DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2023

Centers for Medicare & Medicaid Services

Justification of Estimates for Appropriations Committees

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

Message from the Administrator

I am pleased to present the Centers for Medicare & Medicaid Services (CMS) Fiscal Year (FY) 2023 performance budget. CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes. In FY 2023, over 150 million Americans will rely on the programs CMS administers including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplaces.

While much of our work is focused on these Americans – almost half of the US population – our vision is much broader. As the Nation's largest administrator of health benefit programs, CMS is uniquely positioned to accelerate initiatives that advance the Secretary's commitment to enhance mental health services, transform pandemic preparedness capabilities, and advance health care quality.

To accomplish our vision, CMS will build upon the Affordable Care Act (ACA) to ensure affordable health coverage, address health disparities to promote health equity, and inform policymaking through community and partner engagement. CMS will continue supporting innovative approaches to improving quality, accessibility, and affordability, while finding the best ways to use advanced technology to support person-centered care.

While CMS has always worked to improve its programs, COVID-19 reinforced the need to ensure our programs are accessible, reward high-quality health care, and encourage lower health care costs. This budget also supports the steps we will take to protect our programs' sustainability for future generations through responsible stewardship, and promoting excellence in all aspects of CMS's operations. Additionally, CMS proposes to further modernize our programs by addressing the increasing role of technology in Americans' lives, while safeguarding their data.

The investments proposed in FY 2023 will keep CMS on the leading edge of providing the high-quality health care that all Americans deserve, while also pursuing program integrity methods to better prevent fraudulent and/or improper payments.

On behalf of our beneficiaries and consumers, I thank you for your continued support of CMS and its FY 2023 performance budget.

Administrator Chiquita Brooks-LaSure

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

APPROVED LEADERSHIP As of March 01, 2022

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Modernization of the Public-Facing Digital Services –
21st Century Integrated Digital Experience Act

The 21st Century Integrated Digital Experience Act (IDEA) was signed into law on Dec. 20, 2018. It requires data-driven, user-centric website and digital services modernization, website consolidation, and website design consistency in all Executive Agencies. Departments across the Federal landscape are working to implement innovative digital communications approaches to increase efficiency and create more effective relationships with their intended audiences. The American public expects instant and impactful communications – desired, trusted content available when they want it, where they want it, and in the format, they want it. If the consumer is not satisfied they move on and CMS's opportunity for impact is lost.

Modernization Efforts

In FY 2019, HHS engaged Department leadership and developed a Digital Communications Strategy that aligns with the requirements of IDEA. In FY 2020, HHS Digital Communications Leaders began implementation of the Strategy in alignment with IDEA, beginning to align budgets to modernization requirements.

As the result of a comprehensive review of costs associated with website development, maintenance, and their measures of effectiveness, CMS alongside HHS will prioritize:

- modernization needs of websites, including providing unique digital communications services, and
- continue developing estimated costs and impact measures for achieving IDEA.

Over the next four years HHS will continue to implement IDEA by focusing extensively on a user-centric, Digital First approach to both external and internal communications and developing performance standards, including at CMS. HHS/CMS will focus on training, hiring, and tools that drive the communication culture change necessary to successfully implement IDEA.

Over the next year, CMS will work with HHS Agencies and Offices together to continue to implement IDEA and the HHS Digital Communications Strategy across all communications products and platforms.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Table of Contents

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Table of Contents

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Table of Contents

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EXECUTIVE SUMMARY

Agency Overview

The Centers for Medicare & Medicaid Services (CMS) is an Operating Division within the Department of Health and Human Services (HHS). CMS administers the two largest Federal healthcare programs - Medicare and Medicaid - as well as the Children's Health Insurance Program (CHIP) and the Federal Marketplaces. CMS is a driving force in the healthcare industry, managing programs that will touch the lives of over 150 million beneficiaries and consumers in FY 2023. CMS understands the trust that has been placed with us, as our oversight responsibilities impact millions of citizens and continue to grow dramatically.

This budget request reflects CMS's vision to serve the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes for all our beneficiaries and consumers. The Budget also includes mandatory proposals which support investments in mental health, pandemic preparedness, and beneficiary protections. These legislative proposals demonstrate clear support for policies that expand and enhance benefits for Medicare and Medicaid beneficiaries, broaden access to health care coverage, and improve the lives of all Americans. The President's Budget provides $300 million in mandatory Program Management funding over 10 years for CMS to implement all the administrative proposals included in the budget (details can be found in the FY 2023 HHS Budget in Brief). Ensuring all our populations have equitable access to healthcare, our continued work on reducing Opioid and Substance Use Disorders (SUD) and reducing the costs of healthcare are just a few ways in which CMS will continue to add value and work on behalf of all Americans. CMS strives for meaningful outcomes while ensuring maximum benefit from the use of our resources. As a result, CMS's focus is for a better healthcare system for the populations we serve. To that end, CMS is committed to open engagement with our partners and the communities we serve throughout the policy-making and implementation process.

CMS works closely with its customers and other stakeholders to maintain our programs and foster innovation and collaboration to further enhance our ability to serve the American public. Through such collaboration, CMS is able to promote our work in areas such as child well-being and maternal health. Many of our programs serve a population that often needs strong advocacy, and we understand that all customers are best served through the robust collaboration of Federal, State, and local entities. Therefore, CMS strives to further strengthen our relationships with our partners at all levels. We understand that we are all stronger when we work together, share data, and collaborate on common goals. Strengthened relationships work as a force multiplier for CMS, increasing our ability to do more with our resources. We are transforming healthcare by reducing disparities in health equity, strengthening program integrity by reducing fraud, waste, and abuse, and promoting innovation.

Mobilized under the Biden-Harris Administration, CMS will work, in concert with the White House and other mobilized federal partners, on an effort to end cancer as we know it today. The Administration's effort, known as the Cancer Moonshot, has set ambitious goals to reduce the death rate from cancer by at least 50 percent over the next 25 years and to

improve the experience of people and their families living with and surviving cancer. CMS's initial role has begun with the Oncology Care Model and working with stakeholders to advance the effectiveness and efficiency of specialty care. With patients at the center, CMS is researching ways to improve the overall experience, with an aim to provide higher quality care.

Overview of Budget Request

CMS requests funding for its annually-appropriated accounts, including Program Management (PM), discretionary Health Care Fraud and Abuse Control (HCFAC), Grants to States for Medicaid, and Payments to the Health Care Trust Funds. The table below displays CMS's FY 2021 Final, FY 2022 Continuing Resolution (CR), and FY 2023 President's Budget request for these accounts.

CMS's resource needs are principally driven by workloads that grow annually and by its role in leading national efforts to improve efficiency, healthcare quality, and access to care. The FY 2023 budget request reflects a level of funding that will not only allow CMS to focus on base operations, but also improve its traditional activities throughout its various programs.

CMS Annually-Appropriated Accounts
(Dollars in Millions)

Account	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget
Program Management (PM)	**$3,962.811**	**$3,974.744**	**$4,346.985**
Program Operations[1]	*$2,772.890*	*$2,784.823*	***$2.957.300***
Federal Administration	*$772.533*	*$772.533*	***$895.424***
Survey & Certification	*$397.334*	*$397.334*	***$494.261***
Research[2]	*$20.054*	*$20.054*	***$0***
HCFAC[3]	**$804.578**	**$807.000**	**$899.000**
Total Discretionary Request	**$4,767.390**	**$4,781.744**	**$5,245.990**

FY 2023 Request

Program Management

In FY 2023, CMS requests $4,347.0 million in Budget Authority appropriated funding. The budget invests in mission-critical operations to ensure CMS can better serve its increasing beneficiary population and carry out its growing legislative responsibilities. CMS's budget request supports the Agency's priorities of improving quality and lowering costs, providing flexibility to state and local communities, and expanding access. CMS will find ways to make equity integral in our programs. With this level of requested funding, CMS can appropriately execute core Agency functions, maintain public-facing services, and accomplish the priorities of this Administration.

[1] FY 2021 total reduced to reflect $11.933 million in HHS Secretary's Transfer Authority.
[2] The FY 2023 HHS Request proposes to absorb the Research budget into the Program Operations account.
[3] FY 2021 total reduced to reflect $2.423 million in HHS Secretary's Transfer Authority.

- Program Operations:

  CMS's FY 2023 President's Budget request for Program Operations is $2,957.3 million, an increase of $172.5 million above the FY 2022 CR level. The majority of the Program Operations account funds CMS's traditional Medicare operations. This funding level will allow CMS to process nearly 1.3 billion fee-for-service claims and related workloads, keep our systems running, invest in several critical initiatives including the opioid and substance use disorders, maintain our 1-800-MEDICARE call centers, oversee Part C and D plans, and provide outreach and education to millions of beneficiaries and consumers. In addition, this request invests in several key initiatives aimed to improve CMS's operations to meet the needs of internal/external stakeholders, while also increasing our health equity efforts. As the largest payer for healthcare in the United States, CMS holds an enormous amount of unique health data on a large proportion of the U.S. population. This increase in funding will open up greater analytic and data sharing capabilities which hold the potential to strengthen decision-making at all levels of government. CMS will also use this increase in funding to build the necessary agency infrastructure to drive equity across all of our programs and policies to improve the outcomes for all people served by our programs.

- Federal Administration:

  CMS requests a total of $895.4 million for Federal Administration in FY 2023, an increase of $122.9 million above the FY 2022 CR. Of this request, $844.1 million will support 4,518 direct Full-Time Equivalents (FTEs), an increase of 288 as compared to the FY 2022 CR. CMS's workforce has decreased in recent years while its responsibilities and need for staff with specialized expertise have increased dramatically. This increase in FTEs is an investment in CMS's future and will allow for continued base operations as well as the addition of expertise in skillsets that are tied to Administration priorities. Bolstering our workforce in critically needed skillsets will better position CMS now and in the future. The remaining request supports administrative information technology, communication, utilities, rent and space requirements, as well as administrative contracts and inter-agency agreements.

- Survey and Certification:

  The FY 2023 CMS request for State Survey and Certification activities is $494.3 million, an increase of $96.9 million above the FY 2022 CR. With this level of funding, CMS projects that States will be able to maintain 100 percent survey frequency rates of statutory-facilities, facilities that must be inspected according to survey frequency rates set in statute. Moreover, the requested funding increase will enable States, for the first time in over 5 years, to complete nearly 100 percent of surveys for facilities that have no statutorily required survey frequency rate, but are type of facilities whose survey frequency is guided by Agency policy, developed following best practices and recommendations by OIG and GAO to improve care. Overall, this level of funding will enhance the ability of the program to provide more comprehensive oversight, as State Survey Agencies will be able to increase their frequency of visits to Medicare-Medicaid certified facilities, identifying potential issues early that can exacerbate to life threatening situations or cause harm. Increased opportunities to identify and improve care early can reduce the number of issues that can manifest into costly complaint investigations, a reactive oversight method. The request sustains efforts initiated during the COVID-19 pandemic to ensure long-term care and other facilities have proper

infection controls in place, not only as a response to COVID-19, but also preparing these facilities for future public health emergencies.

Additionally, the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136; CARES Act) provided CMS with $200 million in multi-year Program Management funding available through FY 2023 to "prevent, prepare for, and respond to the Coronavirus (COVID-19) domestically and internationally." Within this amount, the CARES Act includes no less than $100 million to support the necessary expenses of CMS's survey and certification program. In FY 2023, the CARES Act funds dedicated to Survey and Certification will allow the State Survey Agencies to perform additional surveys of nursing homes in localities with community transmission of COVID-19 including complaints alleging infection control concerns and respond to backlog of other types of complaints, recertification surveys, and revisit workload created during the public health emergency. In this final year of availability of CARES Act funding, CMS will continue to use these funds to address the COVID-19 PHE and work down any survey and complaint workload backlog created by the public health emergency (PHE).

Health Care Fraud and Abuse Control

In FY 2023, CMS requests $899.0 million in discretionary HCFAC funding, which would be allocated among CMS, DOJ, and HHS/OIG. Increased funding over the FY 2022 CR level will provide resources for CMS to conduct additional Medicare FFS medical review, increase data analytics efforts, strengthen program integrity in Medicaid, and perform improper payment rate measurement in the Marketplaces. With these additional resources, CMS and its law enforcement partners will invest in new and expanded activities that will reduce fraud in Medicare, Medicaid and CHIP, and the Marketplaces. CMS plans to place emphasis in the following areas: pre-pay claim review with the aid of predictive analytic support; streamlining provider enrollment initiatives and simplifying documentation requirements to reduce provider burden; exploring the use of artificial intelligence tools; individual provider education; increasing communication and data sharing with internal and external stakeholders; and enhancing States' abilities to detect and deter fraud and abuse.

Grants to States for Medicaid

The FY 2023 Medicaid appropriations request is $533.1 billion, an increase of $15.7 billion above the FY 2022 appropriations request, consisting of $367.4 billion for FY 2023 and $165.7 billion in an advance appropriation from FY 2022. These amounts do not reflect anticipated use of $41.3 billion in indefinite appropriations for FY 2022, largely needed for states' COVID-19 related spending. For example, legislation allows states meeting certain continuous eligibility requirements to receive an additional 6.2 percent Federal match on certain Medicaid medical assistance benefits (MAP) through the last quarter of the public health emergency.

Appropriations will support $584.5 billion in estimated gross obligations in FY 2023. These obligations consist of:

- $555.3 billion in Medicaid medical assistance benefits;
- $23.6 billion for Medicaid administrative functions including Medicaid survey and certification and state fraud control units; and

- $5.6 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

Payments to the Health Care Trust Funds

The FY 2023 request for Payments to the Health Care Trust Funds account totals $548,130.0 million, an increase of $60,268.0 million above the FY 2022 estimate level. This account transfers payments from the General Fund to the trust funds in order to make the Supplementary Medical Insurance (SMI) Trust Fund and the Hospital Insurance (HI) Trust Fund whole for certain costs, initially borne by the trust funds, which are properly chargeable to the General Fund. The largest transfer provides the General Fund contribution to the SMI Trust Fund for the General Fund's share of the SMI program. Other transfers include payments from the General Fund to the HI and SMI Trust Funds including the Medicare Prescription Drug Account, for costs such as general revenue for prescription drug benefits, HCFAC, and other administrative costs that are properly chargeable to the General Fund. The change in CMS's FY 2023 request, when compared to the FY 2022 estimate level, is largely driven by increases for the General Fund contributions for the SMI Trust Fund.

Key Initiatives

Opioid and Substance Use Disorders: The opioid crisis continues to be a pressing public health challenge, impacting many Americans, and CMS will be contributing to a significant, government-wide investment to end the opioid epidemic. As the largest healthcare payer in the United States, CMS uses coverage and payment levers to advance evidence-based responses to the epidemic. In FY 2023, CMS anticipates nearly all of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act provisions will have been implemented. CMS will continue to advance its strategy to promote safe and effective treatment options for pain that rely less on opioids, expand access to Substance Use Disorder (SUD) support and treatment, and better use data to inform CMS policy.

Health Equity: As the largest payer of healthcare in the U.S., CMS is uniquely positioned to drive equity in the healthcare system. CMS, in accordance with Executive Orders "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government" and "Ensuring Equitable Pandemic Response and Recovery", will address current and emerging public health issues and related health disparities impacting CMS's priority which is underserved populations. Funds will be used to focus on comprehensive stakeholder engagement through national listening sessions and health literacy initiatives to shape policy and programmatic efforts across CMS. In addition, these funds will expand the Coverage to Care Initiative to focus on specific populations and better tailor resources and outreach efforts to focus on identified underserved populations. To achieve these goals, CMS will invest funding for a minority health analytic data environment to enable expanded modeling of disparity trends over time. This funding would also be used to build upon rural health equity efforts through a CMS Rural Health strategy refresh, development of the Rural Stakeholder Insights Trend & Triage System, and defining and executing activities that will allow us to bridge the policy-to-practice gap between federal employees and rural communities.

Improve CMS's Analytic Capabilities and Data Sharing with Internal and External Stakeholders (to include Health Equity and Behavioral Health):
CMS holds an enormous amount of unique health data on a large proportion of the U.S. population. This initiative will improve the accessibility, timeliness, and comprehensiveness of CMS data made available to stakeholders and the public. These datasets are valuable not only to CMS, but across government, including at the state and local level. This data holds the potential to strengthen the evaluation of federal and state programs for decision-making, assess the impact of policy changes, improve outcomes of people served by multiple federal and/or state programs, and generate knowledge to inform federal and state policy-making. In addition, these datasets are a crucial resource to support public health surveillance, investigations, and interventions, particularly as public health entities prepare for future pandemics. CMS data, particularly the data related to beneficiaries in the Medicare fee-for-service program, are also a critical resource to support clinicians as they transition to value-based care since they provide a fuller picture of a beneficiary's care.

Modernize CMS's Operations to Meet the Needs of Future Beneficiaries:
As an Agency, CMS has always placed our beneficiaries first; however, our operations have not always been able to keep up with the changing needs of the populations we serve. This funding would modernize our operations, increasing our ability to improve care for beneficiaries today, as well as preparing to meet the needs of future beneficiaries. Activities under this initiative will work to enhance or expand upon current access to coverage and services as well as improve our ability to collect and process data. These activities demonstrate strategic and carefully targeted actions that result in benefits beyond the cost of investment. In this way, CMS is taking the steps now to ensure our operations are modernized and ready to serve future beneficiaries and consumers. These investments are driven by data, resulting in activities that will move CMS towards more equitable access to care across our populations.

Overview of Performance

CMS supports the Administration's goals to make government more effective, efficient, and customer-focused in managing and delivering HHS programs by implementing the Government Performance and Results Act of 1993 (GPRA) and GPRA Modernization Act of 2010 (GPRA-MA).

CMS performance measures highlight fundamental program purposes and focus on the Agency's role as an efficient and effective steward of taxpayer dollars. We continue to work on aligning our performance commitments to the CMS and HHS priorities. CMS tracks many of its established performance measures and is currently working to introduce improvements that reflect the Administration's priorities and reinforce the FY 2022-2026 HHS Strategic Plan, which is being developed. Thus, any of our currently proposed performance goals may be subject to change and maybe revised or refocused in the future.

CMS continues to use performance information to identify opportunities for improvement and to shape and improve its programs. The use of performance measures also provides a method of clear communication of CMS programmatic objectives to 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 CMS FY 2023 Performance section format is designed to create a more complete presentation of performance commitments, accomplishments, and trends. Due to the PHE

(COVID-19), some CMS performance reporting is delayed or revised. We continue to assess the impact of this on our program performance reporting.

Conclusion

CMS's FY 2023 program level request for Program Management totals $4,347.0 million. This funding will allow CMS to continue its traditional activities in the Medicare, Medicaid, CHIP and Marketplace programs and address key budgetary initiatives that will move the Agency forward. Key initiatives such as investing in CMS's future and ensuring healthcare equity for our beneficiaries will address immediate areas of concern, while also building the platform to sustain continued improvement for years to come.

This request includes $899.0 million in discretionary HCFAC funds for CMS, DOJ, and HHS/OIG. This funding will be devoted to maintaining and improving oversight programs related to early detection and prevention, and reducing improper payments.

CMS remains committed to finding efficiencies within base workloads, safeguarding its programs, and providing beneficiaries, stakeholders, and healthcare consumers with high quality levels of service.

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Mandatory & Discretionary All-Purpose Table (Comparable)
The Centers for Medicare & Medicaid Services
Dollars in Millions

	FY 2021		FY 2022		FY 2023	
	Final	COVID-19 Supplemental /1	CR /2	Supplemental Funding /3	President's Budget	+/- FY 2022 CR
Program Operations /4	$ 2,772.890	$ -	$ 2,784.823	$ -	$ 2,957.300	$ 172.477
Federal Administration	$ 772.533	$ -	$ 772.533	$ -	$ 895.424	$ 122.891
State Survey & Certification	$ 397.334	$ -	$ 397.334	$ -	$ 494.261	$ 96.927
Research /5	$ 20.054	$ -	$ 20.054	$ -	$ -	$ (20.054)
Subtotal, Appropriation/BA Current Law (Discretionary; 0511)	**$ 3,962.811**	**$ -**	**$ 3,974.744**	**$ -**	**$ 4,346.985**	**$ 372.241**
MIPPA (Mandatory; P.L. 110-275)	$ 3.000	$ -	$ 2.914	$ -	$ 2.829	$ (0.085)
PAMA (P.L. 113-93)	$ 10.000	$ -	$ 4.857	$ -	$ 4.715	$ (0.142)
IMPACT (P.L. 113-185)	$ 5.625	$ -	$ 5.464	$ -	$ 5.304	$ (0.160)
BBA (P.L. 115-123)	$ 5.000	$ -	$ 4.857	$ -	$ 4.715	$ (0.142)
Consolidated Appropriations Act (P.L. 116-260)	$ 98.000	$ -	$ 45.657	$ -	$ 49.036	$ 3.379
American Rescue Plan Act (P.L. 117-2) /6	$ -	$ 500.000	$ -	$ -		$ -
Total, Mandatory Appropriation/BA C.L. (Mandatory; 0511)	**$ 121.625**	**$ 500.000**	**$ 63.749**	**$ -**	**$ 66.599**	**$ 2.850**
Total, Appropriation/BA Current Law (0511)	**$ 4,084.436**	**$ 500.000**	**$ 4,038.493**	**$ -**	**$ 4,413.584**	**$ 375.091**
Proposed Law Appropriation (Mandatory)	$ -	$ -	$ -	$ -	$ 300.000	$ 300.000
Total, Appropriation/BA Proposed Law (0511)	**$ 4,084.436**	**$ 500.000**	**$ 4,038.493**	**$ -**	**$ 4,713.584**	**$ 675.091**
Est. Offsetting Collections from Non-Federal Sources: /7						
User Fees and Reimbursements	$ 258.444	$ -	$ 281.234	$ -	$ 294.688	$ 13.454
Marketplace User Fees (FFM)	$ 1,578.001	$ -	$ 1,608.538	$ -	$ 1,437.526	$ (171.012)
Risk Adjustment User Fees (RA)	$ 49.093	$ -	$ 59.403	$ -	$ 60.000	$ 0.597
Recovery Audit Contracts	$ 625.740	$ -	$ 609.372	$ -	$ 593.685	$ (15.687)
Total, Offsetting Collections	**$ 2,511.278**	**$ -**	**$ 2,558.547**	**$ -**	**$ 2,385.899**	**$ (172.648)**
Subtotal, New BA, Current Law	**$ 6,595.714**	**$ 500.000**	**$ 6,597.040**	**$ -**	**$ 6,799.483**	**$ 202.443**
Proposed Law Discretionary	$ -		$ -	$ -		
Program Level, Proposed Law (0511)	**$ 6,595.714**	**$ 500.000**	**$ 6,597.040**	**$ -**	**$ 7,099.483**	**$ 502.443**
HCFAC Discretionary /8	**$ 804.578**	**$ -**	**$ 807.000**	**$ -**	**$ 899.000**	**$ 92.000**
Non-CMS Administration /9	**$ 2,973.000**	**$ -**	**$ 3,005.000**	**$ -**	**$ 3,478.000**	**$ 473.000**
CMS FTEs:						
Discretionary (Federal Administration)	4,199	0	4,230	0	4,518	288
Reimbursable (CLIA, CoB, RAC, Marketplace)	481	0	584	0	597	13
Mandatory (Direct Appropriations)	62	0	41	0	27	-14
Subtotal, Program Management FTEs	**4,742**	**0**	**4,855**	**0**	**5,142**	**287**
Program Management, Proposed Law	0		0	0	0	0
Total, Program Management FTEs	**4,742**	**0**	**4,855**	**0**	**5,142**	**287**
HCFAC Mandatory	485	0	535	0	535	0
Medicaid Integrity (State Grants; Mandatory)	224	0	246	0	246	0
Affordable Care Act Section 3021 (Mandatory)	523	0	513	0	513	0
Quality Improvement Organizations	270	0	259	0	259	0
Demonstrations	10	0	6	0	6	0
Consolidated Appropriations Act	33	0	49	0	49	0
Subtotal, Other Sources FTEs	**1,545**	**0**	**1,608**	**0**	**1,608**	**0**
Total, CMS FTEs	**6,287**	**0**	**6,463**	**0**	**6,750**	**287**

/1 This column includes both supplemental funding and mandatory funds appropriated in the American Rescue Plan Act of 2021, P.L. 117-2 post-transfer and post-reallocation and the supplemental appropriation in the Consolidated Appropriations Act, 2021 (P.L. 116-260)

/2 Reflects the annualized amounts provided in the continuing resolution ending 2/18/2022

/3 This column includes both supplemental funding and mandatory funds appropriated for FY 2022 in the Infrastructure and Jobs Act.

/4 FY 2021 total reduced to reflect $11.933 million in HHS Secretary's Transfer Authority.

/5 In FY 2023, CMS proposes to request Research funding within the Program Operations account.

/6 The FY 2021 Supplemental Funding for Sections 9402 and 9818 of the American Rescue Plan Act will be transferred from CMS to the Centers for Disease Control and Prevention (CDC). FY 2023 amounts are pre-sequester.

/7 Amounts are net of sequester and pop-up authority, as applicable.

/8 FY 2021 total reduced to reflect $2.423 million in HHS Secretary's Transfer Authority.

/9 Includes discretionary funds only for the SSA, DHHS/OS, MedPac, and the SHIPs.

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Page

NARRATIVES BY ACTIVITY

Discretionary Appropriations

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Program Management

Appropriations Language

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare & Medicaid Services, not to exceed $4,346,985,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 1893(h) of the Social Security Act, and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended: Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: Provided further, That the Secretary is directed to collect fees in fiscal year 2023 from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act: Provided further, That of the amount made available under this heading, $494,261,000 shall remain available until September 30, 2024, and shall be available for the Survey and Certification Program.

Program Management

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare & Medicaid Services, not to exceed $4,346,985,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act;	Provides a one-year appropriation from the HI and SMI Trust Funds for the administration of the Medicare, Medicaid, Children's Health Insurance, and consumer information and insurance oversight and protection programs. The HI Trust Fund will be reimbursed for the General Fund share of these costs through an appropriation in the Payments to the Health Care Trust Funds account.
together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 1893(h) of the Social Security Act, and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended:	Provides funding for the Clinical Laboratory Improvement Amendments program, which is funded solely from user fee collections. Authorizes the collection of fees for the sale of data, and other authorized user fees and offsetting collections to cover administrative costs, including those associated with providing data to the public, and other purposes. All of these collections are available to be carried over from year to year, until expended.
Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation:	Authorizes the crediting of HMO user fee collections to the Program Management account.
Provided further, That the Secretary is directed to collect fees in fiscal year 2023 from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act	Authorizes the collection of user fees from Medicare Advantage organization for costs related to enrollment, dissemination of information and certain counseling and assistance programs.

Language Provision	**Explanation**
Provided further, That of the amount made available under this heading, $494,261,000, to remain available until September 30, 2024 and shall be available for the Survey and Certification Program.	Extends the period of availability of Survey and Certification funding to two-year.

General Provisions

Language Provision	Explanation
SEC. XXX. *For fiscal year 2023, the notification requirements described in sections 1804(a) and 1851(d) of the Social Security Act may be fulfilled by the Secretary in a manner similar to that described in paragraphs (1) and (2) of section 1806(c) of such Act.*	Authorizes the Secretary to allow beneficiaries to opt to receive the Medicare & You Handbook and the Medicare Advantage open season notification through electronic means rather than through the mail. This is a modernization and efficiency measure that would decrease the number of Handbooks that are mailed and would reduce the substantial cost of mailing Medicare & You Handbooks to millions of beneficiaries annually.

CMS Program Management
Amounts Available for Obligation

	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS) /1	$3,962,811,000	$3,974,744,000	$4,346,985,000
CARES Act Supplemental (PL 116-136)	$0	$0	$0
Trust Fund Mandatory Appropriation:			
PAMA/SGR (PL 113-93)	$10,000,000	$4,857,110	$4,715,000
IMPACT Act (PL 113-185)	$5,625,000	$5,464,248	$5,304,375
MACRA (PL 114-10)	$0	$0	$0
BBA (PL 115-123)	$5,000,000	$4,857,110	$4,715,000
Health Extenders (116-59)	$0	$0	$0
Further Health Extenders (116-69)	$0	$0	$0
Further Consolidated Appropriations (116-94)	$0	$0	$0
CARES (PL 116-136)	$0	$0	$0
Consolidated Appropriations (PL 116-260)	$98,000,000	$45,656,830	$49,036,000
American Rescue Plan (PL 117-2) /2	$500,000,000	$0	$0
Subtotal, trust fund mand. Appropriation /3	$618,625,000	$60,835,298	$63,770,375
Mandatory Appropriation:			
MIPPA (PL 110-275)	$3,000,000	$2,914,266	$2,829,000
Subtotal, trust fund mand. Appropriation /3	$3,000,000	$2,914,266	$2,829,000
Offsetting Collections from Non-Federal Sources:			
Sale of data user fees	$37,574,288	$30,000,000	$30,000,000
Independent dispute resolution (IDR) fees	$0	$1,600,000	$1,600,000
Marketplace user fees (FFM)	$1,578,000,555	$1,608,538,420	$1,437,525,772
Risk Adjustment user fees (RA)	$49,092,639	$59,402,561	$60,000,000
Recovery audit contracts	$625,740,005	$609,372,358	$593,685,217
CLIA user fees	$68,050,075	$61,295,000	$66,010,000
Part D COB user fees	$51,033,228	$48,571,096	$47,150,000
MA/PDP user fees	$99,300,000	$96,453,200	$105,153,296
Provider enrollment user fees	$1,354,451	$23,133,981	$24,028,500
Civil Monetary Penalties	$1,132,580	$20,180,200	$20,746,000
Subtotal, offsetting collections /4	$2,511,277,821	$2,558,546,816	$2,385,898,785
Total Budget Authority /5	**$7,095,713,821**	**$6,597,040,380**	**$6,799,483,160**

/1 FY 2021 total reduced to reflect $11.933 million in HHS Secretary's Transfer Authority.
/2 The FY 2021 Final level for Sections 9402 and 9818 of the American Rescue Plan Act reflects the funding to be transferred from CMS to the Centers for Disease Control and Prevention(CDC).
/3 Current law display. Net of sequester.
/4 Amounts are net of sequester and pop-up authority, as applicable.
/5 Totals may not add due to rounding.

Program Management

Summary of Changes

2022 CR	
Total estimated budget authority 1/	$3,974,744,000
(Obligations) 1/	($3,974,744,000)
2023 President's Budget	
Total estimated budget authority 1/	$4,346,985,000
(Obligations) 1/	($4,346,985,000)
Net Change	**$372,241,000**

	FTE	2022 Estimate Budget Authority	FTE	Change from Base Budget Authority
Increases:				
A. Program:				
1. Program Operations		$2,784,823,000		$172,477,000
2. Federal Administration	4,230	$772,533,000	288	$122,891,000
3. State Survey & Certification		$397,334,000		$96,927,000
4. Research 2/		$20,054,000		$0
Subtotal, Program Increases 1/				**$392,295,000**
Total Increases 1/				**$392,295,000**
Decreases:				
A. Program:				
1. Program Operations		$2,824,823,000		$0
2. Federal Administration		$732,533,000		$0
3. State Survey & Certification		$397,334,000		$0
4. Research 2/		$20,054,000		($20,054,000)
Subtotal, Program Decreases 1/				**($20,054,000)**
Total Decreases 1/				**($20,054,000)**
Net Change 1/				**$372,241,000**

1/ Reflects enacted discretionary funds, only. Excludes budget authority and staffing from mandatory funds.
2/ Funding for Research is included within the FY 2023 total for Program Operations.

CMS Program Management
Budget Authority by Activity
(Dollars in Thousands)

	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget
1. Program Operations	$2,467,890	$2,479,823	$2,957,300
Additional Medicare Operations Funding	$305,000	$305,000	$0
CARES Act Supplemental (116-136)	$0	$0	
MIPPA (PL 110-275)	$3,000	$3,000	$3,000
PAMA/SGR (PL 113-93)	$10,000	$5,000	$5,000
MACRA (PL 114-10)	$0	$0	$0
BBA (115-123)	$5,000	$5,000	$5,000
Health Extenders (116-59)	$0	$0	$0
Further Health Extenders (116-69)	$0	$0	$0
Further Consolidated Appropriation (116-94)	$0	$0	$0
CARES Act (116-136)	$0	$0	$0
Consolidated Appropriations Act (116-260)	$98,000	$47,000	$52,000
Sequester	$0	($1,715)	($3,705)
Subtotal, Program Operations /1	**$2,888,890**	**$2,843,108**	**$3,018,595**
(Obligations) /2	($2,897,789)	($2,890,629)	($3,069,049)
2. Federal Administration	$772,533	$772,533	$895,424
Sequester	$0	$0	$0
Subtotal, Federal Administration	**$772,533**	**$772,533**	**$895,424**
(Obligations) /3	($768,652)	($772,533)	($895,424)
3. State Survey & Certification	$397,334	$397,334	$494,261
IMPACT Act (PL 113-185)	$5,625	$5,625	$5,625
CARES Act Supplemental (116-136)	$0	$0	$0
American Rescue Plan Act (117-2) /4	$500,000	$0	$0
Sequester	$0	($161)	($321)
Subtotal, State Survey & Certification	**$902,959**	**$402,798**	**$499,565**
(Obligations)	($425,801)	($402,798)	($499,565)
4. Research, Demonstration & Evaluation /5	$20,054	$20,054	$0
Sequester	$0	$0	$0
Subtotal, Research, Demonstration & Evaluation	**$20,054**	**$20,054**	**$0**
(Obligations)	($19,974)	($20,054)	$0
5. Reimbursables	$2,512,869	$2,589,017	$2,428,269
Sequester	($96,856)	($126,340)	($141,729)
Sequester Pop-Up	$95,265	$95,870	$99,359
Subtotal, User Fees	**$2,511,278**	**$2,558,547**	**$2,385,899**
(Obligations)	($2,210,343)	($2,081,089)	($1,940,659)
Total, Budget Authority /6	**$7,095,714**	**$6,597,040**	**$6,799,483**
(Obligations)	**($6,322,559)**	**($6,167,102)**	**($6,404,697)**
FTE /7	**4,742**	**4,855**	**5,142**

/1 FY 2021 reflects the use of HHS Secretary's Transfer Authority totaling $11.933 million.

/2 Obligations may exceed budget authority as a result of multi-year funding availability.

/3 FY 2021 obligations include administrative cost reimbursements from external agencies.

/4 The FY 2021 Enacted level for Sections 9402 and 9818 of the American Rescue Plan Act reflects the funding to be transferred from CMS to the Centers for Disease Control (CDC).

/5 Research is appropriated its own PPA in FY 2021. In FY 2023, CMS proposes to request this funding within the Program Operations account.

/6 Reflects CMS' current law request. Totals may not add due to rounding.

/7 Includes direct and reimbursable FTEs only.

Centers for Medicare & Medicaid Services Authorizing Legislation								
Account Name	**Program Name**	**Location of Program Authorization**	**Legal Citation (US Code)**	**Most Recent (Re)Authorizing Legislation**	**FY 2022 Funding Level in the Authorization**	**FY 2023 Funding Level in the Authorization**	**FY Auth. Expires or Expired**	**Nature of Expiration**
Program Management								
	Research	Social Security Act, Title XI, Section 1110	42 U.S.C. 1310	Social Security Protection Act of 2004, P.L. 108-203	N/A	N/A	Permanent	Program Authority
		Social Security Act, Title XI, Section 1115	42 U.S.C. 1315	Patient Protection and Affordable Care Act, P.L. 111-148/152	$ 4,000,000	$ 4,000,000	Permanent	Program Authority AND Appropriation in Auth Leg
		Social Security Act, Title XVIII	42 U.S.C. 1395 to 1395lll	Medicare Access and CHIP Reauthorization Act of 2015, P.L. 114-10	N/A	N/A	Permanent	Program Authority
	Program Operations	Social Security Act, Title XI (General Provisions)	42 U.S.C. 1301 to 1320e-3	Patient Protection and Affordable Care Act, P.L. 111-148/152	N/A	N/A	Permanent	Program Authority
		Social Security Act, Title XVIII (Medicare)	42 U.S.C. 1395 to 1395lll	Medicare Access and CHIP Reauthorization Act of 2015, P.L. 114-10	N/A	N/A	Permanent	Program Authority
		Social Security Act, Title XIX (Medicaid)	42 U.S.C. 1396 to 1396w-5	Patient Protection and Affordable Care Act, P.L. 111-148/152	N/A	N/A	Permanent	Program Authority
		Social Security Act, Title XXI (CHIP)	42 U.S.C. 1397aa to 1397mm	Medicare Access and CHIP Reauthorization Act of 2015, P.L. 114-10	N/A	N/A	Permanent	Program Authority
	State Survey & Certification	Social Security Act, Title XVIII, Section 1864	42 U.S.C. 1395aa	Medicare Improvements for Patients and Providers Act of 2008, P.L. 110-275	N/A	N/A	Permanent	Program Authority
	Federal Administration	Reorganization Plan No 1 of 1953	5 U.S.C. 101	Reorganization Act of 1953, P.L. 88-426	N/A	N/A	Permanent	Program Authority
	CLIA	Public Health Services Act, Section 353	42 U.S.C. 263a	Clinical Laboratory Improvement Amendments of 1988, P.L. 100-578	N/A	N/A	Permanent	Program Authority
	MA/PDP	Social Security Act, Title XVIII, Section 1857(e)(2)	42 U.S.C. 1395w-27	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173	Formula Based	Formula Based	Permanent	Program Authority AND Appropriation in Auth Leg
	Coordination of Benefits	Social Security Act, Title, XVIII, Section 1860D-24	42 U.S.C. 1395w-134	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173	N/A	N/A	Permanent	Program Authority
	Provider Enrollment	Social Security Act, Title XVIII, Section 1866 (j)(2)	42 U.S.C. 1935cc	Patient Protection and Affordable Care Act, P.L. 111-148/152	Formula Based	Formula Based	Permanent	Program Authority
	Exchanges	Patient Protection and Affordable Care Act, Title I, Subtitle D, Part II, Section 1311	31 U.S.C. 9701	Patient Protection and Affordable Care Act, P.L. 111-148/152	N/A	N/A	Permanent	Program Authority
	Sale of Data	Making Appropriations for the Executive Bureaus and Sundry Independent Executive Bureaus, Boards, Commissions, Corporations, Agencies, and Offices, for the Fiscal Year Ending June 30,1952, and for Other Purposes.	31 U.S.C. 9701	Treasury, Postal Service, and General Government Appropriations Act of 1993, P.L. 102-393			Permanent	Program Authority
	Recovery Audit Contractors	Social Security Act, Title XVIII, Section 1893	42 U.S.C. 1395ddd	Tax Relief and Health Care Act of 2006	N/A	N/A	Permanent	Program Authority

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2014				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Sequestration	$0	$0	$0	($8,136,000)
Subtotal				$104,864,000
Trust Fund Appropriation:				
Base **1/**	$5,217,357,000	$0	$5,217,357,000	$3,974,744,000
Transfers (P.L. 113-76)	$0	$0	$0	$118,582,000
Sequestration	$0	$0	$0	($1,584,000)
ACA (PL 111-148/152)	$0	$0	$0	$25,341,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$48,500,000
Sequestration	$0	$0	$0	($1,825,000)
Subtotal	$5,217,357,000	$0	$5,217,357,000	$4,163,758,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($10,080,000)
2015				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$50,000,000
Sequestration	$0	$0	$0	($3,869,000)
Subtotal				$49,131,000
Trust Fund Appropriation:				
Base **1/**	$4,199,744,000	$0	$0	$3,974,744,000
ACA (PL 111-148/152)	$0	$0	$0	$5,559,200
Sequestration	$0	$0	$0	($408,000)
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$204,500,000
IMPACT Act (PL 113-185)	$0	$0	$0	$107,333,000
Subtotal	$4,199,744,000	$0	$0	$4,297,728,200
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($10,220,000)
2016				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($204,000)
Subtotal				$2,796,000
Trust Fund Appropriation:				
Base **1/ 2/**	$4,245,186,000	$0	$0	$3,970,785,000
ACA (PL 111-148/152)	$0	$0	$0	$353,000
Sequestration	$0	$0	$0	($1,883,000)
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$216,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$21,333,000
Subtotal	$4,245,186,000	$0	$0	$4,212,588,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$65,000,000
Sequestration	$0	$0	$0	($4,420,000)

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2017				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($207,000)
Subtotal				$2,793,000
Trust Fund Appropriation:				
Base **1/ 2/**	$4,109,549,000	$0	$0	$3,966,314,000
IMPACT Act (PL 113-185)	$0	$0	$0	$21,333,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$211,000,000
21st Century Cures (PL 114-255)	$0	$0	$0	$18,000,000
Sequestration	$0	$0	$0	($16,444,977)
Subtotal	$4,109,549,000	$0	$0	$4,206,202,023
2018				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($198,000)
Subtotal				$2,802,000
Trust Fund Appropriation:				
Base **1/ 2/**	$3,587,996,000	$3,451,141,000	$3,974,744,000	$3,964,880,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$163,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$18,625,000
21st Century Cures Act (PL 114-255)	$0	$0	$0	$12,000,000
BB Act '18 (PL 115-123)	$0	$0	$0	$35,500,000
Sequestration	$0	$0	$0	($13,175,250)
Subtotal	$3,587,996,000	$3,451,141,000	$3,974,744,000	$4,186,829,750
2019				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($186,000)
Subtotal				$2,814,000
Trust Fund Appropriation:				
Base **1/ 2/**	$3,543,879,000	$3,502,024,000	$3,974,744,000	$3,965,796,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
MACRA (PL 114-10)	$0	$0	$0	$115,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$18,625,000
BB Act '18 (PL 115-123)	$0	$0	$0	$25,500,000
SUPPORT Act (PL 115-271)	$0	$0	$0	$83,000,000
Sequestration	$0	$0	$0	($8,904,750)
Subtotal	$3,543,879,000	$3,502,024,000	$3,974,744,000	$4,209,016,250
2020				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($103,008)
Subtotal				$2,896,992
Trust Fund Appropriation:				
Base **1/**	$3,579,427,000	$3,984,744,000	$3,974,744,000	$3,974,744,000
CARES Act Supplemental (PL 116-136)	$0	$0	$0	$200,000,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
MACRA (PL 114-10)	$0	$0	$0	$20,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
BB Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Health Extenders (PL 116-59)	$0	$0	$0	$1,852,000
Further Health Extenders (PL 116-69)	$0	$0	$0	$1,033,000
Further Consolidated Appropriation (PL 116-94	$0	$0	$0	$10,315,000
CARES Act (PL 116-136)	$0	$0	$0	$19,800,000
Sequestration	$0	$0	$0	($1,394,903)
Subtotal	$3,579,427,000	$3,984,744,000	$3,974,744,000	$4,246,974,097

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2021				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	$0
Subtotal				$3,000,000
Trust Fund Appropriation:				
Base **1/ 2/**	$3,693,548,000	$3,984,744,000	$3,974,744,000	$3,962,811,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
BB Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Consolidated Appropriation (PL 116-260)	$0	$0	$0	$98,000,000
American Rescue Plan (PL 117-2) **3/**	$0	$0	$0	$500,000,000
Sequestration	$0	$0	$0	$0
Subtotal	$3,693,548,000	$3,984,744,000	$3,974,744,000	$4,581,436,000
2022				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($85,734)
Subtotal				$2,914,266
Trust Fund Appropriation:				
Base **4/**	$4,315,843,000	$4,315,843,000	$4,250,843,000	$3,974,744,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$5,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
BB Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Consolidated Appropriation (PL 116-260)	$0	$0	$0	$47,000,000
Sequestration	$0	$0	$0	($1,789,702)
Subtotal	$4,315,843,000	$4,315,843,000	$4,250,843,000	$4,035,579,298
2023				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($171,000)
Subtotal				$2,829,000
Trust Fund Appropriation:				
Base **5/**	$4,346,985,000	$0	$0	$0
PAMA/SGR (PL 113-93)	$0	$0	$0	$5,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
BB Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Consolidated Appropriation (PL 116-260)	$0	$0	$0	$52,000,000
Sequestration	$0	$0	$0	($3,854,625)
Subtotal	$4,346,985,000	$0	$0	$63,770,375

1/ Base appropriation includes $305 million to support Program Management activity related to the Medicare Program.

2/ Reduced to reflect HHS Secretary's Transfer in a given Fiscal Year.

3/ The FY 2021 Enacted level for Sections 9402 and 9818 of the American Rescue Plan Act reflects the funding to be transferred from CMS to the Centers for Disease Control (CDC).

4/ The FY 2022 Appropriation is based on an annualized CR.

5/ Based on Current Law Request

CMS Program Management
Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2022

CMS Program Management has no appropriations not authorized by law.

Program Operations
(Dollars in Thousands)

FY 2021 Final[1]	FY 2022 CR	FY 2023 President's Budget	FY 2023 +/- FY 2022
$2,772,890	$2,784,823	$2,957,300	$172,477

Medicare Authorizing Legislation – Social Security Act, Title XVIII, Sections 1816 and 1842, 42 U.S.C. 1395 and the Medicare Prescription Drug Improvement and Modernization Act of 2003.

Medicaid Authorizing Legislation – Social Security Act, Title XIX, Section 1901

Children's Health Insurance Program Authorizing Legislation – Social Security Act, Title XXI

Affordable Care Act Authorizing Legislation – Patient Protection and Affordable Care Act (Public Law 111–148) consolidating the amendments made by title X of the Act and the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152)

FY 2022 Authorization – One Year/Multi-Year P.L. 117-86

Allocation Method – Contracts, Competitive Grants, Cooperative Agreements

OVERVIEW

CMS administers and oversees the nation's largest ongoing health care programs. These programs include the Medicare program, established in 1965 for Americans age 65 and older and for disabled persons, including those with End-Stage Renal Disease (ESRD); the Medicaid program, also established in 1965, for low-income families and aged, blind, and disabled individuals; the Children's Health Insurance Program (CHIP), established in 1997, for low-income children in families with incomes above the Medicaid eligibility levels; and the Health Insurance Marketplaces, established in 2014 for consumers seeking health coverage in individual and small-group markets.

Program Operations primarily funds the processing of Medicare Fee-For-Service (FFS) claims, the National Medicare Education program, information technology (IT) infrastructure, and operational support. It supports Medicare Advantage and Medicare Prescription Drug programs, beneficiary and consumer outreach programs, quality improvement related activities, and ongoing research. It also funds operations and enhancements in the Medicaid and CHIP programs, as well as insurance market reform and oversight.

As the primary account funding the operations for CMS's programs, Program Operations plays a direct role in achieving the Agency's strategic priorities by promoting efficiency in health care, reforming the health care delivery system, decreasing medical costs and payment error rates,

[1] FY 2021 reflects the use of HHS Secretary's Transfer Authority totaling $11.933 million.

creating a more efficient Medicare appeals system, and supporting the Agency's response to public health emergencies.

Program Description and Accomplishments

Medicare

Authorized in 1965 under title XVIII of the Social Security Act, the Medicare program provides hospital and supplemental medical insurance to Americans age 65 and older and to disabled persons, including those with ESRD. The program was expanded in 2006 with the introduction of a voluntary prescription drug benefit, Part D. Medicare enrollment has increased from 21 million in 1966 to a projected 66.3 million beneficiaries in FY 2023. Medicare benefits, that is, the payments made to providers, health plans, and drug plans for their services, are permanently authorized. The Medicare administrative expenses discussed in this chapter are funded annually through the CMS Program Management appropriation.

Medicaid and CHIP

Authorized in 1965 under title XIX of the Social Security Act, Medicaid is a means-tested health care entitlement program financed jointly by states and the federal government that provides health care coverage to low-income families with dependent children, pregnant women, children, aged, blind and disabled individuals, and other adults. Medicaid also provides community based long-term care services and supports seniors and individuals with disabilities, as well as institutional care and long-term care services. As a result of this joint structure, Medicaid programs vary widely from state to state. The grants made to states for the federal share of Medicaid services and state administration of this program are appropriated annually. The funding for Medicaid included in the Program Operations chapter covers certain administrative expenses such as Medicaid systems support, managed care review and oversight, demonstration management, and other program-related initiatives.

The Balanced Budget Act of 1997 created the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act. CHIP is a federal-state matching, capped grant program providing health insurance to targeted, low-income children in families with incomes above Medicaid eligibility levels. This program was the largest single expansion of health insurance coverage for children in more than 30 years and has improved access to health care and quality of life for millions of vulnerable children younger than 19 years old.

Private Health Insurance Protections and Programs

CMS conducts market oversight of Qualified Health Plans (QHPs) and works in collaboration with states and issuers on Medical Loss Ratio (MLR) rules, oversight of State-based Marketplaces (SBMs), financial assistance eligibility determination, and market stabilization activities. CMS is responsible for operating the Federally-facilitated Marketplaces (FFMs) in states that elect not to set up their own SBM. SBMs can partner with CMS to leverage federal platforms for activities such as enrollment. These Marketplaces are referred to as State-based Marketplaces on the Federal Platform (SBM-FPs).

Funding History

Fiscal Year	Amount
FY 2019 [2]	$2,815,875,000
FY 2020 [3]	$2,774,823,000
FY 2021 Final [4]	$2,772,890,000
FY 2022 CR	$2,784,823,000
FY 2023 President's Budget	$2,957,300,000

Budget Request: $2,957.3 Million

CMS's FY 2023 President's Budget request for Program Operations is $2,957.3 million, an increase of $172.5 million above the FY 2022 CR. This request provides the funding needed for CMS to administer, oversee, and support Medicare, Medicaid, CHIP, and private insurance. The funding increase supports state use of the Federal Marketplace Data Services Hub to determine Medicaid eligibility, and an increased investment to our IT infrastructure. In addition, this budget invests in several critical administration initiatives including, but not limited to, the opioid crisis, health equity and rural health, modernizing our operations to meet future beneficiaries' needs, as well as improving our analytic capabilities and sharing of health data with internal and external stakeholders. CMS will continue to invest in high priority activities with a focus on high quality service for beneficiaries and participating providers and will continue evaluating areas for contract efficiencies to maximize resources.

[2] FY 2019 includes $8.948 million in HHS Secretary's Transfer Authority.
[3] FY 2020 includes $50 million reprogrammed to Federal Administration.
[4] FY 2021 includes $11.933 million in HHS Secretary's Transfer Authority.

Program Operations
(Dollars in Thousands)

Activity	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget	FY 2023 +/- FY 2022
I. Medicare Parts A&B				
Ongoing Operations	$792,863	$823,434	$834,299	$10,865
FFS Operations Support	$48,682	$51,810	$49,643	($2,167)
Claims Processing Investments	$81,855	$87,093	$86,756	($337)
DME Competitive Bidding	$61,227	$4,800	$5,161	$361
QIC Appeals	$68,298	$68,891	$83,867	$14,976
II. Medicare Parts C&D				
Oversight and Management of Health Plans	$47,987	$45,663	$45,898	$235
Medicare Parts C and D Appeals	$23,895	$24,483	$26,582	$2,098
Medicare Parts C and D IT Systems Investments	$41,133	$39,818	$41,663	$1,845
III. Medicaid & CHIP				
MACBIS	$80,671	$91,113	$97,699	$6,586
MAC Scorecard	$6,338	$5,442	$6,600	$1,158
Section 1115 Waivers	$20,140	$21,400	$23,032	$1,632
Medicaid Oversight and Support	$68,132	$84,073	$98,088	$14,015
IV. Private Health Insurance				
Market Oversight and Support	$9,245	$12,164	$11,157	($1,007)
Federal Marketplaces	$119,520	$137,088	$134,067	($3,021)
V. Outreach & Education				
NMEP	$304,384	$299,237	$306,127	$6,890
Targeted Outreach and Enrollment	$12,946	$20,393	$16,148	($4,245)
VI. Improving Health Care Quality				
Health Care Quality Initiatives	$70,557	$31,037	$50,009	$18,972
Medicare Quality Improvement - Value Based Transformation	$26,300	$30,512	$37,603	$7,091
Quality Payment Program	$38,965	$39,288	$35,321	($3,966)
VII. Enterprise Operations				
Accounting and Audits	$100,108	$100,702	$101,326	$624
HIPAA Administrative Simplification	$29,935	$34,057	$36,284	$2,227
IT Systems and Support	$615,387	$623,790	$645,724	$21,934
Operational Support	$100,030	$102,662	$77,667	($24,995)
Opioid Support Services	$4,293	$5,873	$16,282	$10,409

Activity	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget	FY 2023 +/- FY 2022
Research, Demonstrations, and Evaluation	$0	$0	$20,297	$20,297
Health Equity/Rural Health	$0	$0	$35,000	$35,000
Improve Analytic Capabilities and Data Sharing	$0	$0	$15,000	$15,000
Modernize CMS's Operations to Meet Future Beneficiaries' Needs	$0	$0	$20,000	$20,000
TOTAL	**$2,772,890**	**$2,784,823**	**$2,957,300**	**$172,477**

I. MEDICARE - PARTS A AND B

Program Description and Accomplishments

CMS administers Medicare Parts A and B (otherwise known as FFS or Original Medicare). Nearly 30 percent of CMS's request supports paying Part A and B claims. In addition to paying providers' claims, CMS must also provide operational support to other Medicare related programs, process claims and FFS data, resolve Part A and B appeals, and manage the DME Competitive Bidding program. The following information describes in detail the operations and funding necessary to administer Medicare Parts A and B.

Ongoing Operations

CMS processes beneficiary claims through Medicare Administrative Contractors (MACs). A MAC is a private healthcare insurer that has been awarded a geographical jurisdiction to process Medicare Part A and B medical claims or durable medical equipment claims for Medicare. In addition to processing Part A and Part B claims, MACs enroll providers in the Medicare program, handle provider reimbursement services, process first-level appeals, respond to provider inquiries, educate providers about the program, and administer the participating physician/supplier program (PARDOC). The MACs are the primary contracts for managing Medicare and are mission critical for the success of CMS.

The FFS claims volume workload history and projection is presented below:

FFS Claims Volume
(Claim Count in Thousands)

Activity	FY 2020 Actual	FY 2021 Actual	FY 2022 Estimate	FY 2023 Estimate
Part A (in thousands)	203,097	225,711	227,968	230,248
Part B (in thousands)	910,600	1,029,726	1,040,023	1,050,423
Total	**1,113,697**	**1,255,437**	**1,267,991**	**1,280,671**

Budget Request: $834.3 Million

The FY 2023 President's Budget request for Ongoing Operations is $834.3 million, an increase of $10.9 million above the FY 2022 CR. With this funding, the MACs would continue processing Medicare claims accurately, in a timely manner, and in accordance with CMS's program requirements. In FY 2023, CMS would use requested funding to support a 1% increase in MAC workloads, to cover wage increase costs as a result of E.O. 13658, and support other MAC business functions. CMS has analyzed the MAC contracts through contract spend optimization and maximized our savings over the years.

In FY 2023, MACs are expected to:

- Process nearly 1.3 billion claims;
- Handle 2.5 million Medicare first-level appeal redeterminations; and
- Answer 11.5 million provider toll-free inquiries.

Provider Enrollment – CMS is responsible for both enrolling providers and suppliers into the Medicare program and ensuring that they continue to meet the enrollment requirements for their provider or supplier type. Program Operations supports the enrollment process by the MACs. The enrollment process includes a number of verification processes to ensure that Medicare is only paying qualified providers and suppliers.

Provider Reimbursement Services – Medicare Part A providers are required to file a cost report on an annual basis. In addition to determining the payment amount for items paid on cost, the cost report is used to finalize Prospective Payment System (PPS) add-on payments such as graduate medical education, indirect medical education, disproportionate share hospital, and bad debt payments. The MACs perform many other payment review activities, maintain claims information systems, and are responsible for making determinations of status.

Medicare Appeals – The Medicare appeals process affords beneficiaries, providers, and suppliers the opportunity to dispute an adverse determination, including coverage and payment decisions. The first level of appeal begins at the MAC with a redetermination of the initial decision. MAC personnel not involved in the original determination review the original claim and any new information to determine if the original determination should be changed and handle any reprocessing activities as required. The statute stipulates that MACs issue a decision within 60 calendar days of receipt of an appeal request. In FY 2023, the MACs are expected to process 2.5 million redeterminations.

Participating Physician/Supplier Program (PARDOC) – This program helps reduce the impact of rising health care costs on beneficiaries by increasing the number of enrolled physicians and suppliers who "participate" in Medicare. Participating providers agree to accept Medicare-allowed payments as payment in full for their services. The MACs conduct an annual enrollment process and monitor limiting charge compliance to ensure that beneficiaries are not being charged more than Medicare allows.

Provider Inquiries and Toll-Free Service – CMS coordinates communication between Medicare contractors and providers to ensure consistent responses. To accomplish this, CMS requires the Medicare contractors to maintain a Provider Contact Center (PCC) that can respond to telephone and written (letters, e-mail, fax) inquiries. The primary goal of the PCC is to deliver timely, accurate, accessible, and consistent information to providers in a courteous and professional manner. These practices are designed to help providers understand the Medicare

program and, ultimately, bill for their services correctly. Costs for the PCC are primarily driven by the number of minutes of telephone service. Other costs include toll-free lines, support contracts, answering inquiries and customer service representatives.

In FY 2023, contractors are expected to respond to 11.5 million telephone inquiries and 265,324 written inquiries (which include rare walk-in inquiries) from 2 million FFS providers. In an effort to drive efficiency, Interactive Voice Response (IVR) systems are used to automate approximately 45 percent of their telephone inquiries. Increased utilization of the IVR frees up customer service representatives to handle the more complex questions.

The provider toll-free call volume history and projection is presented below:

Provider Toll-Free Service Call Volume
(Call Volume in Millions)

	FY 2020 Actual	FY 2021 Actual	FY 2022 Estimate	FY 2023 Estimate
Completed Calls	15.5	12.6	11.5	11.5

Provider Outreach and Education –The goal is to share up-to-date information on Medicare procedures and policies with Medicare providers to ensure appropriate billing and processing. The Medicare contractors are required to educate providers and their staff about the fundamentals of the program, policies and procedures, new initiatives, and significant changes including any of the more than 500 change requests that CMS issues each year.

Coordination of Benefits (COB) Contractor – Coordination of Benefits activities include the collection and processing of coverage data from multiple sources. The data allows accurate claims processing, prevents Medicare from making incorrect payments, and helps identify debts to be recovered under the Medicare Secondary Payer (MSP) statute.

Ongoing Operations Support Activities – The National Provider Education, Outreach, and Training initiative is responsible for the development of the Medicare Learning Network (MLN) Matters® articles and other education products for providers. Educational products/services are branded as part of the MLN and include MLN Matters® national articles, MLN publications (e.g., fact sheets, quick-reference charts, and booklets), web-based training courses, educational tools, and podcasts. CMS and the MACs are required to use MLN products to promote consistency in their outreach efforts which results in reduced costs associated with MACs and OPOLE developing their own materials. Funding supports fulfillment activities related to requests for hard copy products and other operational support to perform related outreach and education.

MAC Transition Cost – CMS must support the transition, termination, and implementation costs associated with transitioning from incumbent MACs to their successor MACs. In FY 2023, CMS has scheduled the contract re-procurements of one A/B MAC Jurisdiction and two DME MAC Jurisdictions.

Virtual Data Center Operations (VDC) – The VDC provides the infrastructure to all CMS Medicare Fee for Service Part A, B, and DME production operations. This includes hosting the Common Working File (CWF), web hosting services for Medicare.gov, CMS.HHS.gov, CMSNet and the Health Plan Management System (HPMS), and Application Hosting services for the

1-800 Medicare Next Generation Desktop Data Warehouse, and the Provider Environment.

Fee-for-Service Operations Support

This section serves as the primary operations support center for the management of Medicare Parts A and B. These contracts support a myriad of critical functions centered on improving Part A and Part B FFS information, education, service initiatives, coverage and payment policies, health care quality, and general administrative and legislative actions. Many of these activities promote accountability, communication, coordination and aid the decision-making for programmatic and functional issues across the organization. These activities help to ensure the effective management of CMS's programs.

Budget Request: $49.6 Million

The FY 2023 President's Budget request for FFS Operations Support is $49.6 million, a decrease of $2.2 million below the FY 2022 CR. In FY 2022, CMS allocated additional funds to support CMS's systems security program requirements for the Common Electronic Data Interchange (CEDI); therefore, this effort will require less funding in FY 2023. At this funding level, CMS will continue funding ongoing operations for critical services supporting the Medicare FFS program. Without these activities, CMS would be unable to administer Medicare Parts A and B and pay claims according to law. These activities are described in more detail below:

- *A-123 Internal Controls Assessment*: The OMB Circular A-123 requires that CMS establish and maintain internal controls to achieve the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. Funding supports a certified public accountant firm to conduct a rigorous assessment of the CMS internal controls over financial reporting. This assessment includes performing internal control reviews (formerly SAS 70 audits) for Title XVIII Medicare contractors. The OMB Circular A-123 also requires the Administrator to submit a statement of assurance on internal controls over financial reporting.

- *Home Health Prospective Payment System Refinement*: Section 5012 of the 21st Century CURES Act introduces a new Medicare home infusion therapy benefit initiated in 2021. Medicare makes a single payment for professional and nursing services, training and education, remote monitoring, and monitoring services for providing home infusion therapy and drugs. This funding will provide for contractor support to analyze data of the home infusion industry to evaluate the scope of the benefit and identify the best and most efficient way to develop the regulation.

- *IT Systems*: CMS hosts many systems that aid in managing contracts for FFS and automate the change management process. This budget request continues funding operations and maintenance for Contractor Management Information System (CMIS), Enterprise Electronic Change Information Management Portal (eChimp) system, and the Common Electronic Data Interchange (CEDI).

- *Medicare Beneficiary Ombudsman*: The legislative mandate for the creation of a Medicare Ombudsman (MMA Section 923) requires the Medicare Beneficiary Ombudsman to provide assistance to Medicare beneficiaries with handling their inquiries, complaints, grievances, appeals, and to provide recommendations for improvement in the administration of the Medicare program. This funding is for existing contract support for a wide variety of

activities, including development of the Medicare Ombudsman annual report to the Secretary and to Congress.

- *Medicare Cures Act Support:* The 21st Century Cures Act requires expanded use of telehealth technology and home infusion therapy for Medicare beneficiaries. CMS requires support to oversee the national implementation of new regulations promulgated under the Cures Act and contract support to aid in education and training, technical assistance, and an evaluation of the findings.

- *Medicare Healthcare Effectiveness Data and Information Set (HEDIS) Quality of Care Performance Measures*: This funding provides for the proper oversight and management of Medicare Advantage organizations (MAOs) and Special Needs Plans (SNPs) quality performance by developing and improving specific HEDIS measures for MAOs and SNPs and reviewing and approving SNP Models of Care. This activity is critical for CMS to be able to evaluate SNPs' ability to effectively coordinate care for older and/or disabled adults and to develop tangible SNP models of care outcome measures.

- *Printing and Postage*: This contract covers the printing and mailing of the Medicare Premium Bill (CMS-500) that is utilized to collect premiums from direct billed beneficiaries (42 CFR Section 408.60), including periodic mandatory and informational bill stuffers. CMS anticipates the number of bills mailed to direct bill beneficiaries to continue to increase by approximately 10% over FY 2022 levels.

- *Medicare Casework Support Contract*: This contract helps resolve system errors in the Medicare enrollment and premium billing systems that result in increased Medicare beneficiary inquiries and complaints. The Eligibility and Enrollment Medicare Online (ELMO) Database is CMS's authoritative source of Medicare enrollment information. It identifies each person entitled to Medicare benefits, adds approximately 200,000 newly enrolled beneficiaries each month and provides change notification to other Medicare systems. Funding is critical to ensure that Medicare beneficiary and premium billing information agree with the beneficiary records of other data systems.

- *Medicare Physician Fee Schedule Contract*: CMS must develop payment rates and policies to update the PFS on an annual basis. This request funds the contract that provides the underlying data that CMS needs to update the proposed and final rates for the PFS through annual notice and comment rulemaking. The data is required to calculate the fiscal impacts of the proposed and final payment policies.

- *Hospital Inpatient and Outpatient PPS:* CMS requests funding for data and policy analysis assistance for the development of payment rates and payment policies for inpatient and outpatient settings. This work is performed annually to keep CMS in compliance with the statute, congressional mandates, and to be able to produce program rulemaking and pay hospital claims.

- *Medicare Premium Billing:* This interagency agreement provides reimbursement to Treasury for remittance services related to premiums collected by the Medicare Premium Collection Center (MPCC) lockbox for directly billed beneficiaries. The directly billed population has historically increased 10% each year. It is expected by FY 2023 the direct billed population will have increased to 3.3 million beneficiaries. CMS anticipates the direct bill population will continue to grow as the Medicare population increases and the Social Security eligibility age

rises, creating a greater proportion of beneficiaries who must be directly billed for their Medicare premiums.

- *Other FFS Operations:* This request supports activities involving program monitoring, provider validation, satisfaction surveys, and many other FFS administrative functions.

Claims Processing Systems

CMS's claims processing systems process nearly 1.3 billion Part A and Part B claims each year. The claims processing systems receive, verify, and log claims and adjustments, perform internal claim edits and claim validation edits, complete claims development and adjudications, maintain pricing and user files, and generate reports. The requested funding provides ongoing systems maintenance and operations.

The main systems include:

- *Medicare Fee-For-Service Shared Systems:* Medicare Administrative Contractors (MACs) use standard systems to adjudicate Part A, Part B, and DME claims. All claims are sent to the Common Working File (CWF) for eligibility, duplication, and utilization checks before final adjudication.
- *Fiscal Intermediary Shared System (FISS): FISS* is used to process more than 225 million Medicare Part A claims, including outpatient claims submitted under Part B.
- *Multi Carrier System (MCS):* MCS is used to process over 1 billion Medicare Part B claims for physician and non-physician practitioner care and other non-DMEPOS Part B services (e.g., ambulance)
- *ViPS Medicare System (VMS):* VMS is used to process claims for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS).
- *Common Working File (CWF):* The CWF system works with Medicare claims processing systems to ensure that:
    - The beneficiary is entitled to either Part A or Part B benefits, depending on the type of claim submitted;
    - The co-pay and/or deductible applied, if any, is accurate; and,
    - Medicare benefits are available for the services submitted on the claim for that beneficiary.

  The CWF system also ensures that the services on the claim have not been paid on another claim - either the same type or another type of claim to prevent duplicate payments.
- *Single Testing Contractor:* provides integration and regression testing for Medicare fee-for-service claims processing systems.

Budget Request: $86.8 Million

The FY 2023 President's Budget request for Claims Processing Systems is $86.8 million, -$0.3 million below the FY 2022 CR. The requested funding provides ongoing systems maintenance and operations.

- *Multi Carrier Claims Processing System (MCS):* This system processes Medicare Part B claims for physician care, durable medical equipment, and other outpatient services nationwide. MCS interfaces directly with the Healthcare Integrated General Ledger Accounting System (HIGLAS) to perform daily functions of payment calculation (following pre-payment validation), formatting, and accounting, thereby ensuring timely and accurate delivery of Medicare benefit payments.

- *Enrollment Database and Direct Billing Support:* This activity supports system development, maintenance, and Federal Information Security Management Act (FISMA) compliance of the Medicare Enrollment and Premium Billing Systems (MEPBS).

- *CWF Program Maintenance*: This activity includes the operational support to ensure interaction with the Medicare claims processing systems.

- *Part A Processing System Maintenance & Implementation*: This supports Part A bills and interface directly with the Common Working File (CWF) system for verification, validation, and payment authorization. This system also interfaces directly with the Healthcare Integrated General Ledger Accounting System (HIGLAS) to perform daily functions of payment calculation (following pre-payment validation), formatting, and accounting, thereby ensuring timely and accurate delivery of Medicare benefit payments.

- *Durable Medical Equipment MAC Claims Processing Systems*: These systems support DME functionality for claims collection, editing, pricing, adjudication, correspondence, on-line inquiry, file maintenance, financial processing and reporting.

- *Other Claims Processing Systems:* These systems support core requirements for processing claims. This includes integration testing for the FFS ecosystem, data collection and validation, claims control, pricing, adjudication, correspondence, on-line inquiry, file maintenance, reimbursement, and financial processing.

DME Competitive Bidding

Section 302(b)(1) of the Medicare Modernization Act (MMA) authorized the establishment of a new Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) acquisition program which replaces the current Medicare Part B fee schedule payment amounts for selected items in certain areas with payment amounts based on competitive bidding. Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in ten metropolitan statistical areas (MSAs) in 2007. The Medicare Improvements for Patients and Providers Act (MIPPA) and the Affordable Care Act (ACA) subsequently amended and expanded the program to cover 100 MSAs. ACA also mandated that all areas of the country be subject to either DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. The program sets appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and

services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Budget Request: $5.2 Million

The FY 2023 President's Budget request for DME Competitive Bidding is $5.2 million, an increase of $0.4 million above the FY 2022 CR. The DME competitive bidding process occurs on a three-year cycle. The most recent cycle, the FY 2021 consolidated round, has been awarded and fully operational. CMS's FY 2023 budget request continues funding ongoing operations and maintenance as well as preparation for the upcoming FY 2024 re-competition.

- *Competitive Bidding Survey Contractor (CBSC)*: The FY 2023 request will fund the contract to conduct baseline surveys via telephone and/or electronically to key stakeholders (i.e., beneficiaries, suppliers, and referral agents), analyze the baseline survey results, and memorialize baseline survey findings. Additionally, the contractor will plan for a new PRA package, as well as preparing for and conducting Round 2024 surveys.

- *DME Bidding Systems (DBidS)*: DBids allows for entities to submit an online application to participate Medicare's DMECB Program. The FY 2023 request supports ongoing operations and maintenance.

Qualified Independent Contractor (QIC) Appeals

Section 521 of the Benefits Improvement and Protection Act of 2000 (BIPA) requires CMS to contract with Qualified Independent Contractors (QICs) to adjudicate second level appeals resulting from an adverse redetermination of a claim by a MAC during the first level of appeal. BIPA requires that QICs process Medicare Parts A and B claim appeals within 60 calendar days of receipt. If a QIC is unable to complete the appeal within the 60-day timeframe, then it must notify the appellant that it cannot timely complete the appeal and offer the appellant an opportunity to escalate the appeal to an Administrative Law Judge at the Office of Medicare Hearings and Appeals (OMHA). This program ensures that Medicare beneficiaries' providers have the opportunity to continue seeking payment for services in the event of an initial adverse claim determination and is essential to maintain provider participation in Medicare.

Budget Request: $83.9 Million

The FY 2023 President's Budget request for QIC Appeals (BIPA section 521) is $83.9 million, an increase of $15.0 million above the FY 2022 CR. The request funds the estimated contractual needs to continue ongoing QIC operations, related workloads, and takes into consideration the planned procurement strategy which requires award of a new Durable Medical Equipment (DME) QIC contract late in FY 2023.

- *QIC Operations*: This request includes annual operational costs and activities to advance the Departmental priority of continuing to timely adjudicate Medicare appeals at the second level in the appeals process. It is difficult to estimate the potential changes in workload and funding needs for FY 2023. Due to the COVID-19 PHE, medical review activities were halted or dramatically reduced during FY 2020 and into FY 2021, making it difficult to use FY 2020 and 2021 receipts to predict future contract budgetary needs. The funding request supports the workload projections presented in this section.

The QIC appeals workload history and projection is presented in the table below. The FY 2022 through FY 2023 appeals (cases) projections were formulated based upon FFS enrollment growth projections from CMS Office of Actuary. As in previous years, CMS will continue to review and analyze workload trends and adjust as necessary.

QIC Appeals Workload
(Volume in Appeals)

	FY 2020 Actual	FY 2021 Actual	FY 2022 Estimate	FY 2023 Estimate
Non-RAC QIC Appeals	217,679	177,966	180,000	189,000
% Increase from Previous Year	-14.1%	-18.2%	1.1%	5.0%

- *Medicare Appeals System (MAS)*: MAS is a system that tracks and records Medicare appeals through multiple levels of the appeal process. The system leverages processes and consolidates data to allow users across appeal levels to realize benefits of reusable, centralized data. The system supports standard processing of appeals and availability of data to other appeal levels while allowing stakeholders and user groups to shape procedures at their desired level. CMS maintains the system and implements all necessary system changes.

II. MEDICARE – PARTS C AND D

Program Description and Accomplishments

CMS administers and oversees private health plans including Medicare Advantage (MA) (Part C) and Medicare prescription drug benefit (Part D) programs. A Medicare Advantage Plan (like an HMO or PPO) is another Medicare health plan choice beneficiaries may have as part of Medicare. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare. Additionally, Medicare prescription drug coverage is available to everyone with Medicare. To get Medicare prescription drug coverage, people must join a plan approved by Medicare that offers Medicare drug coverage. Most people pay a monthly premium for Part D.

The following section describes the oversight and management activities, IT systems and support, and review activities needed to run these programs.

Oversight and Management of Health Plans

CMS oversees health insurance companies that offer health care coverage through private plans. Oversight and management activities needed to run the Part C, Part D, and private insurance programs include obtaining actuarial estimates, reviewing bids from the prescription drug and Medicare Advantage plans, approving new plan applicants for the new contract year, reviewing formularies and benefits, monitoring current plan performance, reconciling prior year plan payments, and supporting Part D enrollment of low-income beneficiaries. CMS funds activities to improve coordination between the federal government and states to enhance

access to quality services for individuals dually eligible for both Medicare and Medicaid benefits, and helps states innovate using data-driven insights to better serve these individuals. These activities are vital to ensuring that beneficiaries are receiving the health care services that they expect from our programs.

Budget Request: $45.9 Million

The FY 2023 President's Budget request for Oversight and Management of Health Plans is $45.9 million, an increase of $0.2 million above the FY 2022 CR. Notable CMS programs supporting the oversight and management of Parts C and D health plans are described below:

- *Retiree Drug Subsidy Program*: CMS provides the retiree drug subsidy program to enable employers and unions to obtain a drug subsidy without disrupting their current coverage. CMS requests funds to continue daily operation of the RDS program, as well as the identification of enhanced compliance reporting, improved education, training, and outreach, process improvements in the recoupment of overpayments, and/or the appeals process to improve the quality of the program.

- *Medicare Part C&D Policy Making, Regulation, Rule Support, and Interoperability*: This activity provides support services for the Medicare Advantage (Part C) and Prescription Drug (Part D) Annual Proposed Final Rule and Advance Notice. The project allows for the triage of public comments received in response to the calendar year and future proposed rules and advanced notices. The project also provides technical assistance and sub-regulatory support where necessary.

- *Low Income Subsidy & Auto-Enrollment*: This activity funds the production and mailing of Daily notices in any given month to approximately 115,000 individuals who are newly deemed eligible for a low-income subsidy (LIS) and approximately 95,000 subsidy-eligible beneficiaries, informing them of their plan assignment and annual notices.

Medicare Parts C and D Appeals

CMS contracts with an independent reviewer to conduct reconsiderations of adverse Medicare Advantage plan determinations, late enrollment penalties (LEP), and coverage denials made by Medicare Advantage and Part D plans. This review stage represents the second level of appeal for the beneficiaries in these plans. All second level reviews are done by the Qualified Independent Contractors (QICs).

Budget Request: $26.6 Million

The FY 2023 President's Budget request for Medicare Parts C and D Appeals is $26.6 million, an increase of $2.1 million above the FY 2022 CR. CMS expects a 12 percent increase in appeals volume for Part C due to the new non-contract payment dispute appeals. The non-contract payment dispute resulting in the increased appeals volume refers to an MAO's refusal to provide or pay for services that the enrollee believes should be furnished or arranged for by the MA organization or a disagreement with a medical provider's diagnosis or medical necessity determination.

The Parts C and D appeals workload history and projection is presented below:

QIC Appeals Workload for Parts C/D
(Volume in Appeals)

	FY 2020 Actual	FY 2021 Actual	FY 2022 Estimate	FY 2023 Estimate
Part C Appeals	104,801	126,647	150,000	176,000
Part D Benefit Appeals	30,317	31,090	32,000	33,000
Part D LEP Appeals	39,443	49,352	51,500	53,000

Parts C and D Information Technology (IT) Systems Investments

CMS maintains several major systems needed to run the Parts C and D programs. These systems include:

- *Medicare Advantage Prescription Drug Payment System (MARx)* – This system supports the Medicare Modernization Act (MMA) Title I and Title II requirements for beneficiary enrollment and calculation of payments. The MARx also supports the Premium Withhold System.

- *Medicare Beneficiary Database Suite of Services (MBDSS)* – This contains beneficiary demographic and entitlement information. The MBDSS stores Low-Income Subsidy (LIS) beneficiary status. It also derives Part D eligibility periods, processes state files for the State Phase Down Billing System and deeming process, deems beneficiaries eligible for LIS, and assigns LIS beneficiaries to a Part D drug plan.

- *Drug Data Processing System (DDPS)* – This system collects the prescription drug event (PDE) data for each Medicare Part D claim and is used to generate invoices to prescription drug manufacturers for the coverage gap discount program (CGDP).

- *Payment Reconciliation System (PRS)* – This system takes prospective payment data from MARx, the PDEs from DDPS, and direct and indirect remuneration (DIR) reports from the Health Plan Management System (HPMS) to calculate final reconciliation payments for Part D sponsors.

- *Retiree Drug Subsidy System* – This system collects sponsor applications, drug cost data, and retiree data, and processes this information in order to pay retiree drug subsidies to plan sponsors. This system supports drug plan sponsors' participation in the Retiree Drug System program through data center hosting, hardware/software maintenance, system technical support, data/database administration, and system security testing.

- *Risk Adjustment System* – This system uses demographic and diagnostic data to produce risk adjustment factors to support payments to Medicare Advantage and Part D plans.

Budget Request: $41.7 Million

The FY 2023 President's Budget request for Parts C and D IT Systems Investments is $41.7 million, an increase of $1.8 million above the FY 2022 CR. The request allows CMS to validate Parts C and D IT systems services contracts, which supports the daily business activities, business deliveries, and ongoing operational enhancements for a variety of systems.

- *MA/Part D Help desk:* This funding supports enrollment-related beneficiary requests applications.

- *Prescription Drug Event (PDE) Support:* This funding supports system development, maintenance of the PDE record containing prescription drug cost and payment data.

- *Retiree Drug Subsidy Program*: This funding supports data center hosting, hardware/software maintenance and software licenses related to the RDS program.

- *Other C & D IT*: This funding supports the Part D Coverage Gap Discount Program, Risk Adjustment Suite of Systems, and Testing for Certification, Accreditation, Corrective Action and collaborative systems for sharing Part C & D data.

III. MEDICAID AND CHIP

Program Description and Accomplishments

CMS serves as the operational and policy center for the formulation, coordination and evaluation of all national program policies and operations relating to Medicaid and the Children's Health Insurance Program (CHIP). Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the states. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally enacted to provide medical assistance to recipients of cash assistance. At the time, cash assistance was provided to low-income families and children through the Aid to Families with Dependent Children program, while the Supplemental Security Income program provided cash assistance to low-income aged, blind and disabled individuals. Over the years, Congress incrementally expanded Medicaid well beyond these original traditional populations. Today, Medicaid is the primary source of health care for a large population of low-income adults and families, pregnant women, people of all ages with disabilities, and people who require long-term care services. CHIP is a federal-state matching, capped grant program providing health insurance to targeted low-income children in families with incomes above Medicaid eligibility levels. Approximately 86.9 million, or nearly 1 in 4, Americans are expected to be enrolled in Medicaid and CHIP in FY 2023.

Medicaid and CHIP Business Information Solution (MACBIS)

In 2010, the Centers for Medicare & Medicaid Services (CMS) initiated the Medicaid and CHIP Business Information Solution (MACBIS) to meet mandates requiring reliable, comprehensive, and timely Medicaid and CHIP operational and programmatic data supported by leading edge technology and analytics solutions. MACBIS is an enterprise-wide initiative to ensure the Medicaid and CHIP data infrastructure and technology are commensurate to the programs' role in evolving health care delivery reforms, access to coverage, and to enable proper monitoring and oversight. Aside from data needs to support the multi-billion dollar waiver negotiations,

CMS will use MACBIS data for program integrity, evaluation of demonstrations, actuarial analysis, quality of care analysis, and to share this data set with states, stakeholders, and the research community.

Budget Request: $97.7 Million

The FY 2023 President's Budget request for MACBIS is $97.7 million, an increase of $6.6 million above the FY 2022 CR. This funding supports the MACBIS operational need in FY 2023 and is directly aligned to meet agency critical objectives. CMS is rapidly increasing our use of MACBIS data to drive quality improvement and accountability for program results. We are implementing capabilities that reduce state burden, ensure every federal dollar is spent with integrity, and deploying systems to improve business processes between CMS and states. This request includes responding to continued demands for data and data products to the Medicaid and CHIP program teams and other CMS users, supporting administration directives to strengthen analytic capabilities to study health equity and disparity issues, long term care, maternal and behavioral health, COVID-19, and strengthening program integrity capabilities.

Medicaid and CHIP (MAC) Scorecard

In June 2018, CMS released its first Medicaid and CHIP (MAC) Scorecard to increase public transparency and accountability about the programs' administration and outcomes. In 2019, using the most recently available data, the Scorecard expanded data in the National Context pages and added measures to the State Health System Performance and the State and Federal Administrative Accountability pillars. The 2020 Scorecard improved upon its functionality and included additional measures across all pillars. Examples of measures added to the Scorecard in 2020 included Asthma Medication Ratio: Ages 5-18; Asthma Medication Ratio: Ages 19-64; and Follow up after ED Visit for Mental Illness. The 2020 release included new features, such as including a "Find a Measure" function on the home page that includes all measures and National Context data points, as well as filtering and sorting options for a subset of the Scorecard measures to allow users to analyze data in a variety of ways. In addition, starting with the 2020 Scorecard, users are able to access state specific data highlighted in the Scorecard through the greatly improved State Profiles (Quality of Care section) on Medicaid.gov. The design, content, and functionality updates made to this section of the State Profiles allows users to view Scorecard and Child/Adult Core Set measures reported by each state. The 2021 MAC Scorecard was a data refresh (no new measures added) with minor changes to how certain existing measures are displayed. Because the COVID-19 public health emergency (PHE) had far-reaching impacts on Medicaid and CHIP programs and data, it was decided not to add new measures to the 2021 MAC Scorecard in an effort to minimize any new reporting burden due to the PHE. In 2021, CMS also released an updated "Quality of Care" section on the Medicaid.gov State Profiles.

The Scorecard includes measures voluntarily reported by states, as well as federally reported measures in three areas:

- State Health System Performance,
- State Administrative Accountability,
- And Federal Administrative Accountability.

Funding is required to maintain operations of the Scorecard and to continue to improve the data available and usability.

Budget Request: $6.6 Million

The FY 2023 President's Budget request for the MAC Scorecard is $6.6 million, an increase of $1.2 million above the FY 2022 CR. Activities include operational support to the Medicaid and CHIP programs such as website management and support for Medicaid.gov as well as performance metrics and data analytics.

The requested funding will also support the annual production of the Scorecard which includes: stakeholder engagement processes used to assist in selecting measures; design of national context and measure pages; content development; measurement development and maintenance; and access to additional Medicaid-relevant data not currently available at CMS. Measurement development work is a multi-year process. The types of measures that CMS has been developing relate to gaps in the Scorecard, including an all-cause adult emergency department use and long-term services and supports related measures (e.g., discharge to the community, direct service workers, etc.). This level of funding would allow that development work to continue and to potentially explore additional gaps. The Scorecard's future work includes additional enhancements to the State Profile Quality of Care Section, improvements to user experience, and working with interested states on quality improvement and technical assistance activities designed to support performance and understanding of the how the Scorecard can be used.

Section 1115 Waivers

Section 1115 of the Social Security Act provides broad authority to CMS and states under Medicaid and CHIP to design, implement and test new approaches to coverage, payment and service delivery, with the intention of improving whether and how low-income people receive health care, the quality and outcomes of that care, and its cost to the federal government and to states. This activity provides policy and operational technical assistance to CMS for states' Section 1115 demonstration implementation and reporting.

Budget Request: $23.0 Million

The FY 2023 President's Budget request for Section 1115 Waivers is $23.0 million, an increase of $1.6 million above the FY 2022 CR. CMS is requesting additional funds to improve capacity to evaluate and monitor 1115 demonstrations. These activities provide technical assistance in the monitoring and evaluation of 1115 demonstrations. This includes developing implementation plan and monitoring plan templates, performance metric sets, and evaluation guidance for additional Administration priority demonstration types such as Social Determinants of Health (SDOH) and Value Based Care (VBC).

Medicaid Oversight and Support

CMS serves as the focal point for assistance with formulation, coordination, integration, and implementation of all national program policies and operations relating to Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP).
In partnership with States, CMS assists State agencies to successfully carry out their responsibilities for effective program administration and beneficiary protection, and, as necessary, supports States in correcting problems and improving the quality of their operations.

This funding request supports activities designated to CMS for oversight and other State support functions that enhance Medicaid operations.

Budget Request: $98.1 Million

The FY 2023 President's Budget request for Medicaid Oversight and Support is $98.1 million, an increase of $14.0 million above the FY 2022 CR. The increase supports Medicaid eligibility determinations transaction costs made via the Federal Data Services Hub by States. CMS projects State Medicaid/CHIP agencies will continue to request increased transaction volumes due to changes in state and federal policy which encourage more verification attempts, especially related to redeterminations and renewals.

In addition, Program Operations funds are necessary to fulfill ongoing statutory requirements of Sec. 1139B of the Act to improve quality of and equitable access to care for Medicaid adults, as demonstrated through performance on the Adult Core Set measures. Because the ACA 2701 funding is estimated to be exhausted in FY 2023, CMS will need to partially fund Adult Health Quality work in Program Operations.

Other activities funded in this section are included below:

- *The National Home and Community-Based Services (HCBS) Oversight and Support*: The National HCBS Quality Enterprise supports several activities that promote improvement in HCBS and address important gaps in quality measures for Medicaid-funded HCBS. These efforts bring states into compliance with the HCBS settings requirements. The landmark set of regulations are designed to ensure aged or disabled Medicaid individuals have the opportunity to live in the community and have equal access to community support. All states must come into compliance with the 2014 regulations by March, 2023. In addition, CMS provides technical assistance to increase states' compliance with the federal Preadmission Screening & Resident Review (PASRR) requirement designed to ensure that individuals belonging to populations overrepresented in nursing facilities (those with mental illness or intellectual disability) who do not require nursing facility placement are diverted to community settings, which are frequently less costly. This requirement also ensures that individuals who are admitted to nursing facilities receive appropriate services that prevent their conditions from deteriorating.

- *Sources of Income for Medicaid Eligibility*: States use the Federal Data Services Hub to make Medicaid eligibility determinations and this request supports a contractor providing this service. In FY 2023, CMS will support 20 million income data transactions for State and Federal ACA related eligibility determinations and provide monthly project management and conduct ongoing service maintenance. These funds will purchase the income data transactions that are requested across 11 State-Based Marketplaces and 23 State Medicaid/CHIP agencies. The state Medicaid/CHIP agencies are likely using the current sources of income (CSI) service for initial income verification for Medicaid/CHIP and for annual, rolling renewals of Medicaid/CHIP eligibility.

- *Learning Collaborative:* These are forums for facilitating consultation between CMS and states with the goal of designing the programs, tools, and systems needed to ensure that high-performing state health insurance programs are in place and are equipped to handle the fundamental changes brought about by legislation. Funding provides technical assistance to states through webinars, policy papers, as well as developing tools designed to address identified issues and advance policy discussions and systems issues for states.

- *Managed Care Review and Oversight*: Managed care is the dominant delivery system for Medicaid benefits. Currently, there are 48 states and the District of Columbia operating over 170 programs covering roughly 65 million individuals. CMS implemented this activity to increase its oversight and technical assistance to states to address the needs created by the growth of managed care and GAO concerns. Under this activity, CMS created guidance for Managed Long-Term Services and Supports and encounter data. Funding supports the development of annual data reports, as required.

- *Survey of Retail Prices*: The Survey of Retail Prices involves a pharmacy survey to aid states in efficiently reimbursing pharmacies for covered outpatient drugs. The purpose of this activity is to perform a monthly nationwide survey of retail community pharmacy invoice drug prices and to provide states with weekly pricing files. The resulting prices derived from this survey have been developed into the National Average Drug Acquisition Cost (NADAC) files and are posted on Medicaid.gov. These files provide states with drug prices by averaging survey invoice prices from retail community pharmacies across the United States. This file also assures that the Federal Medicaid program is paying more accurately for prescription drugs.

- *Other Medicaid and CHIP:* Other operational support to the Medicaid and CHIP programs include website management and support for Medicaid.gov, as well as support to optimize the design, administration and oversight of Medicaid/CHIP. This includes increasing the effectiveness and efficiency of our programs while strengthening Medicaid and creating conditions needed for states to deliver high-value care and services.

  In FY 2023, the budget request assumes approximately $10 million in carryover funding from ACA section 2701. ACA section 2701 funding for adult quality contracts and interagency agreements are projected to be fully exhausted at the end of FY 2023.

IV. PRIVATE HEALTH INSURANCE

Program Description and Accomplishments

CMS is charged with helping implement many insurance market reforms and oversees the implementation of the PPACA provisions related to private health insurance. CMS works closely with state regulators, consumers, and other stakeholders to ensure that provisions established in law best serve the American people. The following details the activities that CMS is charged with administering.

Market Oversight and Support

CMS works in conjunction with states to ensure compliance with market reforms that protect consumers through policies like prohibiting health insurance issuers from denying coverage for pre-existing conditions, prohibiting annual and lifetime dollar limits on essential health benefits, and ensuring that health insurance issuers are complying with rating requirements. CMS is charged with implementing many of the provisions that relate to private health insurance and works to hold health insurance companies accountable for compliance with new market reforms, increase industry transparency, and encourage the promotion of health insurance issuers competing on the basis of price and quality.

Budget Request: $11.2 Million

The FY 2023 President's Budget request for Market Oversight and Support is $11.2 million, a decrease of $1.0 million below the FY 2022 CR. The FY 2023 request fully funds ongoing operations for the following activities:

- *Consumer Support and Information:* CMS is charged with implementing many of the provisions of the ACA that relate to private health insurance. CMS works to hold health insurance companies accountable for compliance with new market reforms, increase industry transparency, and support competition on the basis of price and quality. CMS supports the administration of this effort through contracts or Inter-Agency Agreements. The request supports the Consumer Operated and Oriented Plan (CO-OP), the Federal External Appeals process, Summary of Benefits and Coverage (SBC), and issuer data collection and management. These activities support CMS's market oversight and management responsibilities.

- *Insurance Market Reforms:* CMS, on behalf of HHS, is required to enforce market wide protections under the ACA. To ensure compliance, CMS collects and reviews plan documents from health insurance issuers and conducts investigations and market conduct examinations of non-federal government plans based on complaints received. Funds will be used to continue compliance with market wide requirements, to assist with research to investigate complaints, and to perform market conduct examinations.

- *Medical Loss Ratio (MLR):* Section 2718 of the ACA requires an issuer to publicly report annually how it used its premium revenue for the prior calendar year. This ensures that consumers receive value for their premium by requiring that plans use enrollees' premium dollars on medical care, quality improvement activities, or to pay rebates to policyholders. This data analysis ensures consumers receive the rebates they are entitled to if their health insurance issuer fails to meet the 80 percent (in the individual and small group market) or 85 percent (in the large group market) MLR standard. Based on continuing demand and to encourage states to take over enforcement activities, CMS will continue to develop training resources and provide technical assistance to States in conducting their own MLR examinations.

- *Rate Review:* This request allows CMS to perform statutorily required duties to monitor and review rate submissions from health insurance plans. Rate increases higher than 15 percent must be reviewed and approved by either CMS or the relevant State Department of Insurance. CMS also publicly posts all rate changes on the agency's website in order to increase transparency.

Federal Marketplaces

The Marketplaces allow individuals to compare health plan options, determine eligibility for a number of health insurance programs, obtain financial assistance with premiums, and facilitate enrollment.

Budget Request: $134.1 Million

The FY 2023 President's Budget request for the Marketplaces is $134.1 million, a decrease of $3.0 million below the FY 2022 CR. Program Operations funding supports Payment and Financial Management, Eligibility and Enrollment, Marketplace Information Technology, Consumer Information and Outreach, Marketplace Quality, Planning, Performance, and other Support activities. For additional information, please see the Federal Marketplace Chapter.

V. OUTREACH AND EDUCATION

Program Description and Accomplishments

As the nation's largest healthcare payer, CMS serves over 150 million people and is focused on providing quality care. As such, outreach and education is an integral part of this mission. CMS is responsible for conducting a range of outreach efforts including educational mailings, national communication campaigns to promote CMS programs, and other outreach initiatives to consumers, providers, and other key audiences. Informing and educating Americans about their health care benefits is required through the Balanced Budget Act, the Medicare Modernization Act, and the Affordable Care Act. CMS has an obligation and responsibility to educate our beneficiaries on the programs and services available to them. The activities in this section support CMS's communication and outreach strategy.

National Medicare Education Program (NMEP)

The National Medicare Education Program (NMEP) was established to implement provisions of the Balanced Budget Act of 1997 and continues under the MMA of 2003. The program is comprised of five major activities including: beneficiary materials, 1-800-MEDICARE, internet services, community-based outreach, and program support services.

NMEP is CMS's primary vehicle to educate Medicare beneficiaries and their caregivers so they can make informed health care decisions. The NMEP program is vital for the success of our programs and is the basis for providing excellent customer service to our beneficiaries and providers. As a High Impact Service Provider (HISP), CMS's NMEP will continue to drive Medicare customer experience (CX) improvements for beneficiaries by engaging in iterative and continuous consumer research and gathering customer feedback through ongoing surveys within customer service touchpoints. NMEP continues to focus on using CX data in conjunction with human-centered design best practices to identify opportunities and deliver changes across the customer service platform while continuing to elevate Medicare CX maturity within the Program.

Additionally, CMS, in coordination with the Administration for Community Living and State Health Insurance Assistance Programs (SHIPS), will work to ensure that NMEP activities continue to provide accurate, comprehensive, understandable information to individuals.

Budget Request: $306.1 Million

The FY 2023 President's Budget request for NMEP is $306.1 million, an increase of $6.9 million above the FY 2022 CR. The increase supports enhancing the reach and frequency levels of paid advertising and direct response marketing across General Market and Hispanic audiences. The enhancements will include a larger media buy for the General Market and Hispanic Open Enrollment campaign. It will increase awareness for vulnerable populations who are new to Medicare or aging into Medicare on the steps they need to take in order to have the appropriate Medicare coverage. Funding also helps CMS maintain approximately a 3-5 minute ASA for the 1-800-MEDICARE call center and operations for the eMedicare activities.

National Medicare Education Program Budget Summary
(Dollars in Millions)

NMEP Category/Description of Activity	Funding Source	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget
Beneficiary Materials - National Handbook with comparative information in English and/or Spanish (national & monthly mailing); targeted materials only to the extent that funding is available after funding the Handbook.	PM	$43.30	$38.91	$38.00
	Postage	$17.40	$28.00	$30.00
	Total	**$60.70**	**$66.91**	**$68.00**
Beneficiary Contact Center/1-800-MEDICARE - Call center and print fulfillment services available with 24 hours a day, 7 days a week access to customer service representatives.	PM	$179.81	$170.58	$165.40
	User Fees	$96.00	$93.43	$108.60
	Total	**$275.81**	**$264.01**	**$274.00**
Internet - Maintenance and updates to existing interactive websites to support the CMS initiatives for health and quality of care information; software licenses; enhancements to the on-line capabilities of MyMedicare.gov.	PM	$50.50	$50.50	$50.50
	Total	**$50.50**	**$50.50**	**$50.50**
Community-Based Outreach - Collaborative grassroots coalitions; training on Medicare for partner and local community-based organizations, providers, and Federal/State/local agencies; and partnership building efforts that provide assistance to Medicare beneficiaries in their communities.	PM	$5.88	$5.86	$5.82
	Total	**$5.88**	**$5.86**	**$5.82**
Program Support Services - A multi-media Medicare education campaign, support services to include Handbook support contracts such as Braille, audio and translation support; minimal level of consumer research and assessment for planning, testing, and evaluating communication efforts to include efforts for targeted populations such as Low-Income Subsidy.	PM	$24.90	$33.39	$46.41
	Total	**$24.90**	**$33.39**	**$46.41**
Funding Source Breakout Total	**PM**	**$304.39**	**$299.24**	**$306.13**
	User Fees[5]	**$96.00**	**$93.43**	**$108.60**
	Postage	**$17.40**	**$28.00**	**$30.00**
	Total	**$417.79**	**$420.67**	**$444.73**

[5] User fees: FY 2021 reflects actuals, FY 2022 reflects planned obligations, and FY 2023 reflects total collections.

- *Beneficiary Materials:* The total FY 2023 request is $68.0 million, of which $38.0 million is discretionary budget authority. This estimate is based on historical publication usage data and current market prices for printing and mailing, and a general provision in the FY 2023 budget that gives CMS greater flexibility to distribute The Medicare & You handbook via electronic means. The FY 2023 budget assumes an increased number of beneficiaries will opt for electronic receipt of the Medicare & You handbook. The Medicare & You handbook satisfies numerous statutory requirements including BBA Section 1851 (d) and MMA Section 1860(d) to provide print information to current and newly eligible beneficiaries about Medicare coverage options and available services. The handbook is updated annually and mailed to all current beneficiary households every October. Beneficiaries currently have the option to opt out of receiving a hard copy of the handbook by signing up at Medicare.gov/gopaperless for an electronic copy that gets e-mailed to them each fall. Updates to rates and plan information occur as needed for monthly mailings to newly-eligible beneficiaries.

  The chart below displays the actual number of Medicare & You handbooks distributed for FY 2020 through FY 2021 and the estimated distribution for FY 2022 through FY 2023. The yearly distribution includes the number of handbooks mailed to beneficiary households in October, handbooks pre-ordered for partners and warehouse stock to fulfill incoming requests, and handbooks mailed monthly throughout the year to newly eligible beneficiaries.

The *Medicare & You* Handbook Yearly Distribution
(Handbooks Distributed in Millions)

	FY 2020 Actual	FY 2021 Actual	FY 2022 Estimate	FY 2023 Estimate
Number of Handbooks Distributed	49.2	48.7	50.0	52.0

- *1-800-MEDICARE:* The total FY 2023 request is $274.0 million, of which $165.4 million is discretionary budget authority. The request reflects the contract's operational need supporting the estimated FY 2023 workload under current law. The 1-800-MEDICARE national toll-free line provides beneficiaries with access to Customer Service Representatives (CSRs) who are trained to answer questions regarding the Medicare program. The toll-free line is available 24 hours a day, 7 days a week. CSRs respond to inquiries including, but not limited to: authorizations, benefit periods, claims (including denials, filing or status), election periods, deductibles, coverage, eligibility and enrollment, complaints, plan comparisons, prescription drug benefit enrollment and disenrollment, appeal status, etc. Beneficiaries can also use 1-800-MEDICARE to report fraud allegations.

  1-800-MEDICARE CSRs use a variety of call center tools to help beneficiaries, their families, and caregivers make informed health care decisions and to provide both general and personalized customer service in a real-time environment. CMS is continuously exploring new options for streamlining processes and timeframes at 1-800-MEDICARE while seeking to preserve efficiencies and cost-effectiveness, and a high level of beneficiary satisfaction.

The following table displays call volume experienced in FY 2020 through FY 2021 and the number of calls CMS expects to receive in FY 2022 through FY 2023. All calls are initially answered by the Interactive Voice Response (IVR) system and approximately 30 percent of the calls are handled completely by IVR. At the FY 2023 request level, CMS anticipates an average speed to answer of approximately 3-5 minutes. The 1-800 Medicare call center contract is undergoing re-competition.

1-800-MEDICARE Call Volume
(Call Volume in Millions)

	FY 2020 Actual	FY 2021 Actual	FY 2022 Estimate	FY 2023 Estimate
Number of Calls	24.2	24.0	24.2	24.4

This funding request covers the costs for the operation and management of 1-800 MEDICARE including the CSR's activities, print fulfillment, plan dis-enrollment activity, quality assurance, content development, CSR training, and training development.

- *Internet:* $50.5 million. The Internet budget funds operations and maintenance for three websites. This funding will provide additional software and hardware upgrades, while providing improvements to the web services offered online and improving beneficiary customer service.

  The http://www.cms.gov website is CMS's public website for communicating with public stakeholders including providers, professionals, researchers, and the press on a daily basis. It supports a variety of critical CMS initiatives, including outreach and education, delivery of materials to stakeholders electronically, and data collection.

  The http://www.medicare.gov website is CMS's public beneficiary-focused website with a variety of real-time, interactive, decision-making tools. These tools enable Medicare beneficiaries and their caregivers to obtain information on their benefits, plans, and medical options. The Medicare Plan Finder, Care Compare, and the Medicare Eligibility tool are included under this activity. The website serves as an effective and efficient communication channel and provides self-service options for U.S. citizens, beneficiaries, and caregivers.

  Beneficiaries also have access to numerous authenticated, personalized tools to review and update their online account. These tools were previously available on a separate website, MyMedicare.gov, which has been fully incorporated into Medicare.gov for improved ease of use. Beneficiaries can securely log into Medicare.gov and check their claims within 24 hours of the processing date. In addition, beneficiaries can use the website to view upcoming available preventive services, a Medicare Summary Notice, or enrollment information, update their email address and add emergency contact information. Beneficiaries can also generate an On-the-Go Report which allows them to download personalized health information and share with their healthcare providers.

  CMS expects page views to grow as the Medicare beneficiary population increases, beneficiaries and their caregivers become more internet savvy, and as CMS continues to implement more self-service features for beneficiaries to use, in support of a patient-centered approach to these online resources.

The www.Medicare.gov page view history and projection is presented below:

www.Medicare.gov **Page Views**
(Page Views in Millions)

	FY 2020 Actual	FY 2021 Actual	FY 2022 Estimate	FY 2023 Estimate
Number of Page Views for http://www.Medicare.gov	390.2	530.2	550.0	575.0

- *Community-Based Outreach:* $5.8 million. CMS relies heavily on community-level organizations, state and federal agencies, providers, and other partners to serve as trusted sources of CMS administered program information for consumers, particularly for hard-to-reach populations, and must provide these partners with accurate and up-to-date information and tools that equip them to effectively counsel and assist their constituencies.

  FY 2023 funding is requested for continued support and maintenance of the new Learning Management System and all related tasks. This funding will also provide the resources needed to support face-to-face sessions, web-based training, and regularly scheduled live- and pre-recorded webinars required to educate stakeholders to ensure eligible individuals enroll in CMS programs and make optimum use of their benefits. The request also supports the full availability of the Beneficiary Experience Data Analytics Platform (BEDAP) system which includes segmented outreach to Medicare beneficiaries, caregivers, and coming-of-agers with a wider array of personalized use cases and higher levels of testing and analysis.

- *Program Support Services:* $46.4 million. This activity provides funding for accessible materials for low vision/blind and disabled beneficiaries (audio, Braille and large print and e-reader designs), electronic and composition support for the Medicare & You Handbook, mail file creation for the statutory October mailing of the Medicare & You Handbook, NMEP consumer research and assessment (including consumer testing of the Medicare & You handbook), a publication ordering web site for partners that support the Medicare education program, support for the Advisory Panel on Outreach and Education, and the creation/dissemination of mobile applications for accessing NMEP products and information. This funding also supports the multi-media education program.

  The Multi-Media Medicare Education Campaign raises beneficiary awareness about the coverage options, benefits, and services available through Medicare. It is designed to help people with Medicare and those who help them (caregivers including family and friends, information intermediaries, and others) maximize the use of their Medicare benefits to maintain their health, resulting in healthier beneficiaries and lower costs for Medicare. The campaign also promotes Medicare's official information sources including 1-800-MEDICARE, Medicare.gov, Medicare & You Handbook, and other localized partners and resources.

  As part of a Department-wide priority to invest in health equity, CMS's funding request includes a larger media buy for the General Market and Hispanic open enrollment campaign resulting in the extended reach to vulnerable populations. It will increase awareness for people who are new to Medicare or aging into Medicare on the steps they need to take in order to have the appropriate Medicare coverage. It will also increase the awareness of the Part B and D late enrollment penalty burden, which should encourage

beneficiaries to enroll in Part B and D prior to the penalty being effective. Other points of interest for this campaign include awareness of the compare tool so consumers can find the information that they need to help them make important health care decisions, and other pertinent points such as vaccination coverage.

In addition to the Program Management budget authority request, the NMEP budget request assumes $108.6 million in user fees and $30.0 million in postage funding, bringing the total FY 2023 President's Budget request for NMEP to $444.7 million, an increase of $24.1 million above the total FY 2022 CR.

Targeted Outreach and Enrollment

CMS performs outreach to all eligible persons who can obtain health insurance through the private market, as it relates to CMS programs. This includes efforts to inform, validate, and enroll individuals into insurance programs that they are qualified to receive. The activities included in this section reflect programs that CMS has implemented either based on statutory requirement or good government to inform consumers on health coverage across Medicaid, Medicare, CHIP, and the private insurance market. CMS's outreach activities for consumers are based on proven strategies utilized by the NMEP program to support CMS's Medicare and Medicaid beneficiaries.

Budget Request: $16.1 Million

The FY 2023 President's Budget request for Targeted Outreach and Enrollment is $16.1 million, a decrease of $4.2 million below the FY 2022 CR. The FY 2022 budget includes funding to enroll a growing beneficiary population, perform specialized outreach efforts to reach underserved populations, and supports a health literacy initiative, "Coverage to Care (C2C)". This work expands CMS's resources to reflect changes in telehealth, digital tools, COVID-19, and stresses the importance of primary care and using health coverage. These efforts will be continued in FY 2023 and are included in the FY 2023 Health Equity Initiative funding request.

- *Beneficiary Enrollment and Validation*: Funding will support for the production and mailing of the Initial Enrollment Period (IEP) packages, which include the Medicare card and a second mailing to all IEP beneficiaries who received the initial IEP package. This funding request also supports the ongoing effort to replace Social Security numbers from existing Medicare enrollment cards with the new Medicare Beneficiary Identifier (MBI) and other enrollment verification costs such as the Minimum Essential Coverage (MEC) notices.

- *Consumer Outreach*: Funding supports the printing of resources that allow vulnerable patients and consumers to understand and access health coverage and support our C2C contract. In addition to funding the C2C contract, this budget provides ongoing operations and maintenance to support informational updates to Healthcare.gov, outreach and education for rural communities, and outreach and education contracts to reach special needs groups such as AI/AN's. In support of the Department's health equity efforts, funds requested will allow CMS to be more effective in its minority population outreach regarding CMS's programs and policies in support of *Executive Order 13985 on Advancing Racial Equity* and *Executive Order 13995 on Ensuring Equitable Pandemic Response and Recovery*.

VI. IMPROVING HEALTH CARE QUALITY

Program Description and Accomplishments

Health Care Quality Initiatives

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through health care quality initiatives, such as the Medicare Shared Savings Program (MSSP). Value-based programs such as this not only help our beneficiaries receive high quality of care, but also create a more efficient and better healthcare service experience. The following describes the activities that aid CMS in providing higher quality care at a lower cost.

Budget Request: $50.0 Million

The FY 2023 President's Budget request for Health Care Quality Initiatives is $50.0 million, an increase of $19.0 million above the FY 2022 CR. This increase is primarily related to the timing of contracts, which reflects the cost to exercise the first option year of the ACO program analysis and Consumer Assessment of Healthcare Providers & Systems (CAHPS) contracts. In FY 2021, CMS awarded a new contract to support the ACO PAC and CAHPS tasks for a two-year period (FY 2021 and FY 2022). The following activities will be supported in FY 2023:

- *Medicare Shared Savings Program (MSSP)*: Funding will continue to support ongoing operations for approximately 477 Medicare Shared Savings Program ACOs in FY 2023. The funding request supports operations for multiple contracts that conduct beneficiary assignment, claims data analysis for purposes of calculating financial benchmarks/performance, calculating shared savings payments, generating and disseminating quarterly and annual data/reports, calculation of claims-based quality outcome measures and quarterly/annual reports, and technical assistance (e.g., user guides, templates) to implement the Medicare Shared Savings Program, established by Section 3022 of the Affordable Care Act.

  The Pathways to Success regulation also has an impact on the budget because the program streamlined and redesigned the participation options available under the program to encourage ACOs to transition to performance-based risk contracts. Additionally, increased funding for operations and support contract is due to increased evaluations in the repayment mechanism as a result of ACOs transitioning to risk more rapidly and other on-going program operations.

- *Medicare Data for Performance Measurement:* The Secretary is required to establish a process to certify qualified entities who will combine standardized extracts of Medicare Parts A, B, and D claims data with other sources of claims data to evaluate and report on the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use. The funding requested will support contracts for program management, data preparation and distribution, and technical assistance.

Medicare Quality Improvement – Value-Based Transformation

CMS aims to improve the health and healthcare experiences of the beneficiaries we serve through quality improvement that leverages innovative strategies, is data-driven, and reduces healthcare costs. Through State and local partners, CMS collaborates with healthcare providers

and suppliers to promote improved health status, including quality improvement in nursing homes.

Budget Request: $37.6 Million

The FY 2023 President's Budget request for Medicare Quality Improvement and Value-Based Transformation is $37.6 million, an increase of $7.1 million above the FY 2022 CR. The increase supports efforts working across CMS to make policy and programmatic changes related to improving health, care coordination, quality, access, outcomes, and health care costs for vulnerable populations. This proposed activity and continued efforts are described below:

- *Consumer Assessment of Healthcare Providers and Systems (CAHPS)*: *CAHPS* surveys are an integral part of CMS's efforts to improve healthcare in the U.S. Some CAHPS surveys are used in Value-Based Purchasing (pay for performance) initiatives. The quality of services is measured clinically, administratively, and through the use of patient experience of care surveys. CAHPS surveys are developed with broad stakeholder input, including a public solicitation of measures and a technical expert panel, and the opportunity for anyone to comment on the survey through multiple public comments period through the Federal Register. The surveys are designed to reliably assess the experiences of a large sample of patients. The budget request will fund ongoing operations and data collection.

- *Data Collection, Reporting, and Testing (Data Processing Activities)*: This funding supports the development, calculation, and analysis of performance and quality measures for oversight of plans and is used across all of CMS care offerings. This data is used in the Star Ratings published on the Medicare Plan Finder (MPF) so that Medicare beneficiaries have the information necessary to make informed enrollment decisions based on cost, coverage, and quality by comparing available health and prescription drug plans. For consumers, qualitative testing is conducted in this request to ensure that plan and provider quality reporting is targeted to help consumers make more informed plan and provider choices. Funding for other administrative support items such as CMS's NQF membership cost is included in this request as well.

- *Other Value-Based Transformational Costs*: This request funds new and enhanced work supporting health equity initiatives including additional stakeholder engagement, policy analysis, product development, product enhancement, and Health Equity Technical Assistance. CMS must also fund ongoing efforts such as contract closeout efforts, education and outreach, TA for the National Coverage Decision (NCD) process, and other operational needs that are required to support Value-Based Transformation activities.

Quality Payment Program (QPP)

Prior to the Quality Payment Program (QPP), payment increases for Medicare services were set by the Sustainable Growth Rate (SGR) law. This capped spending increases according to the growth in the Medicare population, and a modest allowance for inflation. However, as clinicians increased their utilization of services, the reimbursement for each unit of service had to be adjusted downward to hold costs constant. In practice, the SGR would have resulted in large decreases in the Physician Fee Schedule, which was not sustainable. To avoid these decreases in reimbursement, Congress had to pass a new law (every year) authorizing the current fee schedule and a small increase for inflation. With the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS no longer uses the SGR. The QPP is now one of CMS's programs to incentivize quality of care over volume.

Budget Request: $35.3 Million

The FY 2023 President's Budget request for the Quality Payment Program (QPP) is $35.3 million, a decrease of $4.0 million below the FY 2022 CR. Formerly funded from a mandatory source, the contracts are foundational to continue this important work and moved to Program Operations in FY 2020. The decrease from FY 2022 is the result of CMS evaluating areas for contract efficiencies to maximize resources. The funding request supports basic ongoing operations.

VII. ENTERPRISE OPERATIONS

Program Description and Accomplishments

CMS requires funding to support its business operations to administer the Medicare program, work in partnership with state governments to administer Medicaid and CHIP, and manage health insurance standards. In addition to these programs, CMS has other responsibilities that span from managing health industry-wide personal privacy protections and e-transmission coding/standards such as administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to financial reporting transparency responsibilities as required by law. All of these programs are managed by in-house staff and systems supporting the Agency. Enterprise Operations activities support CMS's staff in all of our efforts and initiatives as well as managing and directing the health care industry as a whole.

Accounting and Audits

The Healthcare Integrated General Ledger Accounting System (HIGLAS) is a single, integrated dual-entry accounting system that standardizes and centralizes federal financial accounting functions for all of CMS's programs. It reduced 50 separate accounting/payment systems for Medicare and Medicaid into one system. The main objective of this effort was to increase automation and efficiency, while eliminating redundant and inefficient/ineffective manual processes. HIGLAS is a component of the Department of Health and Human Services (HHS) Unified Financial Management System (UFMS), and CMS continues to closely coordinate efforts with HHS to ensure HIGLAS core financial data integration with UFMS. The unification of the financial systems is aimed at improving data consolidation and financial reporting capabilities for all of HHS.

Budget Request: $101.3 Million

The FY 2023 President's Budget request for Accounting and Audits is $101.3 million, an increase of $0.6 million above the FY 2022 CR. The request supports ongoing operations and maintenance.

- *Healthcare Integrated General Ledger Accounting System (HIGLAS):* This funding supports operations and maintenance costs for HIGLAS. HIGLAS implementation strengthened the federal government's fiscal management and program operations of the Medicare program. HIGLAS was a critical success factor in CMS and HHS achieving compliance with the Federal Financial Management Improvement Act (FFMIA) of 1996. In addition, HIGLAS contributes towards HHS' ability to retain a "clean" audit opinion as required by the Chief Financial Officer's (CFO) Act.

HIGLAS is a mission critical system enabling CMS to manage program accounting for its business operations. On average, HIGLAS processes 4.5 million claims daily accounting for approximately $1.4 trillion in annual payment transactions thus making it the largest Oracle Federal Financials System. HIGLAS continues to enhance CMS's oversight of financial operations, in order to achieve reliable, auditable, timely financial accounting, and reporting for CMS's programs and activities.

The HIGLAS effort has significantly improved the ability of CMS/HHS to perform Medicare accounting transactions. These improvements and benefits attributable to HIGLAS include reduced costs due to elimination of redundant individual Medicare financial record systems, improvements in automated Medicare debt collection/referral activities, creation of audit trails for every Medicare transaction/payment/claim in HIGLAS, improved Medicare financial audit ability, and improved capability for CMS to more systematically and efficiently recover identified Medicare overpayments. Moreover, CMS now has better internal financial controls across Medicare contractor operations. Maintaining a state-of-the-art financial system like HIGLAS has a significant and positive impact on the amount of additional interest earned (saved) in the Medicare Trust Funds. Internal CMS analysis has shown that Medicare contractors transitioned to HIGLAS are collecting monies quicker than in a pre-HIGLAS environment. This is a direct result of efficiencies gained in the process of offsetting or "netting" receivables that are owed by Medicare providers to the government.

In addition, HIGLAS supports the Federal Payment Levy Program (FPLP) operated by Treasury by offsetting payments. Through February 4, 2022, CMS has recouped $1.434 billion in Federal Tax debts and Non-Tax debts from Medicare Provider Payments under the FPLP.

- *CFO/Financial Statement Audits*: This funding is necessary for the statutorily required CFO audit which ensures CMS financial statements are reasonable, internal controls are adequate, and CMS complies with laws and regulations. The cost of the audit is funded through an interagency agreement between CMS and HHS and is based upon the General Services Administration rate schedules and federal audit requirements.

  CMS is required under OMB Bulletin A-136 to prepare annual and quarterly financial statements. The yearly CMS financial statements must be audited annually in accordance with the Government Management Reform Act of 1994 and OMB Bulletin No. 07-04. CMS's goal is to maintain an unmodified audit opinion, which indicates that our financial statements present fairly in all material respects, the financial position, net costs, social insurance, changes in net position, budgetary resources, and financing of CMS.

HIPAA Administrative Simplification

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Secretary of HHS to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data. As the industry adopts these standards for the efficiency and effectiveness of the nation's health care system, it will improve the use of electronic data interchange which serves as one of CMS's long-standing goals for the nation's healthcare.

Budget Request: $36.3 Million

The FY 2023 President's Budget request for HIPAA Administrative Simplification is $36.3 million, an increase of $2.2 million above the FY 2022 CR. This increase will allow CMS to enhance identity and authorization applications for HIPAA administrative systems and cloud migration functions. Funding is requested for the following activities:

- *HIPAA HETS Claims-Based Transaction and licensing:* The Medicare program responds to electronic requests for eligibility information from providers and health care institutions using the adopted standard. CMS built the HETS, which provides eligibility information to FFS providers to assist them with properly billing for the services they provide to Medicare beneficiaries and in the processing of Medicare claims. This systems application is considered mission critical as it provides eligibility information on a real-time basis as well as assists in determining how Medicare should be billed for the services rendered. The request will support the maintenance and operation of this eligibility system as well as allow CMS to be in compliance with the HIPAA Electronic Data Interchange standard. The HETS will continue to mature in the cloud environment to realize cost efficiencies and reduce the number of epics/features in the HETS product backlog.

- *NPI and NPPES*: HIPAA requires the assignment of a unique National Provider Identifier (NPI) to all covered health care providers and non-covered health care providers who apply and are eligible for NPIs. This project covers the operational support for issuing NPIs, a national customer service call center to assist providers in obtaining their NPI, and operational costs for the NPPES system. CMS built NPPES to assign NPIs and process NPI applications. Currently, over 5 million NPIs have been assigned and over 4.9 million changes have been applied to the NPPES records of enumerated providers. In FY 2021, functionality was expanded to send new NPIs to the Automated Provider Screening (APS) system in order to screen providers for identity, licensure, and criminal checks before they apply for Medicare Enrollment in the Provider Enrollment Chain Ownership System (PECOS), as well as sending provider identifications to the Data Exchange System (DEX) for Medicaid. In FY 2023, CMS expects the migration to the cloud will be nearly complete.

IT Systems and Support

Information Technology Systems and Support activities provide infrastructure and support for applications and operations that are used across the agency. These activities provide CMS the capability to quickly expand to address future system needs, adopt new and more efficient technologies, and support new programs. CMS must continue to invest in expansions of software, licensing, and processing capacity to manage system growth, and consolidation and replacement of end of life and/or less efficient equipment in its efforts to modernize its information technology. IT systems and support activities also include security and governance within CMS, which provide the standards and guidelines for compliance and response capabilities. CMS protects our networks and information systems against the continual attacks of malicious cyber actions through a comprehensive 24/7 cyber threat monitoring program.

In FY 2023, CMS will continue to align systems to cloud hosting and migration to the Virtual Data Center, which supports Medicare Part C and D operations. CMS will continue to invest in securing identity and authorization for all systems within the IT portfolio.

Budget Request: $645.7 Million

The FY 2023 President's Budget request for Information Technology Systems and Support activities is $645.7 million, an increase of $21.9 million above the FY 2022 CR. This request is necessary to continue ongoing IT operations, including making necessary investments to existing systems that support improvements in the effectiveness and efficiency of CMS operations. These activities provide the operational support to manage CMS's data environment for mission-critical and enterprise-wide CMS IT strategies for systems. The increase in funding will support security operations services such as network monitoring, penetration testing, forensics, and real time IT asset information. Security funding will also effectively manage risk by maintaining visibility across IT investments and verifying incident response readiness for all systems. CMS continues to find efficiencies in cloud migration and looks to continue to maximize the cost savings of these investments.

The following are highlighted priorities within the system and support category:

- *IT Security:* CMS faces a daily cybersecurity threat to the value of data we safeguard and the increased technical capacity of "bad actors" across the globe. Threats continue to intensify and CMS must enhance the robust IT security program to meet these vulnerabilities. The increased threats coupled with the need to keep our security infrastructure updated requires CMS to prioritize security. CMS has successfully implemented Continuous Diagnostics and Mitigation (CDM) at the core data center and has progressed beyond the Baltimore Data Centers, targeting Data Centers containing high value assets and large numbers of the Federal Information Security Management Act (FISMA) systems. This is a multiyear effort that will require CMS to comply with OMB's mandate to fully implement CDM across the entire IT landscape. This process will require CMS to establish and maintain ongoing authorization, automate Indicators of Compromise (IOCs) sharing with data centers, increase the viability of cloud security and maintain the development security operations programs. OMB and HHS have accelerated the timeline for all CDM phases, which will require CMS to plan and execute multiple CDM phases simultaneously. CDM implementation and prioritization has increased program expansions for reporting, testing, training, and customer focused process changes.

- *Continuity of Operations Disaster Recovery (COOP/DR):* CMS continues to revitalize the agency-wide COOP and DR programs following audit findings in 2019 that determined the programs and systems that support CMS mission-essential functions require increased capabilities to meet federal requirements. CMS made major investments in DR in FY 2020 and 2021, and will resume in FY 2022 with closing recovery gaps and technology improvements. CMS will continue to posture and improve the use of the cloud environment for the CMS enterprise. In FY 2023, CMS anticipates having a base foundation for this capability and be in the process of covering those critical IT systems at both Cloud Computing services as well as traditional data center locations. Funding will be used to expedite the implementation of DR/COOP capability for these critical IT systems.

- *Medicare Payment Systems Modernization (MPSM) Initiative:* To maintain the reliability of Medicare as a first-class payer and continue to support policy initiatives that reflect evolving delivery and payment methods in the healthcare industry, CMS initiated Medicare Payment System Modernization. MPSM efforts have improved the process and technical agility to support original Medicare policy and program implementation to best serve providers and beneficiaries.

In FY 2023, modernization efforts continue to focus on three essential building blocks – people, process, and technology. We are using human-centered design to solve business problems, migrating software to the cloud, converting older computer languages such as COBOL into modern ones such as Java, and implementing Application Programming Interfaces (APIs) that allow easy, flexible access to data and system functionality. CMS is also modernizing contracting and change management processes in order to fully realize the benefits that modern technology offers. Lastly, we are arming our workforce with the knowledge and skills of modern software development principles, practices, and technology to effectively lead and manage our efforts.

- *Application Processing System:* In FY 2023, CMS will continue to build the infrastructure and development of new modules and program maintenance that supports on-going operations and technical assistance of the new cloud based Accountable Care Organization (ACO) Management System (MS). This system supports automated applications, adjudication, code updates and the new Hospital Price Transparency compliance and enrollment module.

Operational Support

CMS is charged with providing support to beneficiaries of Medicare (Parts A and B, and C and D), Medicaid, CHIP, and those receiving private health insurance. There are several activities that support overall CMS operations, crossing multiple programs. This cross-cutting approach improves workload efficiencies and aids in conceptual decision-making. These activities aim to improve quality, cost, and care coordination for all who receive health care in the US. This work includes navigating a number of very complex operational issues, merging often conflicting systems, policies, financing, monitoring and oversight protocols, and data requirements across Medicare and Medicaid, and at times private insurance.

Budget Request: $77.7 Million

The FY 2023 President's Budget request for Operational Support is $77.7 million, a decrease of $25.0 million below the FY 2022 CR. This funding level allows CMS to maintain historical operating support costs. The decrease from FY 2022 reflects CMS's shifting administrative priorities and funding for current Agency initiatives are requested in the Health Equity, Improving Data Analytic Capabilities, and Operations Modernization sections of the Program Operations chapter. The main activities funded in this section are described below:

- *Actuarial Services*: This contract provides additional actuarial services, including modeling, for the numerous requests that the Office of the Actuary is unable to handle due to time constraints and staff shortages. This contract also assists CMS in providing actuarial cost estimates for various demonstrations and other statutorily required issues.

- *Acquisition Support*: Funding is requested to continue the system build and associated costs for CMS's new acquisition system called CMS Acquisition Lifecycle Modernization (CALM). This system will increase productivity and security, increase our ability to leverage data, and improve management of major acquisitions.

- *Data Analytics*: Funding is requested to support the collection and distribution of data to CMS users and other outside entities. Ongoing support is needed to maintain claims data for Medicare and DME, geographic variation data for claims and beneficiaries, and Medicare market basket & price index studies.

- *Document Processing Unit*: The Document Processing Unit is a customer service support contract that is tasked to provide document handling and processing support for inquiries, documents CMS receives from Medicare beneficiaries regarding Medicare enrollment, which includes Initial Enrollment Period and General Enrollment Period packages and Medicare Beneficiary Identifier Cards; premium billing; inquiries from direct billed Medicare beneficiaries concerning Medicare premium payments, enrollment, and entitlement; and data validation for State rental assistance benefits.

- *Federal Coverage and Payment Coordination:* Federal Coverage and Payment Coordination funds necessary activities and resources to implement the Medicare-Medicaid Coordination Office's (MMCO's) statutory obligations, as well as the HHS and CMS strategic goals. Each activity is pivotal in CMS's success in improving quality, cost, and care coordination for dually eligible beneficiaries. CMS supports a technical resource center for states interested in integrating services and financing for dually eligible individuals. These facilitates sharing of best practices across states and assists states with program design, stakeholder engagement, and data analysis.

- *Improve Patient Care*: CMS established an internal process to eliminate overly burdensome and unnecessary regulations; simplify, clarify, or remove sub-regulation guidance, and achieve greater efficiency in CMS operations that affect the day-to-day activities of health care providers, clinicians, beneficiaries, health plans, and clearinghouses.

- *Emergency Preparedness/COOP*: This request supports the non-IT components of the COOP/DR initiative as described in the IT section of this chapter. CMS must continue addressing gaps identified in CMS's programs to ensure alignment with the FFEMA, DHS and HHS to provide an enterprise wide continuity program that considers programmatic and operational needs.

- *Prototypic Shared Services*: The funding is for ongoing operations and licensing costs to launch a single sign-on authorization through integration with CMS Enterprise Identify Management and Enterprise Portal (ePortal) shared services while utilizing the Salesforce platform.

- *Rural Health Council*: This funding will allow for the continuation of the implementation and evaluation of the Rural Health Strategic Initiatives based on Agency priorities. In addition, this funding will support the continuation of rural health stakeholder engagement and the support of agency priorities and initiatives.

- *Workplace Innovation and Modernization*: This activity funds contracts supporting enterprise operational improvements related to performance and data analytics, enterprise risk management, change management, and continuous process improvements to modernize and invest in CMS's strategic initiatives.

Opioid and Substance Use Disorders (SUD) Support

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act addresses the nation's opioid overdose and Substance Use Disorders (SUD) crisis impacting millions of Americans, including those enrolled in CMS's programs. CMS requests funding for our efforts to sustain various provisions of the SUPPORT Act that address improved behavioral health; access to SUD prevention, treatment and recovery services; effective pain treatment and management; and data for effective actions and impact.

Budget Request: $16.3 Million

As part of a government-wide investment to help end the nations opioid and SUD crisis, CMS's FY 2023 President's Budget request for Opioid and SUD Support is $16.3 million, an increase of $10.4 million above the FY 2022 CR. In FY 2023, CMS anticipates nearly all of the SUPPORT Act provisions will have been implemented. CMS will focus on Medicaid activities to improve crisis/emergency care and implement a multimedia campaign to promote beneficiary/provider awareness of the benefits of Medicare's free Annual Wellness Visit, which includes cognitive/depression/ SUD screening and advance care planning.

Other activities include data and information technology needs, provider education, monitoring and auditing, contract resources, performance measurement, and claims analysis. CMS will continue to provide technical assistance to states on behavioral health, develop an updated Opioid and SUD Action Plan, work with the Office of National Drug Control Policy (ONDCP) on the National Drug Control Strategy, participate on the HHS Behavioral Health Coordinating Committee, and collaborate with other HHS operating divisions on opioid and SUD actions, behavioral health, and pain initiatives.

Research, Demonstration, and Evaluation (RDE)

This program supports CMS's key role as a beneficiary centered purchaser of high-quality health care at reasonable costs. CMS develops, implements, and evaluates a variety of research and demonstration projects. These projects, in addition to data and information products, were created to support internal and external research, and continue to inform and guide CMS's efforts to improve the efficiency of payment, delivery, access, and quality of our health care programs. CMS leverages other funding sources, such as ACA 3021 (Innovation Center) funding, to support RDE projects wherever possible.

Budget Request: $20.3 Million

The FY 2023 President's Budget request for RDE is $20.3 million, an increase of $20.3 million above the FY 2022 CR. As of FY 2022, the activities described below are funded in the Research PPA. CMS is requesting to permanently move the Research PPA into the Program Operations budget to provide funding flexibility for these activities and programs. The Program Operations request represents an $0.2 million increase above the Research accounts FY 2022 CR level.

- *Medicare Current Beneficiary Survey (MCBS)*: Funding for the MCBS has been held flat for many years and costs have grown. The request allows CMS to maintain the survey's existing content and utility and supports statutory requirements. In FY 2023, CMS plans to

continue an equal split of the MCBS' total operational cost between RDE and the Innovation Center.

The MCBS is an in-person, nationally-representative, longitudinal survey of Medicare beneficiaries. The survey captures beneficiary information whether aged or disabled, living in the community or facility, or serviced by managed care or fee-for-service. Data produced as part of the MCBS are enhanced with CMS administrative data (e.g., fee-for-service claims, prescription drug event data, enrollment, etc.) to provide users with more accurate and complete estimates of total health care costs and utilization. The MCBS has been continuously fielded for more than 20 years (encompassing over 1 million interviews) and consists of three annual interviews per survey participant.

- *Chronic Condition Warehouse (CCW):* CMS is required to comply with Section 723 of the MMA to provide a database to support chronically ill Medicare beneficiaries. The CCW houses a large amount of data and serves as an important resource for both internal and external researchers. Researchers accessing the data in the CCW are performing research to identify ways to improve the quality of care and ensure cost effective care for chronically ill Medicare beneficiaries. These research projects evaluate possible changes in or alternatives to the current Medicare and Medicaid programs that can lead to improvements in patient outcomes. The funding request supports maintaining data sources and research and public use files, ad hoc requests, loading future data sources, and the creation of new research files.

- *Other Research:* This funding supports efforts that build and improve CMS's health service research, data, and analytical capacity, as well as program evaluations. These activities include the Research Data Assistance Center (ResDAC), Public Use Data Files, Medicaid Analytic Data, Historically Black Colleges and Universities, and Hispanic-Serving Institutions Research Grant Programs.

Health Equity and Rural Health

The Affordable Care Act established six offices of minority health within HHS agencies, including the CMS Office of Minority Health. These offices joined forces with the HHS Office of Minority Health and the National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of minority populations. CMS seeks to continue its engagement and partnership with these offices to ensure the mission and vision is carried out in accordance with HHS' Office of Minority Health priority areas. To advance the aim of a "whole-of-government" approach ordered in *Executive Order 13985: Advancing Racial Equity and Support for Underserved Communities*, CMS must make bold investments to build necessary agency infrastructure and position itself to drive equity across all of its programs and policies.

Budget Request: $35.0 Million

The FY 2023 President's Budget request for Health Equity and Rural Health is $35.0 million, an increase of $35.0 million above the FY 2022 CR. Funds would be used to focus on comprehensive stakeholder engagement through national listening sessions and health literacy initiatives to shape policy and programmatic efforts across CMS; expand the Coverage to Care Initiative to focus on specific populations; and better tailor resources and outreach efforts to focus populations. These funds would also build an Office of Minority Health analytic data environment to enable expanded modeling of disparity trends over time.
A few highlights for this request are described below:

- *Minority Research Grant Program:* These funds would expand the investment and scope of the Minority Research Grant Program to embed health equity into CMS programs as well as conduct policy research and development on the health care needs of LGBTQ+ people eligible for CMS programs, including Medicare, Medicaid, CHIP, and Marketplace, and to expand and maintain the CMS Sexual and Gender Minority Clearinghouse. Further, CMS would conduct policy research and development on the health care needs of underserved children including those who are: LGBTQ+, living with disabilities, limited English proficiency, live in rural communities, and eligible for CHIP enrollment.

- *CMS Health Equity Policy Collaborative:* These funds would establish a new CMS Health Equity Policy Collaborative, a cross-agency, policy-focused group of staff experts who systematically identify and work to resolve barrier to equity in each CMS program by offering on-going technical assistance to CMS Components. Within this funding would also be new Grants to States on Advancing Racial Equity and Support for Underserved Communities to compile data and information on state target populations, assess barriers to health care, meaningfully engage stakeholders, and develop a four-year State Strategy with metric, and evaluate investment.

- *Rural Health Strategy*: This funding would be used to build upon rural health equity efforts through refreshing the CMS Rural Health strategy, developing the Rural Stakeholder Insights Trend & Triage System, and defining and executing activities that will allow us to bridge the policy-to-practice gap between federal employees and rural communities.

Improve CMS's Analytic Capabilities and Data Sharing with Internal and External Stakeholders (to include Health Equity and Behavioral Health)

As the largest payer for healthcare in the United States, CMS holds an enormous amount of unique health data on a large proportion of the U.S. population. These data are valuable not only to CMS, but across government. These datasets hold the potential to strengthen the evaluation of federal programs for decision-making, assess the impact of policy changes, improve outcomes of people served by multiple federal programs, and generate knowledge to inform federal policy-making. In addition, these datasets are a crucial resource to support public health surveillance, investigations, and interventions, particularly as public health entities prepare for future pandemics.

Budget Request: $15.0 Million

The FY 2023 President's Budget request for Improving CMS's Analytic Capabilities and Data Sharing with Internal and External Stakeholders (to include Health Equity and Behavioral Health) is $15.0 million, an increase of $15.0 million above the FY 2022 CR. This funding would improve CMS's analytic capabilities and provide greater access to CMS data for internal and external stakeholders.

- *Access to Data:* This funding supports expansion of limited secure access to record-level CMS data for other federal agencies for research and public health purposes.

- *Timeliness in Data Availability:* In addition to providing greater access to our data, we are seeking to improve and support enhancements in the timeliness of data available to all stakeholders. The pandemic has demonstrated the importance of access to the timeliest data possible to support decision-making.

- *Development of Other Data Products*: This funding will also enable CMS to develop additional public use files, dashboards, and other aggregated/de-identified information products for public release. These information products would be targeted at enhancing data available on health equity and behavioral health as well as increasing the number of products based on newer CMS data collections (e.g., Medicare Advantage encounter data, Transformed-MSIS data). Data is the raw material; with the funding requested, CMS can also build robust tools to extract value from our data, better informing the agency and all of our stakeholders.

Modernize CMS's Operations to Meet the Needs of Future Beneficiaries

As an Agency, CMS has always placed our beneficiaries first, however, our operations have not always been able to keep up with the changing needs of the populations we serve. The enhancements and expansions included below would serve to increase our ability to improve our operations for beneficiaries today as well as meet the needs of future beneficiaries. These activities demonstrate strategic and carefully targeted actions that result in benefits beyond the cost of investment. In this way, CMS is taking the steps now to ensure our operations are modernized and ready to serve future beneficiaries and consumers. These investments are driven by data, resulting in activities that will move CMS towards more equitable access to care across our populations.

Budget Request: $20.0 Million

The FY 2023 President's Budget request for Modernizing CMS's Operations to Meet the Needs of Future Beneficiaries is $20.0 million, an increase of $20.0 million above the FY 2022 CR. This funding would enable CMS to perform some of the below mentioned improvements and enhancements for services available to our beneficiaries and provide better access to coverage. In addition, this funding would improve the data collection efforts relating to our IT systems, as well as through patient surveys and other quality improvement tools.

- *Enhancing the Medicaid and CHIP Scorecard to Advance Access:* These funds will allow CMS to enhance existing activities that support the Agency in moving towards access that is more equitable across populations and payment systems. A main vehicle that CMS will employ as part of its strategy is the Medicaid & CHIP Scorecard, which allows CMS to leverage data and technical support to states in ways that promote increased Medicaid and CHIP beneficiaries' access to care, enhanced understanding of the Medicaid/CHIP programs, and improvements in health care quality and equity. The Scorecard would be leveraged by CMS as one of many ways to help monitor various dimensions of access (e.g., access to coverage; access to services; beneficiaries experience with accessing services, etc.) across Medicaid and CHIP programs. Additional funding will allow us to update and redesign every Medicaid agency's (56 total) State Profile on Medicaid.gov, develop enhanced Access-specific pages in the Scorecard, and create a "Mini" Access Scorecard. With funding and additional data/measures, CMS could create new organizational and enhanced features to the website where the user could sort all related "access measures or related access data" by state, as relevant. This new function would be used as a mini access Scorecard and quick way of displaying a state's relevant access measures, as applicable. This funding would also support CMS in developing/refining measures that support CMS's understanding of access (e.g., performance indicators, churn, retention, and access to services measures, etc.). In addition, CMS may be able to provided limited technical assistance resources to a subset of states in ways that support implementing

actions related to the Medicaid & CHIP Access Strategy, future access-related regulatory actions, and/or sub-regulatory activities.

- *Expanding Medicare coverage of new technologies:* These funds would support analytic and programmatic work to evaluate coverage, coding, and payment for new and innovative technologies as they emerge. Currently, CMS does not have sufficient resources to conduct the reviews necessary to achieve coverage of these new technologies in a timely and careful manner. These funds would also support the identification and analysis of groups of items and services that could be beneficial to Medicare beneficiaries if covered under the Medicare Fee-For-Service (FFS) program.

- *Expanding Access to Mental Health Services under Traditional Medicare:* These funds would support necessary operational work to design and implement pathways for an expanded array of mental health clinicians to participate in the Medicare FFS program. The Administration is expanding access to mental health and beneficiary-centered care under Medicare via greater use of telehealth and other telecommunications technologies to provide behavioral and mental health care. This would include designing proposals for necessary legislative change, developing and administrative framework for coverage expansion, and building needed infrastructure to enroll and support new participating clinicians.

- *Medicare Advantage and Medicare Part D Data Collection, Patient Surveys, and Quality Improvement Tools:* With these funds, CMS would improve information systems that CMS relies on to collect data from MA and Part D plan sponsors. The changes would allow for more granular data collection, especially about Medicare Advantage supplemental benefits, improve processing of the data, and provide more efficient program administration. These funds would also support analysis and development activities to provide plans and providers with additional tools to help improve patient experiences of care across a variety of settings (e.g., health and drug plans, in-center dialysis facilities, hospices, hospitals, home health agencies and clinician and physician offices). As many of these surveys are currently being tested to include new content, these funds would also support translations of the revised surveys into a variety of languages.

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Federal Administration
(Dollars in Thousands)

	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget	FY 2023 +/- FY 2022
Budget Authority	$772,533	$772,533	$895,424	$122,891
Indirect Costs	$142,652	$177,628	$176,908	($720)
Program Level	**$915,185**	**$950,161**	**$1,072,332**	**$122,171**
FTE	4,199	4,230	4,518	288

Authorizing Legislation – Reorganization Act of 1953

FY 2021 Authorization – Public Law 116-94

Authorization Status – Permanent

Allocation Method – Direct Federal, Contracts, Other

Program Description and Accomplishments

The Federal Administration account funds the majority of the routine operating expenses in support of CMS's mission. This account provides funding for employee compensation, rent and utilities, administrative information technology and contractual services, as well as providing for business administration needs such as supplies, equipment, printing, training, and travel. Many of these costs are impacted, on an annual basis, by escalation factors akin to inflation, such as increased costs for benefits paid on behalf of the employee and annual cost of living adjustments (COLA).

While CMS is deployed throughout the country, our structure is designed to focus on facilitating cohesion and integration to carry out the Agency's mission. Employees accomplish the CMS mission by writing health care policies and regulations; setting payment rates; developing national health care operating systems; contractor monitoring and oversight; developing and implementing customer service improvements; providing education and outreach to beneficiaries, consumers, employers, and providers; implementing guidelines to fight fraud, waste, and abuse; and assisting law enforcement agencies in the prosecution of fraudulent activities. This request reflects an investment in CMS's workforce, thereby allowing us to continue to hire specialized skillset staff to successfully achieve the agency's goals and to help modernize CMS's operations.

CMS employees also accompany State surveyors to health care facilities to ensure compliance with CMS health and safety standards; and assist States with Medicaid, Children's Health Insurance Program (CHIP), and other health care programs. Through CMS's nationwide footprint, we are positioned where our beneficiaries need us, allowing us to accomplish our mission.

Funding History

Fiscal Year	Amount
FY 2019	$732,533,000
FY 2020[1]	$782,533,000
FY 2021 Final	$772,533,000
FY 2022 CR	$772,533,000
FY 2023 President's Budget	$895,424,000

Personnel and associated costs for programs and activities, where specific funding sources, including mandatory funding, are available and utilized, are not included in the Federal Administration request. In order to ensure indirect costs are appropriately applied to these funding sources, CMS utilizes a cost allocation methodology to offset some costs that would otherwise be funded out of the Federal Administration account.

Budget Request: $895.4 million

The FY 2023 budget request for Federal Administration is $895.4 million, an increase of $122.9 million above the FY 2022 Continuing Resolution (CR). In addition, CMS projects $176.9 million will be available from the administrative cost allocation; bringing the total program level to $1,072.3 million.

Federal Administration Program Level Summary Table[2]
(Dollars in Thousands)

Objects of Expense	**FY 2021 Final**	**FY 2022 CR**	**FY 2023 President's Budget**	**FY 2023 +/-FY 2022**
Personnel Compensation and Benefits	$724,561	$757,519	$844,075	$86,556
Travel	$5,282	$4,933	$5,282	$349
Rent, Communications and Utilities	$35,630	$35,630	$40,300	$4,670
Printing	$2,430	$2,432	$2,430	($2)
Contractual Services	$143,278	$145,750	$176,254	$30,504
Service and Supply Fund (non-add)	*$42,640*	*$41,000*	*$43,640*	*$2,640*
Administrative Services (non-add)	*$6,329*	*$11,364*	*$34,838*	*$23,474*
Administrative IT (non-add)	*$40,727*	*$40,555*	*$41,499*	*$944*

[1] The FY 2020 Final level includes $50 million in reprogrammed funds from Program Operations.
[2] This table and corresponding narrative, below, reflect program level funding, which includes appropriated resources in addition to funds from CMS indirect cost allocations.

Objects of Expense (continued)	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget	FY 2023 +/- FY 2022
Inter-Agency Agreements (non-add)	*$2,492*	*$2,611*	*$3,408*	*$797*
Administrative Contracts and Intra-Agency Agreements (non-add)	*$51,090*	*$50,220*	*$52,869*	*$2,649*
Supplies	$766	$716	$763	$47
Training	$3,238	$3,181	$3,228	$47
Total, Federal Administration	**$915,185**	**$950,161**	**$1,072,332**	**$122,171**

- *Personnel Compensation and Benefits:* $844.1 million

The FY 2023 budget request includes $844.1 million in discretionary funding, an increase of $86.6 million above the FY 2022 CR. The requested funding will support 4,518 direct Full-Time Equivalents (FTEs), an increase of 288 FTEs as compared to the FY 2022 CR. This budget also accounts for the absorption of additional FTEs from expiring and exhausting mandatory funding sources, ensuring continued operations of required activities. The 2023 Budget includes $5.0 million for the CMS Digital Service team, which will be used to further expand the United States Digital Service (USDS) footprint within CMS. The USDS staff supports the enhancement of CMS's information technology digital services. They will also work with other CMS staff to build digital services solutions, coordinate IT programs, and address technical issues. This will allow CMS to ensure our delivery of digital services meets the agencies goals and objectives.

The Federal Administration account is a crucial aspect in providing payroll and benefit funding for staff to continue to support the development and execution of policies and enhances our ability to meet our agencies mission. Our request for an increase in FTEs is an investment in CMS's future. CMS's responsibilities have grown, including impacts from COVID, new legislative mandates, and various coverage expansion and access initiatives, while our administrative budget has not kept pace, creating a gap in staff levels and skillsets. As we advance with the Administration's priorities, CMS must cover essential positions by expanding its expertise such as behavioral and mental health, drug dependency, and other clinical areas. CMS is prioritizing the way we collect, manage, and make data available to internal and external stakeholders. To get this right, we need to increase our professional data staff, bringing in data scientists to drive us toward 'best practices' and more advanced data analytics. We have identified the need to enhance our level of expertise in policy strategists and specialists, especially in the arenas of prescription drug, new innovative technologies, and other upcoming policy priorities. As these three specialized skillsets are needed across CMS, one area where we have a direct need to reinforce is within our Office of Acquisition and Grants Management. With over 500 active contracts, CMS has a need (above current levels) for acquisition professionals for both awarding and managing contracts. The contract workload has risen over time, while also becoming more complex. The overall increase in FTEs will bolster our workforce in these critically needed skillsets. This targeted FTE increase is vital to bring CMS back to staffing levels that were decreased by a history of strained staffing resources, providing flexibility for the Agency to quickly adapt to emerging public health and Administration

needs.

With this requested level of funding, CMS will continue base operations, while increasing the FTE level for essential positions, as detailed above, for the Administration's priorities. This request shores up core operations and provides needed resources to promote the Administration's priorities.

Personnel Compensation and Benefits encompass the full range of civilian and Commissioned Corps pay, within grade increases, awards and overtime, as well as fringe benefits. Commissioned Corps staff are entitled to additional benefits including housing and other allowances. Also, included in the FY 2023 FTE request is a 4.6 percent pay inflation assumption for civilian and commissioned corps and a 1.0 percent inflation estimate to cover increases in benefits costs. The impact of these assumptions for payroll inflation are projected to result in a $36.8 million increase which is assumed in this request.

The nature of CMS's work is not static; it is dynamic and fluid, requiring flexibility and the need to keep pace with variables largely outside its control such as COVID impacts, unfunded legislative mandates, or annual payroll increases. CMS's staffing levels, tied with related compensation and benefits expenses, are largely workload-driven. Staffing levels will enable CMS to execute the Administration's priorities and increased workload, while maintaining and improving the performance of our traditional programs, including Medicare, Medicaid, Marketplace, CHIP operations, and other federal health programs, to ensure they are successfully delivered with the highest quality. Additional CMS staffing levels are funded through other directly appropriated accounts, such as HCFAC, HITECH, and the Federal Marketplace. These accounts will cover FTE costs required to execute their specific workload required to meet the Agency's needs.

- *Travel:* $5.3 million

The FY 2023 budget request includes $5.3 million in program level funding, $0.3 million above the FY 2022 CR. Our mission, comprising of on-site visits to contractors, states, healthcare facilities, and other providers, dictates CMS's travel. Since CMS administers its programs primarily through contractors or third parties, site visits are critical to managing and evaluating these programs and ensuring compliance with the terms and conditions of contracts and cooperative agreements. Site visits also allow CMS to oversee the level of care our beneficiaries and consumers are receiving. Travel also directly places our staff on the ground to identify and address fraudulent practices. This level of funding represents a return to pre-COVID travel levels across the Agency.

- *Rent, Communications, & Utilities*: $40.3 million

The FY 2023 budget request includes $40.3 million in program level funding, a $4.7 million increase above the FY 2022 CR. This object class provides funding for CMS's offices, including rent and operational costs, which are calculated by the General Services Administration for CMS. Other items in this category include certain contract labor costs, such as grounds maintenance, cleaning, and trash and snow removal.

- *Printing:* $2.4 million

The FY 2023 budget request includes $2.4 million in program level funding, roughly the same as the FY 2022 CR. The largest expense in this category is for printing notices in the

Federal Register and Congressional Record. CMS is required to publish regulations that adhere to notice and comment rulemaking procedures. Historically, one major piece of new authorizing legislation involving CMS's programs is enacted annually. Each piece of legislation requires CMS to publish regulations that implement the numerous provisions in these bills.

- *Contractual Services:* $176.2 million

The FY 2023 budget request includes $176.2 million in program level funding, an increase of $30.5 million above the FY 2022 CR. Within this line is the Real Estate Consolidation (REC) project, which CMS undertook to reduce its overall rent/leased space usage, to gain fiscal, environmental, and logistical benefits. The REC has been progressively making strides over the past few years with the goal of reducing the overall net CMS office space footprint to meet the GSA requirements as a primary focus. As progress remodeling and updating the main Baltimore campus continues, CMS will be able to eliminate leases, saving funds through rent avoidance, in the Baltimore vicinity. The innovative REC project will meet GSA requirements to reduce the overall net footprint to about 135 square feet per employee as well as result in estimated long-term savings of $88.0 million. Now, in light of the PHE, CMS is maximizing the efforts of the REC project to further enhance its main campus, such as taking steps to create a more flexible work environment, ensuring meeting areas provide collaboration space, and modernizing our copy/printing space. CMS has the primary focus of reducing our overall real estate footprint fast, getting us to a greener, more cost-effective operations sooner. And now, CMS also has the aim of making the main campus a 'workplace of the future,' where there is a seamless transition from other locations to main campus and the workspace of main campus is inviting and conducive to positive, rewarding team engagements.

Contractual Services also include costs for our day-to-day operations via contracts and interagency agreements (IAAs). This funding supports critical information technology infrastructure and services, which provide CMS employees with a secure and technologically efficient workplace. Within these contract lines are IT products and services which support, among other enterprise services, projects focused on modernizing CMS's human resource operations. CMS has also made a concerted effort to promote a more user-friendly IT environment for employees with integrated data, voice, and video services that provide seamless connections between meeting rooms, work stations, and remote locations.

Essential IAAs, such as legal services with the HHS's Office of General Counsel and security services with the Department of Homeland Security, are also included within this category and are crucial in supporting CMS operations. In addition, the CMS share of the HHS's Program Support Center and other shared expenses, including payroll, financial management, and e-mail systems, are funded within this object code. This category also includes support for other aspects of our operations such as mailroom, interpreter services, and warehouse operations. Additionally, funding to conduct background investigations are provided via IAAs to the servicing Federal Agency. The HSPD-12 credentialing is partially funded within this category and provides support for continuous credentialing of employees and contractors to meet the requirements of Federal policies. In FY 2023, CMS will continue to credential new employees and rebadge existing staff. CMS also projects to credential approximately 5,000 contractors, an existing effort that was slowed due to COVID-19.

- *Supplies:* $0.8 million

The FY 2023 budget request includes $0.8 million in program level funding, roughly the same as the FY 2022 CR. This category funds general everyday office supplies and materials for CMS employees, including office equipment, paper, and small desktop-related supplies. As we continue to revamp the CMS work environment, fluctuations in these costs could occur based on employees needs for resources.

- *Training:* $3.2 million

The FY 2023 budget request includes $3.2 million in program level funding, roughly the same as the FY 2022 CR. This category supports continuous learning of technical, professional, and general business skills. The technical and professional training provide continuing education in areas such as contract and project management, advance program and policy administration, and information technology. The category also includes a special emphasis on leadership and management development, and includes certifications for staff, such as actuaries, contract specialists, financial managers, nurses, and other health care professionals. Funding also supports agency wide trainings, such as Reasonable Accommodation, Alternative Dispute Resolution, and Ethics.

State Survey and Certification

(Dollars in Thousands)

	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget	FY 2023 +/- FY 2022
Discretionary				
State Survey and Certification Appropriation	$397,334	$397,334	$494,261	$96,927
Medicare Quality Improvement - Value Based Transformation (non-add)	*$7,000*	*$7,000*	*$7,000*	*$0*
Subtotal, Discretionary	**$397,334**	**$397,334**	**$494,261**	**$96,927**
Mandatory				
IMPACT Act[1]	$5,625	$5,464	$5,304	($160)
Consolidated Appropriations Act[1]	$0	$9,714	$9,430	($284)
American Rescue Plan (ARP) (non-add)[2]	*$500,000*	*$0*	*$0*	*$0*
Grants to States for Medicaid (S&C)	$296,000	$306,000	$328,000	$22,000
CLIA Lab Fees	$71,963	$77,550	$78,000	$450
Subtotal, Mandatory	**$373,588**	**$398,729**	**$420,734**	**$22,006**
Total	**$770,922**	**$796,063**	**$914,995**	**$118,932**

Authorizing Legislation – Social Security Act (SSA), Title XVIII, Sections 1151-61, 1819(k), 1822, 1862(g), and 1864; SSA, Title XIX Sections 1901 and 1919(k); and Public Health Service Act; SSA, Title XIII, Section 353

FY 2022 Authorization – Public Law 117-70

Allocation Method – Contract and Grants

Program Description and Accomplishments

State Survey and Certification (S&C) is a CMS-administered program that ensures Medicare and Medicaid certified health care providers meet applicable quality standards through onsite, objective, and outcome-based verification activities carried out by knowledgeable and trained surveyors. The S&C program serves residents and other beneficiaries who receive care from approximately 340,000 Medicare and Medicaid-certified institutional providers, suppliers, and laboratories. CMS acts when quality standards are not met by utilizing appropriate remedies, which can include imposition of civil monetary penalties (CMPs) or termination of participation in the Medicare, Medicaid, or the Clinical Laboratory Improvement Amendments (CLIA) programs.

CMS accomplishes its quality assurance functions through collaboration with states and their respective State Survey Agencies (SAs), private accrediting organizations (AOs), and through

[1] Funding provided through the Improving Medicare Post-Acute Care Transformation (IMPACT) and Consolidated Appropriations Acts are net of sequester.
[2] The FY 2021 Enacted level for Sections 9402 and 9818 of the American Rescue Plan Act reflects funding to be transferred from CMS to the Centers for Disease Control and Prevention (CDC).

contractor-supplied private sector survey organizations to conduct specialized surveys and investigations. When significant problems are identified, either through onsite observation during periodic comprehensive surveys or from complaint investigations, CMS is authorized to impose remedies on providers, suppliers, or clinical laboratories. Failure of the provider to implement suitable remedial action for serious deficiencies can result in termination from the Medicare and/or Medicaid programs. In the case of clinical laboratories, failure to implement corrective actions may also result in sanctions, including revocation of CLIA certificates.

CMS also operates a Special Focus Facility (SFF) program, which identifies the poorest-performing nursing homes in the country for increased scrutiny in an effort to immediately improve the care they deliver. The SFF program currently requires more frequent compliance surveys for program participants, which must pass two consecutive inspections to "graduate" from the program. CMS is working to strengthen this program's requirements and make them more impactful, and when appropriate, terminating non-compliant facilities from participating in the Medicare and Medicaid programs.

The S&C program is funded by multiple sources. The Program Management annual discretionary appropriation supports the S&C program's oversight efforts. These oversight efforts are also supported by funding from the Improving Medicare Post-Acute Care Transformation Act (P.L.113-185; IMPACT Act) and the Consolidated Appropriations Act of 2021 (P.L. 116-260; CA Act) which helps keep hospice survey frequencies at a three-year rate. To help address the Public Health Emergency (PHE), Congress provided $200 million in funding to Program Management within the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136; CARES Act), of which, no less than $100 million was designated for the necessary expenses of CMS's survey and certification program response to the COVID-19 pandemic. Grants to States for Medicaid support the oversight of Medicaid and dual (Medicare/Medicaid) certified provider types.

Additionally, the American Rescue Plan Act of 2021 (P.L. 117-2; ARP) appropriated funds for the deployment of strike teams to skilled nursing and nursing facilities in states (including the District of Columbia and territories) with diagnosed or suspected cases of COVID-19 among residents or staff. The strike teams can be composed of clinicians and public health service officials who provide onsite technical assistance and education to nursing homes to reduce transmission and spread of COVID-19 by providing clinical care, implementing continued infection control standards, or staffing. The funding from Sections 9402 and 9818 of the ARP has been transferred to the Centers for Disease Control and Prevention (CDC) to implement and manage the Federal Strike teams.

CMS prioritizes the activities within the S&C program which are required by law, but also uses policies developed, in part, through an evidence-based approach following recommendations by the Government Accountability Office (GAO) and the Office of the Inspector General (OIG) to prioritize certain other activities. The recommendations aim to ensure the quality and safety of patients seeking care in CMS-certified facilities. GAO has placed oversight of nursing homes and dialysis facilities into a high-risk category, indicting a greater vulnerability of fraud, waste, abuse, and mismanagement. OIG has also published reports that stress the need for regular oversight of hospitals and Ambulatory Surgical Centers to avoid adverse events. Additionally, OIG and GAO reports emphasize that maintaining survey and certification frequency rates at or above the levels guided by policy and required by law is critical to ensuring federal dollars support quality care. Accordingly, CMS requires SAs and survey contractors to prioritize:

1. Investigation of reported complaints indicating immediate jeopardy and harm;
2. Conducting Focused Infection Control (FIC) surveys in nursing homes;
3. Survey and recertification of statutory facilities (nursing homes, home health agencies (HHAs), and hospices), as required by law;
4. Survey and recertification of non-statutory facilities as required by CMS policy; and
5. Vaccination reporting, administration, and staff mandate compliance.

CMS exercises oversight of SAs through a combination of federal surveys and contracts with national surveyors. CMS contractors perform mandatory comparative surveys of SAs to ensure states are effectively investigating and enforcing compliance with the Medicare health and safety standards. CMS also contracts for other programmatic activities, such as online surveyor training, AO oversight, and to improve key processes, including the survey procedure for nursing homes, the identification of new methods for collecting and reporting data used to evaluate survey variation and performance, and the strengthening of state oversight.

To improve CMS's existing data systems, funding is also used to support a broad array of information technology efforts that make program information, such as deficiency and survey reports, publicly available in understandable and more accessible formats. An example of such efforts is CMS's Five-Star Quality Rating System on the Care Compare website, which is regularly updated to increase quality and customer usability.

Recent S&C program accomplishments include the implementation of FIC surveys in response to the COVID-19 public health emergency (PHE) and two initiatives, which are highlighted below, that seek to ensure continued quality and safety for the Nation's health care services.

Implementation of Focused Infection Control (FIC) Nursing Home Surveys

Supplemental funding provided through the CARES Act is being used in coordination with SAs to conduct FIC surveys. To ensure minimum standards of nursing home infection control practices and education are followed, SAs performed over 15,000 FIC surveys in FY 2020. To maintain these best practices, a minimum of 20 percent of nursing homes will be surveyed for infection control annually based on COVID-19 infection rates or other factors, such as new variants of communicable diseases. In FY 2021 to FY 2023 CMS projects states will need to conduct these surveys at approximately 3,000 nursing homes annually to maintain the 20 percent FIC rate. CMS foresees that states will need to maintain this workload and retain the level of their trained workforce, even after the CARES Act funding is exhausted.

Initiative 1: Improve Care in Long-Term Care Facilities

Given the number of Long-Term Care (LTC) facilities and the vulnerability of its beneficiaries, CMS places high programmatic priority on maintaining and improving the quality of care and transparency in these facilities. In FY 2023, CMS projects, based on historical trends, that LTC facilities will account for over 90 percent of all complaint surveys. The goal of the LTC initiative is to protect resident health and safety by improving the identification of noncompliance and remediation. This effort directly addresses key questions including: How will the quality of life and care improve for nursing home residents? How will survey effectiveness and efficiency improve?

CMS has achieved a number of key milestones related to this initiative in recent years, including:

- Implementation of a revised survey process and training that accompanied the first revisions to the LTC regulations in 25 years;
- Implementation of a revised Federal Monitoring Survey process;
- Improved oversight of abuse and neglect through reporting criteria for facility-reported incidents, and making referrals to law enforcement;
- Improved consistency of CMS's enforcement actions;
- Targeted after-hours and weekend surveys for LTC facilities that fail to meet RN staffing levels;
- Revision of State Performance Standards System measurement and improved monitoring of health, safety and emergency preparedness compliance;
- Improved transparency and the use of publicly-reported information on Care Compare and the Five-Star Quality Rating System to monitor trends and to drive quality improvement; and,
- Reinvestment of CMP funds to support activities to further improve resident health and safety, including support for residents in the event of facility closure, joint training of facility staff and surveyors, technical assistance, and the appointment of temporary management.

Initiative 2: Improve Oversight of Accrediting Organizations (AOs)

AOs receive deeming authority from CMS to affirm that AOs' health and safety standards meet or exceed those of Medicare. There are currently 11 CMS-approved AOs, each of which surveys one or more different types of facilities including hospitals, HHAs, hospices, ambulatory surgical centers, and ESRD facilities. Facilities surveyed and certified through AOs are considered "Deemed" to match CMS's Conditions of Participation (COPs).

In response to ongoing concerns, such as disparities in the number of AO identified deficiencies in deemed facilities versus the number identified by the state survey agency during validation surveys performed within 60 days of the AO's survey, CMS has developed this strategic initiative to improve its oversight of AOs. CMS aims to improve the transparency and effectiveness of the AO program, thus strengthening our commitment to quality and patient safety. This initiative is designed to answer questions surrounding the following: How has compliance with Medicare quality and safety standards improved care in acute care settings? Has increased oversight improved disparity findings? And, how has CMS improved partnerships and communications with AOs? CMS has proposed crucial milestones to implement this initiative:

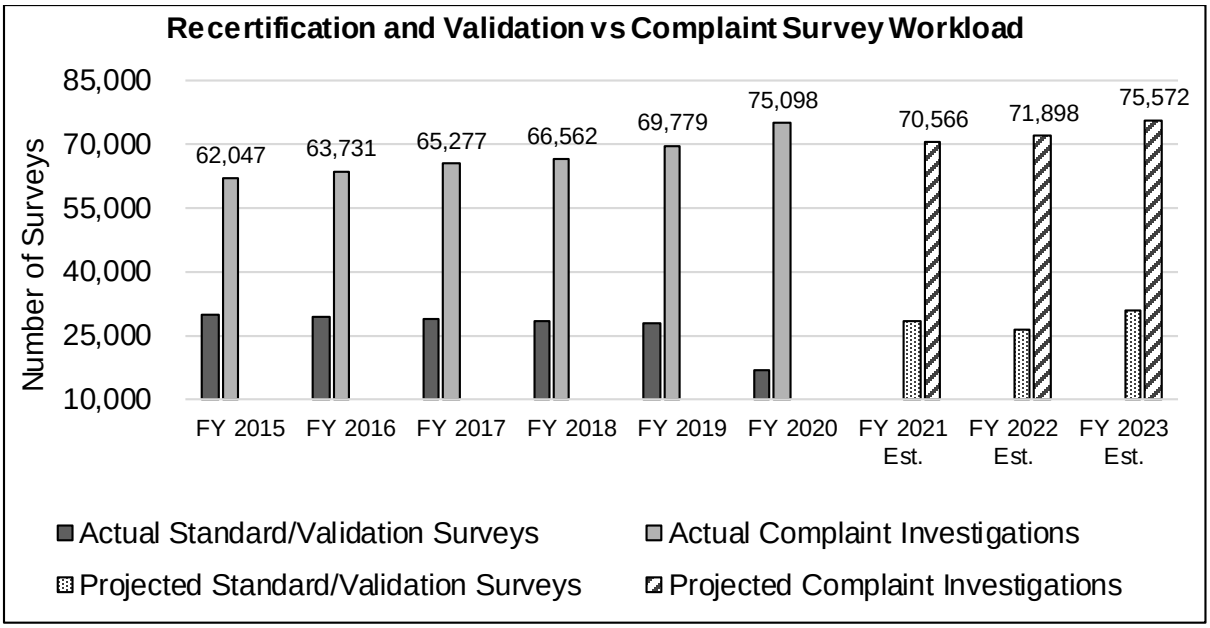
- Public posting of information about AO performance;
- Establishment of an AO Liaison Program; and
- AO validation survey redesign

While there are a number of factors that determine the overall quality of care in a hospital setting, CMS is committed to significantly reducing the number of serious health and safety violations in accredited hospitals each year. A number of important steps have been taken to improve the survey processes and oversight responsibilities to continually improve CMS-identified major risk areas, which could jeopardize the ongoing effectiveness of the S&C program.

Improved Program Efficiency

The S&C program annual discretionary appropriation has remained flat since FY 2015, which, over time, has limited the program's capacity to perform routine standard recertification and validation surveys. Further, the ongoing growth in complaints and associated survey workload inhibits the SAs' ability to address issues proactively through standard surveys. As a result, complaint surveys have become the primary oversight mechanism for many provider types. In some cases, issues that could be identified during standard health surveys go unaddressed and become more difficult and expensive to correct. At times, these issues escalate to possible life threating circumstances, as substantiated through reported complaints.

The graph below compares the number of recertification and validation surveys versus complaint surveys from a historical perspective. It also provides the estimated number of surveys that states can perform with the level of funding requested from FY 2021 through FY 2023 respectively. Between FY 2018 and FY 2020 the actual number of complaints that states responded to grew by close to 13 percent or by 8,536 complaint surveys. To pay for the rise in complaint surveys, under years of flat budget, the funding dedicated to conduct standard surveys was reduced, resulting in a year-over-year decrease in the number of recertification and validation surveys. However, with increased funding levels, CMS envisions a reduction in out-year complaint levels over-time, as a result of increasing the level of recertification and validation surveys.



CMS's Response to COVID-19

The CARES Act provided CMS with $200 million in multi-year Program Management funding through FY 2023 to "prevent, prepare for, and respond to the Coronavirus (COVID-19) domestically and internationally." Of this amount, the CARES Act held that no less than $100 million was provided to cover the necessary expenses of CMS's S&C program. CMS leveraged its oversight role to increase focus on infection control in facilities to prevent the spread of COVID-19. While this increased FIC surveys, it reduced the number of standard surveys. CMS

also limited the scope of complaints and facility reported incidents to allegations of immediate jeopardy (IJ) to beneficiary health and safety; revisit surveys needed to verify removal of IJ; and complaints related to infection control (see QSO-20-20-All and QSO-21-13). This temporary suspension and reprioritization of survey activity nationwide resulted in a backlog of complaint and recertification surveys.

Current nursing home COVID-19 data shows approximately 86 percent of residents and 74 percent of staff are fully vaccinated, and the number of new COVID-19 cases each week has been dramatically reduced. For example, the average number of national resident COVID-19 weekly cases in January 2021 was approximately 20,000 per week, whereas the average number in September 2021 was approximately 5,100 per week (approximately an 80 percent reduction), demonstrating the effectiveness of the vaccines and FIC surveys.

Additionally, in November 2021, CMS implemented a regulation requiring staff vaccinations for COVID-19 to help protect the health and safety of patients receiving care in Medicare and Medicaid-certified facilities. This regulation seeks to help contain the spread of COVID-19 and is a condition of participation in the Medicare and Medicaid programs for healthcare providers.

CMS is working to ensure that activities funded through the CARES Act are effectively managed. CMS is closely coordinating with federal, state, local, and private sector stakeholders to make sure these efforts are complementary across programs, reflect evolving factors associated with the COVID-19 pandemic, and provide the highest priority response activities, without overly burdening facilities treating patients with COVID-19. The $100 million CARES Act funding expires in FY 2023, but the required FIC and related enforcement action workloads will need to continue.

Funding History

Fiscal Year	Amount
FY 2019	$397,334,000
FY 2020	$397,334,000
FY 2021 Final	$397,334,000
FY 2022 CR	$397,334,000
FY 2023 President's Budget	$494,261,000

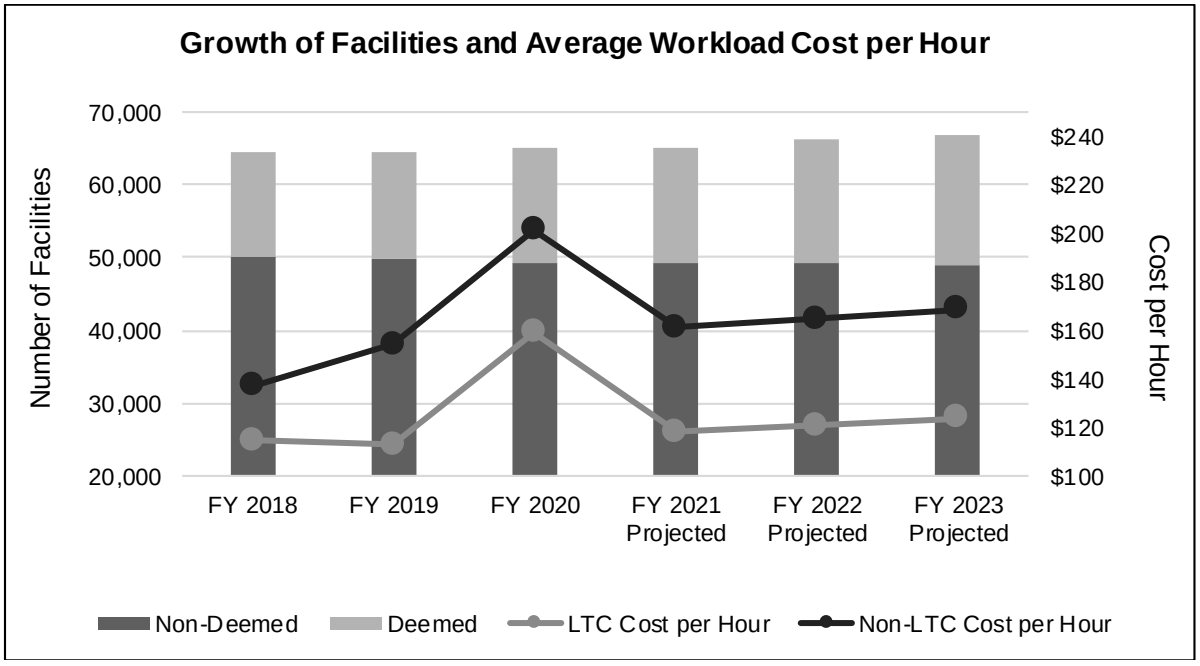
Budget Request: $494.3 million

The FY 2023 Program Management discretionary budget request for S&C is $494.3 million, an increase of $96.9 million above the FY 2022 Continuing Resolution (CR) level. This increase will keep mandatory survey levels at 100 percent, increase non-mandatory levels, help address the backlog of complaints and allow states to investigate facilities prone to outbreaks of infectious diseases like COVID-19. CMS projects that this funding increase will help states maintain the increased workload in response to COVID-19. Increased funding will allow states to maintain a trained and appropriately equipped workforce and a reporting system for tracking, tracing, and testing for infectious diseases. This budget request will also aid in ensuring that Medicare and Medicaid certified facilities are better prepared for any future public health emergency. This budget request includes funding for SA surveys, along with ongoing contract support to strengthen quality improvement efforts, improve national survey consistency, improve AO oversight, and adhere to GAO and OIG recommendations to promote gains in efficiency and

effectiveness. The budget also supports legislation to increase the accountability of substandard facilities. Above all, at this funding level, CMS projects that SAs will be in a better position to identify deficiencies in facilities, that if left unaddressed, can reach to Actual Harm, IJ, or Non-IJ High levels.

The FY 2023 budget request accounts for the rise in the cost to operate the S&C program. The S&C program has faced increased costs due, in part, from growth in the number of beneficiaries (which has created a demand for more facilities), surveyor wage growth, and improvements in quality standards. From FY 2018 to FY 2023, participating facilities are expected to grow by nearly 4 percent, or 2,489 facilities. During this time, deemed facilities are projected to account for a majority of this growth, with an increase of nearly 25 percent, whereas the total number of non-deemed facilities are expected to decrease by 2 percent. This growth in the number of deemed facilities reinforces the importance of the above-mentioned initiative to Improve Oversight of Accrediting Organizations.

The overall average cost per hour to conduct the S&C workload is projected to increase by about 16 percent between the end of FY 2018 through the end of FY 2023. This is due in part to cost growth at the state level; as states have increased wages to attract and retain surveyors, who are high demand, medical professionals. On average, the LTC cost per hour is projected to increase by nearly 8 percent and the non-LTC cost per hour to grow by 23 percent. Finally, contributing further to the cost growth to conduct surveys, certifications, and investigations is the implementation of revised COPs, which will result in average survey length increases of nearly 6 percent by the end of FY 2023. The graph below demonstrates the overall growth in number of facilities, the incremental increase of more facilities entering the Medicare and Medicaid programs through accreditation (i.e., the “deeming” process), and the increase in costs to conduct surveys for LTC and non-LTC facilities.



The S&C program also receives $5.6 million through FY 2025 from the IMPACT Act, and starting in FY 2022, and continuing for each subsequent fiscal year, an additional $10.0 million from the CA Act of 2021 to maintain hospice survey frequencies at a three-year rate. The CA Act of 2021 required CMS to established a special focus program for hospice agencies. Under this program, low performing hospices would be subject to be surveyed every six months. In addition, the CARES Act funding will be used for FIC surveys and supplement the payment of standard surveys through FY 2023. The following table provides each funding source and its respective breakout per fiscal year.

Survey and Certification Sources Breakout by Activity
(Dollars in Thousands)

	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget
State Direct Survey	$363,847	$361,097	$457,747
Mandatory Surveys (Nursing Homes/Home Health/Hospice) (non-add)	*$322,694*	*$322,970*	*$335,934*
Non-Statutory Surveys Non-Deemed and Deemed (non-add)	*$41,153*	*$38,127*	*$121,812*
Federal Direct Surveys	$6,040	$6,240	$6,240
Support Contract and Information Technology	$27,447	$29,997	$30,274
Total S&C PM Discretionary	**$397,334**	**$397,334**	**$494,261**
IMPACT Act, Hospice Surveys[3]	$5,625	$5,464	$5,304
Consolidated Appropriations Act of 2021, Hospice Surveys[3]	$0	$9,714	$9,430
Grants to States for Medicaid - S&C	$296,000	$306,000	$328,000
ARP, P.L. 117-2[4]	$500,000	$0	$0
CLIA Lab Fees	$71,963	$77,550	$78,000

State Direct Survey

The State Direct Survey activity under the discretionary request provides funding directly to states to conduct surveys and complaint investigations of health care facilities. It also includes funds to support SAs' cost for travel, training, and supplies.

Budget Request: $457.7 million

The total discretionary State Direct Survey budget request is $457.7 million, an increase of $96.6 million above the FY 2022 CR level. This increase includes $335.9 million to inspect, survey, and certify statutory facilities, and $121.8 million to inspect, survey, and certify non-statutory facilities.

With this level of funding, CMS projects that states will have the resources to complete 100 percent of surveys for all provider types, including statutorily required surveys and non-statutory surveys. This level of survey completion (at 100 percent), which has not been

[3] Funding provided through the Improving Medicare Post-Acute Care Transformation (IMPACT) and Consolidated Appropriations Acts are net of sequester.
[4] The FY 2021 Enacted level for Sections 9402 and 9818 of the American Rescue Plan Act reflects funding to be transferred from CMS to the Centers for Disease Control and Prevention (CDC).

projected since the submission of the FY 2017 President's Budget, places the program in a situation to provide oversight for all facility types and is the first step in shifting from a reactive to proactive posture. With this level of funding, CMS can better ensure compliance with and enforcement of the rules that protect our most vulnerable beneficiaries. With America still impacted by the COVID-19 PHE, fully funding this program will strengthen CMS's oversight of all provider types at a time when it is most needed.

The cost to reach the projected survey frequency completion rate for each provider type displayed in the following table is funded by all sources shown in the above table, excluding Clinical Laboratory Fees. In addition, the remaining funding from the CARES Act will carry over into FY 2023 and is prioritized to combat the spread of COVID-19 via FIC surveys and support the completion of the backlog of pending recertification surveys created during the PHE. With this additional funding, CMS projects an improved survey frequency rate for all providers. The survey frequencies are based on current law and CMS's administrative policy, resulting in varying survey intervals depending on provider type (facility). For example, ESRD facilities have a policy-set, three-year survey frequency interval for the entire population. This means that at the end of a three-year cycle, if policy-set levels are met, 100 percent of ESRD facilities will have been surveyed. To accomplish this, one-third of the ESRD facilities should be surveyed each year. The percentages seen in the table below are the completion rates of the one-third (or 33 percent) of all ESRD facility initial and recertification surveys. Following this methodology, under President's Budget request, CMS projects that a 100 percent of one-third of all ESRD facilities will be surveyed in FY 2023, fulfilling policy-set levels, which is a significant increase over FY 2021 levels. Deemed provider types on the other hand are surveyed on intervals by CMS approved Accrediting Organizations. CMS along with SAs conduct validation surveys of five percent of these deemed providers. These validation surveys serve as an effort of oversight of AO's survey workload. In FY 2023, CMS projects that SAs will be able to complete 100 percent of the five percent sample validation surveys of Deemed ASCs, or conduct 114 validation surveys of the 2,277 Deemed ASCs.

Provider Survey Frequency Rate Completion Projections[5]

Provider Status and Type	Survey Frequency Intervals	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget
Statutory				
Nursing Facilities (NF)	100% Surveyed 12.9-15.9 months	100%	100%	100%
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	100% Surveyed 12.9-15.9 months	100%	100%	100%
Special Focus Facility Nursing Homes (SFF)	100% Surveyed 6 months	100%	100%	100%
Skilled Nursing Facilities (SNF)	100% Surveyed 12.9-15.9 months	100%	100%	100%
ICF/IID	100% Surveyed 12.9-15.9 months	100%	100%	100%
Home Health Agencies (HHAs)	100% Surveyed 36.9 months	100%	100%	100%
Hospice Agencies	100% Surveyed 36.9 months	100%	100%	100%
Special Focus Facility Hospice Agencies (SFF)[6]	100% Surveyed 6 months	0%	100%	100%
Non-Statutory Non-Deemed				
Ambulatory Surgical Centers (ASCs)	100% Surveyed 36 months	62%	26%	100%
Community Mental Health Centers (CMHCs)	100% Surveyed 72 months	65%	28%	100%
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	100% Surveyed 72 months	77%	36%	100%
End Stage Renal Disease (ESRD)	100% Surveyed 36 months	66%	28%	100%
Hospitals[7]	100% Surveyed 36 months	60%	25%	100%
Outpatient Physical Therapy (OPT)	100% Surveyed 72 months	72%	30%	100%
Portable X-Ray Suppliers	100% Surveyed 72 months	57%	24%	100%
Rural Health Clinics (RHCs)	100% Surveyed 72 months	67%	28%	100%
Transplant Centers	100% Surveyed 60 months	37%	15%	100%
Non-Statutory Deemed				
Ambulatory Surgical Centers (ASCs)	5% of Validation Surveys	22%	9%	100%
End Stage Renal Disease (ESRD)	5% of Validation Surveys	0%[8]	0%[6]	0%[6]
Home Health Agencies (HHAs)	5% of Validation Surveys	10%	29%	100%
Hospice Agencies	5% of Validation Surveys	6%	3%	100%
Hospitals	5% of Validation Surveys	37%	15%	100%
Outpatient Physical Therapy (OPT)	5% of Validation Surveys	0%[6]	0%[6]	100%
Rural Health Clinics (RHCs)	5% of Validation Surveys	0%[6]	0%[6]	0%[6]

[5] Funding from the CARES Act is included to pay for the projected survey frequency completion rates.
[6] Surveys of Special Focus Facility for Hospice Agencies will start in FY 2022.
[7] Starting in FY 2021, surveys, certifications, and complaint investigation in psychiatric hospitals will be transitioned from being conducted by federal contractors to State Agencies.
[8] States will respond to complaints, and based on availability of resources, conduct recertification surveys, and certify new facilities.

The next table displays the projected costs to respond to reported complaints and the costs to conduct the projected survey frequency rates provided in the Survey Frequency Rates table per provider type from FY 2021 to FY 2023. This table also includes supplemental funding provided through the IMPACT Act, and the Consolidated Appropriations Act of 2021 for hospice surveys.

Medicare PM Discretionary Survey and Complaint Visit Cost Projections
(Dollars in Thousands)

	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget
Statutory	**$322,694**	**$322,970**	**$335,934**
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	$284,817	$291,939	$301,115
Special Focus Facility Nursing Homes (SFF)	$2,411	$2,445	$2,452
Skilled Nursing Facilities (SNF)	$14,925	$14,371	$18,222
Home Health Agencies (HHAs)	$14,641	$14,215	$14,145
Hospice Agencies	$5,900	$0	$0
Special Focus Facility Hospice Agencies (SFF)	$0	$0	$0
Non-Statutory Non-Deemed	**$12,561**	**$10,125**	**$75,423**
Ambulatory Surgical Centers (ASCs)	$2,087	$1,379	$17,889
Community Mental Health Centers (CMHCs)	$21	$28	$434
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	$184	$6	$103
End Stage Renal Disease (ESRD)	$6,374	$5,527	$34,175
Hospitals	$3,160	$2,807	$17,043
Outpatient Physical Therapy (OPT)	$173	$97	$1,257
Portable X-Ray Suppliers	$23	$16	$363
Rural Health Clinics (RHCs)	$284	$205	$3,226
Transplant Centers	$255	$61	$933
Non-Statutory Deemed	**$28,592**	**$28,002**	**$46,390**
Ambulatory Surgical Centers (ASCs)	$58	$25	$1,651
End Stage Renal Disease (ESRD)	$0	$0	$0
Home Health Agencies (HHAs)	$48	$17	$1,542
Hospice Agencies	$30	$10	$2,564
Hospitals	$28,455	$27,951	$40,561
Outpatient Physical Therapy (OPT)	$0	$0	$73
Rural Health Clinics (RHCs)	$0	$0	$0
Total State Direct Survey Budget	**$363,847**	**$361,097**	**$457,747**
IMPACT Act, Hospice Surveys	$5,625	$5,464	$5,304
Consolidated Appropriations Act, Hospice Surveys	$0	$9,714	$9,430

With the level of funding from the FY 2023 President's Budget request, CMS expects SAs to complete approximately 31,045 initial and recertification surveys, 75,572 visits in response to complaints. The tables below show that the majority of surveys and complaint visits in FY 2023 are projected to be in nursing homes, illustrating the challenges discussed in the Accomplishment Section's Initiative 1.

FY 2023 Survey and Complaint Visit Table – Projected[9]

	Facilities Beginning of Year	Recertification Survey	Initial Survey	Complaint Survey	Total Surveys
Total State Direct Survey Budget	**66,908**	**30,183**	**862**	**75,572**	**109,631**
Statutory	**29,653**	**23,988**	**236**	**70,578**	**97,816**
Nursing Facilities (NF)	290	290	18	1,142	1,508
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	14,184	14,184	81	60,848	77,950
Special Focus Facility Nursing Homes (SFF)	88	176	0	0	176
Skilled Nursing Facilities (SNF)	598	598	15	2,492	3,225
ICF/IID	5,644	5,644	28	4,662	10,334
Home Health Agencies (HHAs)	6,498	2,166	41	918	3,125
Hospice Agencies	2,263	754	53	515	1,322
Special Focus Facility Hospice Agencies (SFF)	88	176	0	0	176
Non-Statutory Non-Deemed	**19,327**	**5,401**	**626**	**1,742**	**7,769**
Ambulatory Surgical Centers (ASCs)	3,860	1,287	53	180	1,520
Community Mental Health Centers (CMHCs)	132	22	3	3	28
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	155	26	2	0	28
End Stage Renal Disease (ESRD)	7,471	2,490	291	1,258	4,039
Hospitals	1,694	565	32	262	859
Outpatient Physical Therapy (OPT)	1,650	275	61	8	344
Portable X-Ray Suppliers	525	88	29	1	118
Rural Health Clinics (RHCs)	3,601	600	155	28	783
Transplant Centers	239	48	0	2	50
Non-Statutory Deemed	**17,928**	**794**	**0**	**3,252**	**4,046**
Ambulatory Surgical Centers (ASCs)	2,277	114	0	0	114
End Stage Renal Disease (ESRD)	536	0	0		0
Home Health Agencies (HHAs)	5,030	252	0	0	252
Hospice Agencies	3,489	174	0	0	174
Hospitals	4,686	234	0	3,252	3,486
Outpatient Physical Therapy (OPT)	397	20	0	0	20
Rural Health Clinics (RHCs)	1,513	0	0	0	0

[9] Funding from the CARES Act is included to pay for the projected workload.

FY 2022 CR Survey and Complaint Visit Table – Projected[10]

	Facilities Beginning of Year	Recertification Survey	Initial Survey	Complaint Survey	Total Surveys
Total State Direct Survey Budget	**66,138**	**25,349**	**830**	**71,898**	**101,113**
Statutory	**30,004**	**24,218**	**226**	**67,060**	**94,540**
Nursing Facilities (NF)	304	304	19	1,031	1,415
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	14,248	14,248	79	59,324	76,501
Special Focus Facility Nursing Homes (SFF)	88	176	0	0	176
Skilled Nursing Facilities (SNF)	630	630	16	1,068	1,840
ICF/IID	5,704	5,704	28	4,261	9,993
Home Health Agencies (HHAs)	6,661	2,220	36	899	3,155
Hospice Agencies	2,281	760	48	477	1,285
Special Focus Facility Hospice Agencies (SFF)	88	176	0	0	176
Non-Statutory Non-Deemed	**19,259**	**1,012**	**604**	**1,594**	**3,210**
Ambulatory Surgical Centers (ASCs)	3,829	288	58	149	495
Community Mental Health Centers (CMHCs)	129	4	3	2	9
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	159	8	2	0	10
End Stage Renal Disease (ESRD)	7,506	478	292	1,168	1,938
Hospitals	1,579	112	26	237	375
Outpatient Physical Therapy (OPT)	1,680	44	58	8	110
Portable X-Ray Suppliers	512	1	26	1	28
Rural Health Clinics (RHCs)	3,626	70	139	26	235
Transplant Centers	239	7	0	3	10
Non-Statutory Deemed	**16,875**	**119**	**0**	**3,244**	**3,363**
Ambulatory Surgical Centers (ASCs)	2,198	10	0	0	10
End Stage Renal Disease (ESRD)	357	0	0	0	0
Home Health Agencies (HHAs)	4,829	69	0	0	69
Hospice Agencies	3,173	4	0	0	4
Hospitals	4,691	36	0	3,244	3,280
Outpatient Physical Therapy (OPT)	359	0	0	0	0
Rural Health Clinics (RHCs)	1,268	0	0	0	0

[10] Funding from the CARES Act is included to pay for the projected workload.

FY 2021 Survey and Complaint Visit Table – Projected[11]

	Facilities Beginning of Year	Recertification Survey	Initial Survey	Complaint Survey	Total Surveys
Total State Direct Survey Budget	**65,056**	**27,473**	**929**	**70,566**	**102,020**
Statutory	**30,222**	**24,244**	**224**	**65,773**	**93,293**
Nursing Facilities (NF)	314	314	19	1,051	1,447
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	14,287	14,287	82	58,119	75,345
Special Focus Facility Nursing Homes (SFF)	88	176	0	0	176
Skilled Nursing Facilities (SNF)	661	661	17	1,063	1,873
ICF/IID	5,773	5,773	32	4,142	9,947
Home Health Agencies (HHAs)	6,752	2,251	34	881	3,166
Hospice Agencies	2,347	782	40	517	1,339
Special Focus Facility Hospice Agencies (SFF)	0	0	0	0	0
Non-Statutory Non-Deemed	**19,046**	**3,349**	**443**	**1,555**	**5,347**
Ambulatory Surgical Centers (ASCs)	3,771	778	5	141	924
Community Mental Health Centers (CMHCs)	125	13	2	2	17
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	162	0	264	0	264
End Stage Renal Disease (ESRD)	7,511	1,644	21	1,119	2,784
Hospitals	1,377	257	49	254	560
Outpatient Physical Therapy (OPT)	1,732	202	26	7	235
Portable X-Ray Suppliers	502	48	0	1	49
Rural Health Clinics (RHCs)	3,630	407	1	28	436
Transplant Centers	236	0	75	3	78
Non-Statutory Deemed	**15,788**	**142**	**0**	**3,238**	**3,380**
Ambulatory Surgical Centers (ASCs)	2,105	23	0	0	23
End Stage Renal Disease (ESRD)	216	0	0	0	0
Home Health Agencies (HHAs)	4,620	23	0	0	23
Hospice Agencies	2,788	8	0	0	8
Hospitals	4,702	88	0	3,238	3,326
Outpatient Physical Therapy (OPT)	327	0	0	0	0
Rural Health Clinics (RHCs)	1,030	0	0	0	0

[11] Funding from the CARES Act is included to pay for the projected workload.

Federal Direct Surveys

Federal Direct Surveys are conducted by national contractors to oversee surveys conducted by SAs. National contractors evaluate SAs' Life Safety Code (LSC) survey performance of long-term care facilities by conducting statutorily required comparative LSC surveys including parts of the physical environment standards applicable to long term care facilities, as well as Emergency Preparedness (EP) requirements. CMS also contracts to conduct targeted and performance surveys covering emergency surveys, enforcement surveys, implementation of new survey requirements, and GAO and OIG recommendations to improve care.

Budget Request: $6.2 million

The FY 2023 budget request for Federal Direct Surveys is $6.2 million, which is flat with the FY 2022 CR level, as cost for this workload is not expected to increase in FY 2023.

Support Contracts and Information Technology (IT)

Support and IT contracts include a variety of activities to support programmatic needs such as conducting mandatory surveyor training, gathering and organizing of data for the development, education, and implementation of procedures. These efforts include replacing CMS's legacy IT infrastructure with a newly designed internet facing system with improved accessibility and reporting that can be modified efficiently at a lower cost.

Budget Request: $30.3 million

The FY 2023 budget request for Support Contracts and IT is $30.3 million, an increase of $0.277 million above the FY 2022 CR level. This amount includes $22.4 million for support contracts and $7.9 million for IT contracts. This increase supports the rise in cost for surveyor training.

Grants to States Mandatory Appropriation: $328.0 million

The FY 2023 mandatory appropriation for the Grants to States for Medicaid is $328 million, $22 million above the FY 2022 level. This funding will allow states to conduct surveys, certifications, and investigations of Medicaid eligible facilities. With this funding, CMS projects to meet all statutory requirements of the S&C program, including responding to IJ complaints and adherence to statutorily required survey frequencies.

Mandatory Facilities' Survey Cost Projections
(Dollars in Thousands)

	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget
Medicaid Grants to States	**$296,000**	**$306,000**	**$328,000**
Statutory	***$295,934***	***$305,268***	**$326,430**
Nursing Facilities (NF)	$7,766	$9,363	$9,659
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	$226,534	$234,375	$251,874
Special Focus Facility Nursing Homes (SFF)	$1,873	$1,925	$2,051
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	$45,794	$45,879	$48,439
Home Health Agencies (HHAs)	$13,967	$13,726	$14,407
Non-Statutory Deemed	***$66***	***$732***	**$1,570**
Home Health Agencies (HHAs)	$66	$732	$1,570
Total Medicaid S&C Funding	**$296,000**	**$306,000**	**$328,000**

Offsetting Collections CLIA: $78.0 million

The CLIA program is entirely funded by user fees that are charged to the laboratories regulated by the program. The FY 2023 budget projection for CLIA is $78.0 million in user fee collections, which is $0.5 million above the FY 2022 CR level.

CLIA established quality standards for laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test is performed and to extend beyond Medicare and Medicaid. These outcomes are determined by onsite inspections of CLIA-identified laboratories. CMS works with SAs and AOs who perform inspections to ensure CLIA policies and procedures are followed.

CLIA laboratories can include traditional laboratories, hospitals, physician office laboratories, ambulatory surgical centers, rural health clinics, insurance laboratories, federal, state, city/county laboratories, and community health screenings. CLIA provisions are based on the complexity of performed tests, as defined by the Food and Drug Administration (FDA). CMS also has inter-agency agreements with the CDC to define quality and safety standards. Laboratories performing similar tests must meet similar standards, whether located in a hospital, doctor's office, or other sites. The more complex the tests performed, the more stringent the requirements.

The CLIA program approves Laboratory AOs such as the Joint Commission and the College of American Pathologists (CAP) as deeming organizations for certification of CLIA testing. AOs must meet the minimum CLIA regulations but can also be more stringent than CMS defined requirements. Laboratories which are accredited or which operate in exempt states are inspected by an AO or SA every two years.

The table below provides the number of labs that are subject to CLIA oversight. From FY 2018 to FY 2023, CMS is expecting the number of labs to grow by 21 percent, with waived labs making up majority of this growth at 31 percent.

Number of Laboratories Subject to CLIA Oversight[12]

Lab Type	FY 2018 Actual	FY 2019 Actual	FY 2020 Actual	FY 2021 Actual	FY 2022 Actual	FY 2023 Projected
Compliance Labs	17,883	17,717	17,404	17,411	17,934	17,934
Accredited Labs	16,311	16,035	15,746	15,656	15,907	15,907
Waived Labs	178,616	184,458	189,410	193,146	233,909	233,909
PPMP Labs	33,411	32,578	31,254	30,248	29,826	29,826
Total	**246,221**	**250,788**	**253,814**	**256,461**	**297,576**	**297,576**

The table below provides the projected CLIA Survey Workload from FY 2017 to FY 2023, and directly following is a table showing what the actual CLIA Survey workload was between FY 2017 to FY 2021.

[12] Waived Labs and Provider Performed Microscopy Procedure (PPMP) Labs are excluded and exempt from routine surveys but are subject to announced or unannounced surveys under certain circumstances (i.e., complaints).

Projected CLIA Survey Workload

Type of Survey	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Compliance: Initial and Recertification	8,941	8,858	8,702	8,620	9,508	9,508
Complaint/Follow-up	185	229	207	155	132	132
Validation Surveys	435	428	420	418	430	430
Total	**9,561**	**9,515**	**9,329**	**9,193**	**10,070**	**10,070**

Actual CLIA Survey Workload

Type of Survey	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Compliance: Initial and Recertification	8,857	7,858	4,818	8,127	TBD	TBD
Complaint/Follow-up	142	75	333	1,212	TBD	TBD
Validation Surveys	198	27	21	69	TBD	TBD
Total	**9,197**	**7,960**	**5,172**	**9,408**	**TBD**	**TBD**

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Grants to States for Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, $367,357,090,000, to remain available until expended.

In addition, for carrying out such titles after May 31, 2023, for the last quarter of fiscal year 2023 for unanticipated costs incurred for the current fiscal year, such sums as may be necessary, to remain available until expended.

In addition, for carrying out such titles for the first quarter of fiscal year 2024, $197,580,474,000, to remain available until expended.

Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.

Grants to States for Medicaid

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, $367,357,090,000, to remain available until expended.	This section provides a no-year appropriation for Medicaid for FY 2023. This appropriation is in addition to the advance appropriation of $165.7 billion for the first quarter of FY 2023. Funds will be used under title XIX for medical assistance payments and administrative costs and under title XI for demonstrations and waivers.
In addition, for carrying out such titles after May 31, 2023 for the last quarter of fiscal year 2023 for unanticipated costs incurred for the current fiscal year, such sums as may be necessary, to remain available until expended.	This section provides indefinite authority for payments to states in the last quarter of FY 2023 to meet unanticipated costs for carrying out titles XI and XIX, including the costs of the Vaccines for Children program.

Grants to States for Medicaid

Language Analysis

Language Provision	Explanation
In addition, for carrying out such titles for the first quarter of fiscal year 2024, $197,580,474,000, to remain available until expended.	This section provides an advance appropriation for the first quarter of FY 2024 to ensure continuity of funding for activities authorized under titles XI and XIX. This allows the Medicaid program, including the Vaccines for Children program, to continue operating in the event a regular appropriation for FY 2024 is not enacted by October 1, 2023.
Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.	This section makes clear that funds are available with respect to state plans or plan amendments only for expenditures on or after the beginning of the quarter in which a plan or amendment is submitted to the Department of Health and Human Services for approval.

Grants to States for Medicaid
Amounts Available for Obligation
(Dollars in Thousands)

	FY 2021 Actual	FY 2022 Est.	FY 2023 Est.	FY 2023 +/- FY 2022
Mandatory Appropriation:				
Advanced Appropriation.....	$139,903,075	$148,732,315	$165,722,018	$16,989,703
Annual Appropriation.....	$313,904,098	$368,666,106	$367,357,090	($1,309,016)
Indefinite Annual Appropriation..	$65,676,685	$41,257,234	$0	($41,257,234)
Subtotal, Mandatory Appropriation	$519,483,858	$558,655,655	$533,079,108	($25,576,547)
Offsetting Collections from Federal Sources:				
Collection Authority: Medicare Part D……..	$0	$5,000	$5,000	$0
Collection Authority: Medicare Part B……..	$1,360,315	$1,596,000	$1,434,000	($162,000)
Subtotal, Collections Authority	$1,360,315	$1,601,000	$1,439,000	($162,000)
Total New Budget Authority	**$520,844,173**	**$560,256,655**	**$534,518,108**	**($25,738,547)**
Unobligated Balances:				
Unobligated balance, Start of year.....	$311,287	$417,598	$0	($417,598)
Unobligated balance, Recoveries of Prior Year Obligations (Unpaid)……	$27,080,809	$52,757,000	$49,991,106	($2,765,894)
Recoveries of Prior Year Obligations (Paid)……	$11,780,507			
Subtotal, Unobligated Balances.....	$39,172,603	$53,174,598	$49,991,106	($3,183,492)
Total Budgetary Resources (Amounts Available for Obligation)	**$560,016,775**	**$613,431,253**	**$584,509,214**	**($28,922,039)**
Unobligated balance, end of year……..	$417,598	$0	$0	$0
Total, Gross Obligations.....	**$559,599,179**	**$613,431,253**	**$584,509,214**	**($28,922,039)**
Net Obligations:				
Gross Obligations.....	$559,599,179	$613,431,253	$584,509,214	($28,922,039)
Actual Collections: Medicare Part D……..	$0	($5,000)	($5,000)	$0
Actual Collections: Medicare Part B……..	($1,360,315)	($1,596,000)	($1,434,000)	($162,000)
Unobligated balance, Start of year.....	($311,287)	($417,598)	$0	$417,598
Unobligated balance, Recoveries of Unpaid and paid Obligations.....	($38,861,316)	($52,757,000)	($49,991,106)	($2,765,894)
Total Net Obligations	**$519,066,261**	**$558,655,655**	**$533,079,108**	**($25,576,547)**

Funding History

Fiscal Year	Amount
2019	$411,083,971,000
2020 [1]	$467,569,094,000
2021 [2]	$519,483,858,000
2022 [3]	$517,398,421,000
2023	$533,079,108,000

Grants to States for Medicaid
Budget Authority by Object
(Dollars in Thousands)

	FY 2022 Estimate	FY 2023 Estimate	FY 2023 +/- FY 2022
CMS - Grants to States			
Grants to States, Subsidies	$554,701,951	$528,909,502	($25,792,449)
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$5,554,706	$5,608,606	$53,900
Total Budget Authority	**$560,256,657**	**$534,518,108**	**($25,738,549)**

[1] Includes $56.5 billion in indefinite funding authority obligated during FY 2020.
[2] Includes $65.7 billion in indefinite funding authority obligated during FY 2021.
[3] Does not include an estimate of $41.3 billion in indefinite authority to be obligated during FY 2022.

Grants to States for Medicaid
Budget Authority by Program Activity
(Dollars in Thousands)

	FY 2021 Actual	FY 2022 Estimate	FY 2023 Estimate	FY 2023 +/- FY 2022
1. Medical Assistance Payments				
Medical Assistance Payments.....	$531,283,644	$534,931,139	$507,958,202	($26,972,937)
Benefits Due and Payable (IBNR)	$0	$49,991,106	$47,293,347	($2,697,759)
Subtotal, Benefits	**$513,283,644**	**$584,922,245**	**$555,251,549**	**($29,670,696)**
2. Vaccine for Children				
Vaccines for Children.....	$3,806,080	$5,554,706	$5,608,606	$53,900
Subtotal, Vaccine for Children	**$3,806,080**	**$5,554,706**	**$5,608,606**	**$53,900**
3. State Administration				
State and Local Administration.....	$22,765,590	$22,300,243	$22,992,000	$691,757
HIT- Incentives.....	$0	$0	$0	$0
HIT- Provider.....	$173,416	$17,000	$1,000	($16,000)
HIT- Administration.....	$989,307	$23,059	$23,059	$0
State Survey and Certification.....	$294,242	$318,000	$328,000	$10,000
State Fraud Control Units.....	$286,900	$296,000	$305,000	$9,000
Subtotal, State Administration	**$24,509,455**	**$22,954,302**	**$23,649,059**	**$694,757**
Total Mandatory Appropriation……..	$519,483,858	$558,655,657	$533,079,108	($25,576,549)
Total Offsetting Collection Authority [4,5]……..	$1,360,315	$1,601,000	$1,439,000	($162,000)
Total, Budget Authority	**$520,844,173**	**$560,256,657**	**$534,518,108**	**($25,738,549)**
Recoveries and unobligated balances	$39,172,602	$53,174,596	$49,991,106	($3,183,490)
Total, Budgetary Resources	**$560,016,775**	**$613,431,253**	**$584,509,214**	**($28,922,039)**

Authorizing Legislation - Social Security Act, title XIX, Section 1901 and Public Law 111-5, Public Law 111-148, Public Law 111-152

FY 2021 Authorization – Public Laws 116-62, 116-59, 116-260

FY 2022 Authorization – Public Laws 116-450, 117-43

Allocation Method - Formula Grants

[4] Budget authority authorized and appropriated through offsetting collection authority under Social Security Act, title XIX, Section 1933(f).
[5] Budget authority authorized and appropriated through offsetting collection authority under Social Security Act, title XVIII, 1860D-16(b)(2).

Grants to States for Medicaid
Appropriated Budget Request [6]
(Dollars in Thousands)

	FY 2021 Actual	FY 2022 Estimate	FY 2023 President's Budget	FY 2023 +/- FY 2022
Program Activity				
Medical Assistance Payments.....	$425,491,638	$488,889,413	$503,821,443	$14,932,030
State and Local Administration.....	$24,509,455	$22,954,302	$23,649,059	$694,757
Vaccine for Children.....	$3,806,080	$5,554,706	$5,608,606	$53,900
Subtotal, Medicaid Program Level	**$453,807,173**	**$517,398,421**	**$533,079,108**	**$15,680,687**
Less funds advanced in prior year.	$139,903,075	$148,732,315	$165,722,018	$16,989,703
Total, Grants to States for Medicaid	**$313,904,098**	**$368,666,106**	**$367,357,090**	**($1,309,016)**
New advance 1st quarter of subsequent FY.....	$148,732,315	$165,722,018	$197,580,474	$31,858,456

[6] Funding represented in the chart equals the respective President's Budget requests. FY 2021 does not include $65.7 billion in indefinite funding authority obligated during FY 2021. FY 2022 does not include projected indefinite funding need of $41.3 billion.

Grants to States for Medicaid

Authorized under title XIX of the Social Security Act, Medicaid provides health coverage for millions of America's most vulnerable populations, including low-income families with dependent children, pregnant women, children, aged, blind and disabled individuals, and other eligible adults. In addition, Medicaid provides home and community-based services and support to seniors and individuals with disabilities, as well as institutional long-term care services. Medicaid is administered by CMS in partnership with the states.

The table below, and the following language, provides additional detail on each of the Grants to States for Medicaid program activities for FY 2023.

Summary of Request
Grants to States for Medicaid Mandatory Appropriation Request Summary Table
(Dollars in Thousands)

Program Activity	FY 2021 Actual	FY 2022 Estimate	FY 2023 Estimate	FY 2023 +/- FY 2022
Medical Assistance Payments	$425,491,638	$488,889,413	$503,821,443	$14,932,030
State and Local Administration	$24,509,455	$22,954,302	$23,649,059	$694,757
Vaccine for Children	$3,806,080	$5,554,706	$5,608,606	$53,900
Total Mandatory Appropriation Request [7]	**$453,807,173**	**$517,398,421**	**$533,079,108**	**$15,680,687**

FY 2023 Mandatory Appropriation Request: $533.1 billion

CMS' FY 2023 mandatory appropriation request for the Grants to States for Medicaid account is $533.1 billion, an increase of $15.7 billion relative to the FY 2022 request level of $517.4 billion. This appropriation is composed of $165.7 billion in an authorized advance appropriation for FY 2022 and a remaining appropriation of $367.4 billion for FY 2023.

Resources will help fund $584.5 billion in anticipated FY 2023 Medicaid obligations. CMS also anticipates carryover balances and recoveries in the amount of $50.0 billion as well as budget authority from offsetting collections from the Supplementary Medical Insurance trust fund and Medicare Part D account in the amount of $1.4 billion to fund the remaining anticipated obligations. These estimated obligations include:

- $555.3 billion in Medicaid medical assistance payments (MAP);
- $23.6 billion for Medicaid state and local administrative functions including funding for Medicaid state survey and certification and the state Medicaid fraud control units; and
- $5.6 billion for the Centers for Disease Control and Prevention's Vaccines for Children (VFC) program.

[7] Numbers may not add due to rounding.

This submission is based on projections from state-submitted estimates and CMS using Medicaid expenditure data as recent as the third quarter of FY 2021. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget (OMB) for the FY 2023 President's Budget.

Under current law, the federal share of Medicaid net outlays is estimated to be $535.8 billion in FY 2023, a decrease of $26.0 billion from the FY2022 level of $561.8 billion.

The FY 2023 estimate will be discussed in further detail by the major program activities of the Grants to States for Medicaid account; Medical Assistance Payments, Vaccines for Children, and State and Local Administration.

Grants to States for Medicaid
Medical Assistance Payments
(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023 Estimate	FY 2023 +/- FY 2022
Medical Assistance Payments	$425,491,638	$488,889,413	$503,821,443	$14,932,030

Program Activity Description and Accomplishments

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist States in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's low-income population.

Within broad national guidelines established by Federal statutes, regulations, and policies, each State establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among States of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one State may not be eligible in another State, and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, State legislatures may change Medicaid eligibility, benefits, and/or reimbursement, subject to federal standards, at any time.

Medicaid payments are made directly by states to health care providers or health plans for services rendered to beneficiaries. Providers must accept the state's payment as full reimbursement. By law, Medicaid is generally the payer of last resort. If other parties, including Medicare, are legally liable for services provided to a Medicaid beneficiary, that party generally must first meet its financial obligation before Medicaid payment is made.

Medicaid Eligibility and Enrollment

Medicaid provides health coverage for millions of America's most vulnerable populations, including low-income families with dependent children, pregnant women, children, aged, blind and disabled individuals, and other eligible adults.

The following table reflects the estimated annual Medicaid enrollment in number of person-years, which represents full-year equivalent enrollment. It is based on the 56 jurisdictions in the program.

Medicaid Enrollment
(Person -Years in Millions)

	FY 2021	FY 2022	FY 2023 Estimate	FY 2023 +/- FY 2022
Aged	6.6	6.8	6.9	0.1
Disabled	10.6	10.8	10.8	0.0
Adults	18.0	18.9	16.4	(2.5)
Children	30.3	31.1	30.0	(1.1)
Expansion Adult	15.7	16.9	15.4	(1.5)
Territories	1.3	1.4	1.4	0.0
Total [8]	**82.4**	**85.9**	**81.0**	**(5.0)**

According to CMS projections of Medicaid enrollment, 81 million Americans will be enrolled in Medicaid for the equivalent of a full year during FY 2023. In FY 2023, Medicaid is projected to provide coverage to more than one out of every five people in the nation. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to remain the same in FY 2023.

Scope of Medicaid Services

Title XIX of the Social Security Act allows considerable flexibility within the states' Medicaid plans. However, a state's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Pregnancy-related services, including prenatal care and 60 days postpartum pregnancy-related services.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons aged 21 or older.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled nursing services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

[8] Totals do not add due to rounding.

States may also receive federal matching funds to provide certain optional services. Following are some of the most common, currently approved optional Medicaid services:

- Diagnostic services.
- Clinic services.
- Intermediate care facility services.
- Prescribed drugs and prosthetic devices.
- Optometrist services and eyeglasses.
- Nursing facility services for children under age 21.
- Rehabilitation and physical therapy services.
- Hospice care.
- Home and community-based care to certain persons with chronic impairments.
- Targeted case management services.

FY 2023 Estimate

Budget Estimate: $503.8 Billion

CMS' Medical Assistance Payments (MAP) budget estimate is $503.8 billion, a $14.9 billion increase above the FY 2022 request. The following language provides additional detail on CMS' FY 2023 estimate: In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to reflect actuarial estimates developed by CMS' Office of the Actuary (OACT), legislative and regulatory impacts, entitlement benefits due and payable, CMS financial management reviews and estimates of expenditure transfer authority from the Medicare trust funds.

Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

CMS' OACT has found that state-submitted estimates of the grant awards tend to be higher than actual expenditures and, because of this, CMS' OACT relies more on actual expenditure data than the state-submitted estimates. CMS' OACT developed the MAP estimate for FY 2023 using the three quarters of FY 2021 state-reported expenditures as a base. Expenditures for FY 2021, FY 2022, and FY 2023 were projected by applying factors to account for assumed growth rates in Medicaid caseloads, utilization of services, and payment rates. These growth rates were derived mainly from economic assumptions promulgated by OMB and demographic trends in Medicaid enrollment. CMS' OACT also incorporated adjustments to the Medicaid benefit estimates based on their analysis of the state-submitted estimates.

Entitlement Benefits Due and Payable (Incurred but not Reported)

The FY 2023 estimate of $47.3 billion represents the entire liability for Medicaid medical services incurred but not paid from October 1, 2022 to September 30, 2023. This Medicaid liability is developed from estimates received from the states. The incurred but not reported estimate represents the net of unreported expenses incurred by the states less amounts owed to the states for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases.

Transfer from the Supplementary Medical Insurance Trust Fund for Qualified Individuals

Social Security Act Title XIX Section 1933(f) authorizes a transfer from the Supplementary Medical Insurance Trust Fund to the Grants to States for Medicaid account to account for the Medicare programs costs attributable to state coverage of Medicare cost-sharing for certain low-income Medicare beneficiaries. This estimate is developed by CMS' OACT, which for FY 2023 is estimated to be $1.4 billion. This transfer of funding is used to offset MAP obligations, thereby reducing the overall mandatory appropriation request.

Legislative and Regulatory Impacts to the Medicaid Baseline

In addition to adjusting the state estimates, CMS' OACT also estimates the impact of recent legislative and regulatory actions. Below is a list of select recent actions that impacted the current actuarial baseline estimate.

Legislative Actions

SUPPORT for Patients and Communities Act of 2018 (P.L. 115-271)

This Act contains a number of Medicaid provisions related to coverage and services for beneficiaries with substance use disorders.

Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16)

This law temporarily extends the applicability of Medicaid eligibility criteria that protect against spousal impoverishment for recipients of home- and community-based services. The law also establishes a state Medicaid option to provide for medical assistance with respect to coordinated care provided through a health home (i.e., a designated provider or team of health-care professionals) for children with medically complex conditions. States must determine payment methodologies in accordance with specified requirements; payments also temporarily qualify for an enhanced federal matching rate.

Further, drug manufacturers with Medicaid rebate agreements for covered outpatient drugs must disclose drug product information. Manufacturers are subject to civil penalties for knowingly misclassifying drugs. Manufacturers are also required to compensate for rebates that were initially underpaid because of misclassification (whether or not such misclassification was committed knowingly).

Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. 116-159)

This Act extends the Money Follows the Person program and extends the application of Medicaid rebates to medication-assisted treatment (MAT) drugs.

American Rescue Plan Act of 2021 (P.L. 117-2)

This Act provides additional relief to address the continued impact of COVID-19. For Medicaid, the bill provides coverage of COVID-19 vaccines and administration and treatment, creates a state option to extend coverage for pregnant and postpartum women, creates a state option to provider qualifying community-based mobile crisis intervention services, and temporarily increases the FMAP for states that adopt Medicaid expansion.

Further, the bill extends 100% FMAP to Urban Indian Health Organizations and Native Hawaiian Health Care Systems for two years, sunsets the limit of maximum rebate amount

for single source drugs and innovator multiple source drugs, increases Medicaid home and community-based services FMAP during the COVID-19 emergency, and funds state strike teams for resident and employee safety in nursing facilities.

Regulatory Actions

CMS-2482-F: Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third-Party Liability (TPL) Requirements

This final rule allows states to enter into value-based purchasing arrangements (VBPs) with manufacturers, and to provide manufacturers with regulatory support to enter into VBPs with payers, including Medicaid. The final rule also revises regulations regarding: authorized generic sales when manufacturers calculate average manufacturer price (AMP) for the brand name drug; pharmacy benefit managers (PBM) accumulator programs and their impact on AMP and best price when manufacturer-sponsored assistance is not passed through to the patient; state and manufacturer reporting requirements to the MDRP; new Medicaid Drug Utilization Review (DUR) provisions designed to reduce opioid related fraud, misuse and abuse; the definitions of CMS-authorized supplemental rebate agreement, line extension, new formulation, oral solid dosage form, single source drug, multiple source drug, innovator multiple source drug for purposes of the MDRP; payments for prescription drugs under the Medicaid program; and coordination of benefits (COB) and third party liability (TPL) rules related to the special treatment of certain types of care and payment in Medicaid and Children's Health Insurance Program (CHIP).

Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees

Discounts for prescription pharmaceutical products are central to this final rule, in which the Department of Health and Human Services (Department or HHS) amends the safe harbor regulation concerning discounts. Amending this regulation changes the definition of certain conduct that is protected from liability under the Federal anti-kickback statute of the Social Security Act (the Act). New regulatory text in the amendment revises the discount safe harbor. By excluding from the definition of a discount eligible for safe harbor protection certain reductions in price or other remuneration from a manufacturer of prescription pharmaceutical products to plan sponsors under Medicare Part D or pharmacy benefit managers (PBMs) under contract with them, the Department modifies the existing discount safe harbor in particular contexts. Existing safe harbors otherwise remain unchanged. Safe harbors are also created for two additional types of arrangements. The first protects certain point-of-sale reductions in price on prescription pharmaceutical products, and the second protects certain PBM service fees.

Grants to States for Medicaid
Vaccines for Children
(Dollars in Thousands)

	FY 2021 Actual	FY 2022 Estimate	FY 2023 Estimate	FY 2023 +/- FY2022
Vaccines for Children	$3,806,080	$5,554,706	$5,608,606	$53,900

Program Activity Description and Accomplishments

The Vaccines for Children (VFC) program is 100 percent federally funded by the Medicaid appropriation and operated by the Centers for Disease Control and Prevention. This program allows vulnerable children access to lifesaving vaccines as a part of routine preventive care, focusing on children without insurance, those eligible for Medicaid, and American Indian/Alaska Native children. Children with commercial insurance that lack an immunization benefit are also entitled to VFC vaccine, but only at Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). To reach eligible children under the VFC program, federally purchased vaccines are distributed to public health clinics and enrolled private providers. Through VFC, the Centers for Disease Control and Prevention provides funding to 61 state and local public health immunization programs that include all 50 states, six city/urban areas, and five U.S. territories and protectorates.

The nation's childhood immunization coverage rates are at high levels for most vaccines and vaccination series measures. As childhood immunization coverage rates increase, cases of vaccine-preventable diseases (VPDs) decline significantly. Vaccination against diphtheria, *haemophilus influenza* type b, hepatitis A, hepatitis B, measles, mumps, pneumococcal, pertussis, polio, rotavirus, rubella, tetanus, and varicella is recommended. In addition to the health benefits of immunization, vaccines also provide significant economic value. Millions of children have benefited from vaccination since the Vaccines for Children Program began in 1994. Among children born during 1994-2018, vaccination will prevent an estimated 419 million illnesses, 26.8 million hospitalizations, and 936,000 early deaths over the course of their lifetimes, at a net savings of $406 billion in direct costs and $1.9 trillion in total societal costs. [9]

FY 2023 Budget Estimate: $5.6 Billion

CMS' Vaccine for Children (VFC) estimate is $5.6 billion, a $53.9 million increase above the FY 2022 estimated level.

This estimate includes funds for vaccine-purchase contract costs and quality assurance and quality improvement site visits to VFC-enrolled providers. This budget will ensure sufficient quantities of pediatric vaccines are available to immunize VFC eligible children; approximately 96 percent of the VFC budget are used to purchase vaccines, including vaccine purchases for the VFC stockpile. The VFC stockpile is a strategic asset for the nation's immunization system that is used to fight outbreaks of VPDs and mitigate the impact of unanticipated shortages of routinely recommended vaccines. The remaining

[9] https://www.cdc.gov/vaccines/programs/vfc/protecting-children.html

budget supports vaccine ordering and distribution, including costs of ordering vaccines on behalf of states, immunization coverage surveys, and program support and oversight.

Grants to States for Medicaid
State and Local Administration
(Dollars in Thousands)

	FY 2021 Actual	FY 2022 Estimate	FY 2023 Estimate	FY 2023 +/- FY 2022
State and Local Administration	$24,509,455	$22,954,302	$23,649,059	$694,757

Program Activity Description and Accomplishments

State and Local Administration

State and Local Administration funding includes Medicaid management information systems (MMIS) design, development, and operation, immigration status verification systems; non-MMIS automated data processing activities; skilled professional medical personnel (SPMP); salaries, fringe benefits, and training; and other state and local administrative costs. These other costs include quality improvement organizations, pre-admission screening and resident review, nurse aide training and competency evaluation programs, and all other general administrative costs.

Medicaid Survey and Certification

In order to secure quality care for the nation's most vulnerable populations, CMS requires that certain facilities seeking participation in Medicaid undergo an inspection when they initially enter the program and on a regular basis thereafter. To conduct these inspection surveys, CMS contracts with state survey agencies in each of the 50 states, the District of Columbia, Puerto Rico, and two other territories. Utilizing more than 7,500 surveyors across the country, state survey agencies inspect providers and determine their compliance with specific federal health, safety, and quality standards.

Medicaid Fraud Control Units

Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud as well as neglect or abuse of patients in health care facilities and board and care facilities. The MFCUs are typically part of the state Attorney General's office, or have arrangements with the Attorney General or another office with statewide prosecutorial authority.

Health Information Technology Meaningful Use Incentive Program

The American Recovery and Reinvestment Act of 2009 (ARRA) authorizes Medicaid to provide incentive payments to doctors, hospitals, and other providers for the implementation and meaningful use of certified EHRs. The provision allows for enhanced federal financial participation (FFP) of 100 percent for incentive payments to providers for the purchase, maintenance, and meaningful use of certified EHRs, and 90 percent FFP for state and local administrative expenses associated with administering the incentive payments.

FY 2023 Budget Estimate: $23.6 Billion

CMS' State Administration estimate is $23.6 billion; a $694.8 million dollar increase compared to the FY 2022 estimated level.

This estimate is composed of $328.0 million for Medicaid state survey and certification, $305 million for state Medicaid Fraud Control Units, $1.0 million for the Health Information Technology Provider Incentives, and $23.1 million for other Medicaid state and local administration. The estimate is also reduced by the estimated expenditure transfer authority from the Medicare Part D account for state low income determinations.

Medicaid State Survey and Certification

The purpose of survey and certification inspections for nursing facilities home health agencies and intermediate care facilities for individuals with intellectual disabilities in FY 2023 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2023 estimate for Medicaid state survey and certification is $328.0 million. This represents an increase of $10.0 million above the FY 2022 estimated amount of $318.0 million. This funding level supports increasing workload requirements (i.e., increases in the average hours per survey) and labor costs; costs associated with survey and certification activities covering over 33,500 Medicaid participating facilities with nearly 24,500 health and life safety code annual certifications, as well as over 55,800 complaint survey investigations; and direct state survey costs associated with nursing home and home health agency quality.

Medicaid Fraud Control Units

In FY 2023, MFCUs in 53 states and territories will investigate and prosecute Medicaid providers and protect beneficiaries from patient abuse or neglect. These operations are currently estimated to total $305.0 million. This represents an increase of $9.0 million over the FY 2022 estimate of $296.0 million. Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud as well as neglect or abuse of patients in health care facilities and board and care facilities and of Medicaid beneficiaries in non-institutional or other settings. The MFCUs are typically a part of the state Attorney General's office or have arrangements with the Attorney General or another office with statewide prosecutorial authority. In FY 2021, MFCUs were responsible for 1,105 convictions, 716 civil settlements and judgments, and expected monetary recoveries for both civil and criminal cases of $1.7 billion. MFCU cases in FY 2021 were also responsible for the exclusion of 540 individuals and entities from participation in Medicaid and other federally funded health care programs.

Health Information Technology Meaningful Use Incentive Program

The current FY 2023 estimate for the provider incentives payments and state administrative costs is $24.1 million. These incentives continue to encourage adoption and meaningful use of electronic health records (EHRs). As providers have utilized the incentive payments to enhance their EHRs, states are seeing an increase in the need for ways to securely share these records among health care providers. States are committed to supporting this and other initiatives like the Electronic health information exchange (HIE), which allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care.

Transfer from the Medicare Part D account for State Low Income Determinations

The current FY 2023 estimate for this transfer is $5.0 million, a flatline from the FY 2022 estimate. Social Security Act Title XVIII Section 1860D-16(b)(2) authorizes a transfer from the Medicare Part D account to the Grants to States for Medicaid account to account for state administrative costs relating to Medicare prescription drug low-income subsidies, Medicare transitional prescription drug assistance, and Medicare cost-sharing. This amount is determined by CMS using actual state-submitted expenditure data projected into FY 2023.

All Other Medicaid State and Local Administration

The CMS estimate for FY 2023 is $23.0 billion. CMS adjusted the FY 2022 state-submitted estimates of $22.3 billion upward to reflect a growth rate more consistent with recent expenditure history and current economic conditions relative to the conditions when states submitted estimates.

FY 2023 MANDATORY STATE/FORMULA GRANTS [10]

(Dollars in Thousands)

CFDA No/Program Name: 93.778 Medical Assistance Program

State or Territory	FY 2021 Actual	Estimated FY 2022 obligations from:		FY 2022 (estimated)	FY 2023 (estimated) Obligation	FY 2023 +/- FY 2022
		Previous authority	New Authority			
Alabama	$5,257,674	$0	$5,466,799	$5,466,799	$5,422,702	($44,097)
Alaska	$1,630,099	$0	$1,790,104	$1,790,104	$1,868,773	$78,669
Arizona	$14,274,761	$0	$15,941,123	$15,941,123	$14,750,992	($1,190,131)
Arkansas	$5,818,491	$0	$6,334,172	$6,334,172	$6,117,628	($216,544)
California	$71,002,861	$0	$78,797,341	$78,797,341	$71,250,433	($7,546,908)
Colorado	$6,935,100	$0	$7,374,616	$7,374,616	$7,133,870	($240,746)
Connecticut	$4,454,875	$0	$5,727,183	$5,727,183	$5,625,314	($101,869)
Delaware	$1,667,481	$0	$1,888,737	$1,888,737	$1,672,051	($216,686)
District of Columbia	$2,658,873	$0	$2,425,743	$2,425,743	$2,366,137	($59,606)
Florida	$19,377,610	$0	$22,373,405	$22,373,405	$19,234,928	($3,138,477)
Georgia	$8,991,603	$0	$9,585,126	$9,585,126	$10,238,862	$653,736
Hawaii	$1,915,209	$0	$1,949,300	$1,949,300	$1,944,649	($4,651)
Idaho	$2,288,482	$0	$2,596,484	$2,596,484	$2,561,919	($34,565)
Illinois	$17,436,334	$0	$15,415,614	$15,415,614	$15,651,913	$236,299
Indiana	$12,012,078	$0	$12,313,738	$12,313,738	$11,811,394	($502,344)
Iowa	$4,318,520	$0	$4,188,753	$4,188,753	$3,843,497	($345,256)
Kansas	$2,688,072	$0	$2,777,089	$2,777,089	$2,652,421	($124,668)
Kentucky	$11,908,797	$0	$12,290,124	$12,290,124	$12,476,086	$185,962
Louisiana	$10,463,217	$0	$12,470,328	$12,470,328	$12,026,923	($443,405)
Maine	$2,434,458	$0	$2,665,376	$2,665,376	$2,378,606	($286,770)
Maryland	$8,672,339	$0	$8,643,369	$8,643,369	$8,437,037	($206,332)
Massachusetts	$12,285,778	$0	$12,709,408	$12,709,408	$11,579,287	($1,130,121)
Michigan	$15,680,232	$0	$16,847,835	$16,847,835	$16,771,567	($76,268)
Minnesota	$9,200,564	$0	$10,792,625	$10,792,625	$10,362,812	($429,813)

[10] Obligation estimates for FY 2022 and 2023 reflect the State-reported estimates of Medicaid needs available to CMS in November 2021 and do not account for recently enacted legislation, regulations, or guidance.

State or Territory	FY 2021 Actual	Estimated FY 2022 obligations from:		FY 2022 (estimated)	FY 2023 (estimated) Obligation	FY 2023 +/- FY 2022
		Previous authority	New Authority			
Mississippi	$4,851,058	$0	$5,106,802	$5,106,802	$4,844,629	($262,173)
Missouri	$8,277,488	$0	$10,447,198	$10,447,198	$12,761,897	$2,314,699
Montana	$1,749,109	$0	$1,856,810	$1,856,810	$1,846,543	($10,267)
Nebraska	$2,020,387	$0	$2,350,575	$2,350,575	$2,217,136	($133,439)
Nevada	$3,642,278	$0	$3,996,246	$3,996,246	$4,008,211	$11,965
New Hampshire	$1,505,293	$0	$1,449,012	$1,449,012	$1,214,637	($234,375)
New Jersey	$12,279,322	$0	$14,120,918	$14,120,918	$15,609,997	$1,489,079
New Mexico	$5,743,575	$0	$6,761,145	$6,761,145	$6,583,412	($177,733)
New York	$45,534,302	$0	$55,389,210	$55,389,210	$48,085,499	($7,303,711)
North Carolina	$12,332,274	$0	$13,508,305	$13,508,305	$12,855,712	($652,593)
North Dakota	$943,052	$0	$921,712	$921,712	$816,002	($105,710)
Ohio	$20,362,852	$0	$23,721,600	$23,721,600	$22,605,292	($1,116,308)
Oklahoma	$4,169,105	$0	$5,728,391	$5,728,391	$5,497,862	($230,529)
Oregon	$8,496,035	$0	$10,169,876	$10,169,876	$10,177,897	$8,021
Pennsylvania	$23,824,459	$0	$26,939,646	$26,939,646	$25,426,646	($1,513,000)
Rhode Island	$2,022,983	$0	$2,130,897	$2,130,897	$1,920,733	($210,164)
South Carolina	$5,393,151	$0	$5,099,133	$5,099,133	$4,593,150	($505,983)
South Dakota	$693,994	$0	$732,379	$732,379	$690,864	($41,515)
Tennessee	$8,041,230	$0	$8,917,560	$8,917,560	$9,072,799	$155,239
Texas	$30,800,522	$0	$31,537,765	$31,537,765	$28,072,548	($3,465,217)
Utah	$2,743,898	$0	$2,921,497	$2,921,497	$3,095,871	$174,374
Vermont	$1,128,346	$0	$1,122,959	$1,122,959	$1,096,785	($26,174)
Virginia	$7,695,624	$0	$12,783,430	$12,783,430	$12,521,039	($262,391)
Washington	$11,442,944	$0	$12,499,149	$12,499,149	$12,968,022	$468,873
West Virginia	$3,854,311	$0	$4,163,871	$4,163,871	$4,276,973	$113,102
Wisconsin	$6,688,745	$0	$7,186,864	$7,186,864	$6,929,082	($257,782)
Wyoming	$354,581	$0	$349,577	$349,577	$332,103	($17,474)
American Samoa	[11] 85,550	$0	[11] 87,860	[11] 87,860	[11] 90,232	$2,372
Guam	[11] 129,713	$0	[11] 133,210	[11] 133,210	[11] 136,807	$3,597
Northern Mariana Islands	[11] 62,325	$0	[11] 64,010	[11] 64,010	[11] 65,738	$1,728
Puerto Rico	[11] 3,009,063	$0	[11] 2,943,000	[11] 2,943,000	[11] 3,022,461	$79,461
Freely Associated States	$0	$0	$0	$0	$0	$0
Virgin Islands	[11] 127,938	$0	[11] 131,390	[11] 131,390	[11] 134,938	$3,548
Indian Tribes	$0	$0	$0	$0	$0	$0
Undistributed	[12] 66,220,165	$0	[12] 64,794,864	[12] 64,794,864	[12] 62,873,896	($1,920,968)
Total	**$559,599,180**	**$0**	**$613,431,253**	**$613,431,253**	**$584,625,214**	**($28,806,039)**

[10] Obligation estimates for FY 2022 and 2023 reflect the State-reported estimates of Medicaid needs available to CMS in November 2021 and do not account for recently enacted legislation, regulations, or guidance.

[11] Territory obligation amounts reflect funding limitations defined by 42 U.S.C. 1308 (Social Security Act section 1108), and use a proxy growth rate for FY 2023 to account for the percentage increase in the medical care component of the Consumer Price Index for all urban consumers. Actual territory obligation amounts may differ.

[12] Includes grants to states for survey and certification, Medicaid Fraud Control Units, the Vaccines for Children program, and other adjustments. FY 2023 undistributed amounts also capture increased amounts anticipated to be available for obligation to states consistent with legislative proposals in the Budget.

Payments to the Health Care Trust Funds

Appropriations Language

For payment to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as provided under sections 217(g),1844, and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d)(3) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, [$487,862,000,000] $548,130,000,000.

In addition, for making matching payments under section 1844 and benefit payments under section 1860D-16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary.

Payments to the Health Care Trust Fund

Language Analysis

Language Provision	Explanation
For payment to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as provided under sections 217(g), 1844, and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d)(3) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act,	Provides a one-year appropriation from general revenues to make the HI and SMI Trust Funds whole for certain costs initially borne by the trust funds which are properly charged to general funds, and to provide the SMI Trust Fund with the general fund contribution for the cost of the SMI program.
In addition, for making matching payments under section 1844 and benefit payments under section 1860D-16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary.	Provides indefinite authority for paying the general revenue portion of the Part B premium match and for general fund resources for Part D prescription drug benefit payments in the event that the annual appropriation is insufficient.

Payments to the Health Care Trust Funds
Summary of Changes

FY 2022 Enacted

Total Budget Authority - $487,862,000,000

FY 2023 President's Budget

Total Budget Authority - $548,130,000,000

Net Change, Total Appropriation – $60,268,000,000

Changes	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget	FY 2023 +/- FY 2022
Federal Payment for Supplementary Medical Insurance (SMI)	$325,500,000,000	$384,646,000,000	$434,349,000,000	$49,703,000,000
Indefinite Annual Appropriation, SMI	$0	$0	$0	$0
Hospital Insurance for Uninsured Federal Annuitants	$95,000,000	$82,000,000	$52,000,000	($30,000,000)
Program Management Administrative Expenses	$904,000,000	$929,000,000	$1,000,000,000	$71,000,000
General Revenue for Part D (Drug) Benefit	$111,800,000,000	$100,968,883,000	$111,800,000,000	$10,831,117,000
Indefinite Annual Appropriation, Part D Benefits	$0	$0	$0	$0
General Revenue for Part D Federal Administration	$882,000,000	$882,000,000	$600,000,000	($282,000,000)
Part D: State Low-Income Determination	$5,000,000	$5,000,000	$5,000,000	$0
Reimbursement for HCFAC	$328,000,000	$349,117,000	$324,000,000	($25,117,000)
Net Change	$439,514,000,000	$487,862,000,000	$548,130,000,000	$60,268,000,000)

Payments to the Health Care Trust Funds
Budget Authority by Activity
(Dollars in Thousands)

	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget	FY 2023 +/- FY 2022
Supplementary Medical Insurance	$325,500,000	$384,646,000	$434,349,000	$49,703,000
Indefinite Annual Appropriation, SMI	$0	$0	$0	$0
Hospital Insurance for Uninsured Federal Annuitants	$95,000	$82,000	$52,000	($30,000)
Program Management Administrative Expenses	$904,000	$929,000	$1,000,000	$71,000
General Revenue for Part D Benefit	$111,800,000	$100,968,883	$111,800,000	$10,831,117
Indefinite Annual Appropriation, Part D Benefits	$0	$0	$0	$0
General Revenue for Part D Federal Administration	$882,000	$882,000	$600,000	($282,0000)
Part D: State Low-Income Determination	$5,000	$5,000	$5,000	$0
Reimbursement for HCFAC	$328,000	$349,117	$324,000	($25,117)
Total Budget Authority	$439,514,000	$487,862,000	$548,130,000	$60,268,000

Payments to the Health Care Trust Funds
Authorizing Legislation
(Dollars in Thousands)

	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget	FY 2023+/- FY 2022
Payments to the Health Care Trust Funds (sections 217(g), 201(g), 1844, and 1860D-16 of the Social Security Act, section 103(c) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248)	$439,514,000	$487,862,000	$548,130,000	$60,268,000
Total Budget Authority	$439,514,000	$487,862,000	$548,130,000	$60,268,000

Annual Budget Authority by Activity
(Dollars in Thousands)

	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget	FY 2023 +/- FY 2022
Budget Authority	$439,514,000	$487,862,000	$548,130,000	$60,268,000

Authorizing Legislation - Sections 217(g), 201(g), 1844 and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248.
Allocation Method - Direct federal/intramural

Program Description and Accomplishments

The annual appropriation for the Payments to the Health Care Trust Funds account makes payments from the general fund to the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) Trust Funds to reimburse the trust funds for amounts to which they are entitled under law. These payments make the Medicare Trust Funds whole for certain costs, described below, initially borne by the trust funds which are properly charged to the General Fund under current law, including amounts due to the SMI Trust Fund for the General Fund contribution for the cost of the Part B and Part D programs.

Through this appropriation, the Trust Funds are made whole for:

Federal Contribution for SMI:

Federal Contribution for SMI consists of a federal match for premiums paid by or for individuals voluntarily enrolled in the SMI program, also referred to as Part B of Medicare. The Part B premium for all beneficiaries is generally set to cover 25 percent of the estimated incurred benefit costs for aged beneficiaries, including a sufficient contingency margin. The federal match, supplemented with interest payments to the SMI Trust Fund, covers the remaining benefit costs of both aged and disabled beneficiaries.

The FY 2023 President's Budget request of $434.3 billion is a net increase of $49.7 billion over the FY 2022 enacted amount of $384.6 billion. The cost of the federal match continues to rise from year to year because of beneficiary population and program cost growth.

Hospital Insurance for the Uninsured Federal Annuitants:

Hospital Insurance for Uninsured Federal Annuitants includes costs for civil service annuitants who earned coverage for Medicare under transitional provisions enacted when Medicare coverage was first extended to Federal employees.

The FY 2023 estimated request of $52.0 million for Hospital Insurance for Uninsured Federal Annuitants is a net decrease of $30 million from the FY 2022 estimated amount of $82.0 million. The Medicare-eligible retirees are no longer growing, therefore less funding is needed.

Program Management Administrative Expenses:

Program Management Administrative Expenses includes the portion of CMS' administrative costs, initially borne by the Hospital Insurance (HI) Trust Fund, which is properly chargeable to the general funds, e.g., federal administrative costs for the Medicaid program, and for Center for Consumer Information and Insurance Oversight (CCIIO) related activities.

The FY 2023 budget estimate of $1,000.0 billion to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare trust fund activities is a net increase of $71 million over the FY 2022 estimate of $929.0 million.

General Revenue for Part D (Benefits) and Federal Administration:

The Medicare Prescription Drug Plan program was created as a result of the enactment of P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Beginning in FY 2006, the reimbursements through the Payments to the Health Care Trust Funds account include General Revenue for Part D (Benefits) and General Revenue for Part D Federal Administration. General fund payments to the SMI Trust Fund offset these Medicare Prescription Drug Account costs.

The FY 2023 President's Budget request of $111.8 billion for General Revenue for Part D (Benefits) is a net increase of $10.8 billion over the FY 2022 Enacted amount of $100.9 billion. The benefit contribution decreases due to change in methodology for estimating General Revenue for Part D (Benefits) to be more in line with actual experience.

The FY 2023 President's Budget request of $600.0 million for General Revenue for Part D (Administrative) is a net decrease of $282.0 million below the FY 2022 Enacted amount of $882.0 million.

The FY 2023 President's request for General Revenue for Part D State Eligibility Determinations remains at $5.0 million

Reimbursement for HCFAC:

The Health Care Fraud and Abuse Control (HCFAC) account includes program integrity activities for Medicare, Medicare Advantage, Medicaid, the Children's Health Insurance Program, and the Federal Exchanges. The reimbursement includes that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the Hospital Insurance and Supplementary Medical Insurance Trust Funds, which are properly chargeable to the general fund.

The FY 2023 budget estimate of $324.0 million for reimbursement of HCFAC is a net decrease of $25.1 million below the FY 2022 estimate of $349.1 million. This amount reflects an estimate of that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the HI and SMI Trust Funds, but which are

properly chargeable to the general fund. The FY 2022 request reflects the estimated Medicare non-trust fund burdens only. This is based on the current allocation of HCFAC spending data for the above mentioned non-trust fund program integrity activities.

CMS and Social Security Administration (SSA) Cost-sharing Agreement Workgroup

The Social Security Administration's Limitation on Administrative Expenses (LAE) account is funded by the Social Security trust funds, the General Fund, the Medicare trust funds, and applicable user fees. Section 201(g) of the Social Security Act provides that SSA determine the share of administrative expenses that should have been borne by the appropriate trust funds for the administration of their respective programs and the General Fund for administration of the SSI program. SSA and CMS are currently working together to evaluate the cost-sharing agreement that determines the portion of administrative expenses borne by the SSA and Medicare trust funds and the general fund.

Funding History

The funding history for Payments to the Health Care Trust Funds is represented in the chart below:

Fiscal Year	Budget Authority
FY 2019	$391,343,800,000
FY 2020	$410,796,100,000
FY 2021	$439,514,000,000
FY 2022	$487,862,000,000
FY 2023	$548,130,000,000

Permanent Budget Authority
(Dollars in Thousands)

	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget	FY 2023 +/- FY 2022
Tax on OASDI Benefits	$24,975,000	$32,439,000	$35,072,000	$2,633,000
SECA Tax Credits	$0	$0	$0	$0
HCFAC, FBI	$148,000	$153,000	$157,000	$4,000
HCFAC, Asset Forfeitures	$135,000	$33,000	$34,000	$1,000
HCFAC, Criminal Fines	$68,000	$34,447	$20,900	($13,547)
HCFAC, Civil Penalties and Damages: Administration	$15,000	$53,000	$53,500	$500
Total Budget Authority	$25,341,000	$32,712,447	$35,337,400	$2,624,953

Authorizing Legislation - Sections 1817(k) and 1860D-31 of the Social Security Act, and sections 121 and 124 of the Social Security Amendments Act of 1983.

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

A permanent indefinite appropriation of general funds for the taxation of Social Security benefits is made to the HI Trust Fund through the Payments to the Health Care Trust Funds account. Additionally, the following permanent indefinite appropriations associated with the Health Care Fraud and Abuse Control (HCFAC) account activities will pass through the Payments to the Health Care Trust Funds account: Federal Bureau of Investigation (FBI) funding, asset forfeitures, criminal fines, and the administrative costs of activities associated with civil penalties and damages (CP&D) collections. FBI and CP&D administrative funds address prosecution of health care matters, investigations, financial and performance audits, inspections, and other evaluations. Asset forfeitures and criminal fines are amounts collected from health care fraud activities, and are permanent indefinite appropriations from the general fund, transferred to the HI Trust Fund.

Payments to the Health Care Trust Funds
Budget Authority by Object
(Dollars in Thousands)

	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget	FY 2023 +/- FY 2022
Grants, subsidies and contributions: Non-Drug	$325,500,000	$384,646,000	$434,349,000	$49,703,000
Indefinite Annual Appropriation	$0	$0	$0	$0
Grants, subsidies and contributions: Drug	$111,800,000	$100,968,883	$111,800,000	$10,831,117
Indefinite Annual Appropriation, Part D Benefits	$0	$0	$0	$0
Insurance claims and indemnities	$95,000	$82,000	$52,000	($30,000)
Administrative costs-General Fund Share	$2,114,000	$2,160,117	$1,924,000	($236,117)
General Revenue Part D: State Eligibility Determinations	$5,000	$5,000	$5,000	$0
Total Budget Authority	$439,514,000	$487,862,000	$548,130,000	$60,268,000

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Health Care Fraud and Abuse Control

Appropriations Language

In addition to amounts otherwise available for program integrity and program management, $899,000,000, to remain available through September 30, 2024, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act, of which $692,174,000 shall be for the Centers for Medicare & Medicaid Services program integrity activities, of which $109,612,000 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act, and of which $97,214,000 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act: Provided, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year 2023 shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation: Provided further, That of the amount provided under this heading, $323,000,000 is provided to meet the terms of a concurrent resolution on the budget for health care fraud and abuse control activities, and $576,000,000 is additional new budget authority specified for purposes of a concurrent resolution on the budget for additional health care fraud and abuse control activities: Provided further, That the Secretary shall provide not less than $20,000,000 from amounts made available under this heading and amounts made available for fiscal year 2023 under section 1817(k)(3)(A) of the Social Security Act for the Senior Medicare Patrol program to combat health care fraud and abuse.

Language Analysis

Language Provision	Explanation
In addition to amounts otherwise available for program integrity and program management, $899,000,000, to remain available through September 30, 2024, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act,	Authorizes appropriation to be available for obligation over two fiscal years.
of which $692,174,000 shall be for the Centers for Medicare & Medicaid Services program integrity activities,	Provides funding for Centers for Medicare & Medicaid Services for program integrity activities.
of which $109,612,000 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act,	Provides funding for the Office of Inspector General, and limits activities to those authorized under the original HIPAA statute.
and of which $97,214,000 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act:	Provides funding for the Department of Justice, and limits activities to those authorized under the original HIPAA statute.
Provided, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year 2023 shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation:	Specifies reporting requirement.
Provided further, That of the amount provided under this heading, $323,000,000 is provided to meet the terms of a concurrent resolution on the budget for health care fraud and abuse control activities, and $576,000,000 is additional new budget authority specified for purposes of a concurrent resolution on the budget for additional health care fraud and abuse control activities:	Specifies $323,000,000 for ongoing base health care fraud and abuse control activities, and $576,000,000 is available as additional budget authority to meet the terms of a concurrent resolution on the budget to pay for additional health care fraud and abuse control activities in FY 2023.
Provided further, That the Secretary shall provide not less than $20,000,000 from amounts made available under this heading and amounts made available for fiscal year 2023 under	Provides funding for the Administration for Community Living to conduct the Senior Medicare Patrol program to combat health care fraud and abuse and flexibility to

section 1817(k)(3)(A) of the Social Security Act for the Senior Medicare Patrol program to combat health care fraud and abuse.	fund through either discretionary or mandatory HCFAC funds.

Health Care Fraud and Abuse Control
(Dollars in Thousands)

	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget	FY 2023 +/- FY 2022
Discretionary[1]				
CMS Program Integrity	$614,151	$616,000	$692,174	$76,174
OIG	$98,703	$99,000	$109,612	$10,612
DOJ	$91,724	$92,000	$97,214	$5,214
Subtotal, Discretionary	**$804,578**	**$807,000**	**$899,000**	**$92,000**
Mandatory[2]				
CMS Program Integrity	$941,463	$963,369	$1,002,794	$39,425
FBI	$152,394	$152,924	$156,763	$3,839
OIG	$213,887	$214,631	$220,019	$5,388
DOJ Wedge	$66,781	$67,014	$68,696	$1,682
HHS Wedge	$40,908	$41,051	$42,081	$1,030
Subtotal, Mandatory	**$1,415,433**	**$1,438,989**	**$1,490,353**	**$51,364**
Total	**$2,220,011**	**$2,245,989**	**$2,389,353**	**$143,364**

Authorizing Legislation – Social Security Act, Title XVIII, Section 1817(k)

FY 2022 Authorization – Public Law (P.L.) 104-191 and P.L. 117-86

Allocation Method – Other

Program Description and Accomplishments

Title II of the Health Insurance Portability and Accountability Act of 1996 established the Health Care Fraud and Abuse Control (HCFAC) program to detect, prevent, and combat health care fraud, waste, and abuse. The HCFAC account is structured to ensure resources provided to the Department of Health and Human Services (HHS) Office of Inspector General (OIG), the Department of Justice (DOJ), and CMS allow for these entities to coordinate oversight and law enforcement efforts to target bad actors efficiently and effectively.

CMS works with law enforcement partners who take a lead role in investigating and prosecuting alleged fraud. CMS has pursued this through participating in the Medicare Fraud Strike Force teams, which investigate and track down individuals and entities that are defrauding Medicare and other government health care programs. Since their inception in March 2007, Strike Force prosecutors have charged more than 4,600 defendants who have

[1] FY 2021 includes $2.423 million in HHS Secretary's Transfer Authority.
[2] All mandatory amounts are post-sequester and include the impacts of the Medicare sequestration suspension enacted in section 3709(a) of the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), as amended by P.L. 116-260 and further amended by P.L. 117-7.

collectively billed federal health care programs and private insurers approximately $23.0 billion.

CMS also coordinates with its law enforcement partners through the Major Case Coordination (MCC) effort, which provides a forum for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and CMS fraud investigators to collaborate before, during, and after the development of fraud leads. CMS leverages its program integrity contractors and systems, discussed in detail in this chapter, to develop many of these fraud leads. Since implementation, there have been over 2,200 cases reviewed at MCC and 1,750 law enforcement referrals.

All three partners target areas with high incidence of fraud in order to carry out the synchronized efforts to reduce fraud and recover taxpayer dollars. Together, activities like the MCC; CMS's enhanced provider screening and fraud prevention activities; HHS OIG's investigative, audit, evaluation, and data analytic work; and DOJ's investigative and prosecutorial actions and tougher sentencing guidelines, root out existing fraud and abuse while acting as a deterrent for potential future bad actors. HCFAC investments in law enforcement collaboration continue to demonstrate positive results, yielding a $4.30 to $1.00 return on investment for law enforcement and detection efforts over a three-year period (2018-2020).

Medicare Integrity Program (MIP)

CMS's program integrity activities in Medicare address fraud, waste, abuse, and improper payments at multiple distinct stages of the claims process. Provider screening and enrollment is a powerful tool in ensuring only eligible providers and suppliers are able to bill Medicare to begin with, and outreach and education activities promote proper billing practices. Pre-payment checks such as prior authorization and automated edits allow CMS to prevent improper payments, reducing the need to "pay and chase." Post-payment audits, medical review, and investigations allow CMS to uncover improper payments and take appropriate action. Meanwhile, ongoing activities such as error rate measurement give CMS greater insight into new developments as well as high-value areas to prioritize resources.

HCFAC investments have allowed CMS to address fraud, waste, and abuse and protect the Medicare Trust Funds. Steps CMS is taking with the current legislative authorities and financial resources available include: more stringent scrutiny of applicants seeking to bill the Medicare program; increased collaboration with law enforcement; enhanced oversight of Medicare Advantage (MA) and Part D Prescription Drug Plans (PDPs); and testing new methods to detect and deter potential fraudulent behaviors before and after providers and suppliers are enrolled in the Medicare program.

Medicaid Program Integrity

While states have primary responsibility for combating Medicaid fraud, waste, and abuse, CMS plays a significant role in supporting state efforts while also ensuring state oversight, accountability, and transparency. CMS uses the resources associated with Section 1936 of the Social Security Act (described in greater detail in the State Grants and Demonstrations chapter) along with discretionary HCFAC funding in a unified, coordinated Medicaid program integrity effort.

HCFAC funding allows CMS to address Medicaid program integrity through oversight, data analytics, and education/technical assistance. CMS continues to collect and analyze state data through the Transformed Medicaid Statistical Information System (T-MSIS), which is being used for new efforts to detect fraud, waste, and abuse; exercises appropriate oversight over Medicaid expenditures as well as states' enterprise systems; and uses the Payment Error Rate Measurement (PERM) program to produce improper payment rates at a national and state level, supporting efforts to reduce improper payments. Investments in the MACPro system support the collection of data regarding states' program operations and ensures that CMS can efficiently and consistently review and adjudicate submissions for approval.

Marketplace Program Integrity

The Health Insurance Marketplaces are important avenues for individuals and families to obtain private market health insurance coverage and get financial assistance, in the form of advanced premium tax credits, to help pay for insurance premiums. CMS investigates complaints and leads from health insurance issuers and other partners to protect consumers. Through the use of data analytics, CMS supports and prioritizes investigations that aim to safeguard the integrity of the Federally-facilitated Marketplace (FFM) and expenditures of federal dollars. In FY 2021, nearly 16,000 complaints were reviewed and approximately 7,500 complaints have been reviewed in the first half of FY 2022. CMS cancelled more than 13,000 insurance policies that met CMS's criteria for unauthorized enrollments without consumers' consent; over 7,000 of those were in FY 2021 alone. In addition, CMS initiated over 400 investigations of insurance agent misconduct and referred the most egregious cases to states' Departments of Insurance and HHS OIG for prosecution or other administrative actions.

Funding History[3]

Fiscal Year	Amount
FY 2019	$2,095,374,000
FY 2020	$2,163,363,000
FY 2021 Final[4]	$2,220,011,000
FY 2022 CR	$2,245,989,000
FY 2023 President's Budget	$2,389,353,000

Since its inception in 1997, HCFAC has been financed from the Federal Hospital Insurance Trust Fund, which provides both mandatory and discretionary funding.

Budget Request: $899.0 million

The FY 2023 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2023 request for discretionary funding is $899.0 million, $92.0 million above the FY 2022 Continuing Resolution (CR)

[3] Includes both mandatory and discretionary resources; mandatory amounts are post-sequester and include the impact of the Medicare sequester suspension.
[4] FY 2021 includes $2.423 million in HHS Secretary's Transfer Authority.

level. The total post-sequester FY 2023 mandatory funding level is $1,490.4 million, $51.4 million above the FY 2022 CR level.

The Budget assumes the discretionary HCFAC account will include an allocation adjustment to be used pursuant to the Congressional Budget Act in the Congressional Budget Resolution, over the ten-year budget window. For FY 2023, of the $899.0 million in discretionary HCFAC funding, $576.0 million is additional new budget authority for the allocation adjustment.

Over ten years, the Budget invests $6.6 billion in additional new discretionary HCFAC budget authority, yielding $13.6 billion in mandatory health care savings to Medicare and Medicaid, for an over $2:1 return-on-investment. The FY 2023 allocation adjustment request includes funding priorities to invest in Medicare medical review; support data analytics and other program integrity activities in Medicaid; and increase data analytics and improper payment measurement work for the Marketplaces.

HCFAC Allocation Adjustment (outlays in millions)										
	2023	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**
HCFAC discretionary spending, allocation adjustment	$576	$593	$611	$629	$648	$667	$687	$708	$729	$751
Savings to Medicare and Medicaid	$1,119	$1,181	$1,246	$1,315	$1,354	$1,393	$1,435	$1,479	$1,523	$1,569

The FY 2023 CMS allocation of the discretionary HCFAC request is $692.2 million, which is $76.2 million above the FY 2022 CR level and reflects activities that support the emerging needs across all health care programs under CMS's jurisdiction. In addition to ongoing operations for a wide array of program integrity activities, the request focuses increased discretionary resources on activities such as medical review and prior authorization, modeling and analytics support, strengthening program integrity in Medicaid, and improper payment measurement in the Marketplaces.

CMS Program Integrity – HCFAC Funding by Authority

(Dollars in Thousands)

Activity	FY 2023 Discretionary Request	FY 2023 Mandatory Funding[5]	FY 2023 Total
Provider Enrollment & Screening	$59,234	$43,232	$102,466
Technical Assistance, Outreach & Education	$58,124	$36,818	$94,942
Medical Review	$87,067	$201,336	$288,403
Medicare Secondary Payer	$0	$119,598	$119,598
PI Investigation, Systems & Analytics	$162,634	$186,626	$349,260
Audits & Appeals	$113,478	$178,877	$292,355
Provider & Plan Oversight	$39,202	$17,873	$57,075
Error Rate Measurement	$85,649	$27,100	$112,749
Program Support & Administration	$86,787	$191,334	$278,121
Total[6]	**$692,175**	**$1,002,794**	**$1,694,969**

Provider Enrollment & Screening

Provider enrollment is the gateway to the Medicare and Medicaid programs and is the key to preventing ineligible providers, or if applicable, suppliers from entering either program. Medicare and Medicaid providers and suppliers are required to undergo screening, including enhanced screening for certain high-risk providers and suppliers, and may be deemed ineligible to participate in CMS's health care programs or have their enrollment revoked and consequently, ineligible for continued participation. Through investments in provider screening and enrollment, CMS continues to prevent and reduce fraud, waste, and abuse in the Medicare and Medicaid programs and ensure that only eligible providers are caring for beneficiaries and receiving payment; therefore, protecting the Medicare Trust Funds.

Budget Request: $59.2 million

The discretionary request for Provider Enrollment & Screening activities is $59.2 million, an increase of $1.9 million above the FY 2022 CR level. Funding will support provider enrollment operations.

- *Provider Enrollment, Chain, and Ownership System (PECOS):* $29.0 million. PECOS is the system of record for all Medicare provider/supplier enrollment data, which includes Part A, Part B, and DME. PECOS stores all information furnished by providers/suppliers; tracks all enrollment processing by MACs; and provides feeds to FFS claims payment systems that are mission critical to processing all claims. State Medicaid programs also rely on data-sharing efforts to support requirements for screening providers.

[5] Includes post-sequester HCFAC funding provided by Section 1817(k)(4) of the Social Security Act for the Medicare Integrity Program, including the Medicare-Medicaid Data Match Program.
[6] Totals reflect budget authority; activity amounts may not add due to rounding.

PECOS 2.0 is a ground-up redesign of the current system, and CMS is focused on modernizing the system to create an enterprise resource that is a platform for all enrollments across Medicare, Medicaid, and emerging provider programs. PECOS 2.0 will be a centralized system that can support the collection, screening, and processing of multiple types of enrollments (i.e., Medicare and Medicaid), as well as the operational oversight and program management functions associated with enrollment. The underlying system changes will simplify access to data, create operational efficiency, increase alignment between Medicare and Medicaid, and strengthen overall program integrity. CMS is taking an agile approach to develop the broad operational capability required for ensuring continuity of operations and expects PECOS 2.0 to begin operations by mid-FY 2023; therefore, we anticipate using a portion of this funding to operate and maintain the current system. [This activity will be funded with $30.0 million in mandatory HCFAC funds.]

- *Advanced Provider Screening (APS):* $28.1 million. APS is an interactive screening, monitoring, and alerting system that identifies ineligible providers and houses a centralized provider repository of criminal activity, licensure status, and identity information. In FY 2021, APS resulted in more than 7.7 million screenings which generated more than 29,000 potential licensure alerts and more than 3,000 criminal alerts for potentially fraudulent providers for further review by CMS. Such review resulted in approximately 84 criminal revocations and over 200 licensure revocations. In FY 2021, licensure alerts were held due to PHE regulations, and as a result a lower number of licensures alerts were generated than in FY 2020. [This activity will be supplemented with $5.2 million in mandatory HCFAC funds.]

- *National Supplier Clearinghouse (NSC):* This funding supports the contractual arrangement for the NSC's receipt, review, and processing of applications from organizations and individuals seeking to become suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) in Medicare and Medicaid. [This activity will be funded with $8.0 million in mandatory HCFAC funds.]

- *Medicaid Provider Enrollment:* $2.1 million. This funding supports ongoing development, maintenance, and support for the Medicaid Data Exchange (DEX) system. The primary function of DEX is to share provider termination and revocation data among CMS and the separate Medicaid programs. CMS verifies and maintains a centralized repository of these providers in which all 50 states, the District of Columbia, and Puerto Rico have access. In FY 2021, CMS received 2,854 termination submissions through the DEX system from states.

Technical Assistance, Outreach & Education

CMS and its contractors use a variety of strategies and communication channels to offer Medicare providers and suppliers a broad spectrum of information about the Medicare program to promote appropriate billing and reducing improper payments. The activities detailed below also include effective tools in reaching beneficiaries with ways to protect against health care fraud, waste, and abuse.

CMS also maintains key relationships, materials, and methods for representatives of CMS, relevant Federal and State agencies, and other stakeholders affected by CMS's program integrity-related activities.

Budget Request: $58.1 million

The discretionary request for Technical Assistance, Outreach & Education activities is $58.1 million, a decrease of $2.3 million below the FY 2022 CR level.

- *Outreach and Education - Ongoing Operations (MACs):* This funding is necessary for the MACs to maintain and execute an outreach and education program that will expand and enhance efforts to reduce improper payments. This includes disseminating information, education, training, and technical assistance. [This activity will be funded with $30.1 million in mandatory HCFAC funds.]

- *Fraud Prevention Campaign:* The Fraud Prevention Campaign is a national, multi-media outreach effort to increase the awareness of fraud in the Medicare program and provide beneficiaries with tools to protect themselves. This funding level is in line with historical funding needs which are required for a strong media delivery, to ensure beneficiaries are educated on how to protect their Medicare number and expand outreach in in communities that are particularly susceptible to scammers. [This activity will be funded with $5.0 million in mandatory HCFAC funds.]

- *Healthcare Fraud Prevention Partnership (HFPP):* $16.3 million. The HFPP is a voluntary, public-private partnership between the Federal Government, state and local agencies, law enforcement, private health insurance plans, employer organizations, and health care anti-fraud associations to identify and reduce fraud, waste, and abuse across the health care sector. The HFPP allows for the exchange of data and information, leveraging various analytic tools using claims and other data provided by HFPP partners, and providing a forum for leaders and subject matter experts to share successful practices and effective methodologies. As of February 2022, the HFPP reached a total membership level of 244 partner organizations, comprised of federal agencies, associations, private payers, and state and local partners.

  The FY 2023 request will support ongoing operations for the Trusted Third Party (TTP), medical review conducted by the Supplemental Medical Review Contractor (SMRC), data analytics, and activities required under the Consolidated Appropriations Act of 2021. The negotiated amount for the TTP's final option year covers a 6-month period starting at the end of September 2023 and ends by March 2024; therefore, less funding is required.

- *Senior Medicare Patrol:* $20.0 million. CMS requests $20.0 million for the Administration for Community Living (ACL) Senior Medicare Patrol (SMP) program. The mission of the SMP program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. In calendar year 2020, SMP activities reached an estimated 425,103 people through 9,870 group outreach and education events and held 249,134 individual counseling sessions with, or on behalf of, Medicare beneficiaries. The COVID-19 public health emergency (PHE) limited the SMP program's outreach efforts in 2020, and as a result, these numbers represent an overall decrease from 2019.

- *Medicaid Enterprise System:* $12.3 million. CMS provides over $12 billion annually in federal financial participation for state Medicaid systems that determine Medicaid eligibility, screen and enroll providers, and pay enrolled providers' claims, which are critical to reducing fraud, waste, and abuse. This funding supports an outcomes-based

oversight model for states' Medicaid enterprise systems and provides technical assistance to states during development and implementation in accordance with regulatory and sub-regulatory guidance. This outcome-based methodology allows CMS to ensure funding for IT systems is closely aligned with and in support of the state Medicaid and CHIP programs to ensure federal dollars are spent appropriately. The outcomes-based oversight model provides CMS with a mechanism to track and monitor state Medicaid systems performance, including metrics such as timely and accurate eligibility determinations, timely processing of provider claims, and provider enrollment functions. This funding will also support the operation and further enhancement of the oversight model, including design and prototyping of business processes, reports, statistics, and data analytics. This activity reduces costs and risks, shortens development timelines, and more effectively manages these expenditures.

- *Other Targeted Outreach, Education and Assistance:* $9.5 million. This funding supports ongoing needs for the Local Coverage Determination Database, support for states' use of Medicare data for program integrity purposes, and general PI outreach and education. [This activity will be supplemented with $1.7 million in mandatory HCFAC funds.]

Medical Review

Medical Review (MR) is the collection of information and clinical review of medical records to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements. MR activities can be conducted pre-payment or post-payment and concentrate on areas identified through a variety of means, including targeted data analysis, Comprehensive Error Rate Testing results, and oversight agency findings that indicate questionable billing patterns. Complex medical review is conducted on less than one percent of claims to confirm that services and items rendered are reasonable, necessary, and comply with all Medicare coding and documentation requirements.

Budget Request: $87.1 million

The discretionary request for MR activities is $87.1 million, an increase of $47.5 million above the FY 2022 CR level. Additional funding in FY 2023 would increase the level of medical review conducted by CMS contractors, including prior authorization.

- *Medical Review - Ongoing Operations (MACs):* $41.9 million. CMS contracts with the MACs to perform analysis of FFS claims data to identify atypical billing patterns and perform claims review. Medical reviews are an example of such FFS claims data analysis. The FY 2023 request supports ongoing MR operations, including Targeted Probe and Educate (TPE). In FY 2020, the MACs conducted more than 210,000 TPE reviews.

  Medical review improves compliance and results in savings; however, medical review also requires significant resources to conduct and there is a high volume of Medicare FFS claims each year. Many improper claims can be identified only by manually reviewing associated medical records and a beneficiary's claim history, and exercising clinical judgment to determine whether a service is reasonable and necessary. Significantly less than one percent of Medicare claims undergo manual reviews; this is substantially lower than private health insurers. CMS proposes to significantly increase funding to allow the MACs to conduct additional reviews in FY 2023. [This activity will also be funded with $163.7 million in mandatory HCFAC funds.]

- *Supplemental Medical Review Contractor (SMRC):* $16.6 million. The SMRC performs and provides support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of Medicare. The SMRC supports three initiatives: 1) Specialty Reviews for issues identified by Federal agencies such as HHS-OIG, the Government Accountability Office, and other CMS groups; 2) HFPP Reviews on providers or service types that have been identified as being aberrant in HFPP studies; and 3) Program Integrity Reviews that will focus on ensuring claims, encounter data, and Prescription Drug Event records are paid correctly. In FY 2021, the SMRC reviewed approximately 86,697 claims. [This activity will be supplemented with $22.4 million in mandatory HCFAC funds.]

- *Prior Authorization:* $11.0 million. Prior authorization is a key corrective action towards lowering improper payments. This funding will allow the MACs to review prior authorization requests, perform work related to appeals, conduct customer service operations, provide outreach and education, and create reports.

  CMS has continued to increase the number of DMEPOS items subject to prior authorization in recent years. In FY 2020, CMS established a nationwide prior authorization process and requirements for certain hospital outpatient department services as well as certain DMEPOS items. CMS continually performs data analysis to determine if there are services or items that are exhibiting unnecessary increases in volume or utilization due to fraud, waste, or abuse, for which prior authorization would be appropriate. As a result, CMS plans to continue increasing the number of items and services subject to required prior authorization. CMS is requesting additional funding in FY 2023 to meet the growing workload related to prior authorization.

- *Accuracy Reviews:* $1.4 million. The Medical Review Accuracy Contractor (MRAC) conducts MR of review determinations made by CMS contractors (e.g., MACs and SMRC). The results allow CMS to develop an accuracy score for each contractor and determine where inconsistencies may exist. As of the end of August 2021, the MRAC completed 9,630 standard claim reviews. The FY 2021 standard average accuracy review percentage is 99.4 percent. CMS expects approximately 11,666 accuracy reviews to be completed in FY 2022, the final year of the contract. CMS expects to recompete the contract. [This activity will be supplemented with $2.7 million in mandatory HCFAC funds.]

- *MR Systems:* $13.7 million. This funding supports IT operations for multiple MR activities including the National Correct Coding Initiative (NCCI) for Medicare and Medicaid, the Services Tracking Analysis and Reporting System (STARS), and the Electronic Submission of Medical Documentation (esMD). These systems ensure proper coding of claims, control overpayments, and assist in detecting, analyzing, investigating, coordinating, and documenting cases of fraud, waste, and abuse. [This activity will be supplemented with $6.5 million in mandatory HCFAC funds.]

- *Other MR Activities:* $2.5 million. This funding provides operational support for MR activities and error rate reduction. CMS provides hospital-specific Medicare data statistics in areas identified as at risk for improper payments (unnecessary admissions, readmissions, improper billing, or coding errors). Additionally, CMS will provide Comparative Billing Reports, giving providers the opportunity to compare their billing patterns to those of their peers. This funding will also allow CMS to continue to explore the use of artificial intelligence (AI) technologies such as machine learning (ML) to assist with the review of medical records. The use of ML and other AI technologies will

assist clinicians in making review decisions and allow claims to be reviewed with greater efficiency. [This activity will be supplemented with $6.0 million in mandatory HCFAC funds.]

Medicare Secondary Payer

Medicare Secondary Payer (MSP) protects the Medicare Trust Funds by ensuring that Medicare does not pay for items and services that certain health insurance or coverage is primarily responsible for paying. Medicare statute and regulations require all entities that bill Medicare must determine whether Medicare is the primary payer for those items or services. MSP annually saves nearly $9 billion through cost avoidance and recoveries.

In FY 2023, this activity will be funded with $119.6 million in mandatory HCFAC funds. This funding will support MAC operations related to MSP as well as the centralized MSP Coordination of Benefits & Recovery (COB&R) program and ancillary services such as postage, telecommunications services, and outreach and education. System and database costs include operations and maintenance, software development, and creating efficiencies for the program. In addition, CMS continues to modernize its MSP infrastructure to remove dependencies on COBOL code, migrate to cloud-based services, and perform data center decommissioning.

PI Investigation, Systems & Analytics

The contractors and supporting systems detailed in this section aid CMS in identifying cases of suspected fraud, waste, and abuse; developing cases thoroughly and in a timely manner; and taking immediate action to protect Medicare, Medicaid, and the Marketplaces. Benefits resulting from these activities include reduced state and provider burden, increased contractor accountability, enhanced data and reporting capabilities, and improved program oversight.

Budget Request: $162.6 million

The discretionary request for PI Investigation, Systems & Analytics activities is $162.6 million, an increase of $9.5 million above the FY 2022 CR level. This request includes funding to support ongoing operations, with increased funding for modeling and analytics activities as well as data management initiatives.

- *PI Investigative Activities - Ongoing Operations (MACs):* CMS works with each MAC to develop improper payment reduction strategies, based on vulnerabilities identified by the Comprehensive Error Rate Testing (CERT) program, the Government Accountability Office (GAO), HHS/OIG, the Medicare FFS RACs, and other sources. These funds will be used to support the MIP operational activities of the MACs in identifying and reducing payment errors. [This activity will be funded with $22.6 million in mandatory HCFAC funds.]

- *Unified Program Integrity Contractors (UPICs):* The UPICs consolidate Medicare and Medicaid program integrity audit and investigation work across five jurisdictions throughout the United States. Benefits resulting from this consolidation include reduced state and provider burden, increased contractor accountability, enhanced data and reporting capabilities, and improved program oversight. The UPICs will continue to perform data analysis projects, support requests for information, and perform Medicare and Medicaid investigations. [This activity will be funded with $88.3 million in

mandatory HCFAC funds.]

- *PI Modeling & Analytics Support:* $24.7 million. Aligning modeling and analytics with financial transparency helps CMS evaluate its program integrity efforts and make crucial decisions regarding future direction and program funding. CMS conducts analytics to identify Medicare fraud, waste, and abuse; utilizes rigorous statistical methodologies to assess whether program integrity vulnerabilities can be captured as models or edits in the Fraud Prevention System (FPS); and measures outcomes from its efforts. This request supports other program integrity activities such as provider revalidation, the Medicare Exclusion Database, operations for the Plan and Provider Enumeration System (NPPES) application, the Part C and Part D preclusion list, and changes of ownership tracking. On the Medicaid side, this work provides data to support states' efforts to prevent risky providers from enrolling in Medicaid and revoke problematic providers.

  In addition to scaling up existing work, CMS requests funding for several new activities for FY 2023. With increased T-MSIS data availability across all states, there is planned development of Medicaid modeling in the FPS, as well as the expansion of Medi-Medi analytics. The Program Integrity Modeling and Analytics program is expanding the current use of innovative analytical tools such as artificial intelligence and machine learning, social network analysis, graph database analytics, natural language processing, and text mining. CMS will continue to monitor providers who may be exploiting the waivers and flexibilities promulgated as a result of the COVID-19 PHE. CMS also seeks contractor support in reviewing, and making recommendations related to, statistical methodologies used for sampling estimation and extrapolation in the calculation of Medicare and Medicaid overpayments. [This activity will be supplemented with $31.9 million in mandatory HCFAC funds.]

- *Fraud Prevention System (FPS):* FPS is the predictive analytics technology required under the Small Business Jobs Act of 2010. FPS applies proven and effective predictive modeling tools into the Medicare claims processing system to stop payment on high-risk claims and perform analysis on paid claims to generate alerts of potentially fraudulent providers for further investigation. During FY 2021, the FPS generated alerts that resulted in 545 new leads for program integrity contractors (PICs) and augmented information for 577 existing PIC leads or investigations. [This activity will be funded with $30.5 million in mandatory HCFAC funds.]

- *One PI:* $22.6 million. The One PI program provides program integrity contractors, law enforcement, and HHS-OIG with centralized access to multiple analytical tools and data sources. The program provides access to current and historical Medicare and Medicaid data that is used to develop and refine predictive analytic models prior to integration into FPS. CMS will award a new 12-month contract in FY 2022 as well as a transition period for the incumbent contractor. The FY 2023 decreased request supports ongoing operations. [This activity will be supplemented with $1.0 million in mandatory HCFAC funds.]

- *Case Management:* $16.4 million. The Unified Case Management (UCM) System provides a central repository to support the UPICs, MEDICs, and other stakeholders across the Medicare and Medicaid programs. This includes the capability to track leads, audits, and investigations; capturing and managing workflow activities; reporting workload metrics; reporting status of administrative actions and referrals to law enforcement; and recording outcomes or disposition of program integrity audit and

investigative actions across Medicare. The FY 2023 request supports ongoing operations as well as a redesign to modernize the system utilizing open source to remove limitations from commercial off-the-shelf (COTS) software that is no longer being supported or meeting needs of CMS. The modernization effort includes major enhancements to several critical business functionalities, including Medical Review, Major Case Coordination, and Lead Management. The modernization also includes an updated, business-centric data design as well as migration from an on-premise, COTS-based solution to an open source, cloud-based solution. [This activity will be supplemented with $12.4 million in mandatory HCFAC funds.]

- *Application Programming Interface (API) Gateway:* $14.5 million. CMS requests funding for development of the Application Programming Interface (API) Gateway, which will define CMS's approach and implementation to manage and use data and information to support business and technology goals. CMS will implement a full lifecycle API management platform that will be used to develop, deploy, and manage APIs for various program integrity systems.

  CMS's program integrity partners (e.g., law enforcement and CMS contractors) depend on these systems and related data for fraud, waste, and abuse activities. In order to consolidate data from these disparate systems, CMS is leveraging the use of APIs so that information can be accessed across systems and through a light-weight web interface. This will be of tremendous value to the program integrity community to have more real-time access to information across systems in one consolidated view.

  CMS requests increased funding in FY 2023 to implement a data strategy that will include Metadata Management and Data Governance initiatives across CMS's program integrity systems. CMS expects a range of benefits, including enhanced data insights and business value, alignment of data requirements with organizational strategic goals, improvement and simplification of the current as-is data landscape, improved data sharing capabilities, rationalization of reporting requirements across CMS information systems, and the promotion of stakeholder and data stewardship engagement.

- *Medicare Drug Integrity Contractors (MEDICs):* $23.0 million. CMS supports ongoing program integrity efforts in Medicare Part C and Part D through the use of two MEDICs: the Investigations MEDIC (I-MEDIC) and the Plan Program Integrity MEDIC (PPI MEDIC). The I-MEDIC conducts investigations, recommends administrative actions, and submits case referrals to law enforcement. The PPI MEDIC analyzes Part C and Part D data, conducts audits of plan sponsors, and provides outreach and education support.

  In FY 2021, the I-MEDIC initiated 764 investigations; submitted 20 recommendations for provider revocations; submitted 251 referrals to law enforcement, including 56 immediate advisements; and submitted 185 referrals to other entities, such as state pharmacy boards, Medicare quality improvement organizations, and other Medicare contractors.

  The PPI MEDIC implemented five Self-Audits, five National Audits, and three Program Integrity (PI) Audits in FY 2021, and supported additional education and outreach initiatives for plan sponsors. For FY 2022 and FY 2023, the PPI MEDIC is tentatively scheduled to implement six Self-Audits, six National Audits, and four PI Audits. Additionally, plan sponsors outreach and education efforts will continue.

- *Encounter Data Collection System:* $19.8 million. MA organizations and Medicare-Medicaid Plans submit on average 3.2 million encounter data records per day via the Encounter Data Processing System. Funding supports all development, maintenance, enhancements, requirements gathering, and analytic activities related to the collection and processing of this data. This request also supports CMS's oversight and integrity efforts regarding encounter data, including outreach, analysis, development of benchmarks to evaluate the completeness and accuracy of the data for plan monitoring.

- *Medicaid and CHIP Program System (MACPro):* $5.7 million. MACPro is a portfolio of product tools that supports the data collection and workflow around the adjudication of state plan amendments (SPAs), waivers, and managed care contracts, and includes a data collection platform that collects quantitative data on Medicaid and CHIP programs including: Core Set Measures, annual and quarterly CHIP reporting on goals and enrollment, and managed care oversight data. This suite of products enables online collaboration between CMS and States ensuring the consistent adjudication of SPAs, waivers, managed care contracts, and advance planning documents (APDs) across all states and regional offices, and provides CMS with insight into how Medicaid and CHIP programs operate across the country. The efficient collection of State-submitted data also allows CMS to verify delivery of services and verify cost data, such as premiums and cost sharing, against T-MSIS or the Medicaid and CHIP Budget & Expenditure System (MBES). Less HCFAC funding is requested for FY 2023 due to implementing cloud improvements that resulted in cost savings for cloud services.

- *Transformed Medicaid Statistical Information System (T-MSIS):* $10.0 million. T-MSIS is a state data ingestion application and reporting tool that encompasses a collection of beneficiary eligibility and enrollment data, managed care and FFS claims encounter data, and provider data produced in the daily operation of the Medicaid and CHIP programs. This national dataset is integral for program monitoring and oversight, and is necessary for auditing and investigations. Now that all states are submitting data consistently on a monthly basis, focus has shifted to monitoring the quality of state submissions, including data critical for program integrity purposes. Funding supports user-friendly tools, technical reporting instructions and oversight of the state submission process, improvements to overall operations for sustainability, efforts to continue data quality improvement, and cloud computing resources to handle the growing dataset and data user base.

- *MACBIS Data Analytics:* $5.2 million. The enterprise-wide goal for Medicaid and CHIP Business Information Solutions (MACBIS) is to improve CMS's access to timely, complete, and accurate Medicaid and CHIP data through the integration and alignment of federal and state data sources. This funding will support sharing, using, and improving MACBIS data. Specifically, this will be accomplished through a range of tasks including 1) improving the quality of state T-MSIS data submissions; 2) development of data products including T-MSIS Analytic Files and tools; 3) conducting analysis; and 4) providing analytic support to the user community. With robust data analytic capacity, CMS will enhance its ability to conduct Medicaid and CHIP program monitoring and oversight, technical assistance to states, policy and program development, research and evaluation, and public reporting.

- *Marketplace Program Integrity:* $20.7 million. This funding will support general investigation activities, data analytics leveraging data from FFM systems and other sources, and project management resources to help with large operational projects related to oversight and audit activities. This includes targeting high-risk regions for

audits and analytics as well as conducting license verification for agents and brokers to ensure those individuals meet established state standards. CMS will also review and evaluate consumer complaints of fraud to determine whether administrative action can be taken.

Audits & Appeals

Auditing is one of CMS's primary post-payment instruments to safeguard payments made to institutional providers, such as hospitals, skilled nursing facilities, and end-stage renal dialysis facilities. Although many of these providers have most of their claims paid through a prospective payment system, reimbursement of several items continues on an interim basis, subject to final payment after a cost reconciliation process. In addition to provider-based audits, CMS reviews other entities such as MA organizations and Part D PDPs.

Audits are also a significant driver in the number of appeals CMS must process. CMS is implementing several initiatives to improve its appeals processes and reducing the reversal rate.

Budget Request: $113.5 million

The discretionary request for Audit & Appeals activities is $113.5 million, an increase of $3.0 million above the FY 2022 CR level. This funding will continue CMS's auditing functions and appeals initiatives in FY 2023.

- *Provider Cost Report Audit - Ongoing Operations (MACs):* Part A providers are required to submit an annual Medicare cost report, which, after the settlement process, forms the basis for reconciliation and final payment to the provider. During FY 2020, the MACs received and accepted approximately 53,036 Medicare cost reports, which included initial as well as amended cost report filings; approximately 16,399 cost reports were desk reviewed and tentatively settled; and approximately 518 audits were completed. [This activity will be funded with $143.0 million in mandatory HCFAC funds.]

- *Targeted Provider Cost Report Audits:* This activity addresses a wide range of other cost report auditing activities, such as appeals support and risk assessments. CMS is responsible for evaluating Medicare, Medicaid, and other private plan sponsors' performance in the delivery of health and drug services and ensure that beneficiaries receive appropriate services for which these sponsors have already been paid to provide. [This activity will be funded with $28.0 million in mandatory HCFAC funds.]

- *Risk Adjustment Data Validation (RADV):* $41.0 million. CMS uses diagnostic information submitted by MA organizations to risk adjust payments to plans for a given year. CMS conducts RADV audits for a sample of enrollees and MA organization contracts to verify that diagnostic information is supported by medical record documentation. Results are used to estimate and continue using advanced analytics to focus audits on high risk areas, reducing the overall burden of audits on MAOs, improving the timeliness of audits, and exploring ways to improve audit efficiency. CMS is currently performing quality assurance activities on preliminary audit findings for the 2011-2014 payment year (PY) audits and in the medical record review phase for the PY 2015 audits. In addition, CMS announced that it plans to finalize a rule by November 1, 2022 that codifies our RADV methodology in regulation.

- *Cost Plan Audits:* $3.5 million. CMS provides fiscal oversight over Managed Care

Organizations (MCOs). This funding supports audits of Cost Report statements submitted by MCOs to ensure costs are allowable and in accordance with contract requirements and CMS regulations.

- *Part C & D Audits:* $8.5 million. This funding supports the audits of financial records of MA organizations and PDPs, as required in Section 1857(d)(1) and 1860D-12(b)(3)(c) of the Social Security Act. CMS performs approximately 215 audits annually, as well as resolution of the audit issues noted in the audit reports. Prompt audits of the financial data will permit CMS to evaluate and refine CMS's plan oversight, thereby assuring accurate bidding and enhancing CMS's payment accuracy.

- *Targeted Programmatic Compliance Audits:* $20.3 million. This funding supports audits and other oversight initiatives to test whether MA organizations, PDPs, Program for All-Inclusive Care for the Elderly (PACE) plans, and other private plan sponsors provided beneficiaries with the appropriate health services and medications as required under their contract with CMS. These audits help drive the industry towards improvements in the delivery of health services in the MA, Part D, and PACE programs.

- *Medical Loss Ratio (MLR) Audits:* $3.6 million. CMS conducts targeted audits of Medicaid Managed Care Organizations' (MCOs') financial reporting in high-risk states. Specifically, CMS is evaluating compliance with Medicaid MLR requirements. This work includes conducting analyses to identify the States most at risk and reviewing the source data and documentation from the Medicaid MCOs and the State-reported data. This request also supports activities to ensure MA plans and Part D sponsors meet MLR requirements.

- *State Audit Compliance Support:* $3.8 million. This funding will support CMS's efforts to review and analyze audit findings from single state agency audits and OIG audits of state Medicaid programs. Through improvements to its internal audit resolution process, CMS can obtain a global picture of audit results in Medicaid and improve its financial oversight through guidance on how to address audit findings and better target audit resources towards high risk areas. The FY 2023 request supports CMS's audit and audit reporting efforts to improve efficiency and financial oversight of Medicaid programs.

- *Internal Controls Audits:* $2.7 million. The OMB Circular A-123 requires that CMS establish and maintain internal controls to achieve the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. Funding supports a certified public accountant firm to conduct a rigorous assessment of the CMS internal controls over financial reporting. This assessment includes performing internal control reviews (formerly SAS 70 audits) for Title XVIII Medicare contractors. This request includes funding for SSAE-18 audits for MACs. [This activity will be supplemented with $1.0 million in mandatory HCFAC funds.]

- *Audit Systems:* $18.7 million. This request includes IT operations for multiple systems that perform oversight and audit activities required by CMS in regulations and statute. These systems include the Health Plan Management System (HPMS), Healthcare Cost Report Information System (HCRIS), PS&R-Provider Statistical & Reimbursement Report, and CMS administrative audit tracking for documentation clearances. [This activity will be supplemented with $6.9 million in mandatory HCFAC funds.]

- *Appeals Initiatives:* $11.5 million. CMS requests resources to support appeals activities as well as initiatives designed to reduce reversal rates. HCFAC funding supports the timely and efficient processing of appeals, including the Office of Hearings Case and Document Management System. This funding will also support the administrative adjudicative process that the Agency established for MA organizations to appeal RADV determinations to a CMS Hearing Officer. Funding for this activity ensures that CMS is able to adequately process the current workload of RADV appeals as well as an expected increase in future volume.

  Additionally, this request will allow Qualified Independent Contractors (QICs) to participate as a party in approximately 2,150 Administrative Law Judge (ALJ) cases, which affords the QICs additional rights to successfully defend a claim denial. Based on experience, CMS anticipates that by invoking party status in hearings, the QICs may reduce the ALJ reversal rate and lower Medicare Trust Fund expenditures.

Provider & Plan Oversight

CMS promotes transparency by linking financial, programmatic, and performance data to push accountability and uphold program efficiency and effectiveness. These activities are also intended to help beneficiaries and consumers make informed decisions about their treatment based on knowledge gained through these activities. At the State level, CMS conducts reviews to determine if state policies and practices comply with federal regulations, identifies program vulnerabilities that may not rise to the level of regulatory compliance issues, identifies states' program integrity best practices, and monitors state corrective action plans. CMS also conducts program integrity-related oversight functions that aid in State/Federal governance, the management of Medicare and Medicaid, and activities that aid with enforcement and compliance with statutes and regulatory guidance.

Budget Request: $39.2 million

The discretionary request for Provider & Plan Oversight activities is $39.2 million, an increase of $2.5 million above the FY 2022 CR level. In addition to ongoing operations for oversight activities, CMS requests additional resources for work supporting section 1115 demonstrations.

- *Open Payments:* The Open Payments program provides the public with information regarding the financial relationships between the health care industry (pharmaceutical and medical device manufacturers and their distributors) and health care providers (physicians and teaching hospitals). The SUPPORT for Patients and Communities Act of 2018 expanded the population of provider types covered under the program to include physician assistants and certain advanced practice nurses. These changes went live in the Open Payments system in February 2022. The FY 2023 request supports ongoing operations and enhancements as well as a recompete of the data analytics contract. [This activity will be funded with $17.9 million in mandatory HCFAC funds.]

- *Part C & D Payment Analysis, Validation and Reconciliation:* $7.6 million. This funding supports the monthly Beneficiary Payment Validation (BPV) process. CMS conducts a routine monthly BPV process prior to payment authorization in order to confirm that the calculated payments for MA, Part D, Cost Plan, PACE, and demonstration plans are accurate with regard to using the appropriate source data and consistent application of the current payment rules. As of February, 2022, monthly beneficiary level payments

average $41.0 billion for 52.8 beneficiaries.

- *Part C & D Review of Plans and Performance:* $21.6 million. This funding supports several activities that provide critical infrastructure to support the monitoring and oversight strategy for the Part C and Part D programs including sponsors' compliance with CMS marketing, formulary, and enrollment guidelines. Review of annual plan benefit package submissions and performance and subsequent consequences of possible enforcement actions drive improvements in the industry and are increasing sponsors' compliance with core program functions in the Part C and Part D programs. The funding also supports CMS in the development and collection of MA HEDIS® measures for MA organizations and Special Needs Plans (SNPs), and reviews and approves SNP models of care as required under 1859(f) of the Social Security Act. CMS also evaluates the impact of agency guidance and regulations that could negatively impact the quality of care provided to beneficiaries.

- *Rate Reviews:* $6.6 million. This funding supports CMS's efforts to improve oversight of rate setting and financial reporting for PACE and ensure proper billing and rate reimbursement in Home and Community-Based Services (HCBS) waiver and state plan programs. This includes, but is not limited to, ensuring that states are in compliance with the HCBS assurances as defined in section 1915(c) of the Social Security Act, ensuring that states are in compliance with sections 12006(a) of the 21st Century Cures Act, and the detection and prevention of fraud and abuse in the delivery of personal care and other HCBS services.

- *Upper Payment Limit – Disproportionate Share Hospital (UPL-DSH):* $2.1 million. This activity supports CMS in exercising oversight of Medicaid expenditures. This activity assists CMS in collecting, reviewing, and analyzing data related to state Medicaid financing methods; oversight of Medicaid payment methodologies, which includes analysis of UPL demonstrations; and analysis of supplemental provider payments, including DSH payments. This activity will provide an analysis related to the distribution of payments while developing options for achieving greater accountability and transparency in payment.

- *Section 1115:* $1.3 million. CMS requests funding to improve the Agency's oversight of section 1115 demonstrations, including development and monitoring of state budget neutrality models. CMS also seeks to better ensure consistency and rigor to the demonstration process through the development of a comprehensive manual as well as job aids and other internal controls relating to budget neutrality. In addition, CMS is interested in developing data specifications that would allow quality and/or performance monitoring for high-priority demonstrations through T-MSIS, as well as testing and implementing certain data enhancements in T-MSIS.

Error Rate Measurement

CMS is required by statute to estimate the amount of improper payments, submit those estimates to Congress, and report on actions the agency is taking to reduce improper payments. Through this work, CMS better understands not only the amount of improper payments in its health care programs but also the drivers of those improper payments. CMS currently measures Medicare, Medicaid, and CHIP improper payments, and is implementing a measurement program for Advance Premium Tax Credits.

Budget Request: $85.6 million

The discretionary request for Error Rate Measurement activities is $85.6 million, an increase of $15.7 million above the FY 2022 CR level. This funding supports ongoing activities, with increased resources for Marketplace improper payment measurement activities.

- *Comprehensive Error Rate Testing (CERT):* This funding supports the CERT program, which calculates the Medicare FFS improper payment rate. The CERT program calculates national, contractor-specific, and service-specific improper payment rates. [This activity will be funded with $27.1 million in mandatory HCFAC funds.]

- *Part C & D Error Rate Measurement:* $13.0 million. This funding supports the Part C and D Improper Payment Measurement (Part C and Part D IPM) processes. These processes measure and report annual payment error estimates for the Medicare Part C and Part D programs, respectively.

- *Payment Error Rate Measurement (PERM):* $45.9 million. This funding supports the PERM program, which calculates the improper payment rates for Medicaid and the Children's Health Insurance Program (CHIP). The improper payment rates are based on reviews of the FFS, managed care, and eligibility components of Medicaid and CHIP.

- *Marketplace Improper Payment Assessment:* $26.8 million. This funding supports the measurement and reporting of estimated improper payments in the Advance Premium Tax Credit (APTC) program. This activity includes ongoing operations for the Federally-facilitated Marketplace measurement program, risk assessment development, and implementation of a pilot of the state-based Marketplace improper payment measurement program for compliance with the Payment Integrity Information Act of 2019. The FY 2023 request requires increased resources to award new base years for the two operational contractors as well as to add 19 State-based Marketplaces to the measurement program.

Program Support and Administration

This funding supports multiple programs and enterprise-level services that are critical to achieving CMS's program integrity goals, including infrastructure, shared IT services, data communications, IT security, and administrative services. These activities achieve economies of scale and allow for business owners to reuse existing processes to reduce cost.

Budget Request: $86.8 million

The discretionary request for Program Integrity Support and Administration activities is $86.8 million, a decrease of $1.6 million below the FY 2022 CR level.

- *Administrative Costs:* This funding will cover employee compensation, rent, utilities, information technology, contracts, supplies, equipment, training, and travel. In FY 2023, HCFAC funding will support 535 FTEs. [This activity will be funded with $146.4 million in mandatory HCFAC funds.]

- *Medicaid PI Improvements:* $5.5 million. This funding will support continued efforts to improve program integrity in the Medicaid program. With this funding, CMS will be able to more effectively identify and mitigate program vulnerabilities in Medicaid and reduce risks. In FY 2023, CMS requests additional funding to strengthen its oversight of state Medicaid managed care programs. This would include the development of risk mitigation strategies as well as tools and analysis relating to MLR reporting, and state directed payments.

- *Risk Management Support:* $5.0 million. This funding supports contractor operations to identify fraud risks and vulnerabilities in CMS programs and initiatives, as well as provide recommendations on how to mitigate those risks. CMS requests additional funding for this activity in FY 2023 to focus on risk assessments relating to waivers and flexibilities that CMS promulgated as a result of the COVID-19 public health pandemic as well as to continue developing a comprehensive program integrity risk assessment for Medicare.

- *PI Process Improvements:* $8.1 million. This funding supports specialized technical expertise to assist CMS in developing a conceptual and technical vision for its program integrity data infrastructures and systems. This activity involves reviewing the current vulnerability management structure for the purpose of implementing new processes to ensure operational efficiency. This activity also includes acquisition support to assist CMS with its IT and non-IT contracting needs.

- *System Infrastructure Upgrades and Software Support:* This funding supports enterprise software licenses, the Payment Recovery Information System (PRIS), and One PI Infrastructure Support & Expansion. This funding will be used to support Law Enforcement Investigation, which includes but is not limited to: data needs, data mining tools, database support, hardware needs and licenses. [This activity will be funded with $20.8 million in mandatory HCFAC funds.]

- *Ongoing Systematic Support for all PI Programs:* $29.4 million. This funding supports operations and maintenance for the Common Working File (CWF), the Single Testing Contract (STC), the CMS Analysis Reporting and Tracking System (ART), Virtual Data Centers, and other CMS enterprise data, database management, records management, and claims systems. CMS hosts many systems to aid in supporting the Agency and contractors in managing our program integrity efforts, tracking detailed financial activity, deliverables and the performance of contracts, and other electronic data interchanges. This funding also supports operations and maintenance for the Command Center. [This activity will be supplemented with $22.2 million in mandatory HCFAC funds.]

- *Enterprise Services:* $38.7 million. This funding supports investments that span multiple program areas or provide CMS-wide services, such as shared IT services and litigation and enforcement support from the Office of General Counsel. [This activity will be supplemented with $2.0 million in mandatory HCFAC funds.]

FEDERAL BUREAU OF INVESTIGATION (FBI)

Program Description and Accomplishments

The FBI is responsible for detecting and investigating health care fraud in the United States and has jurisdiction over crimes targeting Federal health insurance programs and private health insurance plans. Each of the FBI's 56 field offices have personnel assigned to investigate health care fraud matters. FBI special agents, intelligence analysts, and professional staff members at headquarters and in the field, work proactively to identify and target health care fraud in all its forms. As described in the FY 2020 HCFAC Report to Congress, in FY 2020, the FBI opened 683 new health care fraud investigations. At the end of FY 2020, 2,346 investigations were pending. Investigative efforts throughout the fiscal year produced 426 criminal health care fraud convictions and 537 indictments and prosecutors' informations. In addition, investigative efforts resulted in over 407 operational disruptions of criminal fraud organizations and the dismantlement of more than 101 health care fraud criminal enterprises. The FBI's efforts in combatting health care fraud, in coordination with the efforts of our Federal, state, and local law enforcement and regulatory partners, as well as our partners in the private sector in combatting health care fraud, are crucial to the success and sustainability of the health care system that so many Americans depend upon.

The FY 2023 FBI budget includes mandatory resources in the amount of $156.8 million.

HHS OFFICE OF INSPECTOR GENERAL (OIG)

Program Description and Accomplishments

HHS-OIG uses HCFAC funding to conduct oversight of the Medicare and Medicaid programs. This includes holding individuals and corporations that engage in healthcare-related offenses accountable through criminal and civil actions, while providing recommendations for improving the health care system to HHS policymakers, program officials, and Congress. As described in the FY 2020 HCFAC Report to Congress, in FY 2020, HHS-OIG's Medicare and Medicaid oversight efforts in resulted in 578 criminal actions and 781 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties settlements and administrative recoveries related to provider self-disclosure matters. In addition, HHS-OIG excluded a total of 2,148 individuals and entities from participation in Federal health care programs. For FY 2020, potential savings from legislative and administrative actions that were supported by HHS-OIG recommendations were estimated by third parties, such as the Congressional Budget Office or actuaries within HHS, to be $2.4 billion.

Budget Request: $109.6 million

The FY 2023 HHS-OIG discretionary request is $109.6 million, which represents an increase of $10.6 million above the FY 2022 CR level. In addition, mandatory resources total $220.0 million for a total operating budget of $329.6 million.

DEPARTMENT OF JUSTICE (DOJ)

Program Description and Accomplishments

The DOJ's litigating components (United States Attorneys, Civil Division, Criminal Division, and Civil Rights Division) receive HCFAC program funds to support civil and criminal health care fraud and abuse investigation and litigation. These offices dedicate substantial resources to combating health care fraud and abuse. HCFAC funding builds on those resources by providing dedicated positions for attorneys, paralegals, auditors and investigators, as well as funds for electronic discovery, data analysis, and litigation of resource-intensive health care fraud cases. DOJ also provides additional funding to the FBI for Strike Force and other health care fraud investigations.

Budget Request: $97.2 million

The FY 2023 DOJ discretionary request is $97.2 million, an increase of $5.2 million above the FY 2022 CR level. In addition, mandatory resources total $68.7 million for a total operating budget of $165.9 million.

HHS WEDGE FUNDING

Program Description and Accomplishments

HHS uses resources from the wedge funds to carry out fraud and abuse activities. Decisions about wedge funding levels for DOJ and the HHS agencies are made by agreement between the Attorney General and the Secretary of HHS. For FY 2021, negotiated amounts were $38.6 million for distribution among HHS components and $63.0 million for DOJ. The HHS portion of the wedge awards funded the following activities during FY 2021:

Administration for Community Living (ACL): Wedge funds have allowed ACL to address the increased demand for Senior Medicare Patrol (SMP) education and assistance, and the related need to increase SMP grantee capacity. Funding has supported changes in grantee business practices to establish and manage programs with a greater virtual presence beyond the COVID-19 crisis to meet the growing demands for new and innovative ways to reach Medicare beneficiaries and expand program capacity. This Wedge funding has supplemented ACL's base funding.

Office of the Assistant Secretary for Planning and Evaluation (ASPE): ASPE requested a second installment of $5 million for a four-year, $10 million project to link data from child welfare and Medicaid systems for parents and children in a few pilot states, and to develop tools to identify claims that are at a high risk of fraud and abuse. ASPE received an initial $5 million for this project in FY 2020. The Family First Prevention Services Act authorized health care payments for child welfare services, some of which are also payable through Medicaid, raising the emerging fraud threat of double-billing, excessive services, and services without sufficient medical documentation to both federal programs.

Office of the General Counsel (OGC): OGC primarily uses HCFAC funds on activities focused on litigation aimed at the recovery of program funds and review of CMS programs to strengthen them against potential fraud, waste, and abuse. As a result of its program integrity activities, OGC estimates that its HCFAC program has contributed to anticipated government recoveries of over $569.87 million to date in FY 2021.

Food and Drug Administration (FDA): The Pharmaceutical Fraud Program (PFP) is designed to detect, prosecute, and prevent pharmaceutical, biologic, and medical device fraud. The PFP has identified multiple alleged medical product fraud schemes through various avenues. Since the inception of the PFP, FDA's Office of Criminal Investigation (OCI) has opened a total of 297 criminal HCFAC investigations. In FY 2021 FDA's twelfth fiscal year of HCFAC Program activity, OCI, through its PFP, opened 13 criminal investigations, including investigations involving drug compounders, clinical trials, and foreign and domestic medical-product manufacturers.

HHS Office of Inspector General (OIG): FY 21 Wedge funds have allowed HHS/OIG to complete four existing, top priority projects that aim to improve HHS/OIG's ability to conduct oversight of the Medicare and Medicaid programs. These existing projects include: developing artificial intelligence (AI) solutions by automating some analytic operations to better target investigative efforts; modernizing the exclusion program online database or the List of Excluded Individuals and Entities; contracting for developer and infrastructure resources to expand enhanced analytics capabilities ; and building new innovative capabilities for the Investigative Reporting and Information System (IRIS).

HHS Wedge Budget: $42.1 Million

The FY 2023 HHS Wedge request includes post-sequester mandatory funding of $42.1 million, which is an increase of $1.0 million above the FY 2022 CR level. The HHS Wedge is subject to agreement between the Secretary of HHS and the Attorney General. Funding allocations are determined after HHS and DOJ complete negotiations.

Children's Health Insurance Program

Current Law
(Dollars in Thousands)

	FY 2021 Final	FY 2022 Estimate	FY 2023 Estimate	FY 2023 +/- FY2022
State Allotments (Healthy Kids Act P.L. 115-120)	$24,800,000	$25,900,000	$25,900,000	$0
CHIP Performance Bonus Payments (P.L. 111-3, P.L. 113-235)	$0	$0	$0	$0
Child Health Quality Improvement (P.L. 111-3,114-10, 115-120)	$0	$0	$0	$0
Redistribution Payments	$0	$0	$0	$0
Performance Bonus Payments Preclusion (P.L. 116-260)	$0	($4,000,000)	$0	$4,000,000
Previously Unavailable from FY 2022 Performance Bonus Payments	$0	$0	$4,000,000	$4,000,000
Rescission of Unobligated Balance (P.L. 116-260)[1]	($3,000,000)	($2,000,000)	$0	$2,000,000
Total Budgetary Resources[2]	**$21,800,000**	**$19,900,000**	**$29,900,000**	**$10,000,000**
CHIP State Allotment Outlays	$16,123,088	$16,592,000	$16,152,000	($440,000)
Performance Bonus Payments Outlays[3]	($36,561)	$0	$0	$0
Child Health Quality Improvement Outlays	$6,227	$21,000	$16,000	($5,000)
Redistribution Payments	$359	$0	$0	$0
Total Outlays	**$16,093,113**	**$16,613,000**	**$16,168,000**	**($445,000)**

[1] The Consolidated Appropriations Act, 2021 (P.L. 116-260) rescinded $1 billion from unobligated FY 2021 allotments and $2 billion from unobligated FY 2017 no-year allotment funding. This table displays a $2 billion rescission carried forward from FY 2021 by the series of Continuing Resolutions (CR) in FY 2022. This $2 billion in funding is made temporarily unavailable for obligation for the period of the CR, and is not executed unless enacted in a full-year appropriations bill.

[2] Funding levels reflect new appropriations and carry-forward balances from amounts made temporarily unavailable for obligation in prior years. These funding levels are subject to change due to adjustments throughout the year.

[3] Reflects recoveries related to OIG determinations regarding improper CHIPRA bonus payments (see https://oig.hhs.gov/oas/reports/region4/41708061.pdf).

Child Enrollment
Contingency Fund
Current Law
(Dollars in Thousands)

	FY 2021 Enacted	FY 2022 Estimate	FY 2023 Estimate	FY 2023 +/- FY 2022
Child Enrollment Contingency Fund, Budget Authority[4]	$15,966,184	$21,159,225	$24,380,720	$3,220,982
Temporarily Unavailable[5]	($14,000,000)	($14,000,000)	$0	$14,000,000
Transfer to CHIP Performance Bonus Fund[6]	($523)	($1,979,738)	($19,200,720)	($17,220,982)
Payments to Shortfall States	$0	$0	$0	$0
Interest Estimate	$14,077	$20,720	$29,074	$8,354
Total Budgetary Resources, end of year[7]	**$1,979,738**	**$5,200,720**	**$5,209,074**	**$8,354**
Total Outlays	**$0**	**$0**	**$0**	**$0**

Authorizing Legislation –

The Balanced Budget Act of 1997 (BBA) (P.L. 105-33),
The Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-113),
The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173),
The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3),
The Patient Protection and Affordable Care Act (P.L. 111-148),
The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10),
The Continuing Appropriations Act, 2018 (P.L. 115-96),
The Extension of Continuing Appropriations Act, 2018 or The HEALTHY KIDS Act (P.L. 115-120),
Advancing Chronic Care, Extenders, and Social Security (ACCESS) Act (P.L. 115-123),

[4] Reflects both carryover resources and deposits into the Fund.
[5] The Consolidated Appropriations Act, 2021 (P.L.116-260) made $14.0 billion not available for obligation in FY 2021. This provision was carried forward into FY 2022 by the series of Continuing Resolutions (CR), and remains temporarily unavailable for obligation for the duration of the CR.
[6] These amounts are transferred to the CHIP Performance Bonus Fund. CMS no longer has authority to spend from the Performance Bonus Fund, thus transfer amounts are not reflected in the CHIP table on the previous page as available budget authority. FY 2022 transfer amounts assume continuing resolution levels are equivalent to the full year appropriation.
[7] Funding levels reflect new appropriations and carry-forward balances from prior year's net of enacted rescissions and amounts made temporarily unavailable for obligation.

The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 (P.L. 115-245).
The Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2020 (P.L. 116-94).
The Departments of Labor, Health and Human Services, and Educations and Related Agencies Appropriations Act, 2021 (P.L. 116-133).

Allocation Method – Formula grants

Program Description and Accomplishments

The Balanced Budget Act of 1997 authorized the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act. CHIP is a federal-state matching, capped grant program providing health insurance to targeted low-income children in families with incomes above Medicaid eligibility levels. This program has improved access to health care and the quality of life for millions of vulnerable children under 19 years of age. Under title XXI, states have the option to expand Medicaid (Title XIX) coverage, create separate CHIP programs, or have a combination of the two.

Since September 1999, all states, territories, commonwealths, and the District of Columbia have had approved CHIP plans. CMS continues to review states' CHIP plan amendments as they respond to the challenges of operating this program and take advantage of program flexibilities to make innovative changes.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3) reauthorized CHIP from April 2009 through September 30, 2013 and increased funding by $68.9 billion through FY 2013 to maintain state programs and to cover more uninsured children. The Patient Protection and Affordable Care Act (P.L 111-148) extended funding for CHIP through FY 2015, providing an additional $40.2 billion in budget authority over the baseline. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) provided an additional $39.7 billion in budget authority for FYs 2016 and 2017. On January 22, 2018, the HEALTHY KIDS Act (P.L. 115-120) appropriated funding to CHIP for six years from FY 2018 through FY 2023. On February 9, 2018, the Bipartisan Budget Act (BBA) (P.L. 115-123) further extended CHIP funding through FY 2027.

CHIPRA also created several programmatic features of the CHIP program. A few of the major provisions include:

CHIP Performance Bonus Payments – Created as an incentive for states to enact policies promoting the enrollment and retention of eligible children, states received bonus payments for the enrollment increase on a per child basis equal to a portion of the state's annual per capita Medicaid expenditure on children. In order to receive a performance bonus payment, states had to implement five of eight enrollment and retention provisions throughout the year and exceed a threshold enrollment level defined in statute. Performance bonus payments were initially funded with a $3.2 billion appropriation, and transfers of any unobligated national allotments and excess funds exceeding the aggregate cap from the Child Enrollment Contingency Fund. The authority for Performance Bonus payments expired at the end of FY 2013.

Child Enrollment Contingency Fund – This fund is used to provide supplemental funding to states that exceed their allotment due to higher-than-expected child enrollment in CHIP. A state may qualify for a contingency fund payment if it projects a funding shortfall for the fiscal year and if its average monthly child enrollment exceeds the targeted average number of enrollees for the fiscal year. MACRA (P.L. 114-10) extended the Child Enrollment Contingency Fund authorization through FY 2017. The HEALTHY KIDS Act (P.L. 115-120) extended the Contingency Fund through FY 2023 and the BBA authorized the Contingency Fund through FY 2027.

The Contingency Fund receives an appropriation equal to 20 percent of the Section 2104(a) CHIP national allotment appropriation under the Social Security Act. Any amounts in excess of the aggregate cap are transferred to the CHIP Performance Bonus Fund. In addition, the Contingency Fund is invested in interest bearing securities of the United States; income derived from these investments constitutes a part of the fund. To date, four states (Iowa, Michigan, Tennessee, and Oregon) have met statutory criteria and qualified for payments from the Contingency Fund. Under current law, states are not required to spend Contingency Fund payments on activities related to children's health, and territories are not eligible to receive Contingency Fund payments.

CHIP Redistribution Fund – CHIPRA also amended 2104(f) of the Social Security Act, which permits CMS to recoup unused state allotment funding to redistribute to states facing a funding shortfall if their current allotment is insufficient to meet program demand. A shortfall state is defined as a state that will not have allotment or Contingency Fund resources to meet projected costs in the current year. If there is not sufficient redistribution funding to meet the needs of all shortfall states, each state receives a pro rata share of the total funds available. Since 2012, CMS has redistributed approximately $1.9 billion to 32 states and territories. This includes $1.4 billion awarded to 28 states and territories when CHIP did not have a full-year appropriation at the beginning of FY 2018 that was ultimately returned to the redistribution fund upon enactment of a full-year appropriation. Approximately $2.7 billion in funding is currently available for redistribution.

Child Health Quality Improvement in Medicaid and CHIP – Section 1139A of the Social Security Act requires the Secretary to identify and annually publish a recommended core set of child health quality measures for use under Medicaid and CHIP and to encourage successful quality improvement strategies. Other CHIPRA requirements include developing a standardized reporting format that encourages states to voluntarily report information regarding the quality of pediatric health care, encouraging the development and dissemination of a model electronic health record format for children enrolled in the state plan under Medicaid or CHIP, and authorizing several grants and contracts to support states in reporting measures and driving quality improvement.

A total of $225.0 million at $45.0 million per year for FYs 2009-2013 was appropriated and is available until expended. Section 210 of the Protecting Access to Medicare Act of 2014 (P.L. 113-3) ensured at least $15.0 million is transferred from Medicaid Adult Health Quality funding. The transfer occurred in FY 2015 and is available until expended. In addition, MACRA (P.L. 114-10) provided $20.0 million available for Child Health Quality activities beginning on October 1, 2015. The HEALTHY KIDS Act provided $90.0 million for child health quality activities for FYs 2018 through 2023, and the ACCESS Act provided $60 million for FYs 2024 through 2027. The ACCESS Act also makes annual state reporting on the Child Core Set measures mandatory starting in FY 2024.

Medicaid and CHIP quality funding supports the Pediatric Quality Measures Program (PQMP), the CHIPRA Electronic Health Record Program, and CHIPRA Quality Demonstration Grants. CMS annually updates and publishes the Medicaid and CHIP Child Core Set of quality measures and provides technical assistance to states to assist them in reporting the measures and applying promising practices for improving performance in these critical health care areas. The status of Child Health Quality Improvement activities in Medicaid and CHIP are discussed below:

CHIPRA Pediatric Quality Measures Program--Current efforts in the Children's Health Insurance Program Reauthorization Act Pediatric Quality Measures Program (PQMP) include a collaboration between CMS and the Agency for Healthcare Research and Quality (AHRQ) for a phase of pediatric measure testing under a multi-year competitive cooperative agreement program aimed at establishing partnerships with state Medicaid/CHIP programs to support testing, use and implementation of new or enhanced pediatric quality measures (see https://grants.nih.gov/grants/guide/rfa-files/RFA-HS-16-002.html). CMS and AHRQ are currently in the planning stages for the next iteration of the PQMP with the goal of addressing gap areas in childhood quality measures.

Historically, this funding supported six PQMP grants, initially awarded in FY 2016, which focused on testing and implementing new pediatric quality measures previously developed by the PQMP Centers of Excellence (COE) across various Medicaid and CHIP delivery systems. The grantees collected data on measures and tested quality improvement strategies at multiple levels of care, assessing the feasibility and usability of the new measures within the Medicaid/CHIP patient populations at the state, health plan, and provider levels to support performance monitoring and quality improvement. In addition, CMS funded a PQMP-Learning Collaborative to provide research, implementation, and knowledge-sharing to support the PQMP grantees. The Learning Collaborative focused on improving understanding of best practices for dissemination and implementation of quality measures to build capacity and sustainability for performance monitoring and quality improvement efforts within the Medicaid/CHIP patient populations at the state, health plan, and provider levels.

These funds supported the Medicaid and CHIP child quality measurement and improvement program in FY 2021, including quality measure collection, reporting, analysis, quality improvement work with state agencies, accountability through the Medicaid and CHIP Scorecard, and managed care quality. CMS plans to continue to support this full range of child quality measurement and improvement in FY 2022 and is currently working with AHRQ to develop an Interagency agreement (IAA) for this program.

CHIPRA Electronic Health Record (EHR) Program -- HHS jointly released development standards including data elements and standards for EHR developers to ensure relevant elements are captured in a consistent manner. The standards can be found at https://ushik.ahrq.gov/mdr/portals/cehrf?system=cehrf. Child-specific data elements and functionality recommendations are sorted into topic areas that include prenatal and newborn screening tests, immunizations, growth data, information for children with special health care needs and child abuse reporting. The format allows for the interoperable exchange of data, is compatible with other EHR standards, and facilitates quality measurement and improvement through collection of clinical quality data. Two CHIPRA Quality Demonstration Grantees (see quality grants described below), Pennsylvania and North Carolina, completed testing the impact of the Children's EHR Format in 2014. An assessment of their experience can be found in Appendix A of the Children's EHR Format

Enhancement: Final Recommendation Report (see https://digital.ahrq.gov/sites/default/files/docs/citation/children-ehr-format-enhancement-final-recommendation-report-abridged.pdf). This work was completed.

In FY 2019, CMS began implementation of the next phase of the model EHR format, with support from the Office of the Chief Technology Officer, by initiating activities that will connect immunization data from state immunization information systems (IIS) with existing consumer-based portals. This will enable these portals to provide consumers with access to the most complete immunization data, identify state recommended vaccination schedules, and provide immunization certificates. This phase of the EHR work was initially expected to be completed in FY 2021, however, due to COVID-19, it is now expected to be completed in FY 2022. The implementation of the state pilots were delayed due to the need for state public health staff to shift priorities and the disruption to schools, as the pilot is testing the ability of parents to provide immunization data to schools using consumer based portals.

CHIPRA Quality Demonstration Grants:

- In 2010, CMS awarded ten grants for demonstrations in 18 states to improve health care quality and delivery systems for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Focus areas for the grants included using quality measures, applying health information technology, implementing provider-based service delivery models, investigating electronic health records, and trying other innovative approaches to improve children's health.

- CMS partnered with The Agency for Healthcare Research and Quality (AHRQ) to evaluate the demonstration. The evaluation produced several resources for future use, including Spotlights for each state's work, two implementation guides, and a report.

- Spotlights can be found at: https://www.ahrq.gov/policymakers/chipra/state-spotlights/index.html.

- The final evaluation report, with links to other resources, can be found at: http://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/final-report/index.html.

To share the work of CHIPRA Quality Demonstration Grants and other quality measurement and improvement resources, CMS is in the process of creating searchable web postings as a resource for States and other stakeholders to learn from the experiences of the grantees. In addition, CMS began a knowledge transfer plan in February 2016 with an all-states webinar to leverage the knowledge gains from this demonstration and disseminate lessons learned. The work culminated in September 2017, when CMS began an affinity group with eight states that focused on Medicaid and school-based health services. Specifically, the affinity group addressed ways that Medicaid can partner with schools to improve health outcomes, using the Child Quality Measures Core Set to evaluate progress. CMS provided and facilitated expert-moderated webinars on a broad

range of topics based on the needs of participating states, one-on-one consultation with states, and peer-to-peer learning.

History of Funding for State Allotments

Fiscal Year	Amount
FY 2019[8]	$20,539,000,000
FY 2020[9]	$20,530,000,000
FY 2021[10]	$23,800,000,000
FY 2022	$25,900,000,000
FY 2023	$25,900,000,000

[8] Reflects rescission of $2.1 billion in funding from Section 2104(a)(22) of the Social Security Act from the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 (P.L. 115-245).

[9] Reflects rescission of $3.2 billion in funding from Section 2104(a)(23) of the Social Security Act from the Future Consolidated Appropriations Act, 2020 (P.L. 116-94).

[10] Reflects rescission of $1.0 billion in funding from Section 2104(a)(24) of the Social Security Act from the Consolidated Appropriations Act, 2021 (P.L. 116-133).

Mandatory State/Formula Grants[11]
State Children's Health Insurance Program
CFDA NUMBER/PROGRAM NAME: 93.767
(Dollars in Thousands)

STATE/TERRITORY	FY 2021[12] Actual	FY 2022[13] Estimate	FY 2023[14] Estimate	FY 2023 +/- FY 2022
Alabama	$367,333	$390,033	$417,637	27,604
Alaska	$25,677	$27,206	$27,622	415
Arizona	$248,889	$263,995	$347,8622	83,628
Arkansas	$208,780	$221,210	$180,030	(41,180)
California	$3,337,555	$3,545,882	$3,268,096	(277,786)
Colorado	$279,650	$296,259	$283,881	(12,378)
Connecticut	$73,600	$77,849	$58,809	(19,040)
Delaware	$37,363	$39,587	$41,119	1,532
District of Columbia	$61,115	$65,216	$87,278	22,061
Florida	$781,926	$829,051	$824,729	(4,322)
Georgia	$418,809	$443,553	$506,412	62,858
Hawaii	$55,278	$58,569	$47,297	(11,272)
Idaho	$85,666	$91,174	$92,605	14,313
Illinois	$535,993	$567,905	$550,098	(17,807)
Indiana	$276,994	$288,565	$252,564	(36,001)
Iowa	$167,051	$176,467	$150,519	(25,948)
Kansas	$147,144	$155,119	$154,563	(557)
Kentucky	$253,622	$268,496	$328,207	59,709
Louisiana	$394,071	$417,148	$438,770	21,622
Maine	$35,718	$37,844	$36,522	(1,322)
Maryland	$285,437	$302,351	$305,816	3,465
Massachusetts	$694,235	$722,738	$774,023	51,285
Michigan	$268,437	$287,657	$282,546	(5,110)
Minnesota	$114,765	$121,599	$120,113	(1,486)
Mississippi	$270,793	$286,916	$225,409	(61,507)
Missouri	$327,163	$346,332	$349,925	3,593
Montana	$86,630	$91,994	$90,593	(1,401)
Nebraska	$81,650	$86,511	$97,977	11,466

[11] Represents proposed law baseline projections of obligations
[12] FY2021 projected allotments are calculated based on 2104(m) of the Social Security Act and include any updates for the American Rescue Plan Act (ARPA).
[13] FY 2022 projected allotments do not include amount of increase, if any, determined under section 2104(m)(7) of the Social Security Act or FY 2022 CHIP ARP as it relates to section 9821 and are subject to change.
[14] FY 2023 projected allotments are based on the November 2021 budget submission and are subject to change.

STATE/TERRITORY	FY 2021[12] Actual	FY 2022[13] Estimate	FY 2023[14] Estimate	FY 2023 +/- FY 2022
Nevada	$82,635	$87,643	$87,667	24
New Hampshire	$47,781	$50,626	$61,107	10,481
New Jersey	$615,514	$651,303	$683,014	31,711
New Mexico	$115,403	$122,274	$136,375	14,102
New York	$1,603,892	$1,699,383	$1,380,681	(318,702)
North Carolina	$555,950	$589,003	$625,325	36,322
North Dakota	$18,436	$19,613	$3,818	(15,795)
Ohio	$522,078	$521,186	$576,851	24,665
Oklahoma	$262,802	$278,286	$267,436	(10,848)
Oregon	$429,652	$455,233	$572,598	117,365
Pennsylvania	$695,236	$736,628	$605,415	(131,213)
Rhode Island	$75,618	$80,120	$89,978	9,857
South Carolina	$207,863	$220,684	$186,974	(33,710)
South Dakota	$29,485	$31,241	$29,146	(2,095)
Tennessee	$303,670	$322,595	$297,722	(24,872)
Texas	$1,355,609	$1,437,049	$1,302,613	(134,436)
Utah	$127,322	$134,902	$123,976	(10,926)
Vermont	$20,754	$21,989	$15,294	(6,695)
Virginia	$379,154	$401,147	$406,674	5,527
Washington	$247,639	$262,452	$316,288	53,835
West Virginia	$78,959	$83,615	$101,053	17,438
Wisconsin	$250,093	$265,385	$243,274	(22,110)
Wyoming	$12,190	$12,915	$7,331	(5,584)
Subtotal	17,959,076	19,023,504	18,461,397	(562,107)
Commonwealths and Territories				
American Samoa	$6,485	$6,702	$7,173	472
Guam	$30,678	$32,505	$34,134	1,629
Northern Mariana Islands	$17,224	$18,249	$15,164	(3,085)
Puerto Rico	$118,169	$124,412	$154,928	30,515
Virgin Islands	$12,182	$12,907	$13,066	159
Subtotal	184,738	194,775	224,465	29,690
TOTAL RESOURCES	18,143,814	19,218,279	18,685,862	(532,417)

Note: Allotments to states remain available for federal payments for two years.

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State Grants and Demonstrations

Budget Authority[1] [2]

(Dollars in Thousands)

Program	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget	FY 2023 +/- FY 2022
Medicaid Integrity Program	$89,275	$90,525	$93,513	$2,988
CPI-U	$1,250	$2,987	$3,366	$379
Sequester	($5,160)	($5,330)	($5,522)	($192)
MIP Total	**$85,365**	**$88,182**	**$91,357**	**$3,175**
Money Follows the Person (MFP)	$425,451	$450,000	$450,000	**$0**
Sequester	$0	($25,650)	($25,650)	**$0**
MFP Total	**$425,451**	**$424,350**	**$424,350**	**$0**
Community-based Mobile Crisis Intervention Services	$15,000	$0	$0	**$0**
Total Appropriation	**$525,816**	**$512,532**	**$515,707**	**$3,175**

Authorizing Legislation - Deficit Reduction Act of 2005, Public Law 109-171; Patient Protection and Affordable Care Act, Public Law 111-148 together with the Health Care and Education Reconciliation Act of 2010, Public Law 111-152; Further Consolidated Appropriations Act, 2020, Public Law 116-94; Coronavirus Aid, Relief, and Economic Security Act, 2020 (P.L. 116-136); Consolidated Appropriations Act, 2021 (P.L. 116-260); American Rescue Plan Act of 2021 (P.L. 117-2)

Allocation Method – Grants, Contracts, Other

[1] This table reflects new budget authority and does not include carryover resources. This table does not include the following programs/laws: Ticket to Work, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, the Second Emergency Supplemental Appropriations Act to Meet Immediate Needs Arising From the Consequences of Hurricane Katrina, 2005, Katrina Relief - Additional Federal Payments Under Hurricane-related Multi-state Section 1115 Demonstrations, Application of Prospective Payment System for Services Provided by Federally-Qualified Health Centers and Rural Health Clinics, Medicaid Emergency Psychiatric Demonstration, Medicaid Incentives for the Prevention of Chronic Diseases, Psychiatric Residential Treatment Facilities, Grants to Improve Outreach and Enrollment, and Funding for the Territories since the Budget Authority is $0 or the money has been rescinded.

[2] The budget authority has been adjusted by sequester where applicable.

Gross Outlays[3]
(Dollars in Thousands)

Program	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget	FY 2023 +/- FY 2022
Money Follows the Person (MFP) Demonstration-Grants	$233,622	$264,899	$456,224	**$191,325**
MFP Research & Evaluation	$67	$759	$1,069	**$310**
MFP Best Practices	$0	$227	$295	**$68**
MFP QA/Tech Asst/Oversight	$0	$832	$998	**$166**
Medicaid Integrity Program	$84,813	$81,369	$81,371	**$2**
Grants to Improve Outreach and Enrollment	$20,184	$19,902	$12,540	**($7,362)**
Demonstration Programs to Improve Community Mental Health Services	$182	$151	$181	**$30**
Demonstration Project to Increase Substance Use Provider Capacity	$20,425	$23,204	$1,679	**($21,525)**
Community-based Mobile Crisis Intervention Services	$0	$5,000	$10,000	**$5,000**
Incentives for Prevention of Chronic Diseases in Medicaid	$62	$0	$0	**$0**
Medicaid Emergency Psychiatric Demonstration	$1	$0	$0	**$0**
Ticket to Work	$8	$0	$0	**$0**
Total Outlays for State Grants and Demonstrations	**$359,364**	**$396,343**	**$564,357**	**$168,014**

[3] Amounts on this table include outlays from obligations made in previous fiscal years. These outlay estimates are based on the most recent baseline estimates.

Program Description and Accomplishments

The State Grants and Demonstrations account has historically provided federal funding for a diverse group of grant programs and other activities established under several legislative authorities. The activities have empowered states to drive innovation to improve quality and health outcomes and assist in providing state infrastructure support and services to targeted populations, including resources to combat fraud, waste and abuse, and ensuring taxpayer dollars can focus on providing high quality care to beneficiaries.

Funding History[4]

Fiscal Year	Amount
FY 2019	$391,678,963
FY 2020	$421,508,189
FY 2021	$525,816,455
FY 2022	$512,532,410
FY 2023	$515,706,976

Budget Overview

The various grant and demonstration programs are appropriated federal funds through several legislative authorities. The legislation which authorizes these programs determines the amount and period of availability of funds. The following is a description of each grant and demonstration program and its associated funding.

MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION

Program Description and Accomplishments

Authorized in Section 6071 of the Deficit Reduction Act of 2005 (DRA), as amended by Section 2403 of Patient Protection and Affordable Care Act, the Medicaid Extenders Act of 2019, the Medicaid Services Investment and Accountability Act of 2019, the Consolidated Appropriations Act, 2021, and several additional short-term funding extensions passed in 2019 and 2020, the MFP demonstration supports state efforts to rebalance their long-term services and supports system (LTSS) so that individuals have a choice of where they live and receive services. The MFP demonstration ensures that patients have flexibility and information to make choices as they seek care by:

- Transitioning individuals from institutions who want to live in the community; and
- Implementing a system that provides the person-centered services and a quality management strategy that ensures provision and improvement of both home and community-based settings.

[4] Reflects new appropriations in a given fiscal year. Does not include balances from previous appropriations.

The demonstration provides, from its grant award, an MFP-enhanced Federal Medical Assistance Percentage (FMAP) for 365 days of qualified home and community-based services (HCBS) for each person transitioned from an institution to the community during the demonstration period. To be eligible for the demonstration, individuals must reside in a qualified institution for at least 60 days before they transition to the community. In addition, states must continue to provide community-based services after the 365-day demonstration period for as long as the individual needs community services and is Medicaid eligible.

The CMS MFP Tribal Initiative (TI), which received funding under the authority of Section 2403 of Patient Protection and Affordable Care Act, offers existing MFP state grantees and tribal partners the resources to build sustainable community-based long-term services and supports (CB-LTSS) specifically for American Indian Tribes. The TI may be used to advance the development of an infrastructure required to implement CB-LTSS for American Indians and Alaska Natives (AI/AN) using a single or a variety of applicable Medicaid authorities. In April 2014, CMS awarded a total of $1.5 million to five MFP grantees for the first phase of the program development. The amounts in the table on the following page are inclusive of these supplemental awards.

The CMS MFP Capacity Building Initiative, funded by section 204 of the Consolidation Appropriations Act, 2021, offers states with current MFP transition programs funding for planning and capacity building activities to expand HCBS capacity. This funding is expected to improve focus and attention on LTSS rebalancing among states participating in the MFP demonstration and to support MFP grantees with making meaningful progress with LTSS rebalancing. In 2021, CMS awarded a total of $149,420,228 to 32 grantees for the initiative. The amounts in the table on the following page are inclusive of these supplemental awards.

According to the 2019 Report, *Money Follows the Person Demonstration: Overview of State Grantee Progress*, (https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/mfp-2019-transitions-brief.pdf), between 2008 and 2019, states transitioned 101,540 people to community living through the MFP program.

Budget Overview

Section 6071 of the DRA authorized and appropriated a total of $1.8 billion for the MFP Rebalancing Demonstration over the period January 1, 2007 through FY 2011. Section 2403 of Patient Protection and Affordable Care Act amended the Deficit Reduction Act providing $450.0 million in each fiscal year from 2012-2016, totaling an additional $2.3 billion. In addition, section 6071 of the DRA allows funding from each fiscal year's award to be used that fiscal year and for four additional fiscal years. The Medicaid Extenders Act of 2019 (P.L. 116-3) amended the DRA to make $112.0 million available for states with approved MFP demonstrations for FY 2019 and extended state MFP demonstrations through FY 2021. Of the $112.0 million, $500,000 was made available to carry out funding for quality assurance and improvement, technical assistance, and oversight. The Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16) included an additional $20.0 million and the Sustaining Excellence in Medicaid Act added 122.5 million in funding for the program. The Further Consolidated Appropriations Act, 2020 (P.L. 116-94) provided an additional $176 million and the Coronavirus Aid, Relief, and Economic Security Act, 2020 (P.L. 116-136) added $161.5 million in funding for the program in FY 2020. In FY 2021, the Continuing Appropriations Act, 2021 and Other

Extensions Act (P.L. 116-159) added $66.4 million and the Further Continuing Appropriations Act, 2021, and Other Extensions Act (P.L. 116-215) added $6.5 million. The Consolidated Appropriations Act, 2021 (P.L. 116-260/H.R. 133) added $1.253 billion ($1.201 billion after sequestration) and included statutory changes to enhance and extend the program through September 30, 2023.

States participating in the MFP demonstration are provided reimbursement for approved home and community-based services at an MFP-enhanced FMAP rate. The enhanced FMAP increases the regular FMAP rate for HCBS by the number of percentage points equal to 50 percent of the state share, capped at 90 percent. The American Reinvestment and Recovery Act of 2009 authorized an increased FMAP rate to preserve a significant differential between the MFP-enhanced FMAP and the increased MFP-enhanced FMAP that states were receiving for most other Medicaid funded services under the Recovery Act in order for states to continue to have a financial incentive to meet the goals of the MFP program. To address the national public health emergency, the Families First Coronavirus Response Act (FFCRA), 2020 (P.L. 116-127) included an indirect temporary 6.2 percentage point FMAP increase. These increases are reflected in the chart below.

Of the original DRA appropriation of $1.8 billion, a total of $2.4 million was made available in fiscal years 2007 and 2008 to carry out technical assistance for, and oversight of, states' efforts to improve quality under HCBS waiver programs and $1.1 million per year for evaluation and reporting to Congress. The Medicaid Extenders Act of 2019 included an additional $500,000 for technical assistance. In addition, Section 2403 of Patient Protection and Affordable Care Act authorized $1.1 million from each year's appropriation in FY 2012 through FY 2016 that was used to carry out evaluation and a required report to Congress (https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf). Section 204 of the Consolidated Appropriations Act, 2021 included $1.1 million for each of FY 2021-FY 2023 for research and evaluation, $300,000 for each of FY 2021 and FY 2022 for a Best Practices Report, and $3 million (until expended) for quality assurance and improvement; technical assistance and oversight.

As of December 31, 2021, CMS obligated approximately $4.06 billion in grants to 45 grantee states and the District of Columbia (DC). Grantees have transitioned approximately 101,540 individuals as of December 31, 2019, based on individual state reporting. Currently, there are 34 states and DC participating in the MFP demonstration.

State	***Cumulative Award Total***	***Initial Award Date***
Alabama	$24,162,409	September 27, 2012
Arkansas	$68,256,438	January 1, 2007
California	$213,162,799	January 1, 2007
Colorado	$31,502,302	April 1, 2011
Connecticut	$280,497,914	January 1, 2007
Delaware	$13,304,857	May 1, 2007
District of Columbia	$41,191,272	May 1, 2007
Georgia	$161,982,210	May 1, 2007
Hawaii	$8,576,073	May 1, 2007
Idaho	$26,681,032	April 1, 2011

State	*Cumulative Award Total*	*Initial Award Date*
Illinois	$36,203,422	May 1, 2007
Indiana	$75,112,704	January 1, 2007
Iowa	$90,390,229	January 1, 2007
Kansas	$63,894,877	May 1, 2007
Kentucky	$58,216,133	May 1, 2007
Louisiana	$102,876,962	May 1, 2007
Maine	$12,995,802	April 1, 2011
Maryland	$167,615,166	January 1, 2007
Massachusetts	$95,041,809	April 1, 2011
Michigan	$79,802,401	January 1, 2007
Minnesota	$82,294,777	April 1, 2011
Mississippi	$29,183,470	April 1, 2011
Missouri	$87,390,116	January 1, 2007
Montana	$12,148,150	September 27, 2012
Nebraska	$17,419,791	January 1, 2007
Nevada	$17,229,239	April 1, 2011
New Hampshire	$13,753,793	January 1, 2007
New Jersey	$152,808,420	May 1, 2007
New Mexico	$49,205	April 1, 2011
New York	$241,569,329	January 1, 2007
North Carolina	$63,300,729	May 1, 2007
North Dakota	$38,695,117	May 1, 2007
Ohio	$441,541,502	January 1, 2007
Oklahoma	$52,849,296	January 1, 2007
Oregon	$22,655,153	May 1, 2007
Pennsylvania	$168,853,932	May 1, 2007
Rhode Island	$21,222,204	April 1, 2011
South Carolina	$7,510,709	April 1, 2011
South Dakota	$15,503,977	September 27, 2012
Tennessee	$67,906,189	April 1, 2011
Texas	$394,381,186	January 1, 2007
Vermont	$28,302,078	April 1, 2011
Virginia	$70,866,895	May 1, 2007
Washington	$257,711,886	January 1, 2007
West Virginia	$28,256,924	April 1, 2011
Wisconsin	$73,033,542	January 1, 2007

NOTE: The table represents funding awarded to states. Funding for planning grants, quality initiatives, and reductions associated with sequestration are not reflected. New Mexico and Florida had no transitions through the MFP program, rescinding grant

awards in January 2012 and August 2013 respectively. Oregon deactivated their program in 2011 and officially closed out the grant in September 2016. The following MFP programs ended transitions and closed their grant awards: Illinois (February 2021), Kansas (August 2020), Michigan (February 2020), Mississippi (May 2021), Nebraska (December 2020), New Hampshire (February 2021), and Virginia (February 2021).

MEDICAID INTEGRITY PROGRAM

Program Description and Accomplishments

On February 8, 2006, Section 6034 of the Deficit Reduction Act of 2005 (DRA) (P.L. 109-171) established the Medicaid Integrity Program in Section 1936 of the Social Security Act (the Act). With the passage of this legislation, Congress provided the Centers for Medicare & Medicaid Services (CMS) with increased resources to prevent, detect, and reduce fraud, waste, and abuse in the Medicaid program, ensuring that taxpayer dollars are used to provide high quality care to beneficiaries.

In 2015, the Patient Access and Medicare Protection Act (P.L. 114-115) amended Section 1936 of the Act, providing CMS with greater flexibility to use a mix of contractors and federal personnel to achieve the objectives of the Medicaid Integrity Program and more quickly adapt to changing program integrity needs. Today, CMS staff and contractors funded by the Medicaid Integrity Program work closely with the Health Care Fraud and Abuse Control (HCFAC) program to address Medicaid fraud, waste, and abuse through a unified and coordinated effort. Some of the key projects included in that unified effort are described below. Other details are included in the HCFAC chapter.

Medicaid Program Integrity

The DRA directed CMS to establish a Comprehensive Medicaid Integrity Plan (CMIP) every five years outlining its strategy for combating fraud, waste, and abuse in Medicaid. The first CMIP was published in July 2006, and covered FYs 2006 through 2010. CMS released the most recent CMIP in July 2020 for FYs 2019 through 2023, available at: https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf. Building upon CMS' existing program integrity efforts, the CMIP for FYs 2019 through 2023 includes the new and enhanced Medicaid program integrity initiatives that target seven high-risk areas. Continuing levels of funds will be required through FY 2023 to enable CMS to meet the program goals outlined in the CMIP. CMS' Medicaid program integrity efforts include the following:

Medicaid Improper Payments

- The Payment Error Rate Measurement (PERM) program measures improper payment rates in the Medicaid program and the Children's Health Insurance Program (CHIP), by reviewing each state on a rolling three year basis and annually producing national and state-specific improper payment rates. The improper payment rates are based on federal reviews of the fee-for-service, managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review. In FY 2021, CMS continued implementing a more robust state-specific PERM corrective action plan process that provides enhanced technical assistance and guidance to states. CMS works with states to coordinate state development of corrective action plans to address each error and deficiency

identified during the PERM cycle. After the corrective action plan has been submitted, CMS monitors each state progress in implementing effective corrective actions. Throughout the process, CMS also provides a number of training opportunities to ensure compliance with CMS policies.

- The Medicaid Eligibility Quality Control (MEQC) program uses state-directed reviews in the two off-cycle PERM years to address Medicaid beneficiary eligibility errors and deficiencies. MEQC includes reviews of areas not addressed through PERM reviews as well as areas identified as error-prone through the PERM program. In FY 2021, CMS worked with the Cycle 1 states to submit the MEQC pilot planning documents in November 2020; the Cycle 2 states to complete their MEQC reviews and prepare their summary-level reports and corrective action plans for submission in November 2021; and the Cycle 3 states to design their MEQC pilots and start their case review in January 2021. Because of the continuation of the COVID-19 PHE in FY 2021, CMS issued revised supplemental MEQC guidance in May 2021 that reduced state burden by applying uniform summary reporting requirements and deadline extensions to all cycles, as well as a reduced workload requirement for Cycle 20 and Cycle 3 states.

Medicaid Claiming and Financial Reporting

- A key component of CMS' managed care program integrity work is to conduct targeted examinations of selected states' Medicaid Managed Care Plans' (MCPs) financial reporting. As part of this effort, CMS conducted an examination of the Medical Loss Ratio (MLR) reported by California's 22 Medicaid MCPs to determine if the state's previous review correctly identified findings and overpayments, and the documentation accepted by the state was reasonable to support the amounts included in the MLR calculation. The examination identified several observations and recommendations for improvement, as well as areas for potential future rule making. The report for this examination was released in June 2020.[5] In 2021, CMS initiated a second MLR review in Oregon, which is currently in the draft report phase with an expected release in the coming months of 2022.

Medicaid and CHIP Collaboration

- CMS is conducting oversight of states' program integrity efforts and is working to build a collaborative working relationship to share states' promising practices and strengthen program integrity efforts. CMS is working to strengthen efforts to provide effective Medicaid provider education to reduce aberrant billing including targeted probe and educate efforts and comparative billing reports. Reviews are also conducted to determine if state policies and practices comply with federal regulations, identify program vulnerabilities that may not rise to the level of regulatory compliance issues, identify states program integrity promising practices, and monitor state corrective action plans
- CMS conducts several Technical Assistance Group (TAG) calls during which states share resources and promising practices, have the opportunity to ask questions to CMS and other states, and discuss trending issues in program integrity.
- CMS' Medicaid Integrity Institute (MII) provides training and education to more than one thousand state Medicaid program integrity staff annually. Previous

[5] https://www.cms.gov/files/document/california-medical-loss-ratio-examination-report.pdf

course topics included provider screening and enrollment, managed care, personal care services, opioids, beneficiary fraud, data analytics, and investigatory techniques. In FY 2021, CMS continued a robust training program, which included virtual training opportunities. FY 2021 offerings included trends in Medicaid COVID-19 Vulnerabilities, a PERM Corrective Action Symposium, and an Education and Outreach for the Territories workgroup. CMS cancelled all in-person courses after the start of the COVID-19 PHE and established virtual courses to continue educational offerings. Despite this change, state interest and participation in FY 2021 has remained strong, consistent with previous years. More information is located in the Medicaid Integrity Institute website. Additional FY2022 virtual courses are being developed on various fraud, waste and abuse topics.

- Because CMS announced certain Medicaid and CHIP waivers and flexibilities to allow states to best respond to the PHE, CMS is now working to provide technical assistance and guidance to states regarding the potential program integrity risks that may arise as a result, including potential mitigation strategies to reduce these risks. In July 2021, CMS released a risk assessment template for states to aid in their oversight of COVID-19 waivers and flexibilities.
- As of February 11, 2022, the Healthcare Fraud Prevention Partnership (HFPP) had 43 State Medicaid partners. The HFPP held a virtual State Information Sharing Session on May 27, 2021. During the Event, over 127 partners from across 47 state health care and Medicaid Fraud Control Unit (MFCU) organizations acquired the latest information on COVID-19, law enforcement activities, investigative strategies, and trending schemes to assist with fraud-fighting efforts. Another State Information Session is scheduled for March 24, 2022. The HFPP will continue to engage state partners through a variety of means including producing study results, creating white papers and hosting virtual events which help state partners combat fraud, waste and abuse.
- Under Medicaid Section 1115 demonstration authority, CMCS is working to streghthen internal controls that affect program integrity. Standard operating procedures outlining application review steps were developed for project officers to maintain consistency and a high quality approval process. Training tools and interactive training to support more rigorous monitoring and evaluation were also developed. These materials are being piloted. In addition, CMCS has leveraged the expertise of other groups across CMCS to support financial reviews and systematic monitoring of 1115 demonstrations, and those workflows are also supported by standard operating procedures and a team based approach so that all staff who work on section 1115 demonstrations are informed about the state's performance under its demonstration.
- CMS is continuing to expand and refine the Performance Management Database and Analytics System (PMDA), an IT system that collects section 1115 demonstration reports, budget neutrality data, program performance data and other deliverables from states, and applies analytics to assess trends on standardized data. Upcoming releases will also support application intake from states and the review and approval cycles of the section 1115 workflows.

Medicaid Data Analysis

- CMS is working closely with states to ensure that federal partners, stakeholders, and oversight bodies have access to the best, most complete and accurate

Medicaid data, all 50 states, D.C., Virgin Islands, and Puerto Rico continue to submit data on their programs to the Transformed Medicaid Statistical Information System (T-MSIS) and have partnered with CMS to improve the quality of data submitted. As of January 2021, CMS has released T-MSIS Analytic Files with data for calendar years 2014-2020 to federal partners and stakeholders, and publically released research files for calendar years 2014-2019. This marks the timeliest availability of Medicaid and CHIP data ever. The DQ Atlas, an interactive web-based companion tool which allows users to explore the quality and usability of the data, is currently available for calendar years 2016-2019.

- T-MSIS data quality improvements have resulted in publically available data releases including an annual substance use disorder databook, monthly enrollment reports, annual state-level Medicaid per capita expenditures for the Medicaid and CHIP Scorecard, and a sickle cell disease infographic and report. CMS has also released data snapshots regarding Medicaid and CHIP beneficiaries and their service utilization during the COVID-19 Public Health Emergency (PHE). Data include COVID-19 testing, treatment and outcomes, service use among beneficiaries of Medicaid and the Children's Health Insurance Program (CHIP) who are 18 years of age and under, services delivered via telehealth during the COVID-19 PHE, and services for mental health and substance use disorders during the COVID-19 PHE.
- CMS is working to integrate other sources of data, such as expenditure data and state plan amendment/waiver data, along with data on Medicare-Medicaid Dual Eligibility, within T-MSIS to expand analytic capabilities and strengthen program integrity efforts. T-MSIS data is now geo-coded for all provider and beneficiary addresses and in the near future identification of race/ethnicity will be available by imputing a race/ethnicity model using Census data. CMS also plans to integrate expenditures and state program structures allowing for future validation of areas such as services rendered against expenditures claimed, or evaluating expenditure changes in state programs.
- CMS is sharing their extensive knowledge gained from processing and analyzing large, complex Medicare data sets to help states apply algorithms and insights to analyze Medicaid state claim data and identify potential areas to target for investigation.

Medicaid Provider Enrollment

- CMS is continuing to offer the data compare service which identifies providers states may need to take action against and allows states to compare their provider population to the Medicare provider population in bulk to more easily rely on Medicare's screening and reduce the state's overall revalidation workload.
- CMS is also continuing to screen Medicaid providers on behalf of states. Centralizing the process will improve efficiency and coordination across Medicare and Medicaid and decrease state burden.
- CMS is working with states to enhance data sharing and collaboration to tackle program integrity efforts in both the Medicare and Medicaid programs. For example, CMS has made the Social Security Administration's Death Master File available for states to support provider enrollment activities. CMS has also created and launched the CMS Data Exchange (DEX) system, a platform to more effectively and efficiently share providers' adverse actions with State Medicaid Agencies.

- In FY 2023, CMS will continue to offer assistance to states regarding provider screening and enrollment requirements in an effort to reduce improper payments. Activities under this initiative include: providing one-on-one technical assistance, feedback, and collect and disseminate best practices; continue to offer the CMS data compare service, updates to the Medicaid Provider Enrollment Compendium (MPEC); a dedicated CMS contact to work directly with the state in addressing concerns, questions, and issues that may arise regarding provider screening and enrollment.

Unified Program Integrity Contractors (UPICs)

Congress has mandated that CMS enter into contractual agreements with eligible entities to do the following:

- Review the actions of individuals or entities furnishing items or services to determine whether fraud, waste, or abuse has occurred, is likely to occur, or otherwise might result in expenditures not intended under Medicaid;
- Audit claims, including cost reports, consulting contracts, and risk contracts;
- Identify overpayments; and,
- Conduct education of state or local officers, employees, independent contractors, providers of services; managed care entities, beneficiaries, and other individuals.

CMS meets these obligations through a Unified Program Integrity Contractor (UPIC) strategy that consolidates Medicare and Medicaid program integrity audit and investigation work across five jurisdictions throughout the United States. The overarching goal of the UPICs is to integrate these program integrity functions by implementing a contracting strategy that rationalizes CMS's relationships with providers, leverages existing resources, and enhances cooperative efforts with partners, including states.

In FY 2021, the UPICs initiated Medicaid provider investigations and audits in 42 states. The most common collaborative investigations and audits have been conducted in the areas of durable medical equipment, general hospital services, hospice, laboratories, prescribers of opioids, and skilled nursing facilities. Each of these investigative areas includes both fee for service and managed care providers. In FY 2022, CMS is continuing to collaborate with states to conduct investigations and audits in high priority areas, including addressing COVID-19 vulnerabilities.

Medicaid/CHIP Financial Management Project

Financial Management (FM) staff, including accountants and financial analysts work to improve CMS' financial oversight of the Medicaid and CHIP programs. In FY 2021 through the continued efforts of these specialists, CMS removed an estimated $1.45 billion (with approximately $467.7 million recovered and $983.9 million resolved) of approximately $10.3 billion identified in questionable Medicaid costs.

Furthermore, an estimated $946 million in questionable reimbursement was actually averted due to the FM staff preventative work with states to promote proper state Medicaid financing. The FM staff activities included reviews of proposed Medicaid state plan amendments that related to reimbursement; development of financial management reviews; research regarding state Medicaid financing policy and practices; collaboration with states to resolve the Medicaid and CHIP portions of the A-133 state single audits; and reviews of

sources of the non-federal share.

In late 2018, CMS began a multi-year effort to develop and implement enhancements to the legacy systems supporting Medicaid and CHIP budget and expenditure tracking. Known as MACFin, the effort will, over time, enhance and replace the legacy systems known as Medicaid & CHIP budget and expenditure system (MBES/CBES) and Incurred But Not Reported System (IBNRS). The MACFin project has already implemented several notable enhancements to the budget and expenditure reporting processes, including: MACFIN assuming functions of IBNRS including automated workflows and legacy IBNRS retired; Disproportionate Share Hospital allotments and audits; CHIP allotments; Medicaid Budget (Submission and new Review process with automated workflow); Upper Payment Limit for state demonstrations; and initial and supplemental grant awards. In addition, other enhancements to the federal systems supporting Medicaid & CHIP, including MACPro (Medicaid and CHIP Program) which will track and managed payment-related state plan amendments and MDP (Medicaid Drug Programs) products providing enhanced ability to monitor and track the multiple Medicaid drug programs including enhanced rebate calculation and oversight for outpatient prescription drugs, Federal Upper Limit price calculations, annual Drug Utilization Review (DUR) survey and report, and the Branded Prescription Drug Program with the IRS.

State Program Integrity Reviews

Since 2007, CMS has conducted state program integrity reviews, which assess the operations of each state's Medicaid program integrity unit and report on vulnerabilities and best practices. The Medicaid program integrity review strategy includes both focused reviews (conducted onsite/virtually) and desk reviews (conducted virtually) of states. The program integrity reviews provide the opportunity to identify areas that would benefit from technical assistance from CMS.

CMS has completed 76 focused program integrity reviews on specific target areas since FY 2014 through FY 2021. Focused reviews will continue in FY 2022 and FY 2023. These reviews have focused on a number of issues including the enhanced provider screening and enrollment provisions resulting from the Patient Protection and Affordable Care Act, the extent of states' program integrity oversight of the managed care program, the extent of selected managed care organizations' oversight of their own programs, and issues in personal care services.

CMS also conducts additional reviews that encompass a broader assessment of program vulnerabilities and risk of Medicaid improper payments. Known as desk reviews, these reviews allow CMS to increase the number of states that received customized program integrity oversight.

Since their inception in FY 2016, CMS has completed 325 desk reviews in at least 45 states and the District of Columbia, with 58 desk reviews completed for FY 2021. Desk reviews will continue in FY 2022 and FY 2023.

Budget Overview

The DRA appropriated funds yearly beginning in FY 2006, and beginning in FY 2011, Section 1303(b) (3) of Public Law 111-152 adjusted this funding by the percentage increase

in the CPI-U annually. The final FY 2021 budget authority was $85.4 million. The FY 2022 budget authority is $90.5 million with an estimated CPI-U adjustment of 3.3 percent, bringing the adjusted budget authority to $93.5 million. The FY 2022 budget authority is reduced by 5.7 percent due to sequestration, bringing the estimated FY 2022 budget authority to $88.2 million. The FY 2023 budget authority is $93.5 million with an estimated CPI-U adjustment of 3.6 percent, bringing the adjusted budget authority to $96.9 million. The FY 2023 budget authority is reduced by 5.7 percent due to sequestration, bringing the estimated FY 2023 budget authority to $91.4 million. The CPI-U adjustments are based on the current FY 2022 Mid-Session Review economic assumptions. Funds appropriated remain available until expended.

GRANTS TO IMPROVE OUTREACH AND ENROLLMENT

Program Description and Accomplishments

Program Overview

The Connecting Kids to Coverage grants provide outreach, education, and application assistance to enroll eligible, uninsured children in Medicaid and Children's Health Insurance Program (CHIP) and improve retention of eligible children who are currently enrolled, with a particular focus on children who are the most difficult to reach and enroll. Recognizing that traditional methods of outreach had not been effective with these children and families, the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 introduced funding to develop specialized strategies to target these children by organizations that would have access to, and credibility with families in the communities in which these eligible but uncovered children resided.

Since the Connecting Kids to Coverage Outreach and Enrollment grant funding initiatives began in 2009, 294 awards to eligible entities have been issued for approximately $216.0 million in total grant funding. All of the outreach and enrollment grants share the common goal to help reduce the number of children who are eligible for Medicaid and CHIP but are not enrolled.

Overview of HEALTHY KIDS Act Grant Awards

The following sections provide an overview of the key provision of each of the authorizing pieces of legislation funding these outreach and enrollment grants, and the results of the grant process.

The HEALTHY KIDS Act provided $120.0 million for activities aimed at increasing the participation of eligible children in Medicaid and CHIP. Of the total $120.0 million in funding, 10 percent must be used for outreach to AI/AN children ($12.0 million), 10 percent must be used for the National Campaign ($12.0 million), and the remainder ($96.0 million) is for general grants for the outreach and enrollment of uninsured children and their parents. On June 19, 2019, CMS awarded $48.0 million in cooperative agreements to 39 organizations in 25 states for general outreach. The project period for the initial project is three years, with three independent budget periods (FY 2019, FY 2020, and FY 2021).

Of the $12.0 million available for outreach and enrollment grants targeting the enrollment and retention of eligible AI/AN children in Medicaid and CHIP, CMS issued a Notice of

Funding Opportunity to make available $6.0 million in cooperative agreements to eligible entities on July 16, 2019. On January 13, 2020, CMS awarded $6.0 million in cooperative agreements, in six states, dedicated to the outreach and enrollment of AI/AN children. The project period for the initial project is three years, with three independent budget periods (FY 2021, FY 2022, and FY 2023).

On January 27, 2022, CMS issued a Notice of Funding Opportunity to make available the second phase of $48.0 million, plus an additional $1.4 million in carryover funds from the previous round of funding, for outreach and enrollment grants broadly targeting all eligible children in Medicaid and CHIP from FYs 2022 to 2025. CMS is planning a second phase of $6.0 million for outreach and enrollment grants targeting AI/AN children in Medicaid and CHIP from FYs 2023 to 2026.

National Enrollment Campaign

The statute sets aside 10 percent of appropriations to develop and implement a national enrollment campaign to increase the enrollment of eligible, uninsured children. Through the Connecting Kids to Coverage National Campaign (National Campaign), CMS has developed materials, such as posters, palm cards, social media graphics and posts, and public service announcements, which include a call to action to enroll and retain children in Medicaid and CHIP, as well as their parents in Medicaid. National Campaign efforts have enhanced communications with states, grantees, and other groups working on outreach and enrollment efforts through educational webinars and by distributing free tools that can be easily added to outreach and/or adapted to support these efforts.

With the funding appropriated under the HEALTHY KIDS Act of 2018, CMS awarded a multi-year task order in May 2019 to continue the National Campaign; the option period began in May 2021 and will run through May 2023. The National Campaign informs families that eligible children can enroll in Medicaid and CHIP any time of the year and directs them to InsureKidsNow.gov or 1-877-KIDS-NOW for additional information. Activities funded through the National Campaign include: conducting training webinars and meetings, developing newsletters and other tools on key topics for partners, creating and updating print and digital materials to support outreach and enrollment efforts, and producing public service announcements and a series of animated digital videos. All National Campaign materials can be found on InsureKidsNow.gov where there is a robust Outreach Tool Library, including some materials in 15 different languages. During FY 2020 to FY 2021, the National Campaign created the “Peace of Mind” campaign, which included digital videos as a way to continue to promote Medicaid and CHIP benefits during the COVID-19 pandemic when parents were concerned abouth the health and well-being of their families but were quarantined at home. The campaign was so successful that additional digital series were created into other topics such as mental health, oral health, flu and vaccinations, as well as corresponding social media graphics. In FY 2015 – FY 2019, CMS also developed PSAs for tribal communities and aired these on Good Health TV®, a health education program serving in tribal hospitals and clinic waiting rooms.

Budget Overview

The HEALTHY KIDS Act of 2018 appropriated $120.0 million over FY 2018 through FY 2023 to continue support for outreach and enrollment grants, including grants dedicated to the outreach and enrollment of AI/AN children and the National Enrollment Campaign.

Of the total appropriated amount, 10 percent was set aside for the national enrollment campaign and another 20 percent was for AI/AN outreach. The ACCESS Act of 2018 appropriated an additional $48.0 million from FY 2024 through FY 2027 and established an additional 10 percent set-aside for evaluation and technical assistance to grantees. As part of the National Enrollment Campaign, CMS will continue outreach activities to Tribal communities by creating outreach materials, public service announcements and social media graphics between FY 2021 through FY 2023. The funding will also be used to continue National Campaign activities, including an annual Back-to-School campaign.

Section 50103 of the Advancing Chronic Care, Extenders and Social Services Act (referred to as the ACCESS Act and included in P.L. 115-123) provided an additional $48.0 million, with the combined total of $168.0 million for outreach and enrollment activities for FY 2018 through FY 2027. These programs will continue to conduct outreach and enrollment efforts designed to increase the enrollment of children who are eligible for Medicaid and CHIP.

DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES

Program Description and Accomplishments

Section 223 of the Protecting Access to Medicare Act of 2014 (P. L. 113-93) required the Secretary to establish a two-year demonstration program no later than January 1, 2016 that would increase the Federal Matching Percentages for participating states to improve access to behavioral health services.

HHS has submitted annual reports to Congress in which the program is assessed on the basis of quality, scope, impact, and the use of funds.

On May 20, 2015, SAMHSA, in conjunction with CMS, released a Request for Applications (RFA) for planning grants to states that intended to participate in the section 223 Protecting Access to Medicare Act (PAMA) Demonstration Programs to Improve Community Mental Health Services. On October 19, 2015, SAMHSA, in conjunction with CMS and ASPE, awarded approximately $22.9 million in planning grants to 24 states to support their efforts to improve behavioral health services under the Medicaid program by providing community-based mental health and substance use disorder treatment. SAMHSA, CMS, and ASPE provided robust technical assistance to grantee states throughout the FY 2016 one-year planning phase of the demonstration. When the planning grant phase ended in October 2016, eight states were selected to participate in the section 223 behavioral health demonstration to make services more widely available through certified community behavioral health clinics.

In December 2016, HHS announced the selection of eight states: Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania to receive enhanced federal match for specific behavioral health services over a period of two years. Demonstration programs in selected states began between April and July 1, 2017. HHS reports annually to Congress an assessment of the quality, scope, and impact, and use of funds by demonstration programs, with a final report due no later than December 2021. The final report will provide recommendations for continuation, expansion, modification, or termination of demonstration projects under Section 223.

In October 2018, SAMHSA released the first annual Report to Congress which focuses on activities surrounding implementation of the demonstration, the one-year planning phase, states selected to participate in the 2-year demonstration and CCBHC program launch in the selected states. ASPE is continuing to conduct evaluations of the demonstration and is developing an Analysis Report to assess access to community-based mental health services under the Medicaid program, the quality and scope of services provided by CCBHCs, and the impact of the demonstration on federal and state costs of a full range of mental health services.

On April 18, 2019, H.R. 1839 Medicaid Services Investment and Accountability Act of 2019 (MSIA) P.L. 116-16 was signed into law which provided for a 90-day extension of Oklahoma and Oregon's CCBHC demonstration programs from April – June 2019. These states began their two-year demonstrations on April 1, 2017, 90 days prior to the additional six states. The MSIA allowed OK and OR to bring their program end date into alignment with Minnesota, Missouri, New York, New Jersey, Nevada and Pennsylvania's end date of June 30, 2019.

On July 5, 2019, S. 2047, P.L. 116-29, A bill to provide for a 2-week extension of the Medicaid community mental health services demonstration program was signed into law which provided for a 2-week extension of the demonstration for all eight states from June 30, 2019 to July 14, 2019.

On August 6, 2019, P.L. 116-39 the "Empowering Beneficiaries, Ensuring Access, and Strengthening Accountability Act of 2019," was signed into law by the President. This legislation extends the section 223 demonstration from 7/14/2019 – 9/13/2019.

On September 27, 2019 HR 4378, P.L. 116-59, the "Continuing Appropriations Act, 2020, and Health Extenders Act of 2019," was sign into law, which extended the section 223 demonstration from September 13, 2019 to November 21, 2019.

On November 21, 2019, H.R. 3055, P.L. 116-69, the "Further Continuing Appropriations Act of 2020, and Further Health Extenders Act of 2019," was signed into law, which extended the section 223 demonstration from November 21, 2019 to December 20, 2019.
On December 20, 2019, H.R. 1865, P.L. 116-94, the Further Consolidated Appropriations Act, 2020 was signed into law, which extended the section 223 demonstration from December 20, 2019 to May 22, 2020.

On March 27, 2020, H.R. 748, P.L. 116-136, the Coronavirus Aid, Relief, and Economic Security Act, or the CARES Act, was signed into law, which extended the end date of the section 223 demonstration from May 22, 2020 to November 30, 2020. The CARES Act also mandated the selection of two additional states to participate in the CCBHC demonstration that must be selected no later than September 27, 2020.

On August 5, 2020, CMS and SAMHSA announced the selection of Michigan and Kentucky as the two additional states to participate in the section 223 demonstration. CMS will work with the states to provide any needed technical assistance and will confirm start dates for demonstrations in Michigan and Kentucky as the statute did not specify a program start date. Both states are eligible to receive eight quarters of enhanced FMAP for CCBHC programs in their state.

On October 1, 2020, The Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. 116-159) was signed into law, which extended the section 223 demonstration end date from November 30, 2020 to December 11, 2020.

On December 27, 2020, H.R. 133, the Consolidated Appropriations Act, 2021 (Public Law 116-260) was signed into law, which extended the section 223 demonstration from December 11, 2020 to September 30, 2023. This legislation allows the original eight participating states to continue receiving enhanced FMAP for expenditures covering dates of service through September 30, 2023 for services provided by CCBHCs approved in 2016 under section 223 of the Protecting Access to Medicare Act, as outlined at https://www.samhsa.gov/grants/grant-announcements/sm-16-001. The legislation also indicated that the two newly selected CCBHC states, Kentucky and Michigan, will receive enhanced FMAP for CCBHC expenditures for 2 years from the start of their respective demonstrations or September 30, 2023, whichever is longer. CMS will transfer funds to ASPE under an interagency agreement to evaluate the implementation and impact of the program in the two additional states, as well as look at the longer-term implications of the program in the original states selected for participation.

ASPE leads the development of the remaining CCBHC Reports to Congress and on July 22, 2019, ASPE released the second CCBHC report for Congressional review. The 2018 report can be found on ASPE's website: https://aspe.hhs.gov/pdf-report/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2018.

On September 12, 2020, ASPE released the third annual CCBHC report for Congressional review. The 2019 report is located on ASPE's website: https://aspe.hhs.gov/pdf-report/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2019.

In addition, ASPE released the following CCBHC detailed cost and quality evaluation reports, also located on their website at the following links:

- https://aspe.hhs.gov/pdf-report/preliminary-cost-and-quality-findings-national-evaluation-certified-community-behavioral-health-clinic-demonstration
- https://aspe.hhs.gov/pdf-report/implementation-findings-national-evaluation-certified-community-behavioral-health-clinic-demonstration

CMS is continuing to onboard the two new CCBHC states, Michigan and Kentucky into the section 223 CCBHC demonstration through a series of technical assistance workshops.

In August 2021, CMS transferred funds in the amount of $800,000 to ASPE under an interagency agreement to provide continued evaluation of the CCBHC demonstration program. This ongoing evaluation project will focus on how the two new states implemented the demonstration program and will continue to examine the longer-term impact of the original demonstration states on improving access, the quality services, and the costs of delivering these services to people with behavioral health conditions. The findings from this project will provide key information necessary for ongoing annual reports to Congress, as required by the statute. The findings from this evaluation activity may also be released as standalone reports on the ASPE website.

On October 1, 2021, Michigan Medicaid launched the CCBHC demonstration in its state with 14 clinics certified to provide a comprehensive range of mental health and substance

use disorder services to vulnerable individuals. Kentucky Medicaid launched its CCBHC program on January 1, 2022 with four clinics across the state instead of October 1, 2021 as earlier anticipated. Both states are required to meet established CCBHC criteria related to care coordination, crisis response and service delivery, and provide a robust set of integrated evidence-based services to all persons with any mental illness or substance use disorder diagnosis.

On December 23, 2021, ASPE released the fourth annual CCBHC report for Congressional review. The 2021 report is located on ASPE's website:
Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2020 | ASPE (hhs.gov)

In addition on December 23, 2021, ASPE released the following CCBHC interim cost and quality evaluation report, also located on their website at the following link:
Interim Cost and Quality Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration | ASPE (hhs.gov)

The fourth annual CCBHC Report to Congress focused on cost and quality data. Based on ASPE's evaluation, CCBHCs were successful in reporting on costs and quality in both demonstration years. States made significant investments in technical assistance to CCBHC providers along with adjustments to resources, updating and creating policies and procedures to ensure proper identification and reporting of costs and setting performance targets through monitoring and reporting of quality measures under the demonstration. CCBHCs under the demonstration for the first time were able use the cost reports to better account for the expected cost of care associated with providing services. Most states and clinics did not have a cost-reporting mechanism prior to the demonstration, and therefore could not set rates that covered costs incurred by behavioral health providers in the state. Although the evaluation determined that performance on the quality measures varied across CCBHCs and states lacked a consistent pattern to determine higher or lower performance in certain states, the quality of care provided to CCBHC clients was found to be comparable to national benchmarks when available. ASPE's final Report to Congress is soon to be published and will summarize major findings around implementation, costs, and quality of care, including changes in quality measure performance across the two demonstration years.

Budget Overview

Section 223 authorized and appropriated $2.0 million in FY 2014 and $25.0 million for the planning grants in FY 2016. Amounts appropriated for this program remain available until expended. In FY 2016, $25.0 million in appropriated planning grant funding for this demonstration underwent a 6.8 percent sequestration cut which reduced the budget authority available for the planning grants to $23.3 million.

DEMONSTRATION PROJECT TO INCREASE SUBSTANCE USE PROVIDER CAPACITY UNDER THE MEDICAID PROGRAM

Program Description and Accomplishments

Section 1003 of the SUPPORT for Patients and Community Act (P. L. 115-271) required the Secretary to create a five-year demonstration for the purposes of increasing the number and capacity of providers participating in Medicaid to provide treatment for substance use disorders. The Secretary of HHS shall conduct this demonstration under the authority of Title XIX.

For the first 18-month period of the demonstration project, the Secretary shall award planning grants to at least 10 states (based on geographic diversity, with a preference to states with a prevalence of opioid use disorders comparable to or higher than the national average) to conduct the following activities:

- Activities that support the development of a behavioral health needs assessment; and
- Activities that, taking into account the results of the assessment, support the development of state infrastructure to recruit, train, and provide technical assistance to providers to treat substance use disorders and training for those providers.

For the remaining 36-month period of the demonstration, the Secretary shall select no more than five states (based on information submitted by the state in an application to the Secretary) to continue the demonstration, and to receive an FMAP of 80 percent for expenditures attributable to substance use treatment or recovery services that exceed one-fourth of funds expended by the state in FY 2018.

This provision also required CMS (in consultation with the Director of the Agency for Healthcare Research and Quality (AHRQ) and the Assistant Secretary for Mental Health and Substance Use) to submit an initial, interim, and final report to Congress based on data and reports submitted by the states on the process and outcomes of the demonstrations. CMS shall issue the reports by the following dates:

- Initial Report: October 1, 2021
- Interim Report: October 1, 2022
- Final Report: October 1, 2025

CMS released a Notice of Funding Opportunity (NOFO) for planning grants for the demonstration to increase substance use treatment provider capacity in the Medicaid program on June 25, 2019.

CMS selected and awarded $48.5 million in planning grants to 15 states on September 18, 2019. The statutory date for awarding planning grants was April 24, 2019. The target dates were pushed back to allow adequate time for statutorily required collaboration and clearances.

Selected state Medicaid agencies, were geographically diverse, and had a prevalence of substance use disorder (in particular opioid use disorder) that was comparable to or higher than the national average prevalence.

The project's timetable was modified based on an assessment of the impact of the COVID-19 public health emergency on grantee activities, as well as the April 21, 2020, extension renewal of the COVID-19 public health emergency. Pursuant to section 1135(b)(5) of the Social Security Act (Act), CMS modified the deadlines and timetables set forth in section 1903(aa) of the Act (which was added by section 1003 of the SUPPORT Act). Specifically, for all participating states, CMS modified the end date of the planning phase of the demonstration by 6 months to September 30, 2021. CMS also delayed the start of the 36-month post-planning demonstration phase by 6 months to September 30, 2021.

The Agency for Healthcare Research and Quality (AHRQ) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have met with and continue to collaborate with CMS on all activities to date.

Budget Overview

Section 1003 authorized and appropriated $50.0 million for the planning grants and $5.0 million to support the administration of the demonstration in FY 2019 to carry out this section. Amounts appropriated for this program shall remain available until expended.

Evaluation Contract

On September 1, 2020, CMS procured the services of a contractor to support the design and implementation of the evaluation of the SUPPORT Act section 1003 Demonstration Project to Increase Substance Use Provider Capacity.

The primary objectives of the evaluation are as follows:

- assess the effectiveness of the SUPPORT Act Section 1003 Demonstration Project in increasing the capacity of providers participating under the Medicaid state plan (or a waiver of such plan) to provide substance use disorder treatment or recovery services under such plan (or waiver);
- describe the activities carried out under the planning grants and demonstration project;
- determine the extent to which participating states have achieved the stated goals;
- describe the strengths and limitations of the planning grants and demonstration project;
- develop a plan for sustainability of the project based on findings from the evaluation;
- facilitate data sharing and the sharing of best practices to support dissemination of effective strategies; and
- produce four Congressionally mandated reports:
    i. Initial Report to Congress;
    ii. Agency for Healthcare Research and Quality Report to Congress;
    iii. Interim Report to Congress; and
    iv. Final Report to Congress.

Post-Planning Period

CMS issued a limited competition, notice of funding opportunity (NOFO) for the post-planning period of the demonstration project on July 9, 2021. Nine of the 15 eligible states

submitted applications by the August 20, 2021 deadline to participate in the post-planning period of the demonstration. The post-planning period began on September 30, 2021.

The following state Medicaid agencies were selected in September 2021 to participate in the 36-month post-planning period: Connecticut, Delaware, Illinois, Nevada, and West Virginia. A thorough evaluation of the technical aspects of each application was completed through an objective review process. States participating in the 36-month demonstration will receive enhanced federal reimbursement for increases in Medicaid expenditures for substance use disorder treatment and recovery services.

STATE OPTION TO PROVIDE QUALIFYING COMMUNITY-BASED MOBILE CRISIS INTERVENTION SERVICES

Program Description and Accomplishments

The American Rescue Plan Act of 2021 (Section 9813) amended Title XIX of the Social Security Act (the Act) by adding, after section 1946 (42 U.S.C. 1396w–5), the following new section: "SEC. 1947. State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services." During the period of April 1, 2022 – March 31, 2027, for the first 12 quarters of a program operating in accordance with statutory requirements, there is an increased federal medical assistance percentage (FMAP) of 85 percent for qualifying community-based mobile crisis intervention services. This provision makes available planning grants to state Medicaid agencies to support the developing of this new state option: community-based mobile crisis intervention services for Medicaid recipients in the community who are experiencing a mental health or substance use disorder (MH/SUD) crisis.

A notice of funding opportunity (NOFO), posted on grants.gov on July 13,2021, made available planning grants to states for the purpose of developing state plan amendments (SPA), section 1115 demonstrations, section 1915(b) or 1915(c) waiver program requests (or amendments) to provide qualifying community-based mobile crisis intervention services under the Medicaid program. Activities necessary for developing qualifying community-based mobile crisis intervention services that meet the conditions specified in section 1947(b) of the Social Security Act (the Act) may be included.

In September 2021, CMS awarded planning grants to Alabama, California, Colorado, Delaware, Kentucky, Maine, Maryland, Massachusetts, Missouri, Montana, Nevada, New Mexico, North Carolina, Oklahoma, Oregon, Pennsylvania, Utah, Vermont, West Virginia, and Wisconsin.

On December 28, 2021, CMS issued SHO letter 21-008 on Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services section 9813. On the January 11, 2022 All State call, CMS presented the SHO letter on mobile crisis to provide additional information to state Medicaid agencies and staff on the provision. CMS will continue to monitor state implementation of the grants, including oversight of state expenditures and provide technical assistance to states on implementation of community-based mobile crisis intervention services and review state submissions, as needed.

Budget Overview

Section 9813 authorized and appropriated $15 million for the purposes of implementing, administering, and making planning grants to states for purposes of developing a SPA or section 1115, 1915(b), or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services to remain available until expended.

Information Technology

(Dollars in thousands)

Information Technology Portfolio	FY 2021 Enacted	FY 2022 CR	FY 2023 President's Budget	FY 2023 (+/-) FY2022
Program Management	**$1,968,460**	**$2,153,695**	**$2,128,007**	**($25,688)**
Federal Administration	$41,236	$40,555	$41,499	$944
Program Operations	$1,270,568	$1,354,963	$1,392,560	$37,597
Research	$6,900	$6,999	$ -	($6,999)
Survey & Certification	$7,898	$7,871	$7,876	$5,000
Subtotal: Discretionary Appropriation	**$1,326,602**	**$1,410,388**	**$1,441,935**	**$31,547**
ACA Section 2701	$559	$497	$ -	($497)
BBA Section 50203b	$3,409	$ 1,496	$ -	($1,496)
Medicaid (4201)	$3,474	$3,846	$3,278	($568)
Pediatric Health Quality Measures	$4,582	$9,617	$12,724	$3,107
PAMA Section 210 & 216	$4,380	$3,575	$3,635	$60
No Surprises Act	$48,875	$36,172	$38,018	$1,846
Consolidated Appropriations Act	$4,978	$7,750	3,000	($4,750)
Subtotal: Mandatory Appropriation	**$70,257**	**$62,953**	**$60,655**	**($2,298)**
CLIA	$53	$61	$63	$2
COB User Fees	$10,430	$23,348	$18,730	($4,618)
Marketplace RA User Fees	$13,539	$14,913	$15,063	$150
Marketplace User Fees	$518,210	$601,983	$553,454	($48,529)
RAC MSP & Parts A/B	$13,844	$24,036	$23,934	($102)
Sale of Data	$15,525	$16,013	$14,173	($1,840)
Subtotal: Offsetting Collections	**$571,601**	**$680,354**	**$625,417**	**($54,937)**
Quality Improvement Organizations	**$267,440**	**$302,679**	**$266,234**	**($36,445)**
Innovation Center	**$217,191**	**$198,279**	**$193,434**	**($4,845)**
Health Care Fraud & Abuse	**$444,731**	**$453,256**	**$455,092**	**$1,836**
Total Information Technology	**$2,897,822**	**$3,107,909**	**$3,042,767**	**($65,142)**

Program Description

The Information Technology (IT) portfolio provides funding for all IT investments that support CMS operations. IT encompasses funding for the processing of Medicare Fee-For-Service (FFS) claims as well as infrastructure and operational support. CMS has continued to develop IT infrastructure to facilitate value-based payment arrangements and provide state flexibility to expand outcome-based payments. The IT portfolio supports the Medicare Advantage and Medicare Prescription Drug programs, beneficiary and consumer outreach programs, quality improvement activities, and ongoing research. This portfolio also funds operations and enhancements in the Medicaid and CHIP programs and other areas such as insurance market reform, oversight, and operational contracts supporting the Marketplace. A key aspect of administering these programs ensuring the security of CMS's data, systems, and IT infrastructure. In addition, this IT funding supports CMS's efforts to decrease program payment error rates and increase the program integrity return on investment (ROI).

CMS continues to focus on implementing a cloud-hosting environment throughout the agency, while refining 'single point of entry'. Shifting CMS's IT infrastructure to the cloud will make the agency's operations more cost effective, enhance collaboration, and allow for business scalability. There are currently more than 80 CMS applications and over 40 different tools running in the cloud throughout CMS. This represents both application migration and new development efforts in support of CMS Cloud adoption. To date, over 50 existing CMS applications have fully migrated to the cloud. In FY 2021, CMS added an additional 10 applications and services to the CMS Cloud ecosystem, with approximately 40 applications and/or new services in the queue for continual adoption and expansion of secure cloud at CMS. This effort of expanding CMS's cloud hosting environment will continue in FY 2023 and beyond. CMS has also developed a Data Center Optimization Initiative (DCOI) Strategic Plan. The foundation of the DCOI is to maximize efficiencies through outreach, collaboration, education and transparency to guide agency users in the adoption, implementation, and cost optimization of cloud offerings.

CMS will also continue to improve analytic capabilities and data sharing for stakeholders. CMS holds an enormous amount of unique health data on a large proportion of the U.S. population. This data is valuable, not only to CMS, but to stakeholders across government, including at state and local levels. CMS's datasets hold the potential to strengthen the evaluation of Federal and State programs for decision-making, assess the impact of policy changes, and improve outcomes of people served by multiple federal and/or state programs. In order to ensure the protection of our data, CMS will work to strengthen the access to data, timeliness of data availability, and enabling the development of additional public use files, dashboards, and other aggregated/de-identified information products for public release that can be used for research and public health purposes.

This IT portfolio provides Agency-wide IT spending across all funding sources and programs and provides a high-level view of major CMS IT investments to show how these investments relate to specific activities. While this chapter focuses on major investments, multiple non-major investments support each of the activities as well.

Funding History

Fiscal Year	Amount
FY 2019	$2,685,606,000
FY 2020	$2,994,080,000
FY 2021 Enacted	$2,897,822,000
FY 2022 CR	$3,107,909,000
FY 2023 President's Budget	$3,042,767,000

FY 2023 IT Funding Level: $3,042.8 million

The FY 2023 President's Budget request for CMS-wide IT is $3,042.8 million, a decrease of $65.1 million below the FY 2022 CR. This funding supports all CMS essential IT investments. Below are three of CMS's top priorities within the IT portfolio that account for $174.1 million of the total request.

IT Security ($110.6 million): Protecting beneficiary data continues to be a top priority. CMS faces daily cybersecurity threats from an increasingly technically advanced "bad actors" across the globe. These threats continue to intensify and diversify; therefore, CMS must enhance our IT security program to meet these risks, while still enabling the Agency to move quickly to meet its mission. The increased threats coupled with the need to keep our security infrastructure updated requires CMS to prioritize security and overall cyber resiliency.

Building on the success of the Continuous Diagnostics and Mitigation (CDM) program across cloud and on-premise data centers, several major efforts are underway to safely accelerate systems development, cloud services adoption, and data analytics. CMS has established a metrics-based ongoing authorization strategy to support data-driven decision making against a system's security posture, shifting from point-in-time annual assessments to continuous assessments. Integrated with that ongoing authorization strategy, CMS is building on the success of our cloud engineering program to offer a platform-as-a-service (PaaS) for development teams, which is projected to offer a significant reduction in time and resources spent in development and operation of a system by allowing for a standard set of security tools for the shared operating systems to boost productivity. To complement the cloud authorization strategy in Federal Risk and Authorization Management Program (FedRAMP) and safely enable business owners to adopt cloud services, CMS is building a software-as-a-service (SaaS) accreditation and governance model focused on usage and integration risk. On average, the approval time has already been reduced from approximately one year down to two months

The $110.6 million for IT security is comprised of: $105.2 million of Program Operations funding, $2.1 million in Federal Marketplace funding, $1.7 million in Innovation Center funding, $0.6 million of Health Care Fraud and Abuse Control funding, and $1 million of Federal Administration. This funding allows CMS to expand on its CDM and other security priorities.

Medicare Payment Systems Modernization (MPSM) ($38.5 million): CMS initiated the MPSM effort to maintain the reliability of Medicare as a first-class payer and to continue to support policy initiatives that reflect evolving delivery and payment methods in the healthcare industry. These efforts have improved the process and technical agility to support original Medicare policy and program implementation to best serve providers and beneficiaries' health care delivery. CMS's systems need the ability to pay for value-based care as well as the flexibility and nimbleness to keep up with the pace of innovation and legislative changes. All while providing transparency to give access to information when needed to serve policymakers, beneficiaries, and providers. The benefits of this work are already being realized.

The COVID-19 pandemic has further emphasized the need for the MPSM effort. CMS's payment systems were forced to quickly adapt to meet changing program needs during the pandemic. As MPSM continues to develop CMS will be better prepared for future necessary changes. To apply the lessons, we have learned from the pandemic and further the MSPM effort, we have moved the Medicare pricing software to a modern infrastructure that has resulted in the ability to make changes in days instead of weeks or even months. This is a byproduct of the implementation of modern technology and the improvement of the system's architecture. We anticipate that these process improvements will result in reduced costs in the future.

Modernization efforts focus on three essential building blocks – people, process, and technology. We are using human-centered design to solve business problems, migrating software to the cloud, converting from older computer languages to modern ones, and implementing Application Programming Interfaces (APIs) that allow easy, flexible access to data and system functionality. CMS is also modernizing contracting and change management processes in order to fully realize the benefits that modern technology offers. Lastly, we are arming our workforce with the knowledge and skills of modern software development principles, practices, and technology to effectively lead and manage our efforts.

Through user research, CMS has developed a vision of reusable and constantly available services that provide critical information for processing original Medicare claims and payments, such as provider data, beneficiary data, and quality measures while supporting new ways of paying for care as seen in models developed by CMS's Innovation Center. CMS will modernize strategic pieces of the Fee for Service (FFS) systems, fully integrating them with other modernized and legacy systems to ensure continued delivery of speed and reliability as the nation's top health insurance payer. CMS will also prototype solutions, where appropriate, to ensure viability and intended outcomes before significant financial investments are made. Additionally, CMS will implement additional technology and process solutions to continue increasing the efficiency of our Medicare Administrative Contractors, who not only process claims, but serve as Medicare's operational contact for providers enrolled in the program. Through these modernization efforts, CMS will remain focused on transparency and data availability that will give providers, beneficiaries, and health policy experts the information they need when they need it.

Continuity of Operations Disaster Recovery (COOP/DR) ($25.0 million): CMS continues to revitalize the agency-wide COOP and DR programs following audit findings in 2019 that determined the programs and systems that support CMS mission-essential functions require increased capabilities to meet federal requirements. CMS made major investments in FY 2020 and FY 2021 to bring its COOP and DR capabilities up to federal requirements. The operations that supported the investments made in FY 2020 and 2021 are projected to be completed by FY 2022. Moving into FY 2023 CMS's COOP and DR programs will shift from a reactive approach to proactive, by continuing to close recovery gaps and technology improvements. Future efforts will also include improving the use of the cloud environment for the CMS enterprise. In FY 2023, CMS anticipates having a base foundation for its future cloud capability and will be in the process of protecting critical IT systems in the cloud to provide an additional layer of protection to the already existing traditional data center locations. Funding will be used to expedite the implementation of COOP/DR capability for these critical IT systems.

Information Technology Portfolio Budget
By Investment Category
(Dollars in Thousands)

IT Funding by Category	FY 2021 Enacted	FY 2022 CR	FY 2023 President's Budget	FY 2023 (+/-) FY2022
Medicare Parts A & B	$279,133	$298,236	$287,192	($11,044)
Medicare Parts C & D	$81,924	$91,931	$97,091	$5,160
Medicare Outreach & Education	$54,616	$53,688	$54,572	$884
Medicaid and CHIP	$113,091	$153,087	$170,712	$17,625
Federal Marketplace	$547,702	$653,966	$598,487	($55,479)
Health Care Quality	$334,184	$366,973	$314,941	($52,032)
Enterprise IT	$1,487,172	$1,490,028	$1,519,772	$29,744
Total IT Portfolio	**$2,897,822**	**$3,107,909**	**$3,042,767**	**($65,142)**

Medicare Parts A & B

Medicare Parts A & B investments support the Fee-For-Service (FFS) and durable medical equipment (DME) claims processing operations. For these activities, CMS acts as a traditional insurance company by verifying beneficiary eligibility, enrolling providers and suppliers, and processing and paying out claims. Additionally, CMS administers a number of incentive payment programs that reward eligible providers for improving quality, reducing unnecessary resource utilization, and adopting new technologies.

Funding Level: $287.2 million

The FY 2023 President's Budget request for Medicare Parts A and B investments is $287.2 million, a decrease of $11.0 million from the FY 2022 CR. Among other efforts, this funding supports efficiencies found in the Beta tester modernization efforts for the Medicare Integrated Systems Testing (MIST).

Beneficiary Enrollment: CMS processes Medicare beneficiary enrollment and defines eligibility status. CMS works in coordination with the Social Security Administration (SSA) to verify eligibility, effectuate enrollment, and ensure that premiums are collected. CMS also works with the Railroad Retirement Board (RRB) to manage beneficiaries who receive assistance through those programs. These operations ensure consistent information on enrollment status, including whether premium payments are up-to-date, and that CMS makes appropriate claims payments.

- *Medicare Beneficiary Enrollment Data Management Systems* – These systems provide the authoritative source for Medicare beneficiary eligibility and enrollment status, ensuring that only claims for valid beneficiaries are paid. CMS manages the billing and collection of premiums for both beneficiaries and third-party payers. In coordination with investments in *Beneficiary Enrollment and Plan Payment for Part C & D,* CMS ensures beneficiaries are appropriately enrolled in the various types of insurance coverage offered by the agency.

Provider Enrollment: These investments allow providers and suppliers to enroll in Medicare by verifying their eligibility to participate. In addition, they support collecting required

information, establishing billing relationships, and screening providers to flag potential fraudulent actors.

- *Interoperability & Standardization - PECOS* – Provides the authoritative national repository of all enrolled Medicare and Medicaid providers and suppliers. Entities providing payment under Medicare are required to verify provider participation before issuing payment. This PECOS investment includes collecting and maintaining data on initial enrollment, changes of information, reassignments, and mandated revalidations or re-enrollments. CMS collects information about ownership, authorized officials, delegated officials, managing employees, practice locations, practice types, and affiliated provider information.

  In FY 2023, PECOS 2.0 will replace the current system and is focused on transitioning the current system from a single purpose product to an enterprise resource that is a platform for all enrollments across Medicare, Medicaid, and emerging provider programs. PECOS 2.0 will be a centralized system that can support the collection, screening, and processing of multiple types of enrollments (i.e. Medicare and Medicaid); as well as the operational oversight and program management functions associated with enrollment.

- *Advanced Provider Screening* – Aggregates data from multiple sources to conduct pre- and post-enrollment provider screening. This investment provides the ability to both prospectively and retrospectively assess program eligibility criteria, as well as provide additional data to further assess provider eligibility in Medicare and Medicaid, such as automatically running criminal background checks. By flagging potentially ineligible providers, CMS can take appropriate action to eliminate a potential source of fraud, waste, and abuse.

Claims Processing: Medicare FFS relies on multiple IT investments running on an integrated infrastructure to successfully process and pay claims. Claims processing includes investments that support processing appeals and ensures that Medicare is the most appropriate payer. CMS conducts extensive testing to ensure this suite of investments operates efficiently and effectively.

- *Medicare Shared Systems (MSS)* – Supports a common environment for operating legacy claims processing systems for inpatient hospital services, outpatient services, and DME. A single data source with full individual beneficiary information allows contractors to verify beneficiary eligibility, conduct pre-payment review, and approve claims. These investments support the receipt of claims, editing, pricing, adjudication, correspondence, on-line inquiry, file maintenance, financial processing, and reporting. This investment captures the Certificate of Medical Necessity and supplier interfaces specific to DME claims. Claims are screened through the Fraud Prevention System (FPS) to identify potential waste, fraud, or abuse.

- *HIPAA Eligibility Transaction System (HETS)* – Allows providers to check beneficiary eligibility for Medicare Part A and B services using HIPAA-compliant Accredited Standards Committee (ASC) X12 transactions. HETS processes close to 1.5 billion transactions per year.

- *Medicare Appeals System (MAS)* – Provides a unified appeals case-tracking system that facilitates maintenance and transfer of case-specific data with regard to FFS and Managed Care appeals. MAS is capable of docketing hearings, scheduling expert witnesses for testimony, compiling case notes, and facilitating adjudication. In addition, MAS provides the capability to report on appeals data, enabling more accurate and expedient reporting and allowing for more precise assessments and policy setting.

- *Medicare Secondary Payer System (MSPS)* – Ensures proper benefits coordination and payment recovery when Medicare is not the primary payer. MSPS collects and processes data from other insurers and employers, allowing CMS to make more accurate primary and secondary payment decisions.

- *Fraud Prevention System (FPS)* – Provides state-of-the-art analytical tools to help predict and prevent potentially wasteful, abusive, or fraudulent payments before they occur. Before Medicare fee-for-service claims are approved for payment, they are processed through FPS to identify high-risk claims for further review. Proven predictive models are used in risk scoring to generate alerts and triangulate the results to identify high-risk claims and providers.

- *Medicare Integrated Systems Testing (MIST)* – Supports and completes the integrated testing for the Fee for Service Ecosystem. This testing is designed to represent modular and integrated end-to-end testing with an improvement in agile testing methodologies for the Medicare systems.

Incentive Payment Programs: Providers and some suppliers can be eligible for payment adjustments based on participation in a variety of incentive programs. Recently, the most significant change to these programs is the Quality Payment Program (QPP), which replaced the previous physician incentive programs with a two-track system designed to modernize provider quality reporting and encourage participation in Alternative Payment Models (APMs).

- *Quality Payment Program (QPP)* – Includes two tracks for clinicians under Medicare, one through the Merit-based Incentive Payment System (MIPS), which adjusts clinicians' payment based on performance, cost, quality, improvement activities, promoting interoperability, and through participation in Advanced APMs. Clinicians who reach a certain level of participation in Advanced APMs are eligible for a five percent incentive payment from 2019 through 2024 and a higher payment update under the Medicare physician fee schedule starting in 2026. Implementing the QPP involves a significant investment to develop a single reporting portal that will allow participating clinicians to better understand the program, submit data, and review their information.

- *Hospital Quality Reporting (HQR) System* – Supports the collection and analysis of quality measures from participating hospitals in order to make appropriate payment adjustments based on performance.

- *Accountable Care Organizations (ACOs)* – Support the Medicare Shared Savings Program by providing ACO eligibility verification and beneficiary assignment, and by calculating annual expenditures, performance and quality scores, and shared

savings.

- *End Stage Renal Disease (ESRD) Quality Reporting System* – Provides a comprehensive ESRD patient registry that tracks services provided to ESRD beneficiaries for calculating performance-based payments.

Medicare Parts C and D

Medicare beneficiaries have the option of purchasing prescription drug coverage or combining some or all of their coverage options through private issuers. Prescription drug coverage (Part D) and Medicare Advantage (Part C) have different operational profiles and present different challenges than Parts A and B. Instead of interacting with and paying providers through the claims process, CMS interacts and pays private issuers through specifically designed IT systems. Business processes and IT systems are designed to manage beneficiary enrollment, ensure issuer compliance with benefit design parameters, manage special benefits, and balance risk across issuers.

Funding Level: $97.1 Million

The FY 2023 President's Budget request for Medicare Part C and D IT investments is $97.1 million, an increase of $5.1 million above the FY 2022 CR. The increase in funding supports the various activities that are needed to accurately calculate risk adjustment payments to Medicare Advantage and Part D plans. This includes system infrastructure activities that are required to collect, edit, and process detailed beneficiary specific diagnosis data, the annual development/implementation of the risk adjustment models and payment policy changes that impact both the Part C and Part D payment models and the Risk Adjustment System.

Beneficiary and Plan Management: Ensures that beneficiaries are able to enroll in Part C and D coverage. CMS works extensively with private issuers to review their plans, collect data, and ensure proper payment.

- *Beneficiary Enrollment and Plan Payment for Parts C and D* – Delivers enrollment and health plan payment for approximately 48.6 million Parts C and D enrollees. This investment is dependent upon certain beneficiary demographic and entitlement data in the *Medicare Beneficiary Enrollment Data Management* systems. CMS maintains, updates, tests, and monitors system operations for enrollment and payment functions, and provides technical assistance and customer service associated with audits and compliance.

- *Health Plan Management System (HPMS)* – HPMS is a web-enabled information system that supports the business operations of the Medicare Advantage (MA) and Prescription Drug (Part D) programs. Over 70 software modules collect data for and manage the MA and Part D program lifecycle. Funding for this system supports: application submission, formulary submission, bid and benefit package submissions, marketing material review, Part D drug pricing and pharmacy network submission, program audits and compliance oversight, performance monitoring, fraud, waste, and abuse tracking and reporting, improper payments, plan surveys, beneficiary complaint tracking, and data support for the Medicare & You handbook, Medicare Plan Finder, and Online Enrollment Center. HPMS also houses the Plan

Management Dashboard, a visual platform that organizes HPMS data and presents key performance indicators for plan compliance, fiscal soundness, marketing, contract performance, enrollment operations, and account management.

Drug Subsidies: Many Medicare beneficiaries enrolled in Part D are entitled to discounts and rebates through various programs. These investments ensure that beneficiaries receive the correct discounts and support enrollees in managing out-of-pocket expenses.

- *Drug Claims Processing System (DCPS)* – Collects, processes, and stores data from Part D claims to ensure the appropriate payment of covered drugs. Records are submitted electronically on a monthly basis and validated through automatic and manual edits. The claims are used during the payment reconciliation process in order to compare actual expenditures, including discounts for applicable drugs provided at the point-of-sale, to prospective payments made during the year. CMS coordinates the collection of discount payments from manufacturers and participating issuers.

- *Coordination of Benefits/True Out-of-Pocket (TrOOP)* – Provides real-time primary and secondary coverage information to pharmacies and Part D plans via pharmacy industry telecommunications systems. This investment provides eligibility and coverage information to pharmacies to enable real-time billing, and routes information on payments made by secondary payers back to the Part D plans.

Risk Adjustment: Ensures that each Medicare private plan issuer's risk is adjusted based on the medical experiences of individuals enrolled in their plans. Risk adjustment ensures that participating plans are not incentivized to select for healthier enrollees by transferring premiums from low to high-risk issuers.

- *Risk Adjustment Data Collection* – Calculates the risk scores for over 60 million beneficiaries. Multiple risk adjustment factors are created by analyzing the diagnosis history for each beneficiary and using statistical models to adjust the risk experienced by each Part C & D plan. The risk factors are provided to HPMS for initial, mid-year, and final reconciliation payments, as well as reruns of prior years to process overpayments.

- *Encounter Data System* – Collects beneficiary level, per-visit health care encounter data from participating issuers to enable calculation of risk coefficients that accurately reflect the demographics, patterns of care, and the predicted costs of diseases for Part C enrollees.

- *Central Data Abstraction Tool (CDAT)* – Collects diagnosis information from participating issuers to support the risk adjustment data validation (RADV) audits. CMS uses the results of these audits to estimate and recover overpayments.

Medicare Outreach & Education

Medicare Outreach and Education IT systems support the National Medicare Education Program (NMEP). Beneficiary e-Services creates a virtual, enterprise-wide, multi-contact channel for handling beneficiaries' inquiries that maximizes resources and service effectiveness. These systems support medicare.gov and cms.gov websites.

Funding Level: $54.6 Million

The FY 2023 President's Budget request for Medicare Outreach and Education is $54.6 million, a decrease of $0.8 million below the FY 2022 level. The decrease is attributed to the cost savings associated with the migration to the AWS cloud environment for the Durable Medical Equipment Prosthetics, Orthotics and Supplies Bidding System (DBidS).

- *Beneficiary e-Services* – Provides a virtual, enterprise-wide, one-stop service for handling Medicare beneficiary inquiries from multiple channels to meet the unique needs of our beneficiary population. Beneficiaries can contact CMS through beneficiary websites and portals, such as medicare.gov and 1-800 MEDICARE, that handle phone, written, and email communications. Using the Next Generation Desktop application, these processes can access CMS data systems to answer Medicare inquiries on enrollment, claims, health care options, preventive services, and prescription drug benefits. The websites offer beneficiaries interactive tools like Medicare Plan Finder and Care Compare, as well as personalized information, such as enrollment, preventive services, claims, and prescription drugs. 1-800 MEDICARE uses an interactive voice response system to provide beneficiaries with automated self-service information and options. Based on selections made, if the automated system cannot solve the caller's request, they are routed to the next available and best-qualified customer service agent to resolve their inquiry.

- *Medicare and Medicaid Financial Alignment* – Supports the implementation of State programs to integrate care for individuals enrolled in both Medicare and Medicaid. This investment focuses on technical assistance to the States who are engaged in this effort by creating and providing necessary Medicare data files, as well as guidance on the request process and the use of Medicare data.

- *Durable Medical Equipment Prosthetics, Orthotics and Supplies Bidding System (DBidS).* - A web application for Durable Medical Equipment (DME) suppliers to bid for specific product categories in a prescribed competitive bidding area. DBidS collect's the perspective supplier's organization and demographic information to determine which part of the country the supplier operates in. This data is then collected and evaluated based on the supplier's eligibility, its financial stability and the bid price. Contracts are then awarded to the suppliers who offer the best price and meet applicable quality and financial standards.

Medicaid and the Children's Health Insurance Program (CHIP)

CMS serves as the operational and policy center for the formulation, coordination, and evaluation of national policies and operations for Medicaid and CHIP. Investments in data infrastructure and systems ensure an accurate, current, and comprehensive database containing standardized enrollment, eligibility, and paid claims. This data is used to produce statistical reports, support research, and assist in the detection of fraud, waste and abuse.

Funding Level: $170.7 million

The FY 2023 President's Budget request for Medicaid and CHIP IT is $170.7 million, a $17.6 million increase from the FY 22 CR. Increased funding supports the Medicaid & CHIP quality technical assistance efforts that will be used for measure development, testing, reporting, core set policy analysis and data analytics. In addition, funding is necessary for the MACBIS enterprise services support, which program teams need to deliver valuable and quantifiable outcomes to business owners and customers. Finally, CMS anticipates an increased need for Medicaid eligibility checks, which purchase the income data transactions across the Federally-facilitated Exchange (FFE), State Based Exchanges (SBEs) and State Medicaid/CHIP agencies.

- *Medicaid and CHIP Business Information Solutions (MACBIS)* – Provides the data infrastructure and environment to facilitate collection of State-level programmatic claims data, including managed care options, beneficiary, and provider data. MACBIS automates the State plan approval process by collecting programmatic data on State Medicaid and CHIP operations. State plans support evaluation activities and ensure States remain in compliance with policies or waivers. Further, the investment supports a data analytics infrastructure for operational data about recipients, providers, claims, and encounters. This allows the States and CMS to better identify fraudulent activities and to integrate data across programs.

  There are four major information technology upgrades under MACBIS. First, the request supports ongoing operations and maintenance of the Transformed Medicaid Statistical Information System (TMSIS). Both GAO and the HHS OIG have identified the availability of quality claims and encounter data through TMSIS as a necessity of auditing and investigations and is a top priority for the Medicaid program. Second, the request supports completion of the Medicaid drug rebate system rebuild, which is critical for adequate oversight of the Medicaid drug rebate program. Third, the request supports continued work to replace the aging Medicaid financial system that tracks state financial reporting and administrative spending. Finally, the request will support the rollout of additional authorities in the Medicaid and CHIP Program (MACPro) system, which is a state-facing portal to capture states' submissions of state plan amendments, waivers, quality measures, advanced planning documents, and other documents. These MACBIS systems will give users improved access to data quality tools for analysis and evaluation for more informed decision making; allow for easier identification of priority, missing, and anomalous data; and enhance internal and external program monitoring and oversight.

- *Medicaid Data Information System* – Provides comprehensive data warehouse services with standardized enrollment, eligibility, and paid claims of dual-eligible, Medicare-Medicaid beneficiaries.

- *Sources of Income for Medicaid Eligibility* – Income data transactions that CMS anticipates will be requested across the Federally-facilitated Exchange (FFE), State Based Exchanges (SBEs) and State Medicaid/CHIP agencies. This includes approximately 20.2 million in income data transactions for State and Federal Patient Protection and Affordable Care Act eligibility determinations.

- *Technical Assistance Contracts* – State and CMS use a collaborative process of

measure development, testing, reporting and streamlining of data linkages. This provides quality improvements with states and the continued innovation of the Medicaid and CHIP Managed Care Quality Ratings System.

- *MACBIS Enterprise Services* – Innovative strategy for data management, governance, architecture, operations and data quality using a digital service and product-oriented approach.

Federal Marketplace

CMS is responsible for operating the Federally-facilitated Marketplace (FFM) in States that do not elect to set up their own State-based Marketplace. The FFM enables individuals to compare health plan options, receive eligibility determinations for a number of health insurance programs, obtain financial assistance with premiums and cost-sharing, and shop and compare health insurance plans. As enumerated below, some of these platforms support activities beyond the Marketplace, to include risk adjustment, rate review, and MLR.

Funding Level: $598.5 million

The FY 2023 President's Budget request for Federal Marketplace IT is $598.5 million, a decrease of $55.5 million below the FY 2022 level. CMS continues to discover improved methods and increase operational efficiencies such as cloud implementation and data conversion management.

The funding supports:

- *Data Services Hub* – Provides a query-based verification service for information supplied by individuals during the application process with Federal entities and private data sources. Verified data includes citizenship or immigration status, income, household size, and eligibility for Medicare, veteran's benefits, or federal employee status.

- *Health Insurance Oversight System (HIOS)* – Serves as the primary data collection system for issuer oversight and plan information. The system collects issuer data on claims for risk adjustment, rate review justifications, and medical loss ratio reporting for oversight activities.

- *Multidimensional Insurance Data Analytics System (MIDAS)* – Provides a central repository for capturing, organizing, and aggregating data for the Marketplaces.

- *Federal Health Care Marketplace (HIX)* – Provides the back-end functionality of the Federal Marketplace including plan management, eligibility, and enrollment.

- *HealthCare.gov Web Portal* – Allows individuals to search and compare health insurance plans, enroll in coverage, receive financial assistance determinations, upload documents, and submit appeals.

Health Care Quality

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through a variety of health care quality initiatives.

Funding Level: $314.9 million

The FY 2023 President's Budget request for Health Care Quality IT is $314.9 million, a decrease of $52.0 million below the FY 2022 CR. This decrease can be attributed to anticipated investments CMS plans to make in FY 2022, which will create efficiencies in adding and removing quality measures, reducing maintenance costs, and enhancing user experience as a result of current modernization efforts. These investments will enable the Quality Measure and Value Based Incentive Programs to stabilize their systems, which will ultimately lead to cost savings. CMS has also created efficiencies by phasing out QIES and continuing to transition to iQIES. Reducing these operations and maintenance costs align with CMS's current modernization and cost saving efforts.

- *Health Care Quality Improvement and Evaluation System (QIES)* – QIES is the key source of CMS's quality data, aggregating data from State Survey Agencies, Federal contractors, and QIOs to support research, analysis, and beneficiary information, such as the Nursing Home, Home Health, and Hospital Compare websites.

- *iQIES* –The iQIES system is the clinical umbrella web-based solution that has replaced a subset of legacy QIES systems. iQIES is a single application that has three major capabilities that support Patient Assessments (PA), Survey and Certifications (S&C), and Reporting. Providers can either log onto iQIES and submit their data submissions or access a web-based application for assessment record submission.

- *Quality Management and Review System (QMARS)* - QMARS is the system of record that the Beneficiary & Family Centered Care (BFCC) use to review and resolve all case review types including beneficiary complaints and appeals.

- *Quality Enterprise Services* – Provides a common architecture and system for the submission, parsing, staging, and processing of data from multiple quality programs to allow for streamlined measure reporting and calculation.

- *Quality Improvement Organizations (QIO) Information Systems* – Supports collaboration within the QIO community, coordination between CMS and the QIOs, and data collection to support operational analytics to improve the quality of care nationwide.

- *Innovation Core Systems* – Provides core IT systems that support models and demonstrations to manage their specific needs. Investments support a variety of activities, including beneficiary and provider enrollment, managing data collection, conducting analysis, and assisting in model evaluations.

Enterprise Information Technology

Enterprise IT encompasses investments, which span across multiple program areas or provide CMS-wide services. Examples of enterprise-wide investments are those associated with dual-eligible, Medicare-Medicaid beneficiaries, as well as program integrity activities that integrate data from across CMS to identify bad actors. Other investments focus on providing CMS-wide support and solutions to ensure operating and security standards are applied across CMS. These activities achieve economies of scale and allow business owners to reuse existing processes to reduce cost.

Funding Level: $1,519.8 Million

The FY 2023 President's Budget request for Enterprise IT is $1,519.8 million, an increase of $29.8 million above the FY 2022 CR. The FY 2023 request will continue ongoing IT operations, including making necessary investments in existing systems that support the effectiveness and efficiency of CMS's operations. These activities provide the operational support to manage CMS's data environment for mission-critical and enterprise-wide CMS IT strategies. These solutions continue to maximize operational efficiencies through IT modernization and cloud migration. This includes data center migration to the cloud and enterprise-wide software licenses. CMS will continue making these functional enhancements designed to optimize user interfaces, while facilitating improved compliance. Increased funding also supports the Transformed Statistical Information System (T-MSIS) State operation enhancement work and cloud conversion efforts. Efforts associated with the No Surprises Act, funded through the Consolidated Appropriations Act, 2021, which include enterprise services, web development and data collection efforts, also contribute to CMS's increase in total Enterprise IT costs.

Healthcare Integrated General Ledger Accounting System (HIGLAS): Provides a centralized and integrated dual-entry accounting system that standardizes financial accounting functions for all CMS programs.

Infrastructure and Data Management: Supports core IT infrastructure and data management for use across CMS.

- *IT Infrastructure Ongoing Operations* – Provides vital infrastructure and services to CMS employees, researchers, contractors, and beneficiaries, including unified voice, video, and data technologies. This category of investments also supports overall management of data center resources by providing single, virtual entry for accessing hosting and technology offerings, such as private cloud technologies, standardization of architecture, and service management. Other activities in this category include supporting day-to-day operations of the mainframe, network, voice, and data communications, as well as backup and disaster recovery of mission critical applications. This investment provides an enterprise approach for managing information security and privacy, and supports the Large Scale Data Repository (LSDR), allowing for a robust, stable, and effective data repository environment.

- *Information Management and Analysis* – Supports data lifecycle management by providing guidance and technical assistance in the development, maintenance, administration, and enforcement of data asset reuse and metadata standards for over 820 databases. This investment also assures system performance, data availability, communication, and disaster recovery capabilities. Additionally, it

supports coding changes and technical support for ongoing operations of legacy COBOL-based systems.

- *Systems Security* – Ensures that IT systems and data are adequately protected and meet IT security requirements. This investment includes required security control assessments and necessary employee security trainings, and also ensures that the Medicare Administrative Contractor (MACs) meet security requirements. Systems security investments also provide a full-time, enterprise cyber risk management program to maintain situational awareness of cyber threats and enables leadership to make informed decisions.

- *Integrated Data Repository (IDR)* – Provides a multi-view data warehouse orientation that is capable of integrating data on beneficiaries, providers, health plans, claims, and prescriptions, without relying on voluminous raw data extracts. The IDR provides a scalable system to meet current and expanding data volumes.

- *Chronic Condition Warehouse (CCW)* – Provides a centralized research database that combines Medicare, Medicaid, and Part D Prescription Drug Event data for individuals with chronic conditions readily available to support research activities. The CCW contains data dating back to 1999 for Medicare FFS, eligibility and enrollment, and assessments. The data is linked by a unique, unidentifiable beneficiary key, which allows researchers to analyze information across the continuum of care.

- *IT systems supporting the No Surprises Act* - CMS will leverage existing IT systems such as the Salesforce system platform, the Health Insurance Oversight System (HIOS), and the Virtual Audit Management System (VAMS), These systems will help support the following activities: dispute resolution, complaints system, help desk, data collection and gag clause attestation.

<u>*Shared Services*</u>: Provides CMS with cost-effective solutions that eliminate duplication by providing services that can be accessed across the various investments. These solutions provide standardized interfaces and reusable processes.

- *Enterprise Identity Management (EIDM)* – Ensures individuals have secure, authorized access to CMS business applications by providing a single point of entry and conducting remote identity proofing to confirm individual identities.

- *Master Data Management (MDM)* – This master directory provides a common identifier, which allows CMS to link and aggregate beneficiary, provider, program, and organization data from contrasting sources to create a trusted and authoritative data source. MDM is available to other investments, business processes, and applications, ensuring consistent display across CMS.

- *Enterprise Portal* – Provides a common portal for beneficiaries, providers, organizations, and States to access information and applications based on their roles and permissions. The portal combines and displays content and forms from multiple applications, and supports users with easy navigation, cross-enterprise search tools, simplified sign-on, and

personalized, role-based access.

<u>*Crosscutting Program Integrity*</u>: Supports CMS-wide efforts to combat waste, fraud, and abuse by linking data across CMS programs via comprehensive and integrated investments that allow for better analysis and identification of bad actors.

- *Electronic Submission of Medical Documentation (ESMD)* – Allows providers to electronically submit medical documentation in support of medical review and audit efforts in Medicare.

- *Open Payments* – Collects information on payments from drug and device companies to physicians and teaching hospitals for things like travel, research, gifts, speaking fees, and meals. This includes ownership interests of physicians or their immediate family members in these companies. Applicable manufacturers and Group Purchasing Organizations are required to report on an annual basis. The data is publicly available in an easy to use, searchable, and downloadable format.

- *Healthcare Fraud Prevention Partnership (HFPP)* – Provides an opportunity for private and public payers to collaborate on health care fraud identification and prevention activities.

- *One Program Integrity (One PI)* – Provides an integrated data warehouse, which enables state Medicaid data to be combined with claims data from Medicare Parts A, B, and D. This allows for improved analytics to detect fraud, waste, and abuse activities across multiple Medicare programs.

- *The Unified Case Management System* – Serves as a central repository for contractor workload reporting, dashboards to monitor progress, and outcome measure calculations. This investment strategically positions CMS for a coordinated approach to Medicare and Medicaid audits and investigations.

- *Enterprise solutions for the Transformed Statistical Information System (T-MSIS) – Cloud* and system enhancement solutions for the T-MSIS system that collects information that encompasses beneficiary eligibility and enrollment data, managed care and fee-for-service claims encounter data, and provider data produced in the daily operation of the Medicaid and CHIP programs

Federal Marketplace Programs

(Dollars in Thousands)

Treasury Account	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget	FY 2023 +/- FY 2022
Program Management	**$1,939,603**	**$2,116,005**	**$1,952,509**	**($163,496)**
Discretionary Appropriation	$142,455	$161,380	$157,003	*($4,377)*
Program Operations (non-add)	*$119,520*	*$137,088*	*$134,067*	*($3,021)*
Federal Administration (non-add)	*$22,936*	*$24,292*	*$22,936*	*($1,356)*
Offsetting Collections	$1,776,028	$1,931,659	$1,774,385	($157,273)
Federally-facilitated Marketplace User Fee (non-add)	*$1,729,249*	*$1,878,604*	*$1,723,469*	*($155,135)*
Risk Adjustment User Fee (non-add)	*$46,778*	*$53,054*	*$50,916*	*($2,138)*
Other	$21,120	$22,966	$21,120	($1,846)
Heath Care Fraud and Abuse Control	**$24,143**	**$31,217**	**$47,491**	**$16,274**
Discretionary Appropriation	$24,143	$31,217	$47,491	$16,274
Total Program Level	**$1,963,746**	**$2,147,222**	**$2,000,000**	**($147,222)**

Authorizing Legislation – Patient Protection and Affordable Care Act (Public Law 111–148) consolidating the amendments made by title X of the Act and the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152)

Allocation Method – Direct, Contracts, and Competitive Grants

Program Descriptions and Accomplishments

The primary goal of the Affordable Care Act (ACA) is to ensure that people in every state have access to quality, affordable health care coverage and a fully functional Marketplace in which to purchase such coverage. The ACA gives states the option of establishing a Health Insurance Marketplace®. The Marketplace must facilitate the purchase of qualified health plans (QHPs) and meet other requirements specified in section 1311(d) of the ACA. CMS operates a Federally-facilitated Marketplace (FFM) or State-Based Marketplace – Federal Platform (SBM-FP) in those states that elect not to pursue a State-based Marketplace (SBM). SBMs, together with FFM and SBM-FP states, have played a critical role in the Affordable Care Act's success in enabling people to enroll in affordable, high quality private health insurance plans.

Marketplaces provide millions of Americans access to affordable health insurance coverage. Since October 1, 2013, Marketplaces have helped individuals and small employers better understand their insurance options by assisting them in shopping for, selecting, and enrolling in high quality, competitively-priced private health insurance plans. The Marketplaces also facilitate receipt of tax credits to offset premium costs for insurance, provide cost-sharing assistance to individuals, and help eligible individuals enroll in other

federal or state insurance affordability programs. By providing one-stop shopping, Marketplaces make purchasing health insurance more understandable, giving individuals and small businesses access to increased options for, and control over, their health insurance.

CMS has worked with states and other stakeholders of interest to stabilize premiums for health plans offered on the FFM and bring more insurers back into the individual market. In 2021, the American Rescue Plan (ARP) was signed into law, which provides expanded savings and benefits to consumers for the 2021 and 2022 plan years, making coverage more accessible and affordable for consumers. In 2021, due to ongoing effects of the COVID-19 pandemic and to provide a pathway for consumers to take advantage of the new savings provided by the ARP, CMS offered a Special Enrollment Period (SEP) from February 15 to August 15. During the SEP, over 2.1 million Americans signed up for new health insurance through HealthCare.gov and 5.3 million existing HealthCare.gov enrollees obtained improved benefits as a result of ARP savings, that helped lower premiums through higher tax credits. On average, existing FFM consumers saw their premium after APTC reduced by 49%, or $53 per member per month, after the ARP implementation. SBMs also offered similar enrollment opportunities in 2021. In total through August 15, 2021, between FFM and SBM states, 2.8 million new consumers enrolled in health insurance, benefitting from the extra savings provided by ARP.

CMS also expanded the dates for the annual Marketplace Open Enrollment Period. Starting with 2022 Open Enrollment, the Open Enrollment Period now runs from November 1 to January 15. During the 2022 Open Enrollment Period, 10.3 million individuals selected plans in the FFM, the highest number of plan selections in the program to date.

CMS made a number of strategic investments in the Navigator program in 2021 and 2022 to ensure more consumers in the FFM know about and have access to Navigator assistance. CMS provided resources to Navigators to support outreach, education, and enrollment assistance during the 2021 SEP and throughout the Marketplace 2022 Open Enrollment Period. In 2021, CMS funded Navigators at a level which resulted in more than quadrupling the number of Navigators trained and certified to assist consumers for the 2022 plan year (from just over 400 for plan year 2021 to more than 1,500). This investment also resulted in Navigators operating in all FFM states, as required by statute, for the first time since 2017.

In FY 2023, CMS will continue to conduct the following core responsibilities on behalf of all Marketplaces:

- Verifying eligibility data for financial assistance through the Marketplace or other health insurance programs, including Medicaid and the Children's Health Insurance Program (CHIP);
- Ensuring proper payment of financial assistance in the form of advanced payment of the premium tax credit (APTC) to issuers where an applicant is determined eligible;
- Operating a quality rating system for display on Marketplace websites; and
- Conducting certification and oversight of SBMs.

In states electing to use the FFM, CMS will oversee these additional functions:

- Certifying qualified health plans (QHPs) and stand-alone dental plans (SADPs) after reviewing health plan benefits and rates;
- Providing individuals and families the ability to apply for and enroll in coverage, conducting enrollment reconciliation with issuers, conducting appeals, and assisting with APTC reconciliation; and
- Educating individuals about the Marketplace, including the open enrollment period (OEP), coverage options, and providing assistance to applicants and enrollees.

As a High Impact Service Provider (HISP), the Marketplace will continue to drive customer experience improvements by leveraging ongoing Marketplace consumer research, gathering feedback through surveys measuring customer satisfaction, and using research and feedback to identify opportunities to iteratively enhance consumer experience with Program services while leveraging human-centered design best practices.

Funding History

Fiscal Year	Program Level
FY 2019	$1,655,367,000
FY 2020	$1,665,775,000
FY 2021 Final	$1,963,746,000
FY 2022 CR	$2,147,222,000
FY 2023 President's Budget	$2,000,000,000

Budget Request

The FY 2023 Budget request for FFM activities is $2,000.0 million at the program level, of which $1,952.5 million is funded from several Program Management sources and $47.5 million from the discretionary Health Care Fraud and Abuse Control (HCFAC) appropriation. This budget reflects a two-and-a-half-month Open Enrollment Period, fully funds the Navigator program, and supports year-round outreach and education efforts. Year-round outreach will consist of efforts to raise awareness of an SEP for the uninsured, particularly among low income audiences and those with traditionally lower access to health care, as well as educational campaigns on topics relevant for current enrollees. Outreach efforts will continue to focus on underserved and minority populations including African Americans, Hispanics, and Asian American and Pacific Islander communities.

- *Health Plan Bid Review, Management, and Oversight:* $57.1 million. CMS oversees the annual certification process for QHPs and SADPs offered on the individual and small group markets. CMS supports the process by developing operational guidance, creating tools, providing technical assistance to issuers on certification requirements, and certifying agents and brokers to participate in the FFM. CMS supports over 5,100 QHPs and nearly 600 SADPs each year.

- *Payment and Financial Management:* $52.7 million. States and issuers supply a range of enrollment, premium, and claims data to calculate financial payments across multiple Marketplace activities using the Health Insurance Oversight System (HIOS). Marketplace-related payments leverage CMS's Healthcare Integrated General Ledger

Accounting System and financial management processes such as reporting and debt management.

Each month, CMS receives enrollment information from issuers and Marketplaces and then calculates and pays the amount of APTC owed to issuers. The IRS reconciles APTC when the individual or family files a tax return.

The Risk Adjustment program balances the risk pool of compliant plans in the individual and small group markets by transferring premium revenue from plans with below-average actuarial risk to plans with above-average actuarial risk within a market within a state. The Risk Adjustment Data Validation (RADV) program conducts reviews and audits of data that was used to calculate risk adjustment transfers. This funding supports the RADV program, through which CMS is working to strengthen financial oversight, by improving the accuracy and scope of these RADV medical records-based reviews.

- *Eligibility and Enrollment:* $377.2 million. This activity allows individuals to submit applications for health coverage throughout the year, including Open Enrollment, mid-year updates, and with Special Enrollment Periods (SEPs). Electronic applications are processed through HealthCare.gov where eligibility for financial assistance are verified through the Data Services Hub.

  When consumer-provided information does not match electronic data sources, data match inconsistencies are generated. CMS reviews consumer-submitted supporting documentation to resolve the issue. Consumers have the opportunity to appeal determinations for financial assistance and SEP eligibility. Appeal activities include processing incoming documents, reviewing appeal requests and supporting documentation, requesting information and documents from appellants, and general case management.

  CMS works with issuers to reconcile enrollment, resolving discrepancies identified through analytics or by issuers themselves. This process ensures only individuals and families who pay their monthly premium remain enrolled in coverage and that issuers receive the appropriate amount of financial assistance payments.

- *Consumer Information and Outreach:* $740.6 million. CMS ensures applicants and enrollees are fully supported not only during Open Enrollment, but throughout the plan year using mail, phone, digital communications, and HealthCare.gov. The consumer call center is the primary means for individuals to ask questions, get help with online tools, report life event changes and respond to Marketplace notices. The call center offers support in over 200 languages and is open 24 hours a day, 7 days a week. Outreach and education activities are critical to reach both the uninsured and existing enrollees. Efforts focus on building awareness of the Marketplace, Open Enrollment and other important dates and deadlines, coverage information and support, enrollment opportunities, and year-round consumer needs.

  Through the Government Printing Office, CMS prints and mails pertinent consumer notices and provides educational publications on a wide variety of topics.

  Year-round on the ground community-based support is available through Navigators that help families and underserved communities gain access to health coverage options

through the Marketplace, Medicaid, or CHIP. They assist with applications and help consumers receive financial assistance through HealthCare.gov. Navigators focus their efforts on harder-to-reach populations and the uninsured, and aim to meet the needs of underserved and diverse populations in order to promote health equity. This level of funding supports CMS's continued compliance with the statutory requirement of awarding at least one Navigator entity in each FFM state and provides FFM consumers with access to year-round, one-on-one assistance to obtain and maintain health coverage, including assistance in multiple languages to individuals with limited English proficiency.

- *Information Technology (IT):* $558.5 million. The Marketplace IT environment uses a cloud-based approach to support the consumer-facing website and tools, issuer-facing electronic data exchanges, and back end systems. The IT infrastructure is designed to support peak volumes, while ensuring a smooth user experience. New technical architecture and software code is integrated into existing production environments using a comprehensive end-to-end testing methodology that ensures existing performance levels are maintained or improved. CMS administers a comprehensive IT security program that is designed to prevent and detect intrusions into the environments. The Marketplaces also leverage existing CMS Enterprise Shared Services. Major applications that support the Marketplaces include:

    - *Data Services Hub* – Provides a query-based verification service with Federal entities and private data sources for information supplied by individuals during the application process. Verified data includes citizenship or immigration status, income, household size, and eligibility for Medicare, veteran's benefits, or Federal employee benefits.

    - *Health Insurance Oversight System (HIOS)* – Serves as the primary data collection system for issuer oversight and plan information. The system collects issuer data on claims for risk adjustment, rate review justifications, and medical loss ratio reporting for oversight activities.

    - *Federal Health Care Marketplaces (HIX)* – Provides the back end functionality of the Federal Marketplace including plan management, eligibility, and enrollment.

    - *HealthCare.gov Web Portal* – Allows individuals and families to learn about the Marketplace, complete an application, receive eligibility information including financial assistance determinations, search and compare plans, enroll in coverage, receive notices, upload documents, and manage their application and enrollment information year-round.

- *Small Business Health Options Program (SHOP):* $0.2 million. SHOPs furnish small businesses, defined as those with fewer than 50 employees, with options for providing health insurance to their employees. CMS intends to continue to fund the operation of a toll-free telephone hotline to respond to requests for assistance related to the SHOP program in FY 2023.

- *Marketplace Quality:* $7.9 million. CMS provides quality rating information using a five-star rating scale based on clinical quality measures and an enrollee satisfaction survey to give individuals and families easy-to-compare quality metrics on QHPs. Each year, an overall quality rating, along with additional ratings for the three categories (Medical

Care, Member Experience, Plan Administration) that comprise the overall rating, will be displayed during Open Enrollment to increase transparency and empower applicants to make informed health care decisions for themselves and their families.

- *Program Integrity:* $47.5 million. In coordination with efforts funded by the Health Care Fraud and Abuse Control account, this section includes work necessary to ensure program integrity in the Marketplaces. CMS is developing a methodology to measure and report estimated improper payments for APTC and will continue to strengthen oversight of State Marketplace operations. CMS will also continue to operate a consumer complaint call center, investigate complaints, and conduct investigations and data analytics using the FFM and other data sources. CMS operates focused fraud prevention efforts in areas that have high risk factors for enrollment fraud and provides oversight for agents and brokers to ensure they are in good standing with the state.

- *Planning and Performance:* $14.5 million. CMS supports general planning and oversight of Marketplace activities to ensure integration and coordination across CMS with issuers and Federal partners.

- *Administration:* $143.8 million. This funding supports staffing and administration expenses for work across the Federal Marketplace, State-based Marketplaces, and payment programs.

Nonrecurring Expenses Fund
(Dollars in Thousands)

	FY 2021 Final[1]	FY 2022 CR[2]	FY 2023 President's Budget[3]	FY 2023 +/- FY 2022
Notification[4]	$4,000	--	--	--

Authorizing Legislation
Authorization - Section 223 of Division G of the Consolidated Appropriations Act, 2008
Allocation Method - Direct Federal, Competitive Contract

Program Description and Accomplishments

The Nonrecurring Expenses Fund (NEF) permits HHS to transfer unobligated balances of expired discretionary funds from FY 2008 and subsequent years into the NEF account. Congress authorized use of the funds for capital acquisitions necessary for the operation of the Department, specifically information technology (IT) and facilities infrastructure acquisitions.

The FY 2021 NEF funds were used to right-size approximately 70,000 square feet of office space at CMS' 7111 Security Boulevard building, a leased non-main campus location. This effort (Phase 1A) is part of a larger project underway at CMS to consolidate the current real estate footprint. In FY 2021, the General Services Administration (GSA) initiated the design phase of this project which will continue until construction documents are completed in FY 2022. Construction is estimated to start in the 2nd quarter FY 2023 with completion anticipated in 4th quarter FY 2023. The purchase of new fixed furniture will be required to outfit the cubicles as well as private offices and collaboration areas. This project will be used to assist CMS in transitioning to a more remote workforce by creating reservable workspaces for all CMS staff allowing us to accelerate the release of 7210 Ambassador Road and 2810 Lord Baltimore Drive. It is estimated that CMS will be able to terminate the 7210 Ambassador Road lease as early as FY 2022 and the 2810 Lord Baltimore Drive lease on or before FY 2026 reducing the overall CMS real estate footprint, and eliminating approximately $10.4 million in annual operating costs (security and rent).

Phase 1A Components (Dollars in Thousands)		
Renovations (demo/construction including electrical, HVAC and IT)	$	2,000
Replacing outdated furniture with new fixed GSA-approved items	$	1,800
Relocation	$	200
Total NEF	$	4,000

The Real Estate Consolidation (REC) project enables CMS to comply with the OMB Memorandum M-12-12 Section 3: Reduce the Footprint. This project is a priority as it enables CMS to comply with HHS, OMB, and GSA space utilization policies. The NEF funds allow CMS

[1] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on October 22, 2020.
[2] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on June 17, 2021.
[3] The NEF CJ indicates the amounts HHS intends to notify for in 2023; these amounts are planned estimates and subject to final approval.
[4] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.

to optimize and right-size the 7111 Security Boulevard office space to eliminate a costlier CMS non-federal lease and reduce CMS' footprint.

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Drug Control Program
Department of Health and Human Services
Centers for Medicare & Medicaid Services (CMS)

(Dollars in millions except where indicated otherwise)

Resource Summary	FY 2021 Estimates	FY 2022 Estimates	FY 2023 Estimates
Drug Resources by Decision Unit and Function/Program			
Medicaid Treatment	$7,650.0	$8,450.0	$7,810.0
Total Decision Unit #1 Medicaid	**$7,650.0**	**$8,450.0**	**$7,810.0**
Medicare Treatment	$2,980.0	$3,190.0	$3,410.0
Total Decision Unit #2 Medicare	**$2,980.0**	**$3,190.0**	**$3,410.0**
Total Funding	**$10,630.0**	**$11,640.0**	**$11,220.0**
Drug Resources Personnel Summary			
Total FTEs (direct only)	--	--	--
Drug Resources as a Percent of Budget			
Total Agency Budget (in billions)[1]	$1,423.5	$1,512.9	$1,565.0
Drug Resources Percentage	0.7%	0.7%	0.7%

Program Summary

Mission

The Centers for Medicare & Medicaid Services (CMS) is strengthening and modernizing the nation's health care system to provide access to high quality care and improved health at lower cost. Through its coverage of substance use disorder (SUD) treatment services in Medicare and Medicaid, CMS helps support the goals of the Office of National Drug Control Policy (ONDCP) by providing SUD treatment to eligible beneficiaries.

Methodology

Medicaid

The projections provided in the above table were based on data from the Medicaid Analytic

[1] The total agency budget reflects only Medicare and Medicaid current law benefit costs as estimated by the CMS Office of the Actuary. The Medicaid total reflects the net outlays of Medical Assistance Payments benefit grants and the Vaccines for Children Program, administered by the Centers for Disease Control and Prevention. The Medicare total reflects gross benefit outlays.

eXtract (MAX) for Fiscal Year (FY) 2007 through 2013, based on expenditures for claims with SUDs as a primary diagnosis. Managed care expenditures were estimated based on the ratio of SUD expenditures to all expenditures for fee-for-service by eligibility group. The estimates were trended forward to FY 2020 using the growth rate of expenditures by state and eligibility category from the form CMS-64**,** Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, MAX data, and estimates are consistent with the FY 2023 President's Budget. The annual growth rates were adjusted by comparing the rate of SUD expenditure growth from FY 2007 through 2013 to all service expenditure growth and adjusting the growth rate proportionately.

Medicare

The projections of Medicare spending for the treatment of substance abuse are based on the FY 2023 President's Budget baseline. These projections reflect estimated Part A and Part B spending into FY 2023 and are based on an analysis of historical fee-for-service claims through 2020, using the primary diagnosis code[2] included on the claims. The historical trend is then used to make projections into the future. These projections are very similar to those for the FY 2022 President's Budget and vary only due to changes in the baseline.

Within this methodology, an adjustment was made to reflect spending for beneficiaries who are enrolled in Medicare Advantage (MA) plans, since their actual claims are not available. It was assumed that the proportion of costs related to substance abuse treatment was similar for beneficiaries enrolled in MA plans as for those enrolled in fee-for-service Medicare.

These estimates do not include spending under Medicare Part D because there is not a straightforward way to get this information. There is no diagnosis code associated with prescription drug claims, and drugs used to treat SUD are often also used to treat other conditions.

Budget Summary

The total FY 2023 drug control outlay estimate for CMS is $11,220.0 million. This estimate reflects Medicaid and Medicare populations and an inflation to account for the MA plans population (excluding Part D) benefit outlays for SUD treatment. Overall, year-to-year projected growth in SUD spending is a function of estimated overall growth in Medicare and Medicaid spending.

Medicaid

FY 2023 outlay estimate: $7,810.0 million
(Reflects $640.0 million decrease from FY 2022)

Medicaid is a means-tested health care entitlement program financed by the States and the Federal Government. Medicaid mandatory services include SUD services for detoxification

[2] Based on the International Classification of Diseases (ICD) coding system. The applicable ICD-9 codes for substance abuse include a subset of the 291, 292, 303, 304, and 305 category of codes; ICD-9 codes 7903, E9352, and E9401; and *Other Chronic and Potentially Disabling Conditions for Alcohol and Drug Use Disorders*, excluding V65.42 and V79.1. The applicable ICD-10 codes for substance abuse include a subset of the F10, F11, F12, F13, F14, F15, F16, F17, F18, and F19, G62, I42, K29, K70, O35, O99, P04, P96, Q86, R78, T40, T50, and T51 ICD-10 category of codes.

and treatment for SUD needs identified as part of early and periodic screening, and diagnostic and treatment services for individuals under 21 years of age. Additional Medicaid SUD treatment services may be provided as optional services. The *Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act* also requires states to cover medication-assisted treatment (MAT) from FY 2020 - FY 2025.

Medicare
FY 2023 outlay estimate: $3,410.0 million
(Reflects $220.0 million increase from FY 2022)

Medicare provides coverage of hospital, physician, skilled nursing facility, home health care, and other medical care services, as well as prescription drug coverage, to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. Medicare benefits are permanently authorized. Medicare SUD treatment benefit payments are made by Medicare Part A and Medicare Part B. This benefit outlays total includes the estimated impact for services provided to beneficiaries enrolled in Medicare Advantage. As noted above, Medicare Part D prescription drug spending is not counted in these estimates.

Equity

CMS is committed to advancing health equity including the health disparities that underline our health system, including SUD treatment services. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive. Known health disparities exist in access to SUD and related treatment services. Under the Executive Order 13985 and the Agency's prioritization of advancing health equity, CMS will complete an equity impact assessment for any changes to programs or policies, including all of the CMS programs under the HHS Overdose Prevention Strategy.

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SUPPLEMENTARY TABLES

Object Classification - Direct Budget Authority
CMS Program Management[1/]
(Dollars in Thousands)

Object Class	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget
Direct Budget Authority			
Personnel compensation:			
Full-time permanent (11.1)	$ 501,715	$ 526,989	$ 591,723
Other than full-time permanent (11.3)	$ 10,981	$ 11,266	$ 12,779
Other personnel compensation (11.5)	$ 7,620	$ 7,700	$ 8,850
Military personnel (11.7)	$ 13,472	$ 13,147	$ 13,837
Special personnel services payments (11.8)	$ -	$ -	
Subtotal personnel compensation	**$ 533,788**	**$ 559,102**	**$ 627,189**
Civilian benefits (12.1)	$ 183,527	$ 191,517	$ 209,870
Military benefits (12.2)	$ 7,246	$ 6,900	$ 7,016
Benefits to former personnel (13.0)	$ -	$ -	
Subtotal Pay Costs	**$ 724,561**	**$ 757,519**	**$ 844,075**
Travel and transportation of persons (21.0)	$ 5,282	$ 355	$ 5,282
Transportation of things (22.0)			
Rental payments to GSA (23.1)	$ 5,100	$ 5,100	$ 5,100
Communication, utilities, and misc. charges (23.3)		$ -	
Printing and reproduction (24.0)	$ 2,430	$ 2,430	$ 2,430
Other Contractual Services:			
Advisory and assistance services (25.1)	$ -	$ -	$ -
Other services (25.2)	$ 2,011,929	$ 1,968,518	$ 2,161,537
Purchase of goods and services from government accounts (25.3)	$ 2,492	$ -	$ -
Operation and maintenance of facilities (25.4)		$ -	$ -
Research and Development Contracts (25.5)	$ 20,054	$ 20,054	$ 20,297
Medical care (25.6)	$ 1,190,197	$ 1,220,768	$ 1,308,264
Operation and maintenance of equipment (25.7)	$ -	$ -	$ -
Subsistence and support of persons (25.8)	$ -	$ -	$ -
Subtotal Other Contractual Services	**$ 3,224,672**	**$ 3,209,340**	**$ 3,490,098**
Supplies and materials (26.0)	$ 766	$ -	$ -
Equipment (31.0)	$ -	$ -	$ -
Land and Structures (32.0)	$ -	$ -	$ -
Investments and Loans (33.0)	$ -	$ -	$ -
Grants, subsidies, and contributions (41.0)	$ -	$ -	$ -
Interest and dividends (43.0)	$ -	$ -	$ -
Refunds (44.0)	$ -	$ -	$ -
Subtotal Non-Pay Costs	**$ 3,238,250**	**$ 3,217,225**	**$ 3,502,910**
Total Direct Budget Authority[2/]	**$ 3,962,811**	**$ 3,974,744**	**$ 4,346,985**
Average Cost per FTE			
Civilian FTEs	4,075	4,106	4,394
Civilian Average Salary	$ 171	$ 178	$ 185
Percent change	0%	4%	4%
Military FTEs	124	124	124
Military Average Salary	$ 167	$ 162	$ 168
Percent change	0%	-3%	4%
Total OPDIV FTEs	4,199	4,230	4,518
Total OPDIV Average Salary	$ 173	$ 179	$ 187
Percent change	0%	4%	4%

[1/] This table includes discretionary funding. Indirect costs are excluded.

[2/] FY 2021 reflects the use of HHS Secretary's Transfer Authority totaling $11.933 million.

CMS Program Management
Salaries and Expenses [/1]
(Dollars in Thousands)

	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$ 501,715	$ 526,989	$ 591,723
Other than full-time permanent (11.3)	$ 10,981	$ 11,266	$ 12,779
Other personnel compensation (11.5)	$ 7,620	$ 7,700	$ 8,850
Military personnel (11.7)	$ 13,472	$ 13,147	$ 13,837
Special personnel services payments (11.8)	$ -	$ -	$ -
Subtotal personnel compensation	**$ 533,788**	**$ 559,102**	**$ 627,189**
Civilian benefits (12.1)	$ 183,527	$ 191,517	$ 209,870
Military benefits (12.2)	$ 7,246	$ 6,900	$ 7,016
Benefits to former personnel (13.0)	$ -	$ -	$ -
Total Pay Costs	**$ 724,561**	**$ 757,519**	**$ 844,075**
Travel and transportation of persons (21.0)	$ 5,282	$ 355	$ 5,282
Transportation of things (22.0)	$ -	$ -	$ -
Rental payments to GSA (23.1)	$ 5,100	$ 5,100	$ 5,100
Rental payments to Others (23.2)	$ -	$ -	$ -
Communication, utilities, and misc. charges (23.3)	$ -	$ -	$ -
Printing and reproduction (24.0)	$ 2,430	$ 2,430	$ 2,430
Other Contractual Services:			
Advisory and assistance services (25.1)			
Other services (25.2)	$ 2,011,929	$ 1,968,518	$ 2,161,537
Purchase of goods and services from	$ -	$ -	$ -
government accounts (25.3)	$ 2,492	$ -	$ -
Operation and maintenance of facilities (25.4)	$ -	$ -	$ -
Research and Development Contracts (25.5)	$ 20,054	$ 20,054	$ 20,297
Medical care (25.6)	$ 1,190,197	$ 1,220,768	$ 1,308,264
Operation and maintenance of equipment (25.7)	$ -	$ -	$ -
Subsistence and support of persons (25.8)	$ -	$ -	$ -
Subtotal Other Contractual Services	**$ 3,224,672**	**$ 3,209,340**	**$ 3,490,098**
Supplies and materials (26.0)	$ 766	$ -	$ -
Total Non-Pay Costs	**$ 3,238,250**	**$ 3,217,225**	**$ 3,502,910**
Total Salary and Expense /2	**$ 3,962,811**	**$ 3,974,744**	**$ 4,346,985**
Direct FTE	4,199	4,230	4,518

[/1] This table includes discretionary funding. Indirect costs are excluded.

[/2] FY 2021 reflects the use of HHS Secretary's Transfer Authority totaling $11.933 million.

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2021 Actual Total	2022 Est. Total	2023 Est. Total
Office of the Administrator			
Direct FTEs	21	23	23
Reimbursable FTEs	0	0	0
Subtotal	21	23	23
Center for Clinical Standards and Quality			
Direct FTEs	423	414	432
Reimbursable FTEs	67	90	90
Subtotal	490	504	522
Center for Consumer Information and Insurance Oversight			
Direct FTEs	135	136	136
Reimbursable FTEs	292	316	328
Subtotal	427	452	464
Center for Medicaid and CHIP Services			
Direct FTEs	528	530	570
Reimbursable FTEs	0	0	0
Subtotal	528	530	570
Center for Medicare			
Direct FTEs	663	668	758
Reimbursable FTEs	6	9	9
Subtotal	669	677	767
Center for Medicare and Medicaid Innovation			
Direct FTEs	0	0	0
Reimbursable FTEs	0	0	0
Subtotal	0	0	0
Center for Program Integrity			
Direct FTEs	0	0	0
Reimbursable FTEs	30	31	31
Subtotal	30	31	31
Office of Acquisition & Grants Management			
Direct FTEs	144	144	196
Reimbursable FTEs	10	11	11
Subtotal	154	155	207
Office of the Actuary			
Direct FTEs	81	80	80
Reimbursable FTEs	0	0	0
Subtotal	81	80	80
Office of Communications			
Direct FTEs	217	189	189
Reimbursable FTEs	35	60	60
Subtotal	252	249	249
Office of Information Technology			
Direct FTEs	392	396	422
Reimbursable FTEs	4	4	4
Subtotal	396	400	426
Office of Equal Opportunity and Civil Rights			
Direct FTEs	26	25	25
Reimbursable FTEs	0	0	0
Subtotal	26	25	25
Federal Coordinated Health Care Office			
Direct FTEs	24	26	26
Reimbursable FTEs	0	0	0
Subtotal	24	26	26
Office of Financial Management			
Direct FTEs	210	223	223
Reimbursable FTEs	10	10	10
Subtotal	220	233	233
Office of Hearings and Inquiries			
Direct FTEs	118	94	94
Reimbursable FTEs	0	27	27
Subtotal	118	121	121

Office of Legislation			
Direct FTEs	57	57	57
Reimbursable FTEs	0	0	0
Subtotal	57	57	57
Office of Minority Health			
Direct FTEs	26	26	31
Reimbursable FTEs	0	0	0
Subtotal	26	26	31
Office of Human Capital			
Direct FTEs	155	153	153
Reimbursable FTEs	0	0	0
Subtotal	155	153	153
Office of Strategic Operations and Regulatory Affairs			
Direct FTEs	148	147	147
Reimbursable FTEs	4	4	4
Subtotal	152	151	151
Office of Enterprise Data and Analytics			
Direct FTEs	70	71	111
Reimbursable FTEs	0	0	0
Subtotal	70	71	111
Office of Burden Reductions & Health Informatics			
Direct FTEs	36	37	37
Reimbursable FTEs	0	0	0
Subtotal	36	37	37
Office of Program Operations & Local Engagement			
Direct FTEs	580	641	652
Reimbursable FTEs	22	21	21
Subtotal	602	662	673
Emergency Preparedness & Response Operations			
Direct FTEs	9	9	9
Reimbursable FTEs	0	0	0
Subtotal	9	9	9
Office of Security, Facilities and Logistics Operations			
Direct FTEs	92	93	96
Reimbursable FTEs	1	1	1
Subtotal	93	94	97
Office of Strategy, Performance, and Results			
Direct FTEs	35	39	39
Reimbursable FTEs	0	0	0
Subtotal	35	39	39
Digital Services at CMS			
Direct FTEs	11	12	15
Reimbursable FTEs	0	0	0
Subtotal	11	12	15
Total, CMS Program Management FTE	**4,680**	**4,814**	**5,115**
Total, CMS Direct FTEs (non-add)	**4,199**	**4,230**	**4,518**
Total, CMS Reimbursable FTEs (non-add)	**481**	**584**	**596**
American Recovery and Reinvestment Act (ARRA)	*32*	*11*	*6*
CMS Military Staffing - Direct	*5*	*5*	*0*
ACA Directly Appropriated	*14*	*14*	*10*
CMS Military Staffing - Direct	*1*	*1*	*1*
PAMA/IMPACT/MACRA	*10*	*10*	*10*
CMS Military Staffing - Direct	*0*	*0*	*0*
Total, CMS Program Management FTE	***62***	***41***	***27***

1/ FY 2021 reflects actual FTE consumption.
2/ Includes FTEs funded from Program Management Federal Administration and Reimbursables only.

Average GS Grade	
FY 2019	**13.4**
FY 2020	**13.7**
FY 2021	**13.7**
FY 2022	**13.7**
FY 2023	**13.7**

CMS Program Management
Detail of Positions
(Dollars in Thousands)

	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget
Subtotal, EX	1	0	0
Total - Exec. Level Salary	$172	$172	$175
Subtotal	70	70	70
Total - ES Salaries	$13,343	$13,859	$14,056
GS-15	600	604	646
GS-14	639	644	688
GS-13	2,100	2,115	2,259
GS-12	553	557	595
GS-11	128	129	138
GS-10	0	0	0
GS-9	138	139	148
GS-8	0	0	0
GS-7	32	32	34
GS-6	1	1	2
GS-5	3	3	3
GS-4	4	4	5
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal 1/	4,199	4,230	4,518
Total - GS Salary 1/	$488,647	$516,482	$580,989
Average GS grade 1/	13.7	13.7	13.7
Average GS salary 1/	$122.040	$128.318	$134.706

1/ Reflects direct discretionary staffing within the Program Management account.

CMS Program Management
Programs Proposed for Elimination

CMS has no programs proposed for elimination within the Program Management account.

FTEs Funded by the Affordable Care Act
Centers for Medicare & Medicaid
(Dollars in Thousands)

Program	Section	FY 2012			FY 2013			FY 2014		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Health Insurance Consumer Information	1002		0			0			0	
Rate Review Grants	1003		0			0			0	
Pre-existing Condition Insurance Plan Program	1101		18			12			7	
Reinsurance for Early Retirees	1102		4			11			4	
Affordable Choices of Health Benefit Plans 2/	1311	$ 1,672,600	44		$ 2,147,742	56		$ 784,491	51	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322	$ (400,000)	6		$ (2,275,588)	18			15	
Adult Health Quality Measures 2/	2701	$ 60,000	5		$ 56,940	10		$ 40,680	9	
Medicaid Emergency Psychiatric Demonstration	2707								0	
Quality Measurement 2/	3014	$ 20,000	4		$ 18,980	6		$ 18,560	9	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		163			258			355	
Independence At Home Demonstration 2/	3024	$ 5,000	3		$ 4,745	2		$ 4,640	1	
Community Based Care Transitions	3026		2			1			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		2			1			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		1			1			1	
Community Prevention and Wellness	4202		1			1			0	
Graduate Nurse Education 2/	5509	$ 50,000	1		$ 47,450	0		$ 46,400	0	
Sunshine Act	6002		0		$ 16,050	11		$ 1,024	14	
Long Term Care (LTC) National Background Checks	6201		3			4			5	
Provider Screening & Other Enrollment Requirements 1/	6401		8		$ 5,000	10			12	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 10,000	2		$ 13,000	1		$ 3,000	1	
Expansion of the Recovery Audit Contractor Program 1/	6411		2		$ 3,300	1		$ 3,783	2	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323	$ 302,000	2		$ 417,560	1		$ 316,448	1	
Total ACA Direct Appropriated FTEs			**271**			**405**			**487**	

1/ Section 1303 of The Health Care and Education Reconciliation Act of 2010 (HCERA) provides funding that may also be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), FY 2020 (-5.9%), FY 2021 (-5.7%), FY 2022 (-5.7%), and FY 2023 (-5.7%).

FTEs Funded by the Affordable Care Act
Centers for Medicare & Medicaid
(Dollars in Thousands)

Program	Section	FY 2015			FY 2016			FY 2017		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Health Insurance Consumer Information	1002		0			0			0	
Rate Review Grants	1003		0							
Pre-existing Condition Insurance Plan Program	1101		5			0			0	
Reinsurance for Early Retirees	1102		4			0			0	
Affordable Choices of Health Benefit Plans	1311	$ 469,624	49		$ 20,163	34		$ 18,221	25	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322		0			0			0	
Adult Health Quality Measures 2/	2701		11			11			8	
Medicaid Emergency Psychiatric Demonstration	2707		1			0			0	
Quality Measurement 2/	3014		9			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		479			521			551	
Independence At Home Demonstration 2/	3024	$ 4,635	1			1			1	
Community Based Care Transitions	3026		0			1			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		1			0			0	
Community Prevention and Wellness	4202		0			0			0	
Graduate Nurse Education 2/	5509	$ 46,350	1			1			2	
Sunshine Act	6002	$ 21,399	16		$ 4,211	17		$ 5,615	22	
LTC National Background Checks	6201		5			6			6	
Provider Screening & Other Enrollment Requirements 1/	6401	$ 18,035	13		$ 3,509	14		$ 3,509	9	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 27,377	2		$ 468	2		$ 468	1	
Expansion of the Recovery Audit Contractor Program 1/	6411	$ 3,975	2		$ 468	2			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323	$ 548,548	1		$329	1			0	
Total ACA Direct Appropriated FTEs			**600**			**611**			**625**	

1/ Section 1303 of The Health Care and Education Reconciliation Act of 2010 (HCERA) provides funding that may also be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), FY 2020 (-5.9%), FY 2021 (-5.7%), FY 2022 (-5.7%), and FY 2023 (-5.7%).

FTEs Funded by the Affordable Care Act
Centers for Medicare & Medicaid
(Dollars in Thousands)

Program	Section	FY 2018			FY 2019			FY 2020		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Health Insurance Consumer Information	1002		0			0			0	
Rate Review Grants	1003		0			0			0	
Pre-existing Condition Insurance Plan Program	1101		0			0			0	
Reinsurance for Early Retirees	1102		0			0			0	
Affordable Choices of Health Benefit Plans	1311	$ 11,698	24			0			0	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322		0			0			0	
Adult Health Quality Measures 2/	2701		6			10			10	
Medicaid Emergency Psychiatric Demonstration	2707		0			0			0	
Quality Measurement 2/	3014		0			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		540			600		$ 10,000,000	528	
Independence At Home Demonstration 2/	3024		1			0			0	
Community Based Care Transitions	3026		0			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		0			0			0	
Community Prevention and Wellness	4202		0			0			0	
Graduate Nurse Education 2/	5509		2			0			0	
Sunshine Act	6002		0			0			0	
LTC National Background Checks	6201		4			6			6	
Provider Screening & Other Enrollment Requirements 1/	6401		0			0			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402		0			0			0	
Expansion of the Recovery Audit Contractor Program 1/	6411		0			0			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323		0			0			0	
Total ACA Direct Appropriated FTEs			**577**			**616**			**544**	

1/ Section 1303 of The Health Care and Education Reconciliation Act of 2010 (HCERA) provides funding that may also be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), FY 2020 (-5.9%), FY 2021 (-5.7%), FY 2022 (-5.7%), and FY 2023 (-5.7%).

FTEs Funded by the Affordable Care Act
Centers for Medicare & Medicaid
(Dollars in Thousands)

Program	Section	FY 2021			FY 2022			FY 2023		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Health Insurance Consumer Information	1002		0			0			0	
Rate Review Grants	1003		0			0			0	
Pre-existing Condition Insurance Plan Program	1101		0			0			0	
Reinsurance for Early Retirees	1102		0			0			0	
Affordable Choices of Health Benefit Plans	1311		0			0			0	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322		0			0			0	
Adult Health Quality Measures	2701		10			9			5	
Medicaid Emergency Psychiatric Demonstration	2707		0			0			0	
Quality Measurement	3014		0			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		523			513			513	
Independence At Home Demonstration	3024		0			0			0	
Community Based Care Transitions	3026		0			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		0			0			0	
Community Prevention and Wellness	4202		0			0			0	
Graduate Nurse Education	5509		0			0			0	
Sunshine Act	6002		0			0			0	
LTC National Background Checks	6201		10			6			6	
Provider Screening & Other Enrollment Requirements 1/	6401		0			0			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402		0			0			0	
Expansion of the Recovery Audit Contractor Program 1/	6411		0			0			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards	10323		0			0			0	
Total ACA Direct Appropriated FTEs			**543**			**528**			**524**	

1/ Section 1303 of The Health Care and Education Reconciliation Act of 2010 (HCERA) provides funding that may also be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), FY 2020 (-5.9%), FY 2021 (-5.7%), FY 2022 (-5.7%), and FY 2023 (-5.7%).

Physicians' Comparability Allowance (PCA) Worksheet

1) Department and component:

DHHS: Centers for Medicare and Medicaid Services (CMS)

2) Explain the recruitment and retention problem(s) justifying the need for the PCA pay authority.

In order to attract and retain highly skilled and qualified physicians, CMS uses two special pay systems: Physician's Comparability Allowance (PCA) and the Physician's and Dental Pay (PDP). Details of the PDP are not included in this report. The majority of CMS physicians receive PCA and are recruited nationwide for the Central Office and Regional Offices to support the work of Medicare and Medicaid Programs. CMS has a continual need to access highly skilled physicians to carry out the unique mission of the agency. The biggest challenge is that even with the PCA, CMS is unable to match physician salary in the private sector. Generally speaking, physicians tend to accept more private sector opportunities due to the restrictions of the GS pay scale.

3-4) Please complete the table below with details of the PCA agreement for the following years:

	FY 2021 Final	FY 2022 CR[1]	FY 2023 Estimates
3a) Number of Physicians Receiving PCAs	32	29	29
3b) Number of Physicians with One-Year PCA Agreements	1	0	0
3c) Number of Physicians with Multi-Year PCA Agreements	31	29	29
4a) Average Annual PCA Physician Pay (without PCA payment)	$172,735	$173,728	$173,728
4b) Average Annual PCA Payment	$25,652	$26,741	$26,741

5) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

Legislation over the past several years required CMS to implement new programs. Some of these mandates require establishing additional new physician positions or quickly filling vacated physician positions to fill very specific needs. Even though CMS has experienced many hurdles trying to recruit physicians, the PCA is still necessary because the candidates with quality experience make significantly more money in the private sector compared to what CMS would be able to offer them without PCA. PCA has made the salary offers more comparable to give us the opportunity to attract and hire exceptional physicians. Without this allowance, CMS would not be able to attract and retain highly qualified physicians.

6) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

The average annual PCA physician pay (without PCA payment) may increase resultant of physicians being eligible for step increases during that timeframe. The average annual PCA amounts may increase slightly as one physician completes their 24 months as a government physician. There are currently 29 Physicians in CMS receiving PCA, 18 at the maximum PCA amount of $30,000.

[1] FY 2022 data will be approved during the FY 2023 Budget cycle.

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SIGNIFICANT ITEMS AND REPORTS TO CONGRESS FOR INCLUSION IN THE FY 2023 CONGRESSIONAL JUSTIFICATION

Blue Button - The Committee believes that the Blue Button program can play an important patient safety and care coordination role for Medicare beneficiaries and their health care providers, particularly in relation to COVID–19 vaccination efforts and the increasing use of telehealth. Unfortunately, Blue Button has had a low participation rate. The Committee urges the Secretary to examine barriers to participation, including health and technology related inequities, and widely educate beneficiaries about Blue Button.

Action Taken or To Be Taken

CMS publicizes Blue Button 2.0 to Medicare beneficiaries in the Medicare & You handbook and on the Medicare.gov website (https://www.medicare.gov/manage-your-health/share-your-medicare-claims-medicares-blue-button). As of February 2022, nearly 242,000 Medicare beneficiaries have taken advantage of Blue Button. As of February 2022, there are 87 production applications and nearly 3,400 organizations working in the Blue Button sandbox. CMS intends to continue outreach to beneficiaries about the availability of Blue Button.

Community Health Workers - Given their proven effectiveness in improving health outcomes, reducing costs in underserved communities, and advancing health equity, the Committee urges CMS to continue to work with States, in partnership with community health workers and their professional organizations, to incorporate community health workers into coverage in a way that aligns with scientific evidence and fully leverages their expertise and skills.

Action Taken or To Be Taken

States may cover services furnished by community health workers (CHWs) through Medicaid state plan options including the optional screening, diagnostic, preventive services and other licensed practitioner benefits and mandatory state plan benefits such as physicians' services and federally qualified health centers. CMS has approved state plan amendments and section 1115 demonstrations that incorporate such CHW services, and these authorities are available to states on an ongoing basis. CMS is available to consider states' proposals for different or new services that CHWs are qualified to furnish, provided the services meet the requirements for the benefit. CMS encourages states that are considering covering CHWs to engage early with CMS for technical assistance in identifying which state plan benefit or other authority most accurately meets the state's needs. Additionally, in January 2021, CMS released a letter to State Health Officials that describes opportunities under Medicaid and CHIP to better address social determinants of health and includes information about how states can incorporate CHWs into care coordination teams under managed care.

Evidence-based Home Visiting Programs - The Committee recognizes the wide range of improved outcomes and cost savings that evidence-based home visiting programs provide to first-time mothers and their children. Additionally, in light of the impact of the COVID–19 pandemic on care and the rising rates of maternal and infant health disparities among families of color, the need for quality supports in the home is even greater, especially for mothers and babies. The Committee is pleased that CMS is assisting States that choose to design a Medicaid benefit package to provide home visiting services for pregnant and postpartum individuals, and for families with young children. The Committee urges CMS to continue to build upon its 2016 Joint Informational Bulletin to clearly articulate how Medicaid dollars can be used

appropriately in-home visiting programs to reach eligible families, provide streamlined coverage options for home visiting services, and cover specific components of home visiting programs.

Actions Taken or To Be Taken

CMS continues to work with its HHS partners, including HRSA, which administers the Maternal, Infant, and Early Childhood Home Visiting Program. CMS assists states that choose to design a Medicaid benefit package to provide home visiting services for pregnant and postpartum women, and for families with young children. CMS believes states are in the best position to design solutions that address the unique needs of their Medicaid-eligible populations. There are various Medicaid authorities, including state plan amendments, Medicaid demonstration waivers, and managed care, that states can utilize to incorporate components of home visiting services into their Medicaid programs.

For example, CMS has approved state requests to pilot home visiting programs under section 1115 demonstrations, including requests from Maryland and Rhode Island. Section 1115 demonstrations offer states additional freedom to test and evaluate innovative solutions to improve the quality, accessibility, and health outcomes of women and infants enrolled in Medicaid. Under its "Maryland Health Choice" demonstration, Maryland is testing an evidence-based Home Visiting Services (HVS) Pilot, through which Medicaid expenditures for evidence-based home visiting services to promote enhanced health outcomes, whole person care, and community integration for high-risk pregnant women and children up to two years of age are permitted. Rhode Island operates a statewide family home visiting services program through its section 1115 demonstration, entitled the "Rhode Island Comprehensive Demonstration". Under this demonstration, Medicaid expenditures for evidence-based home visiting services under the Nurse-Family Partnership and Healthy Families America for qualified beneficiaries are permitted.

Additionally, CMS launched the Maternal and Infant Health Initiative (MIHI) Value-Based Payment (VBP) Initiative through the Innovation Accelerator Program (IAP) to provide technical support opportunities for Medicaid/CHIP agencies. Through this initiative, states could select, design, and test VBP approaches in partnership with care delivery providers to sustain care delivery models that demonstrate improvement in maternal and infant health outcomes, including home visiting. The MIHI VBP track supported states' efforts to develop VBP approaches that sustain innovations in the delivery of maternal and child health care. The track began in July 2017 and continued through July 2019. The final evaluation of the MIHI VBP Initiative and the other initiatives through the IAP were released in September 2020[1].

Medicaid Health Home - The Committee urges the Secretary to establish standards for qualification as a Medicaid health home that ensure the requirement to ''coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times,'' is not limited to facilities with an onsite or affiliated emergency department. The requirement to include access to pediatric emergency services at all times should include facilities that coordinate with another entity that provides emergency services.

[1] The Medicaid Innovation Accelerator: Final Evaluation Report is available at: https://innovation.cms.gov/data-and-reports/2020/miap-finalevalrpt.

Action Taken or To Be Taken

On October 20, 2021, CMS released an Informational Bulletin and accompanying guidance describing best practices for coordinating care among out-of-state providers for children with medically complex conditions and considerations for ensuring such children receive prompt care from such providers when medically necessary. This guidance was released in accordance with section 1945A(e)(1) of the Social Security Act (the Act), as added by the Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16, enacted April 18, 2019) and was also informed by responses to a Request for Information issued by CMS in January 2020.

Additionally, beginning October 1, 2022, states have the option to cover health home services for Medicaid-eligible children with medically complex conditions under section 1945A, in accordance with the requirements specified the Medicaid Services Investment and Accountability Act of 2019. Beginning October 1, 2022, the HHS Secretary may award planning grants to states for purposes of developing a state plan amendment under section 1945A. A planning grant awarded to a state shall remain available until expended.

CMS expects to issue future guidance to states on the development of health homes serving children with medically complex conditions in accordance with section 1945A of the Act and will also be available to provide technical assistance to states.

IMD Exclusion Pilot Program - The Committee is aware that although HHS allows waivers to states permitting short-term stays in Institutions for Mental Disease (IMD) for mental health treatment, there are IMDs that provide care to thousands of individuals in acute psychiatric distress located in states without waivers. Congress urges CMS to pursue a pilot program allowing select IMDs that provide the majority of their care to those suffering from acute psychiatric distress to receive Medicaid funding. CMS should focus on the institutions that receive the largest volumes of cases in states that do not currently have the mental health treatment waiver and which offer longstanding, effective treatment regimens.

Action Taken or To Be Taken

To date, 8 states (including the District of Columbia) have received approval from CMS for section 1115 demonstrations waiving the IMD exclusion for Medicaid beneficiaries who are adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED). These demonstrations have enabled states to design innovative service delivery systems, including systems for providing community-based services, for adults with SMI or children with SED. With CMS approval, states may receive federal financial participation (FFP) for services furnished to Medicaid beneficiaries during short term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an IMD if those states are also using the demonstration to ensure good quality of care in IMDs and to improve access to community-based mental health services as part of a broader state strategy to improve delivery of mental health services.

Additionally, states with Medicaid managed care delivery systems can permit managed care plans to cover mental health services provided to Medicaid beneficiaries in IMDs through the “in lieu of services” authority. Federal regulations at 42 C.F.R. 438.6(e) permit states to use federal Medicaid matching funds to make capitation payments to managed care organizations or prepaid inpatient health plans on behalf of beneficiaries aged 21 to 64 receiving treatment in IMDs in lieu of covered Medicaid services if certain conditions are met. As of 2019, 32 states

reported allowing managed care plans to receive capitation payments on behalf of beneficiaries receiving treatment in IMDs using this in lieu of services authority.
Federal statute requires state Medicaid programs to make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low income patients, subject to annual DSH allotments. States have the option to make DSH payments to IMDs and certain other mental health facilities, subject to federally established annual IMD DSH limits.

Medicare Promotion - The Committee reiterates its direction that CMS avoid taking any action that actively promotes one form of Medicare coverage over another, particularly with respect to the choice between traditional Medicare and Medicare Advantage. The Committee further directs CMS to design and maintain its online coverage options tool in a manner that provides complete and unbiased information, particularly as CMS works to replace the Medicare Plan Finder with the new Medicare Coverage Tools platform. CMS should remain objective and neutral in its education and outreach materials concerning options that beneficiaries have during the open enrollment period and at any other time.

Action Taken or to be Taken

CMS has worked to ensure that Medicare beneficiaries have clear, accurate information for making choices about their Medicare coverage. CMS continually strives to improve its Medicare beneficiary outreach and education so as to support beneficiary decision making.

Our outreach goal during Medicare Open Enrollment has been to encourage beneficiaries to review and compare their Medicare coverage options, including considering whether Original Medicare or a Medicare Advantage Plan is the best choice. CMS conducts a multi-faceted campaign during Open Enrollment underpinned by this message.

The Medicare Plan Finder allows people to compare Original Medicare with Medicare Advantage Plans and Prescription Drug Plans in their area. Building on previous redesign and modernization efforts, and based on consumer feedback, CMS has continued to make changes to the Medicare Plan Finder that have focused on improving the experience for beneficiaries in using the Plan Finder to learn about different options and select coverage that best meets their health needs.

In addition, CMS has continued to update other resources for beneficiaries to use in learning about their Medicare coverage options. This includes the Medicare & You handbook mailed to beneficiary households each fall. The handbook clarifies the distinctions between Original Medicare and Medicare Advantage.

It is important that beneficiaries choose the Medicare coverage option that provides them with the care they need. CMS remains committed to making sure that Medicare beneficiaries have clear, accurate information for making that decision.

Navigators - The Committee strongly supports the Navigators program, which helps consumers understand their health coverage options and sign up for health insurance coverage during enrollment periods. The Committee urges CMS to return to providing robust funding for Navigator activities.

Action Taken or To Be Taken

Navigators help families and those in underserved communities gain access to health coverage options by helping them complete their Marketplace applications, access financial assistance through HealthCare.gov, and enroll in coverage through the Marketplace, Medicaid, or the Children's Health Insurance Program (CHIP). Navigator grant awardees include community and consumer-focused non-profits, faith-based organizations, hospitals, trade and professional associations, and Tribes or Tribal organizations.

To help communities with disproportionately high uninsurance rates, the Biden-Harris Administration quadrupled its Navigator footprint of people who can assist with the process of getting covered for the 2022 Open Enrollment Period. With more than 1,500 Navigators, the Administration made assistance available in nearly every county in the country.

CMS awarded 60 Navigator organizations $80 million in grants for the 2022 plan year, and approximately $10.2 million in additional funding was awarded to Navigators to support their additional outreach, education, and enrollment activities during the expanded HealthCare.gov Open Enrollment Period. CMS anticipates awarding $80 million per 12-month budget period for a total of $240 million for the 36-month period of performance beginning in August 2021, subject to funding availability.

Oral Health Services - The Committee urges the Chief Dental Officer to examine opportunities within existing statutory authority to expand Medicare coverage of dental services. The Committee also urges CMS to provide recommendations no later than one year after enactment of this Act regarding policies to increase coverage of, and access to, comprehensive dental benefits for adults in State Medicaid programs.

Action Taken or to be Taken

The Medicare statute excludes coverage of most dental services. Section 1862(a)(12) of the Social Security Act prohibits Medicare coverage for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services. Therefore, Medicare will cover and pay for a limited set of dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Medicare will also cover and pay for oral examinations performed on an inpatient basis as part of a comprehensive workup preceding kidney transplantation or heart valve replacement, under certain circumstances.

With respect to Medicaid, under federal law, states are required to provide dental benefits to children under 21 years of age enrolled in Medicaid and the Children's Health Insurance Program, but states have flexibility to choose what dental benefits are provided to adult Medicaid enrollees. Most states cover at least emergency dental services for adults; however, many states do not cover comprehensive dental care for all adults. On October 20, 2021, CMS published a slide deck that examines 2018 Medicaid data to calculate the number and rate, by state, of adult Medicaid beneficiaries using hospital emergency departments for dental needs

that may have been prevented with routine care; it is available at: https://www.medicaid.gov/medicaid/benefits/downloads/adult-non-trauma-dental-ed-visits.pdf.

Peripheral Artery Disease - The Committee urges CMS to raise public awareness in Medicare beneficiaries and providers of racial disparities in amputations due to peripheral artery disease, diabetes, and related comorbidities through a nationwide awareness and education campaign. Further, the Committee encourages the Secretary to establish an interagency working group in coordination with CMS, the Indian Health Service (IHS), and the Department of Veterans Affairs (VA) and to study the implementation of a comprehensive amputation reduction program with in CMS and IHS based on the VA Preventing Amputations in Veterans Everywhere Program. The Committee directs the Secretary to provide recommendations on how to reduce amputations no later than one year after enactment of this Act.

Action Taken or to be Taken

A strategic pillar of CMS's vision is to advance health equity by addressing the health disparities that underlie our health system. At CMS, for every decision being made, we are asking ourselves how it is advancing health equity. We are committed to embedding health equity and addressing health disparities in all CMS programs including by working with our colleagues in the Department of Health and Human Services. CMS offers a variety of resources to help increase awareness about health disparities. These include data snapshots highlighting disparities in different disease conditions such as diabetes and the Mapping Medicare Disparities Tool, an interactive map that identifies areas of disparities between subgroups of Medicare beneficiaries (e.g., racial and ethnic groups) in health outcomes, utilization, and spending. The data snapshots are available at: https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/information-products/data-snapshots and the tool is available at: https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities. More information on other CMS work in the area of health disparities is available at: https://www.cms.gov/About-CMS/Agency-Information/OMH.

Medicare covers several services for beneficiaries with Peripheral Artery Disease (PAD) intended to help reduce amputation. For example, Supervised Exercise Therapy for Symptomatic Peripheral Artery Disease (PAD) (NCD 20.35) which includes up to 36 sessions over a 12-week period for the treatment of symptomatic PAD if all of the required components of a SET program are met. Medicare also covers certain diagnostic tests, including Hemorheograph (NCD 250.2) which is a diagnostic instrument used to determine the adequacy of skin perfusion prior to procedures on the extremities and Plethysmography (NCD 20.14), which is the measurement and recording of changes in the size of a body part as modified by the circulation of blood in that part.

Programs of All-Inclusive Care for the Elderly - The Committee urges CMS to consider moving forward on PACE-specific pilots in fiscal year 2022, so this community-based model of care may be evaluated as to whether it increases access and affordability for Medicare or Medicaid beneficiaries.

Action Taken or to be Taken

CMS is committed to driving innovative solutions to make comprehensive health care more equitable, more accessible, and more affordable. PACE has an important role in providing integrated care. PACE provides comprehensive medical and social services that help people meet their health care needs in the community instead of going to a nursing home or other care

facility. PACE covers all Medicare- and Medicaid-covered services under the care of interdisciplinary provider teams that ensure that individuals receive the coordinated care they need. PACE will continue to be a key approach for providing access for Medicare and Medicaid beneficiaries to integrated, affordable care that is an alternative to institutional care.

Regulatory and Payment Reforms - The Committee urges CMS to work with hospitals, community-based organizations, and other stakeholders to identify substantive regulatory delivery and payment reforms that integrate behavioral health in primary care; create new and evaluate existing delivery models to improve efficiency and value-based care; and incentivize the health care workforce to meet the unmet care needs of Medicare beneficiaries in underserved areas.

Action Taken or To Be Taken

An essential pillar of CMS strategic vision for a stronger Medicare is to engage with our partners and the communities we serve. CMS must work with our partners to put people with Medicare at the center of all that we do. CMS continues to meet with stakeholders to listen to their perspectives on where we can work together to drive meaningful change in the health care system particularly on how we can advance health equity, expand access, drive high-quality, person-centered care, and promote affordability and sustainability in the Medicare program. We are committed to ensuring we integrate the perspectives of the communities that Medicare serves, as well as the hospitals, community-based organizations and other stakeholders that deliver health care, into our policies.

Integrating behavioral health care with primary care (behavioral health integration or BHI) is widely considered an effective strategy for improving outcomes for millions of Americans with mental or behavioral health conditions. Medicare makes separate payment to physicians and non-physician practitioners for BHI services they furnish to beneficiaries over a calendar month service period. CMS established codes to allow billing for monthly services using the psychiatric collaborative care model, an evidence-based approach to behavioral health integration that enhances "usual" primary care by adding care management support and regular psychiatric inter-specialty consultation, and continues to look for opportunities to improve payment for care management services such as BHI. For example, recently CMS added a new BHI service by refining coding for psychiatric collaborative care model services. CMS developed this coding in response to requests from stakeholders who reported the need for additional coding to capture shorter increments of time spent with a patient.

CMS works with stakeholders, including hospitals and community-based organizations, to implement and evaluate models to improve efficiency and increase the delivery of value-based care, and to meet the care needs of beneficiaries in underserved areas. Having taken stock of lessons learned from its first decade, the Centers for Medicare and Medicaid Innovation has charted a strategic direction to work toward those goals for the next ten years, as described in a white paper at https://innovation.cms.gov/strategic-direction-whitepaper. For example, the Community Health Access and Rural Transformation Model aims to address disparities by providing a way for rural communities to transform their health care delivery systems by leveraging innovative financial arrangements as well as operational and regulatory flexibilities. CMS also engages with hospitals and community-based organizations on regularly, such as through Open Door Forums.

The Consolidated Appropriations Act, 2021 includes a provision establishing rural emergency hospitals as a new provider under Medicare that will serve patients in rural areas. CMS will

engage with stakeholders through the rulemaking process in implementing this provision by January 1, 2023.

Robotic Stereotactic Radiosurgery - The Committee continues to support robotic stereotactic radiosurgery (SRS) and robotic stereotactic body radiation therapy (SBRT). The Committee urges CMS to maintain sufficient payment for SRS and SBRT to ensure viability in both the freestanding and hospital outpatient setting.

Action Taken or To Be Taken

Medicare payment rates for services paid under the Hospital Outpatient Prospective Payment System (OPPS) and the freestanding centers under the Medicare Physician Fee Schedule (PFS) are set in statute and may result in different rates that reflect the unique methodology for each payment system. Medicare payment rates under the Hospital OPPS are developed annually using the most recent hospital outpatient claims data and cost report data available. In contrast, payment rates for freestanding centers under the PFS are established based on national uniform relative value units that account for the relative resources used in furnishing a service for three categories of resources: work, practice expense (PE), and malpractice expense.

Most recently, for the PFS payment rates, CMS updated the supply and equipment pricing using an in-depth and robust market research study. CMS also sought information from stakeholders in the calendar year 2022 PFS proposed rule to update the supply and equipment pricing for PFS services such as SRS and SBRT. Such information may include the time involved in furnishing services; the amounts, types and prices of PE inputs; overhead and accounting information for practices of physicians and other suppliers, and any other elements that would improve the valuation of services under the PFS. CMS continues to welcome feedback from stakeholders on the updated supply and equipment pricing, including the submission of additional invoices for consideration.

Screening and Diagnostic Testing in Cancer Treatment - The Committee urges CMS to identify ways to expand access to screening and testing, especially among the most at-risk patient populations, eligibility criteria for testing and screenings recommended by USPSTF and relevant medical societies, and increase public and health care provider awareness of the importance of appropriate testing and diagnostics.

Action Taken or to be Taken

It is important to make sure individuals have access to screening and testing. Medicare covers a number of cancer screenings at zero cost to eligible beneficiaries including cervical and vaginal cancer screening, colorectal cancer screening, lung cancer screening, prostate cancer screening, and mammograms. In addition, Medicare covers diagnostic laboratory tests, including next generation sequencing when patients with germline or somatic cancer meet the requirements of the National Coverage Determination for Next Generation Sequencing. CMS will continue to review coverage policies as appropriate and keep the public informed regarding Medicare coverage of cancer screening and diagnostic testing.

STI Screening and Treatment Initiative - The Committee urges CMS to collaborate with the CDC's Division of STD Prevention to develop a screening, treatment, and education initiative under the Medicaid program.

Action Taken or To Be Taken

Under section 1905(a)(4)(C) of the Social Security Act, family planning services and supplies are mandatory benefits for Medicaid-eligible individuals of child-bearing age (including minors who can be considered to be sexually active). As such, all state Medicaid programs must offer some family planning benefits, and most provide coverage for prescription contraceptives, as well as health education and promotion, testing and treatment for sexually transmitted infections (STIs), and preconception services such as screening for obesity, smoking, and mental illness. Although STI testing is not a mandatory benefit for all eligibility groups, STI testing services that are preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) with a Grade "A" or "B" rating must be covered without cost-sharing for individuals made eligible under Medicaid expansion. States that cover all USPSTF preventive services with a Grade "A" or "B" rating without cost-sharing are eligible for a one-percentage point increase in the federal matching rate for those services.

Additionally, states are encouraged to report to CMS certain quality measures known as the adult and child "core sets"; these measure sets include certain reproductive health screenings, including cervical cancer screening for adults and chlamydia screening in women ages 16 to 24.

Mental Health Parity - The Committee continues to be concerned that 12 years since enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA), there is still a lack of oversight and compliance among insurance companies and health plans not adequately covering mental and behavioral health services and providers. In December 2019, the GAO reported that this lack of compliance extends beyond plans investigated by the Department of Labor (DOL) and includes plans over which HHS has oversight authority. The Committee urges the HHS Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, to establish a process through which employer-sponsored health plans and health insurance issuers subject to MHPAEA may submit a public report regarding nonquantitative treatment limitations while ensuring that any personal or confidential consumer information is protected. The Secretaries shall also report annually any auditing and enforcement of all plans and issuers within the jurisdiction of the respective Department.

Action Taken or To Be Taken

The Consolidated Appropriations Act, 2021 (CAA), furnished the Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments) with an important new enforcement tool by amending MHPAEA to require plans and issuers to provide comparative analyses of their non-quantitative treatment limitations (NQTLs) to the Secretary of the Treasury, the Secretary of Labor, and the Secretary of HHS (collectively, the Secretaries) upon request and to authorize the Secretaries to determine whether those NQTLs comply with MHPAEA.

The Departments recently issued the 2022 MHPAEA Report to Congress on January 25, 2022. This report highlights the Secretaries' recent emphasis on greater MHPAEA enforcement and discusses the significant resources dedicated to supporting these efforts. As the first report since the enactment of the CAA, the 2022 Report also details the efforts by the Departments to interpret, implement, and enforce the amendments to MHPAEA made by the CAA. The 2022 MHPAEA Report to Congress can be found here: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf

MHPAEA promotes equal access to treatment for MH/SUDs by prohibiting coverage limitations that apply more restrictively to MH/SUD benefits than for medical/surgical benefits. Such limitations include higher copayments, separate deductibles, and stricter preauthorization or medical necessity reviews, as compared to other medical treatments covered by a plan. CMS has increased its enforcement activities of MHPAEA requirements in the individual and fully-insured group markets in states where it has enforcement authority and over non-Federal governmental group health plans in all states (e.g. plans sponsored by state and local governments for their employees).

Health Insurance Exchange Transparency - The agreement continues bill language requiring CMS to provide cost information for the Health Insurance exchange, including all categories described under this heading in the explanatory statement accompanying division B of Public Law 115-245 (Federal Payroll and Other Administrative Costs; Marketplace related Information Technology [IT]; Non-IT Program Costs, including Health Plan Benefit and Rate Review, Marketplace Oversight, Payment and Financial Management, Eligibility and Enrollment; Consumer Information and Outreach, including the Call Center, Navigator Grants and Consumer Education and Outreach; Marketplace Quality Review; Small Business Health Options Program and Employer Activities; and Other Marketplace Activities), for each fiscal year since the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148), as well as estimated costs for fiscal year 2023.

Health Insurance Marketplaces Transparency Table

Dollars in Thousands

Activity	FY 2017 Actual	FY 2018 Actual	FY 2019 Actual	FY 2020 Actual	FY 2021 Actual	FY 2022 CR	FY 2023 President's Budget
Health Plan Bid Review, Management and Oversight	**$39,846**	**$37,910**	**$45,797**	**$45,480**	**$38,841**	**$53,615**	**$57,082**
Payment and Financial Management	**$47,640**	**$45,141**	**$50,220**	**$39,178**	**$49,821**	**$52,700**	**$52,700**
Eligibility and Enrollment [2]	**$484,144**	**$392,660**	**$348,488**	**$371,802**	**$350,482**	**$386,359**	**$377,226**
Consumer Information and Outreach	**$640,232**	**$591,948**	**$579,088**	**$503,271**	**$843,729**	**$834,395**	**$740,631**
Call Center (non-add)	*$540,197*	*$525,326*	*$499,053*	*$440,000*	*$477,247*	*$517,000*	*$491,540*
Navigators Grants & Enrollment Assisters (non-add)	*$51,166*	*$12,720*	*$19,499*	*$19,689*	*$91,233*	*$101,045*	*$89,591*
Consumer Education and Outreach (non-add)	*$16,599*	*$10,744*	*$11,231*	*$14,082*	*$245,749*	*$184,350*	*$130,000*
Information Technology	**$710,867**	**$767,413**	**$504,283**	**$549,369**	**$515,388**	**$608,332**	**$558,477**
Quality	**$7,301**	**$7,240**	**$7,334**	**$7,063**	**$6,391**	**$7,285**	**$7,875**
SHOP and Employer Activities	**$16,500**	**$4,418**	**$2,117**	**$200**	**$197**	**$196**	**$190**
Other Marketplace	**$49,584**	**$31,196**	**$40,290**	**$63,579**	**$38,827**	**$60,539**	**$62,018**
Federal Payroll and Other Administrative Activities	**$79,602**	**$70,892**	**$77,750**	**$85,833**	**$120,071**	**$143,800**	**$143,800**
Total	**$2,075,714**	**$1,948,818**	**$1,655,367**	**$1,665,775**	**$1,963,746**	**$2,147,222**	**$2,000,000**

[2] Funding for Enrollment Assisters ended in FY 2017.

Note: Fiscal years 2010 through 2021 include obligations as of September 30 of each year.
Note: Before the Marketplaces were transferred to CMS, $4.7 million and $66.3 million in obligations were incurred in FY 2010 and FY 2011, respectively.

Health Insurance Marketplaces Transparency Table

Dollars in Thousands

Activity	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Actual
Health Plan Bid Review, Management and Oversight	$0	**$300**	**$21,936**	**$40,595**	**$33,497**	**$43,960**	**$40,520**
Payment and Financial Management	$0	**$1,698**	**$24,998**	**$25,832**	**$49,615**	**$43,733**	**$51,325**
Eligibility and Enrollment [3]	$0	**$2,218**	**$3,433**	**$275,501**	**$339,754**	**$363,768**	**$445,249**
Consumer Information and Outreach	$0	**$2,427**	**$32,610**	**$701,075**	**$704,136**	**$753,238**	**$805,833**
Call Center (non-add)	*$0*	*$0*	*$22,000*	*$505,446*	*$545,600*	*$566,178*	*$563,638*
Navigators Grants & Enrollment Assisters (non-add)	*$0*	*$0*	*$0*	*$107,513*	*$97,152*	*$75,996*	*$99,677*
Consumer Education and Outreach (non-add)	*$0*	*$0*	*$7,043*	*$77,436*	*$49,334*	*$54,897*	*$101,048*
Information Technology	**$2,346**	**$92,672**	**$166,455**	**$402,553**	**$770,957**	**$798,648**	**$664,083**
Quality	**$0**	**$0**	**$0**	**$0**	**$17,189**	**$15,634**	**$11,736**
SHOP and Employer Activities	**$0**	**$366**	**$18,479**	**$25,076**	**$30,541**	**$42,717**	**$34,520**
Other Marketplace	**$1,879**	**$14,906**	**$13,738**	**$4,400**	**$6,728**	**$3,614**	**$12,032**
Federal Payroll and Other Administrative Activities	**$429**	**$10,805**	**$43,493**	**$68,429**	**$80,000**	**$80,000**	**$85,000**
Total	**$4,654**	**$125,392**	**$325,142**	**$1,543,461**	**$2,032,418**	**$2,145,312**	**$2,150,297**

[3] Funding for Enrollment Assisters ended in FY 2017.

Note: Fiscal years 2010 through 2021 include obligations as of September 30 of each year.
Note: Before the Marketplaces were transferred to CMS, $4.7 million and $66.3 million in obligations were incurred in FY 2010 and FY 2011, respectively.

Page

CMS SPECIFIC ITEMS

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Program Management Proposed Law Summary

- **Provide CMS Mandatory Funding to Implement Legislative Proposals**

  This request includes $300 million in proposed mandatory funding to cover the costs associated with implementing the Department's proposed legislative changes to Medicare, Medicaid, and CHIP.

Program Management Appropriation Summary

Proposed Law

(Dollars in Thousands)

Activity	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget
Program Operations /1	$2,772,890	$2,784,823	$2,957,300
Discretionary Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$2,772,890	$2,784,823	$2,957,300
Federal Administration	$772,533	$772,533	$895,424
Discretionary Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$772,533	$772,533	$895,424
State Survey & Certification	$397,334	$397,334	$494,261
Discretionary Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$397,334	$397,334	$494,261
Research, Demonstration & Evaluation /2	$20,054	$20,054	$0
Discretionary Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$20,054	$20,054	$0
Discretionary Appropriation, Net	**$3,962,811**	**$3,974,744**	**$4,346,985**
Discretionary Appropriation, Proposed Law	**$0**	**$0**	**$0**
Total Appropriation, Proposed Law	**$3,962,811**	**$3,974,744**	**$4,346,985**

/1 FY 2021 total reduced to reflect $11.933 million in HHS Secretary's Transfer Authority.

/2 In FY 2023, the funding request is included within Program Operations.

Page

CMS PERFORMANCE APPENDIX

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PROGRAM OPERATIONS

MCR9: Ensure Beneficiary Telephone Customer Service

Measure	FY	Target	Result
MCR9.1a: Quality Standards: Minimum of 90 percent pass rate for Adherence to Privacy Act	2023	90%	October 31, 2023
	2022	90%	October 31, 2022
	2021	90%	99% (Target Exceeded)
	2020	90%	99% (Target Exceeded)
	2019	90%	99% (Target Exceeded)
	2018	90%	98% (Target Exceeded)
	2017	90%	98% (Target Exceeded)
	2016	90%	98% (Target Exceeded)
MCR9.1b: Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment	2023	90%	October 31, 2023
	2022	90%	October 31, 2022
	2021	90%	99% (Target Exceeded)
	2020	90%	99% (Target Exceeded)
	2019	90%	94% (Target Exceeded)
	2018	90%	97% (Target Exceeded)
	2017	90%	97% (Target Exceeded)
	2016	90%	96% (Target Exceeded)
MCR9.1c: Quality Standards: Minimum of 90 percent meets expectations for Knowledge Skills Assessment	2023	90%	October 31, 2023
	2022	90%	October 31, 2022
	2021	90%	95% (Target Exceeded)
	2020	90%	93% (Target Exceeded)
	2019	90%	95% (Target Exceeded)

	2018	90%	97% (Target Exceeded)
	2017	90%	97% (Target Exceeded)
	2016	90%	95% (Target Exceeded)
Measure	**FY**	**Target**	**Result**
MCR9.3: Minimum of 90 percent pass rate for the Customer Satisfaction Survey	2023	90%	October 31, 2023
	2022	90%	October 31, 2022
	2021	90%	94% (Target Exceeded)
	2020	90%	94% (Target Exceeded)
	2019	90%	94% (Target Exceeded)
	2018	90%	94% (Target Exceeded)
	2017	90%	93% (Target Exceeded)
	2016	90%	92% (Target Exceeded)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.

The Contact Center Operations (CCO) handles both beneficiary (Medicare) and consumer (Marketplace) inquiries. A CMS Quality Call Monitoring process is used by the CCO to evaluate each Customer Service Representative's (CSR's) performance in responding to telephone inquiries. The CCO is responsible for evaluating and scoring each CSR's performance each month in handling telephone inquiries using the quality standards of privacy act, knowledge skills, and customer skills.

For each fiscal year, the CCO has met or exceeded the target of 90 percent for each standard. Despite exceeding targets in previous reporting years, CMS will continue to maintain the quality standards target levels at 90 percent. In order to increase contact center quality standards, contact centers would need to increase the amount of quality assurance staff responsible for monitoring and coaching. This would mean additional costs for the contractors supporting the contact center. The resources required to ensure a higher quality metric would be better allocated to the increased contacts associated with the incoming baby boomer population.

Since FY 2009, the CCO has been assessed annually by an Independent Quality Assurance (IQA) contractor. The intent of this assessment is to gather more detail on where improvements can be made in handling telephone inquiries, to better serve the calling population. There is currently a parallel effort between the CCO and the IQA

contractor to assess quality through quality monitoring tools – but for separate purposes.

The CCO contractor uses Quality Call Monitoring for coaching individual CSRs. Alternatively, CMS' IQA contractor uses Quality Call Monitoring to assess quality from a global perspective, as well as to identify processes and areas needing attention and make specific recommendations regarding quality improvements. Part of the IQA Plan addresses quality oversight of English and Spanish inbound and outbound telephone and written correspondence, as well as e-mail, web chat, and faxed inquiries. CMS will use the results of the IQA audits for root cause analysis and for identifying areas of improvement for training and content materials as well as any other tools currently available to CSRs.

Since 2009, this performance measure has been based on survey methods designed by CMS, with questions approved by the Office of Management and Budget (OMB). The survey measures a variety of customer service dimensions, including overall satisfaction, program knowledge, clarity, rapport, customer effort, and First Call Resolution, capturing an aggregated score of these dimensions.

Our call centers are achieving and advancing Equity as follows: 1-800 MEDICARE and the Federal Marketplace Call Center both provide a language translation line that supports inquiries for over 200 languages. Both call centers also provide a TTY line and CMS supports FTC technologies for assistive services for those that are hearing impaired.

MCR12: Maintain CMS' Improved Rating on Financial Statements

Measure	FY	Target	Result
MCR12: Maintain an unmodified opinion	2023	Maintain an unmodified opinion	November 15, 2023
	2022	Maintain an unmodified opinion	November 15, 2022
	2021	Maintain an unmodified opinion	Target Met
	2020	Maintain an unmodified opinion	Target Met
	2019	Maintain an unmodified opinion	Target Met
	2018	Maintain an unmodified opinion	Target Met
	2017	Maintain an unmodified opinion	Target Met
	2016	Maintain an unmodified opinion	Target Met

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.

The Chief Financial Officers (CFO) Act of 1990 creates a framework for the federal government to focus on the integration of accounting, budget, and other financial activities under one umbrella. This is meant to reduce waste and to provide complete, reliable, timely, and consistent information to Congress on the financial status of the federal government.

CMS's annual goal is to maintain an unmodified opinion, which indicates that its financial statements fairly present, in all material respects, the financial position, net costs, changes in net position, budgetary resources, and the projected future value of Medicare's social insurance programs. An independent audit firm reviews the financial operations, internal controls, and compliance with laws and regulations at CMS and its contractors.

CMS met its FY 2021 target of maintaining an unmodified opinion on four out of the six principal financial statements. During FY 2021, the auditors could not express an opinion on the CMS Statement of Social Insurance (SOSI) or the CMS Statement of Changes in Social Insurance Amounts (SCSIA). CMS has been substantially compliant with the Federal Financial Management Improvement Act (FFMIA) since FY 2010. CMS considers its financial systems to be integrated in accordance with OMB Circular A-127, *Financial Management Systems.* The Healthcare Integrated General Ledger Accounting System (HIGLAS) is CMS's official financial system of record used to produce its financial statements. Overall, CMS continued to improve its financial management performance in many areas, as evidenced by no material weaknesses being reported as a result of the agency's CFO audit and OMB Circular A-123 review. In addition, CMS provided a FY 2021 Federal Managers' Financial Integrity Act

(FMFIA) statement of reasonable assurance regarding the Agency's internal controls over financial reporting for June 30 and September 30.

MCR26: Reduce All-Cause Hospital Readmission Rates for Medicare Beneficiaries

Measure	CY	Target	Result
MCR26: Reduce all-cause hospital readmission rate by 1% per year from the prior year's actual rate[1] Baseline: 18.7% (based on CY 2010	2023	TBD	March 1, 2023 (based on CY 2021 data)
	2022	17.5%	April 30, 2022 (based on CY 2020 data)
	2021	17.5%	17.8% (Target Not Met) (based on CY 2019 data)
	2020	17.5%	17.7% (Target Not Met) (based on CY 2018 data)
	2019	17.4%	17.7% (Target Not Met) (based on CY 2017 data)
	2018	17.8%	17.6% (Target Exceeded) (based on CY 2016 data)
	2017	17.4%	18.0% (Target Not Met) (based on CY 2015 data)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.

[1] CMS targets reduction of all-cause Medicare hospital readmissions by one percent (not to be confused with one percentage point) per year from the prior year's actual rate (if available) or the prior year's target for the time period when the prior year's actual rate is not yet known. To meet or exceed the Target, the Result must be less than or equal to the calculated Target.

A "hospital readmission" occurs when a patient who has recently been discharged from a hospital is once again readmitted to a hospital. A thirty-day period for readmission data has been standard across the quality measure industry for several years. One way that the Medicare statute incentivizes hospitals to reduce preventable readmissions is through the Hospital Readmissions Reduction Program (HRRP). Established by Congress beginning in FY 2013, the HRRP reduces a statutorily defined portion of Medicare's payment amounts for certain potentially preventable Medicare inpatient hospital readmissions covering three conditions: Acute Myocardial Infarction, Pneumonia, and Congestive Heart Failure. For FY 2015 and beyond, two additional readmission measures were added to the program: (1) Chronic Obstructive Pulmonary Disease and (2) Total Hip Arthroplasty and Total Knee Arthroplasty. For FY 2017 and beyond, CMS established an additional measure for patients readmitted following Coronary Artery Bypass Graft Surgery, and CMS refined the Pneumonia readmission measure cohort. Additionally, the 21st Century Cures Act required CMS to assess a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid beginning in FY 2019.

In addition to the HRRP, CMS leverages efforts of other programs to reduce hospital readmissions. Among these are the Quality Improvement Network – Quality Improvement Organizations that work to reduce preventable complications (e.g. sepsis by proper diagnosis and treatment of bacterial infection while in the hospital) during a transition from one care setting to another, which includes partnership with the Community-Based Care Transitions Program and Quality Improvement

Organizations. CMS' efforts to reduce readmissions also extend to Accountable Care Organizations, which must report on and meet targets for quality measures if they wish to receive incentives under the Medicare Fee-for-Service Shared Savings Program, and to CMS Innovation Center's Bundled Payments for Care Improvement Advanced Model, which includes a readmissions measure to encourage hospitals and their care teams to collaborate and ensure that they provide appropriate discharge planning, instructions, and follow up care to patients to help reduce the risk of readmission.

CMS addresses health equity using two important policy tools, payment and providing feedback to hospitals on their patients. The Cures Act of 2016 mandated that CMS penalize hospitals that perform poorly on their HRRP measures beginning with 2019 payment, compared to other hospitals that treat a similar proportion of dual-eligible Medicare/Medicaid beneficiaries.

CMS also provides hospitals with confidential feedback reports on their patients. Our experience with both Quality Improvement Network – Quality Improvement Organizations and HRRP have demonstrated that these reports can help target disparities to improve their health equity on hospital readmissions. CMS provides hospitals with annual confidential feedback reports on HRRP readmission measure performance for dual-eligible Beneficiaries. Hospitals can review their dual-eligible readmission measure performance relative to non-dual-eligible Beneficiaries, and relative to other hospitals treating dual-eligible Beneficiaries. In CY 2022, CMS is also targeting to expand its health equity confidential feedback to hospitals to stratify readmission measure performance by race and ethnicity.

CMS did not meet its target for CYs 2019, 2020, and 2021 following one year, CY 2018, where its target was exceeded. This followed two years, CYs 2017 and 2016, where the targets were not met. Overall the readmission rates continue to appear to be relatively constant since CY 2015 following a historical pattern of slight reductions (the slight increase in CY 2017 appears to be an anomaly). It is unclear whether this trend will continue or whether rates will increase or decrease further. In light of these results and impacts of the PHE, CMS set slightly less aggressive targets for CY 2021 and CY 2022. CMS set the 2022 target at 17.5 percent based on the CY 2021 result. CMS will continue to monitor the data and will report on the CY 2022 target in the first half of 2022. The CY 2023 target will be set when CY 2020 data is received and calibrated.

Note: CMS recognizes that the COVID-19 Public Health Emergency (PHE) likely impacted hospital readmission, case mix, and admission volume trends since the early 2020 PHE declaration. CMS will incorporate this information into our CY 2022 report that measures calendar year 2020 discharge results.

MCR36: Shift Medicare Health Care Payments from Volume to Value

Measure	FY	Target	Result
MCR36: Increase the percentage of Traditional Medicare health care dollars tied to Alternative Payment Models (APMs) incorporating downside risk	2023	TBD	TBD
	2022	TBD	TBD
	2021	40%	December 15, 2022
	2020	30%	24.2% (Target Not Met)
	2019	Baseline	20.21%

The Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS), through the Center for Medicare and Medicaid Innovation (CMMI), identifies, tests, evaluates, and expands, as appropriate, innovative payment and service delivery models. The Medicare Shared Savings Program Accountable Care Organizations (ACOs) also play an integral role in moving Medicare toward value-based payment models and person-centered care, with over 11 million people with Medicare receiving care from a health care provider in a Shared Savings Program ACOs as of January 1, 2022. These innovative payment and service delivery models can reduce program expenditures for Medicare, Medicaid, and the Children's Health Insurance Program, while improving or preserving beneficiary health and quality of care.

To further accelerate movement away from paying volume and towards paying for value and outcomes, CMS is launching a bold new strategy with the goal of achieving equitable outcomes through high quality, affordable, person-centered care. On October 20, 2021, CMS published a white paper detailing CMS's vision for the next 10 years (Innovation Strategy Refresh). As part of this strategic refresh, CMS set a new 10-year Medicare goal and target to have all beneficiaries in a care relationship with accountability for quality and total cost of care by 2030. This new care relationship goal measures the amount of Traditional Medicare dollars tied to APMs, as defined by the Health Care Payment Learning and Action Network's (LAN) Refreshed APM Framework. CMS is working with LAN partners and reevaluating the current APM methodology for this measure by including future targets and to ensure alignment with the new CMS 2030 goals.

CMS did not meet its FY 2020 target because of the unprecedented impact of the COVID-19 pandemic, more limited opportunities for enrollment in new CMMI models, and a plateauing of participation in the Medicare Shared Savings Program. CMS is currently planning to establish FY 2022 and FY 2023 targets during the next budget cycle.

MCR37: Increase Patient Choice in Dialysis Treatment

Measure	CY	Target	Result
MCR37: Increase the percentage of new dialysis patients who choose home dialysis modalities	2023	23.60%	June 30, 2024
	2022	22.57%	June 30, 2023
	2021	19.92	June 30, 2022
	2020	19.02	20.52% (Target Exceeded)
	2019	Baseline	18.11%

This measure monitors the number of new End-Stage Renal Disease (ESRD) patients that start dialysis with a home modality within 180 days of initial dialysis. This measure focuses on increased patient choice to use home dialysis.

The U.S. Department of Health and Human Services (HHS) has a goal of 80 percent of new ESRD patients either receiving dialysis at home or receiving a transplant by 2025. The targets set for this measure up to 2021 are calculated based on a 10 percent relative increase in measure rate starting from the 2019 baseline to 2021. For example, CY 2020 target is 19.02 percent (5 percent relative increase over baseline) and CY 2021 target is 19.92 percent (10 percent relative increase over baseline). The target for 2022 is based on the observed measure rate in 2020 and uses a similar calculation. For example, the observed measure rate in 2020 was 20.52 percent, then a 10 percent relative increase over 2 years to 2020 yields a target of 22.57 percent. Similarly, a 15 percent relative increase between 2020 and 2023 yields a target of 23.60%. To calculate this measure, home dialysis is defined as receiving dialysis treatments in a home setting. This includes both peritoneal dialysis and home hemodialysis. The admission and treatment records data collected in ESRD Quality Reporting System (EQRS) is used as the data collection source for dialysis facilities. Other aligned CMS efforts around home dialysis include work on the Kidney Care Choices (KCC) Model and the ESRD Treatment Choices (ETC) Model.

The ESRD Networks are addressing health equity by utilizing a home dialysis change package, which adopts a mindset that home dialysis is possible and all patients should be considered. The change package is a set of best practices that provide a set of evidence-based interventions for use by ESRD Networks to increase home dialysis usage and address identified health equity issues. Distinct interventions related to health inequities will be added to the change package when it is revised later this contract year. The Networks will use the data analysis of disparities and evaluation of grievances to identify improvement areas for ESRD patients. The Networks will also be conducting listening and learning sessions with dialysis patients, Office of Minority Health, and dialysis facilities to advance the work of health equity.

Studies have shown that use of home dialysis results in better or equal clinical outcomes and reduced hospitalization as compared to In-Center Hemodialysis (ICHD). Patients who choose home dialysis for treatment report more energy, flexible treatment schedules, fewer diet and fluid restrictions and more freedom to travel. Despite these reported benefits, in 2019 home dialysis was still underutilized in the U.S. with approximately 13.5 percent of the dialysis patients undergoing renal replacement therapy at home versus approximately 86.5 percent being treated with in-center hemodialysis ESRD Network Program Summary Reports. Home dialysis modalities includes:

- Peritoneal Dialysis (PD): This treatment uses the patients' peritoneum and dialysis fluid to filter waste and extra fluid utilizing a catheter that is placed in the abdomen. It can be done almost anywhere, including home, school, work and while traveling. A patient can complete this treatment without any assistance.

- Home Hemodialysis (HHD): Similar to in-center hemodialysis, HHD cleans a patients' blood utilizing a vascular access site (e.g., arteriovenous fistula, arteriovenous graft), dialysis machine and an artificial kidney (i.e., filter). The HHD machines are smaller and portable than in-center, allowing for patients to dialyze at home or when traveling. Most often a care partner is required for treatment, but some new technology allows for patients to dialyze unaided.

Data from the U.S. Renal Data System (USRDS) indicate that annual cost of home dialysis is substantially less than in-center dialysis for qualified patients. The annual cost of in- center therapy for all modalities is approximately $78,049 a year versus approximately $66,751 for therapy at home—a difference of $11,298 per year.

There are a number of barriers related to increasing the use of home dialysis. Key examples include: 1) lack of patient and provider education about home dialysis modalities, 2) provider hesitancy to refer patients due to lack of familiarity with the referral process and requirements with home dialysis, and 3) lack of psychosocial and financial support for patients and care partners.[1] Current ESRD Network projects focus efforts to mitigate these challenges. As a result of the ongoing work of the ESRD Network Program Summary Reports, specifically the 2020 home dialysis quality improvement activity, in which Networks partnered with all dialysis facilities nationwide, 14.7% of ESRD patients use a home dialysis modality which is an increase of 1.2% from 2019, representing an approximate cost savings of $54 million. CMS continues to promote increased use of home dialysis modalities through the ESRD Networks' Quality Improvement Activity (QIA) projects and other collaborative activities with the renal community.

However, as of March 2020, the COVID-19 pandemic added new vulnerabilities that may negatively impact the agency's ability to meet performance targets in a timely manner. Note, initiating home with new ESRD patients could be protective, and reduce the chances of contracting COVID, as compared to in-center hemodialysis.

[1] Chan, Christopher T. et al. Exploring Barriers and Potential Solutions in Home Dialysis: An NKF-KDOQI Conference Outcomes Report. American Journal of Kidney Diseases (March 2019), Volume 73, Issue 3, 363-371

There continues to be a shortage of dialysis staff to train patients to utilize a home modality or participate in ESRD Networks quality improvement efforts to support the patient's choice of a home modality. The ESRD Networks are continuing to: 1) provide educational materials to patients and dialysis facility staff, 2) maintain communication with the renal community in an effort to increase the number of patients dialyzing at home, and 3) vaccinate dialysis patients and staff for COVID-19. Starting on June 1, 2021, the ESRD Networks began implementing quality improvement efforts nationally, including a focus on home dialysis and COVID-19 vaccinations. Home dialysis goals for the 5-year contract period through May 2026, includes:

- 60% increase in the number of incident patients starting dialysis with a home modality, and;
- 30% increase in the number of prevalent patients moving to a home dialysis modality.

MMB2: Reduce All-Cause Hospital Readmission Rate for Medicare-Medicaid Enrollees

Measure	CY	Target	Result
MMB2: Reduce All-Cause Hospital Readmission Rate for Medicare-Medicaid Enrollees Baseline: 92.7[1] (Readmissions per 1,000 Beneficiaries)	2023	0.25% Reduction from 2022 Actual	April 30, 2025
	2022	0.25% Reduction from 2021 Actual	April 30, 2024
	2021	0.25% Reduction From 2020 Actual	April 30, 2023
	2020	0.5% Reduction From 2019 Actual	April 30, 2022
	2019	1% Reduction From 2018 Actual	84.6 per 1000 (Target Not Met)
	2018	1% Reduction From 2017 Actual	83.7 per 1000 (Target Not Met) (0.9% below 2017 actual)
	2017	Historical Actual	84.5 per 1000 (0.8% above 2016 actual)
	2016	Historical Actual	83.7 per 1,000 (0.4% below 2015 actual)
	2015	Historical Actual	84.0 per 1,000 (0.8% above 2014 actual)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.
[1] The methodology for this goal was updated in 2017 to reflect changes in the Yale readmissions measure used in Medicare's Hospital Readmissions Reduction Program (HRRP). This is the measure upon which this goal was developed. As a result of the revised methodology that eliminated the old data coding, CMS re-calculated the prior years' reports (including the 2012 baseline), since they were based on outdated Yale measure specifications. The new calculation ensures consistent methodology across all years.

A "hospital readmission" occurs when a patient who has recently been discharged from a hospital is once again readmitted to a hospital. A thirty-day period for readmission data has been standard across the quality measure industry for several years. Discharge from a hospital is a critical transition point in a patient's care; incomplete handoffs at discharge can lead to adverse events for patients and avoidable readmissions. Hospital readmissions may indicate poor care or missed opportunities to better coordinate care, and may result in unnecessary costs.

While many studies have pointed to opportunities for improving hospital readmission rates, the rate of readmissions for individuals who are dually eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees) is often higher than for Medicare beneficiaries overall. During 2020, an estimated 12.3 million beneficiaries were dually eligible for Medicare and Medicaid.

Compared to non-dually eligible Medicare beneficiaries, dually eligible individuals have higher rates of chronic and co-morbid conditions and higher rates of

institutionalization, in addition to challenges posed by low socioeconomic status. As a result, CMS seeks to assess the impact of interventions on this sub-population.

CMS calculates this measure using the number of readmissions per 1,000 eligible beneficiaries. Eligible beneficiaries are dually eligible individuals of any age.

From 2012 to 2019, we saw an 8.7 percent decrease in the readmission rate (from 92.7 readmissions per 1,000 dually eligible beneficiaries, to 84.6 per 1,000). However, the rate of decrease appears to be slowing. From 2018 to 2019, CMS found a slight increase in the readmissions rate in this measure of 1.07 percent. Similarly, in MCR26: *Reduce All-Cause Hospital Readmission Rates for Medicare Beneficiaries by One Percent over the Previous Year's Actual Rate* measure, we found a slight increase in the readmission rate and an overall stabilization of the rate in recent years. Therefore, CMS recommends maintaining the target reduction rate of 0.25 percent for CY 2023 based on this measure's apparent plateau and national trends reflecting a slowing in readmissions reductions for all Medicare beneficiaries (after a number of years of larger declines). COVID-19 Public Health Emergency (PHE) impacts are not reflected in this year's report, which only captures data through December 31, 2019.

At CMS there are a number of programs and innovations aimed at incentivizing a reduction in Medicare fee-for-service hospital readmissions, including for dually eligible individuals. While CMS is seeing a plateauing in the measure results, CMS continues to focus on reductions through, for example:

- The Medicare-Medicaid Financial Alignment Initiative managed fee-for-service demonstration in Washington State, which focuses on improving care coordination for high-risk dually eligible beneficiaries and holds the state accountable for readmission and associated costs;
- The Medicare Hospital Readmissions Reduction Program (HRRP), which in FY 2019 began assessing a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full Medicaid benefits;
- The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) program, which rewards SNFs with incentive payments based on hospital readmissions;
- Accountable care organizations, including the Medicare Shared Savings Program (MSSP); and
- An array of CMS Innovation Center models with financial incentives to reduce utilization and readmissions, including the Bundled Payments Care Improvement (BPCI-A) initiative, the ACO REACH model, and Primary Care First.

CMS continues to improve our existing quality programs and develop new models focused on value-based care. These initiatives create strong incentives to reduce hospital readmissions, including for dually eligible individuals.

MMB3: Support Integrated Care for Medicare-Medicaid Dually Eligible Individuals

Measure	FY	Target	Result
MMB3: Number of full benefit dually eligible individuals in Medicare Medicaid integrated care nationally	2023	Contextual Measure	Nov 30, 2023
	2022	Contextual Measure	Nov 30, 2022
	2021	Contextual Measure	1,550,608
	2020	Contextual Measure	1,107,518
	2019	Contextual Measure	1,006,927
	2018	Baseline	832,494

Over 12 million Americans are concurrently enrolled in both the Medicare and Medicaid programs. Overall, dually eligible individuals have a higher prevalence of many health conditions than their Medicare-only and Medicaid-only peers. These individuals must navigate two separate programs: Medicare for the coverage of most preventive, primary, and acute health care services and drugs, and Medicaid for coverage of long-term services and supports (LTSS), certain behavioral health services, and for help with Medicare premiums and cost sharing.

A lack of alignment and cohesiveness between the Medicare and Medicaid programs can lead to fragmented and episodic care for dually eligible individuals and misaligned incentives for both payers and providers. This may result in reduced quality and increased costs to both programs and to enrollees. Dually eligible individuals could benefit from more integrated systems that meet all of their care needs – primary, acute, long-term, behavioral, and social – in a high quality, cost-effective manner. Better alignment of the administrative, regulatory, statutory, and financial aspects of these two programs holds promise for improving the quality and cost of care for this complex population.

In recent years, CMS has partnered with states to develop innovative, integrated care and financing approaches. 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 Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), the Programs of All-inclusive Care for the Elderly (PACE), and integrated care models and demonstrations such as the Medicare-Medicaid Financial Alignment Initiative. Over the past several years, CMS has worked extensively with states to help them to understand, develop, and implement integrated care programs, increasing beneficiary access to quality integrated care. Promoting integrated care through these approaches, and maximizing their value to beneficiaries, is a high priority for CMS. Most recently, in January 2022, CMS released a Notice of Proposed Rulemaking (NPRM) to further improve integration of Medicare and Medicaid programs for dually eligible individuals enrolled in D-SNPs. The provisions of the NPRM build on the

Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), Bipartisan Budget Act of 2018, experience administering the MA and Part D programs, and experiences with the Financial Alignment Initiative to better align and integrate benefits for dually eligible individuals. Specifically, CMS proposed requirements for enrollee participation in D-SNP governance, standardized questions about housing, food insecurity, and transportation in all special needs plan health risk assessments, and new pathways toward greater transparency and accountability for D-SNPs.

Since 2011, the number of full-benefit dually eligible individuals in integrated care and/or financing models has increased from 161,777 to 1,550,608[2]. In 2021, about 18 percent of full benefit dually eligible individuals are enrolled in integrated care programs. Barriers to integrated care include state capacity, misaligned enrollment across Medicare and Medicaid health plans, and other factors. Data for FY 2023 for this contextual measure will be available in fall 2023, following an annual process through which CMS works with contractors, state officials, and public data sources to update the total number of people in integrated care.

[2] Additional information regarding total integrated care enrollment by program type is available https://www.cms.gov/files/document/reporttocongressmmco.pdf

MEDICARE SURVEY & CERTIFICATION PROGRAM

MSC5: Decrease the Percentage of Long-stay Nursing Home Residents Receiving an Antipsychotic Medication

Measure	CY	Target	Result
MSC5: Decrease the population of long stay nursing home residents receiving an antipsychotic medication*	2023	14.7%	July 31, 2024
	2022	15.0%	July 31, 2023
	2021	15.3%	July 31, 2022
	2020	15.4%	14.5% (Target Exceeded)
	2019	15.5%	14.0% (Target Exceeded)
	2018	16.0%	14.6% (Target Exceeded)
	2017	16.)%	15.4% (Target Exceeded)
	2016	16.7%	16.7% (Target Met)
	2015	17.9%	17.1% (Target Exceeded)

*Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budget

The purpose of this performance measure is to decrease the use of antipsychotic medications in nursing homes with an emphasis on improving dementia care. These medications have common and dangerous side effects when used for the behavioral and psychological symptoms of dementia.

In 2012, CMS began a nationwide initiative - the National Partnership to Improve Dementia Care in Nursing Homes - to improve dementia care and reduce the use of antipsychotic medications. CMS staff works with partners, including state coalitions, provider associations, nursing home resident advocates, and stakeholders, to decrease the use of these drugs. Some of this work includes developing and conducting trainings for nursing home providers, surveyors, and consumers; conducting research; raising public awareness; using regulatory oversight; improving surveyor guidance; national calls with the public; and public reporting, to increase transparency. CMS hopes to enhance person-centered care for all nursing home residents, particularly for individuals living with dementia.

A number of evidence-based, non-pharmacological interventions and approaches have been reviewed by national scientists and thought leaders through the National Partnership to Improve Dementia Care. These have been incorporated into clinical practice guidelines and various tools and resources and are now posted on the CMS website at National Partnership to Improve Dementia Care in NH. State Coalitions are reaching out to providers in every state and encouraging the use of these resources, as well as Hand in Hand, the training for nursing home staff developed by CMS. A number of meta-analyses have reviewed the use of non-pharmacological approaches to behaviors in people with dementia. Studies have shown that these interventions may be effective in reducing behaviors associated with dementia that may be distressing to residents or families.

Person-centered care is an approach that focuses on residents as individuals, and supports the caregivers working most closely with them. It utilizes a continual process of listening, testing new approaches, and changing routines and organizational strategies in an effort to individualize and de-institutionalize the care environment. Person-centered care is the central theme of the Hand in Hand training.

Since inception, the partnership has utilized a multidimensional approach, which includes public reporting, partnerships and state-based coalitions, research, and training for providers and surveyors.

CMS launched the Civil Money Penalty Reinvestment Program (CMPRP), a multi-year effort to reduce adverse events, improve staffing quality and improve dementia care in nursing homes. The efforts related to improving dementia care have provided direct assistance to nursing homes through one-on-one technical assistance and peer-to-peer learning using a breakthrough community model. Because of this effort, a toolkit, entitled Developing a Restful Environment Action Manual (DREAM), was developed and disseminated nationwide.

In July 2012, CMS began posting on the Care Compare web site, quality measures of antipsychotic use in long-stay and short-stay nursing home residents, excluding residents with schizophrenia, Tourette's syndrome, or Huntington's disease. In 2015, CMS added the quality measures to the Five-Star Quality Rating System on the website.

For this goal, CMS reports the prevalence of antipsychotic use in the last three months of the fiscal year. The numerator consists of long-stay residents receiving an antipsychotic medication on the most recent assessment. The denominator is all long-stay nursing home residents, excluding residents with schizophrenia, Tourette's syndrome, or Huntington's disease. Residents are considered to be long-stay residents if they have resided in the nursing home for 101 or more days. The baseline number reflects the prevalence of use in the last quarter of the calendar year 2011. It was selected because it was the last quarter in the pre-intervention period.

In 2011 Q4, 23.9 percent of long-stay nursing home residents were receiving an antipsychotic medication; since then there has been a decrease of 39.4 percent to a national prevalence of 14.5 percent in 2020 Q4. Success has varied by state and CMS region, with some states and regions having seen a reduction of greater than 45 percent.

MSC7: Improve Staffing Reports to Support Better Outcomes for Residents of Long Term Care (LTC) facilities

Measure	FY	Target	Result
MSC7: Percentage of LTC facilities submitting complete staffing data through the Payroll-Based Journal (PBJ)	2023	98%	December 31, 2023
	2022	97.5%	December 31, 2022
	2021	96.9%	97% (Target Exceeded)
	2020	95.8%	95.8% (Target Met)
	2019	95.6%	96.7% (Target Exceeded)
	2018	Baseline	95.2%

Defined as the percentage of providers whose data meet the criteria to be included in the public use file.

This measure aims to improve CMS' ability to publicly report information about the staffing in long-term care (LTC) facilities, and ultimately improve care. Staffing levels, turnover, and tenure can have a significant impact on the quality of care provided by LTC facilities. This information is also very important to consumers when selecting or evaluating a LTC facility.

As of July 1, 2016, LTC providers are required to electronically submit staffing data that is auditable back to payrolls and other verifiable information in accordance with 42 Code of Federal Regulations (CFR) §483.70(q) under current law. Receiving complete staffing data from providers is essential in order to calculate and publicly report accurate staffing measures, which is the primary intent of the new program.

To publish accurate information, it is critical for CMS to obtain complete data from providers, which this measure seeks to address. In April 2018, CMS began using this data to calculate staffing measures and star ratings as part of the *Five Star Quality Rating System*. Stakeholders and LTC facilities use the published information to identify targets for staffing that lead to better outcomes for residents.

To incentivize improvement, CMS adjusts how a provider is reported on Nursing Home Compare, now known as Care Compare, and in the Nursing Home Five Star Quality Rating System (e.g., suppress or reduce ratings). This has proven to be an effective method to improve reporting in the past. Also, CMS is conducting audits of the data submitted by providers, and will use the results of those audits to evaluate other actions that may be needed to improve the data submitted.

Baseline data for FY 2017 indicated 90.3 percent (14,162) of facilities submitted staffing data. CMS notes that this is a new program, and therefore difficult to predict the trajectory of performance. CMS will adjust the targets (lower or higher) as needed to ensure realistic and appropriate goals. Results will be calculated after the end of the first quarter for each fiscal year. For FY 2019, 96.7 percent of facilities submitted staffing data, exceeding the target of 95.6 percent. CMS believes this positive result is attributed to actions CMS has taken to rapidly improve reporting, such as suppressing or downgrading facilities' star ratings if their data is not reported or inaccurate. Due to this result, CMS increased the targets for FYs 2020 and 2021 slightly because the trend for improvement decreased the second half of FY 2019 and the percent of providers reporting may be nearing a threshold of a maximum achievable level (i.e., ceiling). For 2021, 97 percent of facilities submitted data, meeting the target of 96.9 percent.

Due to the COVID-19 public health emergency (PHE), CMS waived the deadline to report the 2020 Fiscal Quarter 2 PBJ data (January 1, 2020 through March 31, 2020). Facilities were encouraged to report data as they were able to and maintain a lower target percentage due to the challenges nursing homes faced during this PHE. Although they were expected to report staffing thru PBJ using the waiver guidelines, there were issues with hard hit nursing homes. Therefore, CMS did not impose penalties, and there were no negative impacts to staffing ratings not submitted by May 15, 2020. It should be noted that 60 percent of all nursing homes did submit staffing data during this quarter, and all data received will be publicly posted but not applied to ratings.

The PBJ waiver was removed at the end of June 2020, and all nursing homes were expected to report staffing for the remaining three quarters of CY 2020. Even with three quarters of reported data applied to the 2020 target prediction, the FY target is not being changed. This is because these predictions are based on CY fourth quarter reports, and historically, adjacent quarters of calendar years have reported very similar results.

MEDICAID

MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (CHIP) through Implementation of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality initiatives

Measure	FY	Target	Result
MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (CHIP) through Implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Initiatives	2023	Work with States to ensure that 95% of States report on at least fourteen quality measures in the CHIPRA children's core set of quality measures	June 1, 2024
	2022	Work with States to ensure that 90% of States report on at least thirteen quality measures in the CHIPRA children's core set of quality measures	June 1, 2023
	2021	Work with States to ensure that 90% of States report on at least twelve quality measures in the CHIPRA children's core set of quality measures	February 28, 2023
	2020	Work with States to ensure that 90% of States report on at least twelve quality measures in the CHIPRA children's core set of quality measures	92% of States reported on at least twelve quality measures (Target Exceeded)
	2019	Work with States to ensure that 90% of States report on at least eleven quality measures in the CHIPRA children's core set of quality measures	94% of States reported on at least eleven quality measures (Target Exceeded)
	2018	Work with States to ensure that 90% of States report on at least eleven quality measures in the CHIPRA children's core set of quality measures	86% of States reported on at least eleven quality measures (Target Not Met)
	2017	Work with States to ensure that 90% of States report on at least eleven quality measures in the CHIPRA children's core set of quality measures	88.2% of States reported on at least eleven quality measures (Target Not Met)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.

The purpose of this measure is to improve the quality of children's health care across Medicaid and CHIP.

CMS exceeded the goal of 90 percent of states reporting on at least twelve quality measures through FY 2020, with 92 percent of states reporting at least twelve measures. A new target for FY 2023 was set for 95 percent of states reporting on at least fourteen quality measures.

Section 1139A of the Social Security Act establishes a national pediatric quality measures program. The first step in the development of this program was the publication of an initial core set (Child Core Set) of 24 children's quality measures in 2010. The 2020 Child Core Set contains 24 measures. While the use of the Child Core Set is voluntary for states until FY 2024, CMS encourages all states to use and report on the Child Core Set to collect data that will lead to improved health outcomes and enhance the accuracy and applicability of the pediatric quality measures program. By encouraging states to report the core measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for children in Medicaid and CHIP.

Since 2014, CMS has hosted a Medicaid and CHIP track at annual CMS Quality Conferences. The conference agendas included interactive sessions on the core measures related to data collection, reporting, and quality improvement. CMS also annually releases an updated Child Core Set Technical Specifications and Guidance for Reporting Manual, which contains technical instructions for collecting and calculating the core set measures for Medicaid and CHIP programs.

CMS will continue to work with its Technical Assistance/Analytic Support (TA/AS) contracting team to provide states with specific clarifications on measurement collection questions, hold all-state webinars as well as one-on-one calls with states around specific measurement challenges, and publish technical assistance briefs designed to provide states with guidance on measurement collection and reporting.

By using a multi-pronged approach to providing Technical Assistance (TA), CMS targets States that are already reporting multiple measures as well as those that are just beginning to understand how to collect and report them. Further, as the TA/Analytic Support program continues to mature, CMS is also expanding the scope of the TA to help states understand how to use the data they collect to drive quality improvement at the state and programmatic levels.

CMS also anticipates that states may want to prioritize certain voluntary core measures for collection and reporting in order to target improvement strategies, rather than reporting on a large volume of measures.

It is significant to note that the Bipartisan Budget Act of 2018 (P.L. 115-123), also referred to as the ACCESS Act, requires state reporting on Child Core Set measures starting in 2024. This new requirement will likely result in an uptick in child core set reporting by states. CMS will be providing guidance and significant technical assistance to states to help them prepare for mandatory reporting.

Findings from state reporting on the Child Core Set are published annually and available on the webpage Children's Health Care Quality Measures of Medicaid.gov and on https://data.medicaid.gov/.

Note: CMS is developing a new quality measure reporting system. The development of this new system will impact both the timing of FY 2021 state core set reporting and the release of data. The table reflects the expected date when the FY 2021 data will be available. However, it is important to note that there could be additional delays, which would also impact the timing of FY 2022 reporting.

MCD7: Improve Access to and Utilization of Oral Health Care Services for Children Covered by Medicaid and Medicaid Expansion CHIP Programs

Measure	FY	Target	Result
MCD7: Increase the national rate of low income children and adolescents, who are enrolled in Medicaid and Medicaid expansion Children's Health Insurance Programs (CHIP), who receive any preventive dental service Baseline: 43%	2023	+10 percentage points over 2011 baseline	October 15, 2024
	2022	+9 percentage points over 2011 baseline	October 15, 2023
	2021	+8 percentage points over 2011 baseline	October 15, 2022
	2020	+7 percentage points over 2011 baseline	43% (Target Not Met)
	2019	+6 percentage points over 2011 baseline	52% (Target Exceeded)
	2018	+5 percentage points over 2011 baseline	51% (Target Exceeded)
	2017	+4 percentage points over 2011 baseline	51% (Target Exceeded)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.

CMS did not meet the FY2020 target. The FY 2020 result does not include Idaho due to issues with the state's submission of annual CMS-416 data from which data is drawn for the annual GPRA reporting. There was a significant disruption in state performance, which is likely to continue into FY 2021, due to families foregoing preventive care during the COVID-19 pandemic. Dental services were impacted to a greater extent than most other types of services. Comparing March 2020–May 2021 to the same period in 2019, the data shows about 24% fewer dental services being provided. This included a steep drop-off in March and April 2020, when most dental practices in the country were closed for routine care. See slide 22 of the Medicaid and CHIP and the COVID-19 Public Health Emergency: Preliminary Medicaid and CHIP Data Snapshot. CMS is working with states to regain the ground lost due to foregone care.

Prior to the pandemic, states' efforts over the past decade have resulted in improved access to dental care for children covered by Medicaid and Medicaid expansion CHIP programs. Between FY 2007 and FY 2019, 38 states achieved at least a ten percentage point increase in the proportion of enrolled children, ages 1-20, who received a preventive dental service during the reporting year. Despite this improvement, only 52 percent of all enrolled children nationally received a preventive dental or oral health service in FY 2019. CMS engaged in a vigorous fact-finding process in the late 2000s to understand the issues related to state performance on children's access to dental care. To help improve performance, from 2010 to 2015 CMS implemented the Oral Health Initiative 1.0. This initiative worked with federal and state partners, the dental and medical provider communities, children's advocates, and other stakeholders to expand the number of dental professionals participating in Medicaid and to increase the awareness of the need for dental care

among beneficiaries in order to continue to improve children's access to dental care, with an emphasis on prevention.

Since 2016, the Oral Health Initiative (OHI) 2.0 has taken an integrated approach to quality measurement and improvement, including identifying opportunities across CMCS to engage with states through existing levers such as Section 1115 demonstration renewals and State Plan Amendment reviews and approvals, and providing technical support to promote oral health's importance within broader Medicaid and CHIP program objectives. For example, CMS has been deeply engaged with California's Dental Transformation Initiative, which dedicates $740 million to test several strategies to improve oral health in the state's 1115 demonstration. The State reports that the proportion of children ages 1-20 who have received preventive dental services has risen from 37 percent in FY 2015 to 47 percent in FY 2019. OHI's nonitiative staff are assisting California in applying lessons learned from this demonstration to its State Plan as the state concludes the demonstration period.

In 2020, as part of the OHI 2.0, CMS launched an oral health technical assistance opportunity, including webinars and an affinity group, on preventive oral health care, with direct technical assistance to states beginning in early 2021. Through this opportunity, participating states will receive assistance in planning and carrying out quality improvement projects focused on increasing access to two evidence-based preventive strategies: fluoride varnish, which can be provided in settings outside the dental office, and silver diamine fluoride, a promising new modality to arrest tooth decay. State interest in this learning collaborative has been robust. Thirteen states are participating in this technical assistance offering.

CMS continues to work closely with other stakeholders who engage in improvement efforts with states. For example, CMS provides technical support to the Dental Quality Alliance (DQA) to support states in developing and implementing performance improvement projects, which deliver dental services through managed care contracts. CMS continues to host regular Oral Health Technical Advisory Group (OTAG) calls with state Medicaid and CHIP programs to share information on core measure data collection, reporting, and related quality improvement efforts. Recent OTAG topics includes dental quality measure development, implementation of a DQA measure for application of dental sealants, coordinating management of oral conditions in medical and dental settings, and resources for state dental program managers to address oral health through State Plan Amendments and 1915(c) waivers.

MCD8: Improve Adult Health Care Quality across Medicaid

Measure	FY	Target	Result
MCD8: Improve Adult Health Care Quality Across Medicaid	2023	Work with States to ensure that 90% of States report on at least thirteen quality measures in the Adult Medicaid core set of quality measures	June 1, 2024
	2022	Work with States to ensure that 85% of States report on at least fifteen quality measures in the Adult Medicaid core set of quality measures	June 1, 2023
	2021	Work with States to ensure that 80% of States report on at least twelve quality measures in the Adult Medicaid core set of quality measures	February 28, 2023
	2020	Work with States to ensure that 75% of States report on at least twelve quality measures in the Adult Medicaid core set of quality measures	86% (Target Exceeded)
	2019	Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures	84% (Target Exceeded)
	2018	Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures	76% (Target Exceeded)
	2017	Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures	76% (Target Exceeded)

Prior years targets and results (including baseline) for this goal can be found in previous CMS Budgets

The purpose of this measure is to improve health care quality for adults across Medicaid.

The target for the adult core set has been met or exceeded since 2014. In 2020, the target was exceeded with 44 states reporting twelve or more Adult Core Set measures. CMS will continue to work with states to ensure that 80 percent of states report on at least twelve quality measures through FY 2021, 85 percent of states report on at least fifteen quality measures in FY 2022, and 90 percent report on at least thirteen quality measures in FY 2023.

Section 1139B of the Social Security Act established a national adult quality measures program for Medicaid. The 2020 Adult Core Set contains 33 measures. While the use of the Adult Core Set is voluntary for states, CMS encourages all states to use and report on the Adult Core Set to collect data that will lead to improved health outcomes and enhance the accuracy and applicability of the adult quality measures program. By encouraging states to report the core measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid.

Since 2014, CMS has hosted a Medicaid and CHIP track at annual CMS Quality Conferences. The conference agendas include interactive sessions on the core measures related to data collection, reporting, and quality improvement. CMS also annually releases an updated Adult Core Set Technical Specifications and Guidance for Reporting Manual, which contains technical instructions for collecting and calculating the core set measures for Medicaid and CHIP programs.

CMS will continue to work with its Technical Assistance/Analytic Support (TA/AS) contracting team to provide states with specific clarifications on measurement collection questions, hold all-state webinars and one-on-one calls with states around specific measurement challenges, and publish technical assistance briefs designed to provide states with guidance on measurement collection and reporting.

By using a multi-pronged approach to providing TA, CMS targets states that are already reporting multiple measures as well as those that are just beginning to understand how to collect and report them. Further, as the TA/AS program continues to mature, CMS is also expanding the scope of the TA to help states understand how to use the data they collect to drive quality improvement at the state and programmatic levels.

CMS has also anticipated that states may want to prioritize certain voluntary core measures for collection and reporting in order to target improvement strategies, rather than reporting on a large volume of measures.

It is significant to note that the Bipartisan Budget Act of 2018 (P.L. 115-123), also referred to as the ACCESS Act, requires state reporting on Child Core Set measures starting in 2024. This new requirement will likely result in an uptick in child core set reporting by states. It does not require mandatory reporting of the adult core set but may positively influence improved adult core set reporting. Additionally, the *Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018*, requires state reporting on measures in the Behavioral Health Core Set (a subset of behavioral health measures

from the Adult and Child Core Sets) starting in 2024. It is expected that this mandatory reporting may also positively influence improved adult core set reporting. CMS is assessing the potential impact of these statutory changes. CMS will be providing guidance and significant technical assistance to states to help them prepare for mandatory reporting.

Findings from state reporting on the Adult Core Set are published annually and available on the Adult Health Care Quality Measures webpage of Medicaid.gov and on https://data.medicaid.gov.

Note: CMS is developing a new quality measure reporting system. The development of this new system will impact both the timing of FY 2021 state core set reporting and the release of data. The table reflects the expected date when the FY 2021 data is expected to be available. However, it is important to note that there could be additional delays, which would also impact the timing of FY 2022 reporting.

MCD9: Improve Capacity to Collect Quality and Other Performance Data for Monitoring 1115 Demonstration Programs

Measure	FY	Target	Result

MCD9.2 Improve Capacity to Collect Quality and Other Performance Data for Monitoring Substance Use Disorder (SUD) 1115 Demonstrations	2023	Discontinued	N/A
	2022	CMS produce SUD performance trends across time and states for at least 25 demonstrations	September 30, 2022
	2021	CMS produce SUD performance trends across time and states for at least 16 demonstrations	Reports from 21 states submitted (Target Exceeded)
	2020	CMS produce SUD performance trends across time and states for at least 10 states	Reports from 13 states submitted (Target Exceeded)
	2019	Require states to submit the SUD metric data in the reporting platform from a minimum of 10 states	Reports from 14 states submitted (Target Exceeded)
	2018		Built new SUD-specific data collection instrument and trained states with approved 1115 SUD demonstrations on use of the instrument and system
MCD9.3 Reduce Emergency Department (ED) Use Under Substance Use Disorder (SUD)1115 Demonstration	2024	TBD	TBD
	2023	Baseline	September 30, 2023

Section 1115 of the Social Security Act (the Act) provides broad authority to the HHS Secretary to grant demonstrations to states for testing innovative reforms in Medicaid and the Children's Health Insurance Program (CHIP). These measures track the development of an automated infrastructure to support Section 1115 Medicaid demonstrations by focusing on comprehensive treatment for substance use disorders (SUD) (MCD9.2).

States are using Section 1115 demonstration authority to achieve Medicaid reform through innovative approaches to eligibility and coverage, and delivery system reforms including: 1) addressing social determinants of health, 2) integrating physical and behavioral health, and 3) home and community-based services (HCBS) rebalancing, to improve equity in access to and quality of care delivery and health outcomes. These reforms are aimed at improving the quality of their Medicaid programs, their capacity to serve more people, to find alternatives to eligibility, enrollment, and coverage, to promote health improvement, and to improve health equity. CMS is making significant investments in these types of demonstrations and their effective monitoring and evaluation in order to understand the results of these programs both at the state and national levels. To help accomplish these goals, CMS

created a reporting system through which states report performance and quality metrics, to assess progress in implementing the demonstrations, and to understand demonstration outcomes. CMS developed several sets of performance metrics for high priority Section 1115 demonstrations, including but not limited to Substance Use Disorders (SUD) and Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) section 1115 demonstrations. These sets have been reviewed by Medicaid State Technical Advisory Groups (TAGs). Expectations for reporting are stipulated in the special terms and conditions of these demonstrations, and states are adopting these metrics. Additional CMS improvements include the development of a monitoring protocol template for states to complete, as well as templates for reporting these metrics. CMS is focused on improving the quality and structure of both quantitative and qualitative data for Section 1115 demonstrations through a more structured process that will improve federal monitoring of demonstration progress and performance. This initiative aligns with the Medicaid and CHIP Program System (MACBIS) initiative to receive more complete and timelier Medicaid and CHIP related data from states to support better program oversight, administration, and integrity.

Our targets reflect the increasing scope of the work to consistently incorporate the standard metric sets and structured monitoring reporting into the Medicaid Section 1115 demonstrations across states that are testing similar innovative approaches (e.g. to improve service delivery for people with SUD) to improve CMS's capability to monitor performance and outcomes for those demonstrations. As new demonstrations are approved and existing demonstrations are extended, CMS will work with states to incorporate the appropriate metrics into state reporting to CMS.

CMS is focused on addressing the opioid crisis, and, to that end committed to systematically monitor state performance to improve access to, and health outcomes related to, comprehensive treatment for Medicaid beneficiaries with a SUD. CMS introduced the measure, MCD9.2, to reflect these efforts. In 2018, CMS focused on developing a metric set for the SUD demonstrations, including drafting a metric data collection template and a quarterly and annual reporting template for qualitative information. CMS was delayed in finalizing the SUD metric technical specifications until September 2018. The Performance Metrics Database and Analytics (PMDA) portal is being adjusted to collect such data and monitoring reports while assuring these reports meet requirements set forth in states' special terms and conditions. In Spring 2019, the SUD metrics and reporting templates were approved under the Paperwork Reduction Act (PRA). CMS is providing states with technical assistance on these templates and metrics. As of May 31, 2021, there are 32 approved SUD demonstrations. These 31 states and the District of Columbia (together referred to as 32 states) are in various phases of understanding and adopting the SUD metrics and reporting templates, and the uptake by each state has taken longer than initially expected. As of July 31, 2021, 24 of the 32 states submitted monitoring reports using the SUD templates to CMS.[3]

CMS is making significant progress on standardizing and collecting demonstration performance data through the PMDA portal from states approved to develop and provide comprehensive services across the SUD assessment and treatment continuum

[3] The monitoring reporting templates include two parts, an Excel workbook for states to submit metrics data and a narrative template for states to provide discussion on metrics trends and information on demonstration implementation updates. As of July 31, 2021, 20 of these 24 states have been reporting to CMS using both parts of the reporting templates, whereas four states have been using only the narrative template to provide relevant information to CMS.

under Section 1115 demonstration authority in exchange for federal financial participation for services provided during stays in facilities that qualify as Institutions for Mental Diseases. Therefore, CMS is proposing to refocus its MCD9.2 performance assessment for FY 2023 from a process goal to an outcome goal centered on assessing state-reported performance metrics data for emergency department (ED) utilization. Individuals with SUD utilize EDs at high rates[4], which can result in resource constraints for health systems[5]. Therefore, a common goal among Section 1115 SUD demonstrations is for the utilization of EDs to either remain consistent or to decrease, particularly whenever such utilization might be preventable or medically inappropriate. Specifically, starting with FY 2023, CMS proposes to assess state-specific trends in ED utilization rates for beneficiaries with SUD. This metric is captured monthly and provided to CMS through quarterly monitoring reports. Each state's baseline performance is compared to subsequent demonstration years. Thus, for FY 2023, CMS proposes to discontinue MCD9.2 and implement a new measure (MCD9.3) to assess the proportion of states who maintain or decrease ED use for SUD over the course of their demonstration. Some states may reach their directional demonstration goal, and subsequently reach saturation in this metric, and therefore, may not demonstrate further notable improvement and may represent stabilization in performance. As such, MCD9.3 will examine the percentage of states that either demonstrate a decrease or remain consistent in their ED utilization over the course of the demonstration. The analysis will examine year over year progression compared to the baseline period.

[4] Wani, R. Emergency Department Utilization for Substance Use-Related Disorders and Assessment of Treatment Facilities in New York State, 2011-2013. Available at https://pubmed.ncbi.nlm.nih.gov/30380976/
[5] Weiss, A. Overview of Emergency Department Visits in the United States, 2011. Available at. https://www.ncbi.nlm.nih.gov/books/NBK235856/

MCD11: Increase the Proportion of Medicaid Long-Term Services and Supports (LTSS) Beneficiaries Who Receive Home and Community-Based Services (HCBS)

Measure	FY	Target	Result
MCD11: Increase the proportion of Medicaid LTSS beneficiaries receiving HCBS	2023	TBD	April 30, 2025
	2022	TBD	April 30, 2024
	2021	Historical Actual	April 30, 2023
	2020	Historical Actual	April 30, 2022
	2019	Baseline (Developmental)	April 30, 2022

The new GPRA rebalancing goal is expected to increase public transparency and accountability and better reflect progress towards LTSS rebalancing from institutional services to HCBS. The COVID-19 public health emergency brought attention to the pandemic's disproportionate impact on older adults and people with disabilities, particularly those living in medical institutions such as nursing homes.[6] As a consequence, there is an emergent focus on the need for additional HCBS and the growing older adult population that will further intensify the need for these services.

This new performance goal was informed by feedback from state associations, states, researchers, and other stakeholders. The assumptions and methodology for this goal are under development. It is anticipated that CMS will have fully developed assumptions and methodology in FY 2022. The goal would be based on data from the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF), the most comprehensive national dataset on beneficiary enrollment and service use for Medicaid and the Children's Health Insurance Program.

[6] https://www.kff.org/medicaid/issue-brief/potential-impact-of-additional-federal-funds-for-medicaid-hcbs-for-seniors-and-people-with-disabilities/

LTSS encompass a wide range of medical and nonmedical services and supports for people with physical, cognitive, mental, or other disabilities or conditions. Medicaid is the primary payer of LTSS in the United States, accounting for about 52 percent of national LTSS spending.[7] Medicaid covers various institutional and home and community-based LTSS, but the type of services, populations covered, and delivery models differ substantially across states.

Over the last several decades, states have sought to rebalance their LTSS systems by increasing access to HCBS and reducing reliance on institutional care. Changes in Medicaid policy options, services, and state delivery models, along with strong consumer preferences to live and receive LTSS in the community, have led to shifts in Medicaid LTSS use patterns in recent years toward more HCBS.[8]

In a landmark action, on March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2). Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. CMS expects states to use the state funds equivalent to the amount of federal funds attributable to the increased FMAP by March 31, 2024, on activities aligned with the goals of section 9817 of the ARP, including to expand and sustain individuals' access to HCBS beyond 2024.[9] This new performance goal will contribute to our understanding of the impact of federal reimbursement for HCBS on the proportion of individuals accessing HCBS out of all qualifying for LTSS.

On January 21, 2021, President Biden issued an *Executive Order on Ensuring an Equitable Pandemic Response and Recovery*.[10] This order called for identifying and eliminating health and social inequities resulting in disproportionately higher rates of exposure, illness, and death. The order reported that certain communities, often obscured in the data, are disproportionately affected by COVID-19, including those living with disabilities. This new goal aims to support data-driven decision-making and thus contribute to efforts to improve access to services for older adults and individuals living with disabilities who are served through states' Medicaid programs.

Several factors (in addition to the effect of the ARP section 9817 increased FMAP), may have an impact on the proportion of individuals accessing HCBS over the next

[7] Kim, Min-Young, Edward Weizenegger, and Andrea Wysocki. "Medicaid Beneficiaries Who Use Long-Term Services and Supports: 2019." Chicago, IL: Mathematica, July 16, 2021.
[8] O'Malley Watts, M., M. Musumeci, and P. Chidambaram. "Medicaid Home and Community-Based Services Enrollment and Spending." San Francisco, CA: Kaiser Family Foundation, February 2020. Available at https://www.kff.org/medicaid/issue-brief/medicaid-home-and-community-based-services-enrollment-and-spending/
[9] https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf
[10] https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/21/executive-order-ensuring-an-equitable-pandemic-response-and-recovery/

several years. These factors may include provider capacity, e.g., number of qualified Direct Support Professionals serving a growing population or states' funding of additional optional Medicaid eligibility groups. In addition, the state and national experience with the COVID-19 public health emergency, which placed older adults and people with disabilities in institutions at increased risk of illness and death, is expected to accelerate efforts to increase access to HCBS and reduce the reliance on institutional services.

Previous GPRA goals concerning the proportion of expenditures spent on HCBS, (MCD10.1 and 10.2; reporting to be discontinued in 2022), were based on data from various sources, including the CMS-64 Medicaid program expenditure forms. These reports did not include information on the number of Medicaid LTSS users because the underlying sources, such as the CMS-64 data, do not include beneficiary-level data. Through this new goal, CMS seeks to explore the capabilities of the TAF, to identify Medicaid users of 15 Medicaid LTSS service categories. The identification of the Medicaid LTSS service categories and the Medicaid users is critical for developing the baseline assumptions, however this information is not available at this time. These data will inform the new goal.

CMS expects that a baseline will be established for FY 2019, by April 30, 2022. CMS seeks to pilot test a methodology prior to this date and work with states on improving data quality, if needed. Note that FY 2019 occurred prior to the COVID-19 public health emergency and, CMS assumes, it is likely to better reflect typical utilization of HCBS than the following year when the pandemic impacted reporting systems and actual provision of all services. By April 30, 2022, CMS also expects that actual data will be available for FY 2020. Subsequent reporting periods will look back two years to allow for reporting lags and adjustments related to data quality.

HEALTH CARE FRAUD AND ABUSE CONTROL (HCFAC)

MIP1: Reduce the Improper Payment Rate in the Medicare Fee-for-Service (FFS) Program

Measure	FY	Target	Result
MIP1: Reduce the Improper Payment Rate in the Medicare Fee-for-Service (FFS) Program	2023	TBD	November 15, 2023
	2022	6.16%	November 15, 2022
	2021	6.17%	6.26% (Target Met)*
	2020	7.15%	6.27% (Target Exceeded)
	2019	8.00%	7.25% (Target Exceeded)
	2018	9.40%	8.12% (Target Exceeded)
	2017	10.40%	9.51% (Target Exceeded)
	2016	11.50%	11.00% (Target Exceeded)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets and HHS AFRs.

* CMS uses Payment Integrity Information Act (PIIA) standards, rather than GPRAMA standards, for performance reporting on improper payments. Programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

The Medicare Fee-for-Service (FFS) improper payment rate is calculated by the Comprehensive Error Rate Testing (CERT) program and reported in the Department of Health and Human Services (HHS) Agency Financial Report (AFR) on an annual basis. Information on the Medicare FFS improper payment methodology can be found in the 2021 HHS AFR. Starting in FY 2017, per OMB guidance, CMS establishes improper payment rate targets only for the next fiscal year. Therefore, the FY 2023 target will be established in the FY 2022 HHS AFR.

In response to COVID-19, the CERT program stopped sending documentation request letters to or conducting phone calls with providers or suppliers to request medical documentation for claims in the fiscal year FY 2021 report period (claims submitted July 1, 2019 through June 30, 2020). As a result, the FY 2021 rate reflects CERT program processes that had a four-month pause in contacting providers and suppliers for documentation and an adjusted sample size. Lastly, the waivers and flexibilities provided by CMS for providers and suppliers during COVID-19 apply to claims in the fourth quarter of the FY 2021 report period.

CMS met its FY 2021 target. The Medicare FFS improper payment estimate for FY 2021 is 6.26 percent, or $25.03 billion. While the factors contributing to improper payments are complex and vary by year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors as described in the following four driver service areas:

- Hospital Outpatient: Insufficient documentation continues to be the major error reason for hospital outpatient claims. The improper payment estimate for hospital outpatient claims increased from 4.02 percent in FY 2020 to 4.57 percent in FY 2021; the change is not statistically significant. The primary reason for these errors is missing documentation to support the order, or the intent to order for certain services. (42 United States Code [U.S.C.] §1395y, 42 Code of Federal Regulations [CFR] §410.32).
- Skilled Nursing Facilities (SNF): Insufficient documentation continues to be the major error reason for SNF claims. The improper payment estimate for SNF claims increased from 5.43 percent in FY 2020 to 7.79 percent in FY 2021. The primary reason for these errors is missing or insufficient documentation to support certification or recertification. Medicare coverage of SNF services requires certification and recertification for these services (42 CFR §424.20).
- Home Health: Insufficient documentation for home health claims continues to be prevalent. The improper payment estimate for home health claims increased from 9.30 percent in FY 2020 to 10.24 percent in FY 2021; the change is not statistically significant. The primary reason for these errors is missing or insufficient documentation to support the certification of home health eligibility requirements. Medicare coverage of home health services requires physician certification of the beneficiary's eligibility for the home health benefit (42 CFR §424.22).
- Hospice: Insufficient documentation is the major error reason for hospice claims. The improper payment estimate for hospice claims increased from 6.69 percent in FY 2020 to 7.77 percent in FY 2021; the change is not statistically significant. The primary reason for these errors is missing or insufficient documentation to support certification or recertification. Medicare coverage of hospice services requires physician certification that the individual is terminally ill (42 CFR §418.22) and must meet all coverage criteria (42 CFR §418.200).

CMS develops and refines multiple preventive and detective measures for specific service areas with high improper payment estimates, such as hospital outpatient, SNF, home health, hospice, and other areas. CMS believes implementing targeted corrective actions will prevent and reduce improper payments in these areas and reduce the overall improper payment estimate. Detailed information on corrective actions can be found in the 2021 HHS AFR.

MIP5: Reduce the Percentage of Improper Payments Made under Medicare Part C, the Medicare Advantage (MA) Program

Measure	FY	Target	Result
MIP5: Reduce the Percentage of Improper Payments Made under Medicare Part C, the Medicare Advantage (MA) Program Baseline: 15.4%	2023	TBD	November 15, 2023
	2022	9.69%	November 15, 2022
	2021	Historical Actual	10.28% (Historical Actual)
	2020	7.77% (target in FY 2019 AFR)	6.78% (Target Exceeded)
	2019	7.90% (target in FY 2018 AFR)	7.87% (Target Exceeded)
	2018	8.08% (target in FY 2017 AFR)	8.10%* (Target Met)
	2017	9.50% (target in FY 2016 AFR)	8.31% (Target Exceeded)
	2016	9.14% (target in FY 2015 AFR)	9.99% (Target Not Met)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets and HHS AFRs.
* CMS uses Payment Integrity Information Act (PIIA) standards, rather than GPRAMA standards, for performance reporting on improper payments. Programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

In FY 2021, CMS reported an actual improper payment estimate of 10.28 percent or $23.19 billion. Beginning with FY 2021, the Part C measurement implemented refinements to the denominator methodology to only include for the calculation of the population of MA payments reviewed and at risk for diagnostic error, which led to the increase in the FY 2021 error estimate. Prior to FY 2021, the Part C denominator methodology reflected total MA payments and included some payments that were non-risk adjusted or were based on a different model resulting in a reported error biased downward, or potentially understated.

The Part C Improper Payment Measurement (IPM) methodology estimates improper payments resulting from errors in beneficiary risk scores. The primary component of most beneficiary risk scores is clinical diagnoses (the CMS Hierarchical Condition Category [CMS-HCC]) submitted by the MA plan. If medical records do not support the diagnoses, or CMS-HCC, submitted to HHS, the risk scores may be inaccurate and result in payment errors.

In FY 2021, HHS selected a stratified random sample of beneficiaries with a risk adjusted payment in calendar year 2019 (where the strata are high, medium, and low risk scores) and reviewed medical records of the diagnoses submitted by plans for the sample beneficiaries. In FY 2021, HHS implemented refinements to the denominator methodology to only include the population of MA payments reviewed and at risk for diagnostic error, which led to the increase in the FY 2021 error estimate. For prior

years, the Part C denominator methodology reflected total MA payments, and included some payments that were non-risk adjusted or based on a different model resulting in a reported error rate that was biased downward, or potentially understated. Therefore, the FY 2021 reporting year is a baseline and should not be compared with prior reporting years.

The primary root cause of FY 2021 Medicare Part C improper payments consist of medical record discrepancies (5.96 percent in overpayments and 3.55 percent in underpayments), with a smaller portion of improper payments resulting from insufficient documentation to determine whether proper or improper, such as missing documentation (0.77 percent). Improper payments due medical record discrepancies occur when medical record documentation submitted by the MA organization does not substantiate the CMS-HCC for which it received payment. The underpayment component is comprised of risk scores identified during the medical review process that the MA organization did not submit for payment.

The factors contributing to improper payments are complex and vary from year to year. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments in Medicare Part C. Detailed information on corrective actions can be found in the 2021 HHS AFR.

MIP6: Reduce the Percentage of Improper Payments Made under the Part D Prescription Drug Program

Measure	FY	Target	Result
MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program Baseline: 3.2%	2023	TBD	November 15, 2023
	2022	1.20%	November 15, 2022
	2021	1.14% (target in FY 2020 AFR)	1.58%* (Target Met)
	2020	0.74% (target in FY 2019 AFR)	1.15%* (Target Met)
	2019	1.65% (target in FY 2018 AFR)	0.75% (Target Exceeded)
	2018	1.66% (target in FY 2017 AFR)	1.66% (Target Met)
	2017	3.30% (target in FY 2015 AFR)	1.67% (Target Exceeded)
	2016	3.40% (target in FY 2013 AFR)	3.41%* (Target Met)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets and HHS AFRs.
* CMS uses Payment Integrity Information Act (PIIA) standards, rather than GPRAMA standards, for performance reporting on improper payments. Programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

In FY 2021, CMS reported an improper payment estimate of 1.58 percent, or $1.37 billion. The improper payment estimate due to lacking or insufficient documentation is 0.65 percent or $0.56 billion, representing 41.19 percent of total improper payments. The increase from the prior year's estimate of 0.43 percent is due to year-over-year variability, and is not statistically different from the prior year. As the rate is already low, variation in sampled error values or error category breakouts can cause minor shifts in the total estimated error rate. Starting in FY 2017, per OMB guidance, CMS establishes improper payment rate targets only for the next fiscal year, therefore the FY 2023 target will be established in the FY 2022 HHS AFR.

The Part D program payment error estimate measures the payment error related to Prescription Drug Event (PDE) data, where most errors for the program exist. CMS measures inconsistencies between information reported on PDEs and supporting documentation submitted by Part D sponsors: prescription record hardcopies (or medication orders as appropriate) and detailed claims information. Based on these reviews, each PDE in the audit sample is assigned a gross drug cost error. A representative sample of beneficiaries undergoes a simulation to determine the Part D improper payment estimate.

The FY 2021 Medicare Part D improper payment root causes are drug or drug pricing discrepancies (0.14 percent in Overpayments and 0.79 percent in Underpayments) and insufficient documentation to determine whether payments are proper or improper, i.e., missing documentation (0.65 percent). Improper payments due to drug

or drug pricing discrepancies occur when the prescription documentation submitted indicates that an overpayment occurred. Underpayments result when prescription record hard copies (or medication orders) indicates that CMS should have paid more.

The factors contributing to improper payments are complex and vary from year to year. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments in Medicare Part D. Detailed information on corrective actions can be found in the 2021 HHS AFR.

MIP9: Reduce the Improper Payment Rates in the Medicaid Program and the Children's Health Insurance Program (CHIP)

Measure	FY	Target	Result
MIP9.1: Reduce the Improper Payment Rate in the Medicaid Program	2023	TBD	November 15, 2023
	2022	18.94%	November 15, 2022
	2021	Historical Actual	21.69%
	2020	Historical Actual	21.36%
	2019	Historical Actual	14.90%
	2018	7.93%	9.79% (Target Not Met)
	2017	9.57%	10.10% (Target Not Met)
	2016	11.53%	10.48% (Target Exceeded)
MIP9.2: Reduce the Improper Payment Rate in the Children's Health Insurance Program (CHIP)	2023	TBD	November 15, 2023
	2022	27.88%	November 15, 2022
	2021	Historical Actual	31.84%
	2020	Historical Actual	27.00%
	2019	Historical Actual	15.83%
	2018	8.20%	8.57% (Target Not Met)
	2017	7.38%	8.64% (Target Not Met)
	2016	6.81%	7.99% (Target Not Met)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets and HHS AFRs.
Note: Targets are re-established as of FY 2022. FY 2019-2021 results do not reflect all states under the new eligibility methodology.

The Payment Error Rate Measurement (PERM) program measures improper payments for the Fee-For-Service (FFS), Managed Care, and eligibility components in both Medicaid (MIP9.1) and the Children's Health Insurance Program (CHIP) (MIP9.2). CMS measures improper payments in 17 states each year to calculate a rolling, three-year national improper payment rate for both Medicaid and CHIP. The national Medicaid and CHIP improper payment rates reported in the FY 2021 HHS AFR is based on measurements that were conducted in FYs 2019, 2020, and 2021. Information on the Medicaid and CHIP statistical sampling process and review period can be found in the 2020 HHS AFR. Starting in FY 2017, per OMB guidance, CMS establishes improper payment targets only for the next fiscal year, therefore the FY 2023 target will be established in the FY 2022 HHS AFR.

Due to the COVID-19 Public Health Emergency (PHE), in FY 2020 CMS exercised its enforcement discretion by temporarily suspending all improper payment related

engagement/communications and data requests to providers and state agencies from CMS. CMS adjusted the sample size for the FY 2021 Medicaid and CHIP measurement programs to account for ongoing challenges incurred by providers and states during COVID-19 while continuing to maintain appropriate accountability measures and meet the statutory obligations. In response to COVID-19, the FY 2021 national Medicaid improper payment estimate reflects PERM reviews that accounted for certain flexibilities afforded to states during COVID-19, such as postponed eligibility determinations and reduced requirements around provider enrollment/validations.

The national Medicaid improper payment estimate for FY 2021 is 21.69 percent or $98.72 billion. The national Medicaid component rates are 13.90 percent for Medicaid FFS, 0.04 percent for Medicaid managed care, and 16.62 percent for the Medicaid eligibility component.

One area driving the FY 2021 Medicaid improper payment estimate is the continued reintegration of the PERM eligibility component, which was revamped to incorporate the *Patient Protection and Affordable Care Act* (PPACA) requirements in the PERM eligibility reviews. CMS began utilizing the updated eligibility component beginning in the FY 2019 measurement cycle, so this was the first time Cycle 3 states were measured using the methodology. Under the updated eligibility component, a federal contractor conducts the eligibility measurement, allowing for consistent insight into the accuracy of Medicaid eligibility determinations and increased oversight of identified vulnerabilities. With the measurement of Cycle 3 states, CMS has completed the measurement of all states under the revamped eligibility component and established a national baseline in FY 2021.

Eligibility errors are mostly due to insufficient documentation to affirmatively verify the eligibility determination or noncompliance with federal eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification of eligibility data, such as income, was not done at all and where there is an indication that eligibility verification was initiated but the state provided no documentation to validate the verification process was completed.

The Medicaid improper payment estimate has also been driven by errors due to state noncompliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements. Most improper payments cited on claims were related to enrolled providers not being appropriately screened by the state; providers not being appropriately rescreened at revalidation; providers not being enrolled; and/or providers without the required NPI on the claim.

Although these errors remain one of the drivers of the Medicaid rate, state compliance has improved as the Medicaid FFS component decreased from 16.84 percent in FY 2020 to 13.90 percent in FY 2021. COVID-19 review flexibilities afforded to states should also be considered in the identified decrease in the Medicaid FFS component between FY 2020 and FY 2021. Moving forward, CMS will track improvement in compliance with revalidation requirements as CMS measures each cycle of states a second time.

The national CHIP gross improper payment estimate for FY 2021 is 31.84 percent or $5.37 billion. The national CHIP component rates are 13.67 percent for CHIP FFS,

0.48 percent for CHIP managed care and 28.71 percent for the CHIP eligibility component.

One area driving the FY 2021 CHIP improper payment estimate is the continued reintegration of the PERM eligibility component, which was revamped to incorporate the PPACA requirements in the PERM eligibility reviews. CMS began utilizing the updated eligibility component beginning in the FY 2019 measurement cycle, so this was the first time Cycle 3 states were measured using the methodology. Under the updated eligibility component, a federal contractor conducts the eligibility measurement, allowing for consistent insight into the accuracy of CHIP eligibility determinations and increased oversight of identified vulnerabilities. With the measurement of Cycle 3 states, CMS has completed the measurement of all states under the revamped eligibility component and established a national baseline in FY 2021.

Eligibility errors are mostly due to insufficient documentation to affirmatively verify the eligibility determination or noncompliance with eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification of eligibility data, such as income, was not done at all and where there is indication that the eligibility verification was initiated but the state provided no documentation to validate the verification process was completed. The CHIP improper payment estimate was also driven by claims 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, or household composition/tax filer status.

The CHIP improper payment estimate is also driven by errors due to state non-compliance with provider screening, revalidation, enrollment, and NPI requirements. Most improper payments cited on claims were related to enrolled providers not being appropriately screened by the state; providers not being appropriately rescreened at revalidation; providers not being enrolled; and/or providers without the required NPI on the claim. Although these errors remain one of the drivers of the CHIP rate, state compliance has improved as the CHIP FFS improper payment estimate has decreased from 14.15 percent in FY 2020 to 13.67 percent in FY 2021. COVID-19 review flexibilities afforded to states should also be considered in the identified decrease in the CHIP FFS component between FY 2020 and FY 2021. Moving forward, CMS will track improvement in compliance with revalidation requirements as CMS measures each cycle of states a second time.

A majority of Medicaid and CHIP improper payments were due to instances where information required for payment was missing, an eligibility determination was missing from the state system, states did not follow the appropriate process for enrolling providers, and/or states did not follow the appropriate process for determining beneficiary eligibility. However, these payments do not necessarily represent payments to illegitimate providers or on behalf of ineligible beneficiaries. If the missing information had been on the claim and/or the state had complied with the enrollment or redetermination requirements, 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/CHIP reimbursement and, therefore, improper.

The factors contributing to improper payments are complex and vary from year to year. In order to reduce the national Medicaid and CHIP improper payment rates, states are required to develop and submit states-specific Corrective Action Plans (CAPs) to CMS. Each year, CMS also outlines actions the agency will implement to prevent and reduce improper payments for all error categories on a national level. Detailed information on corrective actions can be found in the 2021 HHS AFR.

MIP11: Improve Efficiency in the Medicare Enrollment Process by Increasing the Proportion of Providers Initially Enrolling in the Medicare Program Online

Measure	CY	Target	Result
MIP11: Increase the proportion of providers performing initial enrollment in the Medicare Program online Baseline: 30.1%	2023	56%	April 30, 2024
	2022	52%	April 30, 2023
	2021	50%	April 30, 2022
	2020	46%	59.08% (Target Exceeded)
	2019	44%	53.23% (Target Exceeded)
	2018	38.7%	49.11% (Target Exceeded)
	2017	36.7%	42.51% (Target Exceeded)
	2016	34%	34.7% (Target Exceeded)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.

The Medicare Provider Enrollment, Chain, and Ownership System (PECOS) is the CMS national repository and system of record for all enrollment information on Medicare providers and suppliers. Providers and suppliers are required to enroll in the Medicare program in order to bill and receive payment for items and services provided to program beneficiaries. More information about PECOS can be found at https://pecos.cms.hhs.gov/. As an online electronic application system, PECOS helps to improve operational efficiency in CMS' enrollment process, reduce the cost associated with processing paper enrollment applications, and improve beneficiary access to care by reducing the time needed to issue provider certifications. This measure identifies annual improvement (increases) in electronic applications for initial enrollments that provide savings.

This is a calendar year (CY) goal. The baseline was established in CY 2015 when the result was measured at 30.1 percent. The CY 2016 target was established at 34 percent, based on the expectation of a modest increase over the baseline result. Consistent with this concept, the subsequent years have been based on a 2-4 percent per year increase. Due to the planned PECOS 2.0 release in late 2022, the PECOS system will be in a transition out phase, which is the reason for the increase of 2% for that year and will return to 4% for the first full year that PECOS 2.0 is released.

The purpose of the measure is to increase online submission of enrollment applications and reduce the number of paper applications, thereby increasing operational efficiency. Further information or explanation for paper applications necessitates the return of an estimated 50 to 70 percent of applications. This process unnecessarily lengthens the provider enrollment timeframe and increases the CMS enrollment contractors' time and effort when processing enrollment applications. This added time and expense negatively impacts CMS' operational efficiency and can affect program beneficiaries' access to services. The average time to process an electronic enrollment application is 45 days. This compares favorably to the 60 days' average time for processing a paper enrollment. The annual average of more than a million enrollment applications processed by CMS

further amplifies this difference.

This measure improves operational efficiency by reducing the number of hours needed to process enrollment applications by Medicare Contractors through PECOS, resulting in reduction of operating costs and improvement of access to care through timelier provider certification. Increasing usability of online enrollment submissions by providers will also result in more complete applications and faster screening results through real time data verification to the Medicare contractors, reducing overall processing time. The online enrollment application supplies information needed by the provider with quick and easy access to update the information. The electronic enrollment process also enhances CMS' capacity to perform its responsibilities under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP). The QPP relies on PECOS data for Merit-Based Incentive Payment System (MIPS) eligibility. States leverage PECOS data for screening and enrollment of Medicaid fee-for-service providers. Faster processing and timely updates of enrollment information in PECOS facilitates data sharing and the identification and determination of the eligibility of providers and groups in MACRA programs such as MIPS, Alternative Payment Models, and State Medicaid Agencies.

CMS is measuring the increase in the proportion of providers enrolling online. The baseline measurement was established in CY 2015 and goal implementation occurred in the CY 2016.

The CY 2020 result was 59.06 percent, which exceeds the target of 46 percent. Targets set for CY 2021 (50 percent), CY 2022 (52 percent) and CY 2023 (56 percent) with subsequent measurements available by April of the year following the calendar year measured.

MIP12: Savings from the Prevention of Improper Medicare Payments by Successful Implementation of Fraud Prevention System (FPS) Edits

Measure	FY	Target	Result
MIP12: Maintain or increase estimated savings from Fraud Prevention System (FPS) Edits *	2023	$62.0 million	April 30, 2024
	2022	$45.0 million	April 30, 2023
	2021	$40.0 million	April 30, 2022
	2020	$33.5 million	$61.1 million (Target Exceeded)
	2019	$33.5 million	$69.4 million (Target Exceeded)
	2018	$33.0 million	$57.8 million (Target Exceeded)
	2017	Baseline	$32.1 million

* Note: this measure was previously titled, "Maintain or increase dollar savings through the prevention of improper payments in Medicare Fee-For-Service (FFS) claims through innovative edit techniques employed by Fraud Prevention System (FPS) Edits."

Fraud Prevention System (FPS) edits screen Medicare Fee-For-Service (FFS) claims prior to payment and automatically reject or deny claim lines for non-covered, incorrectly coded, or inappropriately billed services not payable under Medicare policy. To maintain performance of FPS edits, CMS continually monitors Medicare FFS payments for program vulnerabilities. When a vulnerability is identified, CMS conducts a rigorous assessment to determine if an FPS edit is an appropriate and effective action against that vulnerability, or if other approaches, such as an FPS model or provider education, are better suited for the issue. CMS continuously develops new FPS edits and updates existing edits.

This goal measures estimated savings resulting from claim lines rejected or denied by the FPS edits. For a given FPS denied or rejected claim line, CMS reports savings in the fiscal year during which the claim line was processed. The calculation uses claims data captured 90 days after the end of the fiscal year to allow time for appeals. Appendix B of the *Annual Report to Congress on the Medicare and Medicaid Integrity Programs* documents the FPS edits savings methodology.

The existing and newly implemented FPS edits addressed costly program vulnerabilities by preventing payments for thousands of claims that violate billing guidelines. In April, 2020, due to the COVID-19 public health emergency (PHE), CMS issued a number of waivers, allowing for certain billing scenarios which normally would be prohibited. This resulted in the deactivation of numerous FPS Edits during FY 2020. Several of those deactivated edits were reimplemented in summer 2021, and over the course of the year, several new edits were implemented. When the PHE ends, CMS anticipates that the remaining deactivated edits will be reactivated.

MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS (QIO)

QIO8: Strengthening Person and Family Engagement in Beneficiary Health Care Quality by Increasing Satisfaction of Quality of Care Complaint Resolution

Measure	FY	Target	Result
QIO8: Increase beneficiary satisfaction with the resolution of all beneficiary initiated quality of care complaints.	2023	85% QIO Satisfaction	January 15, 2024
	2022	83% QIO Satisfaction	January 15, 2023
	2021	80% QIO Satisfaction	81% (Target Exceeded)
	2020	80% QIO Satisfaction	80.8% (Target Exceeded)
	2019	75% QIO Satisfaction	81.1% (Target Exceeded)
	2018	75% QIO Satisfaction	83.3% (Target Exceeded)
	2017	70% QIO satisfaction	67.8% (Target Not Met)
	2016	62% - Baseline	65.7% (Target Met)

The primary focus of the Beneficiary and Family Centered Care (BFCC) program is to improve healthcare services for Medicare beneficiaries, through the Quality Improvement Organization (QIO) performance of statutory review functions. This includes, but is not limited to: quality of care reviews, beneficiary complaint reviews, discharge and termination of service appeals in various provider settings, medical necessity reviews, and the Emergency Medical Treatment and Labor Act (EMTALA) reviews. Beneficiary satisfaction with the QIO review process has been mixed over the course of the past several years, with concerns raised by patients and families regarding the quality of the reviews and the impartiality of the reviewers.

The BFCC QIOs develop activities that engage patients and families, with the goal of increasing patient knowledge, skill, and confidence in taking an active role in managing patient health care. Engagement in these activities is captured on the Beneficiary Experience surveys. The current survey measures beneficiary satisfaction with Quality of Care Complaint Reviews, Immediate Advocacy, and Appeals Reviews. The BFCC Oversight and Review Center (ORC) began administering the satisfaction survey in April 2016, beginning with cases closed in November 2015 and continuing to the present. CMS began receiving QIO performance data for satisfaction in July 2016. The 11th Scope of Work (SOW) survey scoring was used to develop the targets for this goal prior to FY 2020 and the 12th SOW is being used for target development as of FY 2020. The ORC contract ended

August 2020 and the surveys are now being administered by the BFCC Survey Center (SC) as of September 2020.

The survey is conducted monthly via a computer-assisted telephone interviewing (CATI) process with mail follow-up to randomly-chosen Medicare beneficiaries, who file a Quality of Care Complaint or Appeal. Beneficiaries share their views about the Medicare Complaint or Appeal process.

The survey assesses beneficiary satisfaction in three domains which include:

(1) Effectiveness of the QIO review process;
(2) Courtesy & Respect of BFCC-QIO staff in handling a beneficiary's complaint; and
(3) Responsiveness of BFCC QIO staff.

BFCC QIOs continue to sustain good levels of performance. The FY 2020 target was exceeded.

QIO12: Make Nursing Home Care Safer by Reducing the Infection Control Survey Deficiencies (of F880) for Nursing Homes that Have Received a Targeted Response Quality Improvement Initiative (TR-QII)

Measure	FY	Target	Result
QIO12: Reduce Infection Control Deficiencies of F880 of TR-QII	2023	15% reduction from baseline	January 31, 2024
	2022	10% reduction from baseline	January 31, 2023
	2021	5% reduction from baseline	20.97% (Target (Exceeded)
	2020	Developmental (Baseline)	30.7%

The purpose of this goal is to make nursing home care safer by providing targeted technical assistance interventions to those nursing homes that have previously been cited as having deficiencies in proper infection control when surveyed. Although this goal is facility-based and measures an improvement in systemic related issues that impact infection control, CMS recognizes that an improvement in this metric will impact all residents within the facility. It is our contingent that more vulnerable residents within nursing homes will be affected at higher rates as they are more likely to have an adverse event if the nursing home does not comply with infection control methods. The requirements for infection control are contained in 42 CFR § 483.80. Currently, more than 1.3 million residents live in approximately 15,450 Medicare and Medicaid certified nursing homes in the United States that must meet federal quality standards. These standards include compliance with establishing and maintaining an infection prevention and control program. Under an agreement with CMS, state agencies perform surveys to determine whether nursing homes meet specified program requirements, known as Federal participation requirements. Based on the result of these surveys, state agencies may certify nursing homes' compliance with those requirements.

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection. The facility must establish an infection prevention and control program that must include, at a minimum, the following elements: A system for preventing, identifying, reporting, investigating, controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment…" Appendix PP November 22, 2017 State Operations Manual (SOM), A statement of deficiency document uses a federal tag numbering system (F-tag) that addresses the degree to which a facility meets minimal federal standards. F-tags correspond to specific stipulations within the Code of Federal Regulations. During the survey process, when a facility is out of compliance, in infection prevention and control, they receive a F880 tag, it is noted on Form CMS-2567, Statement of Deficiencies and Plan of Correction.

Each deficiency is given a letter rating of A through L based on the State agency's determination of the scope and severity of the deficiency. A-rated deficiencies are the least serious, and L-rated deficiencies are the most serious. F880 maintains its position as the one of the most frequently cited survey tags across the country. Nursing home surveys are conducted in accordance with survey protocols and Federal requirements to determine whether a citation of non-compliance is appropriate. Deficiencies are based on violations of the regulations based on observations of the nursing home's performance or practices. Nursing homes struggling to comply with infection control requirements may be subjected to fines and/or termination from federal programs.

CMS data shows that infection prevention and control deficiencies were the most common type of deficiency cited in surveyed nursing homes, with most homes having an infection prevention and control deficiency cited in one or more years from 2013 through 2017 (13,299 nursing homes, or 82 percent of all surveyed homes. Recently, nursing homes are a major source of U.S. coronavirus disease 2019 (COVID-19) cases. According to the CDC, COVID-19 is known to be particularly lethal to adults in their 60s and older who have underlying health conditions. It can spread more easily through congregate facilities, where many people live in a confined environment and workers move from room to room. QIN-QIOs have been addressing the COVID-19 pandemic by monitoring NHSN data for COVID outbreaks and infection rates in nursing homes and providing targeted technical assistance to those nursing homes.

The baseline for this measure was set by analyzing the universe of nursing homes that received a survey and identifying the nursing homes that received multiple infection control deficiencies using the, Quality, Certification & Oversight Reports Nursing homes that received additional infection control survey deficiencies after receiving a TR-QII constituted the numerator at baseline. CMS' anticipates reducing the number of infection control deficiencies over the course of the 5-year period of performance for the QIN-QIO 12th Scope of Work. This is a new process, so CMS did not have program data on which to set reduction targets. Therefore, CMS' set this ambitious goal to reduce deficiencies by 15 percent from baseline by considering both the barriers to quality improvement in this particular area and quality improvement achievements from similar programs in prior years. Assuming reduction is linear, CMS set a progression of 5 percent per year towards a 15 percent goal after 4 years of implementation.

CMS targets, through analysis of survey data, nursing homes with infection control deficiencies by deploying the QIOs to provide timely education and technical assistance through its TR-QIIs. Technical assistance includes a complete assessment and root cause analysis, development of an implementation plan, implementation of best practice interventions, and monitoring outcome metrics. The QIN-QIOs will work with facilities to improve compliance using the CDC infection control assessment tools. This high degree of technical assistance will provide the nursing home with a one-on-one action plan developed in conjunction with the QIO experts and infection preventionists. Upon completion of the TR-QII, nursing home performance is tracked using Care Compare and/or the next CMS or state survey. CMS refers QIOs to nursing homes based on infection control deficiencies identified through the regulatory process over the last 12-15 months for the initial cycle of referrals.

QIO13: Reduce Healthcare Associated Infections [HAIs] in Critical Access Hospitals (CAH)

Measure	CY	Target	Result
QIO13.1: Reduce CAUTI SIR in critical access hospitals	2024	4.5% reduction from baseline	June 30, 2025
	2023	3.3% reduction from baseline	June 30, 2024
	2022	2.2% reduction from baseline	June 30, 2023
	2021	1.1% reduction from baseline	June 30, 2022
	2020	Historical Actual	0.641
	2019	Baseline	0.59
QIO13.2: Reduce CDI SIR in critical access hospitals	2024	4.5% reduction from baseline	June 30, 2025
	2023	3.3% reduction from baseline	June 30, 2024
	2022	2.2% reduction from baseline	June 30, 2023
	2021	1.1% reduction from baseline	June 30, 2022
	2020	Historical Actual	0.709
	2019	Baseline	0.81

The purpose of this performance goal is to identify and reduce Healthcare-associated infections (HAIs) that are a threat to patient safety in Critical Access Hospitals (CAHs). CAHs are an important element to achieving the objectives of the CMS Rural Health Strategy, given that many of individuals they serve are at risk for increased comorbidities and mortality.

The two HAIs that will be reduced are Catheter-Associated Urinary Tract Infections (CAUTI) and Clostridium Difficile Infections (CDI). These infections are the most common type of HAI reported to the National Healthcare Safety Network (NHSN), which is the nation's most widely used HAI tracking system.

A urinary tract infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney. The CDC states, overall, among all acute care hospitals, between 15-25 percent of hospitalized patients receive urinary catheters during their hospital stay. Among UTIs acquired in the hospital, approximately 75 percent are associated with a urinary catheter.

Clostridiodes Difficile is a germ (bacterium) that causes life-threatening diarrhea. It is usually associated with taking antibiotics. It affects older patients taking antibiotics

who receive hospital medical care and have weakened immune systems. Based on the Centers for Disease Control and Prevention (CDC) biggest threat list, in 2017, CDI accounts for 223,900 infections and 12,800 deaths per year.

Both CAUTI and CDI are major concerns for patients in healthcare facilities and associated with increased morbidity, mortality, hospital cost, and length of stay. The standardized infection ratio (SIR) is a summary measure used to track CAUTI and CDI at a national, state, or local level over time. The SIR adjusts for various facility and/or patient-level factors that contribute to HAI risk within each facility. SIR compares the actual number of HAIs reported to the number that would be predicted, given the standard population, adjusting for several risk factors that have been found to be significantly associated with differences in infection incidence. Overall, the purpose of the goal is to reduce hospital infections as measured by SIR and these two measures (CAUTI and CDI) are fully developed and endorsed by the National Quality Forum (NQF).

Since there is no CMS requirement for CAHs to report these infections to NHSN, this effort supports CAHs in reporting HAIs to NHSN, thus providing a better national picture of HAIs in CAHs. In addition, this aligns with the Medicare Rural Hospital Flexibility Program, which has an NHSN reporting requirement for CAHs. This initiative supports CMS's work to reduce patient harm, using the two most commonly occurring NHSN infections and the most widely reported NHSN metrics. Given the COVID-19 pandemic, the metrics are especially timely with regards to infection control and prevention and antibiotic stewardship.

The two NHSN Patient Safety metrics CMS will be monitoring/tracking include the following:

- Catheter utilization ratio (catheter days per 10,000 patient days)
- NHSN C. Difficile Outcome Measure (NQF 1717) (SIR) hospital-acquired CDI laboratory identified events.

Quality Improvement Organizations (QIOs) will work with facilities to implement evidenced- based interventions to reduce CAUTI and CDI, such as prevention of inappropriate short term catheters; timely removal of urinary catheters, and catheter care during placement, as well as best practices for antibiotic stewardship. This work dovetails with related ongoing infection prevention and control work related to the coronavirus pandemic.

The data system for collection and reporting are high functioning and the systems are in place to receive the data, consistent with the CMS's Inter-Agency Agreement (IAA) with the CDC. Both metrics are reported by CAHs with more than 800 CAHs reporting on each of the two metrics. CMS will be working with approximately 44 percent of CAHs. CDC uses knowledge gained through activities to detect infections and develop new strategies to prevent HAIs. Public health action by CDC and other healthcare partners has led to improvements in clinical practice, medical procedures, and the ongoing development of evidence-based infection control guidance and prevention successes. In addition, proven and effective intervention strategies have been known, in some cases for decades, on how to reduce or eliminate these infections. Effective control of these infections does not require the discovery of new

drugs, new treatments, or the development of any vaccines. The requirements for hospitals and other health care facilities is to establish an effective infection prevention program, generate awareness among all Health Care Practitioners and for leaders to commit to measure and reduce their hospital infection rates.

An essential element of the efforts to improve the quality of care to all beneficiaries includes action to identify, address, track, and reduce healthcare disparities in harm and readmissions. As part of this commitment in improving health equity, quality improvement efforts shall be embedded as an element of the support provided to hospitals. At a minimum, hospital quality improvement contractors shall provide technical assistance to hospitals to:

- Improve the health of the general population including underserved sub-populations
- Analyze Race, Ethnicity, Age, and Language (REAL) data to inform quality improvement
- Customize interventions to improve the health of the general population including sub-populations.
- Ensure quality improvement program includes patient feedback for greater effectiveness.

The first set of SIRs for both CAUTI and CDI in CAHs are reflected in the table above. These are the final numbers for 2020. Of note, the CAUTI SIR in CAHs went up between 2019 and 2020 from 0.56 to 0.641. Notable about 2020 was the global pandemic, COVID-19, which led to multiple hospitalizations across the United States including patients who became ventilator-dependent for long periods of time; consequently, it would be typical for them to have a Foley catheter for extended periods, which is a risk factor for developing CAUTI. Research reveals the following factors possibly involved in this increase in the CAUTI SIR:

There was an observed increase in Critical Access Hospital CAUTI rates during 2020 compared to 2019, during the interval most impacted by COVID-19 care. Likely contributors to this increase are:

1) COVID-19 care episodes often included known risk factors for both urinary catheter placement and CAUTI, including long hospital stays, long ICU stays, prolonged immobilization and ventilation.[11,12,13]
2) Urinary irritation and frequency is a COVID-19 symptom, and might have further contributed to urinary catheter placement; COVID-19 may also cause or lead to urinary tract infection (bladder urothelium expresses ACE2).[14]

[11] Bryan C Knepper, MPH, MS, Kristin Wallace, MPH, Heather Young, MD, 95. CAUTI and CLABSI in Hospitalized COVID-19 Patients, *Open Forum Infectious Diseases*, Volume 7, Issue Supplement_1, October 2020, Page S178, https://doi.org/10.1093/ofid/ofaa439.405

[12] McMullen KM, Smith BA, Rebmann T. Impact of SARS-CoV-2 on hospital acquired infection rates in the United States: Predictions and early results. Am J Infect Control. 2020 Nov;48(11):1409-1411. doi: 10.1016/j.ajic.2020.06.209. Epub 2020 Jul 2. PMID: 32621857; PMCID: PMC7329659.

[13] Fakih MG, Bufalino A, Sturm L, Huang RH, Ottenbacher A, Saake K, Winegar A, Fogel R, Cacchione J. Coronavirus disease 2019 (COVID-19) pandemic, central-line-associated bloodstream infection (CLABSI), and catheter-associated urinary tract infection (CAUTI): The urgent need to refocus on hardwiring prevention efforts. Infect Control Hosp Epidemiol. 2021 Feb 19:1-6. doi: 10.1017/ice.2021.70. Epub ahead of print. PMID: 33602361; PMCID: PMC8007950.

[14] Mumm JN, Osterman A, Ruzicka M, et al. Urinary Frequency as a Possibly Overlooked Symptom in COVID-19 Patients: Does SARS-CoV-2 Cause Viral Cystitis?. *Eur Urol*. 2020;78(4):624-628. doi:10.1016/j.eururo.2020.05.013

3) Prone positioning changes, routine catheter care and requires staff training;[15] during a surge of critically ill patients, staff may not have been able to complete or practice or attain proficiency in new skills.[1,2]
4) Hospital staff were consumed with staffing and care decisions, and care provision for multiple critically ill patients and catheter care was likely not a top priority.[1-3]

All references above are from studies in larger PPS hospitals. No published studies of COVID care in CAHs were found. The CDC does not have separate information or recommendations for small vs large or urban vs rural hospitals; the American Hospital Association is also unaware of CAH and/or rural specific data sources/analyses or conclusions.

[15] Law AC, Forbath N, O'Donoghue S, Stevens JP, Walkey AJ. Hospital-Level Availability of Prone Positioning in Massachusetts ICUs. Am J Respir Crit Care Med. 2020 Apr 15;201(8):1006-1008. doi: 10.1164/rccm.201910-2097LE. PMID: 31899648; PMCID: PMC7159431.

MEDICARE BENEFITS

MCR1: Ensure Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive

Measure	FY	Target	Result
MCR1.1a: Maintain or exceed percent of beneficiaries in Medicare Fee-for-Service (FFS) who report access to care	2023	Contextual Indicator	December 31, 2023
	2022	Contextual Indicator	December 31, 2022
	2021	Contextual Indicator	91%
	2020	Contextual Indicator	Not Available**
	2019	Contextual Indicator	92%
	2018	Contextual Indicator	91%
	2017	Contextual Indicator	91%
	2016	Contextual Indicator	90%
MCR1.1b: Maintain or exceed percent of beneficiaries in Medicare Advantage (MA) who report access to care	2023	Contextual Indicator	December 31, 2023
	2022	Contextual Indicator	December 31, 2022
	2021	Contextual Indicator	91%
	2020	Contextual Indicator	Not Available**
	2019	Contextual Indicator	90%
	2018	Contextual Indicator	91%
	2017	Contextual Indicator	91%
	2016	Contextual Indicator	90%

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.
** Survey data are not available due to survey administration being curtailed as a result of the Coronavirus (COVID-19) pandemic.

CMS has monitored Medicare FFS and MA access to care through measures of beneficiary satisfaction since the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. CMS is continuing to monitor FFS and MA access to care in order to maintain the same level of access to care for its beneficiaries. To measure access, we use the percent of, persons with FFS (or MA Plans) that report they usually or always get needed care right away, as soon as they needed it. CMS has met or exceeded its targets for this performance goal since the inception of the goal. Since FY 2016, CMS has reported the data trend annually as a contextual measure. High performance has continued for this measure. CMS is undertaking many efforts to address risk management within the agency's programs. For FY 2020 CMS did not have data to determine the impact of the pandemic on scores since the survey operations had to be curtailed due to the public health risk of continuing to administer the surveys. Going forward it is hard to predict how COVID-19 will influence these types of measures given the significant impact of the pandemic on the health care system.

MCR23: Reduce the Average Out-of-Pocket Share of Prescription Drug Costs while in the Medicare Part D Prescription Drug Benefit Coverage Gap for Non-Low Income Subsidy (LIS) Medicare Beneficiaries who Reach the Gap and have no Supplemental Coverage in the Gap

Measure	FY	Target	Result
MCR23: Reduce the Average Out-of-Pocket Share of Prescription Drug Costs while in the Medicare Part D Prescription Drug Benefit Coverage Gap for Non-Low Income Subsidy (LIS) Medicare Beneficiaries who Reach the Gap and have no Supplemental Coverage in the Gap Baseline: 100%	2023	25%	April 30, 2025
	2022	25%	April 30, 2024
	2021	25%	April 30, 2023
	2020	25%	April 30, 2022
	2019	28%	27% (Target Exceeded)
	2018	37%	36.7% (Target Exceeded)
	2017	43%	42% (Target Exceeded)
	2016	48%	48% (Target Met)
	2015	50%	49% (Target Exceeded)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), amends Title XVIII (Medicare) of the Social Security Act by adding a Voluntary Prescription Drug Benefit Program (Medicare Part D). Since its inception, Medicare Part D has significantly increased the number of beneficiaries with comprehensive drug coverage, and enhanced access to medicines.

While Medicare Part D offers substantial insurance coverage for prescription drugs, it does not offer complete coverage. Prior to 2010, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the out-of-pocket threshold (or catastrophic limit). Only once the beneficiary reached the catastrophic limit, did Medicare coverage recommence. This is known as the coverage gap (or "donut hole"). The Affordable Care Act began closing the coverage gap through a combination of manufacturer discounts and gradually increasing federal subsidies until it closed in 2020. For CY 2020 and beyond, this means that non-LIS beneficiaries who reach this phase of Medicare Part D coverage will pay no more than 25 percent of costs for all covered Part D drugs. For 2022, beneficiaries reach this phase when total drug costs amount to $4,430 and stay in this phase until they pay $7,050 in qualified out-of-pocket costs. CMS' tracking of this measure has shown that that in most years non-LIS out-of-pocket costs have decreased beyond the targets required by statute.

The statute which established the Coverage Gap Discount Program gave CMS the authority to authorize exceptions to the requirement that manufacturers have their

applicable drugs be covered under a Coverage Gap Discount Program agreement (Section 1860D-43 (C)) in extenuating circumstances. However, CMS successfully encourages all manufacturers of applicable drug products to participate in the program, which results in the consistent application of discounts for all branded products. Furthermore, the infrastructure which has been put in place treats manufacturers fairly, which has resulted in manufacturers choosing to stay in the Part D program. Specifically, it: 1) allows public access to information about which manufacturers are participating in the program, and 2) offers an equitable process for manufacturers to dispute invoiced amounts. This has occurred without any meaningful decreases in manufacturer participation in the Part D market. As generic utilization in the Part D program has remained static, and very high (over 75 percent since 2012), that is not a strong contributor to the success of this goal. Rather, CMS' application and management of the Coverage Gap Discount Program, coupled with the strong incentives for manufacturers to participate in the Part D program, are the primary drivers of this goal's success.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

CHIP3: Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in CHIP and Medicaid

Measure	FY	Target	Result
CHIP3.3: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid Baseline: 37,311,641 children	2023	44,538,869 children (Medicaid - 35,391,786/CHIP - 9,147,083)	March 31, 2024
	2022	44,650,216 children (Medicaid – 35,720,173/ CHIP – 8,930,043)	March 31, 2023
	2021	46,672,893 children (Medicaid – 37,338,314/CHIP – 9,334,579)	March 31, 2022
	2020	46,672,893 children (Medicaid – 37,338,314/CHIP – 9,334,579)	44,098,421 children (Medicaid-35,055,383/CHIP-9,043,038 (Target Not Met)
	2019	46,556,502 children (Medicaid - 37,245,202/CHIP - 9,311,300)	44,745,129 children (Medicaid – 35,090,387/CHIP – 9,654,742) (Target Not Met)
	2018	46,440,401 children (Medicaid – 37,152,321/CHIP – 9,288,080)	45,919,430 children (Medicaid - 36,287,063/CHIP - 9,632,367) (Target Not Met)
	2017	46,062,581 children (Medicaid – 36,850,065/CHIP – 9,212,516	46,322,217 children (Medicaid – 36,862,057/CHIP – 9,460,160) (Target Exceeded)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.

The purpose of this measure is to increase enrollment in CHIP and Medicaid from 43,542,385 children in FY 2011 to 44,538,869 children by the end of FY 2023. Our enrollment target for FY 2023 takes into consideration that the prior FY enrollment targets have not been met since FY 2017, and that the majority of eligible children are enrolled in Medicaid and CHIP. The remaining uninsured children are the hardest to reach. Under the CHIP and Medicaid programs, States submit quarterly and annual statistical forms, which report the number of children who are enrolled in Medicaid, separate CHIP programs, and Medicaid expansion CHIP programs. The enrollment counts reflect an unduplicated number of children ever enrolled during each year, and are not reflective of point-in-time enrollment.

The FY 2020 enrollment result as of June 23, 2021 is 44,259,975 children enrolled in Medicaid and CHIP, which does not meet the FY 2020 enrollment target of 46,672,893 children enrolled in Medicaid and CHIP. The program specific enrollment

targets of 37,338,314 children enrolled in Medicaid and 9,334,579 children enrolled in CHIP were also not met by the enrollment results, which indicate that 35,197,225 children were enrolled in Medicaid, and 9,062,750 children were enrolled in CHIP during FY 2020.

It is important to note that many states' enrollment totals were impacted by changes to policies and state operations as a result of the COVID-19 public health emergency (PHE). For example, the Families First Coronavirus Response Act (FFCRA) makes available to states a temporary 6.2 percent Federal Medical Assistance Percentage (FMAP) bump that includes a requirement to maintain Medicaid enrollment (for continuous coverage requirement) starting in March 2020. This requirement increased retention in Medicaid and potentially reduced churn in and out of the Medicaid program throughout the second half of FY 2020. The continuous coverage requirement in the FFCRA does not apply to CHIP. Therefore, the FY 2020 enrollment result shows a large enrollment decline in CHIP over FY 2019. The decline in CHIP enrollment may largely be due to losses in family incomes throughout FY 2020, resulting in children becoming ineligible for CHIP coverage. CMS anticipates an increase in the Medicaid and CHIP enrollment total for FY 2021, as data submitted by states for this timeframe should reflect the growth in enrollment due to policy changes in response to the COVID-19 PHE mentioned above. CMS issued guidance on resuming normal operations related to processing renewals following the end of the PHE on March 3, 2022, and is providing intensive technical assistance to states on this process.

The FY 2020 enrollment results should be considered in the context of a recent Urban Institute Analysis highlighting 2019 data that show that nationally, 91.9 percent of children eligible for Medicaid and CHIP are enrolled in these programs, with participation rates at or above 90 percent in 36 states. In contrast, in 2008, only five States had participation rates of at least 90 percent. With such gains in increasing children's participation in Medicaid and CHIP, it is important to note that the remaining eligible uninsured children will be the hardest to reach. CMS' strategy to increase the availability and accessibility of health insurance coverage for children includes collaborating with its State and Federal partners, continuing to implement statutory provisions that encourage program simplification, supporting CHIP outreach grantees, and bolstering its data collection activities.

The HEALTHY KIDS Act, as included in P.L. 115-120, extended CHIP funding for six years through FY 2023, and the Advancing Chronic Care, Extenders and Social Services Act (referred to as the ACCESS Act and included in Pub. L. No. 115-123), provides CHIP funding for an additional four years, for FY 2024 through FY 2027. The HEALTHY KIDS Act and the ACCESS Act also included provisions related to the extension and reduction of federal financial participation for CHIP and maintenance of effort for children's Medicaid and CHIP coverage, the extension of express lane eligibility and the Connecting Kids to Coverage Outreach and Enrollment Program.[16] Through the HEALTHY KIDS Act and the ACCESS Act, the Connecting

[16] Key provisions of the HEALTHY KIDS Act and the ACCESS Act are described in State Health Official Letter# 18-010. Enrollment grants have been awarded to a variety of community organizations—such as health care providers, schools, tribal organizations, and other types of nonprofits—through four, two-year funding cycles since 2009. Thus far, 294 Connecting Kids to Coverage grant awards have been issue to eligible entities. The National Campaign conducts training webinars and works with partners on outreach, creates and updates existing outreach print materials, produces new social media graphics, and publishes a newsletter that has over 30,000 subscribers

Kids to Coverage Outreach and Enrollment grants and National Campaign received $120 million in funding for outreach and enrollment activities through FY 2023, and $48 million for FY 2024 to FY 2027.

The Connecting Kids to Coverage grants and the National Campaign fund activities that are aimed at reducing the number of children who are eligible for Medicaid and CHIP but are not enrolled, and improving retention of eligible children who are currently enrolled. On November 30, 2018, CMS issued the Connecting Kids to Coverage HEALTHY KIDS 2019 Outreach and Enrollment Cooperative Agreement Notice of Funding Opportunity, which made available $48 million in cooperative agreements to states, local governments, Indian tribes, tribal consortium, urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act, federal health safety net organizations, community-based organizations, faith-based organizations, and schools. On June 19, 2019, CMS awarded 39 new cooperative agreements, with awarded amounts ranging from just over $360,000 to $1,500,000. These grants have a 3-year period of performance which began on July 1, 2019. On July 17, 2019, CMS issued the Connecting Kids to Coverage HEALTHY KIDS American Indian/ Alaska Native (AI/AN) 2020 Outreach and Enrollment Cooperative Agreement Notice of Funding Opportunity, which made available $6 million in cooperative agreements to enroll and retain AI/AN children in Medicaid and CHIP. Eligible entities for this funding opportunity include Indian Health Service providers, Tribes and Tribal organizations operating a health program under a contract or compact with the Indian Health Service under the Indian Self Determination and Education Assistance Act, and Urban Indian organizations operating a health program under the Indian Health Care Improvement Act. CMS awarded nine cooperative agreements on January 13, 2020, with award amounts ranging from $297,533 to $750,002 over a 3-year performance period. On January 17, 2022, CMS announced an additional $49.4 million in funding for Connecting Kids to Coverage grants.

With 91.9 percent of eligible children enrolled in Medicaid and CHIP in 2019, effective and targeted strategies are needed to enroll the remaining 8.1 percent of eligible uninsured children. As noted above, continuous coverage in Medicaid as required by the FFCRA is expected to increase enrollment and retention of children in Medicaid throughout FY 2021 and moving forward for the duration of the COVID-19 PHE.

CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMMI)

CMMI3: Accelerate the Spread of Successful Practices and Models

Measure	FY	Target	Result
CMMI3.1: Percentage of Medicare beneficiaries impacted by Innovation Center models Baseline: 5%	2023	Contextual Indicator	November 30, 2023
	2022	Contextual Indicator	November 30, 2022
	2021	Contextual Indicator	17%
	2020	Contextual Indicator	13%
	2019	Contextual Indicator	15%
	2018	Contextual Indicator	17%
	2017	Contextual Indicator	13%
	2016	Contextual Indicator	9%
CMMI3.2: Number of states developing and implementing a health system transformation and payment reform plan Baseline: 25	2022	Discontinued	N/A
	2021	13	3 (Target Not Met)
	2020	7	7 (Target Met)
	2019	15	14 (Target Not Met)
	2018	16	16 (Target Met)
	2017	17	20 (Target Exceeded)
	2016	38	38 (Target Met)

Measure	FY	Target	Result
CMMI3.3: Number of providers participating in Innovation Center models Baseline: < 60,000	2023	Contextual Indicator	November 30, 2023
	2022	Contextual Indicator	November 30, 2022
	2021	Contextual Indicator	139,788
	2020	Contextual Indicator	136,682
	2019	Contextual Indicator	261,767
	2018	Contextual Indicator	574,467
	2017	Contextual Indicator	219,719
	2016	Contextual Indicator	103,291
CMMI3.4: Increase the percentage of active model participants who are highly engaged in Innovation Center or related learning activities	2018	Discontinued	N/A
	2017	59.7%	47.6% (Target Not Met)
	2016	64.5%	56.9% (Target Not Met)
	2015	61.0%	58.6% (Target Not Met)
	2014	Baseline	56%
CMMI3.5: Percentage of Model awardees participating in learning activities	2023	54%	November 30, 2024
	2022	52%	November 30, 2023
	2021	50%	November 30, 2022
	2020	50%	54% (Target Exceeded)
	2019	50%	54.2% (Target Exceeded)
	2018	Baseline	61%

CMS' Center for Medicare and Medicaid Innovation (CMMI) aims to test innovative payment and service delivery models to reduce program expenditures, while improving health outcomes and quality of healthcare delivery to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. Every CMS test of a new service delivery or payment model also includes a plan of action to ensure that the lessons learned and promising practices identified during the test can be spread as widely and effectively as possible to support improvement for both CMS and the health care system at large.

CMS strives to understand the level of participation and engagement from beneficiaries, providers, states, payers, and other stakeholders to effectively design, test, and evaluate its portfolio of models.

To date, CMS has introduced a wide range of Medicare initiatives, involving a broad array of Medicare Fee-for-Service (FFS) beneficiaries, health care providers, states, payers, and other stakeholders. As a contextual indicator, CMMI3.1 provides a snapshot of the impact on the Medicare beneficiary population of CMMI's models at a given point in time (not cumulative impact), for models that have been operational for more than 6 months. The FY 2021 result was 17 percent.

States play a critical role in determining the effectiveness of the health care system and the health of their populations. For FY 2021, the CMMI3.2 target includes three All-Payer states (Pennsylvania, Maryland and Vermont) as well as participants from the Community Health Access and Rural Transformation (CHART) Model. COVID flexibilities resulted in a delayed performance period start date for the CHART model, therefore, CMS did not meet the FY 2021 target of 13. In FY 2022, in addition to the three All-Payer states, CMS will launch the Community Health Access and Rural Transformation (CHART) Model among four additional states. Given the change in strategy away from SIM-like models and moving toward the new "state-based initiatives", which are different in size and scope, CMS is discontinuing CMMI3.2 starting in FY 2022.

To accelerate the development and testing of new payment and service delivery models, CMS recognizes that many robust ideas will come from a broad array of health care providers, states, payers, and other stakeholders in communities across the country. CMMI3.3 seeks to understand the level of interest and participation among providers in CMS' model portfolio. CMS estimated that the number of participating providers in its payment and service delivery models was more than 60,000 in FY 2014, approximately 61,000 in FY 2015, 103,291 in FY 2016, 219,719 in FY 2017, 574,467 in FY 2018, 261,767 in FY 2019, 136,682 in FY 2020, and 139,788 in FY 2021.

CMS has created collaborative learning systems for providers and other model participants in order to promote the broad and rapid dissemination of lessons learned and promising practices to deliver better health outcomes, higher quality and lower cost of care for Medicare, Medicaid, and CHIP beneficiaries. Most new service delivery or payment models include a plan of action to ensure that the lessons learned and promising practices identified during the test can be spread as widely and effectively as possible. For measure CMMI3.5, CMS is reporting the FY 2018 baseline of 61 percent. In FY 2019, CMMI3.5 achieved 54.2 percent (exceeding the target of 50 percent). In FY 2020, CMMI3.5 achieved 54.0 percent (exceeding the target of 50 percent). As CMS moves into future model support, CMS continues to optimize measurement of the content and delivery of learning events, to deliver information to support innovation using participant-centered, evidenced-based methodologies designed to optimize adult learning.

CMMI6: Increase the Percentage of Original Medicare Beneficiaries in a Care Relationship with Accountability for Quality and Cost of Care

Measure	FY	Target	Result
CMMI6: Increase the Percentage of Original Medicare Beneficiaries in a Care Relationship with Accountability for Quality and Cost of Care	2023	TBD	November 30, 2024
	2022	TBD	November 30, 2023
Developmental	2021	Baseline	November 30, 2022

CMS recently conducted a strategic refresh. On October 20, 2021, CMS published a white paper detailing CMS's vision for the next 10 years (Innovation Strategy Refresh). This new developmental measure aligns to the Administration's priority to reduce care fragmentation by aligning beneficiaries with providers with accountability for quality and cost of care. These care relationships enable providers to provide person-centered care through enhanced flexibilities, incentives, and tools. This new measure remains under development as CMS continues to finalize definitions and align methodologies across the agency. CMS is committed to using FY 2021 data for the baseline, and is currently planning to establish FY 2022 and FY 2023 targets during the next budget cycle.

CMS DISCONTINUED PERFORMANCE MEASURES

Medicare Survey & Certification Program

MSC6: Percentage of Hospice Facilities that Have Been Surveyed within 36 Months

MSC6 was implemented to ensure that the shorter duration of hospice recertification was being met due to *The Improving Medicare Post-Acute Care Transformation Act of 2014* (the IMPACT Act) which mandated the frequency of hospice recertification surveys to be not less frequently than once every 36 months. Prior to the IMPACT Act, CMS did not have a legislative or regulatory standard for the frequency of hospice recertification surveys.

The Consolidated Appropriations Act (CAA), 2021, replaced the IMPACT Act and made this survey frequency permanent for certified hospice programs. Specifically, Part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) is amended by adding at the end a new section at 1822 (Hospice Program Survey and Enforcement Procedures). This section added the mandate that "any entity that is certified as a hospice program (as defined in section 1861(dd)(2)) shall be subject to a standard survey by an appropriate State or local survey agency, or an approved accreditation agency, as determined by the Secretary, **not less frequently than once every 36 months**."

CMS is discontinuing this measure since State Agencies and Accreditation Organizations are required under statute to comply with this survey frequency. CMS will continue to report on this goal through 2022.

Measure	FY	Target	Result
MSC6.2: Percentage of facilities that are surveyed within the required 36 month timeframe	2022	Discontinued	Discontinued
	2021	98% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2022
	2020	98% of hospice facilities are surveyed within the required 36 month timeframe	*87.1% (Target Not Met)
	2019	98% of hospice facilities are surveyed within the required 36 month timeframe	98.3% (Target Exceeded)
	2018	95% of hospice facilities are surveyed within the required 36 month timeframe	96.5% (Target Exceeded)

*CMS did not meet the target FY 2020 goal of 98% due to the COVID-19 Public Health Emergency (PHE) and reprioritization of survey activities based on guidance published throughout the PHE.

Medicaid Discontinued Measures

MCD10: Improve Access for People with Disabilities and Older Adults, by Increasing the Proportion of Public Funding Directed to Home and Community-Based Services (HCBS) as a Portion of Long Term Services and Supports (LTSS) Expenditures

Home and community-based services (HCBS) are more cost-effective than institutional care for many beneficiaries (https://www.medicaid.gov/medicaid/ltss/downloads/moneyfollows-the-person/mfp-2015annual-report.pdf). Several statutory programs, in addition to §1915(c) HCBS waiver programs, provide options for people to receive long-term services and supports in the community. These include the Community First Choice state plan option, flexibilities in §1915(i) state plan HCBS, the extension of and improvements to the Money Follows the Person (MFP) Rebalancing Demonstration, and an extension of spousal impoverishment protections to people who receive HCBS.

CMS is discontinuing these measures which reached their end dates in 2020. CMS is proposing a new goal (MCD11) to reflect current progress related to Long Term Services and Supports (LTSS) rebalancing, which refers to the extent to which LTSS spending and use are for services delivered in home and community-based settings rather than institutional settings. CMS will continue to report on these goals through 2022. Further, data associated with these goals have been incorporated into CMS's Medicaid and Children's Health Insurance Program (CHIP) Scorecard: Percentage of Long-Term Services and Supports Expenditures on Home & Community Based Services by State. The Scorecard serves to increase public transparency and accountability about the Medicaid programs' administration and outcomes. Information in the Scorecard spans all life stages covered by Medicaid and CHIP. The Scorecard includes information on selected health and program indicators. It also describes the Medicaid and CHIP programs and how they operate (https://www.medicaid.gov/state-overviews/scorecard/ltss-expenditures-onhcbs/index.html). CMS plans to establish a new GPRA measure before final reporting of the current measures ends. Federal and state Medicaid policies have had a major impact on shifting service modalities for people who need LTSS away from institutional services and toward community-based services. These policies have not only increased the quality of life for people with LTSS needs, but they also have been successful in using limited Medicaid resources more effectively[17] [18].

[17] https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html
[18] https://www.medicaid.gov/sites/default/files/2019-12/ltss-toptenreport.pdf

Measure	FY	Target	Result
MCD10.1: Increase the percentage of Medicaid spending on long-term services and supports for home and community based services (HCBS) to 65 percent by 2020. Baseline: 49.5%	2021	Discontinued	Discontinued
	2020	65%	April 30, 2022
	2019	63%	April 30, 2021 59% (Target Not Met)
	2018	61%	56% (Target Not Met)
	2017	59%	58% (Target Not Met)
Measure	**FY**	**Target**	**Result**
MCD10.2: Increase the Number of States that Utilize at least 50 percent of Medicaid Spending on Long-Term Services and Supports for Home and Community Based Services (HCBS) by 2020.* Baseline: 45.1%	2021	Discontinued	Discontinued
	2020	38 States and District of Columbia (76.5%)*	April 30, 2022
	2019	37 States and District of Columbia (74.5%)*	April 30, 2021 29 States and District of Columbia 58.8% (Target Not Met)
	2018	36 States and District of Columbia (72.5%)*	26 States and District of Columbia 52.9% (Target Not Met)
	2017	35 States and District of Columbia (70.6%)*	28 States and District of Columbia 56.9% (Target Not Met)

* The target and result percentages for MCD10.2 have been corrected from previous versions appearing in past versions of the CMS budget.

Center for Medicare and Medicaid Innovation Discontinued Measures

CMMI2: Identify, Test, and Improve Payment and Service Delivery Models

Measure	FY	Target	Result
CMMI2.1: Increase the number of model tests that currently indicate: 1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost. Baseline: 1.0	2023	Discontinued	N/A
	2022	Discontinued	N/A
	2021	8.0	8.0 (Target Met)
	2020	8.0	9.0 (Target Exceeded)
	2019	7.0	7 (Target Met)
	2018	6.0	6 (Target Met)
	2017	5.0	5 (Target Met)
	2016	4.0	4 (Target Met)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.

CMS routinely and rigorously assesses the impact of each model on quality and cost. To formally evaluate models, evaluators employ advanced statistical methods and carefully define and select comparison groups, as appropriate, to ensure that models deemed to be successful, represent high-value investments of taxpayer dollars. Similarly, model teams often employ implementation contractors to apply rigorous self-monitoring methodologies that assess the performance of models and generate value-based payments.

The purpose of measure CMMI2.1 was to identify those models, based on available data that indicate cost savings and/or quality improvements. This measure reflects the documented progress that CMS has made toward sustainable success of its models.

The CMS Innovation Center recently conducted a strategic refresh and will be discontinuing this goal after 2021. Please refer to the Innovation Strategy Refresh for more information.

Medicare Quality Improvement Organizations Discontinued Measures

QIO7: Make Nursing Home Care Safer via the National Nursing Home Quality Care Collaboration (NNHQCC)

The purpose of this measure "quality improvement in one-star nursing homes" was to track the change in the percentage of nursing homes with a one-star quality rating, over time. CMS monitors quality improvement progress in the 9,162 homes eligible for technical assistance from the Quality Innovative Network-Quality Improvement Organization (QIN-QIOs). The QIN-QIO program has a focus on improving quality in vulnerable populations, including those from rural areas, and also improving poor performance where the only available beds are in poor performing nursing homes.

In April 2019, CMS made improvements to each of the rating system domains under the Five Star Quality Rating System. In October 2019, CMS removed quality measures (QMs) related to residents' reported experience with pain. As a result, CMS set a new baseline for the period describing performance from 2019 through 2021. CMS advised providers that thresholds for quality measure ratings will be updated every six months beginning April 2020, however CMS is no longer able to calculate future targets or results based on the former methodology, therefore this goal is non-viable for continued monitoring beyond 2021. CMS will discontinue reporting on this goal as of FY 2022. CMS developed a new goal (QIO12) that will focus on making nursing home care safer by providing targeted interventions to those nursing homes that have previously been cited as having deficiencies in proper infection control.

Measure	FY	Target	Result
QIO7.3: Demonstrate improvement in nursing home health care quality by reducing the number of one-star nursing homes	2022	Discontinued	N/A
	2021	8.8%	*October 1, 2022
	2020	Baseline	9.4% (based on 4Q 2018- 3Q 2019 data)

*Note: The result reported will be based on the newer methodology and not consistent with the previously reported target.