FINANCIAL REPORT

FY 2023

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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) 2023 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

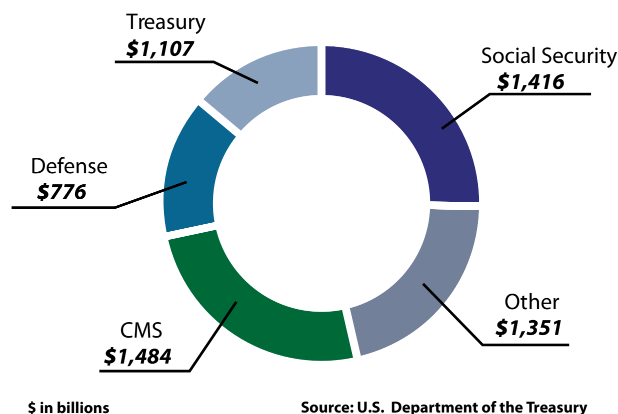
This section contains the message from our Chief Financial Officer, financial statements and notes, required supplementary information, and audit reports.

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.

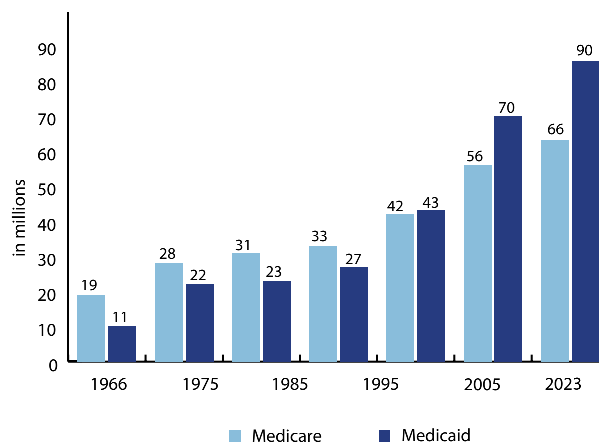
2023 FEDERAL OUTLAYS

CMS has outlays of approximately $1,484 billion (net of offsetting receipts and payments of the Healthcare Trust Funds) in fiscal year (FY) 2023, approximately 14 percent of total Federal outlays. CMS employs approximately 6,700 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 healthcare data in the United States (U.S.).



2023 PROGRAM ENROLLMENT

CMS is one of the largest purchasers of healthcare in the world. Medicare, Medicaid, and Children's Health Insurance Program (CHIP) provide healthcare for one in four Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to approximately 66 million beneficiaries. Medicaid enrollment has increased from 11 million beneficiaries in 1966 to about 90 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) 2023. Over the past year, CMS has continued to achieve meaningful progress toward our mission of advancing health equity, expanding coverage, and improving health outcomes as a trusted partner and steward. Over 150 million Americans received health coverage through Medicare, Medicaid, and the Health Insurance Marketplaces, underscoring the vital role that CMS programs play in helping people achieve their highest level of health and well-being.

I am especially proud of CMS's achievements in implementing the historic *Inflation Reduction Act of 2022* (P.L 117-169). This law has enabled CMS to improve Medicare for the millions of people it serves by expanding benefits, lowering drug costs, and strengthening Medicare for the future. Thanks to the *Inflation Reduction Act*, for the first time in history, Medicare can directly negotiate the prices of prescription drugs. CMS has been busy building this new program, and in August, we announced the first 10 drugs covered under Medicare Part D selected for negotiation under the Medicare Drug Price Negotiation Program. CMS also issued initial guidance for the Medicare Prescription Drug Inflation Rebate Program for Part B and Part D, which has already lowered beneficiary coinsurance for certain drugs in Part B, lowered out-of-pocket costs for some people with Medicare, and will reduce Medicare program spending for costly drugs by discouraging drug companies from increasing prices faster than inflation.

By implementing the policies in the *Inflation Reduction Act*, CMS has also provided meaningful financial relief for millions of people with Medicare by improving access to affordable treatments and strengthening the Medicare program. Starting in 2023, CMS lowered insulin costs for 4 million seniors and other Medicare beneficiaries with diabetes by capping a month's supply of each covered insulin at $35. That same month, CMS made adult vaccines recommended by the Advisory Committee on Immunization Practices available at no cost to people with Medicare prescription drug coverage. CMS also released draft guidance outlining requirements and procedures for the new Medicare Prescription Payment Plan to reduce the burden of high upfront out-of-pocket prescription drug costs by spreading out cost sharing over the year.

CMS and the Social Security Administration are preparing to implement provisions of the *Inflation Reduction Act* that expand eligibility for the full Medicare Part D Low Income Subsidy (LIS) or "Extra Help" program benefit. Concurrently, CMS is improving access to healthcare and lower costs for millions of Americans by streamlining enrollment in the Medicare Savings Programs (MSPs). CMS estimates these improvements will save older adults and people with disabilities nearly 19 million hours in paperwork each year and reduce state administrative burden by over 2 million hours annually. These actions together will help an estimated 1.2 million older adults and people with disabilities with limited income afford their Medicare coverage and healthcare costs. CMS has also launched an extensive public education campaign to help educate people who are eligible for these new benefits about the savings available to them.

Under the *Inflation Reduction Act*, CMS has also extended enhanced financial help to purchase health coverage through HealthCare.gov and State-based Marketplaces, saving consumers an average of more than $800 per year. These supports contributed to historic lows in the nation's uninsured rate, as over 16 million consumers signed up for 2023 individual market health insurance coverage through the Marketplaces.

CMS has also continued to advance strategic priorities that cut across our programs to improve health equity and access to coverage. I am proud of the progress CMS has made through our Maternity Care Action Plan in strengthening access to life-saving care after pregnancy. Thanks to *the American Rescue Plan Act of 2021* (P.L. 117-2) and *the Consolidated Appropriations Act, 2023* (P.L.117-328), as of September 2023, CMS has approved 37 states, the District of Columbia and one territory to provide 12 months of continuous postpartum coverage in Medicaid and Children's Health Insurance Program (CHIP). CMS is also continuing its work to implement a publicly reported hospital designation, the "Birthing-Friendly" hospital, to drive improvements in maternal health outcomes. 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.

Addressing the nation's mental health crisis also remains a critical priority. Over the past year, CMS has continued to execute a multi-pronged approach to increase access to equitable and high-quality behavioral health services. In Medicare, CMS is working to make behavioral healthcare more accessible through adding coverage for outpatient mental health programs across different settings of care and to cover treatment provided by marriage and family therapists and mental health counselors. CMS also awarded the first 200 of 1,000 Medicare-funded physician residency slots to enhance the healthcare workforce in medically underserved communities, with approximately three-quarters of new positions in mental health and primary care. In Medicaid, CMS has approved eight state proposals expanding access to community-based mental health and substance use crisis care enacted through the *American Rescue Plan*. These states can provide Medicaid services through mobile crisis teams by connecting eligible individuals in crisis to a behavioral health provider 24 hours per day, 365 days a year and will temporarily receive an enhanced federal match for such services.

Additionally, CMS is implementing provisions of the *Bipartisan Safer Communities Act* (P.L. 117-159), which expands and extends several CMS initiatives to improve behavioral healthcare, including the Certified Community Behavioral Health Clinics Demonstration. The CMS Innovation Center continues to operate the Value in Opioid Use Disorder Treatment Demonstration Program authorized by *the SUPPORT Act* (P.L. 115-271). CMS has also taken action to help schools deliver mental health and other healthcare services, including by working with the Department of Education to release guidance supporting the delivery of care to Medicaid and CHIP beneficiaries in school-based settings. CMS continues to advance additional impactful policies that respond to the urgent behavioral health challenges facing our nation.

Another key priority is ensuring people receive high-quality long-term services and supports in the setting of their choice. CMS has focused resources across the agency toward advancing President Biden's initiative to improve safety and quality of care in the nation's nursing homes, including through actions to increase transparency around nursing home ownership and management, strengthening oversight of the worst-performing nursing homes, and addressing inappropriate antipsychotic prescribing. In September, CMS issued a proposed rule that seeks to establish comprehensive staffing requirements for nursing homes—including, for the first time, national minimum nurse staffing standards—to ensure access to safe, high-quality care for the over 1.2 million residents living in Medicare and Medicaid certified in nursing homes. CMS also announced a new national nursing career pathways campaign to help recruit, train, retain, and transition workers into nursing home careers. These are critical steps to delivering meaningful improvements for nursing home residents, which accompany actions to strengthen support for home and community-based services. In April, CMS issued a proposed rule with numerous provisions that would help improve access to and the quality of home and community-based services for people with Medicaid. CMS's Innovation Center also announced a new model that aims to support people living with dementia and their unpaid caregivers and to prevent nursing home admissions called the Guiding an Improved Dementia Experience (GUIDE) Model.

CMS also worked collaboratively with the health sector to support a smooth transition following the end of the federal Public Health Emergency for COVID-19 in May 2023, including through guidance and fact sheets on continuing flexibilities, COVID-19 vaccines, testing, treatments, telehealth services, and the Acute Hospital Care at Home initiative. Thanks to the Administration's whole-of-government approach and CMS's efforts to combat the virus, our country is in a better place in our response transitioning away from an emergency phase.

As part of this work, CMS is also working hard to keep eligible people covered as pandemic-era protections for Medicaid enrollment end and states across the country resume regular eligibility and enrollment operations in Medicaid and CHIP. CMS has been working with states and stakeholders since the pause on Medicaid terminations began three years ago, and that work has grown immensely over time to include extensive technical assistance, oversight, and resources such as policy guidance, best practices, and strategies to support specific populations, planning tools and templates, and communications tools. CMS is overseeing each state's renewal activities and using every tool within our authority to address issues as they arise to support CMS's priority of ensuring access to affordable, quality health coverage.

A MESSAGE FROM THE ADMINISTRATOR (CONT...)

Together, these activities reflect CMS's ambitious agenda and bold plan to meet our mission as organized through the CMS Strategic Plan and six CMS Strategic Pillars. Inherent in all of our work is an unyielding focus on customer experience as we work to expand coverage and equitable access to people covered by one or more programs. We are laser-focused on the continuous improvement of CMS's operations to ensure that we are best in class and set the benchmark for our peers. This includes driving results through thirteen cross-cutting initiatives that coordinate critical, multi-year work requiring collaboration across the agency, as well as a robust strategic planning process informed by our maturing use of data and risk management strategies. Our accomplishments extend to improve the integrity of all our programs to ensure they remain sustainable for future generations of beneficiaries and consumers, enhance the interoperability of our healthcare system, to modernize the Medicare payment system infrastructure, increase data transparency and data-driven policymaking, and bring new efficiencies to internal operational processes. I am especially proud that CMS has again scored in the top quartile of all federal agencies in employee satisfaction.

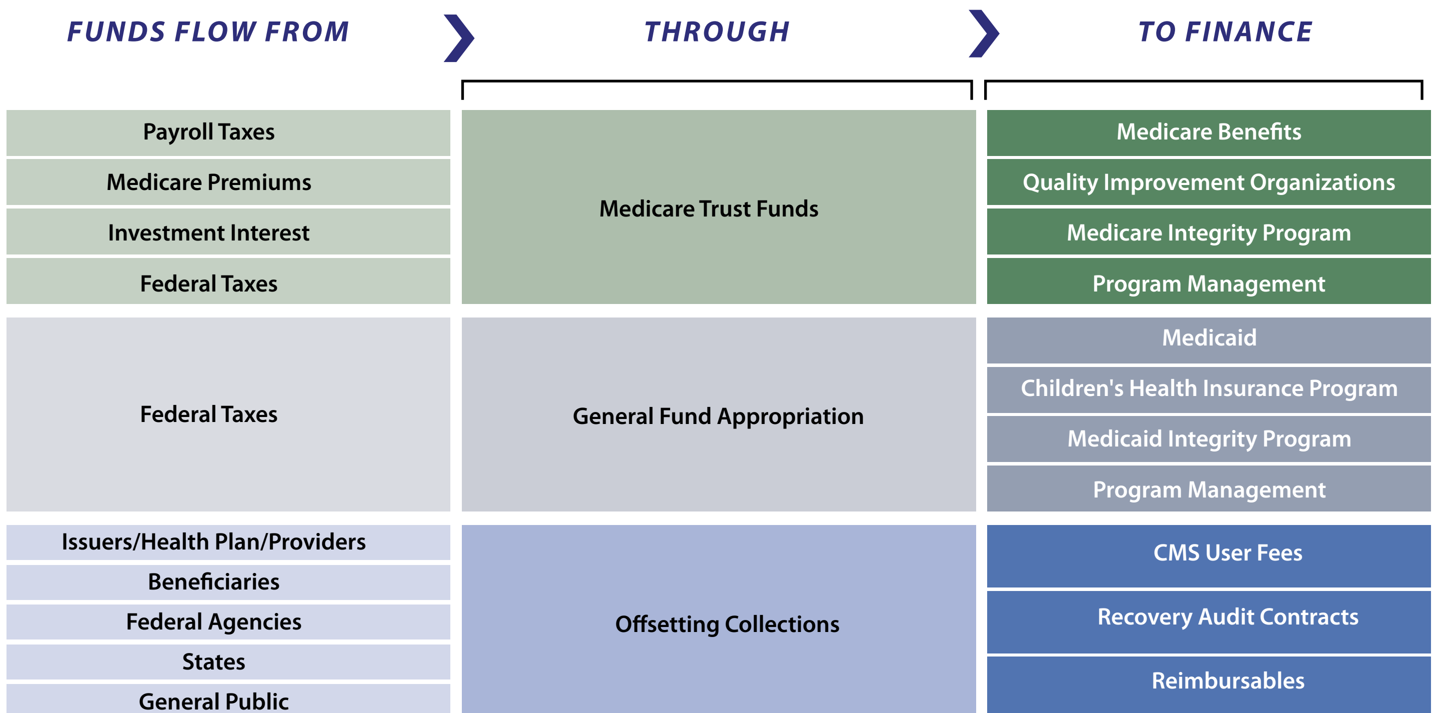
This progress in policy and operations has been carefully stewarded by all 23 of CMS's Centers and Offices, at locations across the nation serving as hubs of local support and collaboration. On-the-ground insight helps inform our policymaking and implementation work, which is why we are supporting more projects to learn from and respond to the experiences of our stakeholders and customers. CMS teams have engaged in extensive engagement with rural stakeholders in particular this past year, providing valuable input to programs across the agency about the unique challenges these communities face. These engagements enable us to put the people we serve at the center of what we do, from priority-setting to implementation details.

Hearing firsthand the experiences of people covered through our programs continues to be a powerful reminder of just how critical CMS's work is, as complex and challenging as it may be. I am grateful for the tireless contributions of our fantastic team as we work together to drive positive health system transformation and achieve better health across the nation.

Chiquita Brooks-LaSure

CMS Administrator
November 2023

FINANCING OF CMS PROGRAMS & OPERATIONS



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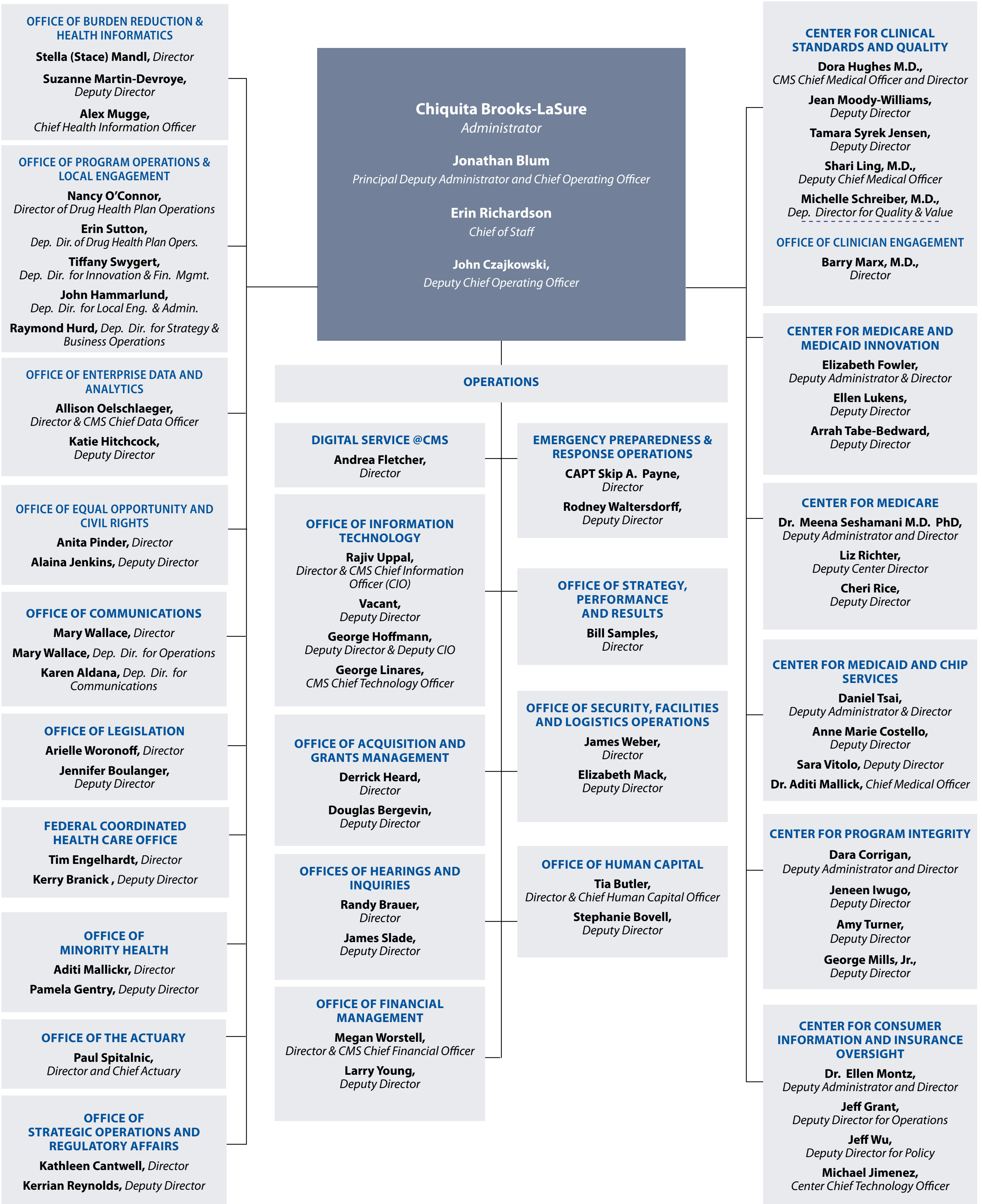
AGENCY ORGANIZATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Approved leadership as of September 15, 2023*
*Acting



MANAGEMENT'S DISCUSSION & ANALYSIS

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PERFORMANCE MANAGEMENT // CMS STRATEGIC GOALS
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OVERVIEW OF FINANCIAL DATA //
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OUR ORGANIZATION

CMS, an operating division of the Department of Health and Human Services (HHS), employs approximately 6,700 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.

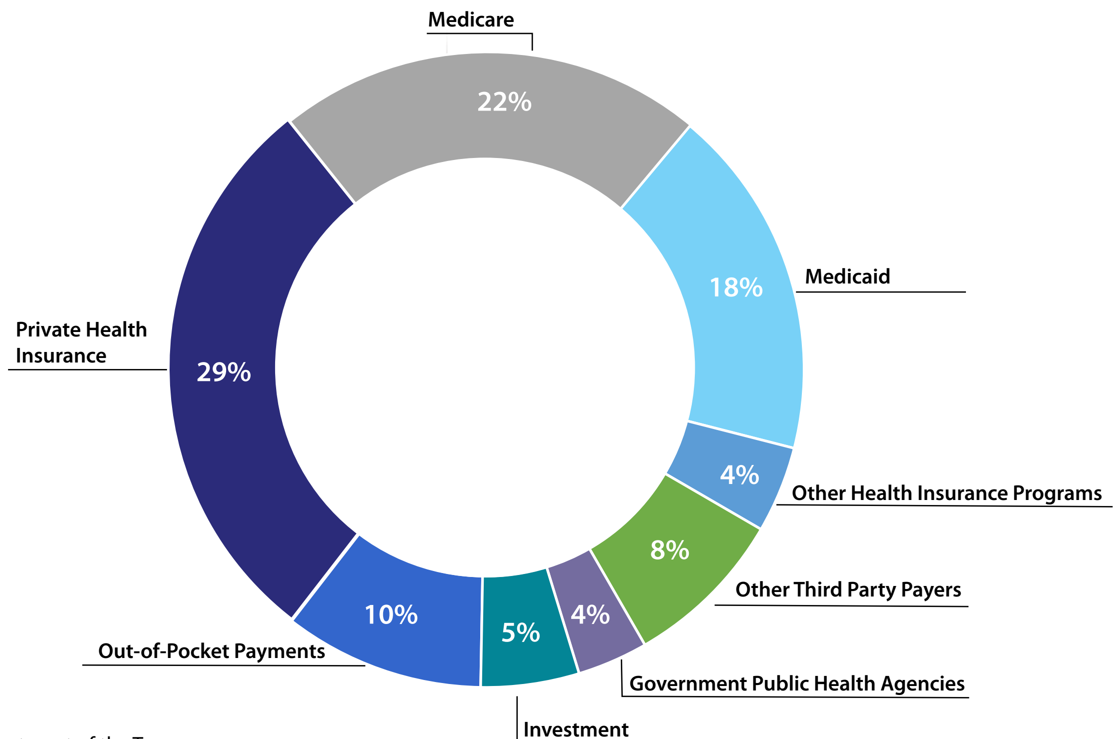
CMS also contracts and/or partners with third parties to operate many of its important activities. Each state administers a Medicaid program and a Children's Health Insurance Program (CHIP). States inspect hospitals, nursing homes, and other facilities to ensure that health and safety standards are met. The Medicare Administrative Contractors (MACs) 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 2023 projections[1], Medicare and Medicaid (including state funding) represent 40 cents of every dollar spent on healthcare in the U.S.— or looked at from three different perspectives: 50 cents of every dollar spent on nursing homes, 46 cents of every dollar received by U.S. hospitals, and 40 cents of every dollar spent on physician services.

The Nation's Healthcare Dollar Fiscal Year 2023



Source: U.S. the Department of the Treasury

1 CMS, National Health Expenditure Projections, 2022-2031. 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 24 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 66 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, ambulance services, 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 dually-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, older adults, and people with disabilities. Medicaid is the primary source of healthcare for over 90 million individuals. Over 13 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.

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 319,199 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 based on 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.

Permanent Risk Adjustment Transfers

The Health Insurance Marketplace 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 *Patient Protection and Affordable Care Act* (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 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 extended. Waivers must not increase the federal deficit.

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 that support the HHS Strategic Plan are featured in the **FY 2024 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 2023 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 2024 President's Budget process.

The *Foundations for Evidence-based Policymaking Act of 2018* (also referred to as the *Evidence Act*) was established to advance evidence-building in the federal government by improving access to data and expanding evaluation capacity. The *Evidence Act* requires changes to how the federal government manages and uses the information it collects, emphasizing strong agency coordination for the strategic use of data.

CMS coordinates with HHS to submit Evidence-Building Plans (also known as Learning Agendas), Evaluation Plans, and Capacity Assessments. The **FY2023-2026 Evidence-Building Plan** is a four-year plan submitted in conjunction with the 4-year Strategic Plan. This plan outlines evidence-building priorities for the next four years, including priority questions and the methods and data required to answer them. The **FY2024 HHS Evaluation Plan** is an annual plan that outlines evaluations and analyses agencies aim to undertake to answer the questions outlined in the Evidence-Building Plans. This plan includes priority questions, data needs, methods, anticipated challenges, and plans for dissemination and use of results. To be submitted in conjunction with the Annual Performance Plan. The **FY2023-2026 HHS Capacity Assessment** is an agency evaluation and evidence-building capacity and functions conducted every four years.

CMS'S FY 2023 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. 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

Health Equity Action Plan

CMS is focused on addressing the health disparities that underlie our health system. To that end, CMS released the CMS Health Equity Action Plan, which lays out the central role advancing health equity plays in the work of all CMS centers and offices. Important highlights include the following:

- Through the Maternity Care Action Plan, which aligns with the Biden-Harris Administration's Maternal Health Blueprint, CMS is seizing every opportunity to improve maternity care access and quality, improve health outcomes, and reduce disparities
- CMS established the first-ever Birthing-Friendly designation, a consumer-friendly display to indicate a hospital's commitment to improving maternal health. This designation will be shown on CMS's Care Compare website. Health plans covering more than 150 million Americans have also committed to using the designation on their provider directories in 2023.
- CMS released frameworks to focus agency efforts to operationalize health equity across CMS programs and policies for the next 10 years. The CMS Framework for Health Equity identifies five priority areas to reduce health disparities, including health equity data, causes of disparities, workforce capacity, language access, and accessibility. The Path Forward: Improving Data to Advance Health Equity Solutions, details steps taken and next steps to improve health equity data collection, analysis, stratification, and reporting in support of the CMS Framework for Health Equity. In addition, the CMS Framework for Advancing Healthcare in Rural, Tribal, and Geographically Isolated Communities builds on the larger framework to identify six priorities specific to rural communities, Tribal nations, territories, and those in geographically isolated areas. Together, these frameworks provide an integrated approach to build health equity into existing and new efforts by CMS and our stakeholders.
- CMS issued a final rule establishing Rural Emergency Hospitals (REH) as a new Medicare provider type and established the Conditions of Participation, along with REH payment policies and quality measures, to address the growing concerns over closures of rural hospitals.
- CMS issued a final rule for the Medicare Advantage and Part D prescription drug programs that will help address health disparities by delivering person-centered integrated care that can lead to better health outcomes for enrollees and by improving the operational functions of these programs. The rule also requires all MA special needs plans to annually assess certain social risk factors for their enrollees, because identifying social needs is a key step to delivering person-centered care.
- CMS also proposed to establish a health equity index in the Medicare Advantage and Part D Star Ratings program that will enhance the Star Ratings. The proposed health equity index is intended to allow beneficiaries to assess plans based on performance on health equity measures, and incentivize plans to invest in health equity initiatives.
- CMS made progress in embedding health equity in all of its models by developing approaches to implementing sociodemographic data collection and reporting requirements, health equity plans, and innovative payment incentives for healthcare providers caring for underserved populations in models.

Addressing Health-Related Social Needs for Medicaid Beneficiaries

Reducing health disparities and addressing unmet health-related social needs, such as housing instability and nutrition insecurity, is critical to improving the health of Medicaid beneficiaries. On January 4, 2023, CMS released a State Medicaid Director Letter on an innovative opportunity for states to address health-related social needs (HRSNs) for people with Medicaid coverage using "in lieu of services and settings" (ILOSs) in Medicaid managed care. This option will help states offer ILOSs, which are alternative benefits, that targets a range of unmet health-related social needs to help Medicaid managed care enrollees improve their health outcomes. ILOSs can be utilized by states and their managed care plans to strengthen access to care by expanding settings options and address certain Medicaid enrollees' HRSNs to reduce the need for future costly state plan-covered services. Under Section 1115 Demonstration authority, six states have CMS-approved expenditure authority to provide HRSN services, and additional applications are under CMS review. This may improve population health, reduce health inequities, and lower overall healthcare costs in Medicaid.

Increasing Healthcare for People Leaving Carceral Facilities

Ensuring that people who were formerly incarcerated can transition successfully back into the community with the healthcare supports and services they need is an essential step for advancing health equity. On April 17, 2023, CMS issued a State Medicaid Director Letter that announced a new opportunity for states to help increase care for individuals who are incarcerated, in the period immediately prior to their release, to help them succeed and thrive during reentry into the community. The new Medicaid Reentry Section 1115 Demonstration Opportunity allows state Medicaid programs to cover services for incarcerated individuals

to address various health concerns, including substance use disorders and other chronic health conditions in the short-term pre-release to improve healthcare transitions to the community. CMS has approved two demonstrations under this new demonstration opportunity, California and Washington, and has 13 additional applications under review.

Expanding HCBS through the Money Follows the Person Demonstration

The Money Follows the Person (MFP) Demonstration provides states with flexible funding opportunities to develop and test the necessary processes, tools, and infrastructure to advance the rebalancing of long-term services and supports (LTSS) and to facilitate individuals' transitions from institutions to community-based settings. As of December 2020, MFP had transitioned 107,128 individuals. In 2022, five new grantees received funding ($25 million) and are in a planning phase which began on September 1, 2022. In 2023, the *Consolidated Appropriations Act* (CAA) made available $450 million per year through FY 2027 for states' and territories' MFP demonstrations. Demonstration funding is now available for new supplemental services to support food security, short-term housing assistance, and services that are typically not coverable under the Medicaid program.

Health Equity Measurement

CMS considers the full range of Medicaid and CHIP enrollees in its decision-making and in its efforts to measure disparities in access to care and make focused investments to improve health equity. Building on this commitment to inclusion, CMS geocoded more than 400 million Medicaid records to inform a race ethnicity imputation model used to create race ethnicity data (2016-2020) for analytics. This data is a first in program history where national estimates of the racial and ethnic composition of the Medicaid and CHIP programs is available, which together constitute some of the nation's largest and most vital health coverage programs.

Using this data, CMS released a series of data briefs representing a major step forward in data transparency. These data briefs more accurately describe the demographic makeup of program enrollees and provide a richer picture of the individuals served by Medicaid and CHIP. Aided by this data enhancement, for the first time in agency's history, CMS knows that Medicaid and CHIP provided coverage for nearly 55 million people of color in 2020.

Health Equity Dashboard and Briefs

Medicaid and CHIP provide essential healthcare coverage for millions of people across a wide breadth of the U.S. population, including but not limited to low-income adults, parents, seniors, individuals with disabilities, pregnant women, and children. CMS has developed a well-validated, evidenced-based method for combining high-quality, self-reported race and ethnicity data with indirect estimates. As a result of this new imputation method, CMS is developing and releasing multiple data briefs describing the composition of the Medicaid and CHIP programs. These data enhancements and briefs reflect CMS's commitment to evidence-based, data-driven health policy and investments, and increased transparency into and prioritization of data to identify disparities in access, quality of care, and health outcomes.

National Quality Strategy

To continue advancing healthcare equity and address healthcare disparities, CMS introduced the National Quality Strategy (NQS) in 2022 as a long-term, cross-cutting initiative with eight specific goals. In developing the NQS, areas of overlap with other initiatives across HHS and CMS were identified, such as cross-cutting strategies for behavioral health, value, and health equity, to pinpoint areas for alignment. The NQS directly supports the agency's efforts to ensure equitable access, quality, and outcomes for all individuals that CMS serves. Within this goal area, CMS continues to address the ways in which Medicare, Medicaid, CHIP, and the Marketplace meet the needs of those we serve, particularly individuals and communities that have been underserved. CMS incorporated equity into the measurement strategy of every CMS quality and value-based program to reward high-quality care for underserved populations. CMS has begun collecting social drivers/determinants of health (SDOH) data across programs and healthcare settings and implementing as well as utilizing health equity scores and equity-specific measures, such as the proportion of adults screened for SDOH and a commitment to equity attestation measure. Additionally, to reduce disparities in communities identified for healthcare disparities, CMS is targeting Quality improvement resources to 11,492 zip codes greatly impacted by healthcare disparities. All zip codes were enrolled and currently 23,589 community partnerships and participants are enrolled.

Rewarding Excellent Care for Underserved Populations

CMS is rewarding excellent care for underserved populations in a number of settings in order to further promote equity across quality and value programs. For the Medicare Shared Savings Program for 2023, CMS finalized a health equity adjustment for those Accountable Care Organizations (ACOs) treating a disproportionate percentage of underserved populations. This upside-only reward is added to the ACO quality score at the end of a year if the ACO succeeds at providing high quality care and treats a disproportionate amount of persons who are dually eligible, receiving low-income subsidies, or are residing in areas of high

deprivation, as measured by the Area Deprivation Index. Similarly, in April 2023, CMS finalized a health equity index, which rewards those Medicare Advantage plans that enroll a high number of, and provide excellent care to, individuals who are dually eligible, receiving low-income subsidies for Medicare Part D, or are disabled.

CMS has recently proposed a similar approach in the Hospital Value-Based Purchasing (HVBP) and the SNF Value-Based Purchasing (SNF VBP) programs for FY 2024. The HVBP proposal calls for changes to the scoring methodology to allow for additional points for high performance for dual eligible individuals, with a sliding scale of more points for those hospitals with the greatest proportion of dual eligible patients. For the SNF VBP, CMS also proposes changes to the scoring methodology, which allows for additional points for excellent care for dually eligible patients, again with the most points going to those facilities caring for a high percentage of duals.

Improving Access to Care in Rural Communities

CMS is implementing policies that support rural providers, improve access to care in rural areas, and support the transformation of the rural health delivery system. Following the enactment of the *Consolidated Appropriations Act of 2021*, CMS implemented a new Rural Emergency Hospital benefit. In exchange for providing emergency department and other outpatient services, Medicare is paying Rural Emergency Hospitals an additional five percent compared to the normal Medicare outpatient rates for most services and will provide a monthly payment that will increase every year with inflation. The intent is that these measures will support financial stability and give rural hospitals at risk of closure another option to provide access to care in rural communities. To further increase access for people in rural areas, CMS has proposed incentives for Medicare Advantage plans to include behavioral health clinicians who can provide telehealth services in their networks. Finally, under the Medicare Shared Savings Program, CMS will begin providing up-front investment dollars to newly-formed, smaller ACOs that treat low-income patients or patients who live in rural or other underserved areas starting in 2024. ACOs could use these upfront payments to hire new healthcare workers, such as community health workers or behavioral health practitioners, helping to address provider shortages in rural areas.

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

Inflation Reduction Plan to Expand Affordable Coverage

Building on the subsidy expansions under the *American Rescue Plan Act of 2021*, the *Inflation Reduction Act of 2022* (IRA) extended provisions that aim at improving health insurance affordability and access through 2025. The provisions extended by the IRA reduced the amount of income individuals are required to contribute to their health insurance premiums and eliminated the income cap of 400 percent of the federal poverty level for premium assistance eligibility, also known as the "subsidy cliff." Under these provisions, millions of Americans have been able to access health insurance plans with low- or zero-cost monthly premiums. Additionally, households over 400 percent of the federal poverty level were able to maintain eligibility for Marketplace subsidies. In part due to the expansion of these subsidies, the 2023 annual Open Enrollment Period was a record-breaking success. From November 1, 2022, to January 15, 2023, more than 16.3 million Americans signed up for health insurance, including 3.6 million who signed up for new coverage. Four out of five people returning to HealthCare.gov were able to find plans for $10 or less a month after accounting for premium assistance.

Enhancing Consumer Options and Choice on the Marketplaces

This year, CMS advanced the goal of health equity by finalizing proposals to address the health disparities that underlie our health system, such as strengthening network adequacy standards and creating a new special enrollment period for those who lose Medicaid or CHIP coverage. Now, consumers will have access to two new essential community provider categories that are critical to delivering needed behavioral healthcare: Substance Use Disorder Treatment Centers and Mental Health Facilities. CMS also finalized rules requiring issuers to offer standardized plan options and limiting the number of non-standardized plan options that issuers can offer. These rules facilitate a simplified plan selection process and reduce the risk of plan choice overload. Standardized plan options include copayments and pre-deductible benefits for a broad range of categories, making care more accessible and reducing the risk of unexpected financial costs. In line with the regulation finalized by Treasury and the Internal Revenue Service, CMS implemented changes to the way health insurance affordability is determined for members of an employee's family for the 2023 Plan Year. These changes allow family members of workers who are offered affordable self-only coverage but unaffordable family coverage to qualify for premium tax credits to buy Marketplace coverage.

Furthermore, in FY 2023, CMS, along with the Department of Labor (DOL) and Treasury, announced actions to protect consumers from junk health plans, surprise medical bills, and excess costs that lead to medical debt. These actions build on the Biden-Harris Administration's effort to eliminate hidden fees in every sector of the economy and lower healthcare costs for American seniors and families. These same agencies also issued guidance to protect consumers from surprise billing and out-of-pocket cost protections

under the *No Surprises Act* and the *Affordable Care Act*, helping to ensure that consumers receive the appropriate protections under these laws. CMS, along with Treasury, also have approved 19 section 1332 waivers, some of which have reduced premiums 4 to 40 percent compared to without the waiver and increased consumer coverage options.

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 Federal Employees Health Benefits 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 process to resolve payment disputes. The *No Surprises Act* also offers protections to individuals without insurance or who aren't using insurance to pay for care (uninsured or self-pay individuals). It entitles these individuals to a "good faith estimate" of the cost of healthcare items and services in advance of receiving care. If the ultimate cost of those items and 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 the Patient Provider Dispute Resolution Process. Protecting consumers from unexpected medical bills will decrease the percentage of people who forgo needed care due to cost and ensure consumers have access to quality, affordable health coverage and care.

Access to Medicaid and CHIP Services

Ensuring beneficiaries can access covered services is a critical function of the Medicaid and CHIP programs and a top priority of the CMS. In April 2023, CMS released two proposed rules, Ensuring Access to Medicaid Services [Access Notice of Proposed Rulemaking (NPRM)] and Managed Care Access, Finance, and Quality (Managed Care NPRM), which outline proposed advancements in access to care, quality of care, and improved health outcomes for Medicaid beneficiaries across FFS and managed care delivery systems, including HCBS provided through those delivery systems, and for CHIP beneficiaries. Medicaid and CHIP are among the nation's largest health coverage programs. If adopted as proposed, these rules would build on Medicaid's already strong foundation as an essential program for millions of families and individuals, especially children, pregnant people, older adults, and people with disabilities.

Resources on Strengthening the Direct Service Workforce

Direct service workers provide essential supports to older adults and people with intellectual and developmental disabilities, physical disabilities, and behavioral health needs. During FY 2023, CMS continued to incorporate input received from State Medicaid Agencies and other stakeholders through a summit, learning collaborative, and technical expert panel in the development of several tools focused on the direct service workforce (DSW) for states and individuals with disabilities receiving Medicaid services. On January 27, 2023, CMS released an online training course and a series of resources that offer strategies and information on self-direction, strengthening the DSW in rural areas, and strategies emerging from CMS' 2021 DSW State Medicaid Learning Collaborative. Furthermore, on June 6, 2023, CMS released a set of resources designed to support state Medicaid and partner agencies that play critical roles in designing and delivering supports and services that meet the current and future needs of adults with intellectual and developmental disabilities and their aging parents and caregivers.

Under Medicaid Section 1115 authority, as part of comprehensive programs to improve access to primary care and close health equity gaps, several states are proposing workforce investment programs. For example, the recently approved loan repayment program approved in Massachusetts which is tied to a significant commitment to service in underserved areas. Also under Section 1115 authority - a condition for approval of federal investments to advance comprehensive health equity initiatives, provision of HRSN services, and designated state health program funding for significant innovation to expand access to care and closure of health disparity gaps - is a requirement that states also make investments to increase provider rates for primary care, behavioral health, and obstetrics if the Medicaid payment rate for these services is below 80 percent of the Medicare rate.

Section 9817 of the American Rescue Plan Act of 2021, Temporary Federal Medical Assistance Percentage Increase for HCBS

CMS continued to work with states to implement Section 9817 of the *American Rescue Plan Act of 2021* (ARP) which provided qualifying states with a temporary 10 percentage point increase to the Federal Medical Assistance Percentage (FMAP) for certain Medicaid expenditures for HCBS. This increased funding provided an opportunity for states to identify and implement changes aimed at addressing existing HCBS workforce and structural issues, expand the capacity of critical services, and begin to meet the needs of people on HCBS waitlists and family caregivers. According to states' spending plans submitted to CMS, each state plans to spend between $24.6 million and $5.2 billion on activities that enhance, expand, or strengthen HCBS under Medicaid because of ARP Section 9817. These amounts will change as states further plan and implement their activities through March 2025.

HCBS Quality Measure Set

In July 2022, CMS issued a State Medicaid Director Letter (SMDL) to describe the first-ever HCBS Quality Measure Set. To improve the quality of HCBS and to promote health equity, CMS continued to work with states in FY 2023 to provide technical assistance and to encourage adoption of the measure set, enabling states to identify racial, ethnic, and other disparities in quality, experience of care, and outcomes among the millions of people receiving long-term services and supports. During this time, CMS also worked to incorporate stakeholder feedback regarding the measure set into proposed regulation Ensuring Access to Medicaid Services (Access NPRM) released in April 2023. Under Section 1115 demonstration authority, that provides expenditure authority for HCBS services, state reporting includes these measures as appropriate.

Non-Emergency Medical Transportation

CMS continues to focus on expanding access to quality and affordable healthcare coverage and care. An analysis was conducted, and a report submitted to Congress on the nationwide Transformed Medicaid Statistical Information System (T-MSIS) data set, identifying recommendations relating to Medicaid coverage of Non-Emergency Medical Transportation for medically necessary services. The T-MSIS Substance Use Disorder Data Book is congressionally-mandated through the *Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)*. The *SUPPORT Act* seeks to address the pressing need for substance use disorder treatment and prevention services, with a focus on opioid use. CMS issued the Assurance of Transportation: A Medicaid Transportation Coverage Guide to provide states with a one-stop resource for federal Medicaid transportation requirements and state flexibilities to help improve access to necessary Non-Emergency Medical Transportation and Emergency Medical Transportation.

Improving Drug Affordability

The new IRA is geared towards improving Medicare by expanding benefits, lowering drug costs, keeping prescription drug premiums stable, and strengthening the overall Medicare program. As of January 1, 2023, people with Medicare pay no more than $35/month per covered insulin and recommended adult vaccines are available without cost-sharing. Changes to Medicare Part D will make a real impact in helping people with Medicare afford their medications. Starting in 2024, people with low incomes will have extra help affording their medications. Starting in 2025, prescription drug out-of-pocket costs will be capped at $2,000.

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 *Consolidated Appropriations Act, 2021*, 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.

Strengthening Access to Behavioral Health

For 2023, CMS implemented policies that mobilize the behavioral health workforce, make behavioral healthcare more effective, and address the nation's substance use disorder crisis. For example, CMS now makes payment for clinical psychologists and licensed clinical social workers to provide integrated behavioral health services as part of a patient's primary care team. CMS is also improving access to team-based comprehensive chronic pain treatment through monthly payments. To increase access to opioid treatment for people who are homeless or live in rural areas, CMS now pays for treatment and recovery services from mobile units.

Improving Access to Oral Health

CMS expanded Medicare payment for dental services when a service is integral to medically necessary services required to treat a beneficiary's primary medical condition. These services include dental examinations and necessary treatments to eliminate infection preceding an organ transplant and certain cardiac procedures beginning in CY 2023 and allowing payment for dental services prior to treatment for head and neck cancers beginning in CY 2024. CMS also established a process to review public input on other circumstances when payment for dental services may be allowed. For 2024, CMS proposed that payment can be made for certain dental services prior to and during several different cancer treatments.

Accepting the Dental Claim Format

To support CMS's Oral Health Cross Cutting Initiative and regulatory clarifications, CMS is building a new, modern claims processing system that will allow dental providers to submit claims using the American Dental Association paper claim and the *Health Insurance Portability and Accountability Act* standard electronic dental claim version (837d) to the original Medicare program. Currently, Medicare accepts, processes, and pays professional and institutional versions of health insurance claims, which

many dentists may not use. Using modern technology and system development methodologies, CMS will be able to launch the first iteration of the dental claims system, known in the software development industry as a minimum-viable product, in calendar year (CY) 2024. CMS will iterate on the system to continue to better serve dental providers and beneficiaries and meet CMS strategic objectives. Finally, CMS plans to leverage the research, technology, and system design of the dental system to improve and further our efforts to modernize existing claims systems.

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 CAA of 2021 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 MH/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 DOL, as applicable upon request. CMS and DOL are responsible for reviewing these comparative analyses. They will identify any compliance concerns, and work with the group health plan or health insurance issuer to ensure compliance. CMS, in collaboration with DOL and the Treasury (Treasury), also reports these analysis findings to Congress annually.

On July 25, 2023, DOL, together with HHS, and Treasury (collectively, "the Departments") released a NPRM to update regulations implementing MHPAEA. These proposed rules also include new proposed regulations for the NQTL comparative analyses required under MHPAEA, as amended by the *Consolidated Appropriations Act, 2021*. The NPRM also includes HHS-only regulatory amendments to implement the sunset provision for self-funded, non-federal governmental plan elections to opt out of compliance with MHPAEA, as adopted by the *Consolidated Appropriations Act, 2023*. The proposed rules aim to strengthen and reinforce MHPAEA's protections, considering the experience of the Departments in enforcing MHPAEA since the issuance of the 2013 MHPAEA final regulations.

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

Request for Information on the Essential Health Benefits

In December 2022, CMS issued a Request for Information on the Essential Health Benefits (EHB) to gather input from the public regarding a variety of topics related to the coverage of benefits in health plans subject to the EHB requirements of the *Affordable Care Act*. These topics included: a general solicitation on the coverage of EHB as described in EHB-benchmark plans, the scope of benefits covered in typical employer plans, the review of EHB, coverage of prescription drugs, and issuer substitution of EHB. We intend to use the comments received in response to this Request for Information to inform future policymaking.

Behavioral Health & Telehealth Learning Collaborative

In October 2022, CMS held the first of three Behavioral Health & Telehealth Learning Collaborative (BHTLC) sessions with Department of Insurance officials from seven states representing a mix of geographies, demographic makeups, and experiences with behavioral telehealth policy efforts. The purpose of the BHTLC was to support information sharing among states and to identify paths forward for greater adoption of telehealth for privately-insured consumers accessing behavioral health services.

User Research Project on the Advanced Explanation of Benefits

In May 2023, CMS embarked on a user research project to help CMS and its Departmental partners better understand the business and technological needs of providers and payers of different sizes, technical abilities, geographic regions, and patient populations. The project consisted of a series of 30 interviews with individual providers and payers, as well as some third parties like electronic health record vendors, clearinghouses, and standards development organizations, to provide CMS with independent research to guide policy decisions around some complex implementation issues, particularly with respect to exchanging government furnished equipment and Advanced Explanation of Benefits data between providers, and from providers to payers.

User Research to Develop a Website for Consumers to Understand Protections Under the No Surprises Act

In 2022 and 2023, the CMS Digital Service conducted a user research project to inform the development of a website to help consumers understand their rights under the *No Surprises Act*. Research participants included patients, caregivers, advocates, and help desk representatives. The research also informed the redesign of the No Surprises Help Desk complaint form, making it easier for consumers to submit a complaint. The website (**cms.gov/medical-bill-rights**) and complaint form (**cms.gov/medical-bill-rights/help/submit-a-complaint**) are available in both English and Spanish and went live in June 2023.

Behavioral Health Customer Engagement

CMS released three illustrations in May 2023, as a result of the qualitative research effort seeking to understand the life experiences of individuals and the barriers to accessing prevention, treatment, and recovery services for SUD, including mental health and effective pain management. CMS conducted months of qualitative research using Human-Centered Design methodologies to identify opportunity areas for consideration by the agency. This work directly supports the CMS Behavioral Health Strategy which seeks to remove barriers to care and services, and to adopt a data-informed approach to evaluate our behavioral health programs and policies. The CMS Behavioral Health Strategy will strive to support a person's whole emotional and mental well-being and promotes person-centered behavioral healthcare.

Community Engagement

Stakeholder (partners, communities, and individuals across the health system) engagement related activities continued with the 2022 RFI Make your Voice Heard project to identity potential opportunities for improvement and increased efficiencies across CMS policies, programs, and practices. Focused topic areas included advancing health equity and reducing health disparities, obtaining public input on access to healthcare and related challenges, understanding provider experiences, and assessing the impact of waivers and flexibilities provided in response to the Coronavirus Disease (COVID)-19 Public Health Emergency (PHE). In response to this work, CMS received more than 4,000 comments addressing challenges and recommendations related to the healthcare system and stakeholder personal experiences. The data received supported collaboration with internal stakeholders to identify opportunities to reduce administrative burden, increase healthcare efficiencies, and analyze impact. The ongoing review of customer perspective is focused on improving customer experience across CMS programs and the broader healthcare enterprise.

Partner Engagement

CMS actively engaged with external partners in implementing its ongoing efforts to improve customer service experience around Medicare Secondary Payer (MSP) activities. CMS refined and updated its MSP user and reference guides as well as participated in industry related conferences and outreach and education webinars to gather feedback and improve external parties' knowledge of MSP policies and processes. External parties included Group Health Plans (GHPs), Non-GHPs (liability insurers, no-fault insurers, workers' compensation carriers), Medicare beneficiary attorneys, MSP reporting and recovery agents, and advocacy groups.

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 2023, 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 identifying "do not pay" providers.

Drug Price Transparency

The Medicaid Drug Price Transparency & Access Learning Collaborative (MDPTA-LC) is a highly interactive forum designed for states to collaborate, exchange ideas, and learn from other states and industry experts about Medicaid drug pricing processes across the country. The MDPTA- LC has had three quarterly state meetings thus far, in which topics such as emergence of high-cost drugs, value-based purchasing, spread-pricing, and drug coverage under Medicaid managed care have been extensively discussed. The MDPTA-LC will continue to meet over the next two years to collaborate on the continued challenges Medicaid state agency staff have with the highly complex pharmaceutical marketplace.

Stakeholder Engagement

Stakeholder engagement related activities continued in FY 2023 throughout the policymaking and implementation process. Some of the stakeholder related activities in the fiscal year included the following:

- Throughout CY 2022 and into the first quarter of 2023, CMS continued to utilize a multi-faceted stakeholder engagement plan to gather insight and feedback on multiple topics including, but not limited to, access to services and quality in Medicaid, including HCBS, direct service workforce challenges, health equity, health and safety protections, and managed care related issues. Informed by feedback from a 2020 RFI and other related resources, CMS met on a regular basis with an array of individuals and organizations representing various facets of our stakeholders including states, State Associations, advocates, Managed Care Associations and their member health plans, coalitions comprised of cross-cutting disability and aging stakeholders (including organizations representing individuals with disabilities, providers, self-advocates, etc.), a cross-cutting group of providers, etc., to discuss various topics and challenges, approaches to address those challenges, and potential barriers to implementation of proposed approaches. It also further strengthened relationships and collaborations with our stakeholders and enhanced the quality and ongoing buy-in and adoption of the draft HCBS Quality Measure Set released in July 2022.
- CMS released Medicaid Managed Care ILOS guidance via a SMDL on January 4, 2023, that was informed by targeted state engagement in 2022, and including the first quarter of FY 2023. ILOS, which provides an opportunity for states and managed care plans to offer to Medicaid managed care enrollees at their option alternative benefits that are substitutes for services or settings covered under the state plan can help states reduce health disparities by taking aim at a range of unmet social needs, including housing instability and food insecurity. This new focus on ILOS, as a tool for strengthening access to care and addressing beneficiaries' unmet health-related social needs, reflects CMS's latest step to drive innovation, improve population health, reduce health inequities, and lower healthcare costs, particularly for underserved communities. As part of the development of this new guidance, CMS engaged a sample of states with specific subject matter expertise over the course of three meetings and several rounds of subsequent emails to garner feedback on the draft ILOS guidance in order to help us evaluate the appropriate scope of documentation and review to balance state burden and program integrity. State feedback also informed revisions to both the ILOS SMDL guidance and proposals including the Managed Care Access, Finance, and Quality (Managed Care NPRM) released in April 2023. CMS has continued to provide technical assistance to states to implement ILOS on a case-by-case basis throughout FY 2023.
- CMS has worked very closely with states, federal partners, and an array of HCBS stakeholders since the issuance of the 2014 HCBS Settings Rule providing the framework for ensuring that HCBS are truly person-centered, and that the settings within which they are provided facilitate autonomy and independence. In the months leading up to the March 17, 2023, transition period deadline for full state compliance with the HCBS Settings rule, and in the months since, CMS continued to provide intensive technical assistance to states, and regularly engaged with federal partners, state associations and various HCBS stakeholders including advocates, providers, and researchers to ensure successful and effective implementation of the rule.
- CMS worked closely with a broad spectrum of stakeholders to develop the proposed Quality Rating System (QRS) for Medicaid and CHIP managed care plans. For several years, CMS engaged beneficiaries, state Medicaid agencies, plans, providers, and other stakeholders in a user-centered approach to understand both the needs of the beneficiary when choosing a health plan, as well as the feasibility of implementing such a tool. This QRS is included in the 2023 Managed Care NPRM. CMS also engages annually with stakeholders to update the Medicaid and CHIP Core Sets of measures. The Medicaid and CHIP Child Core Set and Adult Core Set contain measures intended to serve as a set of measures which, taken together, can be used to estimate the overall national quality of healthcare for Medicaid and CHIP beneficiaries. The Core Sets are comprised of quality measures collected at the state level. The annual Core Set review is designed to identify gaps in the existing Core Sets and suggest updates to strengthen and improve the Core Sets. Annual Core Set Review Workgroup is comprised of Medicaid and CHIP stakeholders and measurement experts, including but not limited to federal and state partners, who develop a set of recommendations for changes to the Core Sets.
- CMS increased the number of consumer groups, including consumer advocates and providers, who are or who serve underserved communities across Medicaid, Medicare and the Marketplace who report they feel heard and engaged by CMS.

Medicaid Integrity Institute

CMS offers training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute. In FY 2023, CMS continued a robust virtual training program that continued throughout the COVID-19 PHE. For example, courses included such topics as various Medicaid Coding Boot Camps; Medicaid Provider Auditing Fundamentals; Coding for Non-Coders; HHS-OIG Fraud Schemes & Trends; Do Not Pay State Initiatives for Payment Integrity for Beneficiaries and Providers; Medicaid Provider Enrollment and Terminations; Program integrity Opportunities for the Territories; and Medicaid Managed Care. More information is located at the Medicaid Integrity Institute website: **https://www.cms.gov/medicaid-integrity-institute**.

Engagement Initiatives under the National Quality Strategy

Under the National Quality Strategy, CMS has focused significant attention on increasing engagement and promoting shared decision making across the care continuum. This allows us to continue advancing towards a person-centered approach to care across the lifespan. Focusing on engaging our partners and the communities through policymaking and implementation process, CMS continues to:

- Improve individual and caregiver access to information relevant to healthcare decision-making and amplify the voice of individuals and communities through expanded outreach and increased use of person-reported measures (comprising a minimum of 25 percent of the overall measure set or 25 percent of the overall score calculation weighting).
- Expand individual and community outreach efforts to obtain meaningful, bi-directional engagement and include diverse perspectives in CMS strategy and policy.
- Promote interoperability of healthcare data to ensure all individuals have access to their personal health information through patient portals.
- Increase access to and utilization of public reporting websites (e.g., Care Compare) to promote informed and collaborative decision-making.
- Integrate feedback from individuals and communities through person-reported quality metrics.
- Improve quality and safety of care provided by nursing homes by hosting multiple national nursing home stakeholder calls. CMS in partnership with the CDC hosted six national stakeholder calls for long-term care providers, facility staff, and resident advocates. Attendance for each call range between 900-3,000 attendees.
- Provide opportunities to engage stakeholders on future regulatory requirements that providers and suppliers would need to meet to participate in the Medicare and Medicaid programs. Listening sessions were held with hospital associations and patient advocacy groups. Several topics of interest include Nursing Home staffing, health equity, emergency preparedness to name a few.
- Host external stakeholder listening sessions. Six were conducted that included Accrediting Bodies, Federal Partners, Hospitals, and Medication Safety Groups to address pandemic-related disruptions to patient safety and gain insights into designing quality improvement interventions that would be effective in addressing the challenges.

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

Value-based Care and Payments

CMS remains committed to drive innovation by encouraging issuers and states to advance efforts to support value-based care and value-based payments across the healthcare system, with a particular emphasis on the individual market population. We continue to pursue strategies that will assist in the uptake and offering of value-based insurance design by QHP issuers using a "value-based" model QHP that contains consumer cost-sharing levels aimed at driving utilization of high value services and lowering utilization of low value services. Offering a value-based insurance design QHP is voluntary, and issuers are encouraged to select services and cost sharing that work best for their consumers. In addition to value-based insurance design, one such approach is alignment with Alternative Payment Models through the CMS Innovation Center. As part of the objective to achieve system transformation, the CMS Innovation Center is collaborating with other payers and/or states to amplify the impacts of models across Medicare and Medicaid, as well as commercial payers where possible. Providers have found that multi-payer alignment can make it easier to transition to and sustain participation in value-based care. More information can be found on the **CMS Innovation Center website**.

Transparency in Coverage

CMS's **Transparency in Coverage** final rules, published by HHS, DOL and Treasury, requires most group health plans, and health insurance issuers offering group or individual health insurance coverage to disclose personalized price and cost-sharing information to participants, beneficiaries, and enrollees, in real-time, 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, promoting more value-based consumer decisions about their healthcare. Under these rules, plans and issuers are also required to disclose on a public website their in-network negotiated rates, and allowed amounts and historical billed charges for out- of-network providers. Making this information available to the public will drive innovation in developing advanced consumer shopping tools, support informed, price-conscious decision-making, and ultimately promote competition in the healthcare industry to move towards quality, affordable health coverage and care.

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 and offices across the agency and externally by entities such as the Federal Bureau of Investigation (FBI), OIG, and Department of Justice (DOJ). The IDR allows for a variety of complex data analytic workloads such as investigative and litigious efforts focused on fighting Medicare and Medicaid fraud, waste, and abuse (FWA), Medicare and Medicaid program cost estimations, and innovative healthcare model(s) development.

As part of migrating the IDR to the cloud by December 2023, CMS has designed the IDR Cloud system to be nimbler and more scalable to enhance system throughput, 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 Application Programming Interface 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, CMS is also implementing secure data sharing capabilities within the IDR cloud, so data is centrally stored and logically shared with internal and external customers.

Advancing 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 refers to delivery system and financing approaches that maximize Medicare-Medicaid coordination and mitigate cost-shifting incentives, including total-cost-of-care accountability across Medicare and Medicaid. Most importantly, integrated care leads to a seamless experience for individuals. 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.

Initiatives Under the National Quality Strategy to Drive Innovation

Under the National Quality Strategy, CMS will support and drive innovation and access through advanced data analytics and streamlined evidence-based reviews of novel technologies and devices for coverage decisions. In June 2023, CMS issued a proposed procedural notice outlining a new Medicare coverage pathway to achieve more timely and predictable access to new medical technologies for people with Medicare. The new Transitional Coverage for Emerging Technologies (TCET) pathway for Breakthrough Devices supports both improved patient care and innovation by providing a clear, transparent, and consistent coverage process while maintaining robust safeguards for the Medicare population. As of July 6, 2023, Broader Medicare coverage is now available for Biogen and Eisai's Leqembi (the brand name for lecanemab) following the FDA move to grant traditional approval to the drug that treats individuals with Alzheimer's disease. With the FDA's decision, CMS will cover this medication broadly while continuing to gather data that will help us understand how the drug works.

CMS released its sixth the Innovation Center's **Report to Congress** representing activities, from October 1, 2020 through September 30, 2022, that continue to drive innovation in tackling our health system challenges and promote value based personal centered care including the following:

- CMS released an **update** on implementation of the CMS Innovation Center's **strategy refresh** to drive the delivery system toward meaningful transformation and deliver person-centered care that meets people where they are. More than 110,000 providers participated in the CMS Innovation Center's traditional Medicare models, and more than 4.7 million people with traditional Medicare received care from providers in these models. Additionally, approximately 900,000 people with Medicaid received care from a provider, plan, or organization participating in a CMS Innovation Center model.
- CMS advanced its goal of having all people with traditional Medicare in an accountable care relationship with their healthcare provider by 2030. The , and the redesign of the ACO Realizing Equity, Access, and Community Health (REACH) model, illustrate how CMS is implementing a shared ACO vision of a health system that achieves equitable outcomes through high quality, affordable, person centered care across different ACO programs, by using the Medicare Shared Savings Program (MSSP) as a chassis for growth. CMS finalized changes to the MSSP, the nation's largest ACO program that, in 2022, covered more than 11 million people with Medicare and included more than 500,000 healthcare providers. These policies represented some of the most significant reforms since the program was established in 2011.
- As part of the President's Cancer Moonshot priority to support patients and caregivers, CMS announced the **Enhancing Oncology Model** to transform the way the healthcare system treats cancer patients. The model places cancer patients at the center of the care team and provides support for navigating a cancer diagnosis, treatment, and survivorship.

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

Premium Refunds

Protecting the nation's purse as a responsible steward of public funds continues to be one of the most important cornerstones of CMS's activities. As of May 2023, CMS refunded approximately $2.6 million to beneficiaries in CY 2023, which represents overpayments by beneficiaries for Parts A, B, D and/or Income-related Monthly Adjusted Amounts (IRMAA). A beneficiary who is directly billed for Medicare premiums may be due a refund for several reasons. For example, a beneficiary may pay their Medicare premiums before a third party begins paying on their behalf, such as a state or OPM. Beneficiaries also make overpayments by mistake, resulting in the need to refund directly paid premiums. CMS will continue to process refunds as expeditiously as possible.

Budget Neutrality in Medicaid Section 1115 Demonstrations

CMS has revamped its approach to budget neutrality in Medicaid Section 1115 demonstrations to better achieve a balance between its interest in preserving fiscal integrity of the Medicaid program and its interest in facilitating state innovation.

Vulnerability Collaboration Council

CMS utilizes a centralized vulnerability management process to identify, prioritize, track, and mitigate vulnerabilities that affect the integrity of federal health programs. The centralized component of this process, known as the Vulnerability Collaboration Council (the Council), is comprised of CMS leadership and subject matter experts that work collaboratively to identify and mitigate vulnerabilities in payment and coverage policies. CMS aligned the Council's risk-based approach with the Government Accountability Office's Fraud Risk Management Framework. In FY 2023, CMS conducted five program integrity risk assessments on multiple topics, including Medicaid managed care; home health; and skilled nursing facilities.

Payment Error Rate Measurement Independent Verification Initiative

CMS enhanced reporting on Medicaid and CHIP improper payment data by implementing the PERM independent verification process to better analyze the insufficient documentation findings. CMS was able to independently verify the missing elements, using the same data sources available to states to determine if the beneficiary or provider would have been eligible, had the state performed the required verifications or maintained documentation at the time the state made the determination. The agency now has sufficient information to determine that the individual or provider was eligible for the payment in certain cases and the agency uses the information to provide greater clarity around these technically improper versus monetary loss and unknown improper payments. Although this will not have a direct impact on the improper payment rates reported, this new data will allow for targeted work with states to address their greatest areas of non-compliance and focus on correcting these programmatic vulnerabilities.

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 in order to apply applicable administrative actions when needed. 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 4,900 cases reviewed at MCC and law enforcement partners have requested over 3,000 referrals as a result of MCC case reviews.

Prior Authorization and Pre-Claim Review

CMS continues to protect the Medicare Trust Funds from improper payments through prior two methods, prior authorization and pre-claim review. Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before an item/service is furnished to a Medicare patient and before a claim is submitted for payment. Pre-claim review is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. Both methods help to ensure that all applicable Medicare coverage, payment, and coding rules are met before an item/service is furnished, and a claim is submitted, which helps providers and suppliers address claim issues early and avoid denials and appeals. CMS works closely with providers and associations to share prior authorization and pre-claim review guidelines and procedures. In FY 2023, CMS completed nationwide expansion of prior authorization for certain lower limb and lumbar sacral orthosis, and implemented a voluntary prior authorization program for certain power mobility devices (PMD) accessories when requesting prior authorization for a PMD base. Additionally, CMS added facet joint interventions to

the nationwide prior authorization process for hospital outpatient department services. Lastly, CMS has implemented the Review Choice Demonstration for Inpatient Rehabilitation Facility (IRF) services in Alabama to provide flexibility and choice for IRFs, as well as a risk-based approach to reduce burden on providers demonstrating compliance with Medicare IRF rules. CMS also continued prior authorization of Repetitive, Scheduled Non-Emergent Ambulance Transport and the Review Choice Demonstration for Home Health Services. As prior authorization is an ongoing process, CMS continues to explore additional opportunities to expand Medicare FFS's use of prior authorization and pre-claim review.

Medicare Part C and Part D Oversight

Contract-level RADV audits are HHS's primary strategy to recover Part C risk adjustment overpayments. RADV uses medical record reviews to confirm the accuracy of diagnoses submitted by MAOs for risk-adjusted payments. These audits are expected to improve data quality because they incentivize MAOs to provide valid and accurate diagnosis information. Additionally, contract-level RADV audits encourage MAOs to identify, report, and return overpayments. In January 2023, CMS finalized a regulation that will allow it to collect extrapolated overpayments resulting from RADV audits, beginning with Payment Year 2018.

As required under *the SUPPORT Act*, CMS developed the Health Plan Management System (HPMS) Program Integrity (PI) Portal for 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 Medicare 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 to assist in combatting FWA. Information that must be reported into the PI Portal includes (1) payment suspensions based on credible allegations of fraud against pharmacies under the Medicare Part D program, and (2) inappropriate prescribing of opioids. Plan sponsors may also report any referrals of substantiated or suspicious activities of FWA.

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. In addition, HFPP has conducted a study and submitted 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 the private sector was established to provide strategic direction for the partnership, including membership criteria and a mission statement.

Improving Payment Accuracy in Medicare Advantage

CMS finalized policies in the 2024 MA and Part D Rate Announcement to improve payment accuracy and is part of the agency's overall stewardship of the Medicare program. These policies included clinically-based technical updates to how CMS pays health plans that offer MA. These policies will be phased in over 3 years in order to ensure that MA payments accurately reflect the healthcare costs of Medicare enrollees. As a result, MA plans will receive a projected payment increase of 3.32 percent for 2024.

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

CMS Future of Work

As we emerge from the pandemic with a continued focus on enhancing collaboration, strengthening relationships between our CMS components, external stakeholders and government partners, CMS is transitioning from a pandemic 'remote first' mindset, to a post-pandemic 'telework first' mindset. The changes are being designed to ensure that CMS can best meet its mission, better serve those enrolled in our programs, and recruit and retain exceptional staff. CMS has communicated this vision to the workforce and is now working with its DOL partners to develop a plan to bring that vision to fruition.

Strategic Human Capital Initiatives Focused on Enhancing Partnership, Efficiency, and Excellence

To further the agency's efforts in promoting excellence in all aspects of CMS's operations, CMS implemented an Office of Human Capital (OHC) Helpdesk, which serves as a one-stop shop for managing internal and external inquiries related to the various human capital functional areas. CMS established the Strategic Talent Leader role to strengthen the partnerships between OHC and senior leaders across the agency and implemented service level agreements to ensure data driven, forward thinking decisions are

made in recruiting, on-boarding, and retaining diverse talent from across the United States. CMS also established hiring sprints initially with the six major Centers to assist with the creation of hiring plans and baseline priorities for each quarter.

Diversity, Equity, and Inclusion

CMS is committed to fostering a positive and inclusive workplace and workforce through our agency's Diversity, Equity, and Inclusion (DEI) priorities. CMS implemented the Hiring Panel policy to mitigate biases and enhance equity in talent processes. Major elements of the policy include diverse panel composition, resume review scoring rubric with pre-determined criteria to rank referred candidates, and interview questions that includes health equity and DEI. The process includes a dedicated unconscious bias training for hiring managers and participants in the interview panel. Additional CMS priorities include the DEI Courses offered to all CMS employees, agency Special Emphasis Programs and most recently, the agency adopted a policy for flying non-agency flags and/or pennants which promote a diverse and inclusive work environment. Furthermore, CMS continues to diversify the workforce by increasing the diversity of certifications for senior positions, reducing demographic disparities in new hires, and reducing the disparity in the promotion pipeline across the general schedule spectrum.

Workforce Planning, Succession Planning and Employee Development

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. This year, CMS also launched its first Executive Development Program to enhance participants' executive competencies, strategic foresight, systems thinking, and skills to lead through complex and nuanced issues.

Workforce Resilience

The Workforce Resilience (WR) program is designed for CMS employees who range from curious to passionate about emerging tools and technologies. The WR program helps federal employees to continually develop knowledge, skills, and practical experience across three key phases in the learning lifecycle: Awareness, Competency, and Engagement. Within Awareness, learners build foundational knowledge and skills in a range of subject areas such as artificial intelligence & machine learning, cloud computing, cybersecurity, data science, human-centered design, leadership, and product management. The WR program is designed to help the federal workforce strengthen and continue to build their skills to ensure long term product and program success in an ever-evolving technology landscape.

Section 508 Program

The Section 508 Program strengthens and coordinates the agency's Section 508 compliance activities by providing leadership, guidance, and oversight to ensure all electronic content is accessible in order to foster a positive and inclusive workplace and workforce. The Section 508 Program focuses on demonstrating inclusion and transparency of Section 508 in the governance framework, policies, and risk management processes, as well as creating awareness through communication and education. The Section 508 Program's current initiatives continue to focus on the following: improving service delivery, increasing awareness regarding the program and its regulatory requirements; increasing collaboration and partnership across the enterprise regarding accessibility, and increasing alignment with our existing governance processes to help ensure solutions and accessibility tools to meet our needs. These efforts will help ensure that solutions meet the needs of all users and continue to drive CMS into a culture of greater awareness, and applications built with accessibility considerations embedded.

Data to Drive Decision Making Cross Cutting Initiative

The Data to Drive Decision Making Cross Cutting Initiative (Data CCI) aims to accelerate the appropriate use of data to deliver on CMS's mission and serve the public while protecting security and privacy. This initiative brings together data subject matter experts from across the agency to tackle CMS's greatest data challenges. Through this initiative, CMS is working to fully leverage the value of data by improving data collection and management, advancing analytic capabilities, and promoting data transparency and dissemination. In 2023, the Data CCI developed a set of CMS Data Principles that will serve as a framework to guide all CMS employees in their use, governance processes, and interactions with CMS data. Once finalized, these data principles will be shared with all CMS employees and contractors along with new resources to operationalize the principles such as operating norms to guide employee behavior, new data governance processes, and new educational materials.

Enterprise Data Lake

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 and reducing data duplication and file transfer activities between CMS components. The EDL program provides system-to-system access to many data sources throughout CMS, ongoing EDL operations & maintenance

support, a governance model, and cloud infrastructure and services in Amazon Web Services commercial and GovCloud. EDL's current developments provide end-user-level access to enterprise data. The EDL Data Mesh program continuously grows, onboarding new data sets, metadata, consumers, and new integration capabilities.

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, 2023 and 2022, 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 $873.7 billion. The bulk of these assets are Investments totaling $355.9 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 largest asset is the Fund Balance with Treasury of $430.6 billion, most of which is used for Medicaid, CHIP, and Payments to Healthcare trust funds. Liabilities of $199.5 billion consist primarily of the Entitlement Benefits Due and Payable of $159.5 billion. CMS's Net Position totals $674.2 billion and reflects primarily the Cumulative Results of Operations for the Medicare trust funds and the unexpended balances for Medicaid and CHIP.

Consolidated Statements of Net Cost

The Consolidated Statements of Net Cost present the actual net cost of CMS's operations by program for the years ended September 30, 2023 and 2022. 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 2023, CMS's total Net Cost of Operations was $1,499.6 billion encompassing net benefit/program costs of $1,646.7 billion and operating costs of $7.8 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, 2023 and 2022. 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 $1,104.8 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 $362.5 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, 2023 and 2022. 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 $2,579.0 billion. Obligations of $2,251.8 billion leave unobligated balances of $327.2 billion. Total outlays, net of collections, were $2,142.3 billion. When offset by $658.0 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 $1,482.3 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 *2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.* With two exceptions, the projections are based on the current-law provisions of the *Social Security Act*. The first exception is that the Part A projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted. The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November of 2020, is not reflected in the Part D projections. This final rule imposed a January 1, 2022, effective date; however, implementation was initially delayed until January 1, 2023. Since then, enacted legislation has three times imposed a moratorium on implementation, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The Medicare projections have been significantly affected by the enactment of the IRA. This legislation has wide-ranging provisions, including those that restrain price growth and negotiate drug prices for certain Part B and Part D drugs and that redesign the Part D benefit structure to decrease beneficiary out-of-pocket costs. The law takes several years to implement, resulting in very different effects by year. The Part D benefit enhancements are implemented by 2025, for example, before the negotiation provisions that are effective in 2026 can have any spending reduction impact. The total effect of the IRA is to reduce government expenditures for Part B, to increase expenditures for Part D through 2030, and to decrease Part D expenditures beginning in 2031. Part B savings are due to the substantial lowering of payments, relative to current reimbursement, as a result of negotiated prices. Part D ultimately generates cost savings at the end of the 10-year period, but many of the gains from negotiated prices and lower trends are initially more than offset by increased benefits and decreased manufacturer rebates.

The Board of Trustees assumes that the IRA will affect the ultimate long-range growth rates for Part B and Part D drug spending differently. For Part B drugs, since the Trustees do not anticipate that the market pricing dynamics will be much different from those prior to the implementation of the IRA, they continue to assume that per capita spending growth rates will be similar to those for overall per capita national health expenditures. On the other hand, for Part D drugs, the Trustees assume that per capita spending will grow 0.2 percentage point more slowly than per capita national health expenditures, since the inflation provisions of the IRA are likely to result in a trend rate that is lower than, and price growth that is closer to, the Consumer Price Index (CPI).

Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic. 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, and the use of telehealth was greatly expanded. More than offsetting these additional costs in 2020, spending for non-COVID care declined significantly.

Actual fee-for-service per capita spending has been consistently below the pre-pandemic projections throughout the public health emergency, even into 2022 as the pandemic had diminishing effects on much of the economy and the healthcare delivery system. A number of factors have contributed to this lower spending, including the net effects of (i) lower average morbidity among the surviving population from COVID-related deaths; (ii) a greater share of dual-eligible beneficiaries enrolling in the Medicare Advantage program; and (iii) the shift of joint replacement procedures from an inpatient to an outpatient setting. These reductions are partially offset by certain public health emergency policies.

While these factors account for a significant amount of the difference between actual and expected experience for many of the categories of providers, others are still largely unexplained. For inpatient hospital, outpatient hospital, and SNF spending, these unexplained differences are expected to be eliminated by 2024; for home health services, they are expected to be gradually eliminated by 2026.

It should be noted that there is an unusually large degree of uncertainty with the COVID-related impacts and that future projections could change significantly as more information becomes available. 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. Total payments of approximately $107.2 billion were made from March 2020 through June 2021: roughly $67.2 billion from the HI trust fund and $40.1 billion from the SMI Part B trust fund account. As of January 1, 2023, roughly 99 percent of these amounts have been repaid. The Trustees assumed in their report that the remaining balance would be fully repaid or converted to an extended repayment schedule by March of 2023.

The SOSI presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period;
- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;
- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period; and
- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) increased from $(5.1) trillion, determined as of January 1, 2022, to $(4.6) trillion, determined as of January 1, 2023.

When the combined HI and SMI trust fund assets are included, the present value increases. As of January 1, 2023, the future cash flow for all current and future participants is $(4.2) 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 $(14.1) 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 63 percent at the beginning of FY 2019 to 45 percent at the beginning of FY 2023. The ratio is estimated to increase in 2023 due to higher trust fund assets at the beginning of the year and lower expenditures projected for 2023, mainly as a result of updated expectations for healthcare spending following the COVID-19 pandemic.

TRUST FUND RATIO

Beginning of Fiscal Year[2]

	2019	2020	2021	2022	2023
HI	63%	50%	40%	39%	45%

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 CY are at least as large as program obligations for the year. Estimates in the 2023 Trustees Report indicate that the HI trust fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2023 Trustees Report, the HI trust fund ratio is estimated to increase in 2023 before decreasing for the rest of the projection period until the fund is depleted in CY 2031. Assets at the end of CY 2022 were $196.6 billion and after 2024 are expected to decrease steadily until depleted in 2031.

Long-Term Financing

The short-range financial outlook for the HI trust fund is more favorable than what was projected last year. After 2023, the trust fund ratio declines until the fund is depleted in 2031, three years later than projected in 2022. 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 89 percent in 2031 to 81 percent in 2047, and then to increase to about 96 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 2022 to about 2.2 by 2097. 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 $4.4 trillion, which is 0.6 percent of taxable payroll and 0.3 percent of Gross Domestic Product (GDP) over the same period. Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. 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 SMI trust fund is expected to be adequately financed over the next 10 years and beyond because income from premiums and government contributions for Parts B and D—which are contributions of the Federal Government that the law authorizes to be appropriated and transferred from the general fund of the Treasury—are reset each year to cover projected program costs and ensure a reserve for Part B to provide a contingency for unexpected program variation.

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

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

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 $(48.5) 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 2022, SMI incurred expenditures were 2.2 percent of GDP. By 2097, SMI expenditures are projected to grow to 4.2 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 expeditiously 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 2021 through 2023.

TABLE OF KEY MEASURES[3]
Dollars in billions

	2023	2022	2021
Net Position (end of fiscal year)			
Assets	**$873.7**	**$765.4**	**$690.8**
Less Total Liabilities	**$199.5**	**$171.9**	**$186.4**
Net Position (assets net of liabilities)	**$674.2**	**$593.5**	**$504.4**
Costs (end of fiscal year)			
Net Costs	**$1,499.6**	**$1,383.6**	**$1,272.4**
Total Financing Sources	**$1,477.6**	**$1,430.4**	**$1,285.0**
Net Change in Cumulative Results of Operations	**$(22.0)**	**$46.8**	**$12.7**
Statement of Social Insurance (calendar year basis)			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	**$(4,630)**	**$(5,094)**	**$(5,057)**
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	**$(5,094)**	**$(5,057)**	**$(4,800)**
Change in present value	**$(464)**	**$(37)**	**$(257)**

3 The table or other singular presentation showing the measures described above. Although, the closed group measure is not required to be presented in the table or other singular presentation, CMS presents the closed group measure and open group measure. Totals do not necessarily equal the sums of rounded components.

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, 2023, decreased by $124 billion due to advancing the valuation date by 1 year and including the additional year 2097, by $283 billion due to changes in economic and healthcare assumptions, and by $315 billion due to changes in demographic assumptions. However, changes in the projection base and law increased the present value by $1,186 and $1 billion, respectively. The net overall impact of these changes is an increase in the present value of $464 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 *2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

Limitations of the Financial Statements

The principal financial statements are prepared to report the financial position, 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

As CMS's Chief Financial Officer, I am committed to ensuring our Agency takes the steps needed to protect our programs' sustainability for future generations through responsible stewardship and promoting excellence in all aspects of CMS's financial operations. FY 2023 is a noteworthy milestone year for CMS, as we celebrate the 25th anniversary of our first clean opinion and the achievement of our 25th consecutive unmodified opinion from the annual financial statement audit of four of the six principal financial statements. CMS's continued achievement of a clean opinion solidifies our commitment to the American Public for fiscal accountability and financial management excellence over our programs that work to advance health equity, expand coverage, and improve health outcomes.

I am also proud to present our FY 2023 Agency Financial Report (AFR) which is the cornerstone of our efforts to fully disclose the financial status of the assets entrusted to us. During 2023, we continued to target our limited resources to further modernize our programs by increasing the role of technology in Americans' lives, safeguarding their data, while also pursuing program integrity methods to better prevent fraudulent and/or improper payments. We lead the nation's healthcare industry in ensuring our programs are accessible, reward high-quality healthcare, and encourage lower healthcare costs. The financial information herein truly reflects the size and scope of our vital mission.

Our 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 have not been 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 we move away from the COVID-19 public health emergency, which expired as of May 11, 2023, we can move forward confidently by documenting lessons learned during that time. The accomplishments in this report reflect some of those lessons and continue to reflect our employees' dedication and commitment to hard work. It reflects the work and diligence on an ongoing basis to ensure operational excellence over our programs.

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. As an agency, we are clearly aware of the importance of our fiduciary and operating responsibilities especially given our limited resources. We are facing times where we must do more with less. However, CMS remains committed and resolute as responsible financial stewards to promote fiscal excellence in all aspects of our operations while seeking innovative and cost-effective ways to manage our ever-changing complex programs.

Megan Worstell

Megan Worstell

CMS Chief Financial Officer

November 2023

FINANCIAL STATEMENTS

CONSOLIDATED BALANCE SHEETS

as of September 30, 2023 and September 30, 2022

(in millions)

	FY 2023 Consolidated Totals	FY 2022 Consolidated Totals
ASSETS		
Intragovernmental:		
Fund Balance with Treasury *(Note 2)*	$430,592	$335,668
Investments *(Note 3)*	355,929	347,264
Accounts Receivable, Net *(Note 4)*	634	535
TOTAL INTRAGOVERNMENTAL	787,155	683,467
Other than intragovernmental:		
Accounts Receivable, Net *(Note 4)*	38,580	39,748
General Property, Plant and Equipment, Net	2,342	2,657
Advances and prepayments (*Note 5)*	45,119	39,007
Other assets	532	510
Total other than intragovernmental	86,573	81,922
TOTAL ASSETS	$873,728	$765,389
LIABILITIES		
Intragovernmental:		
Accounts Payable	$1,900	$1,692
Debt *(Note 6)*	3,272	8,256
Other Liabilities	121	31
TOTAL INTRAGOVERNMENTAL	5,293	9,979
Other than intragovernmental:		
Accounts Payable	509	359
Entitlement Benefits Due and Payable *(Note 7)*	159,543	141,177
Other Liabilities		
Contingencies and commitments *(Note 8)*	18,560	6,955
Other	15,560	13,380
Total other than Intragovernmental	194,172	161,871
TOTAL LIABILITIES *(Note 9)*	$199,465	$171,850
NET POSITION		
Unexpended Appropriations-Funds from Dedicated Collections *(Note 11)*	$275,307	$178,704
Unexpended Appropriations-Funds from Other than Dedicated Collections	81,328	75,185
TOTAL UNEXPENDED APPROPRIATIONS	356,635	253,889
Cumulative Results of Operations-Funds from Dedicated Collections *(Note 11)*	317,578	338,604
Cumulative Results of Operations-Funds from Other than Dedicated Collections	50	1,046
TOTAL CUMULATIVE RESULTS OF OPERATIONS	317,628	339,650
TOTAL NET POSITION	$674,263	$593,539
TOTAL LIABILITIES AND NET POSITION	$873,728	$765,389

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST

for the years ended September 30, 2023 and September 30, 2022

(in millions)

	FY 2023 Totals	Intra-CMS Eliminations	FY 2023 Consolidated Totals	FY 2022 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS GPRA PROGRAMS				
Medicare HI				
Benefit/Program	$411,798		$411,798	$367,602
Program Management	1,411		1,411	1,024
Net Cost Medicare HI	**$413,209**		**$413,209**	**$368,626**
Medicare SMI				
Benefit/Program (Part B)	$362,647	$2	$362,649	$318,705
Benefit/Program (Part D)	89,885		89,885	81,875
Program Management	3,060		3,060	2,618
Net Cost Medicare SMI	**$455,592**	**$2**	**$455,594**	**$403,198**
Medicaid				
Benefit/Program	$610,969		$610,969	$592,814
Program Management	196		196	174
Net Cost Medicaid	**$611,165**		**$611,165**	**$592,988**
CHIP				
Benefit/Program	$17,923		$17,923	$16,692
Program Management	22		22	17
Net Cost CHIP	**$17,945**		**$17,945**	**$16,709**
Other				
Benefit/Program	$1,101		$1,101	$1,524
Program Management	617	$(2)	615	531
Net Cost Other	**$1,718**	**$(2)**	**$1,716**	**$2,055**
NET COST OF OPERATIONS *(Note 10)*	**$1,499,629**		**$1,499,629**	**$1,383,576**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2023

(in millions)

	Funds from Dedicated Collections *(Note 11)*	Funds From Other Than Dedicated Collections	FY 2023 Consolidated Total
UNEXPENDED APPROPRIATIONS			
Beginning Balances	$178,704	$75,185	$253,889
Appropriations Received	593,543	716,967	1,310,510
Appropriations Transferred-in/out		(5,231)	(5,231)
Other Adjustments	(19,047)	(78,702)	(97,749)
Appropriations Used	(477,893)	(626,891)	(1,104,784)
Change in Unexpended Appropriations	**96,603**	**6,143**	**102,746**
Total Unexpended Appropriations: Ending Balance	**$275,307**	**$81,328**	**$356,635**
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	$338,604	$1,046	$339,650
Appropriations Used	477,893	626,891	1,104,784
Nonexchange Revenue:			
FICA and SECA Taxes	362,511		362,511
Interest on Investments	9,868	679	10,547
Other	3,233		3,233
Transfers-in/out without reimbursement	(5,043)	1,586	(3,457)
Imputed Financing	66	8	74
Other		(85)	(85)
Net Cost of Operations *(Note 10)*	**869,554**	**630,075**	**1,499,629**
Net Change in Cumulative Results of Operations	**(21,026)**	**(996)**	**(22,022)**
Cumulative Results of Operations: Ending Balance	**$317,578**	**$50**	**$317,628**
NET POSITION	**$592,885**	**$81,378**	**$674,263**

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.

COMBINED STATEMENTS OF BUDGETARY RESOURCES *(NOTE 12)*

for the years ended September 30, 2023 and September 30, 2022

(in millions)

	FY 2023 Combined Totals Budgetary	FY 2022 Combined Totals Budgetary
Budgetary Resources:		
Unobligated balance from prior year budget authority, net (discretionary and mandatory)	$286,779	$224,534
Appropriations (discretionary and mandatory)	2,285,964	2,162,281
Borrowing authority (discretionary and mandatory)		40
Spending authority from offsetting collections (discretionary and mandatory)	6,272	12,797
TOTAL BUDGETARY RESOURCES	**$2,579,015**	**$2,399,652**
Status of Budgetary Resources:		
New Obligations and upward adjustments	$2,251,779	$2,175,016
Unobligated balance, end of year		
Apportioned, unexpired accounts	119,452	72,926
Exempt from Apportionment, unexpired accounts	1,607	
Unapportioned, unexpired accounts	13,154	8,524
Unexpired unobligated balance, end of year	$134,213	$81,450
Expired unobligated balance, end of year	193,023	143,186
Unobligated balance, end of year (total)	$327,236	$224,636
TOTAL BUDGETARY RESOURCES	**$2,579,015**	**$2,399,652**
Outlays, net		
Outlays, net (discretionary and mandatory)	$2,142,269	$2,062,342
Distributed offsetting receipts	(658,008)	(698,163)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	**$1,484,261**	**$1,364,179**
DISBURSEMENTS, NET	**$(70)**	**$25**

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2023 and Prior Base Years

(in billions)

		Estimates from Prior Years (unaudited)			
	2023 (unaudited)	2022	2021	2020	2019
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	$15,360	$14,767	$13,029	$12,454	$11,805
SMI Part B	39,008	39,039	34,467	32,165	27,556
SMI Part D	6,865	7,372	6,881	6,975	7,181
Have attained eligibility age (age 65 or over)					
HI	862	793	664	637	559
SMI Part B	7,683	7,447	6,536	5,864	5,232
SMI Part D	1,315	1,164	1,061	1,016	1,052
Those expected to become participants					
HI	15,046	14,603	13,017	12,464	11,995
SMI Part B	9,934	10,131	9,010	8,567	6,864
SMI Part D	2,372	3,094	2,921	3,043	3,000
All current and future participants					
HI	31,268	30,163	26,710	25,554	24,359
SMI Part B	56,625	56,618	50,013	46,596	39,652
SMI Part D	10,551	11,630	10,863	11,035	11,232
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	$23,622	$23,211	$20,940	$20,103	$20,028
SMI Part B	38,539	38,605	34,075	31,819	27,270
SMI Part D	6,865	7,372	6,881	6,975	7,181
Have attained eligibility age (age 65 and over)					
HI	7,215	7,010	6,230	6,073	5,348
SMI Part B	8,038	7,825	6,892	6,194	5,741
SMI Part D	1,315	1,164	1,061	1,016	1,052
Those expected to become participants					
HI	5,061	5,036	4,597	4,179	4,467
SMI Part B	10,048	10,188	9,046	8,583	6,641
SMI Part D	2,372	3,094	2,921	3,043	3,000
All current and future participants					
HI	35,897	35,257	31,767	30,355	29,843
SMI Part B	56,625	56,618	50,013	46,596	39,652
SMI Part D	10,551	11,630	10,863	11,035	11,232
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 13 and 14)					
HI	$(4,630)	$(5,094)	$(5,057)	$(4,800)	$(5,484)
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	$(4,630)	$(5,094)	$(5,057)	$(4,800)	$(5,484)
SMI Part B					
SMI Part D					
Trust Fund assets at start of period					
HI	$198	$177	$198	$195	$200
SMI Part B	194	163	133	100	96
SMI Part D	18	20	10	9	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	$(4,432)	$(4,917)	$(4,859)	$(4,606)	$(5,283)
SMI Part B	194	163	133	100	96
SMI Part D	18	20	10	9	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, 2023 and Prior Base Years

(in billions)

	2023 (unaudited)	Estimates from Prior Years (unaudited) 2022	2021	2020	2019
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)	$9,860	$9,404	$8,261	$7,517	$6,843
Expenditures	16,567	15,998	14,184	13,284	12,140
Income less expenditures	(6,707)	(6,595)	(5,922)	(5,766)	(5,297)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	61,232	61,178	54,377	51,594	46,542
Expenditures	69,026	69,188	61,895	58,897	54,479
Income less expenditures	(7,794)	(8,010)	(7,519)	(7,303)	(7,937)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(14,501)	(14,605)	(13,441)	(13,069)	(13,234)
Combined Medicare Trust Fund assets at start of period	410	360	341	303	305
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(14,091)	(14,244)	(13,100)	(12,766)	(12,929)
Future Participants: ***Actuarial present value for the 75-year projection period:***					
Income (excluding interest)	$27,352	$27,828	$24,948	$24,074	$21,858
Expenditures	17,480	18,318	16,564	15,805	14,108
Income less expenditures	9,871	9,510	8,384	8,269	7,750
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(4,630)	(5,094)	(5,057)	(4,800)	(5,484)
Combined Medicare Trust Fund assets at start of period	410	360	341	303	305
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(4,220)	(4,734)	(4,716)	(4,497)	(5,179)

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, 2022 to January 1, 2023

(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, 2022	$98,410	$103,504	$(5,094)	$360	$(4,734)
Reasons for change					
Change in the valuation period	2,206	2,331	(124)	(2)	(126)
Change in projection base	(1,961)	(3,148)	1,186	52	1,238
Changes in the demographic assumptions	(375)	(60)	(315)		(315)
Changes in economic and healthcare assumptions	2,873	3,156	(283)		(283)
Changes in law	(2,709)	(2,710)	1		1
Net changes	34	(431)	465	50	515
As of January 1, 2023	$98,444	$103,074	$(4,630)	$410	$(4,220)
HI - Part A *(Note 15)*					
As of January 1, 2022	$30,163	$35,257	$(5,094)	$177	$(4,917)
Reasons for change					
Change in the valuation period	571	696	(124)	(5)	(129)
Change in projection base	(174)	(1,361)	1,186	25	1,212
Changes in the demographic assumptions	(115)	200	(315)		(315)
Changes in economic and healthcare assumptions	824	1,107	(283)		(283)
Changes in law		(1)	1		1
Net changes	1,105	641	465	21	485
As of January 1, 2023	$31,268	$35,897	$(4,630)	$198	$(4,432)
SMI - Part B *(Note 15)*					
As of January 1, 2022	$56,618	$56,618		$163	$163
Reasons for change					
Change in the valuation period	1,355	1,355		13	13
Change in projection base	(2,135)	(2,135)		18	18
Changes in the demographic assumptions	(330)	(330)			
Changes in economic and healthcare assumptions	2,386	2,386			
Changes in law	(1,269)	(1,269)			
Net changes	7	7		31	31
As of January 1, 2023	$56,625	$56,625		$194	$194
SMI - Part D *(Note 15)*					
As of January 1, 2022	$11,630	$11,630		$20	$20
Reasons for change					
Change in the valuation period	280	280		(10)	(10)
Change in projection base	348	348		8	8
Changes in the demographic assumptions	71	71			
Changes in economic and healthcare assumptions	(337)	(337)			
Changes in law	(1,440)	(1,440)			
Net changes	(1,079)	(1,079)		(1)	(1)
As of January 1, 2023	$10,551	$10,551		$18	$18

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, 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 healthcare 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 healthcare 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 healthcare 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 healthcare assumptions	(49)	(49)			
Changes in law	(0)	(0)			
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.

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. CMS allocates funds as the parent to the Centers for Disease Control and Prevention for children's vaccines. 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 Healthcare 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 Healthcare Fraud and Abuse Control Account (HCFAC), 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 Healthcare 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 Healthcare Trust Funds account. The *Social Security Act* also prescribes that criminal fines and civil monetary penalties arising from healthcare cases be transferred to the HCFAC account of the HI trust fund as well as payments to support FBI activities related to healthcare 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 Healthcare 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* (FFCRA). 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 (PHE) declared by the Secretary of HHS for COVID-19, including any extensions, terminates. The COVID-19 PHE ended on May 11, 2023. Pursuant to Section 5131(a) of the CAA, 2023 which amends section 6008(a) of FFCRA, the increased FMAP will continue through December 31, 2023, and will gradually decrease beginning April 1, 2023.

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 Healthcare 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 healthcare providers for their services. CMS recognizes the cost associated with payments in the period incurred and based on entitlement.

State Phased-Down Contributions are reimbursements to the SMI trust fund for the federal assumption of Medicaid prescription drug costs for dually eligible beneficiaries pursuant to the MMA. The MMA prescribes a formula for computing the states' contributions and allows states to make monthly payments. Amounts billed and collected under the State Phased-Down provision are recognized as a reduction to expense.

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

Budgetary Financing Sources (Other than Exchange Revenues) arise primarily from 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 Healthcare 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 were provided to states to establish Health Insurance Marketplaces. All Marketplaces were launched on October 1, 2013.

Marketplace Risk Adjustment Program

The Risk Adjustment program is a permanent program. It applies to non-grandfathered individual and small group plans inside and outside the Marketplaces. It provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions) and transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection. States that operate a State-based 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.

NOTE 2:

FUND BALANCE WITH TREASURY

(Dollars in Millions)

	FY 2023	FY 2022
Status of Fund Balances with Treasury:		
Unobligated Balance:		
Available	$121,059	$72,926
Unavailable	206,177	151,710
Obligated Balance not yet Disbursed	200,049	180,768
Non-Budgetary FBWT	(96,693)	(69,736)
TOTAL	**$430,592**	**$335,668**

The Unobligated Balance Available includes $42,867 million ($29,117 million in FY 2022), 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 2023 Medicare Investments	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2024	4.250%	$20,882
Bonds	June 2025 to June 2032	1.875 - 3.875%	173,479
Accrued Interest			1,214
Total HI TF Investments			**$195,575**
SMI TF			
Certificates	June 2024	4.250%	$3,129
Bonds	June 2025 to June 2037	1.500 - 3.000%	156,408
Accrued Interest			817
Total SMI TF Investments			**$160,354**
Total Medicare Investments			**$355,929**

FY 2022 Medicare Investments	Maturity Range	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**

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.

CMS INVESTMENT SUMMARY *(CONTINUED)*

(Dollars in Millions)

FY 2023	Medicare (Dedicated Collection)			Consolidated Total
	HI TF	SMI TF	Total	
Certificates	$20,882	$3,129	$24,011	$24,011
Bonds	173,479	156,408	329,887	329,887
Accrued Interest	1,214	817	2,031	2,031
Total Investments	**$195,575**	**$160,354**	**$355,929**	**$355,929**

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**

NOTE 4:

ACCOUNTS RECEIVABLE, NET

(Dollars in Millions)

FY 2023	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$634		$634		$634
Total Intragovernmental	**$634**		**$634**		**$634**
Other than intragovernmental					
Entity					
Medicare FFS	$10,069		$10,069	$(4,394)	$5,675
Medicare Advantage/Prescription Drug Program	18,894		18,894	(14)	18,880
Medicaid	7,365		7,365	(787)	6,578
CHIP	138		138		138
Other	8,301		8,301	(1,019)	7,282
Non-Entity	4	$85	89	(62)	27
Total other than intragovernmental	**$44,771**	**$85**	**$44,856**	**$(6,276)**	**$38,580**

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**

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's Bureau of the Fiscal Service (BFS) are eliminated against BFS'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 $45,119 million ($39,007 million in FY 2022) in advances and prepayments which represent Prescription Drug and Medicare Advantage benefit payments for October 1, 2023 that occurred on September 29 instead of October 1. Advances in the amount of $1,255 million at September 2022 for accelerated payments made under the CAAP program have been demanded and are reflected in the Medicare FFS accounts receivable balance. 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.

NOTE 6:

DEBT

(Dollars in Millions)

CMS has $3,272 million ($8,256 million in FY 2022) in total debt due to Treasury. From that total, $154 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 $2,700 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.

	2022 Beginning Balance	2022 Net Borrowing	2022 Ending Balance	2023 Net Borrowing	2023 Ending Balance
Debt to the Treasury:					
COVID-19 Accelerated and Advance Payment Program	$29,352	$(26,468)	$2,884	$(2,730)	$154
Transitional SMI Contribution	6,960	(2,097)	4,863	(2,163)	2,700
Other	469	40	509	(91)	418
TOTAL DEBT TO THE TREASURY	**$36,781**	**$(28,525)**	**$8,256**	**$(4,984)**	**$3,272**

NOTE 7:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(Dollars in Millions)

	FY 2023	FY 2022
Medicare FFS	$88,660	$65,883
Medicare Advantage/Prescription Drug Program	17,560	19,190
Medicaid	52,028	54,835
CHIP	1,295	1,269
TOTALS	**$159,543**	**$141,177**

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, 2023 and 2022 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 2023. 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, 2023.

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 as of September 30, 2023 and September 30, 2022, and we believe these estimates to be reasonable.

NOTE 8:

CONTINGENCIES AND COMMITMENTS

(Dollars in Millions)

The contingencies balance as of September 30, 2023 is $18,560 million ($6,955 million in FY 2022) that consists of $8,160 million for audit and program disallowances, reimbursement of state plan amendments and $10,400 million for legal contingent liabilities. 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. Additionally, 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 (see Note 6), contingencies (see Note 8), employee annual leave earned but not taken, amounts billed by the Department of Labor for *Federal Employee's Compensation Act* (FECA) payments, and the Risk Adjustment program (reflected in the Other line). For CMS revolving funds, all liabilities are funded as they occur.

FY 2023	Medicare		Health						
Intragovernmental	**HI TF**	**SMI TF**	**Medicaid**	**CHIP**	**Other**	**Program Management**	**Combined Total**	**Intra-CMS Eliminations**	**Consolidated Total**
Debt		$2,854					$2,854		$2,854
Other					$200	$2	202	$(87)	115
Total Intragovernmental		**2,854**			**200**	**2**	**3,056**	**(87)**	**2,969**
Federal Employee and Veterans Benefits	$6	1			16	72	95		95
Other					7,750		7,750		7,750
Contingencies	10,400		$8,160				18,560		18,560
Total Liabilities Not Covered by Budgetary Resources	**10,406**	**2,855**	**8,160**		**7,966**	**74**	**29,461**	**(87)**	**29,374**
Total Liabilities Covered by Budgetary Resources	120,072	114,236	52,028	$1,295	6,019	250	293,900	(126,051)	167,849
Total Liabilities Not Requiring Budgetary Resources	237	1,621			384		2,242		2,242
TOTAL LIABILITIES	**$130,715**	**$118,712**	**$60,188**	**$1,295**	**$14,369**	**$324**	**$325,603**	**$(126,138)**	**$199,465**

FY 2022	Medicare		Health						
Intragovernmental	**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**

NOTE 10:

NET COST OF OPERATIONS

(Dollars in Millions)

FY 2023	Medicare		Health			
	HI TF	SMI TF	Medicaid	CHIP	Other	Consolidated Total
BENEFIT/PROGRAM COSTS						
Medicare						
Fee for Service	$228,806	$230,395				$459,201
Medicare Advantage/ Managed Care	185,631	262,729				448,360
Prescription Drug (Part D)		95,993				95,993
Medicaid/CHIP			$610,958	$17,922		628,880
Other					$13,262	13,262
Bad Debt Expense and Writeoffs	100	173	1		724	998
Total Benefit/Program Costs	**$414,537**	**$589,290**	**$610,959**	**$17,922**	**$13,986**	**$1,646,694**
OPERATING COSTS						
Medicare Integrity Program	$1,676					$1,676
Quality Improvement Organizations	646	$166				812
Program Management and Other Expenses	1,123	3,099	$208	$23	$897	5,350
Total Operating Costs	**3,445**	**3,265**	**208**	**23**	**897**	**7,838**
TOTAL COSTS	**$417,982**	**$592,555**	**$611,167**	**$17,945**	**$14,883**	**$1,654,532**
Less: Earned Revenues:						
Medicare Premiums	$4,765	$136,929				$141,694
Other Earned Revenues	8	34	$2		$13,165	13,209
Total Earned Revenues	**4,773**	**136,963**	**2**		**13,165**	**154,903**
Intra-CMS Eliminations		**2**			**(2)**	
TOTAL NET COST OF OPERATIONS	**$413,209**	**$455,594**	**$611,165**	**$17,945**	**$1,716**	**$1,499,629**

NOTE 10:

NET COST OF OPERATIONS *(CONTINUED)*

(Dollars in Millions)

FY 2022	Medicare		Health			
	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**

For purposes of financial statement presentation, non-CMS administrative costs included in the line of Program Management and Other Expenses that consist of the MAC administrative cost and the Bureau of the Fiscal Service 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 $2,334 million ($2,289 million in FY 2022) 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 2023 Part D expense of $95,993 million ($87,396 million in FY 2022) is net of State reimbursements of $15,321 million ($13,463 million in FY 2022). The gross expense would have been $111,314 million ($100,859 million in FY 2022).

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 Healthcare 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 Funds from Dedicated Collections (Consolidated)
Balance Sheet as of September 30, 2023					
ASSETS					
Intragovernmental:					
Fund Balance with Treasury	$280,536	$15,704	$296,240		$296,240
Investments, net	355,929		355,929		355,929
Accounts receivable, net	118,269	6,467	124,736	$(124,102)	634
TOTAL INTRAGOVERNMENTAL ASSETS	**754,734**	**22,171**	**776,905**	**(124,102)**	**652,803**
Other than Intragovernmental:					
Accounts receivable, net	24,555	7,230	31,785		31,785
General property, plant & equipment, net	432	1,716	2,148		2,148
Advances and prepayments	45,119		45,119		45,119
Total other than Intragovernmental	**70,106**	**8,946**	**79,052**		**79,052**
TOTAL ASSETS	**$824,840**	**$31,117**	**$855,957**	**$(124,102)**	**$731,855**
LIABILITIES					
Intragovernmental:					
Accounts payable	$127,912	$38	$127,950	$(124,102)	$3,848
Debt	2,854		2,854		2,854
Other Liabilities		7	7		7
TOTAL INTRAGOVERNMENTAL LIABILITIES	**130,766**	**45**	**130,811**	**(124,102)**	**6,709**
Other than Intragovernmental:					
Accounts payable	173	303	476		476
Entitlement benefits due and payable	106,220		106,220		106,220
Other Liabilities					
Contingencies	10,400		10,400		10,400
Other	1,868	13,297	15,165		15,165
Total other than Intragovernmental	**118,661**	**13,600**	**132,261**		**132,261**
TOTAL LIABILITIES	**$249,427**	**$13,645**	**$263,072**	**$(124,102)**	**$138,970**
NET POSITION					
Unexpended Appropriations-Funds from Dedicated Collections	$271,601	$3,706	$275,307		$275,307
Cumulative Results of Operations-Funds from Dedicated Collections	303,812	13,766	317,578		317,578
TOTAL NET POSITION	**$575,413**	**$17,472**	**$592,885**		**$592,885**
TOTAL LIABILITIES AND NET POSITION	**$824,840**	**$31,117**	**$855,957**	**$(124,102)**	**$731,855**
Statement of Net Cost for the year ended September 30, 2023					
Benefit and Program Expenses	$1,003,827	$12,976	$1,016,803		$1,016,803
Operating Costs	2,197	5,447	7,644	$2	7,646
Total Costs	1,006,024	18,423	1,024,447	2	1,024,449
Less Earned Revenues	(141,694)	(13,199)	(154,893)	(2)	(154,895)
NET COST OF OPERATIONS	**$864,330**	**$5,224**	**$869,554**		**$869,554**

NOTE 11:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Funds from Dedicated Collections (Consolidated)
Statement of Changes in Net Position for the year ended September 30, 2023					
UNEXPENDED APPROPRIATIONS					
Beginning Balances:	$174,874	$3,830	$178,704		$178,704
Budgetary Financing Sources:					
Appropriations received	593,419	124	593,543		593,543
Other Adjustments	(19,035)	(12)	(19,047)		(19,047)
Appropriations used	(477,657)	(236)	(477,893)		(477,893)
Change in Unexpended Appropriations	96,727	(124)	96,603		96,603
TOTAL UNEXPENDED APPROPRIATIONS: ENDING BALANCE	$271,601	$3,706	$275,307		$275,307
CUMULATIVE RESULTS OF OPERATIONS					
Beginning Balances:	$324,469	$14,135	$338,604		$338,604
Appropriations used	477,657	236	477,893		477,893
Nonexchange Revenue:					
Intragovernmental Nonexchange Revenue	375,176		375,176		375,176
Other than Intragovernmental Nonexchange Revenue	436		436		436
Transfers-in/out without reimbursement	(9,602)	4,559	(5,043)		(5,043)
Imputed financing	6	60	66		66
Net Cost of Operations	864,330	5,224	869,554		869,554
NET CHANGE IN CUMULATIVE RESULTS OF OPERATIONS	(20,657)	(369)	(21,026)		(21,026)
CUMULATIVE RESULTS OF OPERATIONS: ENDING BALANCE	$303,812	$13,766	$317,578		$317,578
Net Position	$575,413	$17,472	$592,885		$592,885

NOTE 11:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Funds from 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	**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 Funds from Dedicated Collections (Consolidated)
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 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, 2023 and September 30, 2022 consisted of the following:

Net Adjustment to Unobligated Balance Brought Forward	FY 2023	FY 2022
Budgetary Resources:		
Unobligated balance, brought forward, October 1	$224,636	$169,401
Recoveries of prior year unpaid obligations	55,822	83,162
Recoveries of prior year paid obligations	28,023	18,725
Appropriation withdrawn	(6,595)	(35,912)
Appropriation temporarily precluded from obligations - prior year	(2,519)	
Cancelled authority	(12,653)	(10,902)
Prior year adjustment	5	11
Other	60	49
Unobligated balance from prior year budget authority, net	**$286,779**	**$224,534**

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. The 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 $236,425 million ($261,475 million in FY 2022) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2023 and FY 2022 (in millions):

	FY 2023 Combined Balance	FY 2022 Combined Balance
TRUST FUND BALANCE, BEGINNING	$261,475	$224,136
Receipts	907,732	908,180
Less Obligations	(932,782)	(870,841)
Excess of Receipts over Obligations	(25,050)	37,339
Trust Fund Balance, Ending	**$236,425**	**$261,475**

Explanations of Differences Between the Combined Statement of Budgetary Resources and the Budget of the United States Government for FY 2022 (Dollars in Millions)

CMS reconciled the amounts of the FY 2022 column of the SBR to the actual amounts for FY 2022 from the Appendix in the FY 2024 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 2023) will be available at a later date.

FY 2022	Budgetary Resources	New Obligations & Upward Adjustments	Distributed Offsetting Receipts	Net Outlays
Combined Statement of Budgetary Resources	$2,399,652	$2,175,016	$698,163	$2,062,342
Expired Accounts	(143,287)			
Other	5,540	5,539		5,042
Budget of the US Govt (2022 Actual)	**$2,261,905**	**$2,180,555**	**$698,163**	**$2,067,384**

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 the Office of Secretary (OS) statements and Governmentwide Treasury Account Symbol (GTAS) adjustments.

Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders totaled $78,010 million ($72,166 million FY 2022). The FY 2023 paid amounts include the Medicare Advantage and Prescription Drug benefit payments for October 2023 that occurred on September 29.

	FY 2023		FY 2022	
	Federal	Non-Federal	Federal	Non-Federal
Undelivered orders (unpaid)	$478	$32,414	$393	$32,766
Undelivered orders (paid)		45,118		39,007
Total	$478	$77,532	$393	$71,773

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 *2023 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.

With two exceptions, the projections are based on the current-law provisions of the *Social Security Act*. The first exception is that the Part A projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted. The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November of 2020, is not reflected in the Part D projections. This final rule imposed a January 1, 2022 effective date; however, implementation was initially delayed until January 1, 2023. Since then, enacted legislation has three times imposed a moratorium on implementation, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The Medicare projections have been significantly affected by the enactment of the IRA. This legislation has wide-ranging provisions, including those that restrain price growth and negotiate drug prices for certain Part B and Part D drugs and that redesign the Part D benefit structure to decrease beneficiary out-of-pocket costs. The law takes several years to implement, resulting in very different effects by year. The Part D benefit enhancements are implemented by 2025, for example, before the negotiation provisions that are effective in 2026 can have any spending reduction impact. The total effect of the IRA is to reduce government expenditures for Part B, to increase expenditures for Part D through 2030, and to decrease Part D expenditures beginning in 2031. Part B savings are due to the substantial lowering of payments, relative to current reimbursement, as a result of negotiated prices. Part D ultimately generates cost savings at the end of the 10-year period, but many of the gains from negotiated prices and lower trends are initially more than offset by increased benefits and decreased manufacturer rebates.

The Board of Trustees assumes that the IRA will affect the ultimate long-range growth rates for Part B and Part D drug spending differently. For Part B drugs, since the Trustees do not anticipate that the market pricing dynamics will be much different from those prior to the implementation of the IRA, they continue to assume that per capita spending growth rates will be similar to those for overall per capita national health expenditures. On the other hand, for Part D drugs, the Trustees assume that per capita spending will grow 0.2 percentage point more slowly than per capita national health expenditures, since the inflation provisions of the IRA are likely to result in a trend rate that is lower than, and price growth that is closer to, the Consumer Price Index (CPI).

Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic. 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, and the use of telehealth was greatly expanded. More than offsetting these additional costs in 2020, spending for non-COVID-19 care declined significantly.

Actual fee-for-service per capita spending has been consistently below the pre-pandemic projections throughout the public health emergency, even into 2022 as the pandemic had diminishing effects on much of the economy and the healthcare delivery system. A number of factors have contributed to this lower spending, including the net effects of (i) lower average morbidity among the surviving population from COVID-19-related deaths; (ii) a greater share of dual-eligible beneficiaries enrolling in the Medicare Advantage program; and (iii) the shift of joint replacement procedures from an inpatient to an outpatient setting. These reductions are partially offset by certain public health emergency policies.

While these factors account for a significant amount of the difference between actual and expected experience for many of the categories, others are still largely unexplained. For inpatient hospital, outpatient hospital, and SNF spending, these unexplained differences are expected to be eliminated by 2024; for home health services, they are expected to be gradually eliminated by 2026.

It should be noted that there is an unusually large degree of uncertainty with the COVID-19-related impacts and that future projections could change significantly as more information becomes available. 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 $67.2 billion from the HI trust fund and $40.1 billion from the SMI Part B trust fund account. As of January 1, 2023, roughly 99 percent of these amounts have been repaid. The Trustees assumed in their report that the remaining balance would be fully repaid or converted to an extended repayment schedule by March of 2023.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. They are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments 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 healthcare 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 March 31, 2023, except that the projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund and the impact of the elimination of the safe harbor protection for manufacturer rebates.

In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary healthcare costs, wages, and the consumer price index (CPI); fertility rates; mortality rates; immigration rates; and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary healthcare 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 2023 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2023. 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]

TABLE 1:
Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2023

					Annual percentage change in:						
								Per beneficiary cost[8]			
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage growth[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI		Real-interest rate[11]
									B	D	
2023	**1.70**	**2,030,000**	**798.0**	**0.15**	**4.15**	**4.00**	**0.7**	5.3[9]	7.8[9,10]	2.5[10]	**−1.0**
2030	**1.86**	**1,348,000**	**738.4**	**1.57**	**4.01**	**2.40**	**2.0**	**5.0**	**5.5**	**1.7**	**2.0**
2040	**1.97**	**1,291,000**	**679.9**	**1.20**	**3.63**	**2.40**	**1.9**	**4.2**	**4.9**	**3.6**	**2.3**
2050	**2.00**	**1,258,000**	**627.3**	**1.10**	**3.53**	**2.40**	**2.0**	**3.4**	**3.7**	**4.1**	**2.3**
2060	**2.00**	**1,241,000**	**580.7**	**1.12**	**3.55**	**2.40**	**2.0**	**3.3**	**3.8**	**4.0**	**2.3**
2070	**2.00**	**1,228,000**	**539.4**	**1.14**	**3.57**	**2.40**	**1.9**	**3.4**	**3.5**	**3.8**	**2.3**
2080	**2.00**	**1,220,000**	**502.7**	**1.13**	**3.56**	**2.40**	**2.0**	**3.5**	**3.7**	**3.9**	**2.3**
2090	**2.00**	**1,216,000**	**469.9**	**1.12**	**3.55**	**2.40**	**2.1**	**3.5**	**3.7**	**4.0**	**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. Annual percentage change in average wages adjusted for the average percentage change in 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 updated expectations for healthcare spending following the COVID-19 pandemic.
10. Reflects Inflation Reduction Act.
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.

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 2:
Significant Ultimate Assumptions Used for the Statement of Social Insurance
FY 2023-2019

	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage growth[4]	Annual percentage change in: Wages[5]	CPI[6]	Real GDP[7]	Per beneficiary cost[8] HI	SMI B	SMI D	Real-interest rate[9]
FY 2023	2.0	1,216,000	469.9	1.12	3.55	2.40	2.1	3.5	3.7	4.0	2.3
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

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. Beginning with the 2023 Trustees Report, for consistency with other growth rate measures, the real-wage growth is defined as the annual percentage change in average wages adjusted for the average percentage change in the CPI. In the 2022 and earlier Trustees Reports it is presented as the difference between percentage increases in wages and the CPI and referred to as real-wage differential. 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 negative in 2024 and 2025. Furthermore, additional payments totaling $500 million per year to one group of physicians and annual bonuses to another group are scheduled to expire in 2025 and 2026, respectively. 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.

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.

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. 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 bonuses for qualified physicians in advanced alternative payment models (advanced APMs), which are expected to end after 2025, and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS), which are set to expire in 2024.[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.

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	**$31,268**	**$31,345**
Part B	**56,625**	**64,452**
Part D	**10,551**	**10,551**
Expenditures		
Part A	**35,897**	**42,272**
Part B	**56,625**	**64,452**
Part D	**10,551**	**10,551**
Income less expenditures		
Part A	**(4,630)**	**(10,927)**
Part B	**0**	**0**
Part D	**0**	**0**

1. These amounts are not presented in the 2023 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 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

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.

higher than the current-law projections by roughly 14 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 14 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, 2022 to the period beginning on January 1, 2023, and the reconciliation from the period beginning on January 1, 2021 to the period beginning on January 1, 2022. 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 healthcare 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, 2022 and ending January 1, 2023

Present values as of January 1, 2022 are calculated using interest rates from the intermediate assumptions of the 2022 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2023. 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 2022 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 healthcare assumptions are calculated using the interest rates under the intermediate assumptions of the 2023 Trustees Report.

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 healthcare assumptions are calculated using the interest rates under the intermediate assumptions of the 2022 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2022 to the period beginning on January 1, 2023

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2022-96) to the current valuation period (2023-97) 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 2022, replaces it with a much larger negative net cash flow for 2097, and measures the present values as of January 1, 2023, 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 2022-96 to 2023-97. 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 2022 are realized. The change in valuation period resulted in a slight 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 $126.0 billion.

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 $123.0 billion.

Change in Projection Base

From the period beginning on January 1, 2022 to the period beginning on January 1, 2023

Actual income and expenditures in 2022 were different from what was anticipated when the 2022 Trustees Report projections were prepared. For Part A and Part B income and expenditures were lower than estimated based on actual experience. Part D total 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 $1,238 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, 2022 and January 1, 2023 is incorporated in the current valuation and is less than projected in the prior valuation.

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.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2022 to the period beginning on January 1, 2023

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, 2023) 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.

- Projected birth rates through 2055, during the period of transition to the ultimate level, were slightly lower than in the prior valuation.
- Updates to near-term mortality assumptions to better reflect the effects of the COVID-19 pandemic led to an increase in death rates through 2024 compared to the prior valuation.
- Historical population data, other-than-lawful permanent resident (LPR) immigration data, and marriage and divorce data were updated since the prior valuation.

There was one notable change in demographic methodology. The method for projecting the age distributions of LPR new arrival and adjustment-of-status immigrants was updated reflecting recent data showing a slightly older population at the time of attaining LPR status than had previously been estimated.

These changes resulted in a decrease in the estimated future net cash flow. For Part A the present values of estimated income are lower and the present values of estimated expenditures are higher. The present values of estimated expenditures and income for Part B are lower and are higher for Part D. Overall, these changes decreased the present value of the estimated future net cash flow by $315 billion.

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.

Changes in Economic and Healthcare Assumptions

For the period beginning on January 1, 2022 to the period beginning on January 1, 2023

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, 2023), there was one change to the ultimate economic assumptions.

- The annual percentage change in the average OASDI covered wage, adjusted for inflation, is assumed to average 1.14 percentage points over the last 65 years of the 75-year projection period. This is 0.02 percentage point higher than the value assumed for the prior valuation.

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

- The levels of GDP and labor productivity are assumed to be about 3.0 percent lower by 2026 and for all years thereafter relative to the prior valuation.
- The assumed real interest rates over the first 10 years of the projection period are generally higher than those assumed for the prior valuation.

There was one notable change in economic methodology. The method for estimating the level of OASDI taxable wages for historical years 2000-21 was improved by adopting a more consistent approach for estimating completed values across various types of wages.

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

- Lower projected spending growth because of the anticipated effects of negotiating drug prices and other price growth constraints, as specified in the IRA, and updated expectations with regard to the pandemic recovery.

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 $283 billion.

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 healthcare assumptions are specific to the Medicare projections. The following healthcare 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.

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.

Changes in Law

For the period beginning on January 1, 2022 to the period beginning on January 1, 2023

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

The *Postal Service Reform Act of 2022* (Public Law 117-108, enacted on April 6, 2022) included one provision that affects Parts B and D of the SMI program.

- A new Postal Service Health Benefits (PSHB) program, which will provide health insurance to United States Postal Service (USPS) employees, annuitants, and their eligible family members, is established, with an implementation date of January 1, 2025. The program will be structured similarly to, and established within, the Federal Employees Health Benefits (FEHB) program, with a selection of health insurance plans from which to choose. To participate in the PSHB program, most USPS annuitants and eligible family members who are newly entitled to premium-free Medicare Part A as of January 1, 2025

must be enrolled in Part B as well. Prior to this new PSHB program, enrollment in Part B was voluntary for these individuals. (Those who turn age 64 on or before January 1, 2025 are exempted from this requirement. Also exempted are individuals who are current annuitants as of January 1, 2025, those living abroad, those enrolled in Veterans Administration coverage, and those eligible for services from the Indian Health Service.) In addition, PSHB plans will be required to offer Medicare Part D coverage for these newly entitled, Part D-eligible USPS annuitants and Part D-eligible family members. This legislation is expected to increase Part B enrollment somewhat and to increase Part D enrollment more significantly (particularly in employer/union-only group waiver plans).

The *Inflation Reduction Act of 2022* (Public Law 117-169, enacted on August 16, 2022) included provisions that affect the SMI programs.

- The Secretary of HHS is required to negotiate prices for certain prescription drugs covered under Medicare. Specifically, CMS (on behalf of the Secretary) must negotiate maximum fair prices for certain high-expenditure single-source Part B or Part D drugs (brand-name drugs without generic or biosimilar equivalents). The maximum fair prices that are negotiated for the first set of drugs subject to negotiation will be in effect beginning in 2026. The number of drugs subject to negotiation is phased in, such that CMS must negotiate the prices of (i) 10 drugs covered under Part D for 2026; (ii) 15 drugs covered under Part D for 2027; (iii) 15 drugs covered under Part B or Part D for 2028; and (iv) 20 drugs covered under Part B or Part D for 2029 and each year thereafter. The selected drugs must be among the 50 drugs with the highest total expenditures over the most recent 12-month period under Part B or Part D and must have been approved or licensed, as applicable, by the Food and Drug Administration for at least 7 years (for drug products) or 11 years (for biologics). Excluded are (i) certain orphan drugs that are approved to treat only one rare disease or condition; (ii) plasma-derived products; (iii) drugs that account for less than $200 million in annual Medicare spending (in 2021 and adjusted annually for inflation); and (iv) certain small biotech drugs (for 2026, 2027, and 2028). Manufacturers of drugs selected for negotiation that fail to comply with negotiation requirements are subject to civil penalties and/or excise taxes. If certain requirements are met, negotiations for certain biologics may be delayed for up to 2 years upon request by a manufacturer of a biosimilar for which the biologic is the reference product. Funds in the amount of $3 billion in fiscal year 2022 are provided to CMS, and are to remain available until expended, for the implementation of this provision.
- For Part B, with respect to each quarter beginning January 1, 2023, and for Part D, with respect to each 12-month applicable period beginning October 1, 2022, drug manufacturers must pay rebates to Medicare if they increase drug prices for a rebatable Part B or Part D drug at a rate that is faster than the rate of consumer inflation. In general, for both Part B and Part D, rebatable drugs include certain drugs and biologics that meet the statutory criteria and have an average cost of $100 or more per year per person, as determined by the Secretary. Manufacturers that fail to comply are subject to civil penalties. Beginning April 1, 2023, beneficiary coinsurance under Part B for a Part B rebatable drug will be adjusted downward to reflect inflation-adjusted payment amounts if the drug price increased more rapidly than the rate of inflation. Funds in fiscal years 2022–2031 are provided to CMS for the implementation of this provision.
- For insulin furnished under Part B through durable medical equipment, the Part B deductible is waived and cost sharing is not to exceed $35 per monthly prescription, effective July 1, 2023.
- For insulin products covered under each Part D plan and during all phases of the Part D benefit, beginning January 1, 2023, the deductible does not apply with respect to such products, and cost sharing for a 1-month supply of each covered insulin product must not exceed $35. (For plan year 2023, plans will receive retrospective subsidies equal to the difference between the plans' benefit packages, as submitted and approved under their 2023 bids, and the $35 statutory limit.) For plan years 2026 and later, when the negotiated maximum fair prices for selected drugs will be in effect, the cost sharing for each month's supply for covered insulin under Part D must be limited to the least of (i) the $35 copayment; (ii) 25 percent of the insulin's negotiated price under the plan; or (iii) 25 percent of the insulin's negotiated maximum fair price.
- For biosimilar products separately payable under Part B and administered in physician offices, hospital outpatient departments, and ambulatory surgical centers with an average sale price (ASP) of not more than the price of their associated reference biological product, the add-on payment (which is paid in addition to the biosimilar's ASP) is temporarily raised from 6 percent to 8 percent of the reference product's ASP for 5 years. The add-on payment for biosimilars that do not meet the ASP qualification will continue to be 6 percent of the reference biological product's ASP. (For existing qualifying year biosimilars for which payment was based on the ASP as of September 30, 2022, the 5-year period began on October 1, 2022. For new qualifying biosimilars for which payment based on the ASP is first made between October 1, 2022 and December 31, 2027, the 5-year period begins on the first day of the calendar quarter during which such payment is made.)
- For new biosimilar products furnished under Part B on or after July 1, 2024, the payment rate during the initial period, when an ASP is unavailable, will be the lesser of (i) the biosimilar's wholesale acquisition cost plus 3 percent or (ii) 106 percent of the associated reference biological product's ASP.

- The standard Part D benefit design (for beneficiaries not eligible for cost sharing and/or premium subsidies) is restructured as follows:

  i. In 2024 and later, the 5-percent cost sharing currently required from the beneficiary during the catastrophic coverage phase (that is, after the beneficiary reaches the out-of-pocket threshold) is eliminated, thereby capping previously unlimited out-of-pocket costs for the beneficiary at the out-of-pocket threshold level. The allowed costs in the catastrophic coverage phase will be borne by the drug plan and by Medicare, at 20 percent and 80 percent, respectively, in 2024 (as opposed to the current catastrophic cost distribution of 5 percent from the beneficiary, 15 percent from the drug plan, and 80 percent from Medicare).

  ii. Beginning in 2025, enrollees will have a $2,000 limit on their out-of-pocket costs for covered Part D drugs; that is, neither the initial coverage limit nor the period currently referred to as the coverage gap (the phase between the initial coverage limit and the out-of-pocket threshold)[4] will continue to exist, and the out-of-pocket cap for entering the catastrophic coverage phase (during which there will no longer be beneficiary cost sharing, as described above) will be reduced to $2,000. For 2026 and later, this $2,000 limit will be increased by the annual percentage increase used for other Part D benefit parameters.

  iii. Also beginning in 2025, for the entire period starting after the deductible is met and ending when the catastrophic coverage phase begins, beneficiary cost sharing will be 25 percent for drugs that are neither insulins nor specified vaccines. The remaining allowed costs (after the 25-percent beneficiary cost sharing) will be covered, in general, as follows: (i) for applicable drugs, by a 10-percent discount paid by the drug manufacturer[5] and a 65-percent benefit from the beneficiary's Part D plan, and (ii) for non-applicable drugs, by a 75-percent benefit from the beneficiary's Part D plan. (In contrast, through 2024, the Part D plan covers 75 percent of the remaining allowed costs until the beneficiary enters the coverage gap; then, during the coverage gap, the remaining allowed costs are covered as follows: (i) for applicable drugs, by a 70-percent discount paid by the drug manufacturer and a 5-percent benefit from the Part D plan, and (ii) for non-applicable drugs, by a 75-percent benefit from the Part D plan.) Applicable drugs are generally covered brand-name Part D drugs and biologics, including biosimilars; non-applicable drugs are generally covered non-brand-name—that is, generic—Part D drugs.

     The 10-percent discount paid by the manufacturer will not count toward the out-of-pocket threshold. (In contrast, the dollar value of the 70-percent manufacturer discount for applicable drugs in 2024 is included in a beneficiary's progression toward meeting the out-of-pocket threshold, even though the beneficiary does not pay it. However, certain third-party payments will count as the beneficiary's own out-of-pocket spending, including amounts reimbursed by insurance (which is not the case through 2024). The low-income subsidies currently provided under Part D and from State Pharmacy Assistance programs will continue to count toward the out-of-pocket amount.

  iv. In addition, and also beginning in 2025, the cost coverage distribution during the catastrophic coverage phase will change (from the distribution in 2024, which was previously described). Specifically, (i) Medicare's share will decrease from 80 percent (for all covered prescription drugs) to 20 percent for applicable drugs and to 40 percent for non-applicable drugs; (ii) drug manufacturers[6] will be required, in general, to provide a 20-percent discount on applicable drugs (whereas no manufacturer discount is required in the catastrophic phrase prior to 2025); and (iii) the 20-percent share borne by Part D plans will increase to 60 percent.

  v. Starting in 2025, all enrollees will have the option from their Part D plans to pay out-of-pocket costs spread out in capped, monthly amounts over the plan year (instead of paying as the costs are incurred).

4 Originally, when the Part D program began, the beneficiary had to pay the full cost of prescription drugs while in this phase (hence the term *coverage gap*). However, legislation enacted in 2010 and 2018 phased down the out-of-pocket cost-sharing percentage for beneficiaries in the coverage gap over the period 2010–2020 such that, beginning in 2020, the coverage gap was fully closed, with the beneficiary responsible for 25 percent of all prescription drug costs (that is, the same percentage that is paid by the beneficiary during the initial coverage phase, when the beneficiary has met the deductible but has not yet reached the initial coverage limit).

5 For most applicable drugs, the 10-percent responsibility will be paid by the manufacturer, but for selected drugs there will be a government subsidy for this amount rather than a manufacturer discount. Additionally, for low-income beneficiaries and for small biotech drugs, this amount will be phased in gradually.

6 For most applicable drugs, the 20-percent responsibility will be paid by the manufacturer, but for selected drugs there will be a government subsidy for this amount rather than a manufacturer discount. Additionally, for low-income beneficiaries and for small biotech drugs, this amount will be phased in gradually.

- For each of plan years 2024–2029, the base beneficiary premium increase is to be limited to no more than 6 percent from the prior year. Premiums for some Part D plans may increase by more than 6 percent per year during this period, but the national average is constrained. For plan years 2030 and later, CMS may determine a new beneficiary premium percentage, based on the 2029 constrained premiums, to replace the current value of 25.5 percent. This new percentage may not be less than 20 percent.
- Effective January 1, 2024, Part D low-income subsidies are expanded. Specifically, (i) the income limit for individuals to qualify for the full subsidy will increase from 135 percent to 150 percent of the Federal poverty level (FPL) (whereas, previously, individuals with incomes between 135 percent and 150 percent of the FPL had been eligible for only a partial subsidy); and (ii) the limit on resources required for the full subsidy will also increase (from the limit that had been in place for the partial subsidy, which will no longer exist).
- Effective January 1, 2023, Part D plans may not apply a deductible, coinsurance, or other enrollee cost-sharing amount for Part D-covered adult vaccines recommended by the Advisory Committee on Immunization Practices, such as the shingles (herpes zoster) vaccine. (By comparison, preventive vaccines required by statute to be covered under Part B already have no enrollee cost sharing, except for those vaccines used to treat an injury or exposure to a disease.)

The *Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023* (Public Law 117-180, enacted on September 30, 2022) included provisions that affect the HI and SMI programs.

- Medicare inpatient hospital add-on payments for certain low volume hospitals (those with fewer than 3,800 total discharges annually and located 15 road miles or more from the nearest like hospital) were extended through December 16, 2022 (from September 30, 2022). The sliding scale used to determine the add-on percentages is also extended.
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after September 30, 2022, was extended through December 16, 2022. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals, in light of what had been the impending expiration of the MDH program, may decline this reclassification and reinstate their MDH status.)

The *Further Continuing Appropriations and Extensions Act, 2023* (Public Law 117-229, enacted on December 16, 2022) included provisions that affect the HI and SMI programs.

- Medicare inpatient hospital add-on payments for certain low-volume hospitals (those with fewer than 3,800 total discharges annually and located 15 road miles or more from the nearest like hospital) were extended through December 23, 2022 (from December 16, 2022). The sliding scale used to determine the add-on percentages is also extended. (See Public Law 117-180.)
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after December 16, 2022 (as described under Public Law 117-180), was extended through December 23, 2022. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals, in light of what had been the impending expiration of the MDH program, may decline this reclassification and reinstate their MDH status.)

The *Consolidated Appropriations Act, 2023* (Public Law 117-328, enacted on December 29, 2022) 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 2032 (which, for sequestration purposes, covers April 1, 2032 through March 31, 2033). The benefit payment reductions for this newly added 12-month period are set at 2 percent for the first 6 months and 0 percent for the final 6 months. In addition, the benefit payment reductions for fiscal years 2030 and 2031 (covering April 1, 2030 through March 31, 2032) are changed back to a uniform 2 percent for the entire period (from 2.25 percent, 3 percent, 4 percent, and 0 percent for the first, second, third, and final 6-month periods, respectively).
- The 1-percent add-on payment is extended for 1 year (through December 31, 2023) for those home health agencies that serve beneficiaries in rural areas and that are classified in the low-population-density tier. (This tier is one of three used for determining rural add-on adjustments. The tiers are based on Medicare home health utilization and population density.)
- Medicare inpatient hospital add-on payments for certain low-volume hospitals (those with fewer than 3,800 total discharges annually and located 15 road miles or more from the nearest like hospital) are extended through September 30, 2024 (from December 23, 2022). The sliding scale used to determine the add-on percentages is also extended. (See Public Law 117-229.)
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after December 23, 2022 (as described under Public Law 117-229), is extended through September 30, 2024. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals, in light of what had been the impending expiration of the MDH program, may decline this reclassification and reinstate their MDH status.)
- Beginning in 2026, an additional 200 Medicare graduate medical education (GME) residency positions are provided for, half of which are to be reserved for psychiatry and psychiatry-subspecialty residencies.

- In the formula for determining payment rates under the physician fee schedule, the updates to the conversion factor are changed to be −0.5 percent, −1.2 percent, and −1.2 percent in 2023, 2024, and 2025, respectively (replacing −2.9 percent for 2023 and 0 percent for 2024 and 2025).
- Certain ground ambulance add-on payments that had been extended through December 31, 2022 under previous legislation are now extended through December 31, 2024. These add-on payments include a 3-percent bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.
- For physicians participating in advanced alternative payment models, a 1-year extension of incentive payment availability is provided, but the payments will be at 3.5 percent. (In recent years, physicians could earn a 5-percent incentive payment, but only through the end of performance year 2022, which is payment year 2024.) In addition, the current freeze on participation thresholds that must be met to qualify for the incentive payments is extended for an additional year (that is, for payment year 2025, which is performance year 2023).
- 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 2024 (instead of the first quarter of 2023). 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 2022–2023 and 15 percent for 2024–2026 (as opposed to the previous statutory parameters of 0 percent for 2021–2022 and 15 percent for 2023–2025). That is, tests furnished under the fee schedule during 2022–2023 are to be paid at the same rates as under the 2021 fee schedule, and payments may not be reduced by more than 15 percent for services provided during 2024–2026.
- Marriage and family therapists and mental health counselors are allowed to receive payment from Part B for providing covered mental health services to beneficiaries, beginning January 1, 2024. (The qualifications for these professions are defined in the provision.)
- Effective January 1, 2024, Medicare's partial hospitalization benefit (which provides a structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care) is revised to provide coverage of intensive outpatient services.
- The use of blended payment rates for durable medical equipment in certain non-competitive bid areas, as provided for during the public health emergency by Public Law 116-136, is extended through December 31, 2023.
- Compression garments furnished on or after January 1, 2024 for the treatment of lymphedema are covered under Part B as durable medical equipment.

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 much lower for Part B and Part D. Overall, these changes increased the present value of the estimated future net cash flow by $1 billion.

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 was 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.

NOTE 16:

BUDGET AND ACCRUAL RECONCILIATION

(Dollars in Millions)

as of September 30, 2023	Intragovernmental	Other than Intragovernmental	Total
NET COST OF OPERATIONS (SNC)	$1,293	$1,498,336	$1,499,629
Components of net cost not part of the budgetary outlays			
Property, plant, and equipment depreciation expense		$(978)	$(978)
Applied overhead/cost capitalization offset		663	663
		(315)	(315)
Increase/(Decrease) in Assets:			
Accounts receivable, net	$99	$(1,169)	$(1,070)
Securities and investments	128		128
Advances and Prepayments		6,112	6,112
Other assets		22	22
	$227	$4,965	$5,192
(Increase)/Decrease in Liabilities:			
Accounts payable	$(208)	$(150)	$(358)
Benefits due and payable		(18,367)	(18,367)
Federal employee and veteran benefits payable		(3)	(3)
Debt associated with loans	4,984		4,984
Accrued Grant Liabilities		(2)	(2)
Contingencies and Commitments		(11,605)	(11,605)
Other Liabilities	(1)	(2,093)	(2,094)
	$4,775	$(32,220)	$(27,445)
Other Financing Sources:			
Imputed Cost	$(75)		$(75)
Transfers out (in) without reimbursement	$3,457		$3,457
Total Components of net operating cost not part of the budgetary outlays	$8,384	$(27,570)	$(19,186)
Miscellaneous Items			
Custodial/Non-exchange revenue	$(10,546)	$1,218	$(9,328)
Non-entity activity	3		3
Appropriated receipts for Trust/Special Funds		9,418	9,418
Reconciling items:			
Debt	(4,984)		(4,984)
Custodial/Non-exchange revenue	10,546	(1,218)	9,328
Investment interest receivable	(128)		(128)
Other reconciling items	(1,341)	850	(491)
Total Other Reconciling Items	$(6,450)	$10,268	$3,818
Total Net Outlays	$3,227	$1,481,034	$1,484,261

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

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 long term sustainability and financial condition of the Medicare program and a discussion of trends revealed in the data.

RSI material is generally drawn from the *2023 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.

With two exceptions, the projections are based on the current law provisions of the *Social Security Act*. The first exception is that the Part A projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted. The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November of 2020, is not reflected in the Part D projections. This final rule imposed a January 1, 2022, effective date; however, implementation was initially delayed until January 1, 2023. Since then, enacted legislation has three times imposed a moratorium on implementation, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The Medicare projections have been significantly affected by the enactment of the *Inflation Reduction Act of 2022* (IRA). This legislation has wide-ranging provisions, including those that restrain price growth and negotiate drug prices for certain Part B and Part D drugs and that redesign the Part D benefit structure to decrease beneficiary out-of-pocket costs. The law takes several years to implement, resulting in very different effects by year. The Part D benefit enhancements are implemented by 2025, for example, before the negotiation provisions that are effective in 2026 can have any spending reduction impact. The total effect of the IRA is to reduce government expenditures for Part B, to increase expenditures for Part D through 2030, and to decrease Part D expenditures beginning in 2031. Part B savings are due to the substantial lowering of payments, relative to current reimbursement, as a result of negotiated prices. Part D ultimately generates cost savings at the end of the 10 year period, but many of the gains from negotiated prices and lower trends are initially more than offset by increased benefits and decreased manufacturer rebates.

The Board of Trustees assumes that the IRA will affect the ultimate long-range growth rates for Part B and Part D drug spending differently. For Part B drugs, since the Trustees do not anticipate that the market pricing dynamics will be much different from those prior to the implementation of the IRA, they continue to assume that per capita spending growth rates will be similar to those for overall per capita national health expenditures. On the other hand, for Part D drugs, the Trustees assume that per capita spending will grow 0.2 percentage point more slowly than per capita national health expenditures, since the inflation provisions of the IRA are likely to result in a trend rate that is lower than, and price growth that is closer to, the Consumer Price Index (CPI).

Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic. 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, and the use of telehealth was greatly expanded. More than offsetting these additional costs in 2020, spending for non-COVID-19 care declined significantly.

Actual fee-for-service per capita spending has been consistently below the pre-pandemic projections throughout the public health emergency, even into 2022 as the pandemic had diminishing effects on much of the economy and the healthcare delivery system. A number of factors have contributed to this lower spending, including the net effects of (i) lower average morbidity among the surviving population from COVID-19-related deaths; (ii) a greater share of dual-eligible beneficiaries enrolling in the Medicare Advantage program; and (iii) the shift of joint replacement procedures from an inpatient to an outpatient setting. These reductions are partially offset by certain public health emergency policies.

While these factors account for a significant amount of the difference between actual and expected experience for many of the categories, others are still largely unexplained. For inpatient hospital, outpatient hospital, and skilled nursing facility spending, these unexplained differences are expected to be eliminated by 2024; for home health agency services, they are expected to be gradually eliminated by 2026.

It should be noted that there is an unusually large degree of uncertainty with the COVID-19-related impacts and that future projections could change significantly as more information becomes available. 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 $67.2 billion from the HI trust fund and $40.1 billion from the SMI Part B trust fund account. As of January 1, 2023, roughly 99 percent of these amounts have been repaid. The Trustees assumed in their report that the remaining balance would be fully repaid or converted to an extended repayment schedule by March of 2023.

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 negative in 2024 and 2025. Furthermore, additional payments totaling $500 million per year to one group of physicians and annual bonuses to another group are scheduled to expire in 2025 and 2026, respectively. 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 August 2, 2011), as amended by the American Taxpayer Relief Act of 2012 (Public Law 112-240, enacted on January 2, 2013); the Continuing Appropriations Resolution, 2014 (Public Law 113-67, enacted on December 26, 2013); Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014; the Protecting Access to Medicare Act of 2014 (Public Law 113-93, enacted on April 1, 2014); the Bipartisan Budget Act of 2015 (Public Law 114-74, enacted on November 2, 2015); 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); the Protecting Medicare and American Farmers from Sequester Cuts Act (Public Law 117-71, enacted on December 10, 2021); and the Consolidated Appropriations Act, 2023 (Public Law 117-328, enacted on December 29, 2022).

The sequestration reduces benefit payments by the following percentages: 2 percent from April 1, 2013 through April 30, 2020; 1 percent from April 1, 2022 through June 30, 2022; and 2 percent from July 1, 2022 through September 30, 2032. Because of sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013 through September 30, 2032, 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 physician payment updates would transition from current law[3] to payment updates that reflect the Medicare Economic Index; and (iii) the bonuses for qualified physicians in APMs, which are expected to end after 2025, and the $500 million payments for physicians in the MIPS, which are set to expire after 2024, would both continue indefinitely. The difference between the illustrative

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).

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.

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 (410-786-6386) 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 five 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 agency, and hospice. The primary Part B services affected are outpatient hospital, home health agency, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year cost growth rates for these provider services start at 3.7 percent in 2047, or GDP plus 0.1 percent, declining gradually to 3.4 percent in 2097, 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 3.3 percent in 2047, or GDP minus 0.3 percent, to 2.9 percent in 2097, or GDP minus 0.8 percent.

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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 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 2.9 percent in 2047, or GDP minus 0.7 percent, to 2.6 percent in 2097, or GDP minus 1.1 percent.

iv ***The remaining Part B services, which consist mostly of physician-administered drugs, laboratory tests, and small facility services.***

The Trustees assume that per beneficiary outlays for these other Part B services, which constitute about 33 percent of total Part B expenditures in 2032, grow at the same rate as the overall health sector as determined from the factors model. The services are assumed to grow similarly because their payments are established through market processes. For physician-administered Part B drugs, the key inflation provisions in the IRA are not anticipated to affect such payments over the long range. The corresponding year-by-year cost growth rates decline from 4.4 percent in 2047, or GDP plus 0.8 percent, to 4.1 percent by 2097, or GDP plus 0.4 percent.

v ***Prescription drugs provided through Part D.***

Medicare payments to Part D plans are based on a competitive-bidding process, and prior to the IRA these payments were assumed to grow at the same rate as the overall health sector as determined from the factors model. While the negotiation provisions of the IRA are not anticipated to affect the long-range growth rates for Part D drugs, the inflation provisions would likely lower these trends relative to previous expectations. Specifically, the IRA requires the change in prices (before rebate adjustments) to be limited to the rate of growth in the CPI. Analysis of Part D pricing trends over recent years has consistently shown price growth in excess of the CPI, with a portion of these trends offset by increasing rebate percentages, and in prior reports it was assumed that such trends would continue over the long range. The inflation provisions in the IRA would likely lower these price trends, though it is expected that they would outpace the CPI due to certain manufacturer adaptations to the new law that may mitigate some of the pricing constraints, including new approaches regarding the development and release of new drugs. As a result, they are assumed to grow over the long range slightly more slowly than would be the case if they were determined strictly through market processes. The corresponding year-by-year cost growth rates decline from 4.2 percent in 2047, or GDP plus 0.6 percent, to 3.9 percent by 2097, or GDP plus 0.2 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.[7] This is particularly the case for Part A services—such as inpatient hospital, skilled nursing facility, and home health agency 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 2047, or GDP plus 0.2 percent, declining to 3.7 percent by 2097, or GDP plus 0.0 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 2047, declining to 3.6 percent, or GDP plus 0.1 percent by 2097.

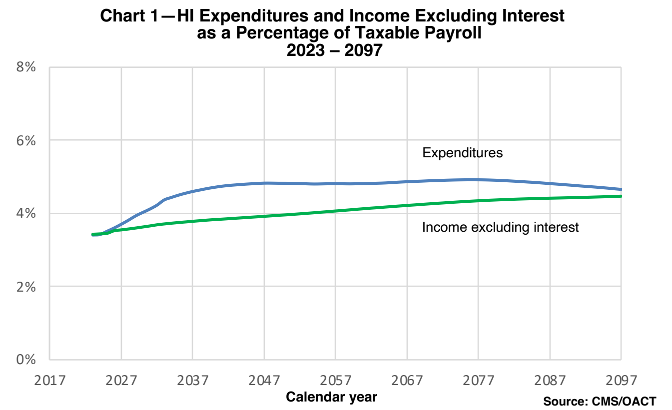
HI Cash Flow as a Percentage of Taxable Payroll

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 2032 due to updated expectations for healthcare spending following the COVID-19 pandemic and (ii) higher taxable payroll in most years resulting from the changing economic and demographic assumptions.

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 2023 Medicare Trustees Report.

7 More information on the TTD adjustment is available on the CMS website.



Since the standard HI payroll 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 (C-CPI-U), which increases at a slower rate than average wages. After 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.[8] Thus, as chart 1 shows, the income rate is expected to gradually increase over current levels.

In 2023 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 0.5 percent through 2032 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 5.2 percent in 2048 and 7.0 percent in 2097.

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

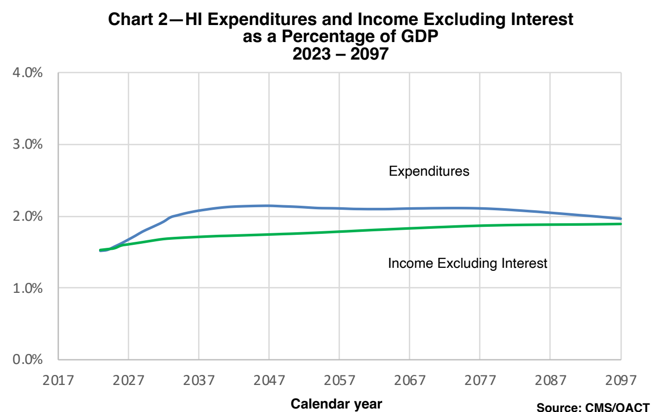


Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2022, the expenditures were $342.7 billion, which was 1.3 percent of GDP.

As chart 2 illustrates, this percentage is projected to increase steadily until about 2046 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.0 percent in 2097.

8 See section V.C7 of the 2023 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.

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 government contributions, which are transfers from the general fund of the Treasury.

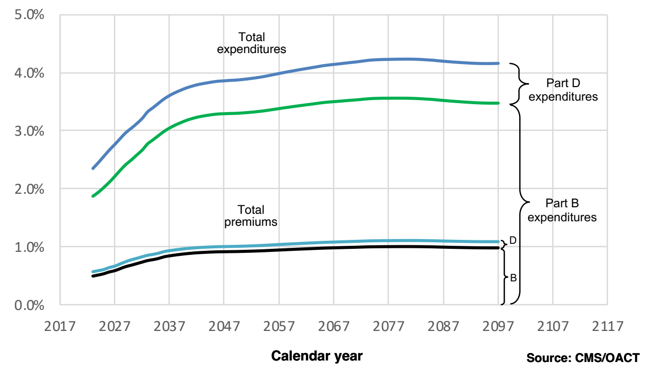


Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the longrange assumption described previously.

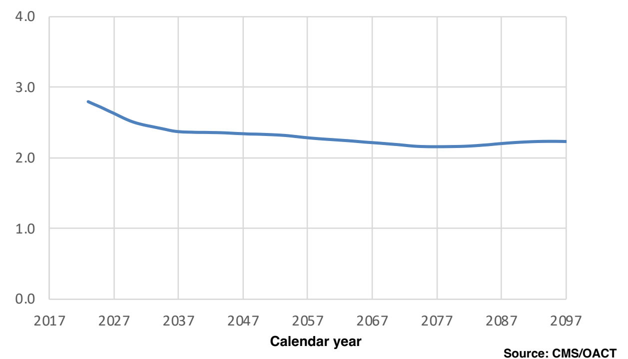
In 2022, SMI expenditures were $562.4 billion, or about 2.2 percent of GDP. Under current law, they would grow to about 3.9 percent of GDP within 25 years and to 4.2 percent by the end of the projection period, as demonstrated in chart 3. Under the illustrative alternative, total SMI expenditures in 2097 would be 5.3 percent of GDP.

To match the faster growth rates for SMI expenditures, government contributions and beneficiary premiums 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 2022 by about 4.2 percent annually. The associated beneficiary premiums—and general fund financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. State payments have increased faster than GDP for almost every year since 2015 and are projected to do so for most of the long-range period; for most of the short-range period, however, they are projected to increase more slowly than GDP.

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 2022, 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 2097.

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

For this analysis, the intermediate economic and demographic assumptions in the 2023 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, 2023 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.

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

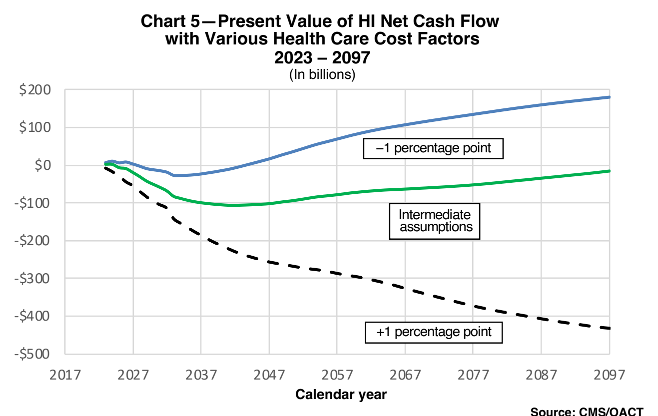
Present Value of Estimated HI Income Less Expenditures under Various Healthcare Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	−1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$5,601	−$4,630	−$21,021

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by approximately $10,230 billion. On the other hand, if the ultimate growth rate assumption is approximately 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by about $16,392 billion.

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

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



9 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.

10 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.

Real-Wage Growth

Table 2 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage growth assumptions: 0.54, 1.14, and 1.74 percentage points.[11] In each case, the assumed ultimate annual increase in the CPI is 2.4 percent.

TABLE 2

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

Ultimate percentage increase in real-wage growth	0.54	1.14	1.74
Income minus expenditures (in billions)	–$7,186	–$4,630	–$850

As indicated in table 2, for a half-point increase in the ultimate real wage growth assumption, the deficit—expressed in present-value dollars—decreases by approximately $3,150 billion. Conversely, for a half-point decrease in the ultimate real-wage growth assumption, the deficit increases by about $2,130 billion.

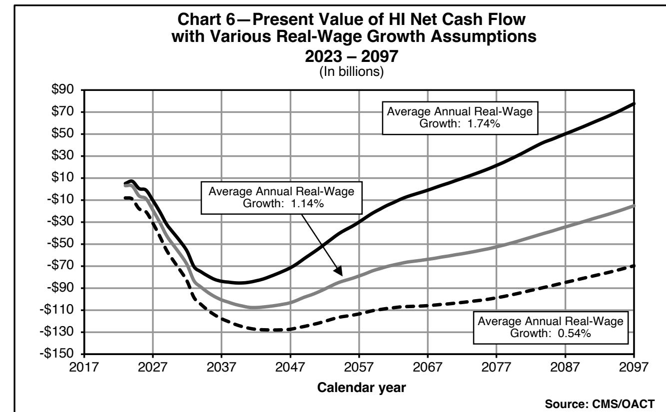


Chart 6 shows projections of the present value of the estimated net cash flow under the three alternative real-wage growth assumptions presented in table 2.

When expressed in present-value dollars, faster real-wage growth results in smaller HI cash flow deficits, as demonstrated in chart 6. Higher real-wage growth 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.

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 ultimate real-wage growth assumption is 1.14 percent.

TABLE 3

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

Ultimate percentage increase in CPI	3.00	2.40	1.80
Income minus expenditures (in billions)	–$3,383	–$4,630	–$6,208

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.0 percent, the deficit decreases by $1,247 billion. On the other hand, if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by about $1,579 billion.

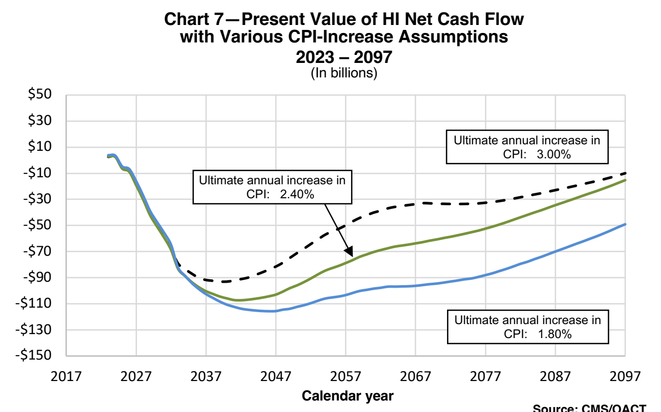


Chart 7 shows projections of the present value of net cash flow under the three alternative CPI rate-of-increase assumptions presented in table 3.

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

11 Real-wage growth is the annual percentage change in average covered wages adjusted for the average percentage change in the CPI.

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.

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.

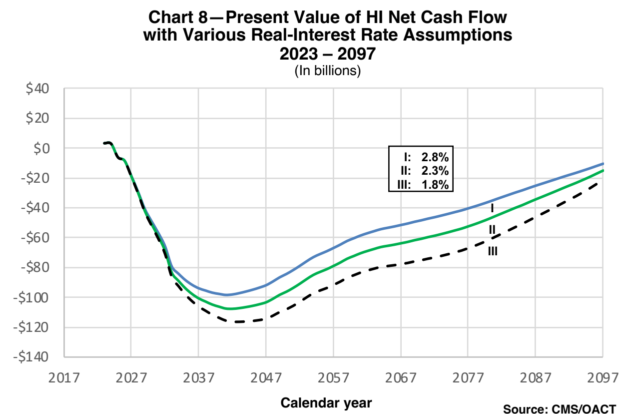
TABLE 4

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)	–$5,374	–$4,630	–$3,963

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 2031. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Fertility Rate

Table 5 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.69, 1.99, and 2.19 children per woman.

TABLE 5

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

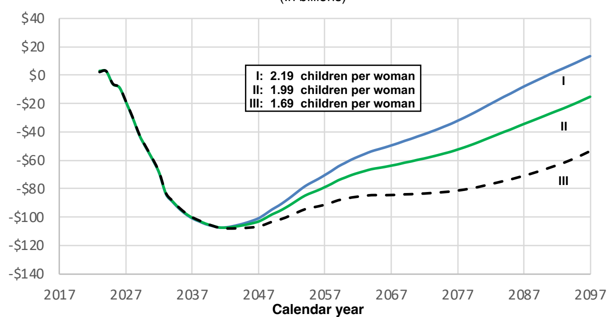
Ultimate fertility rate[1]	1.69	1.99	2.19
Income minus expenditures (in billions)	–$5,845	–$4,630	–$3,764

[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 $420 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.



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: 845,000 persons, 1,277,000 persons, and 1,732,000 persons per year.

TABLE 6

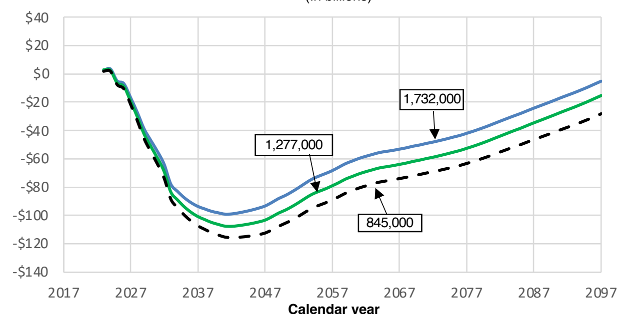
Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	845,000	1,277,000	1,732,000
Income minus expenditures (in billions)	**–$5,316**	**–$4,630**	**–$3,962**

As indicated in table 6, if the average annual net immigration assumption is 845,000 persons, the deficit—expressed in present-value dollars—increases by approximately $687 billion. Conversely, if the assumption is 1,732,000 persons, the deficit decreases by about $667 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.



Trust Fund Finances and Sustainability

HI

The short-range financial outlook for the HI trust fund is more favorable than the projections in last year's Medicare Trustees Report. The estimated depletion date for the HI trust fund is 2031, 3 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 through the short-range period mainly as a result of updated expectations for healthcare spending following the COVID-19 pandemic.

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 resulted in a larger surplus in 2022 of $53.9 billion. The Trustees project

deficits beginning in 2025 and continuing until the trust fund becomes depleted in 2031. 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 fund 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[12] will exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2023–2029). For the 2023 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 2025 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 2022 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 2023 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 to expeditiously address these challenges."

12 Dedicated Medicare financing sources used in this year's determination include HI payroll taxes; income from taxation of Social Security benefits; State payments 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, 2023

(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)	$1,896	$2,411	$91	$174,067	$52,602	$34,429	$19,596	$1,687	$286,779
Appropriations (discretionary and mandatory)	419,527	508,949	117,765	593,015	606,028	28,289	12,399	(8)	2,285,964
Borrowing authority (discretionary and mandatory)									
Spending authority from offsetting collections (discretionary and mandatory)			(2,543)		1,587		2,635	4,593	6,272
TOTAL BUDGETARY RESOURCES	$421,423	$511,360	$115,313	$767,082	$660,217	$62,718	$34,630	$6,272	$2,579,015
STATUS OF BUDGETARY RESOURCES:									
New Obligations and upward adjustments	$421,423	$511,360	$113,706	$505,137	$660,166	$18,995	$16,081	$4,911	$2,251,779
Unobligated balance, end of year									
Apportioned, unexpired accounts				80,067	50	24,437	14,808	90	119,452
Exempt from Apportionment, unexpired accounts			1,607						1,607
Unapportioned, unexpired accounts				7,811	1	1,819	3,497	26	13,154
Unexpired unobligated balance, end of year			1,607	87,878	51	26,256	18,305	116	134,213
Expired unobligated balance, end of year				174,067		17,467	244	1,245	193,023
Unobligated balance, end of year (total)			1,607	261,945	51	43,723	18,549	1,361	327,236
TOTAL BUDGETARY RESOURCES	$421,423	$511,360	$115,313	$767,082	$660,217	$62,718	$34,630	$6,272	$2,579,015
OUTLAYS, NET:									
Outlays, net (discretionary and mandatory)	$407,111	$497,949	$116,815	$480,201	$610,833	$17,897	$11,686	$(223)	$2,142,269
Distributed offsetting receipts	(54,478)	(602,492)				(679)	(359)		(658,008)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	$352,633	$(104,543)	$116,815	$480,201	$610,833	$17,218	$11,327	$(223)	$1,484,261
DISBURSEMENTS, NET							$(70)		$(70)

SUPPLEMENTARY INFORMATION

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

CONSOLIDATING BALANCE SHEET

as of September 30, 2023

(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	$(543)	$281,079	$51,588	$70,883	$26,910	$675	$430,592		$430,592
Investments, Net	195,575	160,354					355,929		355,929
Accounts Receivable, Net	60,882	57,387	1,948		2,225	4,330	126,772	$(126,138)	634
Total intragovernmental	**255,914**	**498,820**	**53,536**	**70,883**	**29,135**	**5,005**	**913,293**	**(126,138)**	**787,155**
Other than intragovernmental:									
Accounts Receivable, net	1,039	23,516	6,578	138	7,309		38,580		38,580
General Property, Plant & Equipment, Net	432				681	1,229	2,342		2,342
Advances and Prepayments	15,484	29,635					45,119		45,119
Other Assets			31		501		532		532
Total Other than Intragovernmental	16,955	53,151	6,609	138	8,491	1,229	86,573		86,573
TOTAL ASSETS	**$272,869**	**$551,971**	**$60,145**	**$71,021**	**$37,626**	**$6,234**	**$999,866**	**$(126,138)**	**$873,728**
LIABILITIES									
Intragovernmental:									
Accounts Payable	$65,432	$62,480			$1	$38	$127,951	$(126,051)	$1,900
Debt		2,854			418		3,272		3,272
Other Liabilities					202	6	208	(87)	121
Total Intragovernmental	**65,432**	**65,334**			**621**	**44**	**131,431**	**(126,138)**	**5,293**
Other than Intragovernmental:									
Accounts Payable	87	86			141	195	509		509
Entitlement Benefits Due and Payable	54,551	51,669	$52,028	$1,295			159,543		159,543
Other Liabilities									
Contingencies and Commitments	10,400		8,160				18,560		18,560
Other	245	1,623			13,607	85	15,560		15,560
Total Other than Intragovernmental	65,283	53,378	60,188	1,295	13,748	280	194,172		194,172
TOTAL LIABILITIES	**$130,715**	**$118,712**	**$60,188**	**$1,295**	**$14,369**	**$324**	**$325,603**	**$(126,138)**	**$199,465**
NET POSITION									
Unexpended Appropriations-Funds from Dedicated Collections	$1,833	$269,768			$3,538	$168	$275,307		$275,307
Unexpended Appropriations-Funds from Other than Dedicated Collections			$1,508	$68,312	11,508		81,328		81,328
Total Unexpended Appropriations	**1,833**	**269,768**	**1,508**	**68,312**	**15,046**	**168**	**356,635**		**356,635**
Cumulative Results of Operations-Funds from Dedicated Collections	140,321	163,491			8,024	5,742	317,578		317,578
Cumulative Results of Operations-Funds from Other than Dedicated Collections			(1,551)	1,414	187		50		50
Total Cumulative Results of Operations	**140,321**	**163,491**	**(1,551)**	**1,414**	**8,211**	**5,742**	**317,628**		**317,628**
TOTAL NET POSITION	**$142,154**	**$433,259**	**$(43)**	**$69,726**	**$23,257**	**$5,910**	**$674,263**		**$674,263**
TOTAL LIABILITIES AND NET POSITION	**$272,869**	**$551,971**	**$60,145**	**$71,021**	**$37,626**	**$6,234**	**$999,866**	**$(126,138)**	**$873,728**

CONSOLIDATING STATEMENT OF NET COST

for the year ended September 30, 2023

(in millions)

	Program	Program Management	Intra-CMS Eliminations	Total
Medicare HI				
Benefit/Program Expenses	$414,537			$414,537
Operating Expenses	2,026	$1,419		3,445
Total Cost	416,563	1,419		417,982
Less: Earned Revenues	(4,765)	(8)		(4,773)
Net Cost Medicare HI	$411,798	$1,411		$413,209
Medicare SMI				
Benefit/Program Expenses (Part B)	$493,297			$493,297
Benefit Expenses (Part D)	95,993			95,993
Operating Expenses	171	$3,094	$2	3,267
Total Cost	589,461	3,094	2	592,557
Less: Earned Revenues	(136,929)	(34)		(136,963)
Net Cost Medicare SMI	$452,532	$3,060	$2	$455,594
Medicaid				
Benefit/Program Expenses	$610,959			$610,959
Operating Expenses	10	$198		208
Total Cost	610,969	198		611,167
Less: Earned Revenues		(2)		(2)
Net Cost Medicaid	$610,969	$196		$611,165
CHIP				
Benefit/Program Expenses	$17,922			$17,922
Operating Expenses	1	$22		23
Total Cost	17,923	22		17,945
Less: Earned Revenues				
Net Cost CHIP	$17,923	$22		$17,945
Other				
Program Expenses	$13,986			$13,986
Operating Expenses	273	$624		897
Total Cost	14,259	624		14,883
Less: Earned Revenues	(13,158)	(7)	$(2)	(13,167)
Net Cost Other	$1,101	$617	$(2)	$1,716
NET COST OF OPERATIONS	$1,494,323	$5,306		$1,499,629

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2023

(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	**$1,477**	**$173,397**	**$3,577**	**$253**	**$178,704**	**$3,207**	**$59,814**	**$12,164**	**$75,185**	**$253,889**
Budgetary Financing Sources:										
Appropriations Received	36,683	556,736	121	3	593,543	689,322	27,040	605	716,967	**1,310,510**
Appropriations Transferred-in/out						(5,205)		(26)	(5,231)	**(5,231)**
Other Adjustments		(19,035)		(12)	(19,047)	(78,076)	(619)	(7)	(78,702)	**(97,749)**
Appropriations Used	(36,327)	(441,330)	(160)	(76)	(477,893)	(607,740)	(17,923)	(1,228)	(626,891)	**(1,104,784)**
Change in Unexpended Appropriations	**356**	**96,371**	**(39)**	**(85)**	**96,603**	**(1,699)**	**8,498**	**(656)**	**6,143**	**102,746**
Total Unexpended Appropriations: Ending Balance	**$1,833**	**$269,768**	**$3,538**	**$168**	**$275,307**	**$1,508**	**$68,312**	**$11,508**	**$81,328**	**$356,635**
CUMULATIVE RESULTS OF OPERATIONS										
Beginning Balances	**$150,427**	**$174,042**	**$7,693**	**$6,442**	**$338,604**	**$92**	**$735**	**$219**	**$1,046**	**$339,650**
Appropriations used	36,327	441,330	160	76	477,893	607,740	17,923	1,228	626,891	**1,104,784**
Nonexchange Revenue:										
FICA and SECA taxes	362,511				362,511					**362,511**
Interest on investments	5,487	4,381			9,868		679		679	**10,547**
Other	398	2,835			3,233					**3,233**
Transfers-in/out without reimbursement	(3,037)	(6,565)	82	4,477	(5,043)	1,586			1,586	**(3,457)**
Imputed financing	6		7	53	66			8	8	**74**
Other								(85)	(85)	**(85)**
Net Cost of Operations	**411,798**	**452,532**	**(82)**	**5,306**	**869,554**	**610,969**	**17,923**	**1,183**	**630,075**	**1,499,629**
Net Change in Cumulative Results of Operations	**(10,106)**	**(10,551)**	**331**	**(700)**	**(21,026)**	**(1,643)**	**679**	**(32)**	**(996)**	**(22,022)**
Cumulative Results of Operations: Ending Balance	**$140,321**	**$163,491**	**$8,024**	**$5,742**	**$317,578**	**$(1,551)**	**$1,414**	**$187**	**$50**	**$317,628**
Net Position	**$142,154**	**$433,259**	**$11,562**	**$5,910**	**$592,885**	**$(43)**	**$69,726**	**$11,695**	**$81,378**	**$674,263**

BUSINESS ACCOUNTING

AUDIT REPORTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

November 7, 2023

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

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

SUBJECT: *Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2023*, A-17-23-53000

This memo transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2023 financial statements, internal controls over financial reporting, 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, 2023 and 2022, 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, 2023, 2022, 2021, 2020, and 2019, 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 24-01, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2023 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, 2023, 2022, 2021, 2020, and 2019, and the related statements of changes in social insurance amounts for the periods ended January 1, 2023, and 2022. 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.

Page 2—Chiquita Brooks-LaSure

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 the following areas merit continued focus as part of the financial reporting processes.

- Limitations as to the reliability of the information contained within the Transformed Medicaid Statistical Information System requires additional verification before it would be considered reliable to use in the financial accounting and reporting for the Medicaid program, and specifically in Medicaid Entitlement Benefits Due and Payable (EBDP) with regard to estimation of the accrual and look-back of prior year estimates.

- As it relates to the Medicare EBDP estimate, specifically the portion related to retroactive cost report settlements, there are additional limitations with the data available and the ability to evaluate this data in a precise manner, which limits the ability by the actuaries to perform further analysis to evaluate whether a change in methodology or refinements of the data were necessary to develop a reasonable Medicare EBDP estimate.

- Verification of the completeness and accuracy of the information produced by the entity when completing the calculation of the return of indefinite authority was also flagged as an area of focus.

  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. Weaknesses in the monitoring or recertification of privileged access for key applications and underlying information technology infrastructure was not consistently performed, and/or evidence of such monitoring or recertification activity was not retained. In addition, CMS did not consistently follow logical access control procedures related to the timely removal of access for terminated personnel supporting CMS. 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 2023, CMS was not in full compliance with the requirements of the Payment Integrity Information Act of 2019 (PIIA P.L. No. 116-117). The Children's Health Insurance Program reported an error rate in excess of 10 percent. The CMS error rate reflects reviews that accounted for certain flexibilities afforded the States during the public health emergency (PHE), such as postponed eligibility requirements around provider enrollment or revalidations that were typically included in the Payment Error Rate Measurement reviews prior to the COVID-19 PHE. CMS works closely with States to develop State-specific corrective plans to reduce improper

payments. CMS was also not in full compliance with PIIA as recovery activities of the identified improper payments for the Part C are delayed.

CMS reported an error rate of 0.58 percent for the Federally Facilitated Exchange component of the Advance Payment Tax Credit program, however it has not calculated and reported an improper payment estimate for the State-based Exchanges. Previously, CMS management was notified during prior FYs that it may have potential violations of the Federal Acquisition Regulation related to contracting matters. CMS was also previously notified of potential violations of the Anti-Deficiency Act for certain contract obligations related to FYs 2014 and 2015. Ernst & Young disclosed no other instances of noncompliance that must be reported under *Government Auditing Standards* and OMB Bulletin 24-01.

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-17-23-53000.

Page 4—Chiquita Brooks-LaSure

Attachment

cc:
Norris Cochran
Acting 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, 2023 and 2022, 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, 2023 and 2022, 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, 2023, 2022, 2021, 2020, and 2019, and the related statement of changes in social insurance amounts for the periods ended January 1, 2023 and 2022, 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 Management and Budget (OMB) Bulletin No. 24-01, *Audit Requirements for Federal Financial*

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Statements. Our responsibilities under those standards and the provisions of OMB Bulletin No. 24-01 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, 2023 and 2022, 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, 2023, 2022, 2021, 2020, and 2019, 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 understatement of projected Medicare costs in future years. The range of the social insurance

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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, 2023, 2022, 2021, 2020 and 2019 and the related statement of changes in social insurance amounts for the periods ended January 1, 2023 and 2022.

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. 24-01 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.

In performing an audit in accordance with GAAS and *Government Auditing Standards* and the provisions of OMB Bulletin No. 24-01, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

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- 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 certain limited procedures to the Management's Discussion and Analysis and other required

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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.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our reports dated November 7, 2023 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

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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, 2023

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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 with the provisions of Office of Management and Budget (OMB) Bulletin No. 24-01, *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, 2023, 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, 2023, and the related statement of changes in social insurance amounts for the period ended January 1, 2023, and the related notes (collectively referred to as the "sustainability financial statements"), and have issued our report thereon dated November 7, 2023. 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 as well as the requirements referred to in the *Federal Financial Management Improvement Act of 1996* (FFMIA), noncompliance with which could have a direct and material effect on the financial statements. 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. 24-01, 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 CHIP improper payment rate 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 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, 2023. 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, 2023 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, 2023

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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 with the provisions of Office of Management and Budget (OMB) Bulletin No. 24-01, *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, 2023, 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, 2023, and the related statement of changes in social insurance amounts for the period ended January 1, 2023, and the related notes (collectively referred to as the "sustainability financial statements"), and have issued our report thereon dated November 7, 2023. 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. We did not consider all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982, such as those controls relevant to preparing performance information and ensuring efficient operations.

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

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies, and therefore, material weaknesses or significant deficiencies may exist, that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. We did identify 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).

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

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.

In prior years, CMS completed the 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. As of the end of fiscal year 2023, while data maintained within T-MSIS is utilized for operational purposes, management has determined that it requires additional verification before it would be considered reliable to utilize in the financial accounting and reporting for Medicaid, and specifically Medicaid EBDP. CMS has continued to take steps to refine the data and continues to evaluate the adequacy of the information within this system. CMS should continue to 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, even if this data ultimately never becomes the basis for the EBDP estimate. 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 continued use of a similar methodology. The Medicaid EBDP is a significant liability on the FY 2023 financial statements and is subject to volatility based on the complexity and judgment required in establishing this estimate. This volatility is inherent in this type of estimate, but could be more pronounced in period of change, such as the current fiscal year due to the ending of the Public Health Emergency (PHE). The lack of detailed claims data limits the ability to detect the impact of such a change, or other changes such as those related to the claims processing timing, on a timely basis or consider the potential impact of these items on the EBDP estimate, 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

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as amounts which may be due/owed to hospitals for adjusted prospective payments. During the current year, an increase in the EBDP liability related to cost report settlements was identified by CMS during their review; however, due to limitations with the data available, further analysis was unable to be performed by the actuaries to evaluate whether a change to the methodology or refinements of the data were necessary to develop a reasonable EBDP estimate. CMS does not currently have detailed claims data nor the ability to accumulate the detailed claims data to evaluate whether outliers existed in the cost report population that should be isolated for the purposes of developing the EBDP estimate. In addition, due to the segregation of parties involved in developing this estimate, the parties exhibited a lack of understanding over the underlying data which limited the actuaries' ability to evaluate the data that existed. 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.

Budgetary Resources

At the end of each fiscal year, CMS is required to return all indefinite authority to Treasury for funding that has not been obligated during the fiscal year. During its year-end close process, CMS processed a return of Medicaid indefinite authority. However, subsequent examination and analysis performed by management prior to the finalization of the financial statements identified an error on the report used as part of the close process, resulting in additional unobligated funding that should have been returned. CMS subsequently processed this additional return as part of the finalization of the FY 2023 financial statements, however controls associated to this process did not initially identify that the information produced by the entity used as part of the performance of this control were not complete and accurate.

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 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.

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Improper Payments

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

CMS remains committed to achieving reductions in all improper payment rates through various corrective actions. CMS has specific initiatives underway to improve results for CHIP, which continues to report improper payment rates above the statutory threshold of 10 percent. The eligibility component of the reported Medicaid and CHIP improper payment rates were significantly impacted by flexibilities afforded by the PHE, such as postponed eligibility determinations and eased requirements around provider enrollment/validations. While the Medicaid improper payment rate for Medicaid fell below the statutory threshold of 10 percent for this reporting year, there is an increased risk that the rate could exceed this 10 percent threshold as these flexibilities expire. In addition, while management continued to implement corrective actions to reduce the Medicare Part C 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 evaluate how the Medicaid claims level data can be refined to analyze trends at a claims level to enable the performance of 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.

- Management should collaborate during fiscal 2024 to determine how the data available can be used, or how additional data can be gathered, to refine the cost report settlement EBDP estimate to gain a complete understanding of the rationale for fluctuations in the available information. When changes are identified in the resulting data used for the estimate, or

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when a large fluctuation results from the output of the calculation, for which management does not have a thorough understanding, further investigation should be performed and data should be analyzed and documented prior to finalizing the estimate.

- Enhance management review controls surrounding the identification and return of unobligated indefinite authority to verify that reports used in the execution of this control are complete and accurate. Consider enhancing fluctuation analyses as part of the overall financial statement review to further investigate unusual balances on a timely basis at year-end.

- 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.

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 Information System Access and Least Privileged 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.

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

- Monitoring and/or recertification of privileged access for key applications and underlying IT infrastructure was not consistently performed, and/or evidence of such monitoring or recertification activity was not retained.
- Logical access control procedures related to the timely removal of access for terminated personnel supporting CMS were not consistently followed.

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

Recommendations

CMS should continue to improve the operating effectiveness of information security access controls to validate that:

- CMS guidance and contractual requirements are followed for the separation of workforce personnel, including the removal of any associated user account for CMS IT systems and/or applications as well as facilities.
- 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.
- User access reviews and recertification of access are being performed timely and by appropriate personnel with the requisite knowledge and experience of the employee access requirements and necessary system functionality.

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, 2023. 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.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 7, 2023 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, 2023

A member firm of Ernst & Young Global Limited

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-01-24
Baltimore, Maryland 21244-1850

November 7, 2023

Ernst & Young, LLP
1201 Wills Street
Suite 310
Baltimore, MD 21231

Dear Sir/Madame:

On behalf of the Centers for Medicare & Medicaid Services, I would like to thank your office for its hard work and professionalism while conducting this year's Chief Financial Officers Act audit. We are pleased with the results of your audit of our fiscal year 2023 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.

We recognize that you are still 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. CMS remains confident that our current law SOSI model projections are fairly presented in accordance with federal government accounting standards, 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.

During fiscal year 2023, CMS made strides in implementing corrective actions to address previously identified deficiencies. While you identified no material weaknesses in our internal controls in this year, you continue to cite significant deficiencies in our financial processes and information systems controls. CMS is committed in establishing effective corrective actions that will strengthen our internal controls and remediate the deficiencies you have noted.
deficiencies you have noted.

The annual financial audit serves as an on We would like to thank you for your continued collaboration in completing the audit efficiently and effectively. We look forward to our continued partnership.

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) OIG audits, and 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 *CFO Act* audit; (7) security assessment and authorization of systems; and (8) Department Enterprise Risk Management efforts. As of September 30, 2023, 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, 2023, with the exception of material non-compliances with: the *Payment Integrity Information Act of 2019* (PIIA), and Section 6411 of the 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 2023 PIIA non-compliance stems from the following:

1. The 2023 Children's Health Insurance Program (CHIP) improper payment estimate was 12.81 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. Despite their success in Medicare FFS, RACs have found Medicare Part C does not represent an appealing business case for them because of differing payment structures, a narrow scope of payment error, and unlimited appeal timeframes. Although CMS has not procured a Part C RAC, CMS's primary corrective action for identifying Medicare Part C payment errors has been the contract-level audits performed under the RADV program. The RADV program is operational with the support of contractors. Given the purpose of RADV audits, CMS believes that the RADV audit program performs Part C RAC functions.

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.

CMS has instituted comprehensive processes that measure improper payments for the Medicare FFS, Medicare Advantage (Part C), Medicare Prescription Drug (Medicare Part D), Medicaid, CHIP, and Advance payment of the Premium Tax Credit (APTC) programs.

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 92.62 percent. This means Medicare paid an estimated $391.78 billion correctly in FY 2023.

The Medicare FFS improper payment estimate for FY 2023 is 7.38 percent or $31.23 billion. The improper payment estimate due to missing or insufficient documentation is 4.91 percent or $20.77 billion, representing 66.51 percent of total improper payments. Improper payments for SNF, hospital outpatient, IRF, and hospice claims were the major contributing factors to the FY 2023 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 ensure 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 and Prescription Drugs

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 2023 is 6.01 percent, or $16.55 billion. The improper payment estimate due to missing or insufficient documentation is 0.01 percent or $0.04 billion, representing 0.24 percent of total improper payments. The estimated percentage of Part C dollars paid correctly was 93.99 percent. This means Part C paid an estimated $259.06 billion correctly in FY 2023.

In FY 2021 and FY 2022, CMS implemented methodology and policy changes which established a new baseline each year. The FY 2023 error rate calculation follows the previously implemented policy changes. FY 2023 and FY 2022 are comparable but not directly comparable to earlier 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 2023 is 3.72 percent, or $3.35 billion. The improper payment estimate due to missing or insufficient documentation is 2.39 percent or $2.16 billion, representing 64.27 percent of total improper payments. The estimated percentage of Part D dollars paid correctly was 96.28 percent. This means Part D paid an estimated $86.72 billion correctly in FY 2023.

In FY 2023, CMS implemented methodology refinements that contributed to an increase in the FY 2023 improper payment rate estimation. Due to the methodology changes introduced in FY 2023, the rates for FY 2022 and FY 2023 are not comparable.

CMS uses data from the improper payment measurement processes to address improper payments in Medicare Part C and D through various corrective actions. Contract-level RADV audits are CMS's primary strategy to recover Part C overpayments. RADV uses medical record reviews to confirm the accuracy of diagnoses submitted by MAOs for risk-adjusted payments. These audits are expected to improve data quality because they incentivize MAOs to provide valid and accurate diagnosis information. CMS also uses activities such as trainings, outreach to plan sponsors for incomplete or invalid documentation, program integrity and other

audits, and investigations to address improper payments in Part C and Part D. CMS believes implementing targeted corrective actions in these areas will prevent and reduce improper payments and reduce the overall improper payment rate.

Medicaid and CHIP

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

The national Medicaid improper payment estimate for FY 2023 is 8.58 percent or $50.33 billion in improper payments based on measurements conducted in FYs 2021, 2022, and 2023. The improper payment estimate due to missing or insufficient documentation is 7.02 percent or $41.19 billion, representing 81.84 percent of total improper payments. The estimated percentage of Medicaid dollars paid correctly was 91.42 percent. This means Medicaid paid an estimated $536.58 billion correctly in FY 2023.

The national improper payment estimate for each Medicaid component is:

- Medicaid FFS: 6.90 percent
- Medicaid managed care: 0.00 percent
- Medicaid eligibility: 5.95 percent

The national CHIP improper payment estimate for FY 2023 is 12.81percent or $2.14 billion in improper payments based on measurements conducted in FYs 2021, 2022, and 2023. The improper payment estimate due to missing or insufficient documentation is 8.72 percent or $1.45 billion, representing 68.05 percent of total improper payments. The estimated percentage of CHIP dollars paid correctly was 87.19 percent. This means CHIP paid an estimated $14.53 billion correctly in FY 2023.

The national improper payment estimate for each CHIP component is:

- CHIP FFS: 7.09 percent
- CHIP managed care: 0.59 percent
- CHIP eligibility: 10.86 percent

The decrease in the FY 2023 national Medicaid and CHIP improper payment estimates reflect: 1) reviews that accounted for certain flexibilities afforded to states during the public health emergency, such as suspended eligibility determinations and reduced requirements around provider enrollment or revalidations which were typically included in the PERM reviews prior to the COVID-19 PHE; and 2) improved state compliance with other program requirements. The FY 2023 national Medicaid and CHIP improper payment data does not capture any effects of the unwinding, as it will be included in future report periods.

The areas driving the FY 2023 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. This includes situations where medical records were either not submitted or were missing required documentation to support the medical necessity of the claim. However, these payments do not necessarily represent payments to ineligible 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, then 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, the payment was improper.
    * During FY 2023, CMS worked with states to independently verify certain situations where the state could not provide documentation to support state actions. This process included CMS independently accessing databases and reviewing submitted eligibility determination information that had been produced after the original claim payment or determination date, to evaluate if a provider or beneficiary would have been eligible to provide or receive goods/services. Of the 330 claims eligible for independent verification, CMS independently verified 92 claims through receipt of verification or access to system information provided by states. Of the 92 claims independently verified, CMS deemed 81 claims technically improper; the payment was to the right recipient for the correct amount, but the payment process did not comply with applicable regulations and statutes. The effect of these independent verifications is reflected as technically improper payments in the reported improper payment rate.

- State Non-Compliance: Represents noncompliance with federal eligibility redetermination requirements; enrolled providers not appropriately screened by the state; providers not enrolled; and/or providers without the required National Provider Identifier (NPI) on the claim. State compliance with provider enrollment or screening requirements has improved as the Medicaid FFS component improper payment estimate decreased from 10.42 percent in FY 2022 to 6.90 percent in FY 2023 and the CHIP FFS component improper payment estimate decreased from 11.23 percent in FY 2022 to 7.09 percent in FY 2023. COVID-19 review flexibilities afforded to states should also be considered in the identified decreases in the Medicaid and CHIP FFS and eligibility components between FY 2022 and FY 2023.
- 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 approximately 21 percent or $0.41billion of total errors cited in CHIP FFS, CHIP managed care, and CHIP eligibility in FY 2023.

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.

APTC

Through the Exchange Improper Payment Measurement Program, CMS measures Advance payment of the Premium Tax Credit (APTC) improper payments. A statistically valid random sample of health insurance applications are reviewed to determine if the Federally-facilitated Exchange properly paid APTC benefits under the statutory and regulatory requirements relating to eligibility and payment determinations.

The Federally-facilitated Exchange improper payment estimate for FY 2023, for measurement of calendar year 2021, is 0.58 percent or $271.75 million. The estimated percentage of APTC dollars paid correctly was 99.42 percent. The Federally-facilitated Exchange paid an estimated $46.23 billion correctly in FY 2023.

Automated process errors generally relate to the Federally-facilitated Exchange's processing of application information and eligibility verification information provided by trusted data sources. The nature of automated process errors may vary between reporting periods. For calendar year 2021, the primary driver of automated errors related to the Federally-facilitated Exchange failing to conduct periodic verifications of consumer eligibility due to technical problems interacting with trusted data sources. The improper payment estimate due to the automated process errors is 0.24 percent or $113.47 million, representing 41.76 percent of total improper payments.

Manual administrative errors generally relate to the Federally-facilitated Exchange's processing of additional documentation provided by consumers in situations where the Federally-facilitated Exchange was unable to verify consumer eligibility using automated processes. Manual eligibility verification involves complex rules and a large variety of documentation types and formats, and therefore has a heightened risk of error. The nature of manual administrative errors may vary between reporting periods. For calendar year 2021, the primary driver of manual errors was related to the Federally-facilitated Exchange accepting consumer-submitted documents which did not contain elements required by policy. The improper payment estimate due to the manual administrative errors is 0.34 percent or $158.28 million, representing 58.24 percent of total improper payments.

The improper payment rate and amounts estimated herein do not reflect APTC payments made by State-based Exchanges. CMS will begin the Improper Payment Pretesting and Assessment program in 2024 to prepare states for the upcoming measurement. CMS will continue to provide updates on the status of the State-based Exchange improper payment program implementation.

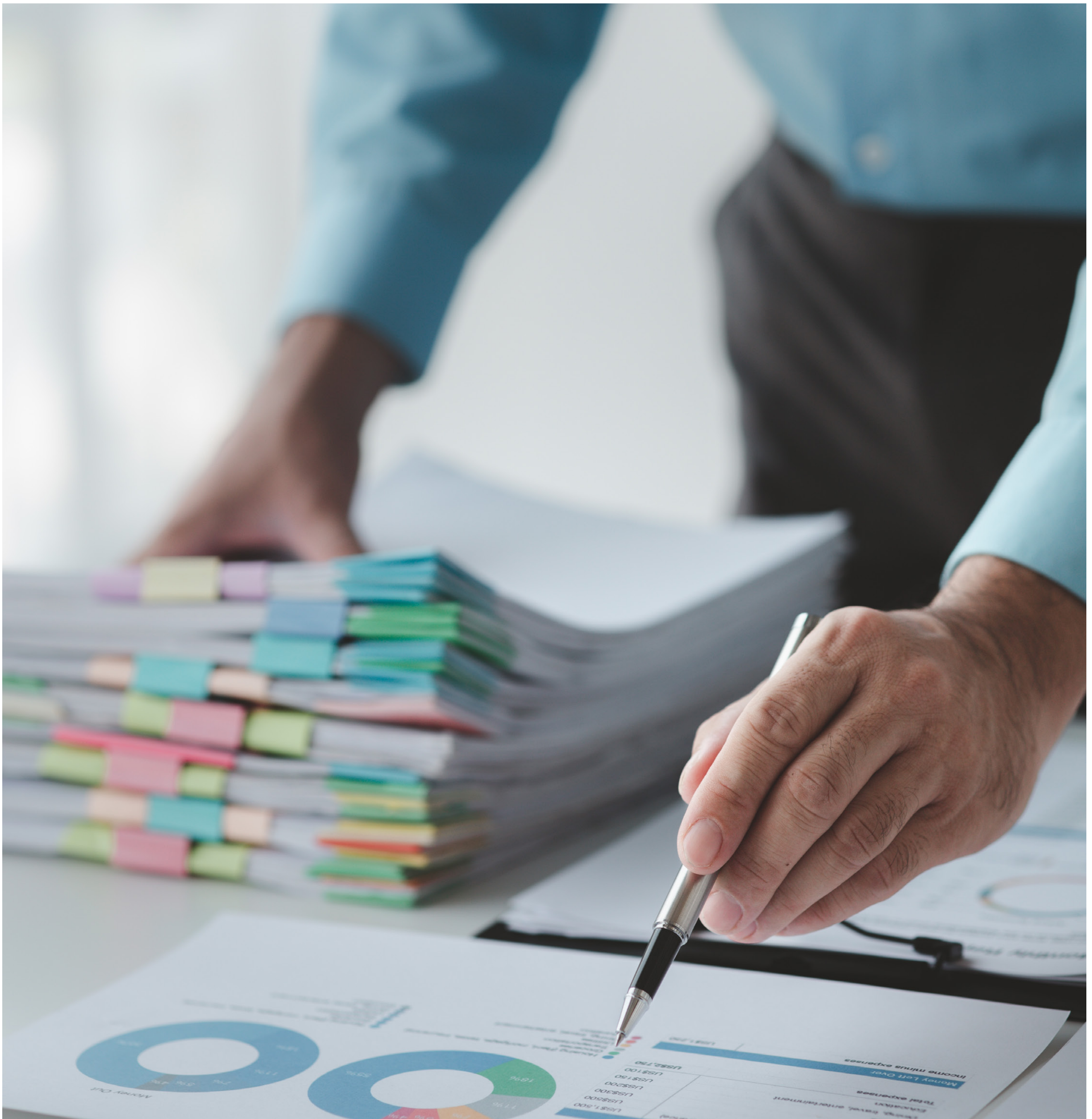
Combined Improper Payment Data

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[1] 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 (IRS) measures improper payments associated with Net PTC claims, and for calendar year 2021 reported Net PTC claims of $1.97 billion, improper payments of $512.71 million, and an improper payment rate of 26.04 percent. The combined APTC and Net PTC improper payment estimate is $784.46 million out of $48.47 billion total Premium Tax Credit outlays/claims, or 1.62 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 The Treasury AFR can be found at **U.S. Department of the Treasury: Agency Financial Report**

In the ordinary course of preparing their tax filing, a consumer may claim a total Premium Tax Credit that is less than the APTC payments made on behalf of the consumer for the respective tax year. For example, a consumer's income for the tax year may exceed what the consumer anticipated when the consumer enrolled in health insurance coverage, resulting in eligibility for a lesser Premium Tax Credit benefit than expected. Amounts paid in APTC exceeding the total Premium Tax Credit a consumer is entitled to is referred to as "Excess APTC." A consumer may have an obligation to repay Excess APTC amounts, and such repayments may relate to amounts that are recognized as improper payments. The combined APTC and Net PTC improper payment information does not reflect any effects related to the repayment of Excess APTC.

Additional information on the Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, and APTC improper payments can be found in the **HHS Agency Financial Reports** and **CMS Improper Payments Measurement Programs** websites.



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 and Part B 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 (when goods are delivered or services are performed) and expenses are recorded when incurred (when goods or services are received), 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.

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 Healthcare 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 received with the amount of the actual premium tax credit for which they are eligible.

***American Rescue Plan Act of 2021* (ARP):** An emergency legislative package to provide economic relief and additional resources for individuals and businesses affected by COVID-19. 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: Benefits consumed or funds outlaid for services delivered to beneficiaries.

C

***Chief Financial Officers Act of 1990* (CFO Act):** The CFO Act was enacted to improve the financial management and accountability of 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. It also designated a Chief Financial Officer in each executive department and each major executive agency in the federal government.

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. CHIPRA increased CHIP funding, strengthened and expanded healthcare for children, reduced the number of uninsured, and promoted outreach, education, and preventative healthcare.

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.

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 Medicare 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.

***Evidence-based Policymaking Act of 2018*:** The Evidence Act, as it is simply known, was established to advance evidence building in the federal government by improving access to data and expanding evaluation capacity.

F

***Federal Financial Management Improvement Act of 1996* (FFMIA):** 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 standards of the U.S. Standard General Ledger (USSGL) at the transaction level). The primary purpose of FFMIA is to enhance the accuracy, reliability, and usefulness of federal financial information.

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 (FFS): A system of healthcare payment in which a provider is paid separately for each particular service rendered.

G

***Government Management Reform Act of 1994* (GMRA):** GMRA aims to improve the management, operation, and accountability of federal agencies. It requires the auditing of executive agencies' annual financial statements prior to submission to OMB.

***Government Performance and Results Act Modernization Act of 2010* (GPRA Modernization Act):** Aims to improve the performance management, accountability, and transparency of federal agencies. It 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.

H

Health Insurance Marketplaces (Marketplaces): A mechanism for facilitating the purchase of Qualified Health Plans and evaluating eligibility for APTCs and Cost Sharing Reductions (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 - Community Based Services (HCBS): Programs that 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): The Medicare trust fund that covers specified inpatient hospital services, post-hospital skilled nursing care, home health services, and hospice care for aged and disabled individuals who meet the eligibility requirements. Also known as Medicare 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.

***Inflation Reduction Act of 2022* (IRA):** Aims to lower prescription drugs costs by allowing Medicare to negotiate prices with drug companies through the imposition of an inflation cap on drug prices; also extends provisions geared toward improving health insurance affordability and access through 2025.

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). 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 previously offered to Medicare beneficiaries by allowing for the establishment of new regional preferred provider organization 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 (MLR): 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): 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* (MHPAEA):** 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.

Merit-Based Incentive Payment System (MIPS): A system for adjusting payments under the Medicare physician fee schedule to nonadvanced alternative payment model (APM) providers based on metrics assessing provider quality, resource use, meaningful use of electronic health records, and clinical practice improvement activities.

N

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

No Surprises 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 trust fund.

Part B: The account within the Medicare Supplementary Medical Insurance or SMI trust fund that pays for a portion of physician and supplier claims.

***Patient Protection and Affordable Care Act* (PPACA):** 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.

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.

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.

Q

Quality Improvement Organizations (QIOs): Formerly known as Peer Review Organizations (PROs), QIOs monitor the quality of care provided to Medicare beneficiaries to ensure that healthcare services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

R

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

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 of 2018*:** 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): The Medicare trust fund comprising the Part B account, the Part D account, and the Transitional Assistance Account. The Part B account pays for a portion of the costs of physician services, outpatient hospital services, and other related medical and health services for voluntarily enrolled aged and disabled individuals. The Part D account pays private plans to provide prescription drug coverage, beginning in 2006. The Transitional Assistance Account paid for transitional assistance under the prescription drug card program in 2004 and 2005.

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