FINANCIAL REPORT

FY 2022








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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 Agency Financial Report for fiscal year (FY) 2022 presents the agency's detailed financial information relative to our mission and the stewardship of those resources entrusted to us. This report is organized into the following three sections:

1 MANAGEMENT'S DISCUSSION & ANALYSIS

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

2 FINANCIAL SECTION

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

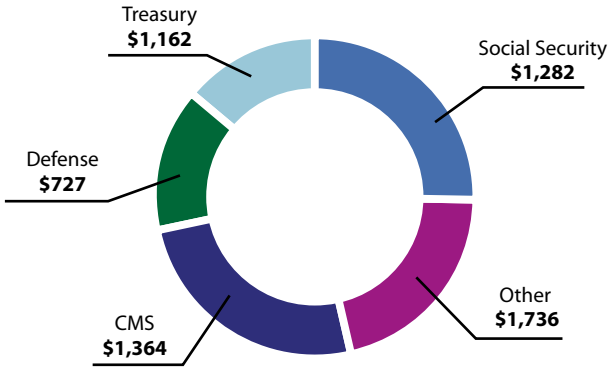
3 OTHER INFORMATION

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

2022 FEDERAL OUTLAYS

CMS has outlays of approximately $1,364 billion (net of offsetting receipts and payments of the Health Care Trust Funds) in fiscal year (FY) 2022, approximately 22 percent of total Federal outlays.

CMS employs approximately 6,400 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.).

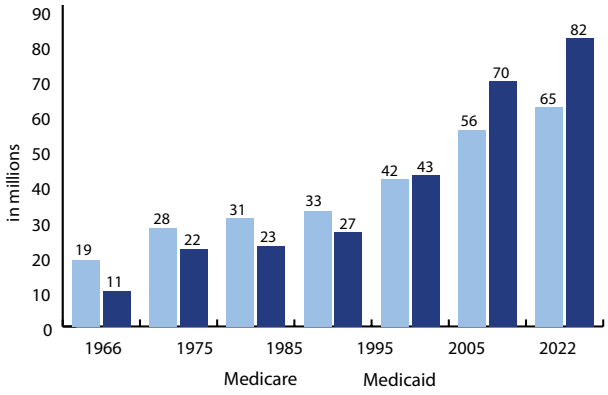


$ in billions

SOURCE: U.S. DEPARTMENT OF THE TREASURY

2022 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 65 million beneficiaries. Medicaid enrollment has increased from 11 million beneficiaries in 1966 to about 82 million beneficiaries.



A MESSAGE FROM THE ADMINISTRATOR

Chiquita Brooks-LaSure

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) Financial Report for fiscal year (FY) 2022. Over the last year, CMS has made meaningful progress toward our ambitious agenda to advance health equity, expand coverage, and improve health outcomes as a trusted partner and steward.

CMS programs cover over 170 million people across the United States, including, more than 89 million people enrolled in Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program and over 64 million people enrolled in Medicare. This unprecedented reach reflects increased enrollment through HealthCare.gov among Hispanic people by 26 percent and Black people by 35 percent, combating historic inequities in access. CMS continues to build on these advances through a record $98.9 million in grant funding invested in Navigator organizations for the 2023 Open Enrollment Period to help consumers navigate enrollment through the Marketplace, Medicaid and CHIP, as well as $49 million in grants through the Connecting Kids to Coverage program to support Medicaid and CHIP enrollment and retention. CMS is working closely with states and other external partners to preserve recent coverage gains once the COVID-19 public health emergency ends.

I am especially proud of the progress we have made in strengthening access to life-saving care after pregnancy. Thanks to the *American Rescue Plan Act of 2021* (P.L. 117-2), as of September 2022, 24 states and the District of Columbia have extended continuous postpartum Medicaid and CHIP coverage to 12 months. CMS is also establishing a publicly-reported hospital designation, the "Birthing-Friendly" hospital, to drive improvements in maternal health outcomes and advance maternity care quality, safety, and equity. These and other actions are aimed at helping to reduce maternal mortality and morbidity as well as disparities in maternal care across the United States.

Over the last year, CMS continued to advance additional impactful policies that respond to the urgent public health challenges facing our nation, including in support of CMS's Behavioral Health Strategy, released in May 2022. CMS implemented provisions enacted in the *Consolidated Appropriations Act, 2021* to expand access to behavioral health care by finalizing rules making telehealth for behavioral health services permanent in Medicare. This change will enable people to receive telehealth services for the diagnosis, evaluation, and treatment of mental health disorders in their homes and in any geographic area. CMS also finalized Medicare payment for behavioral health care provided by Rural Health Clinics and Federally Qualified Health Centers through telecommunications technology, strengthening access to care for rural and medically underserved communities. In September 2022, CMS also approved the nation's first Medicaid mobile crisis intervention services program enabled by the *American Rescue Plan Act of 2021*, providing 24/7 access to community-based crisis stabilization services to people experiencing mental health crises or co-occurring substance use disorders throughout Oregon. Working with partners across the federal government, CMS will continue its multi-faceted approach to increase and enhance access to equitable and high-quality behavioral health services and improve outcomes for people with behavioral health care needs.

CMS also continued to play a critical role in the federal response to the COVID-19 pandemic, unprecedentedly covering over-the-counter COVID-19 tests for people with Medicare and paying for booster COVID-19 vaccine shots with no out-of-pocket costs. CMS is also offering resources through Quality Improvement Organizations to thousands of nursing homes serving older Americans and people with disabilities so they have tools to get residents and staff vaccinated, including by helping schedule on-site vaccination clinics; supporting development of a plan to get staff and residents boosted; and providing other technical assistance and support. As we look to the future, CMS is evaluating lessons learned during the public health emergency to help strengthen quality and build resilience across the continuum of care.

Another area of focus remains strengthening choice in long-term care. CMS awarded nearly $25 million in planning grants to five additional states and territories to expand access to home and community-based services (HCBS) through Medicaid's Money Follows the Person (MFP) demonstration program. With these awards, 41 states and territories across the country will now participate in MFP. First authorized in 2006, MFP has provided states and territories with more than $4 billion to support people who choose to transition out of institutions and back into their homes and communities. These efforts will empower people requiring long-term services and supports to receive high-quality care in the setting of their choice.

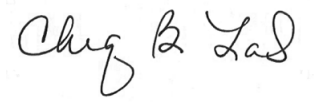
CMS released the first-ever HCBS Quality Measure Set in July 2022, to enable the measurement and improvement of the quality of HCBS programs. This set of nationally standardized quality measures for Medicaid-funded HCBS is intended to promote more common and consistent use within and across states of nationally standardized quality measures in HCBS programs, create opportunities for CMS and states to have comparative quality data on HCBS programs, and drive improvement in quality of care and outcomes for people receiving HCBS.

CMS has also made significant progress improving safety and quality of care in the nation's nursing facilities. CMS continues to work towards proposing to establish staffing requirements by conducting a rigorous, mixed-methods study. CMS has also acted to improve public transparency around nursing facilities, posting new staffing measures on Care Compare to provide consumers with information on staff turnover and weekend staffing levels and publishing detailed information on the ownership of approximately 15,000 Medicare certified Skilled Nursing Facilities. To boost quality of care, we are adding quality measures to the Skilled Nursing Facility Value-Based Purchasing program, and we issued significant updates to guidance on minimum health and safety standards around infection control, room crowding, and other topics.

CMS is making strides in increasing value-based arrangements through participation in the national Accountable Care Organization (ACO) program and accelerating care transformation. As of January 2022, the Medicare Shared Savings Program (Shared Savings Program) includes over 525,000 participating clinicians who provide care to more than 11 million people with Medicare. In 2021, the Shared Savings Program saved Medicare more than $1.6 billion and continued to deliver high-quality care to beneficiaries. Informed by rigorous stakeholder engagement, CMS also finalized the nationwide expansion of the Home Health Value-Based Purchasing Model; redesigned an existing model to become the ACO Realizing Equity, Access, and Community Health (REACH) Model, and promoted health equity through policies to transition ACOs in the Shared Savings Program to all-payer quality measures. Achieving our goals in growing accountable care relationships will improve quality, increase savings, and promote innovative care delivery that better meet people's needs.

These accomplishments are made possible by excellence in CMS's operations across all 23 of CMS's Centers and Offices. We have intentionally fostered collaboration across different components within the agency through 13 cross-cutting initiatives, including an effort to better align policies and experiences across coverage programs. I am especially proud that CMS has again scored in the top quartile of all federal agencies in employee satisfaction. To further promote a positive and inclusive workforce, CMS is undertaking 55 projects across the agency that will improve employee engagement and increase diversity, equity, and inclusion. We are also focused on delivering value using taxpayer dollars, taking concrete steps to streamline the consumer experience across our programs and protecting program funds - including working collaboratively with our law enforcement partners to promote program integrity by combating fraud. In other operational areas, CMS established a formal Enterprise Risk Council; continues to advance equity in procurement; and facilitates increased migration from on-premise data centers to the CMS Cloud.

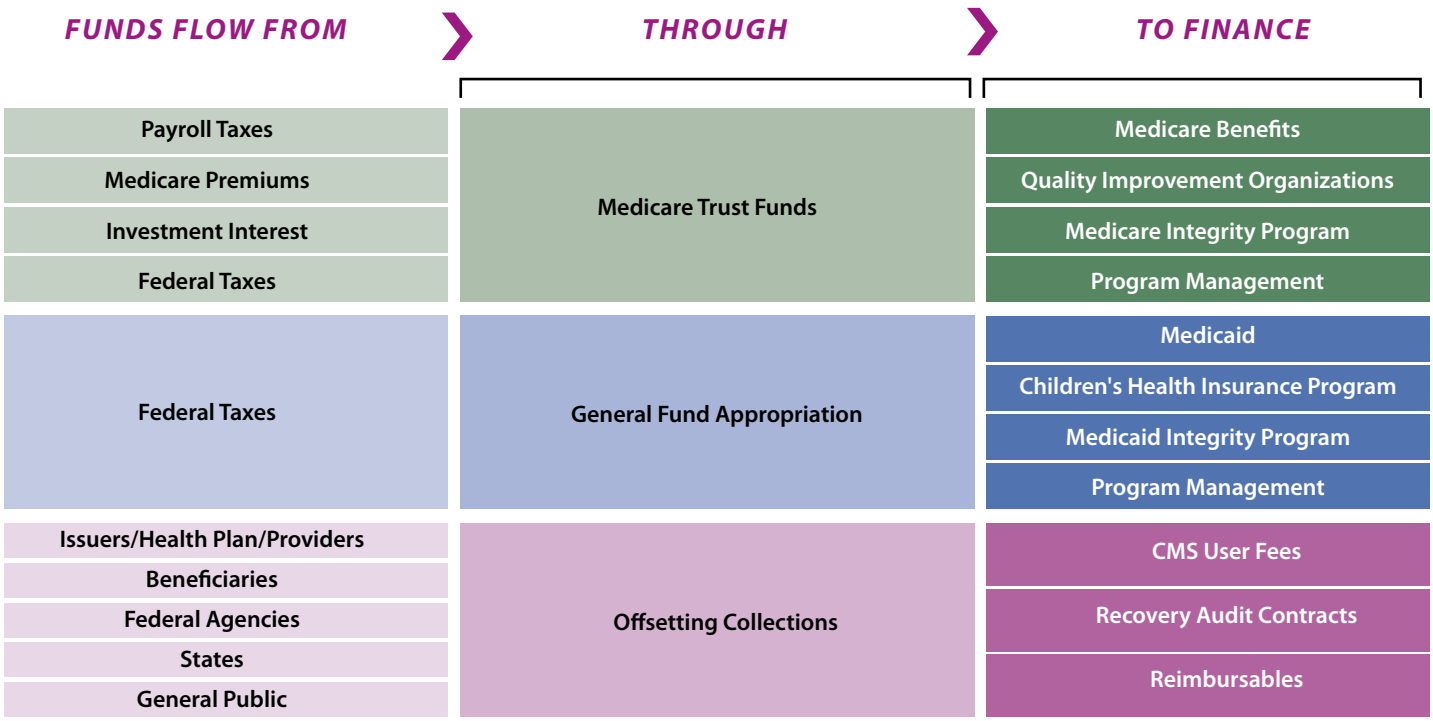
This letter includes just a few highlights from a very productive year. While the challenges we confront are daunting, I am grateful to face them with close engagement from people with lived experience and other external partners, and alongside such a talented and dedicated team. I remain honored to lead an agency that plays such a unique and vital role in advancing health equity, expanding access to coverage and care, and driving innovation for the people we serve.



Chiquita Brooks-LaSure

CMS Administrator
November 2022

FINANCING OF CMS PROGRAMS & OPERATIONS



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AGENCY ORGANIZATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Approved leadership as of September 29, 2022

* Acting

Chiquita Brooks-LaSure
Administrator

Jonathan Blum
Principal Deputy Administrator and Chief Operating Officer

Erin Richardson
Chief of Staff

Karen Jackson
Deputy Chief Operating Officer

OFFICE OF BURDEN REDUCTION & HEALTH INFORMATICS
Mary Greene, M.D., *Director*
Stella (Stace) Mandl, *Deputy Director*

OFFICE OF PROGRAM OPERATIONS & LOCAL ENGAGEMENT
Nancy O'Connor, *Director of Drug Health Plan Operations*
Erin Sutton, *Dep. Dir. of Drug Health Plan Opers.*
Gregory Dill, *Dep. Dir. for Innovation & Fin. Mgmt.*
John Hammarlund, *Dep. Dir. for Local Eng. & Admin.*
Ray Hurd, *Dep. Dir. for Strategy & Business Operations*

OFFICE OF ENTERPRISE DATA AND ANALYTICS
Allison Oelschlaeger, *Director & CMS Chief Data Officer*
Andy Shatto, *Deputy Director*

OFFICE OF EQUAL OPPORTUNITY AND CIVIL RIGHTS
Anita Pinder, *Director*
Alaina Jenkins, *Deputy Director*

OFFICE OF COMMUNICATIONS
Bruce Alexander, *Director*
Mary Wallace, *Dep. Dir. for Operations*
Karen Aldana, *Dep. Dir. for Communications*

OFFICE OF LEGISLATION
Arielle Woronoff, *Director*
Jennifer Boulanger, *Deputy Director*

FEDERAL COORDINATED HEALTH CARE OFFICE
Tim Engelhardt, *Director*
Kerry Branick , *Deputy Director*

OFFICE OF MINORITY HEALTH
Dr. LaShawn McIver, *Director*
Capt. Wanda Finch, *Deputy Director*

OFFICE OF THE ACTUARY
Paul Spitalnic, *Director and Chief Actuary*

OFFICE OF STRATEGIC OPERATIONS AND REGULATORY AFFAIRS
Kathleen Cantwell, *Director*
Olen Clybourn, *Deputy Director*

OPERATIONS

DIGITAL SERVICE @CMS
Andrea Fletcher, *Director*

OFFICE OF INFORMATION TECHNOLOGY
Rajiv Uppal, *Director & CMS Chief Information Officer (CIO)*
Bobby Saxon, *Deputy Director*
George Hoffmann, *Deputy Director & Deputy CIO*
George Linares, *CMS Chief Technology Officer*

OFFICE OF ACQUISITION AND GRANTS MANAGEMENT
Derrick Heard, *Director*
Donald Knode, *Deputy Director*

OFFICES OF HEARINGS AND INQUIRIES
Randy Brauer, *Director*
James Slade, *Deputy Director*

OFFICE OF FINANCIAL MANAGEMENT
Megan Worstell, *Director & CMS Chief Financial Officer*
John Czajkowski, *Deputy Director*

EMERGENCY PREPAREDNESS & RESPONSE OPERATIONS
CAPT Skip A. Payne, *Director*
Vacant, *Deputy Director*

OFFICE OF STRATEGY, PERFORMANCE AND RESULTS
Bill Samples, *Director*

OFFICE OF SECURITY, FACILITIES AND LOGISTICS OPERATIONS
James Weber, *Director*
Elizabeth Mack, *Deputy Director*

OFFICE OF HUMAN CAPITAL
Tia Butler, *Director & Chief Human Capital Officer*
Stephanie Bovell, *Deputy Director*

CENTER FOR CLINICAL STANDARDS AND QUALITY
Lee Fleisher, M.D., *CMS Chief Medical Officer and Director*
Jean Moody-Williams, *Deputy Director*
Jeneen Iwugo, *Deputy Director*
Shari Ling, M.D., *Deputy Chief Medical Officer*
Michelle Schreiber, M.D., *Dep. Director for Quality & Value*

OFFICE OF CLINICIAN ENGAGEMENT
Barry Marx, M.D., *Director*

CENTER FOR MEDICARE AND MEDICAID INNOVATION
Elizabeth Fowler, *Deputy Administrator & Director*
Ellen Lukens, *Deputy Director*
Arrah Tabe-Bedward, *Deputy Director*

CENTER FOR MEDICARE
Dr. Meena Seshamani M.D. PhD, *Deputy Administrator and Director*
Elizabeth Richter, *Deputy Center Director*
Cheri Rice, *Deputy Director*

CENTER FOR MEDICAID AND CHIP SERVICES
Daniel Tsai, *Deputy Administrator & Director*
Anne Marie Costello, *Deputy Director*
Sara Vitolo, *Deputy Director*
Dr. Aditi Mallick, *Chief Medical Officer*

CENTER FOR PROGRAM INTEGRITY
Dara Corrigan, *Deputy Administrator and Director*
Bradley Hart, *Deputy Director*
George Mills, Jr., *Deputy Director*

CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT
Dr. Ellen Montz, *Deputy Administrator and Director*
Jeff Grant, *Deputy Director for Operations*
Jeff Wu, *Deputy Director for Policy*
Michael Jimenez, *Center Chief Technology Officer*

1 MANAGEMENT'S DISCUSSION & ANALYSIS

OUR ORGANIZATION // OVERVIEW //
PERFORMANCE MANAGEMENT // CMS STRATEGIC GOALS
INITIATIVES & OBJECTIVES //
OVERVIEW OF FINANCIAL DATA //
OVERVIEW OF SOCIAL INSURANCE DATA

OUR ORGANIZATION

CMS, an operating division of the Department of Health and Human Services (HHS), employs approximately 6,400 federal employees in Maryland, Washington, DC, and many other states throughout the country. CMS provides direct services to state agencies, healthcare providers and suppliers, individuals with Medicare, sponsors of group health plans, Medicare health and prescription drug plans, and the general public.

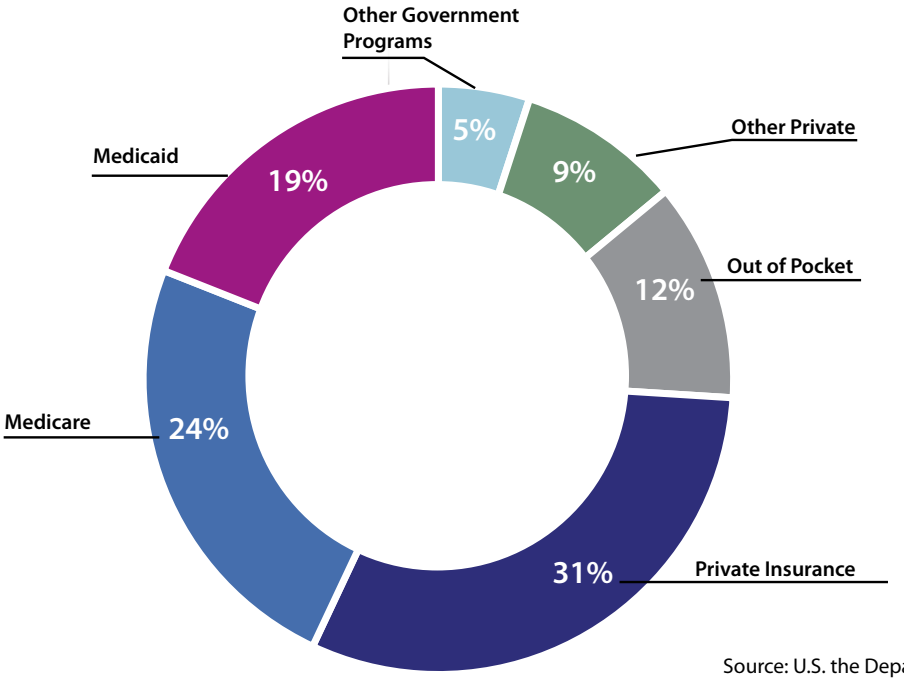
CMS's employees write policies and regulations that establish program eligibility and benefit coverage; set payment rates; safeguard the fiscal integrity of the programs it administers from improper payments including fraud, waste, and abuse; and develop quality measurement systems to monitor quality, 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 and/or partners with third parties to operate many of its important activities. Each state administers a Medicaid program and a Children's Health Insurance Program (CHIP). States inspect hospitals, nursing homes, and other facilities to ensure that health and safety standards are met. The Medicare Administrative Contractors process claims, provide technical education to providers, review medical records, enroll providers, perform a host of financial audit and overpayment recovery services, adjudicate first level appeals and answer inquiries from Medicare providers. Additionally, Quality Improvement Organizations (QIOs) conduct a wide variety of quality improvement programs to ensure quality of care is provided to individuals with Medicare.

OVERVIEW

As the largest single health payer in the U.S., CMS administers Medicare, Medicaid, CHIP, the federal Marketplace, and the *Clinical Laboratory Improvement Act of 1988* (CLIA) program. CMS now maintains the nation's largest collection of healthcare data. According to 2022 projections[1], Medicare and Medicaid (including state funding) represent 43 cents of every dollar spent on healthcare in the U.S.— or looked at from three different perspectives: 55 cents of every dollar spent on nursing homes, 45 cents of every dollar received by U.S. hospitals, and 39 cents of every dollar spent on physician services.

The Nation's Health Care Dollar Fiscal Year 2022



Source: U.S. the Department of the Treasury

1 CMS, National Health Expenditure Projections, 2021-2030. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.

Medicare

Title XVII of the *Social Security Act* established Medicare in 1965. 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 expanded to cover people with disabilities and people with End-Stage Renal Disease (ESRD). The *Medicare Prescription Drug, Improvement, and Modernization Act* (MMA) further expanded the Medicare program, which included a prescription drug benefit for all Americans with Medicare beginning January 1, 2006.

Medicare routinely processes over one billion fee-for-service (FFS) claims a year and accounts for approximately 13 percent of the federal budget. Medicare is a combination of four programs: Hospital Insurance (HI), Supplementary Medical Insurance (SMI), Medicare Advantage (MA), and Medicare Prescription Drug Benefit. Since 1966, Medicare enrollment has increased from 19 million to roughly 65 million individuals.

Hospital Insurance

Hospital Insurance, also known as HI, 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 HI because they or their spouse already paid for it through their payroll taxes while working. The HI program pays for inpatient hospital, skilled nursing facility (SNF), certain home health, and hospice care, and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current individuals with Medicare.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI, is voluntary and available to nearly all people aged 65 and over, people with disabilities, and people with ESRD who are entitled to HI benefits. Medicare SMI pays for doctors' services and outpatient care, certain home healthcare, laboratory tests, durable medical equipment, designated therapy, and certain drugs. SMI pays for these covered services and supplies when they are medically necessary. The SMI coverage is optional, and individuals who elect SMI are subject to monthly premium payments.

Medicare Advantage

The *Balanced Budget Act of 1997* established the Medicare+Choice program, now known as the Medicare Advantage program to provide more healthcare coverage choices for individuals with Medicare. Those who are eligible because of age (65 or older) or disability may choose to join a MA commercial plan servicing their area if they are entitled to HI and enrolled in SMI. Those who are eligible for Medicare because of ESRD could join a MA plan beginning January 1, 2021. Medicare beneficiaries have the option to choose to enroll in healthcare plans that contract with CMS instead of receiving services under fee for service arrangements offered under original Medicare. Many MA plans offer supplemental benefits such as prescription drugs, vision, and dental benefits, and offer different out-of-pocket cost sharing arrangements. MA plans assume full financial risk for care provided to their Medicare enrollees. Individuals with Medicare 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 is an optional prescription drug benefit created by the MMA for individuals with Medicare. 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. Individuals who qualify for both Medicare and Medicaid (full-benefit dually-eligible) are automatically enrolled in the Medicare Prescription Drug Benefit program; assistance with premiums and cost sharing is available to full-benefit dual-eligible, and other qualified low-income, individuals.

Medicaid

Title XIX of the *Social Security Act* established the Medicaid program in 1965. 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; however, states 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. States and the federal government jointly fund the Medicaid program. 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 healthcare for more than 82.3 million individuals. Over 11 million people are dually eligible for both Medicare and Medicaid.

CHIP

CHIP was created through the *Balanced Budget Act of 1997* 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 federal and state governments. States administer CHIP according to federal requirements while working closely with CMS, Congress, and other federal agencies. CMS ensures state programs meet statutory requirements designed to ensure meaningful coverage. CMS provides extensive guidance and technical assistance so states can further develop their CHIP state plans and use federal funds to provide healthcare coverage to as many children as possible. CHIP funds cover the cost of healthcare 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 2022, CMS projects that approximately 10 million children will be 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 on patients, including those performed in physicians' offices, for a total of 319,404 facilities.

The CLIA program is 100 percent user-fee financed and is jointly administered by three HHS operating divisions: CMS, the 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. CDC provides research, technical support, and coordination of the Clinical Laboratory Improvement Advisory Committee, while FDA performs test categorization.

Private Health Insurance and Health Insurance Marketplaces

CMS oversees compliance with private health insurance reforms and works with health insurance issuers to increase industry transparency. CMS also facilitates access to private health insurance through the oversight of the Health Insurance Marketplace (Marketplaces) where health insurance issuers compete on the basis of price and quality. Through these activities, CMS expands access to quality, affordable health coverage and care.

CMS works with states to ensure issuers comply with market reforms through policies like the federal prohibition on denying coverage for pre-existing conditions, the prohibition on annual and lifetime dollar limits on essential health benefits, and rating requirements. CMS also implements a process for states or CMS to review rates of non-grandfathered health insurance products in the individual and small group markets to determine compliance with federal health insurance rating rules. CMS is also responsible for enforcing compliance with a federal minimum Medical Loss Ratio (MLR) requiring health insurance issuers to spend a predetermined portion of premium revenues on clinical services and quality improvement, or provide a rebate to policyholders if the MLR standard is not met. By ensuring issuer compliance with specific market reforms, CMS is expanding consumers' access to quality, affordable health coverage and care.

Mental Health and Substance use Disorder Parity Implementation

The *Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA) generally provides that financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits (M/S) in a classification. In addition, MHPAEA prohibits separate treatment limitations that apply only to MH/SUD benefits. MHPAEA also imposes several important disclosure requirements on group health plans and health insurance issuers.

The *Consolidated Appropriations Act, 2021*(CAA) amended MHPAEA to provide important new consumer protections. Group health plans or health insurance issuers offering group or individual health insurance coverage that provides both M/S and MH/SUD benefits and that impose non-quantitative treatment limitations (NQTLs) on M/H and SUD benefits must perform and document comparative analyses of the design and application of their NQTLs and make their comparative analyses available to CMS or the Department of Labor (DOL), as applicable upon request. CMS and DOL are responsible for reviewing these comparative analyses and identifying any compliance concerns and they work with the group health plan or health insurance issuer to ensure compliance. CMS, in collaboration with DOL and the Department of Treasury, also reports these analysis findings to Congress annually.

Permanent Risk Adjustment Transfers

The risk adjustment program is a budget neutral program that transfers funds from plans with lower risk enrollees to plans with higher risk enrollees (such as those with chronic conditions) in a state market to incentivize health insurance issuers that attract high risk enrollees. Additionally, the high-cost risk pool component of the risk adjustment program helps ensure that risk adjustment transfers better reflect average actuarial risk, while also stabilizing premiums and reimbursing issuers for a portion of costs for exceptionally high-cost enrollees. In doing so, this program continues to help provide access to quality, affordable healthcare coverage and care. The program is designed to reduce the incentives for issuers to avoid those enrollees. The risk adjustment program also 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 available to consumers.

Section 1332 Waivers for State Innovation

Under Section 1332 of the PPACA, states can apply for a Section 1332 Waiver for State Innovation (also referred to as a "Section 1332 waiver" or "1332 waiver") from HHS and the Department of the Treasury (collectively, the Departments). If approved, the waiver allows states to implement innovative programs to provide access to quality healthcare. Through Section 1332 waivers, the Departments aim to assist states with developing health insurance markets that offer expanded coverage, lower costs, and ensure healthcare is truly accessible for all. State innovation waivers became available January 1, 2017, and can be approved for up to a 5-year period and can be extended. Waivers must not increase the federal deficit.

The *No Surprises Act*

The *No Surprises Act*, effective January 1, 2022, protects people covered by group health plans or health insurance issuers offering group or individual health insurance coverage, including FEHB carriers, from receiving surprise medical bills when they receive emergency services from out-of-network providers, including air ambulance providers, or at out-of-network facilities. Under the law, individuals are only responsible for their in-network cost-sharing. The remaining payment amount may be settled between health plans or issuers and providers or facilities, in accordance with the process outlined in statute. In the event plans, issuers, providers and facilities cannot agree on a payment amount, the law establishes an independent dispute resolution (IDR) process to resolve payment disputes. The *No Surprises Act* requires the collection of administrative fees from all parties that participate in the IDR process. These fees are intended to offset the Federal administrative costs associated with the process and to eventually sustain this process long term. In addition, for advanced scheduled services from an out-of-network provider. The *No Surprises Act* entitles individuals to a "good faith estimate" of the cost of those services in advance. If the ultimate cost of those services is substantially greater (more than $400) than the "good faith estimate," uninsured and self-pay individuals may dispute the cost of those services through a new Patient Provider Dispute Resolution Process. Protecting consumers from unexpected medical bills will decrease the percentage of people that forgo needed care due to cost and ensure consumers have access to quality, affordable health coverage and care.

Transparency in Coverage

CMS's Transparency in Coverage final rule, published by HHS, DOL and Treasury, is a historic step towards putting healthcare price information in the hands of consumers and other stakeholders, advancing CMS's goal of ensuring consumers are empowered with the critical information they need to make informed healthcare decisions. This rule requires most group health plans, and health insurance issuers offering group or individual health insurance coverage to disclose price and cost-sharing information to participants, beneficiaries, and enrollees, and to give consumers real-time, personalized access to cost-sharing information, including an estimate of their cost-sharing liability, through an internet based self-service tool. This information is intended to empower consumers to shop and compare costs between specific providers before receiving care. Plans and issuers are also required to disclose on a public website their in-network negotiated rates, billed charges, and allowed amounts paid for out-of-network providers. Making this information available to the public will drive innovation, support informed, price-conscious decision-making, and ultimately promote competition in the healthcare industry to move towards quality, affordable health coverage and care.

Prescription Drug Data Collection

Spending on prescription drugs is rising more quickly than total spending on healthcare services. To understand the increase, we need to know more about prescription drug costs and how rebates and incentives from drug manufacturers influence healthcare expenses. Under Section 204 (of Title II, Division BB) of the CAA, group health plans and health insurance issuers offering group or individual health insurance coverage must submit information about prescription drugs and healthcare spending to CMS. CMS, on behalf of HHS, DOL, and Treasury will publish findings about prescription drug pricing trends and the impact of prescription drug rebates on patient out-of-pocket costs.

Agent and Broker Compensation Disclosure Requirements

Section 202 (of Title II, Division BB) of the CAA amended Title XXVII of the PHS Act to add section 2746, requires a health insurance issuer offering individual health insurance coverage or short-term, limited-duration insurance to disclose to enrollees in such coverage and to report annually to HHS the direct or indirect compensation provided by the issuer to an agent or broker associated with enrolling individuals in such coverage. Section 2746(d) directs HHS to finalize, through notice and comment rulemaking, the timing, form, and manner in which issuers must make these disclosures to consumers and submit reports to HHS. HHS published a proposed rule containing proposed time, form, and manner requirements on September 16, 2021 (86 FR 51730). HHS expects to finalize this rule in or around August 2023.

PERFORMANCE MANAGEMENT

Performance measurement results provide valuable information on the success of CMS's programs and activities. CMS uses performance information for improvement opportunities and to shape its programs. Performance measures clearly communicate 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 encourage accountable stewardship of public programs.

As required by the *GPRA Modernization Act of 2010*, HHS developed a new Strategic Plan (2022-2026), which was released with the President's Budget in February 2022. Key CMS performance measures from the previous Strategic Plan are featured in the **FY 2023 HHS Annual Performance Plan and Report**. Consistent with GPRA principles, the CMS GPRA performance goals reinforce the mission, goals, and objectives of the Administration. We look forward to the challenges represented by our performance goals and are optimistic in our ability to meet them.

Our FY 2022 performance measures track progress in our major program areas, including measuring error rates. In addition, we measure quality improvement initiatives geared towards older adults, children, and people with disabilities, who are served by the Medicare, Medicaid, CHIP, and the QIO programs. Detailed CMS performance measure information and available results are included in the **CMS Budget**. Progress on our measures has been reported through the FY 2023 President's Budget process.

CMS's FY 2022 VISION STATEMENT & OVERARCHING GOALS

CMS'S VISION IS STRAIGHT FORWARD:

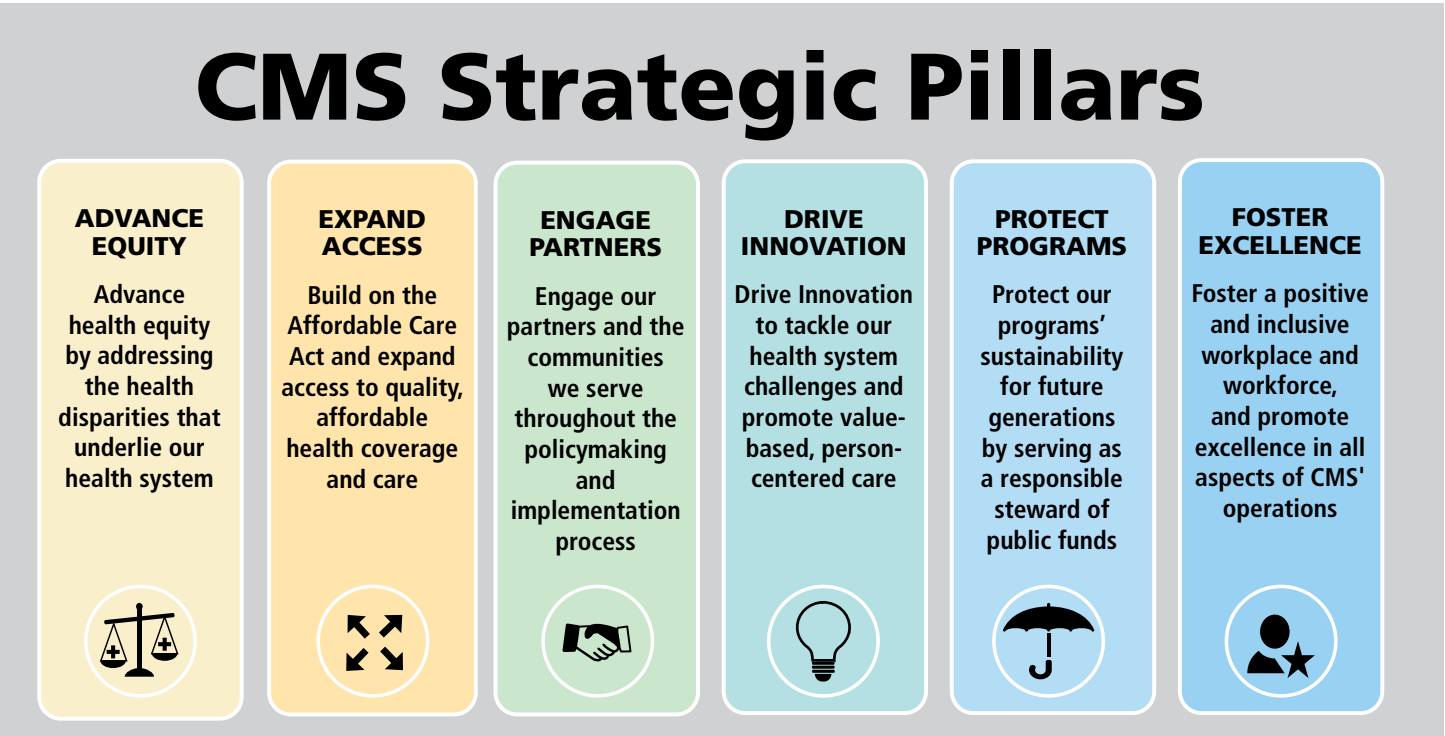
CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes

CMS achieves this vision through the work of thousands of individuals dedicated to improving people's lives through public policy aimed at making the U.S. healthcare system work better for everyone. It is important to lay out the strategy for how the agency will achieve this vision and how it should judge success. Everything we do at CMS should be aligned with one or more of the Agency's overarching strategic pillars.

Strategic Pillars

CMS has an ambitious agenda and a bold plan to meet our mission. All our work is organized and managed along six CMS strategic pillars that promote the establishment of broad programmatic goals. Inherent in our work is an unyielding focus on the customer experience to expand coverage and equitable access to those who are covered by one or more of our programs. Also essential is a focus on continuous improvement of CMS's operations to ensure they are best in class and set a benchmark for health system transformation.

All of CMS's centers and offices are actively developing and implementing projects to collaboratively advance these pillars across the agency. The following pages provide examples of some of the initiatives we have taken to achieve these goals.



Advance Health Equity by Addressing the Health Disparities that Underlie Our Health System

CMS Innovation Strategy Refresh

CMS is committed to developing a healthcare system that attains the highest level of health for all patients and eliminates health disparities. A key part of this work is understanding the current impact of our models across all patients. In 2021, CMS developed a new strategy for the next decade of testing innovative healthcare payment and service delivery models as outlined in the white paper, *Driving Health System Transformation*- A Strategy for the CMS Innovation Center's Second Decade. As part of this work, CMS consulted with external research and health policy experts to reflect on its model portfolio and its impact over the past ten years. Upon review, it was found that models had historically had a limited reach to Medicaid beneficiaries and safety net providers. This finding reiterated CMS's obligation to engage providers who have not previously participated in value-based care initiatives and ensure that eligibility criteria and application processes encourage care for historically disadvantaged populations, including racial, ethnic, and rural communities, as well as those with disabilities.

To this end, CMS sought improvements to programs' financial incentives that would incentivize primary care providers and specialists alike to care for such populations going forward. For example, in the calendar year 2023 Medicare Physician Fee Schedule Proposed Rule, CMS proposed changes to the Medicare Shared Savings Program to incorporate advanced shared savings payments for certain Accountable Care Organizations (ACOs) that could be used to address Medicare beneficiaries' social needs. Additionally, it proposed a health equity payment adjustment that rewards ACOs for providing high-quality care to underserved populations.

Further, CMS will require and consider incentives and support for model participants to collect data on race, ethnicity, geography, disability, and other demographics to help providers address health disparities (in a manner that protected health information complies with the *Health Insurance Portability and Accountability Act* and other applicable laws).

Closing Health Equity Gaps for End-Stage Renal Disease Patients

CMS proposed and finalized steps to close health equity gaps by focusing on improving the experience of people with Medicare who are battling End-Stage Renal Disease (ESRD). The calendar year 2022 ESRD Prospective Payment System (PPS) rule updated ESRD PPS payment rates, made changes to the ESRD Quality Incentive Program, and revised the ESRD Treatment Choices (ETC) Model. The ETC Model policies aim to encourage dialysis providers to decrease disparities in rates of home dialysis and kidney transplants among ESRD patients with a low socioeconomic status. This model is the agency's first model to address health equity directly. To mitigate health disparities among the nation's beneficiaries, the Innovation Center committed to centering equity in all stages of model design, operation, evaluation, and aligning these concepts with other CMS programs. This approach will be integral as CMS aims to develop new models that address social determinants of health and increase the number of people in an accountable care relationship with a primary care physician, especially among underserved communities.

Addressing Implicit Bias in Model Tests

To ensure models reflect the nation's diverse beneficiary population, the CMS Innovation Center conducted an analysis of potential implicit bias within models' algorithms and processes. The assessment examined three models to identify potential sources of bias and found that use of certain risk-assessment and screening tools, provider tools, and payment design and risk-adjustment algorithms had led to the exclusion of some beneficiaries from these models. For example, a review of the Comprehensive Care for Joint Replacement Model found a financial structure that may have inadvertently disincentivized providers to offer joint replacement surgery to Black and low-income individuals. Concerns about this potential selection bias prompted CMS to revise the risk-adjustment formula. Further, CMS is collecting data to help understand the impact of the revised risk-adjustment formula, as well as other changes in patient volume that may indicate selection bias based on patient sociodemographic characteristics. Additionally, to address these underlying disparities, CMS began to develop a step-by-step guide to screen for and mitigate bias in CMS models. This guide will be piloted for use in new models currently in development, with the intention of having all future models screened for implicit bias with this guide prior to launch.

Achieving this goal requires centering equity in all stages of model design, operation, evaluation, and aligning these concepts with other CMS programs. It also requires engaging providers who have not previously participated in value-based care initiatives and ensuring that eligibility criteria and application processes encourage care for historically disadvantaged populations, including racial, ethnic, and rural communities, as well as those with disabilities.

HealthCare Payment Learning and Action Network

The HealthCare Payment Learning and Action Network (LAN) is an active partnership between public and private healthcare leaders dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate our healthcare system's adoption of alternative payment models (APMs). The LAN mobilizes payers, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs as well as improve patient experiences and outcomes by encouraging public/private adoption of value-based approaches to healthcare payment and delivery.

Through 2022, the LAN will engage with Executive Forum members and other organizations to convene action-oriented work groups and undertake strategic initiatives to further advance health equity and reset the LAN goals to align with the new CMS goal to move all beneficiaries into accountable care relationships with total cost of care accountability by 2030. In service of this goal, the LAN recently announced a new definition for "accountable care" and corresponding accountable care commitment curve. These items make clear what is meant by implementing accountable care and accountable care relationships, as well as illustrate the varying levels of commitment and sophistication an organization can have around this concept. In addition to receiving stakeholder feedback and input on these items, the LAN plans to further advance this concept with the creation of the Accountable Care Action Collaborative (ACAC). The LAN will form the ACAC later this year under the goal of advancing the adoption, evolution, and growth of accountable care relationships in the healthcare system by forging new partnerships with national organizations with shared goals and commitments.

Tribal Affairs – Outreach and Enrollment

CMS works with the Indian Health Service (IHS), Tribes and Tribal organizations, and Urban Indian Organizations (UIO's) to provide training, outreach, and education to encourage enrollment of American Indians and Alaska Natives (AI/AN) in Medicare, Medicaid, CHIP, and the Marketplace. AI/AN populations continue to have the highest uninsured rates compared to other populations and experience the most significant health disparities. The majority of AI/ANs reside in rural and frontier communities where access to IHS healthcare might be limited. Increased outreach and enrollment of AI/ANs in CMS programs result in greater access to services that IHS might not be able to provide and bring in third party resources to better support healthcare for the uninsured AI/AN communities.

Build on the Affordable Care Act and Expand Access to Quality, Affordable Health Coverage and Care

American Rescue Plan Implementation

CMS is charged with implementing many of the provisions of the *American Rescue Plan Act of 2021* (ARP) that relate to private insurance. Section 9813 of the ARP amended Title XIX of the *Social Security Act* to authorize a state option to provide qualifying community-based mobile crisis intervention services for a period of up to five years, during the period starting April 1, 2022, and ending March 31, 2027. States that have approved coverage and reimbursement authority through their Medicaid programs may receive an 85 percent federal medical assistance percentage (FMAP) for expenditures on qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters within the five-year period. Implementation guidance was issued December of 2021 and CMS continues the provision of technical assistance to states.

Section 9817 of the ARP provided states with additional federal funding for Medicaid home and community-based services (HCBS). States can use the additional funding for a broad range of activities to enhance, expand, and strengthen their HCBS systems, including to increase community living options for people with disabilities, strengthen the HCBS system in response to the COVID-19 Public Health Emergency (PHE), increase access to HCBS for Medicaid beneficiaries, protect the HCBS workforce, safeguard the financial stability for HCBS providers, and accelerate long-term services and supports (LTSS) reform. States plan to spend about $25 billion on activities that enhance, expand, or strengthen HCBS under Medicaid as a result of ARP Section 9817.

Expanding Access to Mental Health Services under Traditional Medicare

CMS is continuing to expand access to mental health services under Medicare by covering services that support behavioral health and wellness, including alcohol screening and counseling. The annual wellness visit now includes depression screening, behavioral health integration, bundled payments for opioid use disorder, chronic care management for patients with multiple chronic conditions, diagnostic psychological and neuropsychological evaluation and testing, and drug therapy or pharmacological management using medication(s) to treat disease. For 2022, CMS is implementing policies that expand access to care using telehealth and other telecommunications technologies, bringing care directly into patients' homes for certain mental and behavioral health services.

Money Follows the Person Demonstration

In light of high rates of COVID-19 infection and death among persons residing in nursing facilities and other medical institutions, CMS announced the availability of additional funding for states implementing the Money Follows the Person (MFP) Capacity Building demonstration in FY 2021. Up to $5 million was available per state for planning and capacity building activities to support long-term services, system transformation design and implementation, and expansion of HCBS capacity. Since that time, awards have been made on a rolling basis as states submit proposals and a total of $151 million has been awarded to 32 grantees for activities such as:

- Assessing HCBS system capacity and determining the extent to which additional providers and/or services might be needed;
- Expanding access to assistive technology, telehealth, and technology/communication devices;
- Developing housing partnerships with public and private housing providers to increase access to affordable and accessible housing;
- Engaging stakeholders in system planning, development, and implementation activities;
- Provider service worker and direct service worker recruitment, education, training, and technical assistance (including training people with disabilities to become direct service workers);
- Caregiver training and education; and
- Assessing and implementing changes to reimbursement rates and payment methodologies to expand HCBS provider capacity and/or improve HCBS and/or institutional service quality.

In addition, in March 2022, CMS released a Notice of Funding Opportunity (NOFO) that offered up to $110 million to expand access to HCBS through Medicaid's MFP program. The new NOFO, which was authorized under the CAA will make individual awards up to $5 million to states and territories that are not currently participating in MFP. These funds will support states during the initial planning and implementation of their programs, as well as for capacity building activities, including:

- Establishing partnerships with community stakeholders, including those representing diverse and underserved populations, Tribal entities and governments, key state and local agencies (such as state and local public housing authorities), and community-based organizations;
- Conducting system assessments to better understand how HCBS support local residents;
- Developing programs for the types of community transitions MFP supports;
- Establishing or enhancing Medicaid HCBS quality improvement programs;
- Recruiting HCBS providers as well as expert providers for transition coordination and technical assistance; and
- Conducting a range of planning activities deemed necessary by the award recipients and approved by CMS.

The CAA reauthorized funding for the MFP program through FY 2023 and made other statutory changes to the program authorizing additional states to participate in the program and allowing states to provide community transition services earlier in an eligible individual's inpatient stay. In light of these changes, CMS updated the scope of MFP supplemental services and their reimbursement rate to help states address barriers to community transition, increase community transition rates, and increase the effectiveness of the MFP demonstration. Specifically, the definition of supplemental services was modified from one-time services to short-term services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program. Further, the definition was expanded to address critical barriers to transition for MFP participants, including the lack of affordable and accessible housing, food insecurity, and financial and administrative barriers to transitions. Additionally, the reimbursement rate for supplemental services was increased from the state's FMAP rate to full coverage by MFP grant funds at a federal reimbursement rate of 100 percent. Examples of the expanded scope of supplemental services that states may choose to cover under their respective MFP programs include:

- up to 6-months of short-term rental assistance and associated utility expenses;
- food pantry stocking for up to a 30-day period;
- payment for services and activities such as home accessibility modifications, vehicle adaptations, pre-tenancy support, community transition services, and case management prior to an individual transitioning from an institutional setting; and
- costs associated with securing a community-based home that are not coverable under Medicaid such as apartment application and administrative fees.

Enhancing Access to Medicaid and CHIP Coverage

CMS implemented streamlined processes and timelines to review and approve hundreds of state requests for flexibilities during the COVID-19 PHE, including state requests for state plan amendments, concurrence with regulatory authorities, and Section 1135 and 1115 requests. Under these new protocols and timelines, CMS was able to be responsive to state requests to grant flexibilities that promoted access to Medicaid and CHIP coverage during the PHE. In doing so, CMS also developed multiple new streamlined templates and instructions to make it easier for states to submit these requests. CMS also provided extensive technical assistance to states as they have responded to the COVID-19 PHE. CMS utilized Medicaid.gov to provide information and technical assistance to states on complex policy issues.

To help Medicaid and CHIP agencies prepare for and respond to PHEs, disasters, and other emergencies, CMS and the Medicaid and CHIP Coverage Learning Collaborative updated a toolkit on the strategies available to support Medicaid and CHIP operations and beneficiaries. This toolkit was updated with additional strategies and lessons learned from the COVID-19 PHE, and now includes a new strategic framework for Medicaid and CHIP agencies as they prepare to respond to a future disaster or PHE.

Additionally, CMS released a State Medicaid Director Letter on Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions to provide guidance to states on Section 1001 of the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act*, which prohibits states from terminating Medicaid eligibility for eligible juveniles who become inmates of public institutions. Facilitating enrollment in Medicaid and supporting access to healthcare services upon release can be crucial to ensuring a successful transition to the community following incarceration.

Enhancing Consumer Options and Choice on the Marketplaces

Network adequacy standards were introduced for qualified health plans (QHPs) on the federally facilitated Marketplace for plan year 2023. These standards will ensure that consumers, especially those in underserved communities, can utilize their insurance to get needed care. CMS will evaluate QHPs for compliance with quantitative network adequacy standards based on time and distance standards and include a wider breadth of specialties to meet the unique healthcare needs of QHPs enrollees, such as emergency medicine, outpatient clinical behavioral health, pediatric primary care, and urgent care. Obstetrics and gynecology OB/GYN parameters will also be aligned with the parameters for primary care.

Standardized plan options were also introduced for QHPs using the federal platform for plan year 2023. These standardized plan options allow consumers to compare plan options easily to choose a plan that meets their medical and financial needs, as well as makes baseline health benefits more transparent. These policies will ensure consumers can more easily find the right form of quality, affordable coverage for their circumstances.

Implementing the Expanded Home Health Value-Based Purchasing Model

CMS began implementation of the nationwide expanded Home Health Value-Based Purchasing Model (HHVBP), which improves the quality and delivery of home healthcare services to people with Medicare. The original HHVBP Model was tested in home health agencies (HHAs) in nine states beginning in January 2016. The expanded HHVBP Model began on January 1, 2022, and includes Medicare-certified HHAs in all fifty states, District of Columbia, and the U.S. territories. Throughout 2022, CMS will provide HHAs with resources and training, allowing them time to prepare and learn about the expectations and requirements of the expanded HHVBP Model without risk to payments. The first full performance year for the expanded HHVBP Model begins January 1, 2023. Calendar year (CY) 2025 will be the first payment year, with payment adjustment amounts determined on CY 2023 performance.

Engage Our Partners and the Communities We Serve Throughout the Policymaking and Implementation Process

Data Exchange Between CMS and the States

CMS finalized the Interoperability and Patient Access Rule, which mandates daily submission of certain dual eligibility status files by April 1, 2022. Prior to April 2022, states were required to submit these files at least monthly to CMS. Without daily exchanges, CMS lagged in its ability to automatically enroll individuals in Medicare drug plans; deem them automatically eligible for the low-income subsidy for Medicare Prescription Drug Benefit premiums, deductibles, and copayments; and terminate or activate state payment of Medicare premiums. Increasing the frequency of federal-state data exchanges improves beneficiaries' experiences with their Medicare benefits and ensures that Medicare coverage is affordable. This will also reduce burden on states and providers to reconcile incorrect payments due to data lags and improve provider compliance with the prohibition on billing Qualified Medicare Beneficiaries for Medicare HI and SMI cost-sharing.

By June 2022, 49 states submitted files on dual eligibility status daily, and 47 states exchanged data daily on state payment of Medicare premiums. CMS provides technical assistance to states through the State Data Resource Center, including tip sheets, frequently asked questions, and recorded webinars.

To improve processing of State Buy-In actions for vulnerable populations eligible for Medicare through State Buy-In, CMS established an electronic system for states to transmit State Buy-In actions that may impact the ability for certain Medicare beneficiaries to receive services or payment. CMS manages and provides oversight for the control, problem identification, and correction of State Buy-In transactions, and provides resolution to related data discrepancies.

CMS also engages with state partners to improve services for vulnerable communities and to maximize awareness of Medicare and Medicaid services by coordinating and hosting quarterly and monthly state office hours calls for the sharing of operational State Buy-In issues, solutions, resources, lessons learned and experiences among the states and CMS. The response rate of attendees who attest that these state office hours calls were useful, is higher than 75 percent, as measured by the CMS state office hours survey in 2021-2022.

Enhanced Assistance on State Medicaid Provider Screening and Enrollment

CMS provides ongoing guidance, education, and outreach to states about federal requirements for Medicaid provider screening and enrollment. In FY 2022, CMS worked closely with states in their resumption of provider screening and enrollment activities, which may have been paused under the PHE. CMS also continues to offer the Data Compare Service to states, which allows states to rely on Medicare's screening in lieu of conducting a state screening particularly during revalidation. Using the data compare service, a state provides a Medicaid provider enrollment data extract to CMS, and then CMS returns information indicating which providers have undergone a Medicare screening the state can rely on, thereby reducing the state's or territory's work load. Data compare helps states identify providers for termination or deactivation. CMS also conducted a pilot process to screen Medicaid-only providers on behalf of states and to produce a report of providers with licensure issues, criminal activity, as well as do not pay activity.

Medicaid Integrity Institute

CMS offers training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute (MII). Despite the change to a virtual environment in FY 2021, state interest and participation was strong and consistent with previous years. In FY 2022, CMS continued a robust virtual training program that continued throughout the COVID-19 PHE. For example, courses included such topics as Medicaid Program Integrity Risk Assessment Development; Payment Error Rate Measurement (PERM) Corrective Action Plan (CAP) Development and Monitoring; Provider Enrollment and Terminations; Data Analytics; Major Case Coordination; Program integrity Opportunities for the Territories; and Medicaid Managed Care. More information is located at the **Medicaid Integrity Institute**.

Medicaid Eligibility Quality Control Program

Under the Medicaid Eligibility Quality Control (MEQC) program, states design and conduct pilots to evaluate the processes that determine an individual's eligibility for Medicaid and CHIP benefits. States have flexibility in designing pilots to focus on vulnerable or error-prone areas identified by the PERM program and the state. The MEQC program also reviews eligibility determinations that are not reviewed under the PERM program, such as denials and terminations. MEQC pilots are conducted during the 2-year intervals that occur between states' triennial PERM review years ("off-years"). This allows states to implement prospective improvements in eligibility determination processes prior to their next PERM review. In FY 2022, CMS worked with the Cycle 2 states to submit their MEQC summary-level reports and CAPs; the Cycle 3 states to complete their MEQC reviews and begin preparing summary-level reports and CAPs; and the Cycle 1 states to begin their MEQC reviews.

Medicaid Managed Care Oversight

CMS published guidance on June 28, 2021, to announce its Medicaid managed care monitoring and oversight strategy designed to improve access to services by supporting federal and state access monitoring for Medicaid beneficiaries within a Medicaid managed care delivery system. This guidance introduced a series of tools and toolkits for states to use and CMS to improve the monitoring and oversight of Medicaid managed care programs. On July 6, 2022, CMS published a second piece of Medicaid managed care monitoring and oversight guidance. This guidance outlined the latest updates to a new web-based portal for state reporting on managed care programs to CMS. It also offered additional reporting templates and a new technical assistance toolkit, to help states improve their overall monitoring and oversight of managed care.

Redesigned ACO REACH Model

In direct response to stakeholder feedback regarding the CMS Innovation Center's Global and Professional Direct Contracting Model, CMS introduced a redesigned version: the ACO Realizing Equity, Access, and Community Health (REACH) Model. ACO REACH will test an innovative payment approach to better support care delivery and coordination for patients in underserved communities and will require that all model participants develop and implement a robust health equity plan to identify underserved communities and implement initiatives to measurably reduce health disparities within their beneficiary populations.

Stakeholder Engagement

Stakeholder engagement related activities continued in FY 2022 throughout the policymaking and implementation process. Some of the stakeholder related activities in the fiscal year include the following:

- CMS actively engaged with external stakeholders through listening sessions hosted by CDC and Office of the Assistant Secretary for Preparedness and Response (ASPR) to obtain feedback about proposed changes to the hospital and critical access hospital conditions of participation. These proposals pertained to continued COVID-19-related data reporting after the end of the PHE declaration and establishing new requirements for data reporting in the event of a new PHE declaration involving infectious diseases. Pertinent stakeholders included hospitals, health systems, and other healthcare providers or their associations, state, tribal, local, and territorial public health and emergency preparedness professionals.
- Beneficiaries, providers, patient advocacy groups, foundations, research experts, and other stakeholders in five CMS Innovation Center public listening sessions were engaged on the following topics: health equity, beneficiary engagement, safety net providers, advanced primary care, and the Innovation Center's strategy refresh.
- In response to the unprecedented challenges posed by the 2020 COVID-19 PHE, CMS launched a project to gather broad stakeholder feedback. To help CMS better prepare the nation's healthcare system for future disasters, the project conducted discussions with hospitals and nursing homes to understand how they prepared for and responded to the PHE. We conducted voluntary discussions with approximately 30 hospitals and nursing homes to learn perspective on preparedness, resiliency, and implementation of the COVID-19 response and synthesized responses, including qualitative themes and quantitative inputs from provider discussions.
- Worked with our sister agency, Agency for Healthcare Research and Quality (AHRQ), to complete a Technology Assessment, on the Coverage with Evidence Development clinical study requirements.
- Engaged with the Forum of ESRD Networks and patient community to gather feedback regarding emerging issues affecting dialysis patients. Feedback related to COVID directly impacted CMS/ASPR supply chain assessment and response for dialysis related supplies affected by COVID.

Drive Innovation to Tackle Our Health System Challenges and Promote Value-based, Person-centered Care

Chronic Conditions Data Warehouse Cloud Migration

The Chronic Condition Data Warehouse (CCW) is a major CMS IT investment that supports internal and external research and analysis. The CCW is approximately six petabytes in size, contains over 400 billion records from CMS program data, and stores an estimated 3.5 million datasets. Users access the CCW via the Virtual Research Data Center, which is a secure environment allowing researchers to perform their analysis and data manipulation from their independent workstations while still ensuring the data is protected. To keep abreast of new technology and innovation, CMS executed a complex and multiphase migration for the CCW from its on-premise warehouse to a new cloud environment. Cloud technology offers faster, more reliable data processing, additional analytic tools such as Databricks® and Python©, and an improved data access experience. In 2022, CMS successfully transferred all users, and their associated data files, to the new cloud environment with no impact or disruption.

Promote New Innovative Technologies

CMS is committed to ensuring Medicare beneficiaries and their clinicians have timely access to novel medically necessary products and services that drive value-based, person-centered care. CMS is in a notable period of innovation in healthcare with new technologies that facilitate telehealth and remote monitoring, as well as advanced intelligence algorithms to support healthcare decisions, digital health products, novel diagnostic testing, and new types of cancer-fighting drugs and biologicals. To provide access to many types of beneficial new technologies, CMS must make timely decisions regarding Medicare coverage, coding, and payment. In FY 2021, CMS reorganized its workforce to support access and equity for Medicare beneficiaries to new, innovative products and healthcare services. For example, this workforce has seen a more than four-fold increase, compared

to four years ago, in the number of submissions from manufacturers for new technology add-on payment in the inpatient hospital setting. In addition, our workforce is dedicated to customer service by streamlining navigation of our coverage, coding, and payment processes for manufacturers, providers, and other stakeholders who are involved in coordinating the care of our beneficiaries. In support of this, a small team of new technology liaisons was established in FY 2021. This team coordinated and facilitated cross-component and/or product specific meetings with industry stakeholders and CMS policy staff regarding coding, coverage, and/or payment considerations for medical technologies, to support critical information sharing.

Creating New Opportunities for Innovative, Integrated Care

Medicare and Medicaid were originally created as distinct programs with different purposes and have operated as separate systems despite a growing number of people who depend on both programs for their healthcare needs. This lack of coordination can lead to fragmented care for dually eligible individuals, misaligned incentives for payers and providers, and administrative inefficiencies and programmatic burdens for all. Integrated care leads to delivery system and financing approaches that maximize Medicare-Medicaid care coordination and mitigate cost-shifting incentives, including total-cost-of-care accountability across Medicare and Medicaid. Most importantly, it means a seamless experience for beneficiaries. In FY 2021, for which the most recent data was available, about 18 percent of full-benefit dually eligible individuals were in integrated care.[2] CMS will continue to work to increase this percentage in a variety of ways, including through existing and new platforms for integration.

In recent years, CMS has partnered with states to develop innovative, integrated care and financing models. CMS has focused on initiatives to better integrate and strengthen access to care for dually eligible individuals and to eliminate unnecessary cost shifting between the Medicare and Medicaid programs. There are a range of approaches to integrating Medicare and Medicaid benefits and/or financing, including through implementing new demonstrations and enhancing existing programs.

Transforming Oncology Care

The CMS Innovation Center announced its new Enhancing Oncology Model (EOM) in June 2022. The EOM aims to drive transformation and improve care coordination in oncology care by preserving and enhancing the quality of care furnished to beneficiaries undergoing treatment for cancer while reducing program spending under Medicare fee-for-service. Under EOM, participating oncology practices will take on financial and performance accountability for episodes of care surrounding systemic chemotherapy administration to patients with common cancer types. EOM supports President Biden's Unity Agenda and Cancer Moonshot initiative to improve the experience of enrollees and their families living with and surviving cancer. EOM aligns with the Cancer Moonshot pillars and priorities of supporting patients, caregivers, and survivors, learning from all patients, targeting the right treatments for the right patients, and addressing inequities.

Expanded Adoption of Blue Button 2.0

CMS is committed to promoting value-based, person-centered care by empowering patients to share their health information securely with any provider, application, or researcher they choose. In 2022, CMS led efforts to expand adoption of Blue Button 2.0, which allows beneficiaries to connect their data to applications and other tools developed by innovative companies. Information is then shared in an electronic, standards-based format that is commonly accepted and used across the healthcare system while also ensuring privacy and security. Over the last year, CMS has increased the number of beneficiaries using Blue Button 2.0 to seamlessly share their data by nearly 60 percent. Using Blue Button 2.0, private sector vendors have designed innovative applications that support beneficiaries who choose to share their data in multiple ways including helping beneficiaries organize their claims data, find health plans, make care appointments, and donate their data to research studies.

Application Programming Interfaces

Over the past several years, CMS has taken important steps to drive innovation by modernizing how it shares data with external partners such as ACOs and Medicare Prescription Drug Benefit Plan Sponsors. In 2022, CMS continued this effort by leveraging application programming interfaces (APIs) to enable seamless access to claims data for participants in select CMS Innovation Center APMs. In addition, CMS continues to pilot the Data at the Point of Care API, which aims to test sharing claims data directly with providers to provide a complete picture of a patient's medical history and help fill data gaps that may occur as patients move through the healthcare system. Over the last year, CMS has nearly doubled the number of beneficiaries whose claims data are seamlessly shared with an authorized provider, plan, or APM participant via a standards-based API.

2 CMS analysis. Data on number of full-benefit duals: **https://www.cms.gov/files/document/ medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf.** Count of duals in integrated care from Integrated Care Resource Center analysis. MMCO FY 2021 Report to Congress. **https://www.cms.gov/files/document/reporttocongressmmco.pdf**

Integrated Data Repository

The Integrated Data Repository (IDR) is a high-volume data warehouse comprising integrated views of data across Medicare Parts A, B, C, and D; Beneficiary Entitlement; Enrollment and Utilization data; Provider reference information; Drug data; Contracts for plans; and Medicaid and CHIP. The IDR data is leveraged by various components across the agency and externally by entities such as the Federal Bureau of Investigation, Office of Inspector General (OIG), and Department of Justice (DOJ) to facilitate investigative and litigious efforts focused on fighting Medicare and Medicaid fraud, waste, and abuse. As part of migrating the IDR to the cloud by December 2023, we have designed the IDR Cloud system to be nimbler and more scalable to enhance system throughput and workload isolation, and support advanced analytics such as Machine Learning for our customers and data scientists to make better data driven decisions. We are implementing additional data access capabilities such as Data-as-a-Service APIs in the IDR cloud for the downstream applications to consistently and securely access the IDR data. To support the agency's overarching goal to eliminate data duplication, we are also implementing secure data sharing capabilities within the IDR cloud so data is centrally stored and logically shared with internal and external customers.

Protect Our Programs' Sustainability for Future Generations by Serving as a Responsible Steward of Public Funds

Payment Error Rate Measurement Corrective Action Plans

In FY 2022, CMS continued implementation of a more robust, state-specific CAP process that provides enhanced technical assistance and guidance to states. CMS continued working with the states to coordinate state development of CAPs to address each error and deficiency identified during the PERM cycle. After the CAP submissions, CMS monitors states' progress in implementing effective corrective actions to address the errors and deficiencies. CMS continues to use lessons learned from this process to determine areas to evaluate for future guidance and education.

Major Case Coordination

CMS launched its Major Case Coordination (MCC) initiative, which includes representation from the HHS's OIG, DOJ, and CMS. This initiative provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials, and fraud investigators to collaborate before, during, and after the development of fraud leads and investigations. This collaboration contributed to several successfully coordinated law enforcement actions and helped CMS better identify national fraud trends and program vulnerabilities, and better apply applicable administrative actions when appropriate. As a result of the MCC, there has been a marked increase in the number and quality of law enforcement referrals. Since implementation of the MCC, there have been over 3,900 cases reviewed at MCC and law enforcement partners have requested over 2,500 referrals as a result of MCC case reviews.

Prior Authorization

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before a service is furnished to a Medicare patient and before a claim is submitted for payment. Prior authorization helps to ensure that all applicable Medicare coverage, payment, and coding rules are met before a service is furnished, which helps providers and suppliers address claim issues early and avoid denials and appeals. By utilizing prior authorization, CMS protects the Medicare Trust Fund from improper payments.

CMS works closely with providers and associations to share prior authorization guidelines and procedures. In FY 2022, CMS completed the nationwide expansion of the prior authorization model for repetitive, scheduled non-emergent ambulance transports. In addition, CMS began to require prior authorization for certain lower limb orthoses, lumbar sacral orthoses, and additional power mobility devices. CMS also continued prior authorization for certain outpatient hospital services. As prior authorization is an ongoing process, CMS continues to explore additional opportunities to expand Medicare FFS's use of prior authorization.

Medicare Part C and Part D Oversight

As required under the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act*,[3] CMS developed the Health Plan Management System (HPMS) Program Integrity (PI) Portal for Fraud, Waste and Abuse (FWA) Reporting. The HPMS PI Portal for FWA Reporting is a web-based portal that allows for the reporting of certain information related to FWA in the Part C and Part D programs and for sharing of this information between CMS, Medicare Part C and Part D plan sponsors, and the Investigations Medicare Drug Integrity Contractor (I-MEDIC) to assist in combatting FWA in the Medicare Part C and Part D programs. Information that must be reported into the PI Portal includes (1) payment suspensions based on credible allegations of fraud (CAF) against pharmacies under the Medicare Part D program, (2) inappropriate prescribing of opioids, and (3) substantiated or suspicious activities of FWA.

3 Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, Pub. L. No. 115-271, 132 Stat. 3987.

Healthcare Fraud Prevention Partnership

The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary public-private partnership that helps detect and prevent healthcare fraud through collaboration, data and information sharing, and cross-payer research studies. Partners include the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations. The CAA, which amended Section 1128C(a) of the *Social Security Act* (42 U.S.C. 1320a–7c(a)) provided explicit statutory authority for the HFPP. The CAA requires a bi-annual report to Congress on current activities of the HFPP, including any savings attributable to the partnership. The HFPP is also required to conduct a study and submit to Congress a report on the feasibility of the partnership establishing a system to conduct real-time data analysis to proactively identify potentially fraudulent claims and perform substance use disorder treatment analysis. An Executive Board comprised of representatives of the federal government and representatives of the private sector was established to provide strategic direction for the partnership, including membership criteria and a mission statement.

Foster a Positive and Inclusive Workplace and Workforce, and Promote Excellence in All Aspects of CMS's Operations

Foster a Positive and Inclusive Work Environment

CMS continues to improve its ranking as a Best Place to Work through its focused efforts to foster a positive and inclusive work environment. Specifically, in support of this goal, CMS has developed and implemented a Diversity, Equity, and Inclusion (DEI) Strategic Plan, which establishes five goals and initiatives to enable our organization to establish a more inclusive and equitable culture. The goals are: 1) Invest in DEI Infrastructure; 2) Embed Inclusion in the Culture; 3) Build DEI into the Talent Process; 4) Transform CMS DEI Analytics Capability and 5) Equip Every Leader to be a DEI Champion. A few initiatives in support of these goals include: establishing a DEI Council; developing and delivering a DEI Basics course for the workforce; and mitigating biases and enhancing equity into our talent processes and policies. In addition, with a focus on enhancing employees' work-life balance, and in partnership with the labor union, CMS is implementing the CMS Hybrid Workplace providing expanded work flexibilities to include more remote duty stations for the workforce.

Expanding Operational Efficiencies Through Integrated Resource Management

CMS established the Enterprise Workforce Investment Council (EWIC) as a long-term solution for managing full-time equivalent requests for the Agency due to continued budget limitations. The purpose of the EWIC is to review and recommend federal staffing levels by component and funding source and equip leadership with the information needed to make resource decisions based on agency strategic and operational priorities. In support of this effort, CMS is finalizing its Workforce Planning and Succession Planning Models along with its Workforce Optimization services to ensure the enterprise has the skills, data, and tools necessary to successfully manage its personnel resources. Phased implementation of these services will begin with educating leaders and managers to further develop their business acumen, followed by full implementation of on-demand data/tools for leaders to be able to make informed data-driven decisions.

Business Intelligence Tools

The Business Intelligence (BI) Tools support 16 agency Centers, Offices, and external entities with their data analysis and visualization to allow data driven decisions. CMS is modernizing BI tools to the cloud to reduce costs, provide increased functionality, help with data visualization, and increase program excellence. Currently CMS provides and maintains eight enterprise-wide data analytic and visualization tools to support access to the agency data to transform the healthcare system, deliver innovative care, and provide better value and results for patients. To date, CMS has successfully completed migrating five of the six enterprise tools from the Baltimore Data Center to the cloud, and will begin migrating the final BI tool to the cloud by the end of 2023. Additionally, CMS has added two new data visualization tools to the BI suite of tools to provide additional capabilities: Tableau© and Python©.

Enterprise Data Lake (Data mesh)

The Enterprise Data Lake (EDL) (Data Mesh), with a central common metastore, allows users to streamline access to enterprise data hosted in the cloud while eliminating data duplication and reducing/eliminating file transfer activities between CMS components. The EDL program provides system-to-system access to the Provider and Beneficiary data, ongoing EDL operations & maintenance support, in addition to a governance model as well as an enabling cloud infrastructure and services in both Amazon Web Services commercial and GovCloud.

EDL's current developments provide end-user-level access to the enterprise data. The EDL team deployed an enabling model called Launchpad, an enterprise data catalog to capture business information about the data, and a secured role management capability. Launchpad accelerates the delivery of various cloud services to consumers who either do not have a cloud footprint, need expedited analytical and visualization capabilities, or are in the cloud but need custom services like visualization, processing, or data role management. The EDL (Data Mesh) program continues to grow, onboarding new sets of teams on an ongoing basis.

Direct Service Workforce

In 2022, based on State Medicaid Agency and stakeholder input received through the summit, learning collaborative, and a technical expert panel, CMS developed several tools focused on the direct service workforce (DSW) for states and individuals with disabilities receiving services: 1) on-line, interactive training modules that provide practical strategies for individuals directing their own care; 2) issue briefs and reports on emerging practices to address workforce challenges, key components and operational considerations for programs that allow Medicaid beneficiaries to "self-direct" their HCBS, and strategies to strengthen the DSW in rural areas; and 3) a tool-kit on DSW strategies for State Medicaid agencies that offers a collection of practical resources and successful state approaches for improving DSW capacity.

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 its financial management and reporting processes to provide timely, reliable, and accurate financial information. CMS management and other decision makers use this information 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*, the *Chief Financial Officers Act of 1990*, and other requirements, including the Office of Management and Budget Circular A-136, *Financial Reporting Requirements*. CMS management is responsible for the integrity of the financial information in these statements. The OIG selects an independent certified public accounting firm to audit CMS's financial statements and related notes.

Consolidated Balance Sheets

The Consolidated Balance Sheets present, as of September 30, 2022 and 2021, 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 Sheets reported assets of $765.4 billion. The bulk of these assets are Investments totaling $347.3 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 $335.7 billion, most of which is used for Medicaid, CHIP, and Payments to Healthcare trust funds. Liabilities of $171.9 billion consist primarily of the Entitlement Benefits Due and Payable of $141.2 billion. CMS's Net Position totals $593.5 billion and reflects primarily the Cumulative Results of Operations for the Medicare trust funds and the unexpended balances for Medicaid and CHIP.

Consolidated Statements of Net Cost

The Consolidated Statements of Net Cost present the actual net cost of CMS's operations by program for the years ended September 30, 2022 and 2021. 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 and fraud and abuse funding are included under the HI trust fund. The net cost of operations under "Other" includes State Grants and Demonstrations and Other Health. Program Management expenses are allocated and shown separately under each major program. A Consolidating Statement of Net Cost shows the Medicare funds as Dedicated Collection versus Other Fund components of net cost as additional information. In FY 2022, CMS's total Net Cost of Operations was $1,383.6 billion encompassing net benefit/program costs of $1,525.4 billion and operating costs of $7 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, 2022 and 2021. Changes in the Cumulative Results of Operations and Unexpended

Appropriations affect CMS's net position balance. Funds From Dedicated Collections are shown in a separate column from Other Funds. The bulk of the change pertains to Appropriations Used of $1,079.6 billion, which represents the Medicaid and CHIP appropriations, transfers from Payments to the HealthCare Trust Funds to HI and SMI, and State Grants and Demonstrations and general fund-financed Program Management appropriations. Medicaid and CHIP are financed by general fund appropriations provided by Congress. Employment tax revenue is Medicare's portion of payroll and self-employment taxes collected under the *Federal Insurance Contributions Act* and the *Self Employment Contributions Act* for the HI trust fund and totaled $343.7 billion.

Combined Statements of Budgetary Resources

The Combined Statements of Budgetary Resources provide information about the availability of budgetary resources, as well as the status for the years ended September 30, 2022 and 2021. An additional Schedule of Budgetary Resources is provided as Required Supplementary Information (RSI) to present budgetary information by program. In this statement, Program Management is shown separately and Other includes State Grants and Demonstrations, Other Health and Medicare and Medicaid program integrity, and fraud and abuse activities. Also, there are no intra-CMS eliminations in these statements.

CMS total budgetary resources were $2,399.6 billion. Obligations of $2,175 billion leave unobligated balances of $224.6 billion. Total outlays, net of collections, were $2,062.3 billion. When offset by $698.2 billion relating to collection of premiums and general fund transfers from the Payments to the HealthCare Trust Funds, as well as refunds of Medicare Administrative Contractors overpayments, the CMS net outlays were $1,364.1 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 in evaluating the potential future cost of the program. These projected potential future obligations are not included in the Consolidated Balance Sheets, Statements of Net Cost, Statements of Changes in Net Position, or Combined Statements of Budgetary Resources.

Actuarial present values are computed under the intermediate set of assumptions specified in the *2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic. The amount of payroll taxes expected to be collected by the HI trust fund was greatly reduced due to the economic effects of the pandemic on labor markets. Spending was directly affected by the coverage of testing and treatment of the disease. In addition, several regulatory policies and legislative provisions were enacted during the public health emergency that increased spending. More than offsetting these additional costs in 2020, spending for non-COVID care declined significantly (compared to both actual 2019 spending and pre-pandemic expectations for 2020). Overall, the projections are based primarily on actual experience through 2019. However, program costs in 2020 and 2021 were used to help inform the development of adjustment factors by type of service, which account for the impact of COVID-19 through 2028. In spite of these substantial impacts on the Medicare program in 2020, the pandemic was not factored into the SOSI projections until 2021 because of the uncertainty of the impacts at the time the 2020 Trustees Report was released.

Spending for services other than COVID-19 was significantly lower than expected in 2020 and 2021. This decline was more pronounced for elective services. In addition, Medicare beneficiaries whose deaths were identified as related to COVID had costs that were much higher than the average Medicare beneficiary prior to the onset of the pandemic. As a result, compared to the pre-pandemic Medicare population, the surviving Medicare population had lower morbidity, on average, reducing costs by an estimated 1.5 percent in 2020 and 2.9 percent in 2021. This morbidity effect is expected to continue over the next few years but is assumed to decrease over time before ending in 2028.

While the COVID-19 pandemic has significantly affected Medicare short-term financing and spending, it is not expected to have a large effect on the financial status of the trust funds after 2028. As discussed throughout the Trustees Report, the key measures of the financial adequacy for each trust fund are fairly comparable to those included in last year's report.

The Medicare Accelerated and Advance Payments Program was significantly expanded during the COVID-19 public health emergency period. Total payments of approximately $107.2 billion were made from March 2020 through June 2021: roughly $67.1 billion from the HI trust fund and $40.1 billion from the SMI Part B trust fund account. The Trustees assumed that the accelerated and advance payments would be fully repaid by September of 2022, resulting in no net changes to trust fund expenditures. As discussed in Note 5, the majority of these accelerated and advance payments have been repaid as of September 30, 2022.

It should be noted that there is an unusually large degree of uncertainty with these COVID-related impacts and that future projections could change significantly as more information becomes available. Moreover, as a result of developments that have occurred since the assumptions for this year's Trustees Report were selected in mid-February 2022, uncertainty has increased regarding the path of the COVID-19 pandemic and the economy. The estimates do not reflect the potential impact of the *Inflation Reduction Act* (Public Law 117-169), which was enacted on August 16, 2022. As of the date of the financial statements, there is still a considerable amount of uncertainty surrounding these impacts and the projections have not been adjusted. The Trustees will continue to monitor developments and modify the projections in later reports as appropriate. The pandemic is an example of the inherent uncertainty in projecting health care financing and spending over any duration.

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 $(5.057) trillion, determined as of January 1, 2021, to $(5.094) trillion, determined as of January 1, 2022.

When the combined HI and SMI trust fund assets are included, the present value increases. As of January 1, 2022, the future cash flow for all current and future participants is $(4.7) trillion for the 75-year valuation period. The comparable cash flow for the closed group of participants, including the combined HI and SMI trust fund assets, is $(14.2) 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; thus, the HI trust fund assets have been declining. The following table shows the 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 steadily dropped from 66 percent at the beginning of FY 2018 to 38 percent at the beginning of FY 2022.

TRUST FUND RATIO

Beginning of Fiscal Year[4]

	2018	2019	2020	2021	2022
HI	66%	63%	50%	40%	38%

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 2022 Trustees Report indicate that the HI trust fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2022 Trustees Report, the HI trust fund ratio is estimated to remain at about the same level for a few years before decreasing for the rest of the projection period until the fund is depleted in calendar year 2028. Assets at the end of calendar year 2021 were $142.7 billion and after 2022 are expected to decrease steadily until depleted in 2028.

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

Long-Term Financing

The short-range outlook for the HI trust fund is slightly more favorable than what was projected last year. The trust fund ratio declines until the fund is depleted in 2028, two years later than projected in 2021 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 90 percent in 2028 to 80 percent in 2046, and then to increase to about 93 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 individuals eligible for benefits drops from 2.9 in 2021 to about 2.2 by 2096. In addition, healthcare costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $4.9 trillion, which is 0.7 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 this 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 $(47.5) 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 2021, SMI incurred expenditures were 2.4 percent of GDP. By 2096, SMI expenditures are projected to grow to 4.5 percent of the GDP.

Financial Challenges

These Medicare projections continue to demonstrate the need for timely and effective action to address the remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in expenditures. The Board of Trustees believes that solutions can and must be found to ensure the financial integrity of HI in the short and long term and to reduce the rate of growth in Medicare costs through viable means and they recommend that Congress and the executive branch work closely together with a sense of urgency to address these challenges. The sooner solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including healthcare providers, beneficiaries, and taxpayers—to adjust their expectations and behavior.

The following table presents key amounts from our basic financial statements for FY 2020 through 2022.

TABLE OF KEY MEASURES[5]
Dollars in billions

	2022	2021	2020
Net Position (end of fiscal year)			
Assets	$765.4	$690.8	$590.1
Less Total Liabilities	$171.9	$186.4	$133.4
Net Position (assets net of liabilities)	$593.5	$504.4	$456.7
Costs (end of fiscal year)			
Net Costs	$1,383.6	$1,272.4	$1,157.0
Total Financing Sources	$1,430.4	$1,285.0	$1,189.5
Net Change in Cumulative Results of Operations	$46.8	$12.7	$32.5
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	$(5,094)	$(5,057)	$(4,800)
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	$(5,057)	$(4,800)	$(5,484)
Change in present value	$(37)	$(257)	$683

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, 2022, decreased by $98 billion due to advancing the valuation date by 1 year and including the additional year 2096 and decreased by $1,958 billion due to changes in economic and healthcare assumptions. However, changes in the projection base, demographic assumptions, and law increased the present value by $1,996, $18, and $5 billion, respectively. The net overall impact of these changes is a decrease in the present value of $37 billion.

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 individuals with Medicare (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 2022 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.

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, CMS presents the closed group measure and open group measure. Totals do not necessarily equal the sums of rounded components.

Limitations of the Financial Statements

The principal financial statements are prepared to report the financial position, financial condition, and results of operations, pursuant to the requirements of 31 U.S.C. § 3515(b). The statements are prepared from records of Federal entities in accordance with Federal generally accepted accounting principles (GAAP) and the formats prescribed by OMB. Reports used to monitor and control budgetary resources are prepared from the same records. Users of the statements are advised that the statements are for a component of the U.S. Government.

2 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

Megan Worstell

The Centers for Medicare & Medicaid Services (CMS) is committed to fiscal accountability and financial management over its programs that work to advance health equity, expand coverage, and improve health outcomes. Protecting our programs' sustainability for future generations as a responsible steward of public funds remained my core goal in fiscal year (FY) 2022. As CMS's Chief Financial Officer (CFO), I am delighted to present the FY 2022 Agency Financial Report (AFR). The AFR, in addition to fulfilling various statutory requirements, provides timely information that many of CMS's stakeholders and the American public can use to better understand and evaluate our achievements relative to our mission and resources.

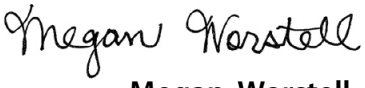
I am pleased to report that for the 24th consecutive year, CMS received an unmodified audit opinion on four of the six principal financial statements. An unmodified audit opinion confirms that our financial statements present fairly our financial position and are free from material misstatement, and conform with generally accepted accounting principles. However, as in previous years, the auditors were not able to express an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts due to the uncertainty in the long-range assumptions applied in our projection models. Nonetheless, CMS remains confident that the projections made are solid and have properly disclosed the purpose of our projections and that they are fairly presented.

As the nation slowly recovers from the effects of the public health emergency, the impact of COVID-19 continued to linger in FY 2022 which reinforced our commitment to ensure our programs' accessibility to high quality health care and lower health care costs. CMS remained dedicated to responsible financial stewardship while promoting excellence in all aspects of CMS's operations by seeking innovative ways to manage our complex programs. We prioritized our commitment to identifying and mitigating program vulnerabilities, strengthening our internal controls environment, and participating in comprehensive oversight activities related to fraud, waste, and abuse. The following are highlights of what we accomplished during FY 2022:

- As of the end of August 2022, CMS reported Medicare Secondary Payer (MSP) savings of $7.6 billion for the current FY. MSP savings are recognized through cost avoidance and recovery. Cost avoidance savings occur where Medicare paid secondary on a medical claim versus paying primary because an identified MSP occurrence prevented payment as primary. Recovery savings reflect actual monies returned to CMS where another entity had primary payer responsibility. The total savings reflect pre-pay (cost avoidance) savings of $6.5 billion and post-pay (recovery) savings of $1.1 billion.
- Over the last 29-months, CMS seamlessly operationalized the repayment terms for the Covid-19 Accelerated and Advanced Payments (CAAP) Program outlined by the Continuing Appropriations Act, 2021, and Other Extensions Act to ensure prompt repayment of funds to the Medicare Trust Funds. As of the end of September 2022, CMS received repayment of $101.4 billion of the $107.2 billion in CAAPs that were distributed to over 50,000 providers and suppliers who experienced disruptions to their billing during the start of the public health emergency.
- FY 2022 was the first year of reporting improper payment data for the Advance Payment of the Premium Tax Credit (APTC) program. CMS achieved a 99.4 percent payment accuracy for APTC payments made by the Federally-facilitated Exchange for plan year 2020. In addition to measuring the APTC improper payment estimate, CMS and the Internal Revenue Service (IRS) are collaborating to report a combined estimate, reflecting total improper payments for all Premium Tax Credit outlays administered by the IRS.

- CMS continued to forge ahead by prioritizing technical innovations in order to enhance operational excellence in FY 2022 through the implementation of RPA. RPA helps in increasing efficiency and capacity, improving accuracy and quality, and enabling the workforce to focus on higher value tasks. For example, the implementation of the Bankruptcy Bot helped to identify bankruptcy filings with Medicare debt and the right to recovery with the court on 39 bankruptcies that could have been missed, with overpayments totaling $5.2 million.
- In FY 2022, CMS program integrity efforts to eliminate, fraud, waste, and abuse yielded a return investment of greater than $7 to $1 ($7 returned for every $1 expended). In FY 2022, these activities included: 1) reviewing 11,877 providers for proper billing practices under the Targeted Probe and Educate program; 2) collecting $464.7 million in overpayments via Recovery auditing; 3) prior authorizing 1,988,469 (provisionally affirmed) claims to ensure beneficiaries received and providers were paid for appropriate services; and 4) saving $330 million using the advanced data analytic capabilities of our Fraud Prevention System. We are also particularly proud of our collaborative efforts in fighting fraud, waste, abuse across government agencies and with our private payer partners. We increased membership in the Healthcare Fraud Prevention Partnership from 224 to 267. Lastly, we referred 512 of potential fraud cases to law enforcement through the Major Case Coordination process.

Our successes in financial management have been, and will continue to be, a joint effort between our dedicated employees and the internal and external stakeholders of our programs. The improvements we made over the last year demonstrate that we take the responsibility for stewardship of the Medicare Trust Funds very seriously and my commitment remains unwavered.



Megan Worstell

CMS Chief Financial Officer

November 2022

FINANCIAL STATEMENTS

CONSOLIDATED BALANCE SHEETS

as of September 30, 2022 and September 30, 2021

(in millions)

	FY 2022 Consolidated Totals	FY 2021 Consolidated Totals
ASSETS		
Intragovernmental:		
Fund Balance with Treasury *(Note 2)*	$335,668	$284,473
Investments, Net *(Note 3)*	347,264	308,133
Accounts Receivable, Net *(Note 4)*	535	542
TOTAL INTRAGOVERNMENTAL	683,467	593,148
Other than intragovernmental:		
Accounts Receivable, Net *(Note 4)*	39,748	27,957
General Property, Plant and Equipment, Net	2,657	1,992
Advances and prepayments (*Note 5)*	39,007	67,184
Other assets	510	518
Total other than intragovernmental	81,922	97,651
TOTAL ASSETS	$765,389	$690,799
LIABILITIES		
Intragovernmental:		
Accounts Payable	$1,692	$1,818
Debt *(Note 6)*	8,256	36,781
Other Liabilities	31	79
TOTAL INTRAGOVERNMENTAL	9,979	38,678
Other than intragovernmental:		
Accounts Payable	359	337
Entitlement Benefits Due and Payable *(Note 7)*	141,177	133,777
Other Liabilities		
Contingencies and commitments *(Note 8)*	6,955	3,659
Other	13,380	9,969
Total other than Intragovernmental	161,871	147,742
TOTAL LIABILITIES *(Note 9)*	$171,850	$186,420
NET POSITION		
Unexpended Appropriations-Funds from Dedicated Collections *(Note 11)*	$178,704	$134,944
Unexpended Appropriations-Funds from Other than Dedicated Collections	75,185	76,618
TOTAL UNEXPENDED APPROPRIATIONS	253,889	211,562
Cumulative Results of Operations-Funds from Dedicated Collections *(Note 11)*	338,604	289,307
Cumulative Results of Operations-Funds from Other than Dedicated Collections	1,046	3,510
TOTAL CUMULATIVE RESULTS OF OPERATIONS	339,650	292,817
TOTAL NET POSITION	$593,539	$504,379
TOTAL LIABILITIES AND NET POSITION	$765,389	$690,799

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST

for the years ended September 30, 2022 and September 30, 2021

(in millions)

	FY 2022 Totals	Intra-CMS Eliminations	FY 2022 Consolidated Totals	FY 2021 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS GPRA PROGRAMS				
Medicare HI				
Benefit/Program	$367,736	$(134)	$367,602	$349,625
Program Management	1,024		1,024	1,228
Net Cost Medicare HI	$368,760	$(134)	$368,626	$350,853
Medicare SMI				
Benefit/Program (Part B)	$319,184	$(479)	$318,705	$300,123
Benefit/Program (Part D)	81,875		81,875	79,820
Program Management	2,618		2,618	2,458
Net Cost Medicare SMI	$403,677	$(479)	$403,198	$382,401
Medicaid				
Benefit/Program	$592,814		$592,814	$521,746
Program Management	174		174	136
Net Cost Medicaid	$592,988		$592,988	$521,882
CHIP				
Benefit/Program	$16,692		$16,692	$15,991
Program Management	17		17	15
Net Cost CHIP	$16,709		$16,709	$16,006
Other				
Benefit/Program	$911	$613	$1,524	$700
Program Management	531		531	515
Net Cost Other	$1,442	$ 613	$2,055	$1,215
NET COST OF OPERATIONS *(Note 10)*	$1,383,576		$1,383,576	$1,272,357

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2022

(in millions)

	Funds from Dedicated Collections *(Note 11)*	Funds From Other Than Dedicated Collections	FY 2022 Consolidated Total
UNEXPENDED APPROPRIATIONS			
Beginning Balances	$134,944	$76,618	$211,562
Appropriations Received	534,019	687,979	1,221,998
Appropriations Transferred-in/out		(5,472)	(5,472)
Other Adjustments	(17,249)	(77,341)	(94,590)
Appropriations Used	(473,010)	(606,599)	(1,079,609)
Change in Unexpended Appropriations	**43,760**	**(1,433)**	**42,327**
Total Unexpended Appropriations: Ending Balance	**$178,704**	**$75,185**	**$253,889**
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	$289,307	$3,510	$292,817
Other Adjustments		(36)	(36)
Appropriations Used	473,010	606,599	1,079,609
Nonexchange Revenue:			
FICA and SECA Taxes	343,729		343,729
Interest on Investments	6,929	94	7,023
Other	3,257		3,257
Transfers-in/out Without Reimbursement	(4,888)	1,597	(3,291)
Imputed Financing	78	7	85
Other		33	33
Net Cost of Operations *(Note 10)*	**772,818**	**610,758**	**1,383,576**
Net Change in Cumulative Results of Operations	**49,297**	**(2,464)**	**46,833**
Cumulative Results of Operations: Ending Balance	**$338,604**	**$1,046**	**$339,650**
NET POSITION	**$517,308**	**$76,231**	**$593,539**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2021

(in millions)

	Funds from Dedicated Collections *(Note 11)*	Funds From Other than Dedicated Collections	FY 2021 Consolidated Total
UNEXPENDED APPROPRIATIONS			
Beginning Balances	$98,116	$78,507	$176,623
Appropriations Received	502,345	627,542	1,129,887
Appropriations Transferred-in/out		(3,766)	(3,766)
Other Adjustments	(23,947)	(86,033)	(109,980)
Appropriations Used	(441,570)	(539,632)	(981,202)
Change in Unexpended Appropriations	**36,828**	**(1,889)**	**34,939**
Total Unexpended Appropriations: Ending Balance	**$134,944**	**$76,618**	**$211,562**
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	$278,725	$1,366	$280,091
Other Adjustments		(342)	(342)
Appropriations Used	441,570	539,632	981,202
Nonexchange Revenue:			
FICA and SECA Taxes	299,147		299,147
Interest on Investments	4,904	14	4,918
Other	3,226		3,226
Transfers-in/out Without Reimbursement	(4,796)	1,361	(3,435)
Imputed Financing	61		61
Other		306	306
Net Cost of Operations *(Note 10)*	**733,530**	**538,827**	**1,272,357**
Net Change in Cumulative Results of Operations	**10,582**	**2,144**	**12,726**
Cumulative Results of Operations: Ending Balance	**$289,307**	**$3,510**	**$292,817**
NET POSITION	**$424,251**	**$80,128**	**$504,379**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES *(NOTE 12)*

for the years ended September 30, 2022 and September 30, 2021

(in millions)

	FY 2022 Combined Totals Budgetary	FY 2021 Combined Totals Budgetary
Budgetary Resources:		
Unobligated balance from prior year budget authority, net (discretionary and mandatory)	$224,534	$218,041
Appropriations (discretionary and mandatory)	2,162,281	1,865,973
Borrowing authority (discretionary and mandatory)	40	46,028
Spending authority from offsetting collections (discretionary and mandatory)	12,797	10,103
TOTAL BUDGETARY RESOURCES	$2,399,652	$2,140,145
Status of Budgetary Resources:		
New Obligations and upward adjustments	$2,175,016	$1,970,746
Unobligated balance, end of year		
Apportioned, unexpired accounts	72,926	46,085
Unapportioned, unexpired accounts	8,524	11,771
Unexpired unobligated balance, end of year	$81,450	$57,856
Expired unobligated balance, end of year	143,186	111,543
Unobligated balance, end of year (total)	$224,636	$169,399
TOTAL BUDGETARY RESOURCES	$2,399,652	$2,140,145
Outlays, net		
Outlays, net (discretionary and mandatory)	$2,062,342	$1,854,897
Distributed offsetting receipts	(698,163)	(619,388)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	$1,364,179	$1,235,509
DISBURSEMENTS, NET	$25	$278

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2022 and Prior Base Years

(in billions)

	2022 (unaudited)	Estimates from Prior Years (unaudited) 2021	2020	2019	2018
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 13 and 14)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$14,767	$13,029	$12,454	$11,805	$11,323
SMI Part B	39,039	34,467	32,165	27,556	24,143
SMI Part D	7,372	6,881	6,975	7,181	7,176
Have attained eligibility age (age 65 or over)					
HI	793	664	637	559	525
SMI Part B	7,447	6,536	5,864	5,232	4,725
SMI Part D	1,164	1,061	1,016	1,052	1,015
Those expected to become participants					
HI	14,603	13,017	12,464	11,995	10,959
SMI Part B	10,131	9,010	8,567	6,864	5,586
SMI Part D	3,094	2,921	3,043	3,000	2,932
All current and future participants					
HI	30,163	26,710	25,554	24,359	22,807
SMI Part B	56,618	50,013	46,596	39,652	34,453
SMI Part D	11,630	10,863	11,035	11,232	11,124
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 13 and 14)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$23,211	$20,940	$20,103	$20,028	$18,604
SMI Part B	38,605	34,075	31,819	27,270	23,832
SMI Part D	7,372	6,881	6,975	7,181	7,176
Have attained eligibility age (age 65 and over)					
HI	7,010	6,230	6,073	5,348	5,027
SMI Part B	7,825	6,892	6,194	5,741	5,180
SMI Part D	1,164	1,061	1,016	1,052	1,015
Those expected to become participants					
HI	5,036	4,597	4,179	4,467	3,884
SMI Part B	10,188	9,046	8,583	6,641	5,442
SMI Part D	3,094	2,921	3,043	3,000	2,932
All current and future participants:					
HI	35,257	31,767	30,355	29,843	27,515
SMI Part B	56,618	50,013	46,596	39,652	34,453
SMI Part D	11,630	10,863	11,035	11,232	11,124
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 13 and 14)					
HI	$(5,094)	$(5,057)	$(4,800)	$(5,484)	$(4,708)
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 13 and 14)					
HI	$(5,094)	$(5,057)	$(4,800)	$(5,484)	$(4,708)
SMI Part B					
SMI Part D					
Trust Fund assets at start of period					
HI	$177	$198	$195	$200	$202
SMI Part B	163	133	100	96	80
SMI Part D	20	10	9	8	8
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 13 and 14)					
HI	$(4,917)	$(4,859)	$(4,606)	$(5,283)	$(4,506)
SMI Part B	163	133	100	96	80
SMI Part D	20	10	9	8	8

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, 2022 and Prior Base Years

(in billions)

		Estimates from Prior Years (unaudited)			
	2022 (unaudited)	2021	2020	2019	2018
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)	$9,404	$8,261	$7,517	$6,843	$6,266
Expenditures	15,998	14,184	13,284	12,140	11,222
Income less expenditures	(6,595)	(5,922)	(5,766)	(5,297)	(4,957)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	61,178	54,377	51,594	46,542	42,643
Expenditures	69,188	61,895	58,897	54,479	49,612
Income less expenditures	(8,010)	(7,519)	(7,303)	(7,937)	(6,970)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(14,605)	(13,441)	(13,069)	(13,234)	(11,926)
Combined Medicare Trust Fund assets at start of period	360	341	303	305	290
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(14,244)	(13,100)	(12,766)	(12,929)	(11,637)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	$27,828	$24,948	$24,074	$21,858	$19,477
Expenditures	18,318	16,564	15,805	14,108	12,258
Income less expenditures	9,510	8,384	8,269	7,750	7,219
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(5,094)	(5,057)	(4,800)	(5,484)	(4,708)
Combined Medicare Trust Fund assets at start of period	360	341	303	305	290
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$(4,734)	$(4,716)	$(4,497)	$(5,179)	$(4,418)

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, 2021 to January 1, 2022

(in billions)

	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures		
Total Medicare *(Note 15)*					
As of January 1, 2021	$87,586	$92,643	$(5,057)	$341	$(4,716)
Reasons for change					
Change in the valuation period	1,843	1,942	(98)	(25)	(123)
Change in projection base	(173)	(2,169)	1,996	44	2,040
Changes in the demographic assumptions	748	730	18		18
Changes in economic and health care assumptions	8,451	10,409	(1,958)		(1,958)
Changes in law	(45)	(50)	5		5
Net changes	10,824	10,861	(37)	19	(18)
As of January 1, 2022	$98,410	$103,504	$(5,094)	$360	$(4,734)
HI - Part A *(Note 15)*					
As of January 1, 2021	$26,710	$31,767	$(5,057)	$198	$(4,859)
Reasons for change					
Change in the valuation period	473	572	(98)	(40)	(138)
Change in projection base	602	(1,394)	1,996	19	2,015
Changes in the demographic assumptions	(53)	(71)	18		18
Changes in economic and health care assumptions	2,431	4,389	(1,958)		(1,958)
Changes in law		(5)	5		5
Net changes	3,453	3,490	(37)	(21)	(58)
As of January 1, 2022	$30,163	$35,257	$(5,094)	$177	$(4,917)
SMI - Part B *(Note 15)*					
As of January 1, 2021	$50,013	$50,013		$133	$133
Reasons for change					
Change in the valuation period	1,121	1,121		16	16
Change in projection base	(1,101)	(1,101)		14	14
Changes in the demographic assumptions	561	561			
Changes in economic and health care assumptions	6,070	6,070			
Changes in law	(45)	(45)			
Net changes	6,605	6,605		30	30
As of January 1, 2022	$56,618	$56,618		$163	$163
SMI - Part D *(Note 15)*					
As of January 1, 2021	$10,863	$10,863		$10	$10
Reasons for change					
Change in the valuation period	249	249		(2)	(2)
Change in projection base	326	326		11	11
Changes in the demographic assumptions	240	240			
Changes in economic and health care assumptions	(49)	(49)			
Changes in law					
Net changes	766	766		10	10
As of January 1, 2022	$11,630	$11,630		$20	$20

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

January 1, 2020 to January 1, 2021

(in billions)

	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures		
Total Medicare *(Note 15)*					
As of January 1, 2020	$83,185	$87,986	$(4,800)	$303	$(4,497)
Reasons for change					
Change in the valuation period	2,766	2,932	(166)	6	(160)
Change in projection base	(3,070)	(3,276)	205	32	237
Changes in the demographic assumptions	(947)	(1,648)	700		700
Changes in economic and health care assumptions	5,512	6,471	(959)		(959)
Changes in law	140	178	(38)		(38)
Net changes	4,401	4,657	(257)	38	(219)
As of January 1, 2021	$87,586	$92,643	$(5,057)	$341	$(4,716)
HI - Part A *(Note 15)*					
As of January 1, 2020	$25,554	$30,355	$(4,800)	$195	$(4,606)
Reasons for change					
Change in the valuation period	753	919	(166)	(9)	(175)
Change in projection base	(700)	(906)	205	13	218
Changes in the demographic assumptions	(110)	(810)	700		700
Changes in economic and health care assumptions	1,212	2,171	(959)		(959)
Changes in law		38	(38)		(38)
Net changes	1,156	1,412	(257)	4	(253)
As of January 1, 2021	$26,710	$31,767	$(5,057)	$198	$(4,859)
SMI - Part B *(Note 15)*					
As of January 1, 2020	$46,596	$46,596		$100	$100
Reasons for change					
Change in the valuation period	1,618	1,618		17	17
Change in projection base	(2,428)	(2,428)		16	16
Changes in the demographic assumptions	(665)	(665)			
Changes in economic and health care assumptions	4,751	4,751			
Changes in law	140	140			
Net changes	3,416	3,416		34	34
As of January 1, 2021	$50,013	$50,013		$133	$133
SMI - Part D *(Note 15)*					
As of January 1, 2020	$11,035	$11,035		$9	$9
Reasons for change					
Change in the valuation period	395	395		(2)	(2)
Change in projection base	58	58		3	3
Changes in the demographic assumptions	(173)	(173)			
Changes in economic and health care assumptions	(451)	(451)			
Changes in law					
Net changes	(171)	(171)		1	1
As of January 1, 2021	$10,863	$10,863		$10	$10

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 (FY) 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 that, 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. Accounting standards require all reporting entities to disclose that accounting standards allow certain presentations and disclosures to be modified, if needed, to prevent the disclosure of classified information.

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. 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 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 the Social Security Administration (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) provided that beneficiary cost sharing in the Part D coverage gap be reduced for brand-name and generic drugs to a 25 percent coinsurance. Part D is considered part of the SMI trust fund and is reported in the SMI 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 *Social Security 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 and SMI 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 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 90 percent of claims for those newly eligible under Medicaid expansion for calendar year (CY) 2020 and beyond. On March 18, 2020, the President signed into law H.R. 6021, the Families First Coronavirus Response Act. This Act provides a temporary 6.2 percentage point increase to each qualifying state and territory's Federal Medical Assistance Percentage (FMAP) effective beginning January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency declared by the Secretary of HHS for COVID-19, including any extensions, terminates. The increased FMAP was in effect through September 30, 2022.

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, Marketplace, 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 Marketplace to offset operating costs. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys, for coordination of benefits for the Part D program, and for new providers of medical or other items or services. Proceeds from the sale of data from the public use files and publications under the Freedom of Information Act 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 based on the CMS cost allocation system. It is reported under the Program Management (administrative) and Other (user fees) columns in the supplemental statements in the Supplementary Information section. Both of these activities are reported as dedicated collections.

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 Earned Revenues) arise primarily from the 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, are also reported as nonexchange revenue.

Appropriations provide budget authority that permits government officials to incur obligations that result in immediate or future outlays of government funds.

Budgetary Resources consist of new budget authority and unobligated balances from prior year budget authority and available for obligation in a given year.

Offsetting Collections are payments to the government which, by law are credited to expenditure accounts and deducted from gross budget authority and outlays of the expenditure account, rather than added to receipts. Offsetting collections are to be spent for the purposes of the account usually without further action by Congress. They result from business-like transactions with the public (i.e., including payments from the public in exchange for goods and services, reimbursements for damages, and gifts or donations of money to the government) and from intragovernmental transactions.

Offsetting Receipts are payments to the government which are credited to offsetting receipt accounts and deducted from gross budget authority and outlays, rather than added to receipts. They are not authorized to be credited directly to expenditure accounts, since the legislation that authorizes the offsetting receipts may designate them for a specific purpose or appropriate them for expenditure for that purpose or require them to be appropriated in annual appropriations acts before they can be spent. Similar to offsetting collections, they usually result from business-like transactions with the public and from intragovernmental transactions with other government accounts.

Obligations are actions that creates a legal liability to disburse funds, immediately or in the future. Budgetary resources must be available before obligating actions can be taken legally. In entitlement programs, obligations may arise under operation of law.

Outlays are payments to liquidate an obligation. Outlays generally are equal to cash disbursements. Outlays are the measure of government spending. Net outlays are gross outlays reduced by offsetting collections.

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, Report on Budget Execution and Budgetary Resources. OMB has mandated that CMS report all Medicare cash collections as an offsetting receipt.

Health Insurance Marketplaces

Grants have been provided to the states to establish Health Insurance Marketplaces. The initial grants were made by HHS to the states "not later than 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 Marketplaces were launched on October 1, 2013.

Marketplace Risk Adjustment Program

The Risk Adjustment program applies to non-grandfathered individual and small group plans inside and outside the Marketplaces. It provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions) and transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection. States that operate a State-based Marketplace are eligible to establish a risk adjustment program. States operating a risk adjustment program may have an entity other than the Marketplace 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 2022, changes have been made to the principal and supplementary Balance Sheet, Statement of Changes to Net Position, and SOSI, as well as various changes to the footnotes for current and prior year for comparability. Any changes and reclassifications have been made in order to comply with OMB Circular A-136.

NOTE 2:

FUND BALANCE WITH TREASURY

(Dollars in Millions)

	FY 2022	FY 2021
Status of Fund Balances with Treasury:		
Unobligated Balance:		
Available	**$72,926**	**$46,085**
Unavailable	**151,710**	**123,314**
Obligated Balance not yet Disbursed	**180,768**	**182,803**
Non-Budgetary FBWT	**(69,736)**	**(67,729)**
TOTAL	**$335,668**	**$284,473**

The Unobligated Balance Available includes $29,117 million ($28,639 million in FY 2021), which is restricted for future use and is not apportioned for current use for CHIP, Program Management, Center for Medicare and Medicaid Innovation, and State Grants and Demonstrations.

NOTE 3:

INVESTMENTS

(Dollars in Millions)

FY 2022 Medicare Investments	aturity ange	Interest Range	Value
HI TF			
Certificates	June 2023	3.375%	$12,740
Bonds	June 2024 to June 2031	1.875 - 3.000%	164,657
Accrued Interest			1,063
Total HI TF Investments			**$178,460**
SMI TF			
Certificates	June 2023	3.375%	$5,244
Bonds	June 2025 to June 2037	1.500 - 3.000%	162,720
Accrued Interest			840
Total SMI TF Investments			**$168,804**
Total Medicare Investments			**$347,264**

FY 2021 Medicare Investments	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2022	1.375 - 1.500%	$24,933
Bonds	June 2023 to June 2029	1.500 - 2.875%	111,235
Accrued Interest			615
Total HI TF Investments			**$136,783**
SMI TF			
Certificates	June 2022	1.375 - 1.500%	$25,829
Bonds	June 2024 to June 2036	.750 - 2.875%	144,848
Accrued Interest			673
Total SMI TF Investments			**$171,350**
Total Medicare Investments			**$308,133**

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.

NOTE 3:

CMS INVESTMENT SUMMARY *(CONTINUED)*

(Dollars in Millions)

FY 2022	Medicare (Dedicated Collection)			Consolidated Total
	HI TF	SMI TF	Total	
Certificates	$12,740	$5,244	$17,984	$17,984
Bonds	164,657	162,720	327,377	327,377
Accrued Interest	1,063	840	1,903	1,903
Total Investments	**$178,460**	**$168,804**	**$347,264**	**$347,264**

FY 2021	Medicare (Dedicated Collection)			Consolidated Total
	HI TF	SMI TF	Total	
Certificates	$24,933	$25,829	$50,762	$50,762
Bonds	111,235	144,848	256,083	256,083
Accrued Interest	615	673	1,288	1,288
Total Investments	**$136,783**	**$171,350**	**$308,133**	**$308,133**

NOTE 4:

ACCOUNTS RECEIVABLE, NET

(Dollars in Millions)

FY 2022	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$535		$535		$535
Total Intragovernmental	**$535**		**$535**		**$535**
Other than intragovernmental					
Entity					
Medicare FFS	$12,877		$12,877	$(4,148)	$8,729
Medicare Advantage/Prescription Drug Program	16,981		16,981	(14)	16,967
Medicaid	7,802		7,802	(786)	7,016
CHIP	138		138		138
Other	7,128		7,128	(250)	6,878
Non-Entity	4	$75	79	(59)	20
Total other than intragovernmental	**$44,930**	**$75**	**$45,005**	**$(5,257)**	**$39,748**

FY 2021	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$542		$542		$542
Total Intragovernmental	**$542**		**$542**		**$542**
Other than intragovernmental					
Entity					
Medicare FFS	$8,495		$8,495	$(3,704)	$4,791
Medicare Advantage/Prescription Drug Program	10,861		10,861	(5)	10,856
Medicaid	7,349		7,349	(1,027)	6,322
CHIP	137		137	(4)	133
Other	6,114		6,114	(286)	5,828
Non-Entity	4	$72	76	(49)	27
Total other than intragovernmental	**$32,960**	**$72**	**$33,032**	**$(5,075)**	**$27,957**

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 from other than intragovernmental are primarily composed of provider and beneficiary overpayments, Medicare Prescription drug overpayments, Medicare premiums, State phased-down contributions, Medicaid/CHIP overpayments, audit disallowances, civil monetary penalties and restitutions, the recognition of Medicare secondary payer (MSP) accounts receivable, and Marketplace activities. The Medicare FFS receivables also include the amounts for the COVID-19 Accelerated and Advance Payment (CAAP) program that have been demanded as of September 30, 2022. The accounts receivable 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 has been recorded to account for amounts due related to collections for Marketplace activities.

NOTE 5:

ADVANCES AND PREPAYMENTS

(Dollars in Millions)

CMS has $39,007 million ($67,184 million in FY 2021) in advances and prepayments. From that amount, $37,751 million represent payment of the Prescription Drug and Medicare Advantage benefit payments for October 2022 that occurred on September 30 instead of October 1. Advances in the amount of $1,255 million remain from accelerated payments made under the CAAP program. The original AAP program was set up to help providers and suppliers who had cash flow concerns due to system issues causing delays in submissions or processing of claims or local emergencies (e.g., hurricanes). On March 30, 2020, the AAP program was expanded based on the language included in the *Coronavirus Aid, Relief, and Economic Security Act* for specific providers. Collections of the CAAP advances began in April 2021 from the offset of future claims. As of September 2022, certain CAAP advances have been demanded and are reflected in the Medicare FFS accounts receivable balance.

NOTE 6:

DEBT

(Dollars in Millions)

CMS has $8,256 million ($36,781 million in FY 2021) in total debt due to Treasury. From that total, $2,884 million is related to amounts borrowed to cover for the advance/accelerated payments made for the CAAP program. CAAP program repayments are based on collections. The $4,863 million is for amounts borrowed to cover premium shortfalls. 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. The *Continuing Appropriations Act, 2021 and Other Extensions Act* (H.R. 8337 enacted on October 1, 2020) made similar changes for 2021. These repayments are transferred quarterly.

	2021 Beginning Balance	2021 Net Borrowing	2021 Ending Balance	2022 Net Borrowing	2022 Ending Balance
Debt to the Treasury:					
COVID-19 Accelerated and Advance Payment Program		$29,352	$29,352	$(26,468)	$ 2,884
Transitional SMI Contribution	$1,154	5,806	6,960	(2,097)	4,863
Other	207	262	469	40	509
TOTAL DEBT TO THE TREASURY	**$1,361**	**$35,420**	**$36,781**	**$(28,525)**	**$8,256**

NOTE 7:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(Dollars in Millions)

	FY 2022	FY 2021
Medicare FFS	$65,883	$57,765
Medicare Advantage/Prescription Drug Program	19,190	22,013
Medicaid	54,835	52,757
CHIP	1,269	1,242
TOTALS	**$141,177**	**$133,777**

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, 2022 and 2021 estimates also include 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 2022. 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, 2022.

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 based on data from the states' latest audited Comprehensive Annual Financial Report. Each state's estimate is subject to variability due to the variety of programs offered by the respective states and the data required to formulate these estimates. Accordingly, the ultimate outcome of these estimates could vary from the amounts recorded at September 30, 2022 and September 30, 2021, and we believe these estimates to be reasonable.

NOTE 8:

CONTINGENCIES AND COMMITMENTS

(Dollars in Millions)

The contingencies balance as of September 30, 2022 is $6,955 million ($3,659 million in FY 2021), all $6,955 million is for Medicaid ($3,654 million in FY 2021) 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. CMS may owe amounts to providers for previous years' disputed cost reports 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 9:

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 debt for the CAAP program (see Note 6), contingencies (see Note 8) and 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.

FY 2022 Intragovernmental	Medicare		Health						
	HI TF	SMI TF	Medicaid	CHIP	Other	Program Management	Combined Total	Intra-CMS Eliminations	Consolidated Total
Debt		$7,747					$7,747		$7,747
Other					$26	$2	28	$(3)	25
Total Intragovernmental		**7,747**			**26**	**2**	**7,775**	**(3)**	**7,772**
Federal Employee and Veterans Benefits	$6	1			14	71	92		92
Other					7,270		7,270		7,270
Contingencies			$6,955				6,955		6,955
Total Liabilities Not Covered by Budgetary Resources	**6**	**7,748**	**6,955**		**7,310**	**73**	**22,092**	**(3)**	**22,089**
Total Liabilities Covered by Budgetary Resources	91,963	94,161	54,837	$1,269	4,998	204	247,432	(99,269)	148,163
Total Liabilities Not Requiring Budgetary Resources	229	1,067			302		1,598		1,598
TOTAL LIABILITIES	**$92,198**	**$102,976**	**$61,792**	**$1,269**	**$12,610**	**$277**	**$271,122**	**$(99,272)**	**$171,850**

FY 2021 Intragovernmental	Medicare		Health						
	HI TF	SMI TF	Medicaid	CHIP	Other	Program Management	Combined Total	Intra-CMS Eliminations	Consolidated Total
Debt		$36,312					$36,312		$36,312
Other					$99	$2	101	$(36)	65
Total Intragovernmental		**36,312**			**99**	**2**	**36,413**	**(36)**	**36,377**
Federal Employee and Veterans Benefits	$5	1			14	74	94		94
Other					6,220		6,220		6,220
Contingencies	5		$3,654				3,659		3,659
Total Liabilities Not Covered by Budgetary Resources	**10**	**36,313**	**3,654**		**6,333**	**76**	**46,386**	**(36)**	**46,350**
Total Liabilities Covered by Budgetary Resources	81,259	94,587	52,790	$1,243	3,206	207	233,292	(94,148)	139,144
Total Liabilities Not Requiring Budgetary Resources	138	676			112		926		926
TOTAL LIABILITIES	**$81,407**	**$131,576**	**$56,444**	**$1,243**	**$9,651**	**$283**	**$280,604**	**$(94,184)**	**$186,420**

NOTE 10:

NET COST OF OPERATIONS

(Dollars in Millions)

	Medicare		Health			
FY 2022	**HI TF**	**SMI TF**	**Medicaid**	**CHIP**	**Other**	**Consolidated Total**
BENEFIT/PROGRAM COSTS						
Medicare						
Fee for Service	$205,122	$217,327				$422,449
Medicare Advantage/ Managed Care	165,175	227,697				392,872
Prescription Drug (Part D)		87,396				87,396
Medicaid/CHIP			$593,046	$16,696		609,742
Other					$12,722	12,722
Bad Debt Expense and Writeoffs	159	268	(240)	(4)	(7)	176
Total Benefit/Program Costs	**$370,456**	**$532,688**	**$592,806**	**$16,692**	**$12,715**	**$1,525,357**
OPERATING COSTS						
Medicare Integrity Program	$1,633					$1,633
Quality Improvement Organizations	542	$153				695
Program Management and Other Expenses	757	3,125	$183	$17	$623	4,705
Total Operating Costs	**2,932**	**3,278**	**183**	**17**	**623**	**7,033**
TOTAL COSTS	**$373,388**	**$535,966**	**$592,989**	**$16,709**	**$13,338**	**$1,532,390**
Less: Earned Revenues:						
Medicare Premiums	$4,624	$132,272				$136,896
Other Earned Revenues	4	17	$1		$11,896	11,918
Total Earned Revenues	**4,628**	**132,289**	**1**		**11,896**	**148,814**
Intra-CMS Eliminations	**(134)**	**(479)**			**613**	
TOTAL NET COST OF OPERATIONS	**$368,626**	**$403,198**	**$592,988**	**$16,709**	**$2,055**	**$1,383,576**

NOTE 10:

NET COST OF OPERATIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare		Health			
FY 2021	**HI TF**	**SMI TF**	**Medicaid**	**CHIP**	**Other**	**Consolidated Total**
BENEFIT/PROGRAM COSTS						
Medicare						
Fee for Service	$208,024	$216,390				$424,414
Medicare Advantage/ Managed Care	144,373	196,110				340,483
Prescription Drug (Part D)		85,423				85,423
Medicaid/CHIP			$521,746	$15,987		537,733
Other					$10,981	10,981
Bad Debt Expense and Writeoffs	25	56	(11)	4	(142)	(68)
Total Benefit/Program Costs	**$352,422**	**$497,979**	**$521,735**	**$15,991**	**$10,839**	**$1,398,966**
OPERATING COSTS						
Medicare Integrity Program	$1,508					$1,508
Quality Improvement Organizations	466	$167				633
Program Management and Other Expenses	1,543	3,030	$148	$15	$646	5,382
Total Operating Costs	**3,517**	**3,197**	**148**	**15**	**646**	**7,523**
TOTAL COSTS	**$355,939**	**$501,176**	**$521,883**	**$16,006**	**$11,485**	**$1,406,489**
Less: Earned Revenues:						
Medicare Premiums	$4,451	$118,183				$122,634
Other Earned Revenues	5	17	$1		$11,475	11,498
Total Earned Revenues	**4,456**	**118,200**	**1**		**11,475**	**134,132**
Intra-CMS Eliminations	**(630)**	**(575)**			**1,205**	
TOTAL NET COST OF OPERATIONS	**$350,853**	**$382,401**	**$521,882**	**$16,006**	**$1,215**	**$1,272,357**

For purposes of financial statement presentation, non-CMS administrative costs are considered expenses to the Medicare trust funds when outlaid 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. Program Management costs allocated to the Medicare program include $2,289 million ($2,271 million in FY 2021) 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 2022 Part D expense of $87,396 million ($85,423 million in FY 2021) is net of State reimbursements of $13,463 million ($11,919 million in FY 2021). The gross expense would have been $100,859 million ($97,342 million in FY 2021).

NOTE 11:

FUNDS FROM DEDICATED COLLECTIONS

(Dollars in Millions)

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. Other Non-Medicare includes user fees and program management (administrative) activities.

	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Dedicated Collections (Consolidated)
Balance Sheet as of September 30, 2022					
ASSETS					
Intragovernmental:					
Fund Balance with Treasury	$191,070	$14,069	$205,139		$205,139
Investments, net	347,264		347,264		347,264
Accounts receivable, net	91,025	7,107	98,132	$(97,598)	534
TOTAL INTRAGOVERNMENTAL ASSETS	**629,359**	**21,176**	**650,535**	**(97,598)**	**552,937**
Other than Intragovernmental:					
Accounts receivable, net	25,696	6,822	32,518		32,518
General property, plant & equipment, net	456	1,967	2,423		2,423
Advances and prepayments	39,006		39,006		39,006
Total other than Intragovernmental	**65,158**	**8,789**	**73,947**		**73,947**
TOTAL ASSETS	**$694,517**	**$29,965**	**$724,482**	**$(97,598)**	**$626,884**
LIABILITIES					
Intragovernmental:					
Accounts payable	$100,906	$44	$100,950	$(97,598)	$3,352
Debt	7,747		7,747		7,747
Other Liabilities		7	7		7
TOTAL INTRAGOVERNMENTAL LIABILITIES	**108,653**	**51**	**108,704**	**(97,598)**	**11,106**
Other than Intragovernmental:					
Accounts payable	145	184	329		329
Entitlement benefits due and payable	85,073		85,073		85,073
Other Liabilities	1,303	11,765	13,068		13,068
Total other than Intragovernmental	**86,521**	**11,949**	**98,470**		**98,470**
TOTAL LIABILITIES	**$195,174**	**$12,000**	**$207,174**	**$(97,598)**	**$109,576**
NET POSITION					
Unexpended Appropriations-Funds from Dedicated Collections	$174,874	$3,830	$178,704		$178,704
Cumulative Results of Operations-Funds from Dedicated Collections	324,469	14,135	338,604		338,604
TOTAL NET POSITION	**$499,343**	**$17,965**	**$517,308**		**$517,308**
TOTAL LIABILITIES AND NET POSITION	**$694,517**	**$29,965**	**$724,482**	**$(97,598)**	**$626,884**
Statement of Net Cost for the year ended September 30, 2022					
Benefit and Program Expenses	$903,144	$11,623	$914,767		$914,767
Operating Costs	2,547	4,307	6,854	$(613)	6,241
Total Costs	**905,691**	**15,930**	**921,621**	**(613)**	**921,008**
Less Earned Revenues	**(136,896)**	**(11,907)**	**(148,803)**	**613**	**(148,190)**
NET COST OF OPERATIONS	**$768,795**	**$4,023**	**$772,818**		**$772,818**

NOTE 11:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Dedicated Collections
Statement of Changes in Net Position for the year ended September 30, 2022					
UNEXPENDED APPROPRIATIONS					
Beginning Balances:	**$134,077**	**$867**	**$134,944**		**$134,944**
Budgetary Financing Sources:					
Appropriations received	**530,954**	**3,065**	**534,019**		**534,019**
Other Adjustments	**(17,249)**		**(17,249)**		**(17,249)**
Appropriations used	**(472,908)**	**(102)**	**(473,010)**		**(473,010)**
Change in Unexpended Appropriations	**40,797**	**2,963**	**43,760**		**43,760**
TOTAL UNEXPENDED APPROPRIATIONS: ENDING BALANCE	**$174,874**	**$3,830**	**$178,704**		**$178,704**
CUMULATIVE RESULTS OF OPERATIONS					
Beginning Balances:	**$275,788**	**$13,519**	**$289,307**		**$289,307**
Appropriations used	**472,908**	**102**	**473,010**		**473,010**
Nonexchange Revenue:					
Intragovernmental Nonexchange Revenue	**354,666**		**354,666**		**354,666**
Other than Intragovernmental Nonexchange Revenue	**(758)**	**7**	**(751)**		**(751)**
Transfers-in/out without reimbursement	**(9,344)**	**4,456**	**(4,888)**		**(4,888)**
Imputed financing	**4**	**74**	**78**		**78**
Net Cost of Operations	**768,795**	**4,023**	**772,818**		**772,818**
NET CHANGE IN CUMULATIVE RESULTS OF OPERATIONS	**48,681**	**616**	**49,297**		**49,297**
CUMULATIVE RESULTS OF OPERATIONS: ENDING BALANCE	**$324,469**	**$14,135**	**$338,604**		**$338,604**
Net Position	**$499,343**	**$17,965**	**$517,308**		**$517,308**

NOTE 11:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Dedicated Collections
Balance Sheet as of September 30, 2021					
ASSETS					
Intragovernmental:					
Fund Balance with Treasury	$145,714	$8,924	$154,638		$154,638
Investments, net	308,133		308,133		308,133
Accounts receivable, net	86,056	7,308	93,364	$(92,821)	543
TOTAL INTRAGOVERNMENTAL	**539,903**	**16,232**	**556,135**	**(92,821)**	**463,314**
Other than Intragovernmental:					
Accounts receivable, net	15,647	5,806	21,453		21,453
General property, plant & equipment, net	286	1,448	1,734		1,734
Advances and prepayments	67,012	76	67,088		67,088
Total other than Intragovernmental	82,945	7,330	90,275		90,275
TOTAL ASSETS	**$622,848**	**$23,562**	**$646,410**	**$(92,821)**	**$553,589**
LIABILITIES					
Intragovernmental:					
Accounts payable	$95,920	$33	$95,953	$(92,821)	$3,132
Debt	36,312		36,312		36,312
Other Liabilities	1	13	14		14
TOTAL INTRAGOVERNMENTAL	**132,233**	**46**	**132,279**	**(92,821)**	**39,458**
Other than Intragovernmental:					
Accounts payable	143	159	302		302
Entitlement benefits due and payable	79,778		79,778		79,778
Other Liabilities					
Contingencies	5		5		5
Other	824	8,971	9,795		9,795
Total other than Intragovernmental	80,750	9,130	89,880		89,880
TOTAL LIABILITIES	**$212,983**	**$9,176**	**$222,159**	**$(92,821)**	**$129,338**
NET POSITION					
Unexpended Appropriations-Funds from Dedicated Collections	$134,077	$867	$134,944		$134,944
Cumulative Results of Operations-Funds from Dedicated Collections	275,788	13,519	289,307		289,307
TOTAL NET POSITION	**$409,865**	**$14,386**	**$424,251**		**$424,251**
TOTAL LIABILITIES AND NET POSITION	**$622,848**	**$23,562**	**$646,410**	**$(92,821)**	**$553,589**
Statement of Net Cost for the year ended September 30, 2021					
Benefit and Program Expenses	$850,401	$9,861	$860,262		$860,262
Operating Costs	3,006	4,384	7,390	$(1,205)	6,185
Total Costs	**853,407**	**14,245**	**867,652**	**(1,205)**	**866,447**
Less Earned Revenues	(122,634)	(11,488)	(134,122)	1,205	(132,917)
NET COST OF OPERATIONS	**$730,773**	**$2,757**	**$733,530**		**$733,530**

NOTE 11:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Dedicated Collections
Statement of Changes in Net Position for the year ended September 30, 2021					
UNEXPENDED APPROPRIATIONS					
Beginning Balances:	**$97,863**	**$253**	**$98,116**		**$98,116**
Budgetary Financing Sources:					
Appropriations received	**501,642**	**703**	**502,345**		**502,345**
Other Adjustments	**(23,947)**		**(23,947)**		**(23,947)**
Appropriations used	**(441,481)**	**(89)**	**(441,570)**		**(441,570)**
Change in Unexpended Appropriations	**36,214**	**614**	**36,828**		**36,828**
TOTAL UNEXPENDED APPROPRIATIONS: ENDING BALANCE	**$134,077**	**$867**	**$134,944**		**$134,944**
CUMULATIVE RESULTS OF OPERATIONS					
Beginning Balances:	**$266,988**	**$11,737**	**$278,725**		**$278,725**
Appropriations used	**441,481**	**89**	**441,570**		**441,570**
Nonexchange Revenue:					
Intragovernmental Nonexchange Revenue	**308,070**		**308,070**		**308,070**
Other than Intragovernmental Nonexchange Revenue	**(793)**		**(793)**		**(793)**
Transfers-in/out without reimbursement	**(9,185)**	**4,389**	**(4,796)**		**(4,796)**
Imputed financing		**61**	**61**		**61**
Net Cost of Operations	**730,773**	**2,757**	**733,530**		**733,530**
Net Change in Cumulative Results of Operations	**8,800**	**1,782**	**10,582**		**10,582**
CUMULATIVE RESULTS OF OPERATIONS: ENDING BALANCE	**$275,788**	**$13,519**	**$289,307**		**$289,307**
NET POSITION	**$409,865**	**$14,386**	**$424,251**		**$424,251**

NOTE 12

STATEMENT OF BUDGETARY RESOURCES DISCLOSURES

(Dollars in Millions)

Net Adjustments to Unobligated Balance, Brought Forward, October 1

Net adjustments to unobligated balance, brought forward, October 1 as of September 30, 2022 and September 30, 2021 consisted of the following:

Net Adjustment to Unobligated Balance Brought Forward	**FY 2022**	**FY 2021**
Budgetary Resources:		
Unobligated balance, brought forward, October 1	$169,401	$133,884
Recoveries of prior year unpaid obligations	83,162	43,295
Recoveries of prior year paid obligations	18,725	53,872
Appropriation withdrawn	(35,912)	
Appropriation temporarily precluded from obligations - prior year		(4,912)
Cancelled authority	(10,902)	(8,956)
Prior year adjustment	11	591
Other	49	267
Unobligated balance from prior year budget authority, net	**$224,534**	**$218,041**

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 of $261,475 million ($224,136 million in FY 2021) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2022 and FY 2021 (in millions):

	FY 2022 Combined Balance	**FY 2021 Combined Balance**
TRUST FUND BALANCE, BEGINNING	$224,136	$146,530
Receipts	908,180	896,253
Less Obligations	870,841	818,647
Excess of Receipts over Obligations	37,339	77,606
TRUST FUND BALANCE, ENDING	**$261,475**	**$224,136**

Explanations of Differences Between the Combined Statement of Budgetary Resources and the Budget of the United States Government for FY 2021 (Dollars in Millions)

CMS reconciled the amounts of the FY 2021 column of the SBR to the actual amounts for FY 2021 from the Appendix in the FY 2023 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 2022) will be available at a later date at https://www.whitehouse.gov/omb/budget.

FY 2021	Budgetary Resources	New Obligations & Upward Adjustments	Distributed Offsetting Receipts	Net Outlays
Combined Statement of Budgetary Resources	$2,140,145	$1,970,746	$619,388	$1,854,897
Expired Accounts	(111,626)			
Other	3,795	3,804		4,773
Budget of the US Govt (2021 Actual)	**$2,032,314**	**$1,974,550**	**$619,388**	**$1,859,670**

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 SBR that are not included in the President's Budget. The Other line, contained in the SBR and 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 $72,166 million ($111,364 million FY 2021). The FY 2022 and FY 2021 Non-Federal paid amounts reflect the advance/accelerated payments made for the CAAP program. In addition, FY 2022 paid amounts include the Medicare Advantage and Prescription Drug benefit payments for October 2022 that occurred on September 30.

	FY 2022		FY 2021	
	Federal	Non-Federal	Federal	Non-Federal
Undelivered orders (unpaid)	$393	$32,766	$414	$43,766
Undelivered orders (paid)		39,007		67,184
Total	**$393**	**$71,773**	**$414**	**$110,950**

NOTE 13

STATEMENT OF SOCIAL INSURANCE (UNAUDITED)

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

Actuarial present values are computed under the intermediate set of assumptions specified in the *2022 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. Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic. The amount of payroll taxes expected to be collected by the HI trust fund was greatly reduced due to the economic effects of the pandemic on labor markets. Spending was directly affected by the coverage of testing and treatment of the disease. In addition, several regulatory policies and legislative provisions were enacted during the public health emergency that increased spending. More than offsetting these additional costs in 2020, spending for non-COVID care declined significantly (compared to both actual 2019 spending and pre-pandemic expectations for 2020). Overall, the projections are based primarily on actual experience through 2019. However, program costs in 2020 and 2021 were used to help inform the development of adjustment factors by type of service, which account for the impact of COVID-19 through 2028. In spite of these substantial impacts on the Medicare program in 2020, the pandemic was not factored into the SOSI projections until 2021 because of the uncertainty of the impacts at the time the 2020 Trustees Report was released.

Spending for services other than COVID-19 was significantly lower than expected in 2020 and 2021. This decline was more pronounced for elective services. In addition, Medicare beneficiaries whose deaths were identified as related to COVID had costs that were much higher than the average Medicare beneficiary prior to the onset of the pandemic. As a result, compared to the pre-pandemic Medicare population, the surviving Medicare population had lower morbidity, on average, reducing costs by an estimated 1.5 percent in 2020 and 2.9 percent in 2021. This morbidity effect is expected to continue over the next few years but is assumed to decrease over time before ending in 2028.

While the COVID-19 pandemic has significantly affected Medicare short-term financing and spending, it is not expected to have a large effect on the financial status of the trust funds after 2028. As discussed throughout the Trustees Report, the key measures of the financial adequacy for each trust fund are fairly comparable to those included in last year's report.

The Medicare Accelerated and Advance Payments Program was significantly expanded during the COVID-19 public health emergency period. Total payments of approximately $107.2 billion were made from March 2020 through June 2021: roughly $67.1 billion from the HI trust fund and $40.1 billion from the SMI Part B trust fund account. The Trustees assumed that the accelerated and advance payments would be fully repaid by September of 2022, resulting in no net changes to trust fund expenditures. As discussed in Note 5, the majority of these accelerated and advance payments have been repaid as of September 30, 2022.

It should be noted that there is an unusually large degree of uncertainty with these COVID-related impacts and that future projections could change significantly as more information becomes available. Moreover, as a result of developments that have occurred since the assumptions for this year's Trustees Report were selected in mid-February 2022, uncertainty has increased regarding the path of the COVID-19 pandemic and the economy. The Trustees will continue to monitor developments and modify the projections in later reports as appropriate. The pandemic is an example of the inherent uncertainty in projecting health care financing and spending over any duration.

Furthermore, the projections disregard payment reductions that would result from the projected depletion of the Medicare HI 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 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. The estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on June 2, 2022, except that the projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. In addition, the estimates do not reflect the potential impact of the Inflation Reduction Act (Public Law 117-169), which was enacted on August 16, 2022. As of the date of the financial statements, there is still a considerable amount of uncertainty surrounding these impacts and the projections have not been adjusted.

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 75year 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 2022 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2022. 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**.[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 2022

					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[11]
									B	D	
2022	**1.68**	**1,440,000**	**824.8**	**1.98**	**6.52**	**4.54**	**3.9**	**6.79**	**6.89**	**−0.210**	**−3.0**
2030	**1.87**	**1,341,000**	**738.4**	**1.25**	**3.65**	**2.40**	**2.0**	**3.7**	**5.3**	**4.3**	**2.1**
2040	**1.98**	**1,288,000**	**679.8**	**1.17**	**3.57**	**2.40**	**1.9**	**4.2**	**4.7**	**4.2**	**2.3**
2050	**2.00**	**1,256,000**	**627.2**	**1.11**	**3.51**	**2.40**	**2.0**	**3.4**	**3.8**	**4.3**	**2.3**
2060	**2.00**	**1,240,000**	**580.6**	**1.16**	**3.56**	**2.40**	**2.0**	**3.4**	**3.8**	**4.2**	**2.3**
2070	**2.00**	**1,228,000**	**539.3**	**1.16**	**3.56**	**2.40**	**1.9**	**3.4**	**3.6**	**4.0**	**2.3**
2080	**2.00**	**1,221,000**	**502.6**	**1.13**	**3.53**	**2.40**	**2.0**	**3.5**	**3.7**	**4.1**	**2.3**
2090	**2.00**	**1,217,000**	**469.9**	**1.14**	**3.54**	**2.40**	**2.1**	**3.5**	**3.7**	**4.2**	**2.3**

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 pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

9 Reflects the assumed return of health care services that were reduced or deferred in 2020 due to the COVID-19 pandemic.

10 Part D cost growth is projected to be negative in 2022 mainly due to slower growth in overall drug prices and higher assumed direct and indirect remuneration.

11 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 2022-2018

					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	
FY 2022	**2.0**	**1,217,000**	**469.9**	**1.14**	**3.54**	**2.40**	**2.1**	**3.5**	**3.7**	**4.2**	**2.3**
FY 2021	**2.0**	**1,218,000**	**472.7**	**1.14**	**3.54**	**2.40**	**2.1**	**3.4**	**3.7**	**4.2**	**2.3**
FY 2020	**1.95**	**1,218,000**	**460.5**	**1.13**	**3.53**	**2.40**	**2.0**	**3.3**	**3.6**	**4.1**	**2.3**
FY 2019	**2.0**	**1,218,000**	**453.5**	**1.16**	**3.76**	**2.60**	**2.0**	**3.5**	**3.6**	**4.3**	**2.5**
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**

1. Average number of children per woman. The continued use of a cohort-based projection approach that was first implemented in the 2021 Trustees Report results in a much longer transition to ultimate birth rates from the current low birth rates. The ultimate fertility rate is assumed to be reached in 2056.
2. Includes lawful permanent resident (LPR) immigration, net of emigration, as well as other-than-LPR immigration. The ultimate level of net LPR immigration is 788,000 persons per year, and the assumption for annual net other-than-LPR varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.
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 2090.
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 2090.

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 2090.
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 2090.
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 2090.
9. Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached soon after the 10th year of each projection period.

NOTE 14

ALTERNATIVE SOSI PROJECTIONS (UNAUDITED)

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

Certain features of current law may result in some challenges for the Medicare program. For physician services, not only are updates below the rate of inflation in all future years, but there are more immediate concerns because updates for these services are projected to be −2.9 percent in 2023 and 0.0 percent for 2024 and 2025 and certain bonuses paid to physicians are scheduled to expire in 2025. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business total factor productivity[2] although these health providers have historically achieved lower levels of productivity growth. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law in this report.

The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. The Trustees previously 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 and will be about 30 percent lower by the end of the projection period. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term. 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 2028–2042. 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 qualified physicians in advanced alternative payment 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.[3] 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 Beginning with the November 18, 2021 release of the productivity data, the Bureau of Labor Statistics replaced the term *multifactor productivity* with the term *total factor productivity*, a change in name only as the underlying methods and data were unchanged.

3 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.

Table 3 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.

TABLE 3:

Medicare Present Values

(in billions)

	Current law (Unaudited)	*Alternative Scenario[1,2] (Unaudited)*
Income		
Part A	**$30,163**	**$30,217**
Part B	**56,618**	**63,733**
Part D	**11,630**	**11,621**
Expenditures		
Part A	**35,257**	**41,560**
Part B	**56,618**	**63,733**
Part D	**11,630**	**11,621**
Income less expenditures		
Part A	**(5,094)**	**(11,343)**
Part B	**0**	**0**
Part D	**0**	**0**

[1] These amounts are not presented in the 2022 Trustees Report.

[2] A set of illustrative alternative Medicare projections has been prepared under a hypothetical modification to 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 40 percent of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.0-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 qualified physicians in advanced APMs did not expire, as illustrated under the alternative scenario, the estimated present values of Part A would be higher than the current-law projections by roughly 18 percent and Part B expenditures would be higher than the current-law projections by roughly 13 percent. 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 13 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

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

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

NOTE 15

STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS (UNAUDITED)

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future 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, 2021 to the period beginning on January 1, 2022, and the reconciliation from the period beginning on January 1, 2020 to the period beginning on January 1, 2021. The reconciliation identifies several significant components of the change and provides reasons for the change.

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, 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 SCSIA are, in order, as follows:

- 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 SCSIA 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 SCSIA are for the current and prior years and are based on various economic and demographic assumptions used for the intermediate assumptions in the Trustees Reports for those years. Table 1 of note 13 summarizes these assumptions for the current year.

Period beginning on January 1, 2021 and ending January 1, 2022

Present values as of January 1, 2021 are calculated using interest rates from the intermediate assumptions of the 2021 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2022. 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 2021 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 2022 Trustees Report.

Period beginning on January 1, 2020 and ending January 1, 2021

Present values as of January 1, 2020 are calculated using interest rates from the intermediate assumptions of the 2020 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2021. 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 2020 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 2021 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2021 to the period beginning on January 1, 2022

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2021-95) to the current valuation period (2022-96) 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 2021, replaces it with a much larger negative net cash flow for 2096, and measures the present values as of January 1, 2022, 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 (was made more negative) when the 75-year valuation period changed from 2021-95 to 2022-96. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming that all values projected in the prior valuation for the year 2021 are realized. The change in valuation period resulted in a small decrease in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $123 billion.

From the period beginning on January 1, 2020 to the period beginning on January 1, 2021

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2020-94) to the current valuation period (2021-95) 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 2020, replaces it with a much larger negative net cash flow for 2095, and measures the present values as of January 1, 2021, 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 (was made more negative) when the 75-year valuation period changed from 2020-94 to 2021-95. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming that all values projected in the prior valuation for the year 2020 are realized. The change in valuation period resulted in a slight increase in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $160 billion.

Change in Projection Base

From the period beginning on January 1, 2021 to the period beginning on January 1, 2022

Actual income and expenditures in 2021 were different from what was anticipated when the 2021 Trustees Report projections were prepared. For Part A, income was higher and expenditures were lower than anticipated in 2021 based on actual experience. Part B income and expenditures were lower than estimated based on actual experience. For Part D income and expenditures were higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is an increase of $2,040 billion in the present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2021 and January 1, 2022 is incorporated in the current valuation and is more than projected in the prior valuation. In section III.B3 of the 2022 Trustees Report, the base change represented the impact of the change in the 2019 experience rather than the 2021 experience. This was done to accurately quantify the full impact of the COVID-19 pandemic by attributing much of the reduction in 2020 and 2021 income and expenditures to it. For purposes of the SCSIA, we have reflected the impact of the change in the 2021 experience to the projection base change in order to be consistent with prior reporting.

From the period beginning on January 1, 2020 to the period beginning on January 1, 2021

Actual income and expenditures in 2020 were different from what was anticipated when the 2020 Trustees Report projections were prepared. For Part A and Part B income and expenditures in 2020 were lower than anticipated based on actual experience, mainly due to the impact of the COVID-19 pandemic. Part D was largely unaffected by the pandemic and total income and expenditures were only slightly higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is an increase of $237 billion in the present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2020 and January 1, 2021 is incorporated in the current valuation and is more than projected in the prior valuation. In section III.B3 of the 2021 Trustees Report, the base change represented the impact of the change in the 2019 experience rather than the 2020 experience. This was done to accurately quantify the full impact of the COVID-19 pandemic by attributing much of the reduction in 2020 income and expenditures to it. For purposes of the SCSIA, we have reflected the impact of the change in the 2020 experience to the projection base change in order to be consistent with prior reporting.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2021 to the period beginning on January 1, 2022

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, 2022) 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 calendar year 2020 indicated slightly lower birth rates than were assumed in the prior valuation.
- Near-term lawful permanent resident (LPR) immigration data were updated since the prior valuation; near-term LPR immigration assumptions were also updated to better reflect the expected effects of the recovery from the pandemic.
- Historical population data and other-than-LPR immigration data were updated since the prior valuation.

There was one notable change in demographic methodology. An improvement was made to put more emphasis on recent mortality data by increasing the weights for the most recent years in the regressions used to calculate the starting rates of improvement and starting death rates.

These changes resulted in an increase in the estimated future net cash flow. The present values of estimated income and expenditures are lower for Part A and higher for Parts B and D. Overall, these changes increased the present value of the estimated future net cash flow by $18 billion.

From the period beginning on January 1, 2020 to the period beginning on January 1, 2021

The demographic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2021), there were two changes to the ultimate demographic assumptions and an associated change in methodology.

- The ultimate total fertility rate was increased from 1.95 to 2.00 children per woman. At the same time, the projection method was improved to project future birth rates using a cohort-based model, rather than a period-based model as used in the prior valuation.
- An additional cause of death category was added, by separating dementia out from the all-other-causes category, and ultimate mortality improvement rates were updated for cardiovascular disease for all age groups and for the all-other-causes category at ages 85 and over.

In addition to these changes in ultimate demographic assumptions and the associated methodology change, the starting demographic values and the way these values transition to the ultimate assumptions were changed. The most significant are identified below.

- Birth rate data through the third quarter of 2020 indicated somewhat lower birth rates than were assumed in the prior valuation.
- Death rates were increased significantly for 2020 and 2021, and to a lesser extent for 2022 and 2023, to account for the elevated deaths during the COVID-19 pandemic period.

These changes resulted in an increase in the estimated future net cash flow. The present values of estimated income and expenditures are lower for Parts A, Part B, and Part D. Overall, these changes increased the present value of the estimated future net cash flow by $700 billion.

Changes in Economic and Health Care Assumptions

For the period beginning on January 1, 2021 to the period beginning on January 1, 2022

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate economic assumptions for the current valuation (beginning on January 1, 2022) 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 most significant are identified below.

- Near-term real interest rates are assumed to be slightly higher on average than those for the prior valuation.
- Economic starting values and near-term growth assumptions were updated to reflect the stronger-than-expected recovery from the pandemic-induced recession.
- The level of potential GDP for years 2021 and later is assumed to be about 1.1 percent higher than the level in the prior valuation, reflecting the strong recovery and the expectation of a permanent level shift in total economy labor productivity.

There were no additional notable changes in economic methodology.

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

- High projected spending growth for outpatient hospital services and for physician-administered drugs.
- Slower price growth and higher direct and indirect remuneration (DIR).

The net impact of these changes was a decrease in the estimated future net cash flow for total Medicare. For Part A and Part B, these changes increased the present value of estimated future income and expenditures. For Part D, these changes resulted in a decrease in the present value of estimated expenditures (and income). Overall, these changes decreased the present value of the estimated future net cash flow by $1,958 billion.

For the period beginning on January 1, 2020 to the period beginning on January 1, 2021

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2021), there were two changes to the ultimate economic assumptions and an associated change in methodology.

- The ultimate average real wage differential was slightly increased from 1.14 percentage points in the prior valuation to 1.15 percentage points in the current valuation. Additionally, the real wage differential assumptions for the first ten years of the projection period were also increased.
- The ultimate age-sex-adjusted unemployment rate was reduced from 5.0 percent for the prior valuation to 4.5 percent in the current valuation. At the same time, the labor force participation model was updated to incorporate data from the latest complete economic cycle, thereby putting more weight on the recent relationships among the various factors affecting labor force participation.

In addition to these changes in ultimate economic assumptions and the associated change methodology change, the starting economic values and the way these values transition to the ultimate assumptions were changed. The most significant are identified below.

- Near-term real interest rates were adjusted downward significantly. Real interest rates are now assumed to be negative for calendar years 2021 through 2024, with a gradual rise to the ultimate real interest rate after the economy has fully recovered from the recession.
- There were several changes in starting values and near-term economic growth assumptions primarily related to the COVID-19 pandemic and ensuing recession. In particular, the level of potential GDP is assumed to be roughly 1 percent lower than the level in the prior valuation beginning with the second quarter of 2020.

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

- Slightly faster projected spending growth for outpatient hospital services and for physician-administered drugs.
- Higher direct and indirect remuneration (DIR) and the continuing enrollment shift from Prescription Drug Plans to Medicare Advantage Prescription Drug Plans, which more than offset the higher gross drug prices assumed in this year's report.

The net impact of these changes was a decrease in the estimated future net cash flow for total Medicare. For Part A and Part B, these changes increased the present value of estimated future income and expenditures. For Part D, these changes resulted in a decrease in the present value of estimated expenditures (and income). Overall, these changes decreased the present value of the estimated future net cash flow by $959 billion.

Changes in Law

For the period beginning on January 1, 2021 to the period beginning on January 1, 2022

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 had a small financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

The Infrastructure Investment and Jobs Act (Public Law 117-58, enacted on November 15, 2021) 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 is extended by 1 year, through fiscal year 2031 (which, for sequestration purposes, covers April 1, 2031 through March 31, 2032). The benefit payment reductions for fiscal year 2030 (covering April 1, 2030 through March 31, 2031) are changed to a uniform 2 percent (instead of 2 percent for the first 5.5 months, 4 percent for the next 6 months, and 0 percent for the final 0.5 months), and the benefit payment reductions for fiscal year 2031 (covering April 1, 2031 through March 31, 2032) are 4 percent for first 6 months and 0 percent for the final 6 months.

The Protecting Medicare and American Farmers from Sequester Cuts Act (Public Law 117-71, enacted on December 10, 2021) included provisions that affect the HI and SMI programs.

- The temporary exemption from sequestration for the Medicare program from May 1, 2020 through December 31, 2021 (as described in last year's report) is extended through March 31, 2022, and the benefit payment reduction for April 1, 2022 through June 30, 2022 is changed to 1 percent (from 2 percent). In addition, the benefit payment reductions for fiscal year 2030 (covering April 1, 2030 through March 31, 2031) are changed to 2.25 percent for the first 6 months and 3 percent for the second 6 months (from a uniform 2 percent for the entire period). (The benefit payment reductions for fiscal year 2031, covering April 1, 2031 through March 31, 2032, remain the same as described under Public Law 117-58.)

- In the formula used for determining Medicare physician payment rates under the physician fee schedule for services furnished during calendar year 2022, the conversion factor is increased by 3 percent over the amount that it would have been in the absence of this provision's enactment. (This increase is not subject to the budget neutrality requirements that typically apply.)

- Implementation of the Medicare Radiation Oncology Model is delayed until January 1, 2023 at the earliest (from January 1, 2022 at the earliest).

- For the market-based system used to update the Medicare clinical laboratory fee schedule, laboratories are exempted for another year from the requirement that they report private payer rates. The next data reporting period is now the first quarter of 2023 (instead of the first quarter of 2022). Also, during the phase-in period for this system, the caps in place to limit reductions in fee schedule payments from year to year are changed to 0 percent for 2021–2022 and 15 percent for 2023–2025 (as opposed to the previous statutory parameters of 0 percent for 2021 and 15 percent for 2022–2024). That is, tests furnished under the fee schedule during 2021–2022 are to be paid at the same rates as under the 2020 fee schedule, and payments may not be reduced by more than 15 percent for services provided during 2023–2025.

The net impact of all legislative changes was a small increase in the estimated future net cash flow for total Medicare. For Part A the present value of estimated expenditures is slightly lower. The present values of estimated income and expenditures are lower for Part B. Overall, these changes increased the present value of the estimated future net cash flow by $5 billion.

For the period beginning on January 1, 2020 to the period beginning on January 1, 2021

Several pieces of legislation were enacted since the prior valuation date, however, most of the provisions had little or no impact on the program. Further, the impact of certain provisions is unknown and still others that in practice had no actual impact because they would have occurred anyway. The following provisions reflect those that had a significant financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow. See section V.A of the 2021 Medicare Trustees Report for the complete list of enacted provisions.

The Coronavirus Aid, Relief, and Economic Support (CARES) Act (Public Law 116-136, enacted on March 27, 2020) included provisions that affect the HI and SMI programs.

- From May 1, 2020 through December 31, 2020, the Medicare program is exempted from the sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines. In addition, the sequestration process is

extended by 1 year, through fiscal year 2030. The benefit payment reductions of 4.0 percent for the first 6 months and 0.0 percent for the second 6 months that were ordered for fiscal year 2029 are now ordered instead for fiscal year 2030, while the reductions ordered for fiscal year 2029 are changed to a uniform 2.0 percent. (The sequestration order for a given fiscal year is applied to expenditures incurred from April 1 of that fiscal year through March 31 of the following fiscal year.)

- The Medicare Accelerated and Advance Payments (AAP) Program is significantly expanded during the COVID-19 public health emergency period. First, critical access, pediatric, and certain cancer hospitals are added to the list of eligible providers and suppliers. (The usual eligibility criteria—to have billed Medicare during the last 180 days, to not be in bankruptcy, to not be under review or investigation, and to not have any outstanding delinquent Medicare overpayments—will still apply.) Next, the maximum amounts available under the AAP program are increased during the emergency period to (i) 100 percent of Medicare payments made during the past 6 months—for inpatient acute care, pediatric, and certain cancer hospitals; (ii) 125 percent of Medicare payments made during the past 6 months—for critical access hospitals; and (iii) 100 percent of Medicare payments made during the past 3 months—for all other eligible entities. (The maximum available AAP amounts had been 70 percent and 80 percent for providers and suppliers, respectively, of Medicare payments made during the past 90 days.) In addition, recoupments begin 120 days after the accelerated or advance payment is issued, and repayment is due in full within 1 year. (Normally, recoupments begin shortly after the payment is issued, and repayment is due in full within 90 days.)

The Continuing Appropriations Act, 2021 and Other Extensions Act (Public Law 116-159, enacted on October 1, 2020) included provisions that affect the HI and SMI programs.

- For providers and suppliers who receive accelerated or advance payments under the AAP program during the COVID-19 public health emergency, the repayment terms are amended from those provided by, and discussed previously under, the CARES Act. Specifically, recoupments are not to begin until 1 year has passed since the payment was issued, after which recoupments are to be 25 percent of the AAP amount over the first 11 months and 50 percent over the following 6 months. After that 29-month period has elapsed, the remaining balance will be due within 30 days. If not repaid, interest will accrue for each full 30-day period that the balance remains unpaid, but at an interest rate of 4 percent (instead of 10.25 percent). In addition, a $10 million limit on advance payments to Part B suppliers is established for the period from October 1, 2020 (the date of enactment) through December 31, 2020 and for each subsequent calendar year in which there is a COVID-19 public health emergency during all or part of the year.

The Consolidated Appropriations Act, 2021 (Public Law 116-260, enacted on December 27, 2020) included provisions that affect the HI and SMI programs.

- The CARES Act provision described above that temporarily exempts the Medicare program from sequestration beginning May 1, 2020 is extended through March 31, 2021 (from December 31, 2020).

An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes (Public Law 117-7, enacted on April 14, 2021) included provisions that affect the HI and SMI programs.

- The temporary exemption from sequestration for the Medicare program from May 1, 2020 to March 31, 2021 (as described previously under Public Laws 116-136 and 116-260) is extended through December 31, 2021. (This exemption extension applied retroactively as well, beginning April 1, 2021.) In addition, the sequestration amounts ordered for fiscal year 2030 are to be increased overall, with benefit payment reductions of 2.0 percent for the first 5.5 months, 4.0 percent for the next 6 months, and 0.0 percent for the final 0.5 months (instead of 4.0 percent for the first 6 months and 0.0 percent for the second 6 months). (The sequestration order for a given fiscal year is applied to expenditures incurred from April 1 of that fiscal year through March 31 of the following fiscal year.)

The net impact of all legislative changes was a decrease in the estimated future net cash flow for total Medicare. For Part A the present value of estimated expenditures is higher. The present values of estimated income and expenditures are higher for Part B. Overall, these changes decreased the present value of the estimated future net cash flow by $38 billion.

NOTE 16:

BUDGET AND ACCRUAL RECONCILIATION

(Dollars in Millions)

as of September 30, 2022	Intragovernmental	Other than Intragovernmental	Total
NET COST OF OPERATIONS (SNC)	**$1,205**	**$1,382,371**	**$1,383,576**
Components of net cost not part of the budget outlays			
Property, plant, and equipment depreciation expense		$(880)	$(880)
Applied overhead/cost capitalization offset		1,545	1,545
		$665	**$665**
Increase/(Decrease) in Assets:			
Accounts receivable, net	$(7)	$11,755	$11,748
Securities and investments	614		614
Advances and Prepayments		(28,177)	(28,177)
Other assets		(8)	(8)
	$607	**$(16,430)**	**$(15,823)**
(Increase)/Decrease in Assets:			
Accounts payable	$126	$(22)	$104
Benefits due and payable		(7,400)	(7,400)
Debt	28,525		28,525
Contingencies and Commitments		(3,296)	(3,296)
Other Liabilities	8	(3,223)	(3,215)
	$28,659	**$(13,941)**	**$14,718**
Other Financing Sources:			
Imputed Cost	$(85)		$(85)
Transfers out (in) without reimbursement	3,291		3,291
Total Components of net operating cost not part of the budgetary outlays	**$32,472**	**$(29,706)**	**$2,766**
Miscellaneous Items			
Custodial/Non-exchange revenue	$(7,022)	$(787)	$(7,809)
Non-entity activity	(36)		(36)
Appropriated receipts for Trust/Special Funds	516	8,117	8,633
Reconciling items:			
Debt	(28,525)		(28,525)
Custodial/Non-exchange revenue	7,022	(752)	6,270
Investment interest receivable	(614)		(614)
Other reconciling items	(82)		(82)
Total Other Reconciling Items	$(28,741)	$6,578	$(22,163)
Total Net Outlays	**$4,936**	**$1,359,243**	**$1,364,179**
Budgetary Agency Outlays, net (SBR 4210)			**$1,364,179**

NOTE 16:

BUDGET AND ACCRUAL RECONCILIATION

(Dollars in Millions)

as of September 30, 2021	Intragovernmental	Other than Intragovernmental	Total
NET COST OF OPERATIONS (SNC)	**$1,099**	**$1,271,258**	**$1,272,357**
Components of net cost not part of the budget outlays			
Property, plant, and equipment depreciation expense		$(569)	$(569)
Applied overhead/cost capitalization offset		949	949
		$380	**$380**
Increase/(Decrease) in Assets:			
Accounts receivable, net	$65	$6,911	$6,976
Securities and investments	366		366
Advances and Prepayments		(36,597)	(36,597)
Other assets		(37)	(37)
	$431	**$(29,723)**	**$(29,292)**
(Increase)/Decrease in Assets:			
Accounts payable	$(283)	$591	$308
Benefits due and payable		(16,843)	(16,843)
Debt	(35,420)		(35,420)
Contingencies and Commitments		27	27
Other Liabilities		(1,358)	(1,358)
	$(35,703)	**$(17,583)**	**$(53,286)**
Other Financing Sources:			
Imputed Cost	$(61)		$(61)
Transfers out (in) without reimbursement	3,435		3,435
Total Components of net operating cost not part of the budgetary outlays	**$(31,898)**	**$(46,926)**	**$(78,824)**
Miscellaneous Items			
Custodial/Non-exchange revenue	$(4,918)	$793	$(4,125)
Non-entity activity	342		342
Appropriated receipts for Trust/Special Funds		6,888	6,888
Reconciling items:			
Debt	35,420		35,420
Custodial/Non-exchange revenue	4,918	(793)	4,125
Investment interest receivable	(14)		(14)
Other reconciling items	637	(1,297)	(660)
Total Other Reconciling Items	$36,385	$5,591	$41,976
Total Net Outlays	**$5,586**	**$1,229,923**	**$1,235,509**
Budgetary Agency Outlays, net (SBR 4210)			**$1,235,509**

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 almost six 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 longterm sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSI material is generally drawn from the *2022 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.

Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic. The amount of payroll taxes expected to be collected by the HI trust fund was greatly reduced due to the economic effects of the pandemic on labor markets. Spending was directly affected by the coverage of testing and treatment of the disease. In addition, several regulatory policies and legislative provisions were enacted during the public health emergency that increased spending; notably, the 3-day inpatient stay requirement to receive skilled nursing facility services was waived, payments for inpatient admission related to COVID-19 were increased by 20 percent, and the use of telehealth was greatly expanded. More than offsetting these additional costs in 2020, spending for non-COVID care declined significantly (compared to both actual 2019 spending and pre-pandemic expectations for 2020). Overall, the projections are based primarily on actual experience through 2019. However, program costs in 2020 and 2021 were used to help inform the development of adjustment factors by type of service, which account for the impact of COVID-19 through 2028. In spite of these substantial impacts on the Medicare program in 2020, the pandemic was not factored into the Statement of Social Insurance projections until 2021 because of the uncertainty of the impacts at the time the 2020 Trustees Report was released.

Spending for services other than COVID-19 was significantly lower than expected in 2020 and 2021. This decline was more pronounced for elective services. In addition, Medicare beneficiaries whose deaths were identified as related to COVID had costs that were much higher than the average Medicare beneficiary prior to the onset of the pandemic. As a result, compared to the pre-pandemic Medicare population, the surviving Medicare population had lower morbidity, on average, reducing costs by an estimated 1.5 percent in 2020 and 2.9 percent in 2021. This morbidity effect is expected to continue over the next few years but is assumed to decrease over time before ending in 2028.

Overall, the projections are based primarily on actual experience through 2019. However, program costs in 2020 and 2021 were used to help inform the development of adjustment factors by type of service, which account for the impact of COVID-19 through 2028. These factors are based on (i) projections of the pandemic; (ii) direct costs associated with the testing and treatment of COVID-19; (iii) projections for non-COVID costs; and (iv) costs for the vaccines. Certain services, such as prescription drugs, durable medical equipment, physician-administered drugs, and hospice, are not materially affected by the pandemic.

Because of the large wave of COVID-19 cases in late 2021 through early 2022, the Trustees estimate that non-COVID-related spending will be lower than previously expected for the beginning of 2022. For the latter part of 2022 and 2023, the return of deferred care that is assumed to be more intensive, and thus more costly, results in spending that increases to a level that is closer to the pre-pandemic expectations. The Trustees assume that healthcare spending patterns will return to pre-pandemic levels in 2024 but that the lingering morbidity effects will continue through 2028.

The estimates also incorporate the costs of the COVID-19 vaccines, which consist of both the payments for the vaccines themselves and the payments for their administration. The Trustees expect vaccine utilization to decrease somewhat over time, reflecting the likely reduction in the required number of doses and the possibility that the seriousness of COVID-19 will decrease.

It should be noted that there is an unusually large degree of uncertainty with these COVID-related impacts and that future projections could change significantly as more information becomes available. Moreover, as a result of developments that have occurred since the assumptions for this report were selected in mid-February 2022, uncertainty has increased regarding the path of the COVID-19 pandemic and the economy. The estimates do not reflect the potential impact of the Inflation Reduction Act (Public Law 117-169), which was enacted on August 16, 2022. There is still a considerable amount of uncertainty surrounding these impacts and the projections have not been adjusted. The Trustees will continue to monitor developments and modify the projections in later reports as appropriate.

The Medicare Accelerated and Advance Payments Program was significantly expanded during the COVID-19 public health emergency period, by both legislative provisions and administrative actions taken by CMS early on during the emergency. Total payments of approximately $107.2 billion were made from March 2020 through June 2021: roughly $67.1 billion from the HI trust fund and $40.1 billion from the SMI Part B trust fund account. The Trustees assumed that the accelerated and advance payments would be fully repaid by September of 2022, resulting in no net changes to trust fund expenditures. As discussed in Note 5, the majority of these accelerated and advance payments have been repaid as of September 30, 2022.

While the COVID-19 pandemic has significantly affected Medicare short-term financing and spending, it is not expected to have a large effect on the financial status of the trust funds after 2028. The key measures of the financial adequacy for each trust fund shown in this year's Trustees Report are fairly comparable to those included in last year's report. This consistency is partly due to the offsetting effects of lower income and expenditures in the HI trust fund and partly due to the expectation that the effects of the pandemic will last only several years. The pandemic is an example of the inherent uncertainty in projecting healthcare financing and spending over any duration.

The projections presented here are based on current law, certain features of which may result in some challenges for the Medicare program. For physician services, not only are updates below the rate of inflation in all future years, but there are more immediate concerns because updates for these services are projected to be −2.9 percent in 2023 and 0.0 percent for 2024 and 2025 and certain bonuses paid to physicians are scheduled to expire in 2025. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business total factor productivity[1] although these health providers have historically achieved lower levels of productivity growth. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law in this report.

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 Au*gust 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, e*nacted on November 2, 2015); *the Bipartisan Budget Act of 2018* (Public Law 115-123, enacted on February 9, 2018); the *Bipartisan Budget Act of 2019* (Public Law 116-37, enacted on August 2, 2019); the *CARES Act (Public Law 116-136*, enacted on March 27, 2020); the *Consolidated Appropriations Act, 2021* (Public Law 116-260, enacted on December 27, 2020); an *Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes* (Public Law 117-7, enacted on April 14, 2021); the *Infrastructure Investment and Jobs Act* (Public Law 117-58, enacted on November 15, 2021); and the *Protecting Medicare and American Farmers from Sequester Cuts Act* (Public Law 117-71, enacted on December 10, 2021).

The sequestration reduces benefit payments by the percentages listed below:

- 2 percent from April 1, 2013 through April 30, 2020;
- 1 percent from April 1, 2022 through June 30, 2022;
- 2 percent from July 1, 2022 through March 31, 2030;
- 2.25 percent from April 1, 2030 through September 30, 2030;
- 3 percent from October 1, 2030 through March 31, 2031; and
- 4 percent from April 1, 2031 through September 30, 2031.

Because of sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013 through September 30, 2031, excluding May 1, 2020 through March 31, 2022 when it was suspended.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from current-law provisions that lower increases in Medicare payment rates to most categories of healthcare providers, but such adjustments would probably not be viable indefinitely without fundamental change in the current delivery system. 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 healthcare cost growth over time. The expenditure projections reflect the cost-reduction provisions required under current law. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes that (i) there would be a transition from current-law[2] payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for healthcare productivity; (ii) the average

1 For convenience the term *economy-wide private nonfarm business total factor productivity will henceforth be referred to as economy-wide productivity.* Beginning with the November 18, 2021 release of the productivity data, the Bureau of Labor Statistics replaced the term *multifactor productivity with the term total factor productivity, a change in name only as the underlying methods and data were unchanged.*

2 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 of economy-wide productivity (1.0 percent over the long range).

physician payment updates would transition from current law[3] to payment updates that reflect the Medicare Economic Index; and (iii) the 5-percent bonuses for qualified 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 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 cost-reduction measures prove problematic and new legislation scales them back.

Additional information on the current-law and illustrative alternative projections is provided in note 14 in these financial statements, in section V.C of this year's Medicare Trustees Report, and in a memorandum prepared by the CMS Office of the Actuary.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410786-6386) or can be downloaded from the **CMS website**.

ACTUARIAL PROJECTIONS

Long-Range Medicare Cost Growth Assumptions

Beginning with the 2013 report, the Trustees used the statutory price updates and the volume and intensity assumptions from the "factors contributing to growth" model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period.[4] 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.[5]

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 healthcare 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.

Medicare payment rates for most non-physician provider categories are 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 healthcare goods and services. These updates are then reduced by the 10-year moving average increase in economy-wide productivity, which the Trustees assume will be 1.0 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 healthcare 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 cost growth rates for these provider services start at 3.6 percent in 2046, or GDP plus 0 percent, declining gradually to 3.4 percent in 2096, or GDP minus 0.3 percent.

ii. ***Physician services***
Payment rate updates are 0.75 percent per year for those qualified physicians assumed to be participating in advanced APMs and 0.25 percent for those assumed to be participating in MIPS. The year-by-year cost growth rates for physician payments are assumed to decline from 3.2 percent in 2046, or GDP minus 0.4 percent, to 2.8 percent in 2096, or GDP minus 0.9 percent.

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3 The law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter for physicians in advanced alternative payment models (advanced APMs) or the merit-based incentive payment system (MIPS), respectively. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.05 percent per year in the long range.

4 This assumed increase in the average expenditures per beneficiary excludes the impacts of the aging of the population, changes in the sex composition of the Medicare population, and changes in the distribution of the Medicare population on the basis of proximity to death, as the Trustees estimated these factors separately. For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate.

5 The Trustees' methodology is consistent with Finding III-2 and Recommendation III-3 of the 2010–2011 Medicare Technical Review Panel (final report available **here**) and with Finding 3-2 of the 2016–2017 Medicare Technical Review Panel (final report available **here**).

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,6 care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the year-by-year cost growth rates for these services to decline from 2.8 percent in 2046, or GDP minus 0.8 percent, to 2.6 percent in 2096, 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 36 percent of total Part B expenditures in 2031 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.7 The long-range cost growth rates for Part D and these Part B services are assumed to equal the growth rates as determined from the factors model. The corresponding year-by-year cost growth rates for these services decline from 4.3 percent in 2046, or GDP plus 0.7 percent, to 4.1 percent by 2096, or GDP plus 0.4 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. Beginning with the 2020 Trustees Report, these impacts reflect the changing distribution of Medicare enrollment by age, sex, and the beneficiary's proximity to death, which is referred to as a time-to-death (TTD) adjustment. The TTD adjustment reflects the fact that the closer an individual is to death, the higher his or her healthcare spending is. Thus, as mortality rates improve and a smaller portion of the Medicare population is likely to die at any given age, the effect of individuals getting older and spending more on healthcare is offset somewhat.[8] This is particularly the case for Part A services—such as inpatient hospital, skilled nursing, and home health services—for which the distribution of spending is more concentrated in the period right before death. For Part B services and Part D, the incorporation of the TTD adjustment has a smaller effect.

After combining the rates of growth from the four long-range assumptions, the weighted average cost growth rate for Part B is 3.8 percent in 2046, or GDP plus 0.2 percent, declining to 3.7 percent by 2096, or GDP plus 0 percent. When Parts A, B, and D are combined, the weighted average cost growth rate for Medicare is 3.8 percent, or GDP plus 0.2 percent in 2046, declining to 3.7 percent, or GDP plus 0 percent by 2096.

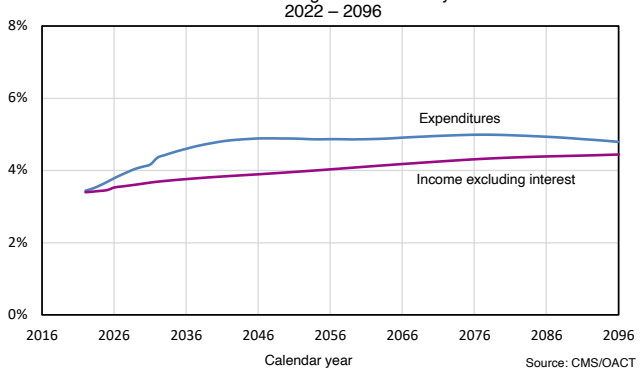
HI Cash Flow as a Percentage of Taxable Payroll

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 are lower than those from last year for all years because of (i) lower healthcare utilization through 2028 due to the pandemic and (ii) higher taxable payroll in all years resulting from the changing economic and demographic assumptions.

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 their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns). Because income thresholds for determining eligibility for the additional HI tax are not indexed, over time an increasing proportion of workers will become subject to a higher 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; this outcome will occur because the income thresholds determining taxable benefits are not indexed for price inflation and because the income tax brackets are indexed to the chained CPI (CCPI-U), which increases at a slower rate than average wages. After

Chart 1—HI Expenditures and Income Excluding Interest as a Percentage of Taxable Payroll
2022 – 2096



Source: CMS/OACT

6 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. For more information on the bidding process, see section IV.B of the 2022 Medicare Trustees Report.

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

8 More information on the TTD adjustment is available on **the CMS website**.

the 10th year of the projection period, income tax brackets are assumed to rise with average wages, rather than with the C-CPI-U as specified in the Internal Revenue Code. As a result of this assumption, income from the taxation of Social Security benefits increases at a similar rate as, rather than significantly faster than, taxable payroll.[9] Thus, as chart 1 shows, the income rate is expected to gradually increase over current levels.

In 2022 and beyond, as indicated in chart 1, the cost rate is projected to rise, primarily due to the continued retirements of those in the baby boom generation and partly due to an acceleration of 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 0.7 percent through 2031 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 5.3 percent in 2047 and 7.2 percent in 2096.

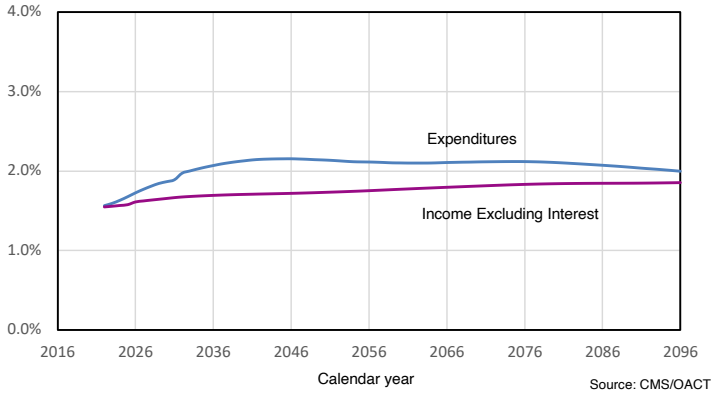
HI and SMI Cash Flow as a Percentage of GDP

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 2021, the expenditures were $328.9 billion, which was 1.4 percent of GDP. As chart 2 illustrates, this percentage is projected to increase steadily until about 2045 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.0 percent in 2096.

Chart 2—HI Expenditures and Income Excluding Interest as a Percentage of GDP
2022 – 2096



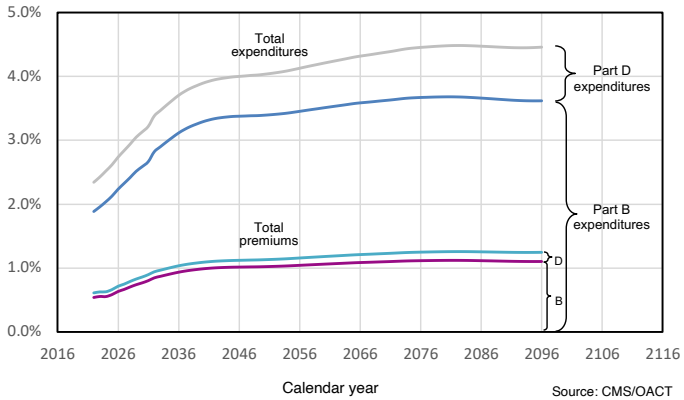
Source: CMS/OACT

SMI

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for longrange 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 longrange assumption described previously.

Chart 3—SMI Expenditures and Premiums as a Percentage of GDP
2022 – 2096



Source: CMS/OACT

In 2021, SMI expenditures were $510.4 billion, or about 2.2 percent of GDP. Under current law, they would grow to about 4.0 percent of GDP within 25 years and to 4.5 percent by the end of the projection period, as demonstrated in chart 3. Under the illustrative alternative, total SMI expenditures in 2096 would be 5.5 percent of GDP.

To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time but at a slower rate compared to the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2021 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

9 See section V.C7 of the *2022 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds for more detailed information on the projection of income from taxation of Social Security benefits.*

benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. State payments have decreased faster than GDP for almost every year since 2015 and are projected to do so for the entire long-range period.

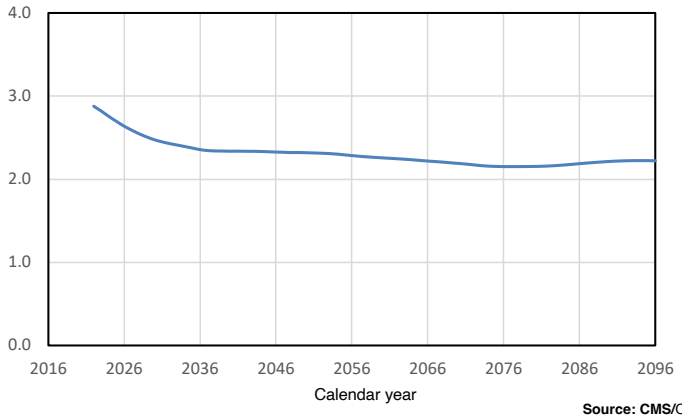
Worker-to-Beneficiary Ratio

HI

Another way to evaluate the longrange 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 2021, every beneficiary had about 2.9 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.5 workers for each beneficiary, as indicated in chart 4. The projected ratio continues to decline until there are only 2.2 workers per beneficiary by 2096.

Chart 4—Number of Covered Workers per HI Beneficiary
2022 – 2096



Source: CMS/OACT

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.[10] The assumptions varied are the healthcare cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.[11]

For this analysis, the intermediate economic and demographic assumptions in the 2022 Medicare Trustees Report 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, 2022 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values decrease through the first 20 to 25 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.

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

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

Healthcare 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 healthcare 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

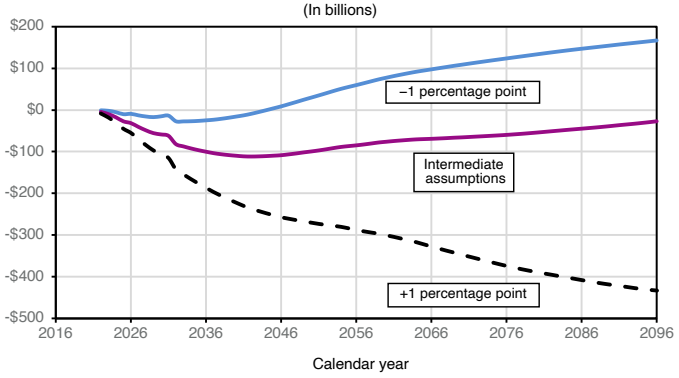
Present Value of Estimated HI Income Less Expenditures under Various Healthcare Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	**–1 percentage point**	**Intermediate assumptions**	**+1 percentage point**
Income minus expenditures (in billions)	**$4,969**	**–$5,094**	**–$21,235**

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $10,063 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 $16,141 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.

Chart 5—Present Value of HI Net Cash Flow with Various Healthcare Cost Factors
2022 – 2096
(In billions)



Source: CMS/OACT

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 cost-reduction provisions required under current law. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As chart 5 indicates, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for healthcare service costs.

Real-Wage Differential

Table 2 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.53, 1.15, and 1.77 percentage points.[12] In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 2.93, 3.55, and 4.17 percent, respectively.

TABLE 2

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

Ultimate percentage increase in wages – CPI	**2.93 – 2.40**	**3.55 – 2.40**	**4.17 – 2.40**
Ultimate percentage increase in real-wage differential	**0.53**	**1.15**	**1.77**
Income minus expenditures (in billions)	**–$7,269**	**–$5,094**	**-$1,871**

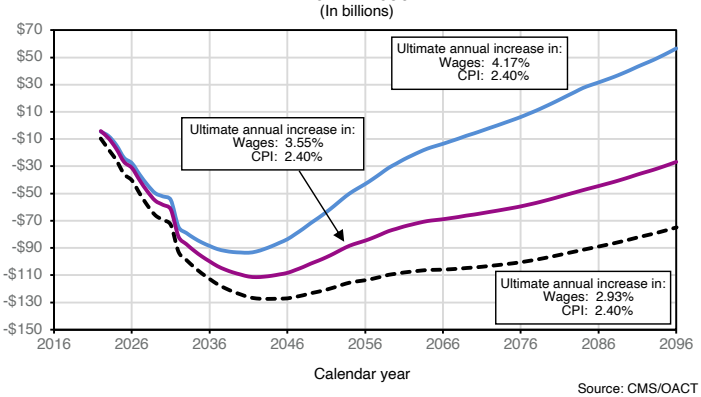
As indicated in table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately $2,599 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $1,754 billion.

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

Chart 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.

When expressed in present-value dollars, faster real-wage growth results in smaller HI cash flow deficits, as demonstrated in chart 6. A higher real-wage differential immediately increases both HI expenditures for healthcare 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 healthcare costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI trust fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI trust fund under the cost-reduction provisions depends critically on the sustainability of the lower Medicare price updates for hospitals and other HI providers.

Chart 6—Present Value of HI Net Cash Flow with Various Real-Wage Assumptions
2022 – 2096
(In billions)



Source: CMS/OACT

Consumer Price Index

Table 3 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.0, 2.4, and 1.8 percent. In each case, the assumed ultimate real-wage differential is 1.15 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.15, 3.55, and 2.95 percent, respectively.

TABLE 3

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

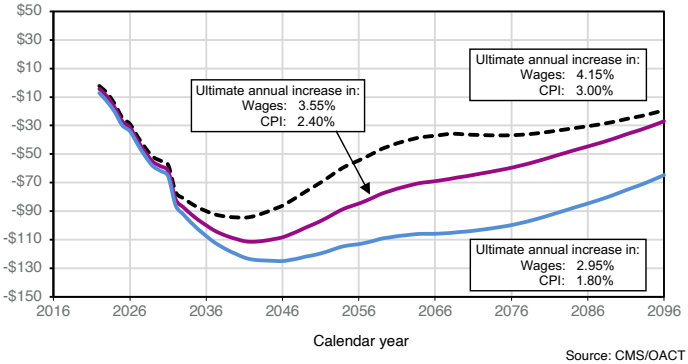
Ultimate percentage increase in wages – CPI	**4.15 – 3.00**	**3.55 – 2.40**	**2.95 – 1.80**
Income minus expenditures (in billions)	**–$3,715**	**–$5,094**	**–$7,033**

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.0 percent, the deficit decreases by $1,379 billion. On the other hand, if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $1,939 billion.

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.

This assumption has a small impact when the cash flow is expressed as present values, as chart 7 indicates. 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 is the result under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios; under high-inflation conditions, however, the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice versa.

Chart 7—Present Value of HI Net Cash Flow with Various CPI-Increase Assumptions
2022 – 2096
(In billions)



Source: CMS/OACT

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: 1.8, 2.3, and 2.8 percent. In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, which results in ultimate annual yields of 4.2, 4.8, and 5.3 percent, respectively.

TABLE 4

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

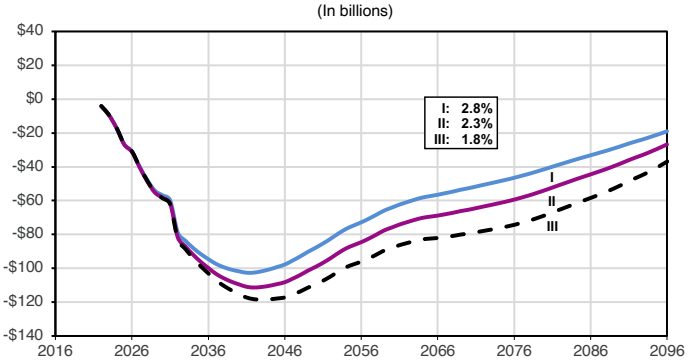
Ultimate real-interest rate	**1.8 percent**	**2.3 percent**	**2.8 percent**
Income minus expenditures (in billions)	**–$5,813**	**–$5,094**	**–$4,412**

As demonstrated in table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $140 billion.

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

The projected HI cash flow when expressed in present values is fairly sensitive to the interest assumption, as shown in chart 8. 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 2028. 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.

Chart 8—Present Value of HI Net Cash Flow with Various Real-Interest Rate Assumptions
2022 – 2096
(In billions)



Source: CMS/OACT

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: 1.69, 1.99, and 2.19 children per woman.

TABLE 5

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

Income minus expenditures (in billions)	**–$6,265**	**–$5,094**	**–$4,263**

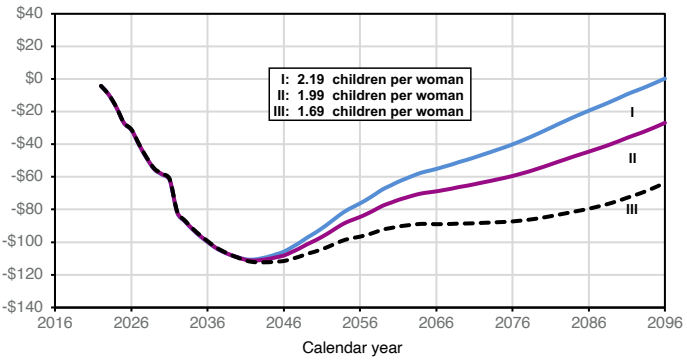
[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

As table 5 demonstrates, for every increase of 0.1 percentage point in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $405 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.

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

Chart 9—Present Value of HI Net Cash Flow with Various Ultimate Fertility Rate Assumptions
2022 – 2096
(In billions)



Source: CMS/OACT

Net Immigration

Table 6 illustrates the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 847,000 persons, 1,281,000 persons, and 1,736,000 persons per year.

TABLE 6

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

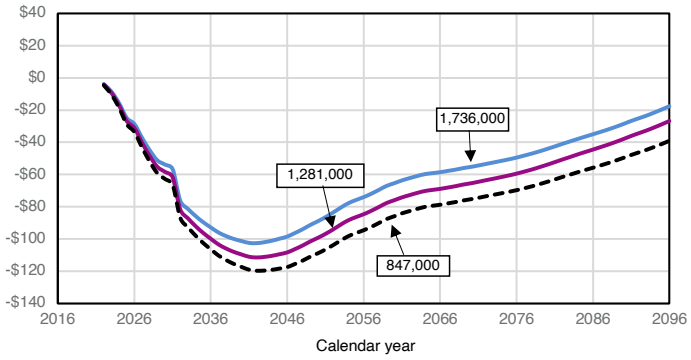
Average annual net immigration	**847,000**	**1,281,000**	**1,736,000**
Income minus expenditures (in billions)	**–$5,754**	**–$5,094**	**–$4,451**

As indicated in table 6, if the average annual net immigration assumption is 847,000 persons, the deficit—expressed in present-value dollars—increases by $660 billion. Conversely, if the assumption is 1,736,000 persons, the deficit decreases by $643 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 demonstrated in chart 10. Since immigration tends to occur most often among people 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.

Chart 10—Present Value of HI Net Cash Flow with Various Net Immigration Assumptions
2022 – 2096
(In billions)



Source: CMS/OACT

Trust Fund Finances and Sustainability

HI

The short-range financial outlook for the HI trust fund is slightly more favorable than the projections in last year's Medicare Trustees Report. The estimated depletion date for the HI trust fund is 2028, 2 years later than projected 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 higher than last year's estimates because both the number of covered workers and average wages are projected to be higher. HI expenditures are projected to be lower than last year's estimates in the beginning of the short-range period mainly due to the pandemic but are projected to become larger after 2023 due to higher projected provider payment updates.

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. In 2018, 2019, and 2020, expenditures again exceeded income, with trust fund deficits of $1.6 billion, $5.8 billion, and $60.4 billion, respectively. The large deficit in 2020 was mostly due to accelerated and advance payments to providers from the trust fund. In 2021, there was a small surplus of $8.5 billion as these payments began to be repaid to the trust fund, and this continued repayment will result in a larger surplus in 2022. After that, the Trustees project deficits in all future years until the trust fund becomes depleted in 2028. 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 healthcare 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. Policymakers 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 nature of the financing for both parts of SMI is similar in that the law establishes a mechanism by which income from the Part B premium and the Part D premium, and the corresponding general revenue transfers for each part, are sufficient to cover the following year's estimated expenditures. Accordingly, each account within SMI is automatically in financial balance under current law. 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 that the Board of Trustees issue a determination of excess general revenue Medicare funding if they project that under current law the difference between program outlays and dedicated financing sources[13] will exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2022–2028). For the 2022 Medicare Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2025, and therefore the Trustees are issuing this determination. Since this determination was made last year as well, this year's determination triggers a Medicare funding warning, which (i) requires the President to submit to Congress proposed legislation to respond to the warning within 15 days after the submission of the Fiscal Year 2024 Budget and (ii) requires Congress to consider the legislation on an expedited basis. Such funding warnings were previously issued in each of the 2007 through 2013 reports and in the 2018 through 2021 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 policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2022 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policymakers to "work closely together with a sense of urgency to address these challenges."

13 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.

COMBINING STATEMENT OF BUDGETARY RESOURCES

for the year ended September 30, 2022

(in millions)

	Medicare			Payments to Trust Funds	Medicaid	CHIP	Other	Program Management	Combined Total
	HI TF	SMI TF	Part D						
BUDGETARY RESOURCES:									
Unobligated balance from prior year budget authority, net (discretionary and mandatory)	$83	$80		$130,320	$50,431	$24,268	$17,422	$1,930	$224,534
Appropriations (discretionary and mandatory)	397,622	473,056	111,132	530,954	603,130	32,495	13,889	3	2,162,281
Borrowing authority (discretionary and mandatory)							40		40
Spending authority from offsetting collections (discretionary and mandatory)			3,883		1,596		2,806	4,512	12,797
TOTAL BUDGETARY RESOURCES	$397,705	$473,136	$115,015	$661,274	$655,157	$56,763	$34,157	$6,445	$2,399,652
STATUS OF BUDGETARY RESOURCES:									
New Obligations and upward adjustments	$397,705	$473,136	$115,015	$495,036	$654,796	$19,353	$14,951	$5,024	$2,175,016
Unobligated balance, end of year									
Apportioned, unexpired accounts				35,918	50	20,190	16,684	84	72,926
Unapportioned, unexpired accounts					311	5,832	2,340	41	8,524
Unexpired unobligated balance, end of year				35,918	361	26,022	19,024	125	81,450
Expired unobligated balance, end of year				130,320		11,388	182	1,296	143,186
Unobligated balance, end of year (total)				166,238	361	37,410	19,206	1,421	224,636
TOTAL BUDGETARY RESOURCES	$397,705	$473,136	$115,015	$661,274	$655,157	$56,763	$34,157	$6,445	$2,399,652
OUTLAYS, NET:									
Outlays, net (discretionary and mandatory)	$392,055	$470,292	$117,889	$469,024	$586,909	$16,670	$9,407	$96	$2,062,342
Distributed offsetting receipts	(88,522)	(607,967)				(94)	(1,580)		(698,163)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	$303,533	$(137,675)	$117,889	$469,024	$586,909	$16,576	$7,827	$96	$1,364,179
DISBURSMENTS, NET							$25		$25

SUPPLEMENTARY INFORMATION

CONSOLIDATING BALANCE SHEET
CONSOLIDATING STATEMENT OF NET COST
CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

CONSOLIDATING BALANCE SHEET

as of September 30, 2022

(in millions)

	Medicare		Health				Combined Totals	Intra-CMS Eliminations	Consolidated Totals
	HI TF	SMI TF	MEDICAID	CHIP	Other	Program Management			
ASSETS									
Intragovernmental:									
Fund Balance with Treasury	$2,281	$188,789	$56,380	$61,680	$26,078	$460	$335,668		$335,668
Investments, Net	178,460	168,804					347,264		347,264
Accounts Receivable, Net	44,851	46,174	1,663		2,134	4,985	99,807	$(99,272)	535
Total intragovernmental	**225,592**	**403,767**	**58,043**	**61,680**	**28,212**	**5,445**	**782,739**	**(99,272)**	**683,467**
Other than intragovernmental:									
Accounts Receivable, net	4,430	21,266	7,016	138	6,881	17	39,748		39,748
General Property, Plant & Equipment, Net	456				691	1,510	2,657		2,657
Advances and Prepayments	13,624	25,382	1				39,007		39,007
Other Assets			31		479		510		510
Total Other than Intragovernmental	18,510	46,648	7,048	138	8,051	1,527	81,922		81,922
TOTAL ASSETS	**$244,102**	**$450,415**	**$65,091**	**$61,818**	**$36,263**	**$6,972**	**$864,661**	**$(99,272)**	**$765,389**
LIABILITIES									
Intragovernmental:									
Accounts Payable	$49,771	$51,135	$2		$11	$42	$100,961	$(99,269)	$1,692
Debt		7,747			509		8,256		8,256
Other Liabilities					28	6	34	(3)	31
Total Intragovernmental	**49,771**	**58,882**	**2**		**548**	**48**	**109,251**	**(99,272)**	**9,979**
Other than Intragovernmental:									
Accounts Payable	66	79			78	136	359		359
Entitlement Benefits Due and Payable	42,124	42,949	54,835	$1,269			141,177		141,177
Other Liabilities									
Contingencies and Commitments			6,955				6,955		6,955
Other	237	1,066			11,984	93	13,380		13,380
Total Other than Intragovernmental	42,427	44,094	61,790	1,269	12,062	229	161,871		161,871
TOTAL LIABILITIES	**$92,198**	**$102,976**	**$61,792**	**$1,269**	**$12,610**	**$277**	**$271,122**	**$(99,272)**	**$171,850**
NET POSITION									
Unexpended Appropriations-Funds from Dedicated Collections	$1,477	$173,397			$3,577	$253	$178,704		$178,704
Unexpended Appropriations-Funds from Other than Dedicated Collections			$3,207	$59,814	12,164		75,185		75,185
Total Unexpended Appropriations	**1,477**	**173,397**	**3,207**	**59,814**	**15,741**	**253**	**253,889**		**253,889**
Cumulative Results of Operations-Funds from Dedicated Collections	150,427	174,042			7,693	6,442	338,604		338,604
Cumulative Results of Operations-Funds from Other than Dedicated Collections			92	735	219		1,046		1,046
Total Cumulative Results of Operations	150,427	174,042	92	735	7,912	6,442	339,650		339,650
TOTAL NET POSITION	**$151,904**	**$347,439**	**$3,299**	**$60,549**	**$23,653**	**$6,695**	**$593,539**		**$593,539**
TOTAL LIABILITIES AND NET POSITION	**$244,102**	**$450,415**	**$65,091**	**$61,818**	**$36,263**	**$6,972**	**$864,661**	**$(99,272)**	**$765,389**

CONSOLIDATING STATEMENT OF NET COST

for the year ended September 30, 2022

(in millions)

	Program	Program Management	Intra-CMS Eliminations	Total
Medicare HI				
Benefit/Program Expenses	$370,456			$370,456
Operating Expenses	1,904	$1,028	$(134)	2,798
Total Cost	372,360	1,028	(134)	373,254
Less: Earned Revenues	(4,624)	(4)		(4,628)
Net Cost Medicare HI	$367,736	$1,024	$(134)	$368,626
Medicare SMI				
Benefit/Program Expenses (Part B)	$445,292			$445,292
Benefit Expenses (Part D)	87,396			87,396
Operating Expenses	643	$2,635	$(479)	2,799
Total Cost	533,331	2,635	(479)	535,487
Less: Earned Revenues	(132,272)	(17)		(132,289)
Net Cost Medicare SMI	$401,059	$2,618	$(479)	$403,198
Medicaid				
Benefit/Program Expenses	$592,806			$592,806
Operating Expenses	8	$175		183
Total Cost	592,814	175		592,989
Less: Earned Revenues		(1)		(1)
Net Cost Medicaid	$592,814	$174		$592,988
CHIP				
Benefit/Program Expenses	$16,692			$16,692
Operating Expenses		$17		17
Total Cost	16,692	17		16,709
Less: Earned Revenues				
Net Cost CHIP	$16,692	$17		$16,709
Other				
Program Expenses	$12,715			$12,715
Operating Expenses	88	$535		623
Total Cost	12,803	535		13,338
Less: Earned Revenues	(11,892)	(4)	$613	(11,283)
Net Cost Other	$911	$531	$613	$2,055
NET COST OF OPERATIONS	$1,379,212	$4,364		$1,383,576

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2022

(in millions)

	Dedicated Collections					Funds from Other than Dedicated Collections				
	Medicare		Health		Total Funds From Dedicated Collections	Health (Other Funds)			Total Funds From Other than Dedicated Collections	Consolidated Total
	HI TF	SMI TF	Other	Program Management		Medicaid	CHIP	Other		
UNEXPENDED APPROPRIATIONS										
Beginning Balances	$1,099	$132,978	$546	$321	$134,944	$18,200	$45,510	$12,908	$76,618	$211,562
Budgetary Financing Sources:										
Appropriations Received	34,452	496,502	3,062	3	534,019	656,347	31,080	552	687,979	1,221,998
Appropriations Transferred-in/out						(5,472)			(5,472)	(5,472)
Other Adjustments		(17,249)			(17,249)	(77,228)	(80)	(33)	(77,341)	(94,590)
Appropriations Used	(34,074)	(438,834)	(31)	(71)	(473,010)	(588,640)	(16,696)	(1,263)	(606,599)	(1,079,609)
Change in Unexpended Appropriations	378	40,419	3,031	(68)	43,760	(14,993)	14,304	(744)	(1,433)	42,327
Total Unexpended Appropriations: Ending Balance	$1,477	$173,397	$3,577	$253	$178,704	$3,207	$59,814	$12,164	$75,185	$253,889
CUMULATIVE RESULTS OF OPERATIONS										
Beginning Balances	$139,742	$136,046	$7,309	$6,210	$289,307	$2,669	$637	$204	$3,510	$292,817
Other Adjustments								(36)	(36)	(36)
Appropriations used	34,074	438,834	31	71	473,010	588,640	16,696	1,263	606,599	1,079,609
Nonexchange Revenue:										
FICA and SECA taxes	343,729				343,729					343,729
Interest on investments	3,526	3,403			6,929		94		94	7,023
Other	457	2,793	7		3,257					3,257
Transfers-in/out without reimbursement	(3,369)	(5,975)		4,456	(4,888)	1,597			1,597	(3,291)
Imputed financing	4		5	69	78			7	7	85
Other								33	33	33
Net Cost of Operations	367,736	401,059	(341)	4,364	772,818	592,814	16,692	1,252	610,758	1,383,576
Net Change in Cumulative Results of Operations	10,685	37,996	384	232	49,297	(2,577)	98	15	(2,464)	46,833
Cumulative Results of Operations: Ending Balance	$150,427	$174,042	$7,693	$6,442	$338,604	$92	$735	$219	$1,046	$339,650
Net Position	$151,904	$347,439	$11,270	$6,695	$517,308	$3,299	$60,549	$12,383	$76,231	$593,539

AUDIT REPORTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

November 7, 2022

TO: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

FROM: Amy J. Frontz
Deputy Inspector General for Audit Services

Amy Frontz

Digitally signed by AMY FRONTZ
Date: 2022.11.07 10:14:49 -05'00'

SUBJECT: *Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2022*, A-17-22-53000

This memorandum transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2022 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 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, 2022 and 2021, 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, 2022, 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 22-01, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2022 CMS consolidated balance sheets and the related consolidated statements of net cost and changes in net position and combined statement of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. Ernst & Young was unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2022, 2021, 2020, 2019, and 2018, and the related statements of changes in social insurance amounts for the periods ended January 1, 2022 and 2021. As a result, Ernst & Young was not able to, 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 that although operational data is currently available, information contained within the Transformed Medicaid Statistical Information System requires additional verification before it would be considered reliable to utilize in the financial accounting and reporting for the Medicaid program. In addition, the process to perform a detailed claims-level look-back analysis related to the Medicaid Entitlement Benefits Due and Payable (EBDP) accrual, which would determine the reasonableness of the various State calculations of the incurred but not reported liability, should be further developed. Also, the EBDP Accrual for the Medicare Program experienced unusual or large fluctuations within its estimates of cost report settlements that were not properly investigated and required an adjustment after they were further analyzed by management.

  It was discovered that CMS did not follow the budgetary accounting treatment set forth by a waiver for the recoupment of advances. The advances involved the COVID-19 Advanced and Accelerated Payments. OMB had previously granted CMS a waiver from the Circular No. A-11 requirement to report the recoveries and refunds of prior year obligations as new budgetary resources for the Medicare program. Accounting for these recoupments within the proprietary financial statements was handled appropriately.

  Ernst & Young also identified a weakness with regard to formula errors associated with various changes incorporated into the Statements of Social Insurance. These formula errors were not detected by the organization's monitoring and review function. 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 controls, including controls over privileged access to CMS's information systems. The distributed nature of CMS's governance of third parties has resulted in the inconsistent application of oversight procedures for contractors with significant security responsibilities. The deficiencies found continue to constitute a significant deficiency in internal control.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2022, CMS was not in full compliance with the requirements of the Payment Integrity Information Act of 2019 (PIIA) (P.L. No. 116-117). The Medicaid and Children's Health Insurance Program (CHIP) programs reported error rates in excess of 10 percent. CMS is incorporating a new eligibility measurement process that would defer the establishment of error rate reduction targets until a baseline measurement was in place. CMS has specific initiatives underway to address these results for the Medicaid and CHIP programs that continue to report improper payment rates above the statutory threshold of 10 percent. CMS was also not in full compliance with PIIA as recovery activities of the identified improper payments for the Part C and Medicare Part D program are delayed.

CMS reported an error rate of 0.62 percent for the Federally Facilitated Healthcare Exchange component of the Advance Payment Tax Credit program. Also, CMS management continues to implement corrective actions to reduce the Medicare FFS improper payment rate, but the rate increased from the prior year. Previously, CMS management was notified during prior FYs that it may have potential violations of the Federal Acquisition Regulation related to contracting matters as well as potential violations of the Antideficiency Act related to certain contract obligations for fiscal years 2014 and 2015. Ernst & Young disclosed no other instances of noncompliance that are required to be reported under *Government Auditing Standards* and OMB Bulletin 22-01.

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, including that 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 reports and the conclusions expressed in those 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 Carla J. Lewis, Assistant Inspector General for Audit Services, at (202) 834-5992 or Carla.Lewis@oig.hhs.gov. Please refer to report number A-17-22-53000.

Page 4—Chiquita Brooks-LaSure

Attachment

cc:
Robert Gordon
Assistant Secretary for Financial Resources

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

Jonathan Blum
Principal Deputy Administrator
and Chief Operating Officer

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Report of Independent Auditors

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

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of the Centers for Medicare and Medicaid Services (CMS), which comprise the consolidated balance sheets as of September 30, 2022 and 2021, and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources for the years then ended, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of CMS at September 30, 2022 and 2021, and the results of its net cost of operations, its changes in net position and its budgetary resources for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts

We were also engaged to audit the sustainability financial statements of CMS, which comprise the statement of social insurance as of January 1, 2022, 2021, 2020, 2019, and 2018, and the related statement of changes in social insurance amounts for the periods ended January 1, 2022 and 2021, and the related notes (collectively referred to as the "sustainability financial statements").

We do not express an opinion on the accompanying sustainability financial statements. Because of the significance of the matters described in the Basis for Disclaimer of Opinion section of our report, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the sustainability financial statements.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS), in accordance with the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States (*Government Auditing Standards*), and in accordance with the provisions of Office of

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Management and Budget (OMB) Bulletin No. 22-01, *Audit Requirements for Federal Financial Statements*. Our responsibilities under those standards and the provisions of OMB Bulletin No. 22-01 are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of CMS and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. 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, 2022 and 2021, and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources for the years then ended.

Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts

As discussed in Note 13 to the financial statements, the statement of social insurance presents the actuarial present value of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from, or on behalf of, the participants and estimated future expenditures to be paid to, or on behalf of, participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. 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 statement of social insurance and the related statement of 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 the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA).

With respect to the estimates for the social insurance program presented as of January 1, 2022, 2021, 2020, 2019, and 2018, 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. Management has developed an illustrative alternative scenario and projections, using certain alternative payment provisions, intended to quantify the potential

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understatement of projected Medicare costs in future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 14, certain features of current law may result in some challenges for the Medicare program. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law in this report. 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, access to Medicare-participating providers 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. As a result of these matters, we were unable to obtain sufficient audit evidence for the amounts presented in the statement of social insurance as of January 1, 2022, 2021, 2020, 2019 and 2018 and the related statement of changes in social insurance amounts for the periods ended January 1, 2022 and 2021.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for 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 Responsibilities for the Audit of the Financial Statements

Except as described in the Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts section of our report, our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* and the provisions of OMB Bulletin No. 22-01 will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

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In performing an audit in accordance with GAAS and *Government Auditing Standards* and the provisions of OMB Bulletin No. 22-01, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit 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 CMS's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about CMS's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis and Required Supplementary Information, as identified on CMS's Agency Financial Report Table of Contents, be presented to supplement the financial statements. Such information is the responsibility of management and, although not a part of the financial statements, is required by the Federal Accounting Standards Advisory Board who considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic or historical context. We were unable to apply certain limited procedures to the Required Supplementary Information related to the sustainability financial statements in accordance with auditing standards generally accepted in the United States of America because of the significance of the matters described in the Basis for Disclaimer of Opinion section of our report. We do not express an opinion or provide any assurance on the Required Supplementary Information related to the sustainability financial statements. We have applied

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certain limited procedures to the Management's Discussion and Analysis and other required supplementary information in accordance with auditing standards generally accepted in the United States of America, 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 financial statements, and other knowledge we obtained during our audit of the 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 Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The Supplementary Information, as identified on CMS's Agency Financial Report Table of Contents, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Information

Management is responsible for the other information included in the annual report. The other information comprises introduction information on pages i through vi, A Message From the Chief Financial Officer, Other Information and Glossary, as identified on CMS's Agency Financial Report Table of Contents, but does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information, and we do not express an opinion or any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and consider whether a material inconsistency exists between the other information and the financial statements, or the other information otherwise appears to be materially misstated. If, based on the work performed, we conclude that an uncorrected material misstatement of the other information exists, we are required to describe it in our report.

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Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our reports dated November 7, 2022 on our consideration of CMS's 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's 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's internal control over financial reporting and compliance.

Ernst & Young LLP

November 7, 2022

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

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

We have audited, in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*) and the provisions of Office of Management and Budget (OMB) Bulletin No. 22-01, *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, 2022, and the related consolidated statements of net cost and changes in net position and the combined statements of budgetary resources for the fiscal year then ended, and the related notes (collectively referred to as the "financial statements"), and we were engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2022, and the related statement of changes in social insurance amounts for the period ended January 1, 2022, and the related notes (collectively referred to as the "sustainability financial statements"), and have issued our report thereon dated November 7, 2022. Our report disclaims an opinion on the sustainability financial statements because of the significance of the matters described in the Basis for Disclaimer of Opinion section of our Report of Independent Auditors, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on these statements.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether CMS's 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 financial statements, as well as the requirements referred to in the *Federal Financial Management Improvement Act of 1996* (FFMIA). However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and the provisions of OMB Bulletin No. 22-01, as described below:

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The *Payment Integrity Information Act of 2019* (hereinafter, the "Act") requires federal agencies to identify programs and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. However, CMS is not in full compliance with the Act. While CMS has calculated and reported an improper payment estimate for the Federally-facilitated Exchange of the Advance Premium Tax Credits program, it has not calculated and reported an improper payment estimate for the State-based Exchanges, which has been deemed susceptible to significant improper payments. In addition, although CMS has reported improper payment rates for each of its other high-risk programs, or components of such programs, the Medicaid and CHIP improper payment rates exceeded the statutorily required maximum of 10 percent. CMS was also not in full compliance with PIIA as recovery activities of the identified improper payments for the Part C and Medicare Part D program are delayed.

During prior fiscal years, CMS management was notified that it may have potential violations of the Federal Acquisition Regulation related to contracting matters, as well as potential violations of the *Anti-Deficiency Act* related to certain contract obligations related to fiscal years 2014 and 2015. These potential violations are still being evaluated.

Under FFMIA, we are required to report whether CMS's financial management systems substantially comply with federal financial management system requirements, applicable federal accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA Section 803(a) requirements. The results of the tests disclosed no instances in which CMS's financial management systems did not substantially comply with requirements as discussed above.

CMS's Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on CMS's response to the findings identified in our audit and described in the accompanying letter dated November 7, 2022. CMS's response was not subjected to the other auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

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.

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Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 7, 2022 on our consideration of CMS's internal control over financial reporting. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and the results of that testing, and not to provide an opinion on the effectiveness of CMS's internal control over financial reporting. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering CMS's internal control over financial reporting.

Ernst & Young LLP

November 7, 2022

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

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

We have audited, in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*) and the provisions of Office of Management and Budget (OMB) Bulletin No. 22-01, *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, 2022, 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 (collectively referred to as the "financial statements"), and we were engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2022, and the related statement of changes in social insurance amounts for the period ended January 1, 2022, and the related notes (collectively referred to as the "sustainability financial statements"), and have issued our report thereon dated November 7, 2022. Our report disclaims an opinion on the sustainability financial statements because of the significance of the matters described in the Basis for Disclaimer of Opinion section of our Report of Independent Auditors, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on these statements.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered CMS's internal control over financial reporting (internal control) as a basis for designing 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's internal control. Accordingly, we do not express an opinion on the effectiveness of CMS's internal control.

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

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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. We identified certain deficiencies in internal control 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 the reporting of financial results related to 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 complexity and size. 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 a high number of 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, branch 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).

The following areas identified in the current year audit merit continued focus as part of the financial reporting processes significant deficiency.

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Entitlement Benefits Due and Payable (EBDP)

Medicaid Entitlement Benefits Due and Payable (EBDP)

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.

CMS previously 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, information contained within T-MSIS requires additional verification before it would be considered reliable to utilize in the financial accounting and reporting for Medicaid. CMS should evaluate whether financial reporting risks can be addressed by using T-MSIS data to identify outliers and unusual or unexpected results that demonstrate abnormalities in state-related Medicaid expenditures that may require consideration in determining the Medicaid EBDP as of year-end. Given the claims level detail is not yet considered reliable for financial accounting and reporting, CMS is unable to perform a claims-level detailed look-back analysis for the Medicaid EBDP to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability calculated during prior periods which could serve to validate the appropriate use of a similar methodology. The Medicaid EBDP is a significant liability on the FY 2022 financial statements and is subject to volatility based on the complexity and judgment 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, presenting a risk that potential updates to CMS's analysis will not be reflected in CMS's financial statements in a timely manner.

Medicare Entitlement Benefits Due and Payable (EBDP)

The estimate of retroactive settlements of cost reports is a portion of the EBDP liability for the Medicare program. This estimate includes amounts which may be due from or owed to providers for previous years' cost report for disproportionate share hospitals and teaching hospitals, as well as amounts which may be due/owed to hospitals for adjusted prospective payments. During our procedures, we identified fluctuations in the cost report accrual which were not properly investigated by management. Upon further investigation, adjustments to the accrual were necessary to properly state the accurate EBDP for these cost reports. When unusual changes are identified in the resulting data used for the estimate or a large fluctuation is identified in the output of the actuarial calculation, for which the actuaries do not have a thorough understanding, further investigation should be performed and documented prior to finalizing the EBDP estimate.

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Budgetary Accounting for Recoveries and Refunds for the COVID-19 Advanced and Accelerated Payment Program

During fiscal 2020, CMS established the COVID-19 Advanced and Accelerated Payment (CAAP) program to help providers and suppliers experiencing cash flow concerns during the Public Health Emergency. Most of these advances were issued during fiscal 2020, and recoupment began in fiscal year 2021. OMB had previously granted CMS a waiver from the Circular No. A-11 requirement to report the recoveries and refunds of prior year obligations as new budgetary resources for the Medicare Program. While accounting for these recoupments within the proprietary financial statements (balance sheet) was handled appropriately, it was discovered in the current year that CMS did not follow the proper budgetary accounting treatment within the statement of budgetary resources set forth by this waiver for the recoupment of these advances. The related control to review the accounting for the significant activity of recoupments was not designed or operated effectively to prevent or detect this error in a timely manner.

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's 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, formula errors and input errors of source information were identified that were not detected by the organization's monitoring and review function, and accordingly, the related control was not functioning at the level of precision 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

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paid, some of which is based on complex financial formulas and/or coding decisions. CMS has developed sophisticated sampling processes for estimating improper payment rates in the high-risk CMS programs of Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), Medicare Prescription Drugs (Part D), Medicaid and CHIP.

CMS remains committed to achieving reductions in all improper payment rates through various corrective actions. CMS has specific initiatives underway to improve results for Medicaid and CHIP, the programs that continue to report improper payment rates above the statutory threshold of 10 percent. While management continued to implement corrective actions to reduce the Medicare FFS improper payment rate, the rate increased from the prior year.

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 financial accounting and reporting of 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 this liability.

- Re-evaluate the procedures performed around the completeness and accuracy used in the cost report accrual. When unusual changes are identified in the data used for the estimate or a large fluctuation is identified in the output of the calculation, for which management does not have a thorough understanding, further investigation should be performed and documented prior to finalizing the estimate.

- Enhance the design of control attributes around the accounting for unique accounting transactions. This may include maintaining a centralized listing of guidance and waivers relevant to the preparation of financial statements and conducting additional training of personnel involved in preparing financial statements.

- 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. When changes are made, such as changes to the methodology or key assumptions, management should require an enhanced review specific to these changes.

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

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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's 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.

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.

Controls Over System Access and Information Security Configuration Controls

CMS has a large number of users requiring access to CMS systems in order to process claims and to support beneficiaries in a timely and effective manner. Accordingly, properly implemented system access controls, including user and system account management and monitoring of system access, are critical to preventing and detecting unauthorized usage of CMS information resources and program and data files. Without maintaining an appropriate level of access controls within CMS systems, the integrity of CMS's information resources could be compromised. Additionally, information systems security configuration controls are vital to safeguard the confidentiality, integrity and availability of data.

Deficiencies continued to be identified in the implementation and monitoring of controls, including controls over privileged access to the CMS information systems. Examples included:

- Procedures for the removal of users who no longer required logical access were not consistently followed.

- Monitoring and/or recertification of privileged access for key applications and underlying IT infrastructure was not performed, or evidence of such monitoring or recertification activity was not retained.

- Inadequate controls over segregation of duties including identifying business justifications for all existing conflicts, implementing the necessary monitoring controls to mitigate known SOD risks, and implementing user access review controls to document waivers as appropriate.

Appropriate consideration over the design of controls of access and monitoring of access as well as information security configuration management controls 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 monitoring of information systems security configuration controls, the risk of errors, fraud or other illegal acts is increased.

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Governance over Implementation of Third-Party Information Security Controls

The distributed nature of CMS' governance of third parties has resulted in the inconsistent application of oversight procedures for contractors with significant security responsibilities in the CMS Information Security Program. This has resulted in the identification of control deficiencies stemming from inadequate implementation of controls related to logical and physical access and system configuration. Specifically:

- CMS's security configuration management policy was not fully implemented and has resulted in several vulnerabilities related to system configurations with the CMS information systems. The remediation, mitigation of risks, or monitoring of these vulnerabilities was not performed or not performed timely. These include settings to disable inactive accounts and password requirements.

- Logical and physical access control procedures related to the timely removal of access for terminated personnel supporting CMS were not followed at contractor operated systems and facilities.

Deficiencies related to the performance of these controls by third parties were also consistently noted in the results of management's internal assessment (OMB A-123) and various HHS OIG audit reports. Commonality in the control deficiencies across the business units indicates monitoring and oversight is an enterprise level risk for which standardized processes should be developed to in order for common controls to be implemented in the varying IT environments.

Without sufficient and consistent third-party oversight and monitoring for compliance with its established information security control policies and procedures, Medicare and Medicaid systems and other enterprise-wide systems may be susceptible to error, fraud, and/or security vulnerabilities that may impact claims processing and financial reporting.

Recommendations

CMS should continue to improve the operating effectiveness of information security controls including access controls and configuration management, to validate that:

- CMS guidance is followed for the removal of users to all systems/facilities and security configurations.

- Privileged access for key applications and the underlying IT infrastructure is in accordance with the principle of least privilege, monitored to detect and correct unauthorized access or activities. Additionally, evidence of such monitoring activities should be retained.

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- User access reviews are being performed timely and by appropriate personnel with the requisite knowledge and experience of the employee access requirements and necessary system functionality.

- Full implementation of the baseline configuration management monitoring process to include formal risk acceptance of vulnerabilities that cannot be remediated within CMS's management expected timeframe.

Specific to the governance over implementation of information systems controls standards and processes, CMS should continually assess the governance and oversight across its organizational units charged with responsibility for the information security of its systems and data at both Headquarters and the CMS FFS Medicare Administrative Contractor contractors. As such, an approach will require continued and active communication and integration of efforts by OFM, Office of Information Technology and the Center for Medicare.

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's information systems. Examples of such processes that should be improved include:

- Enhanced risk management procedures and practices that focus on significant IT systems that support financial management processes and a clear definition of responsibilities associated with the oversight and implementation of controls to address identified risks.

- Ensuring that timely remediation of deficiencies identified as a part of OIG and HHS's OMB A-123 assessments, including tests performed on CMS and its Medicare contractors' IT operations.

CMS's Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on the CMS's response to the findings identified in our audit and described in the accompanying letter dated November 7, 2022. CMS's response was not subjected to the other auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

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.

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Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 7, 2022 on our tests of CMS's compliance with certain provisions of laws, regulations, contracts and grant agreements, and other matters. The purpose of that 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 compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering CMS's compliance.

Ernst & Young LLP

November 7, 2022

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-01-24
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Ernst & Young, LLP
1201 Wills Street
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November 7, 2022

Dear Sir/Madame:

On behalf of the Centers for Medicare & Medicaid Services, I would like to thank you for another successful year in closing out this year's Chief Financial Officer's Act audit. We are pleased with the results of your audit of our fiscal year 2022 financial statements, and are proud of the continued achievement of an unmodified opinion on our Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position and the Combined Statement of Budgetary Resources.

Again, you were not able to express an opinion on the Statement of Social Insurance (SOSI) and the related Statement of Changes in Social Insurance Amounts (SCSIA) due to the uncertainty of the long-range assumptions used in the model. While CMS is 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 the future.

While you identified no material weaknesses in our internal controls, you continue to cite significant deficiencies in our financial reporting processes and information systems controls. As we continue to make progress in eliminating many of our long-standing internal control findings, CMS remains committed to implementing effective corrective actions to strengthen our internal controls and remediate the deficiencies you have noted.

The annual financial audit serves as an on-going catalyst to improving our processes and always helps us improve our internal controls. We would like to thank your office for its diligence in completing the audit efficiently and effectively, and appreciate the strong partnership we have with you. We look forward to your continued support as we work to remediate the issues for the future.

Sincerely,

Megan Worstell

Megan Worstell
Chief Financial Officer

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) Office of Inspector General (OIG) audits, and Government Accountability Office (GAO) audits and High-Risk reports; (4) Statement on Standards for Attestation Engagements (SSAE) 18 internal control audits; (5) evaluations and tests of MACs' controls conducted pursuant to section 912 of the *Medicare Modernization Act*; (6) the annual *Chief Financial Officers* (CFO) *Act* audit; (7) security assessment and authorization of systems; and (8) Department Enterprise Risk Management efforts. As of September 30, 2022, the internal controls and financial management systems of CMS provided reasonable assurance that the objectives of the *Federal Managers' Financial Integrity Act of 1982* (FMFIA) were achieved with the exception of two instances of non-compliance described below.

OMB Circular No. A-123 Statement of Assurance

CMS management is responsible for managing risks and maintaining effective internal control to meet the objectives of Sections 2 and 4 of the FMFIA. These objectives are to ensure: (1) effective and efficient operations, (2) reliable reporting, and (3) compliance with applicable laws and regulations.

CMS conducted its assessment of risk and internal control in accordance with OMB Circular A-123, Management's Responsibility for Enterprise Risk Management and Internal Control. Based on the results of the assessment, CMS provides reasonable assurance that internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2022, with the exception of non-compliances with: the *Payment Integrity Information Act of 2019* (PIIA), and Section 6411 of the *Patient Protection Affordable Care Act* (PPACA).

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 substantially comply with Federal financial management systems requirements, Federal accounting standards, and the United States Standard General Ledger at the transaction level. CMS conducted its evaluation of financial management systems for compliance with FFMIA in accordance with OMB Circular A-123, Appendix D. Based on the results of this assessment, CMS provides reasonable assurance that its overall financial management systems substantially comply with FFMIA and substantially conform to the objectives of FMFIA, Section 4.

Noncompliance – Actions and Accomplishments

CMS did not fully comply with the requirements of PIIA and Section 6411 of PPACA. CMS has developed several corrective actions to reduce improper payments. While some corrective actions have been implemented, others are in the early stages of implementation. CMS believes these major undertakings will have a larger impact over time.

CMS's FY 2022 PIIA non-compliance stems from the following:

1. The 2022 Medicaid improper payment estimate was 15.62 percent, higher than the 10 percent threshold required by PIIA.
2. The 2022 Children's Health Insurance Program (CHIP) improper payment estimate was 26.75 percent, higher than the 10 percent threshold required by PIIA.

CMS continues its efforts to comply with the requirements of PIIA and OMB's implementing guidance.

With regard to compliance with Section 6411 of the PPACA, the intended functions of a Medicare Part C Recovery Audit Contractor (RAC) are already being performed by the existing contract-level Risk Adjustment Data Validation (RADV) program. RADV audits are the primary corrective action that CMS utilizes to address improper payments in Part C. RADV verifies that diagnoses submitted by MA organizations for risk adjusted payment are supported by medical record documentation. In recent years, the RADV program refined its methodology to be more targeted to areas of high risk of improper payments in response to a Government Accountability Office (GAO) report (GAO 16-76). CMS expects to initiate recovery of identified improper payments in FY 2023, pending finalization of the RADV proposed rule, CMS-4185-P.

The FY 2021 President's Budget included a legislative proposal to remove the requirement for HHS to expand the RAC program to Medicare Part C. As stated above, CMS believes that the intended functions of a Part C RAC are already performed by the RADV program, and therefore, would be duplicative of that work. Despite their success in Medicare FFS, RACs have found the incentives for performing recovery audits of the Medicare Part C program not viable because of differing payment structures and a more narrower scope for payment errors. Another concern is the potential for high overturn rates of overpayments identified on appeal, using the early experience of the Medicare Parts A and B RAC programs as a model. Additionally, potential RAC vendors expressed concerns with the unlimited delay in the contingency payment due to timeframes not being established for appeal decisions in the MA appeal process (42 C.F.R. § 423.2600). These expressed concerns have reduced the incentive for government vendors to enter the market as a Part C RAC.

IMPROPER PAYMENTS

PIIA includes requirements for identifying programs susceptible to significant improper payments, annually reporting estimates of improper payments, and implementing corrective actions to reduce improper payments. PIIA 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, and payments for services not received, as well as payments that are missing sufficient documentation to determine if proper.

Since FY 2012, CMS has complied with OMB's implementing guidance and instituted comprehensive processes that measure the payment error rates for the Medicare FFS, Medicare Advantage (Part C), Medicare Prescription Drug (Medicare Part D), Medicaid, and CHIP programs. Due to COVID-19, in FY 2020, HHS exercised its enforcement discretion to temporarily suspend all improper payment related engagement, communications, and data requests to providers and state agencies from HHS as disclosed in HHS's FY 2020 AFR. HHS adjusted the sample size for the FY 2021 Medicare FFS, Medicaid, and CHIP measurement programs to account for the ongoing challenges incurred by providers, suppliers, and states during COVID-19, while continuing to maintain appropriate accountability measures and meet the statutory obligations.

Medicare FFS

CMS measures the Medicare FFS improper payment estimate 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 92.54 percent. This means Medicare paid an estimated $390.46 billion correctly in FY 2022.

The Medicare FFS improper payment estimate for FY 2022 is 7.46 percent or $31.46 billion. The improper payment estimate due to missing or insufficient documentation is 5.03 percent or $21.20 billion, representing 67.40 percent of total improper payments. Improper payments for skilled nursing facility (SNF), hospital outpatient, hospice, and home health claims were the major contributing factors to the FY 2022 Medicare FFS rate. While the factors contributing to improper payments are complex and vary by year, the primary causes continue to be insufficient documentation and medical necessity errors.

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 several preventative measures for specific service areas with high improper payments. 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 (Part C) and Prescription Drugs (Part D)

CMS measures the Medicare Part C improper payments made to MA contracts through the Part C improper payment measurement process. The Part C improper payment estimate for FY 2022 is 5.42 percent, or $13.94 billion. The improper payment estimate due to missing or insufficient documentation is 0.19 percent or $0.49 billion, representing 3.49 percent of total improper payments. The estimated percentage of Part C dollars paid correctly was 94.58 percent. This means Part C paid an estimated $243.23 billion correctly in FY 2022.

In FY 2022, CMS finalized and implemented policy changes which contributed to a decrease in the Part C improper payment estimate, representing a new baseline improper payment rate for Part C that is not directly comparable to prior reporting years.

CMS measures the Medicare Part D improper payments related to prescription drug event data through the Part D improper payment measurement process. The Part D improper payment estimate for FY 2022 is 1.54 percent, or $1.36 billion. The improper payment estimate due to missing or insufficient documentation is 1.21 percent or $1.07 billion, representing 78.49 percent of total improper payments. The estimated percentage of Part D dollars paid correctly was 98.46 percent. This means Part D paid an estimated $87.05 billion correctly in FY 2022.

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. Through Payment Error Rate Measurement (PERM), CMS measures three areas of Medicaid and CHIP: FFS claims, managed care payments, and eligibility determinations. PERM uses a 17states-per-year, 3-year rotation to produce and report national program improper payment rates.

The national Medicaid improper payment estimate for FY 2022 is 15.62 percent or $80.57 billion in improper payments based on measurements conducted in FYs 2020, 2021, and 2022. The improper payment estimate due to missing or insufficient documentation is 13.56 percent or $69.95 billion, representing 86.82 percent of total improper payments. The estimated percentage of Medicaid dollars paid correctly was 84.38 percent. This means Medicaid paid an estimated $435.24 billion correctly in FY 2022.

The national improper payment estimate for each Medicaid component is:

- Medicaid FFS: 10.42 percent
- Medicaid managed care: 0.03 percent
- Medicaid eligibility: 11.89 percent

The national CHIP improper payment estimate for FY 2022 is 26.75 percent or $4.30 billion in improper payments based on measurements conducted in FYs 2020, 2021, and 2022. The improper payment estimate due to missing or insufficient documentation is 20.34 percent or $3.27 billion, representing 76.05 percent of total improper payments. The estimated percentage of CHIP dollars paid correctly was 73.25 percent. This means CHIP paid an estimated $11.79 billion correctly in FY 2022.

The national improper payment estimate for each CHIP component is:

- CHIP FFS: 11.23 percent
- CHIP managed care: 0.62 percent
- CHIP eligibility: 24.01 percent

In response to COVID-19, the FY 2022 national Medicaid and CHIP improper payment estimates reflect reviews that accounted for certain flexibilities afforded to states during the public health emergency, such as postponed eligibility determinations and reduced requirements around provider enrollment or revalidations.

The areas driving the FY 2022 Medicaid and CHIP improper payment estimates are:

- **Insufficient Documentation:** Represents situations where the required verification of eligibility data, such as income was not done and where there was an indication that eligibility verification was initiated but the state provided no documentation to validate the verification process was completed. Additionally, insufficient documentation includes situations where medical records were not submitted or were missing required documentation to support the medical necessity of the claim. However, these payments do not necessarily represent payments to illegitimate providers or on behalf of ineligible beneficiaries. If the missing information had been on the claim and/or the state had complied with the enrollment or redetermination requirements, the claims may have been payable. Conversely, if the missing documentation had been available, it could have affirmatively indicated whether a provider or beneficiary was ineligible for Medicaid or CHIP reimbursement and, therefore, would have been deemed improper.
- **State Non-Compliance:** Represents situations such as noncompliance with federal eligibility redetermination requirements; enrolled providers not appropriately screened by the state; providers not appropriately rescreened at revalidation; providers not enrolled; and/or providers without the required National Provider Identifier (NPI) on the claim. States' compliance with provider enrollment or screening requirements has improved. The Medicaid FFS component improper payment estimate decreased from 13.90 percent in FY 2021 to 10.42 percent in FY 2022 and the CHIP FFS component improper payment estimate decreased from 13.67 percent in FY 2021 to 11.23 percent in FY 2022. Decreases in the Medicaid and CHIP FFS and eligibility components between FY 2021 and FY 2022 can also be attributed to the review flexibilities afforded to states during the COVID-19 public health emergency.

- **Improper Determinations:** Represents situations where the beneficiary was inappropriately claimed under Title XXI (CHIP) rather than Title XIX (Medicaid), mostly related to incorrect state calculations based on beneficiary income, the presence of third party insurance, household composition, or tax filer status. Improper determinations accounted for 14.68 percent or $0.63 billion of total errors cited in CHIP FFS, CHIP managed care and CHIP eligibility in FY 2022.

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 corrective action plans, with assistance and oversight from CMS.

Additional information on the Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, and CHIP improper payments can be found in the **HHS FY 2022 AFR** and **CMS websites**.

Health Insurance Exchanges

The Healthcare Exchanges are also susceptible to erroneous payments, and both the federal government and states have a strong financial interest in ensuring that eligibility determinations are made accurately. Through the Exchange Improper Payment Measurement Program (EIPM), CMS measures Advance Payment of the Premium Tax Credit (APTC) improper payments.

The Federally-facilitated Healthcare Exchange improper payment estimate for FY 2022, for measurement of calendar year 2020, is 0.62 percent or $255.76 million. The improper payment estimate due to missing or insufficient documentation is 0.04 percent or $16.82 million, representing 6.58 percent of total improper payments. The estimated percentage of APTC dollars paid correctly was 99.38 percent. This means the Federally-facilitated Healthcare Exchange paid an estimated $41.00 billion correctly in FY 2022.

The primary cause of improper payments was manual errors associated with determining consumer eligibility for APTC payments, representing 94.30 percent of overpayments, or $222.63 million and 100 percent of underpayments, or $19.69 million. Most health insurance applications have consumer eligibility verified using automated processes. Automated processes refer to those functions which are executed using computer programming, and do not involve manual intervention. Certain eligibility verifications consist of electronically comparing information provided by a consumer to that of third-party databases and determining if any inconsistencies exist that may impact a consumer's eligibility. For certain applications, manual eligibility verifications are necessary because of the circumstances of a consumer's application (for example, an application submitted past the open enrollment period due to certain qualifying life events), or because the automated verification process identified a need for additional information to be provided by the consumer to verify their eligibility. Manual verifications involve complex rules and a large variety of documentation types and formats, and therefore have a heightened risk of error.

The improper payment rate and amounts estimated herein do not reflect APTC payments made by State-based Exchanges. CMS continues to develop the improper payment measurement methodology for the State-based Exchanges.

Combined Improper Payment Data

The APTC program represents the first of two potential payment streams for the overall Premium Tax Credit program. The second payment stream relates to additional Premium Tax Credit amounts claimed by taxpayers at the time of their tax filings, referred to as "Net Premium Tax Credits" (Net PTC). That is, total Premium Tax Credit outlays/claims are equal to APTC payments plus Net PTC claims. The Internal Revenue Service measures improper payments associated with Net PTC claims, and for calendar year 2020 reported[1] Net PTC claims of $1,247.33 billion, improper payments of $342.14 million, and an improper payment rate of 27.43 percent. The combined APTC and Net PTC improper payment estimate is $597.90 million out of $42.50 billion total Premium Tax Credit outlays/claims, or 1.41 percent. Similar to the APTC improper payment information provided above, this combined APTC and Net PTC improper payment information does not reflect payments made by State-based Exchanges.

1 For taxpayers claiming Net PTC which reside in states which use the Federally-facilitated Exchange. Please also see the Fiscal Year 2022 U.S. Department of Treasury's Agency Financial Report for more information.

GLOSSARY

A

Accelerated and Advance Payments (AAP) Program: A Medicare loan program that allows the Centers for Medicare & Medicaid Services (CMS) to make accelerated payments to Part A providers, and advance payments to Part B suppliers, when there is a disruption in claims submission and/or claims processing. CMS can also offer these payments in circumstances such as national emergencies or natural disasters in order to accelerate cash flow to the affected healthcare providers and suppliers.

Accountable Care Organization (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 composed 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. 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.

Advanced Alternative Payment Model (Advanced APM): An APM that meets certain standards for risk-bearing, use of health information technology, and quality.

Alternative payment model (APM): A program or model (except for a healthcare innovation award model) implemented by the Center for Medicare and Medicaid Innovation at CMS; a demonstration under the Health Care Quality Demonstration Program; an ACO model participating in the Medicare shared savings program; or a Medicare demonstration required by law.

Advance Premium Tax Credit (APTC): Payment amounts calculated by the Exchange and paid to an eligible consumer's insurance company on the consumer's behalf to lower the consumer's out-of-pocket cost for health insurance premiums. The amount the consumer is eligible for is based on the cost of the second lowest silver plan available through the applicable Exchange and the consumer's estimated annual household income compared to the Federal poverty line. Consumers that receive the benefit of APTC payments must file a tax return to reconcile the amount of APTC payments with the amount of the actual premium tax credit they are eligible.

American Recovery and Reinvestment Act of 2009 (ARRA): An economic stimulus package enacted by the 111th U.S. Congress in February 2009. This 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.

American Rescue Plan Act of 2021: An emergency legislative package to provide relief and additional resources for individuals and businesses affected by COVID-19 and to spur a strong economic recovery. The act also includes funding for state, local, and tribal governments as well as education and COVID-19-related testing, vaccination support, and research.

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.

Benefit Payments: Expenses accrued or funds outlaid for services delivered to beneficiaries.

C

Chief Financial Officers Act of 1990 (CFO Act): Designated a Chief Financial Officer in each executive department and 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 of 2009 (CHIPRA): 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 (CSR) 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 APTCs and is based on the amount of household income for the insured compared to the poverty line. These payments to issuers ceased in Fiscal Year 2018 in light of a legal opinion from the Attorney General of the U.S. that a valid appropriation does not exist for CSR 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 require wealthier seniors to pay higher premiums for 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 healthcare needs of the nation. Demonstrations are used to evaluate the effects and impact of various healthcare initiatives and the cost implications to the public.

Direct and Indirect Remuneration (DIR): Payments primarily consisting of drug manufacturer rebates and pharmacy rebates that Part D plans negotiate.

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 ventilators, 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 (ESRD): Permanent kidney failure requiring dialysis or a transplant.

Expenditure: Budgeted funds that 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): 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 payroll taxes 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): 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.

Fee-for-Service: A system of healthcare payment in which a provider is paid separately for each particular service rendered.

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 on its public website and to Office of Management and Budget (OMB) on the first Monday in February of any year following that in which the term of the President commences, and to notify the President and Congress 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.

Health Insurance Marketplaces (Marketplaces): A mechanism for facilitating the purchase of Qualified Health Plans and evaluating eligibility for APTCs and CSRs. States can establish their own Marketplace or the Federal government can operate a Marketplace on their behalf.

Healthcare Fraud Prevention Partnership (HFPP): Voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations.

Home and Community Based Services (HCBS): Provide opportunities for Medicaid-eligible older adults and people with disabilities to receive long term services and support in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

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.

I

Information Technology (IT): Any equipment or interconnected system or subsystem of equipment that is used in the automatic acquisition, storage, manipulation, management, movement, control, display, switching, interchange, transmission, or reception of data or information by the executive agency.

Internal Control: Process effected 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 healthcare costs for people 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 ESRD.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): Legislation passed to strengthen Medicare, extend CHIP, and make numerous other improvements to the healthcare 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 of 2003 (MMA). 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): A program established by HIPAA to promote the integrity of the Medicare program, as specified in Section 1893 of the Social Security Act.

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

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 healthcare improvements, and other changes involving administrative improvements, regulatory reduction, administrative appeals, and contracting reform.

Medicare Prescription Drug Program (Part D): Also known as Medicare Part D. An optional prescription drug benefit created by the MMA for individuals with Medicare who are entitled to benefits under Part A or enrolled in Part B. Eligible individuals can enroll in either a stand-alone prescription drug plan to supplement their traditional Medicare coverage, or in an MA prescription drug plan, which integrates basic medical coverage with added prescription drug coverage. Individuals who qualify for both Medicare and Medicaid (full-benefit dual-eligible) are automatically enrolled in the Part D program; assistance with premiums and cost sharing is available to full-benefit dual-eligible and other qualified low-income individuals.

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 Medicare.

Mental Health Parity and Addiction Equity Act of 2008: This legislation requires insurance coverage for mental health conditions, including substance use disorders, to be no more restrictive than insurance coverage for other medical conditions

N

2019 Novel Coronavirus Disease (COVID-19): A respiratory disease caused by SARS-CoV-2, a coronavirus discovered in 2019, in Wuhan, China.

No Surprise Act: Protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers.

O

Obligation: Legal requirement to pay funds.

OMB Circular A-123, Management's Responsibility for Enterprise Risk Management and Internal Control (OMB Circular A-123): 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 (PPACA) (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 benefits, and to charge the same rates regardless of pre-existing conditions.

Payment Integrity Information Act of 2019 (PIIA): A law that requires government agencies to identify, report, and reduce improper payments in the government's programs and activities. The implementation guidance in Appendix C of OMB Circular A-123 requires executive branch agency heads to review their programs and activities annually and identify those that may be susceptible to significant improper payments.

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

Public Health Emergency (PHE): An emergency need for healthcare [medical] services to respond to a disaster, significant outbreak of an infectious disease, bioterrorist attack, or other significant or catastrophic event.

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 PPACA 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 healthcare professional or organization that provides medical services.

Q

Qualified Health Plans (QHPs): Certified health insurance plans that meet minimum standards for health benefit coverage, as required by the PPACA.

Quality Improvement Organizations (QIOs): Formerly known as Peer Review Organizations (PROs), QIOs monitor the quality of care provided to Medicare beneficiaries to ensure that healthcare 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.

Retiree Drug Subsidy (RDS) Program: The 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 (private health insurance market): 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.

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 18 (SSAE 18): For the purposes of CMS, 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). The AICPA SSAE 18 defines the professional standards to assess the internal controls at a service organization.

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act: Legislation that includes Medicaid, Medicare, and public health reforms to combat the opioid crisis by advancing treatment and recovery initiatives, improving prevention, protecting communities, and bolstering efforts to combat illicit synthetic drugs.

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.

T

Transitional Reinsurance Program: The transitional reinsurance program stabilized premiums in the individual market inside and outside of the Marketplaces.

21st Century Cures Act (Cures Act): Legislation which promotes and funds the acceleration of research into preventing and curing serious illnesses, accelerates drug and medical device development, attempts to address the opioid abuse crisis, and tries to improve mental health service delivery. The act includes several provisions that push for greater interoperability, adoption of electronic health records and support for human services programs.

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

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