding the price updates in current law, as lawmakers repeatedly did 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. This scenario illustrates the impact that would occur if the payment updates that are affected by the productivity adjustments transition from current law to the payment updates assumed for private health plans over the period 2028 to 2042. It also reflects physician payment updates that transition from current law to the increase in the Medicare Economic Index over the same period. Finally, the scenario assumes the continuation of the 5 percent bonuses for physicians in advanced alternative models (advanced APMs) and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS), which are set to expire in 2025.[2] 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.

2 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 enactment of MACRA in 2015 replaced the SGR with specified physician updates.

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	$22,807	$22,871
Part B	34,453	40,857
Part D	11,124	11,124
Expenditures		
Part A	27,515	32,581
Part B	34,453	40,857
Part D	11,124	11,124
Income less expenditures		
Part A	(4,708)	(9,710)
Part B	0	0
Part D	0	0

1 These amounts are not presented in the 2018 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 payment updates that are affected by the productivity adjustments were to gradually transition from current law to the payment updates assumed for private health plans, the physician updates transitioned to the Medicare Economic Index, and the 5-percent bonuses paid to physicians in advanced APMs did not expire, as illustrated under the alternative scenario, the estimated present values of Part A and Part B expenditures would each be higher than the current-law projections by roughly 18 and 19 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 19 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are the same under each projection because the services are not affected by the productivity adjustments or the physician updates.

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 14:

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 non-interest 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, 2017 to the period beginning on January 1, 2018, and the reconciliation from the period beginning on January 1, 2016 to the period beginning on January 1, 2017. 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 cash flow. 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 cash flows represents a positive change (improving financing), while a decrease in the present value of net cash flows 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 12 summarizes these assumptions for the current year.

Period beginning on January 1, 2017 and ending January 1, 2018

Present values as of January 1, 2017 are calculated using interest rates from the intermediate assumptions of the 2017 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2018. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2017 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2018 Trustees Report.

Period beginning on January 1, 2016 and ending January 1, 2017

Present values as of January 1, 2016 are calculated using interest rates from the intermediate assumptions of the 2016 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2017. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2016

Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2017 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2017 to the period beginning on January 1, 2018

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2017-91) to the current valuation period (2018-92) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2017, replaces it with a much larger negative net cash flow for 2092, and measures the present values as of January 1, 2018, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (made more negative) when the 75-year valuation period changed from 2017-91 to 2018-92. 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 2017 are realized. The change in valuation period resulted in a very slight increase in the starting level of assets in the combined Medicare Trust Funds.

From the period beginning on January 1, 2016 to the period beginning on January 1, 2017

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2016-90) to the current valuation period (2017-91) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2016, replaces it with a much larger negative net cash flow for 2091, and measures the present values as of January 1, 2017, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (made more negative) when the 75-year valuation period changed from 2016-90 to 2017-91. 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 2016 are realized. The change in valuation period increased the starting level of assets in the combined Medicare Trust Funds.

Change in Projection Base

From the period beginning on January 1, 2017 to the period beginning on January 1, 2018

Actual income and expenditures in 2017 were different than what was anticipated when the 2017 Trustees Report projections were prepared. Part A payroll tax income in 2017 was lower attributable to lowered wages and expenditures were higher than anticipated based on actual experience. Part B total income and expenditures were higher than estimated based on actual experience. For Part D, actual income and expenditures were both lower than prior estimates. The net impact of the Part A, B, and D projection base changes is a decrease in the estimated future net cash flow. Actual experience of the Medicare Trust Funds between January 1, 2017 and January 1, 2018 is incorporated in the current valuation and is less than projected in the prior valuation.

From the period beginning on January 1, 2016 to the period beginning on January 1, 2017

Actual income and expenditures in 2016 were different than what was anticipated when the 2016 Trustees Report projections were prepared. Part A payroll tax income in 2017 was lower attributable to lowered wages, and expenditures were higher than anticipated based on actual experience. Part B total income and expenditures were higher than estimated based on actual experience. For Part D, actual income and expenditures were both lower than prior estimates. The net impact of the Part A, B, and D projection base changes is an increase in the estimated future net cash flow. Actual experience of the Medicare Trust Funds between January 1, 2016 and January 1, 2017 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, 2017 to the period beginning on January 1, 2018

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, 2018), with the exception of a small decrease of 10,000 lawful-permanent-resident (LPR) immigrants per annum in the future, 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 2016 indicated slightly lower birth rates than were assumed in the prior valuation.
- Recent fertility data suggests that the short-term increase in the total fertility rate used in the prior valuation to account for an assumed deferral in childbearing (resulting from the recent economic downturn) was no longer warranted. The observed persistent drop in the total fertility rate in recent years is now assumed to be a loss of potential births rather than just a deferral for this period.
- Incorporating 2015 mortality data obtained from the National Center for Health Statistics for ages under 65 and preliminary 2015 mortality data from Medicare experience for ages 65 and older resulted in higher death rates for all future years than were projected in the prior valuation.
- More recent LPR and other-than-LPR immigration data and historical population data were included.

There was one notable change in demographic methodology:

- Improved the method for projecting mortality rates by marital status by utilizing recent data from NCHS and the American Community Survey.

These changes lowered overall Medicare enrollment for the current valuation period and resulted in an increase in the estimated future net cash flow. The present value of estimated income and expenditures are both lower for Part A and Part B but higher for Part D.

From the period beginning on January 1, 2016 to the period beginning on January 1, 2017

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, 2017) 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 2015 indicated slightly lower birth rates than were assumed in the prior valuation.
- Incorporating 2014 mortality data obtained from the National Center for Health Statistics at ages under 65 and preliminary 2014 mortality data from Medicare experience at ages 65 and older resulted in higher death rates for all future years than were projected in the prior valuation.
- More recent legal and other-than-legal immigration data and historical population data were included.

There were no consequential changes in demographic methodology.

These changes slightly lowered overall Medicare enrollment for the current valuation period and resulted in a decrease in the estimated future net cash flow. The present value of estimated expenditures is lower for Part A but slightly higher for Parts B and D; and the present value of estimated income is also higher for Parts B and D but lower for Part A.

Changes in Economic and Health Care Assumptions

For the period beginning on January 1, 2017 to the period beginning on January 1, 2018

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).

The ultimate economic assumptions for the current valuation (beginning on January 1, 2018) 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 estimated level of potential GDP was reduced by about 1 percent in 2017 and throughout the projection period, primarily due to the slow growth in labor productivity for 2010 through 2017 and low unemployment rates in 2017. This lower estimated

level of potential GDP means that cumulative growth in actual GDP is 1 percent less over the remainder of the projected recovery than was assumed in the prior valuation.

- Near-term interest rates were decreased, reflecting a more gradual path for the rise to the ultimate real interest rate than was assumed in the prior valuation.

- New data from the Bureau of Economic Analysis (BEA) indicated lower-than-expected ratios of labor compensation to GDP for 2016 and 2017, while new data from the Internal Revenue Service (IRS) indicated lower-than-expected ratios of taxable payroll to GDP for 2016 and 2017. This new data led to assumed extended recoveries in these ratios to the unchanged ultimate ratios.

There was one notable change in economic methodology:

- Improved the method for projecting educational attainment among women in age groups 45-49 and 50-54 in the labor force participation model.

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

- Utilization rate assumptions for inpatient hospital were decreased.

- Utilization rate and case mix for skilled nursing facilities services were decreased.

- Payment rates to private health plans are higher than projected in last year's report primarily due to higher risk scores and increased coding by plans.

- Higher projected drug manufacturer rebates.

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

For the period beginning on January 1, 2016 to the period beginning on January 1, 2017

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, 2017), there was one change to the ultimate economic assumptions.

- The ultimate average real-wage differential is assumed to be 1.20 percent in the current valuation, which is close to a 0.01 percent decrease relative to the previous valuation (even though both ultimate average real-wage differentials are 1.20 when rounded to two decimal places).

In addition to this change in assumption, the assumed real-wage differential for the first ten years of the projection period averaged 0.05 percent lower than in the previous valuation. The lower long-term and near-term real-wage differential assumptions are based on new projections of faster growth in employer sponsored group health insurance premiums. Because these premiums are not subject to the payroll tax, faster growth in these premiums means that a smaller 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. Most significantly, an assumed weaker recovery from the recent recession than previously expected led to a reduction in the ultimate level of actual and potential GDP of about 1.0 percent for all years after the short-range period.

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

- Utilization rate assumptions for inpatient hospital and skilled nursing facilities services were decreased.

- The number of beneficiaries enrolled in Medicare Advantage plans and their relative costs are slightly different from last year's assumptions.

- Lower productivity increases through 2025, resulting in higher provider payment updates.

- Higher projected drug rebates.

- Change in projection methodology of drug spending for Part B patients with end-stage renal disease.

The net impact of these changes resulted in an increase in the estimated future net cash flow 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 cash flow. For Part B, these changes increased the present value of estimated future expenditures (and also income). For Part D, these changes decreased the present value of estimated expenditures (and also income).

Changes in Law

For the period beginning on January 1, 2017 to the period beginning on January 1, 2018

Most of the provisions enacted as part of Medicare legislation since the prior valuation date had little or no impact on the program. The following provisions did have a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

- The Disaster Tax Relief and Airport and Airway Extension Act of 2017 (Public Law 115-63, enacted on September 29, 2017) included one provision that affects the HI and SMI Part B programs.
  - » The funding amount of $270 million previously provided to the Medicare Improvement Fund, for services provided during and after fiscal year 2021, is decreased to $220 million. (This fund was intended to be available for improvements to the original fee-for-service program under Parts A and B.)
- An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018 (Public Law 115-97, enacted on December 22, 2017, and also referred to as the Tax Cuts and Jobs Act of 2017) included three provisions that affect the HI program.
  - » Federal income tax rates for individuals are reduced, effective for taxable years beginning after December 31, 2017 and ceasing to apply after December 31, 2025. In addition, the inflation index applied to the tax bracket thresholds and standard deductions is changed, effective for taxable years beginning after December 31, 2017, such that these amounts will permanently grow more slowly than under prior law.
  - » The requirement that most individuals be covered by a health insurance plan or pay a financial penalty, commonly referred to as the individual mandate, is repealed, effective January 1, 2019. Accordingly, the percentage of people without health insurance is expected to increase. Because the change in this percentage is a factor used in determining payments to Medicare disproportionate share hospitals for uncompensated care, these payments are expected to increase as well. In addition, in light of this repeal, it is expected that some individuals will drop their employer-sponsored health insurance, thereby slightly increasing HI covered wages and taxable payroll.
  - » Temporary tax changes for certain small businesses are made that will affect reported self-employment income and, in turn, HI covered wages and taxable payroll.
- An Act Making Further Continuing Appropriations for the Fiscal Year Ending September 30, 2018, and for Other Purposes (Public Law 115-120, enacted on January 22, 2018) included one provision that affects the HI and SMI programs.
  - » A moratorium for calendar year 2019 is placed on the annual fee to be paid by health insurance providers. This fee is imposed on certain large health insurance providers, including those furnishing coverage under Medicare Advantage (Part C) and Medicare Part D.
- The Bipartisan Budget Act of 2018 (BBA 2018; Public Law 115-123, enacted on February 9, 2018) included provisions that affect the HI and SMI programs.
  - » The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines, as described in previous annual reports, is extended by 2 years, through fiscal years 2026 and 2027.
  - » The Independent Payment Advisory Board (IPAB) and all related provisions are repealed, effective upon enactment. (The IPAB was established by the Affordable Care Act to develop and submit

proposals aimed at extending the solvency of Medicare, slowing Medicare cost growth, and improving the quality of care delivered to Medicare beneficiaries.)

» For Medicare Advantage plans and stand-alone Part D plans that undergo a contract consolidation approved on or after January 1, 2019, the star rating (and any quality bonus payment) for the surviving contract is to reflect an enrollment-weighted average of the ratings for the continuing and closed contracts.

» The authority for Medicare Advantage Special Needs Plans (SNPs), which was due to expire on December 31, 2018, is permanently extended. A number of reforms to dual-eligible SNPs and chronic-condition SNPs are also mandated.

» For Medicare Advantage plans, certain provisions are enacted, effective January 1, 2020, which permit plans to offer to chronically ill enrollees (i) a broader range of supplemental benefits (which may include services that are not primarily health care services), as long as the benefit offers a reasonable expectation of improving or maintaining health or overall function, and (ii) expanded telehealth services as supplemental benefits, subject to certain specified requirements. In addition, the Value-Based Insurance Design (VBID) Model, which is a pilot program allowing certain plans to offer supplemental benefits or reduced cost sharing to enrollees with certain chronic conditions, is expanded, effective no later than January 1, 2020, to allow plans in all States the opportunity to participate in it. The VBID program is also made exempt, through December 31, 2021, from certain spending and quality-of-care testing to which it would otherwise be subjected.

» For Medicare Accountable Care Organizations (ACOs), certain provisions are enacted to (i) provide more opportunities for beneficiaries to be assigned to, or voluntarily align with, ACOs; (ii) allow for the use of beneficiary incentive programs; and (iii) allow for expanded use of telehealth services. The specific types of ACOs to which each of these changes apply, as well as the effective dates, vary.

» Funding for the National Quality Forum is provided from the HI and SMI trust funds for the remainder of fiscal year 2017 and for fiscal years 2018 and 2019.

» Funding for certain low-income outreach and assistance programs is extended 2 years, through September 30, 2019.

» Certain existing civil and criminal penalties are substantially increased for providers and suppliers who violate health care fraud and abuse laws, effective upon enactment.

» For home health agencies serving beneficiaries in rural areas, the 3 percent add-on payment is extended 1 year, through December 31, 2018. Then, for services furnished in rural areas from 2019 through 2022, three separate tiers of add-on adjustments are established, based on Medicare home health utilization and low-population density; these adjustments diminish over varying periods of time (and become 0 percent no later than 2020). Also, for services furnished on or after January 1, 2019, home health agencies are required to report the county in which the services are furnished.

» For the Medicare home health prospective payment system (PPS), the annual update for calendar year 2020 is set at 1.5 percent.

» Under the home health PPS, the unit of payment for home health services is changed from a 60 day to a 30-day episode of care, beginning in 2020. This change must be made in a budget-neutral manner, but adjustments to offset anticipated behavior changes that could result from the modified methodology are allowed. Also beginning in 2020, therapy thresholds are removed from the home health case mix adjustment.

» To demonstrate home-bound and medical-necessity status when determining if a patient is eligible for home health services, documentation in the medical records of home health agencies can be used as supporting material, in addition to documentation in the medical records of the certifying physician, effective January 1, 2019.

» For telehealth services furnished for purposes of diagnosis, evaluation, or treatment of

symptoms of an acute stroke, the geographic restriction that limits originating sites to rural areas is eliminated, provided that all other Medicare telehealth coverage requirements are satisfied. In addition, no originating site facility fee is to be paid to sites that do not meet the current geographic and site type requirements. This provision is effective beginning on January 1, 2019.

» For the Medicare electronic health records incentive program, the provision requiring more stringent measures of meaningful use, over time, is eliminated, effective upon enactment.

» The funding amount of $220 million previously provided for the Medicare Improvement Fund (as noted above) is eliminated.

» The Medicare-Dependent Hospital (MDH) program is extended for 5 fiscal years, through September 30, 2022. In addition, the program is extended to certain rural hospitals that are located in all-urban States and that otherwise meet the MDH criteria.

» Medicare inpatient hospital add-on payments for low-volume hospitals are extended for 5 fiscal years, through September 30, 2022. In addition, for fiscal years 2019 through 2022, changes are made to the qualifying criteria (which are to be based on total discharges or Medicare discharges, depending on the year, and on the distance from another inpatient hospital) and to the add-on adjustments (which are to be based on a sliding scale ranging from 25 percent to 0 percent).

» Two changes are made to the long-term care hospital (LTCH) site-neutral provision. First, the originally mandated 2-year transition period is extended for 2 additional years, covering fiscal years 2018 and 2019. Second, the inpatient hospital PPS comparable amount used in the site-neutral payment rate calculations for fiscal years 2018 through 2026 is to be reduced by 4.6 percent.

» For the inpatient hospital diagnosis-related groups (DRGs) subject to the post-acute care transfer policy, hospice is added as a setting of care, effective October 1, 2023.

» For the Medicare skilled nursing facility PPS, the annual update for fiscal year 2019 is set at 2.4 percent.

» Physician assistants are added to the types of providers who may serve as attending physicians for the purposes of hospice care, effective January 1, 2019. (Previously, only physicians and nurse practitioners could serve.) Like nurse practitioners, physician assistants are not permitted to provide the written certification of terminal illness required for hospice services.

» A new income-related premium threshold is established. Specifically, beginning in calendar year 2019, individuals with incomes at or above $500,000 (and couples with incomes at or above $750,000) will pay premiums covering 85 percent (rather than 80 percent) of the average program cost for aged beneficiaries. These new threshold levels will not be inflation-adjusted until 2028 and later.

» The 1.00 floor on the geographic index for physician work is extended for 2 additional years, through December 31, 2019.

» The physician fee schedule update for 2019, which had been set at 0.5 percent, is decreased to 0.25 percent.

» A number of changes are made to the merit-based incentive payment system (MIPS) for physicians, including that it be applied only to covered professional services instead of to items and services (thereby excluding, most prominently, physician-administered Part B drugs) and that its transition period be extended by 3 years (such that the post-transition period now begins in 2022, not 2019). Certain additional changes to the system are mandated for the extended transition period, and others are mandated for the period thereafter. Effective dates vary.

» The annual payment limits on therapy services are permanently repealed, beginning on January 1, 2018. The threshold for the targeted manual medical review process is lowered, from $3,700 to $3,000, effective as of the same date and until 2028, after which the threshold is to be increased by a specified formula.

- Outpatient physical and occupational therapy services furnished by a therapy assistant are paid at 85 percent of the amount that otherwise would have been paid under the fee schedule, effective January 1, 2022.

- The freeze on coding and valuation of certain radiation therapy services reimbursed under the fee schedule, in place for 2017 and 2018, is extended through 2019.

- For qualified home infusion therapy suppliers, a temporary transitional payment for administering home infusion therapy is established, beginning on January 1, 2019. Payment rates in three categories will apply during the transition period, which will end on December 31, 2020, after which a new payment methodology will begin.

- Certain ground ambulance add-on payments are extended 5 additional years, through December 31, 2022. (These add-on payments include a 3 percent bonus for services originating in rural areas, a 2 percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.) The development of a system to collect certain data from providers and suppliers of ground ambulance services is also mandated.

- For non-emergency ground ambulance transports of beneficiaries with end-stage renal disease (ESRD) to and from renal dialysis services, the reduction in payments is increased from 10 percent to 23 percent for transports furnished on or after October 1, 2018.

- For beneficiaries with ESRD who receive home dialysis, all monthly physician visits can be provided via telehealth, beginning on January 1, 2019, as long as the beneficiary receives one in-person visit monthly for the initial 3 months and at least one every 3 months thereafter. (Previously, at least one in-person visit per month was required.) Also, the originating site requirements are modified in several ways, and no site facility fee is to be paid if the beneficiary's home is the originating site.

- Conditions are added to those that allow a beneficiary who qualifies for cardiac rehabilitation services to qualify for the more intensive set of services, effective upon enactment. Also, the supervision requirements for cardiac rehabilitation, intensive cardiac rehabilitation, and pulmonary rehabilitation are changed to allow physician assistants, nurse practitioners, and clinical nurse specialists (in addition to physicians) to supervise these programs, effective January 1, 2024.

- A provision of the Steve Gleason Act of 2015, requiring that Medicare payment for rental or lump-sum purchase of speech-generating devices and accessories be made without a cap on the amount, is made permanent.

- Enforcement is delayed an additional year, through December 31, 2017, for the instruction that, for outpatient therapeutic services provided in critical access and small rural hospitals, a physician or non-physician practitioner must provide direct supervision throughout the performance of a procedure. (In the 2018 outpatient hospital PPS rule, CMS extended these non-enforcement instructions for 2018 and 2019 and noted that, for 2017, while there was not a non-enforcement instruction in place, Medicare administrative contractors were directed not to prioritize enforcement of this requirement for these hospitals. This legislation provides the non-enforcement instruction that had been lacking for 2017.)

- Under the Part D standard benefit structure, the coverage gap closes 1 year earlier than previously scheduled for brand-name drugs only; that is, for brand-name drugs, beneficiaries in the coverage gap (excluding low-income enrollees eligible for cost-sharing subsidies) will pay 25 percent of drug costs beginning on January 1, 2019 (instead of 30 percent in 2019 and 25 percent thereafter). Also beginning on that date, these beneficiaries will receive a 70 percent manufacturer discount (instead of 50 percent) and a 5 percent benefit (instead of 20 percent in 2019 and 25 percent thereafter) from their Part D plans for applicable prescription drugs. (For purposes of drug discounts while beneficiaries are in the Part D coverage gap, applicable drugs are generally covered brand-name Part D drugs, while non-applicable drugs are generally covered generic Part D drugs.) For

generic drugs, the law remains the same, with beneficiaries paying 37 percent of drug costs in 2019 and 25 percent thereafter.

» For purposes of drug discounts while beneficiaries are in the Part D coverage gap, the definition of applicable drugs is expanded to include biosimilars, effective January 1, 2019. (Applicable drugs previously included biologics but not biosimilars.)

Overall these provisions resulted in a decrease in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures and a slight decrease to the present value of estimated future income, with an overall net decrease in the estimated future net cash flow. For Part B and Part D, these changes increased the present value of estimated future expenditures (and also income).

For the period beginning on January 1, 2016 to the period beginning on January 1, 2017

Most of the provisions enacted as part of Medicare legislation since the prior valuation date had little or no impact on the program. The following provisions did have a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

- The 21st Century Cures Act included provisions that affect the HI and SMI Part B programs.

  » For inpatient hospital services, the adjustment to the payment rate increase of 0.5 percentage point for fiscal year 2018, as established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is reduced to an adjustment of 0.4588 percentage point. (The adjustments to the rate increases of 0.5 percentage point for each of fiscal years 2019 through 2023, as also established by MACRA, are unchanged.)

  » For long-term care hospital (LTCH) discharges occurring during fiscal year 2017, the LTCH 25-percent rule is suspended.

  » A change is made to the moratorium that prohibits the classification of new LTCHs and new LTCH satellite facilities and an increase in beds for existing LTCHs and existing LTCH satellite facilities. No exceptions to the moratorium had been provided to allow existing LTCHs and existing LTCH satellite facilities to increase their number of certified beds; however, under the Cures Act, these existing facilities are permitted to do so. This provision is effective as if the exception for these bed increases had always applied during the moratorium. A reduction to high-cost outlier payments to LTCH standard rate cases, through an increase to the qualifying threshold, is also provided for and is intended to offset costs of the moratorium exceptions provision.

  » Several changes are made that involve the LTCH site-neutral provision.

    - The first modification is to the calculation of the average length of stay for certain LTCHs. Under prior law, discharges paid at the site-neutral payment rate or by an MA plan were excluded from calculations determining the hospital's average length of stay, effective for cost-reporting periods starting on or after October 1, 2015. Under the Cures Act, this carve-out of site-neutral and MA discharges (which is generally advantageous to LTCHs) applies to the average length of stay calculation for newer LTCHs as well. Thus, the average length of stay calculation methodology is now the same for all LTCHs. This provision is effective retroactively, for cost-reporting periods starting on or after October 1, 2015.

    - Next, a temporary exception to the site-neutral criteria is provided for certain LTCHs that primarily treat patients with brain and spinal cord injuries, are non-profit, and have a significant number of admissions from out of state, for all discharges in cost-reporting periods beginning during fiscal years 2018 and 2019.

    - Finally, a temporary exception to the site-neutral criteria is created for certain discharges from certain LTCHs for beneficiaries receiving treatment for specified types of severe wounds. To qualify for the exception, the stay for one of the specified types of severe wounds must be classified under one of four specified Medicare severity LTCH diagnosis-related groups (MS-LTC-DRGs). Further, the facility

must be a grandfathered LTCH. This provision is effective for these specified discharges occurring in cost-reporting periods that begin during fiscal year 2018.

» The Secretary of HHS is authorized to deny payment for services provided in temporary moratorium areas (which are geographic areas that have been established by CMS for specified types of providers, for the development and improvement of investigating and prosecuting fraud). Previously, denial was based on the location of the provider rather than on the location of the patient; this provision eliminates the ability of a provider to locate a business office outside of a moratorium area but be paid for services furnished within it.

» Medicare beneficiaries with end-stage renal disease are allowed to enroll in MA plans, effective for plan years beginning in 2021 and later. Standard acquisition costs for kidneys are to be removed from the capitation rates and paid for by traditional Medicare.

» Additional requirements are established for assigning Medicare FFS beneficiaries to accountable care organizations (ACOs) under the Medicare shared savings program. Specifically, the basis for assignment is required to reflect beneficiaries' utilization of not only primary care services provided by ACO physicians but also services furnished in federally qualified health centers or rural health clinics, effective for performance years beginning on or after January 1, 2019.

» Under the competitive bidding program for certain durable medical equipment (DME) items, the transition period is extended, such that the implementation of payments based entirely on the competitively bid rates (rather than on a blend of these rates and rates under the prior fee schedule payment methodology) is delayed retroactively, from July 1, 2016 to January 1, 2017.

  ▪ Also, for DME providers in non-competitively bid, new considerations are stipulated for determining adjustments to the competitively bid prices. Specifically, the Secretary of HHS is required to take into account stakeholder input and the highest winning bid in the competitively bid areas and to compare, with respect to non-competitively and competitively bid areas, the average travel distance and cost associated with furnishing the items and services, the average volume of the items and services furnished by suppliers, and the number of suppliers. This provision is effective for services furnished on or after January 1, 2019.

» For infusion drugs furnished by suppliers of DME, the reimbursement methodology is changed from 95 percent of the average wholesale price to the average sales price plus 6 percent (that is, to the methodology used for most physician-administered drugs), effective January 1, 2017. Also, these drugs are removed from the DME competitive acquisition areas, beginning on the date of enactment.

» Qualified home infusion therapy suppliers are to be reimbursed for administering home infusion therapy, effective January 1, 2021. Certain requirements and standards for suppliers, as well as payment methodology, are established.

» As described in last year's report, the Bipartisan Budget Act of 2015 (BBA) directed that outpatient hospital services provided by new off-campus hospital-based outpatient entities (that is, those established on or after the BBA date of enactment of November 2, 2015 and located more than 250 yards from the hospital campus) are excluded from the outpatient hospital PPS, effective for services provided on or after January 1, 2017 (with certain exceptions, particularly for specific dedicated emergency departments). These services are instead to be reimbursed under the Medicare physician fee schedule or the ambulatory surgical center PPS (both of which provide lower reimbursement rates than the outpatient hospital PPS).

  ▪ The Cures Act provides an exception for off-campus hospital provider-based outpatient entities that were "mid-build" on November 2, 2015. A mid-build entity is one that had a binding written agreement, before November 2, 2015, with an outside unrelated party for actual construction of the

new off-campus department. To be eligible under this exception, the host hospital must (i) file a certification that the department meets the mid-build status requirement; (ii) file an attestation that the department is provider-based; and (iii) add the department to the host hospital's Medicare enrollment form. Entities that qualify will be eligible to bill under the outpatient PPS for services provided on or after January 1, 2018.

- Under the Cures Act, an off-campus outpatient department can also be eligible for payment under the outpatient hospital PPS for services furnished in 2017 if the host hospital submitted a voluntary attestation, prior to December 2, 2015, stating that the department is provider-based. (Under separate guidance from CMS that governs submission of provider-based attestations, for a hospital to have taken this step, the construction of the new off-campus outpatient department would have been completed and the hospital accepting, or poised to accept, patients. Thus, this exception benefits only a small number of departments that fell just outside of the deadline contained in the BBA.)

- To clarify, while the relief for 2017 applies only to off-campus outpatient departments with provider-based attestations filed before December 2, 2015, the relief for 2018 and beyond applies more broadly to off-campus outpatient departments with construction agreements in place as of November 2, 2015 (including hospitals eligible for the 2017 exception). Hence, most hospitals that qualify for the exception under this provision are not eligible for payment under the outpatient PPS during 2017 and are, instead, subject to lower payments for services furnished during that year, with return to the outpatient hospital PPS effective for services furnished on or after January 1, 2018.

» Off-campus outpatient departments of certain cancer hospitals are also granted exception from the BBA provision described above, thereby confirming that the BBA legislation intended these facilities to remain under their existing separate payment system. To qualify, these locations must file attestations stating that they are provider-based, within 60 days of the date of enactment or within 60 days of meeting the provider-based requirement. The attestations are subject to audit. A reduction to the additional payments that cancer hospitals receive (relative to payments under the inpatient hospital PPS) is also provided for and is intended to offset costs of the BBA exception for off-campus outpatient cancer hospital departments.

» Enforcement is delayed an additional year, through December 31, 2016, for the regulation requiring that, for outpatient therapeutic services provided in critical access and small rural hospitals, a physician or non-physician practitioner must provide direct supervision throughout the performance of a procedure.

» For wheelchair accessories and seat and back cushions furnished in connection with complex rehabilitative power wheelchairs, fee schedule adjustments do not apply until July 1, 2017 (which is a delay of 6 months relative to the previously stipulated date of January 1, 2017).

Overall these provisions resulted in a very small increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in a decrease to the present value of estimated future expenditures and had no impact on the present value of estimated future income. For Part B, these changes increased the present value of estimated future expenditures (and also income). These changes had no impact on Part D.

NOTE 15:

BUDGET AND ACCRUAL RECONCILIATION

(DOLLARS IN MILLIONS)

	Intra-Government	With the Public	Total
NET OPERATING COST (SNC)	**$893**	**$1,008,182**	**$1,009,075**
Components of net cost not part of the budget outlays			
Property, plant, and equipment Depreciation		**$(336)**	**$(336)**
Other		**446**	**446**
		$110	**$110**
Increase/(Decrease) in Assets:			
Accounts receivable		**$(5,775)**	**$(5,775)**
Other asset - Regulatory Assets		**(29,554)**	**(29,554)**
		$(35,329)	**$(35,329)**
(Increase)/Decrease in Liabilities:			
Accounts Payable	**$(4)**	**$9,206**	**$9,202**
Other liabilities (Salaries and Benefits, Unfunded Leave, Unfunded FECA, Actuarial FECA)	**(839)**	**3,842**	**3,003**
	$(843)	**$13,048**	**$12,205**
Other Financing Sources:			
Federal employee retirement benefit costs paid by OPM and imputed to the agency	**$(79)**		**$(79)**
Transfers out (in) without reimbursement	**4,057**		**4,057**
	$3,978		**$3,978**
Components of the budget outlays that are not part of net cost:			
Other	**$(423)**	**$5,038**	**$4,615**
	$(423)	**$5,038**	**$4,615**
Other			**$51**
NET OUTLAYS	**$3,605**	**$991,049**	**$994,705**
Related Amounts on the Statement of Budgetary Resources			
Outlays, net			**$1,461,724**
Distributed offsetting receipts			**(467,019)**
AGENCY OUTLAYS, NET			**$994,705**

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's 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 over 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 *2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The projections in this year's report are based on current law and include the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; Public Law 114-10), which repealed the sustainable growth rate (SGR) formula that set physician fee schedule payments. 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 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 gap will continue to widen throughout the projection, and the Trustees previously estimated that physician payment rates under current law will be lower than they would have been under the SGR formula by 2048. Absent a change in the delivery system or level of update by subsequent legislation, access to Medicare-participating physicians may 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 (Public Law 112-240, enacted on January 2, 2013); 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; the Protecting Access to Medicare Act of 2014 (Public Law 113-93, enacted on April 1, 2014); the Bipartisan Budget Act of 2015 (Public Law 114-74, enacted on November 2, 2015); and the Bipartisan Budget Act of 2018 (Public Law 115-123, enacted on February 9, 2018). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2027 and by 4 percent from April 1, 2027 through September 30, 2027. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013 through September 30, 2027.

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 or ACA, contains 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 ACA 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 could 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 challenges in projecting health care cost growth over time. The current-law expenditure projections reflect the physicians' payment levels expected under the MACRA payment rules and the ACA-mandated reductions in other Medicare payment rates. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes that (i) there would be a transition from current-law payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for health care productivity; (ii) the average physician payment updates would transition from current law to payment updates that reflect the Medicare Economic Index; and (iii) the 5-percent bonuses for physicians in advanced alternative payment models (advanced APMs) and the $500-million payments for physicians in the merit-based incentive payment system (MIPS) would continue indefinitely rather than expire in 2025. The timing of these assumed transitions in payment updates is later for this year's annual report than it was in prior reports. The difference between the illustrative alternative and the current-law projections continues to demonstrate that the long-range costs could be substantially higher than shown throughout much of the report if the MACRA[1] and ACA[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 13 in these financial statements, in section 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 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/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.[3]

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 for physicians in advanced APMs or MIPS, respectively. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.2 percent per year in the long range.

2 Under the ACA, Medicare's annual payment rate updates for most categories of provider services 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).

3 The Trustees' methodology is consistent with Finding III-2 and Recommendation III-3 of the 2010-2011 Medicare Technical Review Panel and with Finding 3-2 of the 2016-2017 Medicare Technical Review Panel. The Panels' final reports are available at http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf and at https://aspe.hhs.gov/system/files/pdf/257821/MedicareTechPanelFinalReport2017.pdf.

In December 2011, the Technical Panel unanimously recommended a new approach that builds off of the longstanding Gross Domestic Product (GDP) plus 1 percent assumption while incorporating several key refinements.[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 ACA) 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-ACA 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 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.

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 ACA, 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.[6] 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 ACA were not adjusted for potential productivity gains. Accordingly, Medicare costs per beneficiary would have increased somewhat faster than for the health sector overall. The ACA 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 provider services:

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 3.9 percent in 2042, or GDP plus 0.0 percent, declining gradually to 3.5 percent in 2092, or GDP minus 0.3 percent.[8]

4 See Recommendation III-1. 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.

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

8 These growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent.

ii. Physician services

Payment rate updates are 0.75 percent per year for those physicians assumed to be participating in advanced APMs and 0.25 percent for those assumed to be participating in MIPS. The year-by-year per capita growth rates for physician payments are assumed to be 3.6 percent in 2042, or GDP minus 0.3 percent, declining to 2.8 percent in 2092, or GDP minus 1.0 percent.

iii. Certain SMI Part B services that are updated annually by the Consumer Price Index (CPI) increase less the increase in economy-wide productivity.

Such services include durable medical equipment that is not subject to competitive bidding,[9] care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.1 percent in 2042, or GDP minus 0.8 percent, declining to 2.7 percent in 2092, 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 17 percent of total Part B expenditures in 2026 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.[10] 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 4.7 percent in 2042, or GDP plus 0.8 percent, declining to 4.3 percent by 2092, 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 four long-range assumptions, the weighted average growth rate for Part B is 3.6 percent per year for the last 50 years of the projection period, or GDP minus 0.3 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 3.8 percent over this same time period or GDP minus 0.1 percent, while the growth rate in 2092 is 3.7 percent or GDP minus 0.1 percent.

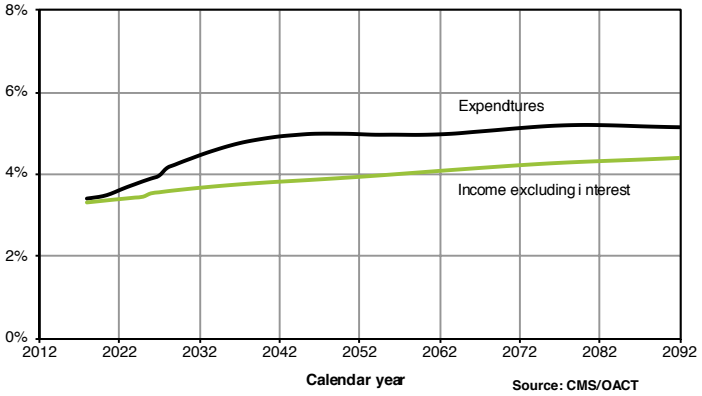
HI Cashflow as a Percentage of Taxable Payroll

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 2018 report are higher than those from the 2017 report for all years largely due to higher spending and lower taxable payroll in all projected years.

CHART 1

HI EXPENDITURES AND INCOME EXCLUDING INTEREST AS A PERCENTAGE OF TAXABLE PAYROLL // 2018 – 2092



Since the standard HI payroll tax rates are not scheduled to change in the future under current law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. In addition, starting in 2013, high-income workers pay an additional 0.9 percent of

9 The portion of durable medical equipment that is subject to competitive bidding is included with all other Medicare services since the price is determined by a competitive bidding process.

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

their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns). Because these income thresholds are not indexed, over time an increasing proportion of workers will become subject to the additional HI tax rate, and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation, since the income thresholds determining taxable benefits are not indexed for price inflation. Thus, as chart 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 in 2018, largely due to (i) expenditure growth that was constrained in part by low utilization and low payment updates and (ii) a rebound of taxable payroll growth from 2007-2009 recession levels. After 2018 the cost rate is projected to rise primarily due to the continued 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 0.8 percent through 2027 and 1.1 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 5.3 percent in 2043 and 8.1 percent in 2092.

HI and SMI Cash Flow 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.

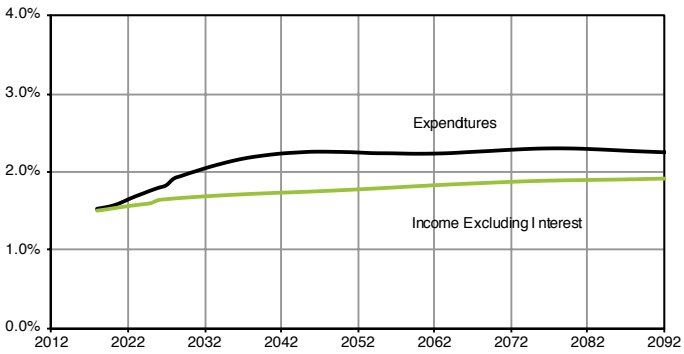
HI

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2017, the expenditures were $296.5 billion, which was 1.5 percent of GDP. This percentage is projected to increase steadily until about 2046 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 3.5 percent in 2092.

CHART 2

HI EXPENDITURES AND INCOME EXCLUDING INTEREST AS A PERCENTAGE OF GDP // 2018 – 2092



Source: CMS/OACT

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 2017, SMI expenditures were $413.6 billion, or about 2.1 percent of GDP. Under current law, they would grow to about 3.7 percent of GDP within 25 years and to 3.9 percent by the end of the projection period. (Under the illustrative alternative, total SMI expenditures in 2092 would be 5.4 percent of GDP.)

CHART 3

SMI EXPENDITURES AND PREMIUMS AS A PERCENTAGE OF GDP // 2018 – 2092

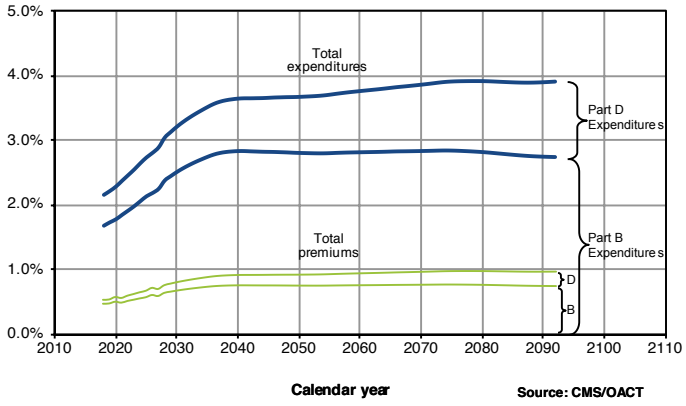
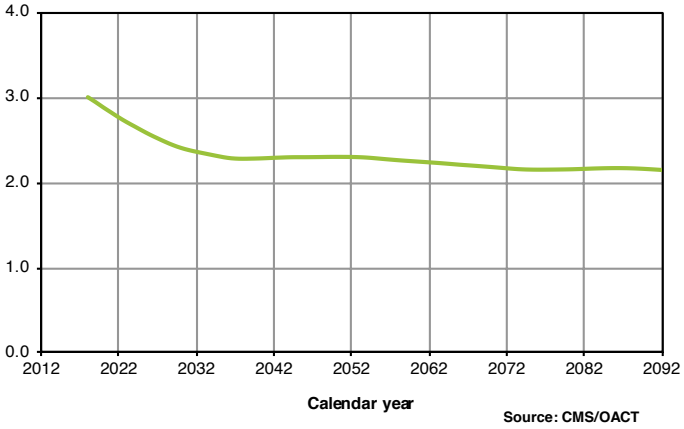


CHART 4

NUMBER OF COVERED WORKERS PER HI BENEFICIARY // 2018 – 2092



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 2017 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 2017, every beneficiary had 3.1 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 2092.

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 current 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.[11] The assumptions varied are the health care cost factors, real wage differential, CPI, real interest rate, fertility rate, and net immigration.[12]

For this analysis, the intermediate economic and demographic assumptions in the *2018 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, 2018 and are based on estimates of income and expenditures during the 75 year projection period.

11 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 cash flow, since the change would affect income and expenditures equally.

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

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values 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 for computing present values, which is used to help interpret the net cash flow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75 year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Health Care Cost Factors

Table 1 shows the net present value of cash flow 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 projections.

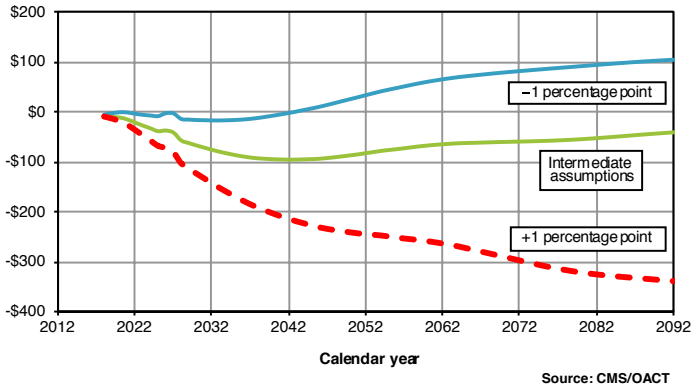
Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $7,812 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $12,473 billion.

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

This assumption has a dramatic impact on projected HI cash flow. The present value of the net cash flow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus due to the improved financial outlook for the HI trust fund as a result of the ACA. Several factors, such as the utilization of services by beneficiaries

CHART 5

PRESENT VALUE OF HI NET CASH FLOW WITH VARIOUS HEALTH CARE COST FACTORS // 2018 – 2092 *(in billions)*



Source: CMS/OACT

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 cash flow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.2, and 1.8 percentage points.[13] In each case, the assumed ultimate annual increase in the CPI is 2.6 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.2, 3.8, and 4.4 percent, respectively.

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 $1,995 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $1,060 billion.

Chart 6 shows projections of the present value of the estimated net cash flow 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 cash flow 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-

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

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)	**$3,104**	**−$4,708**	**−$17,180**

TABLE 2

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

Ultimate percentage increase in wages − CPI	**3.2 – 2.6**	**3.8 – 2.6**	**4.4 – 2.6**
Ultimate percentage increase in real-wage differential	**0.6**	**1.2**	**1.8**
Income minus expenditures (in billions)	**−$5,979**	**−$4,708**	**−$2,314**

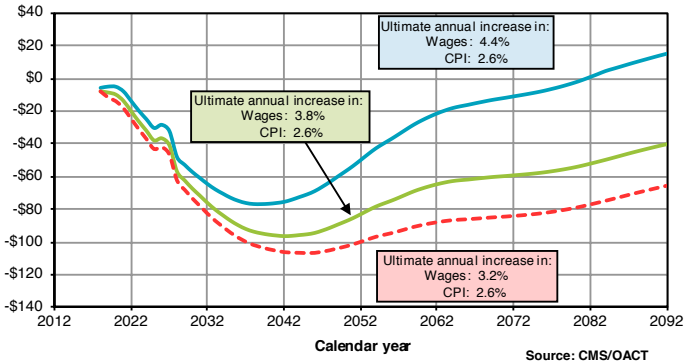
TABLE 3

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

Ultimate percentage increase in wages − CPI	**4.4 – 3.2**	**3.8 – 2.6**	**3.2 – 2.0**
Income minus expenditures (in billions)	**−$3,648**	**−$4,708**	**−$6,083**

CHART 6

PRESENT VALUE OF HI NET CASH FLOW WITH VARIOUS REAL-WAGE ASSUMPTIONS // 2018 – 2092 *(in billions)*



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 ACA and MACRA depends critically on the sustainability of the lower Medicare price updates for hospitals and other HI providers. Sustaining these price reductions will be challenging for health care providers, 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.

Consumer Price Index

Table 3 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.2, 2.6, 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 4.4, 3.8, and 3.2 percent, respectively.

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.2 percent, the deficit decreases by $1,060 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by $1,376 billion.

CHART 7

PRESENT VALUE OF HI NET CASH FLOW WITH VARIOUS CPI-INCREASE ASSUMPTIONS // 2018 – 2092 *(in billions)*

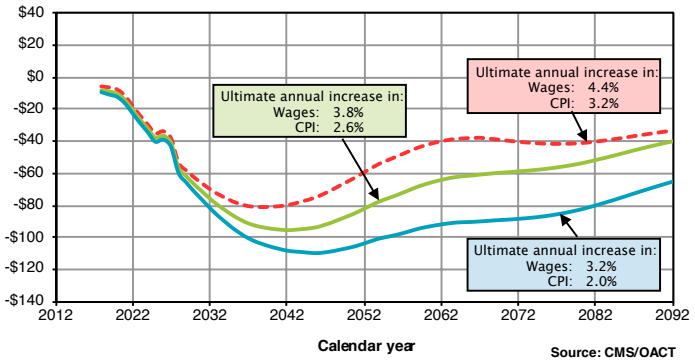


CHART 8

PRESENT VALUE OF HI NET CASH FLOW WITH VARIOUS REAL-INTEREST RATE ASSUMPTIONS // 2018 – 2092 *(in billions)*

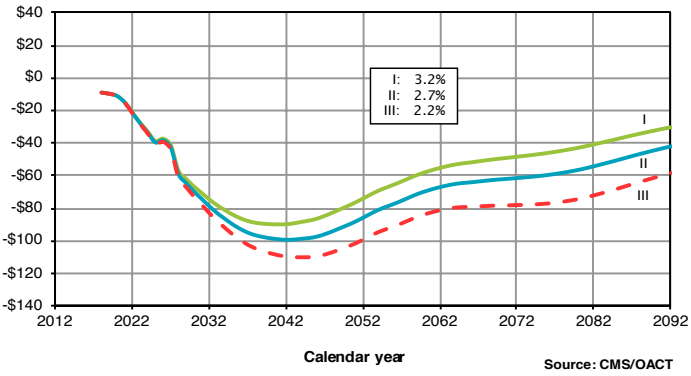


Chart 7 shows projections of the present value of net cash flow under the three alternative CPI rate-of-increase assumptions presented in table 3.

As chart 7 indicates, this assumption has a small impact when the cash flow is expressed as present values. The projected present values of HI cash flow are relatively insensitive to the assumed level of general price inflation because price inflation has about the same proportionate effect on income as it does on costs. 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 ACA for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice versa.

Real-Interest Rate

Table 4 shows the net present value of cash flow during the 75 year projection period under three alternative ultimate annual real-interest assumptions: 2.2, 2.7, and 3.2 percent. In each case, the assumed ultimate annual increase in the CPI is 2.6 percent, which results in ultimate annual yields of 4.8, 5.3, and 5.8 percent, respectively.

As illustrated in table 4, for every increase of 0.1 percentage point in the ultimate real-vinterest rate, the deficit decreases by approximately $150 billion.

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

As shown in chart 8, the projected HI cash flow 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 2026. 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 cash flow 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 $560 billion.

Chart 9 shows projections of the present value of the net cash flow 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 cash flows. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, and many will

TABLE 4

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

Ultimate real-interest rate	2.2 PERCENT	2.7 PERCENT	3.2 PERCENT
Income minus expenditures (in billions)	**–$5,542**	**–$4,708**	**–$4,018**

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)	**–$5,265**	**–$4,708**	**–$4,146**

[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.

TABLE 6

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

Average annual net immigration	952,000	1,272,000	1,607,000
Income minus expenditures (in billions)	**–$4,973**	**–$4,708**	**–$4,503**

CHART 9

PRESENT VALUE OF HI NET CASH FLOW WITH VARIOUS ULTIMATE FERTILITY RATE ASSUMPTIONS // 2018 – 2092 *(in billions)*

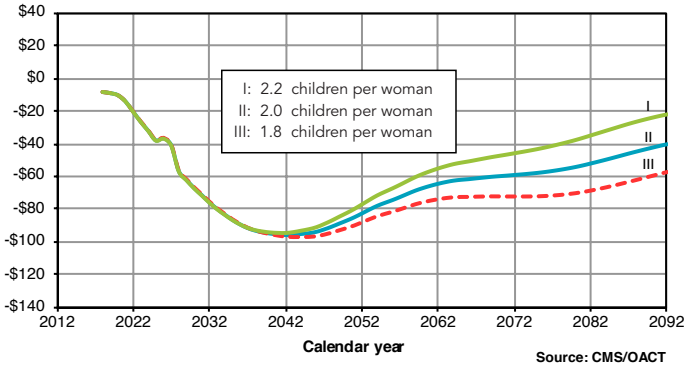
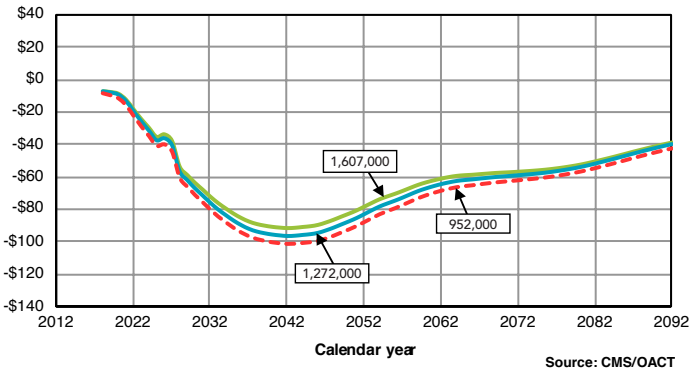


CHART 10

PRESENT VALUE OF HI NET CASH FLOW WITH VARIOUS NET IMMIGRATION ASSUMPTIONS // 2018 – 2092 *(in billions)*



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 cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 952,000 persons, 1,272,000 persons, and 1,607,000 persons per year.

As indicated in table 6, if the average annual net immigration assumption is 952,000 persons, the deficit—expressed in present-value dollars—increases by $265 billion. Conversely, if the assumption is 1,607,000 persons, the deficit decreases by $205 billion.

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

Higher net immigration results in smaller HI cash flow 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 has deteriorated as compared to the projections in last year's annual report. Under the Medicare Trustees' intermediate assumptions, the estimated depletion date for the HI trust fund is 2026, 3 years earlier than 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 income is projected to be lower than last year's estimates due to (i) lower payroll taxes attributable to lowered wages for 2017 and lower levels of projected GDP and (ii) lower income from the taxation of Social Security benefits as a result of legislation. HI expenditures are projected to be slightly higher than last year's estimates, mostly due to higher-than-expected spending in 2017, legislation that increased hospital spending, and higher Medicare Advantage payments.

HI expenditures exceeded income each year from 2008 through 2015. In 2016 and 2017, however, there were fund surpluses amounting to $5.4 billion and $2.8 billion, respectively. The Trustees project deficits in all future years until the trust fund becomes depleted in 2026. 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 2018 is adequate to cover 2018 expected expenditures.[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 trust fund is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

Medicare Overall

Federal law requires the Board of Trustees to test 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 (2018 2024). If this level is attained within the 7-year timeframe, the law requires a determination of projected excess general revenue Medicare funding. For the 2018 Medicare Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2022, and therefore the Trustees are issuing this

14 A hold-harmless provision limited the Part B premium increase in 2016 and 2017 for about 70 percent of enrollees. These Part B enrollees saw an increase in their Part B premium from about $109 in 2017, on average, to about $130, on average, in 2018.

15 Dedicated Medicare financing sources used in this year's determination 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.

determination. Since this is the second consecutive such finding, the law specifies that a Medicare funding warning is triggered and that the President must submit to Congress proposed legislation to respond to the warning within 15 days after the submission of the Fiscal Year 2020 Budget. The law also requires Congress to consider the legislation on an expedited basis. Such funding warnings were previously made in each of the 2007 through 2013 reports. To date, elected officials have not enacted legislation responding to these funding warnings.

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 2018 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."

COMBINING STATEMENT OF BUDGETARY RESOURCES

for the year ended September 30, 2018

(in millions)

	Medicare		Payments to Trust Funds	Medicaid	CHIP	Medicare Part D	Other Health	All Others	Combined Totals Budgetary
	HI TF	SMI TF							
BUDGETARY RESOURCES:									
Unobligated balance from prior year budget authority, net (discretionary and mandatory)	$225	$345	$6,084	$45,360	$23,336	$8	$5,439	$5,166	$85,963
Appropriations (discretionary and mandatory)	302,701	327,134	352,289	405,629	20,113	88,835		2,424	1,504,939
Borrowing authority (discretionary and mandatory)							(127)		(127)
Spending authority from offsetting collections (discretionary and mandatory)				1,417		(7,316)	16	6,447	564
TOTAL BUDGETARY RESOURCES	$302,926	$327,479	$358,373	$452,406	$43,449	$81,527	$11,142	$14,037	$1,591,339
STATUS OF BUDGETARY RESOURCES:									
New Obligations and upward adjustments (Note 11)	$302,926	$327,479	$345,819	$437,004	$17,489	$81,527	$5,771	$8,899	$1,526,914
Unobligated balance, end of year									
Apportioned, unexpired accounts			6,470	15,093	6,602		3,498	2,976	34,639
Exempt from Apportionment, unexpired accounts									
Unapportioned, unexpired accounts				309	4,608		1,873	1,173	7,963
Unexpired unobligated balance, end of year			6,470	15,402	11,210		5,371	4,149	42,602
Expired unobligated balance, end of year			6,084		14,750			989	21,823
Unobligated balance, end of year (total)			12,554	15,402	25,960		5,371	5,138	64,425
TOTAL BUDGETARY RESOURCES	$302,926	$327,479	$358,373	$452,406	$43,449	$81,527	$11,142	$14,037	$1,591,339
OUTLAYS, NET:									
Outlays, net (discretionary and mandatory)	301,412	325,831	343,981	384,997	17,281	82,486	4,424	1,312	1,461,724
Distributed offsetting receipts	(35,893)	(430,777)			(27)			(322)	(467,019)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	$265,519	$(104,946)	$343,981	$384,997	$17,254	$82,486	$4,424	$990	$994,705

SUPPLEMENTARY INFORMATION

CONSOLIDATING BALANCE SHEET

CONSOLIDATING STATEMENT OF NET COST

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

CONSOLIDATING BALANCE SHEET

as of September 30, 2018

(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	$1,587	$25,802	$27,389	$59,896	$35,079	$9,288	$4,020	$135,672		$135,672
Investments	204,487	98,766	303,253					303,253		303,253
Accounts Receivable, Net	36,955	35,318	72,273	844	12	941	2,602	76,672	(76,060)	612
Other Assets	24	1	25					25		25
Total Intragovernmental Assets	243,053	159,887	402,940	60,740	35,091	10,229	6,622	515,622	(76,060)	439,562
Accounts Receivable, Net	741	17,012	17,753	4,144		4,077	61	26,035		26,035
General Property, Plant & Equipment, Net	452	364	816	23	2	247	230	1,318		1,318
Other Assets	22	44	66	31		279	76	452		452
TOTAL ASSETS	$244,268	$177,307	$421,575	$64,938	$35,093	$14,832	$6,989	$543,427	$(76,060)	$467,367
LIABILITIES										
Intragovernmental Liabilities:										
Accounts Payable	$39,594	$37,601	$77,195	$3		$265	$2	$77,465	$(76,060)	$1,405
Other Intragovernmental Liabilities	4	5,028	5,032			474	44	5,550		5,550
Total Intragovernmental Liabilities	39,598	42,629	82,227	3		739	46	83,015	(76,060)	6,955
Accounts Payable	67	14	81			32	54	167		167
Entitlement Benefits Due and Payable	31,541	30,655	62,196	35,570	$1,377		5	99,148		99,148
Contingencies	841		841	6,277				7,118		7,118
Other Liabilities	120	762	882	40	2	9,157	67	10,148		10,148
TOTAL LIABILITIES	$72,167	$74,060	$146,227	$41,890	$1,379	$9,928	$172	$199,596	$(76,060)	$123,536
NET POSITION										
Unexpended Appropriations-Dedicated Collections	$1,114	$21,741	$22,855				$79	$22,934		$22,934
Unexpended Appropriations-Other Funds				$25,013	$33,638	$4,479	2,017	65,147		65,147
Cumulative Results of Operations-Dedicated Collections	170,987	81,506	252,493			(55)	4,539	256,977		256,977
Cumulative Results of Operations-Other Funds				(1,965)	76	480	182	(1,227)		(1,227)
Total Net Position - Dedicated Collections	172,101	103,247	275,348			(55)	4,618	279,911		279,911
Total Net Position - Other Funds				23,048	33,714	4,959	2,199	63,920		63,920
TOTAL NET POSITION	$172,101	$103,247	$275,348	$23,048	$33,714	$4,904	$6,817	$343,831		$343,831
TOTAL LIABILITIES AND NET POSITION	$244,268	$177,307	$421,575	$64,938	$35,093	$14,832	$6,989	$543,427	$(76,060)	$467,367

CONSOLIDATING STATEMENT OF NET COST

for the year ended September 30, 2018

(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)	$302,159	$314,672	$616,831					$616,831
Medicaid				$383,730				383,730
CHIP					$17,329			17,329
Net Cost: GPRA Programs	$302,159	$314,672	$616,831	$383,730	$17,329			$1,017,890
Other Activities:								
State Grants and Demonstrations							$500	500
Other Health						$3,343		3,343
Other							(12,658)	(12,658)
Net Cost: Other Activities						3,343	(12,158)	(8,815)
NET COST OF OPERATIONS	$302,159	$314,672	$616,831	$383,730	$17,329	$3,343	$(12,158)	$1,009,075

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2018

(IN MILLIONS)

	Medicare (Dedicated Collections)			Health (Other Funds)					Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	Dedicated Collections	
UNEXPENDED APPROPRIATIONS									
Beginning Balances	$1,181	$16,106	$17,287	$5,564	$28,877	$5,750	$2,051		$59,529
Budgetary Financing Sources:									
Appropriations Received	25,814	351,150	376,964	490,571	25,890	407	209		894,041
Appropriations Transferred-in/out				(4,378)			(6)		(4,384)
Other Adjustments	(18)	(34,713)	(34,731)	(80,554)	(3,815)	(105)	101	$91	(119,013)
Appropriations Used	(25,863)	(310,802)	(336,665)	(386,190)	(17,314)	(1,573)	(338)	(12)	(742,092)
Total Budgetary Financing Sources	(67)	5,635	5,568	19,449	4,761	(1,271)	(34)	79	28,552
Total Unexpended Appropriations	$1,114	$21,741	$22,855	$25,013	$33,638	$4,479	$2,017	$79	$88,081
CUMULATIVE RESULTS OF OPERATIONS									
Beginning Balances	$177,250	$82,456	$259,706	$(5,993)	$49	$362	$1,126	$(8,086)	$247,164
Budgetary Financing Sources:									
Appropriations Used	25,863	310,802	336,665	386,190	17,314	1,573	338	12	742,092
Nonexchange Revenue:									
FICA and SECA Taxes	264,566		264,566						264,566
Interest on Investments	7,228	2,449	9,677		27				9,704
Other Nonexchange Revenue	541	4,100	4,641				0		4,641
Transfers-in/out Without Reimbursement	(2,323)	(3,660)	(5,983)	1,566	15	771	(592)	803	(3,420)
Other Financing Sources (Nonexchange):									
Transfers-in/out Without Reimbursement									0
Imputed Financing	21	31	52	2		18	4	2	78
Other									
Total Financing Sources	295,896	313,722	609,618	387,758	17,356	2,362	(250)	817	1,017,661
Net Cost of Operations	302,159	314,672	616,831	383,730	17,329	2,244	694	(11,753)	1,009,075
Net Change	(6,263)	(950)	(7,213)	4,028	27	118	(944)	12,570	8,586
Cumulative Results of Operations	$170,987	$81,506	$252,493	$(1,965)	$76	$480	$182	$4,484	$255,750
Net Position	$172,101	$103,247	$275,348	$23,048	$33,714	$4,959	$2,199	$4,563	$343,831

3

OTHER INFORMATION

Summary of Federal Managers' Financial Integrity Act Report and OMB Circular No. A-123, Management's Responsibility for Enterprise Risk Management and Internal Control // Improper Payments

SUMMARY OF FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT REPORT AND OMB CIRCULAR NO. A-123, MANAGEMENT'S RESPONSIBILITY FOR ENTERPRISE RISK MANAGEMENT AND INTERNAL CONTROL

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) 18 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 Officers (CFO) Act audit; (8) security assessment and authorization of systems; and (9) Department Enterprise Risk Management efforts. As of September 30, 2018, 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 described below.

OMB Circular No. A-123 Statement of Assurance

CMS management is responsible for establishing and maintaining effective internal controls and financial management systems that meet the objectives of FMFIA and OMB Circular No. A-123, Management's Responsibility for Enterprise Risk Management and Internal Control, dated July 2016. 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, 2018, CMS provided a modified statement of reasonable assurance that its internal controls and financial management systems met the objectives of FMFIA due to noncompliance with the 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 (hereafter referenced as IPIA); and Section 6411 of the Patient Protection Affordable Care Act.

Assurance for Internal Controls 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, 2018, were operating effectively and no material weaknesses were found in the design or operation of the internal controls 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, 2018, 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, 2018, CMS also complied with applicable laws and regulations, except for the 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, 2018.

Noncompliance – Actions and Accomplishments

CMS did not fully comply with the requirements of the IPIA, and section 6411 of the Patient Protection Affordable Care Act (PPACA). CMS and HHS work together to set aggressive reduction targets in an effort to drive improvement in payment accuracy levels. CMS has multiple 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 fiscal year (FY) 2018 IPIA, as amended, noncompliance stems from the following:

1. The FY 2018 Medicaid improper payment rate was 9.79 percent. Although the improper payment rate was lower than 10 percent, CMS did not meet its previously established target of 7.93 percent.

2. The FY 2018 Children's Health Insurance Program (CHIP) improper payment rate was 8.57 percent. Although the improper payment rate was lower than 10 percent, CMS did not meet its previously established target of 8.20 percent.

CMS has taken, and continues to take a number of actions outlined in the FY 2018 Agency Financial Report (AFR). CMS continues its efforts to comply with the requirements of the IPIA and OMB's implementing guidance regarding compliance with section 6411 of the PPACA. The primary corrective action on Part C payment error has been the Risk Adjustment Data Validation (RADV) audits. RADV verifies that diagnoses submitted by Medicare Advantage (MA) organizations for risk adjusted payment are supported by medical record documentation. The RADV program is currently operational with the support of contractors. As part of the effort to effectively implement a successful Part C RAC program, in 2015, CMS issued a Request for Information on the proposal to put RADV under the purview of a Part C RAC. The request for information did not yield sufficient interest to establish a Part C RAC program.

CMS believes that the functions of the Part C RAC are currently being performed by the RADV program. The proposed scope of the Part C RAC has been subsumed by an updated RADV methodology that addresses recommendations in Government Accountability Office (GAO) 16-76. The new methodology targets payment error using historical payment error data. RADV audits for payment years 2014 and 2015 are expected to commence in FY 2019.

IMPROPER PAYMENTS

IPIA includes requirements for identifying programs susceptible to significant improper payments, annually reporting estimates of improper payments, and implementing corrective actions to reduce improper payments. IPIA defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). Improper payments also include payments to ineligible recipients, payments for ineligible services, duplicate payments, payments for services not received, as well as payments that are lacking sufficient documentation. Since FY 2012, CMS has complied with OMB's implementing guidance and instituted comprehensive processes that measure the payment error rates for the Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), Medicare Prescription Drug (Part D), Medicaid, and CHIP programs.

Medicare FFS

CMS measures the national Medicare FFS improper payment rate annually, through the Comprehensive Error Rate Testing (CERT) program. The Medicare FFS measurement methodology remains the same since FY 2012. The estimated percentage of Medicare FFS dollars paid correctly was 91.88 percent. This means Medicare paid an estimated $357.68 billion correctly in FY 2018.

The CERT program estimates the Medicare FFS payment accuracy rate by reviewing claims and the submitted medical records. These reviews uncover causes of improper payments including insufficient documentation and lack of medical necessity. These types of improper payments are not detectable through automated reviews. To achieve an even greater payment accuracy rate, CMS must focus its corrective actions on specific areas that are most vulnerable to improper payments.

The national Medicare FFS estimated improper payment rate for FY 2018 is 8.12 percent or $31.62 billion in gross improper payments.[1] Improper payments for home health, inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), and hospital outpatient claims were the major contributing factors to the FY 2018 Medicare FFS improper payment rate. While the factors contributing to improper payments are complex and vary by year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors.

- Insufficient documentation for home health claims continues to be prevalent, despite the improper payment rate decrease from 32.28 percent in FY 2017 to 17.61 percent in FY 2018. The primary reason for these errors was that the documentation to support the certification of home health eligibility requirements was missing or insufficient. Medicare coverage of home health services requires physician certification of the beneficiary's eligibility for the home health benefit (42 CFR 424.22).

- Medical necessity (i.e., the services billed were not medically necessary) continues to be the major contributor for IRF claims. The improper payment rate for IRF claims increased from 39.74 percent in FY 2017 to 41.55 percent in FY 2018. The primary reason for these errors was that the IRF coverage criteria for medical necessity were not met. Medicare coverage of IRF services requires a reasonable expectation that the patient meets all of the coverage criteria at the time of IRF admission (42 CFR 412.622(a)(3)).

- Insufficient documentation continues to be the major reason for errors in SNF claims. The improper payment rate for SNF claim errors decreased from 9.33 percent in FY 2017 to 6.55 percent in FY 2018. The primary reason for these errors was that the certification/recertification statement was missing or insufficient. Medicare coverage of SNF services requires certification and recertification for these services (42 CFR 424.20).

- Insufficient documentation was the major error reason for hospital outpatient claims. The improper payment rate for hospital outpatient claims decreased from 4.38 percent in FY 2017 to 3.25 percent in FY 2018. The primary reason for these errors was that the order (or intent to order for certain services) or medical necessity documentation was missing or insufficient (42 U.S.C 1395y, 42 CFR 410.32).

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 from FY 2013 through FY 2018. This approach is consistent with: (1) Administrative Law Judge (ALJ) and Departmental Appeals Board (DAB) decisions that directed CMS 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 0.15 percentage points to 8.12 percent or $31.62 billion in projected improper payments.

CMS uses data from the CERT program and other sources of information to address improper payments in Medicare FFS through various corrective actions, such as policy clarifications and simplifications, when appropriate, as well as targeted probe and educate reviews, which include more individualized education through smaller probe reviews, followed by specific education based on the findings of these reviews. CMS is also continuing prior authorization initiatives, as appropriate, which help to make sure that applicable coverage, payment, and coding rules are met before services are rendered while ensuring access to and quality of care. CMS has developed a number of preventive measures for specific service areas with high improper payment rates. CMS believes implementing targeted corrective actions in these areas will prevent and reduce improper payments in these areas and reduce the overall improper payment rate.

Medicare Advantage and Prescription Drugs

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 organizations for payment (or risk adjustment error). The Part C payment error rate was 8.10 percent for the FY 2018 reporting period.

From FY 2011 to FY 2015, CMS reported a composite improper payment rate for Part D, a Medicare benefit effective calendar year 2006. With OMB's approval for FY 2016 and subsequent years, the Part D payment error estimate measures payment errors related to prescription drug event data, where the majority of errors for the program exists. The Part D improper payment error rate was 1.66 percent for the FY 2018 reporting period.

Medicaid and CHIP

Medicaid and CHIP are susceptible to erroneous payments as well. Thus, the Federal government and the states both 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 2018 Medicaid and CHIP improper payment rate report period covers payments made through September 30, 2017. It is important to note that, for FY 2015 to FY 2018 reporting, Medicaid and CHIP eligibility review pilots were conducted in place of the PERM eligibility component reviews due to changes in Medicaid and CHIP eligibility. During this time, Medicaid and CHIP program improper payment rates were based on the FFS and managed care PERM reviews and an eligibility component improper payment rate that is held constant at the FY 2014 level (which does not reflect eligibility determinations made under new requirements), while CMS updated the PERM eligibility component review methodology. CMS issued a new final regulation and guidance and will resume the PERM eligibility component for reporting in FY 2019.

The national Medicaid improper payment rate reported for FY 2018 is 9.79 percent or $36.25 billion in gross improper payments based on measurements conducted in FYs 2016, 2017, and 2018. The national component improper payment rates are as follows; Medicaid FFS: 14.31 percent; Medicaid managed care: 0.22 percent. Medicaid eligibility remains at the FY 2014 level of 3.11 percent.

The national CHIP improper payment rate reported for FY 2018 is 8.57 percent or $1.39 billion in gross improper payments based on measurements conducted in FYs 2016, 2017, and 2018. The national component improper payment rates are as follows; CHIP FFS: 12.55 percent; CHIP managed care: 1.24 percent. CHIP eligibility remains at the FY 2014 level of 4.22 percent.

CMS works closely with states to develop state-specific corrective action plans to reduce improper payments. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their plans, with assistance and oversight from CMS. The Medicaid and CHIP eligibility review pilots provided rapid feedback to states and CMS on the accuracy of Medicaid and CHIP eligibility determinations. The pilots identify strengths and weaknesses in operations and systems to allow states to quickly implement corrective actions.

Since FY 2014, the Medicaid improper payment estimate has been driven by errors due to state non-compliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements. The majority of improper payments have been cited on claims where a newly enrolled provider had not been appropriately screened by the state, a provider did not have the required NPI on the claim, or a provider was not enrolled. Although these errors remain a driver of the Medicaid rate, state compliance has improved, as the Medicaid FFS improper payment rate for these errors decreased from 9.27 in FY 2017 to 7.21 in FY 2018.

While the screening errors described above are for newly enrolled providers, states are also required to screen providers upon revalidation of enrollment. States are required to revalidate the enrollment of all providers at least every five years and must have completed the revalidation process of all existing providers by September 25, 2016. In FY 2018, CMS measured the first cycle of states for compliance with requirements for provider screening at revalidation. Improper payments cited on claims where a provider had not been appropriately screened at revalidation is a new major source of error in the Medicaid improper payment rate. CMS will complete the measurement of all states for compliance with provider revalidation requirements in FY 2020.

Likewise, the majority of CHIP improper payments have been cited on claims where a newly enrolled provider or a provider due for revalidation had not been appropriately screened by the state or a provider did not have the required NPI on the claim. State compliance with screening requirements has not improved for CHIP. A higher percentage of CHIP providers are not enrolled in Medicare and, therefore, there are more CHIP providers where states cannot rely on Medicare's screening in lieu of conducting state screening.

GLOSSARY

A

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

Accrual Accounting: A system of accounting in which revenues are recorded when earned and expenses are recorded when goods are received or services are performed, even though the actual receipt of revenues and payment for goods or services may occur, in whole or in part, at a different time.

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, expenses, facilities, equipment, rent and utilities). These costs are accounted for in the Program Management account.

Advance Premium Tax Credit: A tax credit in which eligible consumers can receive an advance payment to lower their monthly health insurance premiums for Exchange plans. The amount is based on the cost of health plans in the applicable Exchange and the consumer's estimated annual household income 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 stimulate 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 of the BBA 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: Expenses accrued or funds outlayed for services delivered to beneficiaries.

C

Chief Financial Officers Act of 1990 (CFO Act): The CFO Act designated a Chief Financial Officer in each executive department and in each major executive agency in the Federal Government. It provides for production of complete, reliable, timely, and consistent financial information for use by the executive branch of the Government and the Congress in the financing, management, and evaluation of Federal programs.

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 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 to have an applicable certificate in effect.

Consumer Operated and Oriented Plan Program (CO-OP): The Patient Protection and Affordable Care Act calls for the establishment of the CO-OP Program, which fosters the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets.

Cost-Sharing Reduction Payment: Payments to health insurance issuers on the Exchange on behalf of eligible insured individuals that lower the amount consumers pay for deductibles, copayments, and coinsurance. Eligibility is limited to those in silver plans receiving advance premium tax credits and is based on the amount of household income for the insured compared to the poverty line. These payments to issuers ceased starting in Fiscal Year 2018 in accordance with the October 2017 legal opinion from the Attorney General of the United States that a valid appropriation does not exist for Cost-Sharing Reduction payments. However, issuers are still required by law to reduce cost-sharing for eligible enrollees.

D

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

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

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

Durable Medical Equipment (DME): Purchased or rented items such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home, as well as blood glucose monitors for individuals with diabetes. DME is equipment which: 1) can withstand repeated use; 2) has an expected life of at least 3 years if classified as DME after January 1, 2012; 3) is primarily and customarily used to serve a medical purpose; 4) generally is not useful to a person in the absence of an illness or injury; and 5) is appropriate for use in the home.

E

End Stage Renal Disease: Permanent kidney failure requiring dialysis or a transplant.

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

Expenditure: Budgeted funds which are actually spent. When used in the discussion of the Medicaid program, expenditure refers to funds actually spent as reported by the states.

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 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 Insurance Contribution Act (FICA) Payroll Tax: Medicare's share of FICA is used to fund the Hospital Insurance (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 of 1982 (FMFIA): FMFIA requires agencies to establish internal control and financial systems that provide reasonable assurance of achieving control objectives, including the effectiveness and efficiency of operations; compliance with laws and regulations; and reliability of financial reporting. FMFIA requires agency heads to conduct an annual evaluation and report on the adequacy of internal control systems.

G

Government Performance and Results Act Modernization Act of 2010 (GPRA Modernization Act): Amends the Government Performance and Results Act of 1993 to require each executive agency to make its strategic plan available both on its public website and to 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 that the strategic plan is available.

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

H

Health Information Technology for Economic and Clinical Health Act (HITECH): ARRA includes the "HITECH Act," which established programs under Medicare and Medicaid to incentivize the meaningful use of certified electronic health record technology among eligible professionals, hospitals, and critical access hospitals.

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

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

I

Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA): In 2002, Congress passed the Improper Payments Information Act (IPIA) (Public Law 107-300), which was amended by the Improper Payments Eliminations and Recovery Act of 2010 (IPERA) (Public Law 111-204) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA) (Public Law 112-248). These laws aim to standardize the way Federal agencies report improper payments in programs they oversee or administer, and direct agencies to reduce improper payments through corrective actions and reduction targets. 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). OMB Circular A-123, Appendix C, further defines improper payments as any payment that was made to an ineligible recipient for an ineligible good or service, or payments for goods or services not received (except for such payments authorized by law).

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

Internal Control: Process affected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. 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

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.

Medicare: The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): Legislation passed to strengthen Medicare, extend CHIP, and make 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 DME

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 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 that established a new Medicare program (Medicare Part D) to provide a prescription drug benefit. 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 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.

O

Obligation: Legal requirement to pay funds.

Office of Management and Budget (OMB) Circular A-123, Management's Responsibility for Enterprise Risk Management and Internal Control: 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 FMFIA.

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."

Patient Protection and Affordable Care Act (Affordable Care Act) (P.L. 111-148): A Federal statute enacted in 2010 to drive health insurance reforms. The law requires insurers to accept all (legal) applicants, to cover a specific list of conditions, and to charge the same rates regardless of pre-existing conditions.

Payment Safeguards: Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, medical review/utilization review 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, CHIP, and Affordable Care Act programs. PI activities target the range of causes of improper payments, 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, and other CMS responsibilities. The components of Program Management are: program operations, survey and certification, research, 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.

Quality Payment Program (QPP): Established by MACRA, which repeals the sustainable growth rate formula and streamlines multiple quality reporting programs into a new Merit-based Incentive Payment System. Under the QPP, incentive payments are provided to clinicians for their participation in Advanced Alternative Payment Models or the Merit-based Incentive Payment System. Clinicians can choose how they want to participate based on their practice size, specialty, location, or patient population.

R

Recipient: An individual covered by the Medicaid program. Also referred to as a beneficiary.

Reinsurance: The transitional reinsurance program stabilized premiums in the individual market inside and outside of the Exchanges. The transitional reinsurance program collected 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 is designed to encourage employers and unions to continue to provide high quality prescription drug coverage to their retirees.

Revenue: An inflow of resources that the government earns, demands, or receives by donation. Resources arise when the government entity provides goods and services, or from the government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties).

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 Corridors: The risk corridor program provided 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 Exchange. This program, which was modeled after a similar program used in the Medicare prescription drug benefit, encouraged issuers to keep their rates stable as they adjusted to the new health insurance reforms in the early years of the Exchanges.

S

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

Significant Deficiency: 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.

Statement on Standards for Attestation Engagements (SSAE) 18 (SSAE 18): A report on the internal controls of a servicing organization issued by an independent public accountant in accordance with standards promulgated by the American Institute of Certified Public Accountants (AICPA).

Supplementary Medical Insurance (SMI) (Part B):
The part of Medicare that pays physician services, outpatient hospital services, other related medical and health services for voluntarily insured aged and disabled individuals as well as private plans to provide prescription drug coverage. The prescription drug benefit is funded through the SMI trust fund.

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