DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2024

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) 2024 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 2024, over 160 million Americans will rely on the programs CMS administers or oversees 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.

With the enactment of the Inflation Reduction Act (IRA), CMS will provide relief and meaningful health care savings to millions of Americans. In addition, the IRA provides additional ways to improve access to affordable treatments, strengthen Medicare, and extend subsidies that have lowered Marketplace premiums. Landmark legislation such as the IRA, coupled with other Administration goals, such as improving care in nursing home settings, protecting our programs' sustainability for future generations through improvements in our program integrity work, and promoting excellence in all aspects of CMS operations.

The investments proposed in FY 2024 will keep CMS on the leading edge of providing the high-quality health benefits that all Americans deserve.

On behalf of our beneficiaries and consumers, I thank you for your continued support of CMS and its FY 2024 performance budget.

Administrator Chiquita Brooks-LaSure

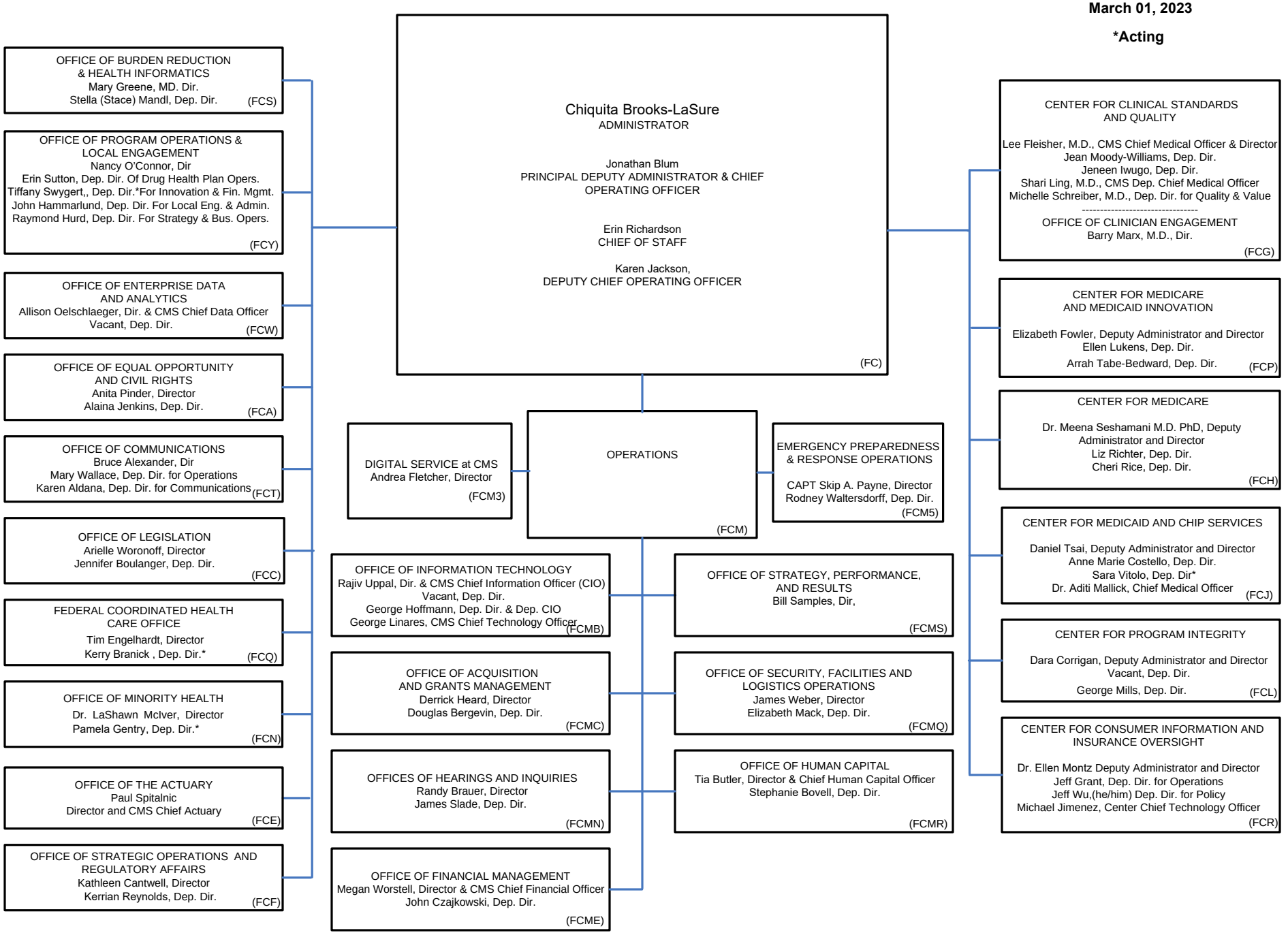
Org Chart Text Version

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

APPROVED LEADERSHIP As of

March 01, 2023

***Acting**



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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 providing oversight for the Children's Health Insurance Program (CHIP) and the Federal Marketplaces. As a driving force in the healthcare industry, CMS recognizes the direct impact its programs have on over 160 million beneficiaries and consumers and is working hard to ensure that our policies and procedures produce meaningful, positive results for the Americans who rely on our services. CMS understands the trust that has been placed with us, as our oversight responsibilities impact millions of citizens and continue to grow dramatically.

CMS's budget request reflects our 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. CMS works closely with its customers and 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 populations that often need strong advocacy, and we understand that our customers are best served through robust teamwork among Federal, State, and local entities. We recognize that we are all stronger when we work together, share data, and work in partnership on common goals. Strengthened relationships work as a workforce multiplier for CMS, increasing our ability to do more within our resources.

At CMS, the voice of the customer is a valuable driver of our operational excellence. Our ability to listen, communicate, and engage with people across the country enables us to build trust locally and deliver results on a national scale. Through these interactions, we can continuously work towards reducing the time and effort it takes for people to get access to equitable, high quality, and affordable care. We continue to transform healthcare by reducing disparities in health equity, promoting innovation to tackle our collective health system challenges, and strengthening program integrity by reducing fraud, waste, and abuse. CMS has much work to do to continue to drive the best value for America and is working to ensure the sustainability of our programs for future generations.

Mobilized under the Biden-Harris Administration, CMS will work, in concert with the White House and other 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, building from our initial Oncology Care Model, has a new model, the Enhancing Oncology Model, which aims to drive transformation in oncology care by preserving or enhancing the quality of care furnished to beneficiaries undergoing treatment for cancer while reducing program spending under Medicare fee-for-service (FFS). With patients at the center, CMS continues to research ways to improve the overall experience, with the goal of providing 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 Fiscal Year (FY) 2022 Enacted level, the FY 2023 Enacted level, and FY 2024 President's Budget request for the aforementioned 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 2024 President's 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.

The architecture of the CMS FY 2024 discretionary program level request is predicated on additional funding sources being leveraged to ensure the Agency can meet both growing statutory responsibilities and administrative directives, such as Executive Orders, in addition to increased workload. This budget request assumes the adoption of a legislative proposal to replenish and extend the No Surprises Act implementation funds to enable CMS, along with the Departments of Labor and the Treasury to continue implementing the many provisions of this law.

CMS Annually-Appropriated Accounts
(Dollars in Millions)

Account	FY 2022 Enacted	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Program Management[1]	**$4,024.744**	**$4,124.744**	**$4,550.070**	**$425.326**
Program Operations	*$2,834.823*	*$2,914.823*	*$3,130.187*	*$215.364*
Federal Administration	*$772.533*	*$782.533*	*$854.023*	*$71.490*
Survey & Certification	*$397.334*	*$407.334*	*$565.860*	*$158.526*
Research[2]	*$20.054*	*$20.054*	*$0*	*($20.054)*
HCFAC	**$873.000**	**$893.000**	**$937.000**	**$44.000**
Grants to States for Medicaid	**$517,398.421**	**$533,079.108**	**$604,537.324**	**$71,458.214**
Payments to Health Care Trust Funds	**$497,862.000**	**$548,130.000**	**$476,725.000**	**($71,405.000)**
Total	**$1,020,158.164**	**$1,086,226.854**	**$1,086,749.394**	**$522.540**

[1] The $355 million and $455 million, in FY 2022 and FY 2023 Enacted bills respectively, in additional Medicare programs funding provided by General Provision in Sec. 227 is included in the Program Management line. Funds are allocated across programs, as later described in the Congressional Justification.
[2] Research funding is requested within the Program Operations line in FY 2024.

FY 2024 Request

Program Management

CMS requests $4,550.1 million in Budget Authority appropriated funding. This budget supports mission-critical operations to ensure CMS can continue to serve its increasing beneficiary population and carry out its growing legislative responsibilities. Within this FY 2024 President's Budget request, CMS can appropriately execute core Agency functions, maintain public-facing services, and accomplish the priorities of the Administration.

- Program Operations:

  CMS's FY 2024 Budget request for Program Operations is $3,130.2 million, an increase of $215.4 million which is 7 percent above the FY 2023 Enacted level. This funding level will allow CMS to process nearly 1.3 billion fee-for-service claims and related statutorily mandated workloads, keep our systems running, invest in several critical initiatives such as combating opioid substance abuse disorder, maintain expected customer service levels for our 1-800-MEDICARE call centers, oversee Part C and D plans, and provide outreach and education to millions of beneficiaries, consumers, and providers. In addition to supporting the administration of Medicare, the request level supports ongoing operations for Medicaid, CHIP, and private insurance programs. The funding increase supports several key Administration initiatives such as, but not limited to, modernizing cybersecurity to protect our data, reducing prescription drug prices, and improving health equity for underserved populations. CMS aims to design consistent, connected, secure, and sustainable care experiences across the country, that are delivered with dignity.

- Federal Administration:

  CMS requests $854.0 million for Federal Administration, an increase of $71.5 million which is 9 percent above the FY 2023 Enacted level. Of this request, $714.6 million in discretionary funding, along with indirect funding, will support 4,330 direct Full-Time Equivalents (FTEs), an increase of 100 FTEs over the FY 2023 Enacted level. A majority of the increased funding request is due to projected Cost of Living Adjustment (COLA) and benefit increases. To deliver best-in-class experiences, we know that our workforce is our greatest asset. This is why we continue to invest in employee experience modernization efforts that cultivate a learning organization prepared for and resilient to what the future brings. 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:

  CMS requests $565.9 million, an increase of $158.5 million which is 39 percent above the FY 2023 Enacted level. The increase of $158.5 million offsets the ending of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) funding in order to maintain the additional workload that was brought about by the COVID-19 pandemic, address the nursing home complaint survey backlog, and address inflationary pressures in state staffing salaries and other expenses. With the requested level of funding, CMS will be able to maintain mandatory survey levels at 100 percent. CMS will focus on maintaining survey frequencies at targeted high-risk non-statutory facilities, specifically

hospitals and end-stage renal disease (ESRD) facilities. In addition, the requested funding provides additional resources to the States, allowing them to hire and retain surveyor staff.

Health Care Fraud and Abuse Control

In FY 2024, CMS requests $937.0 million in discretionary HCFAC funding, which would be allocated among CMS, Department of Justice (DOJ), HHS/Office of Inspector General (OIG), and Administration for Community Living (ACL). This budget creates a new earmark for ACL's Senior Medicare Patrol program to combat health care fraud and abuse in order to ensure no erosion in Medicare program integrity efforts, which continue to expand due to program, beneficiary and inflationary growth but are compromised by growth in the ACL earmark. The request provides CMS and its law enforcement partners resources to continue investing in new and expanded activities that reduce fraud in Medicare, Medicaid and CHIP, and the Marketplaces. Increased funding over the FY 2023 Enacted level provides resources for CMS to conduct additional medical review, particularly prior authorization; enhance modeling and analytics support, and strengthen program integrity in Medicaid and the Marketplace. In addition, CMS plans to place emphasis in the following areas: promote the integrity of the Medicare and Medicaid programs and CHIP through provider/contractor audits and policy reviews; identify, monitor, and resolve program vulnerabilities; optimize collaboration to detect and prevent fraud, waste, and abuse; leverage new and emerging technologies to modernize program integrity tools; strengthen Medicaid program integrity; enhance program integrity oversight in managed care; and improve detection of emerging fraud schemes.

Grants to States for Medicaid

The FY 2024 Medicaid appropriations request is $604.5 billion, an increase of $71.4 billion above the FY 2023 Enacted level, consisting of $406.9 billion for FY 2024 and $197.6 billion in an advance appropriation from FY 2023.

Appropriations will support $606.1 billion in estimated gross obligations in FY 2024. These obligations consist of:

- $575.7 billion in Medicaid medical assistance benefits;
- $24.6 billion for Medicaid administrative functions including Medicaid survey and certification and state fraud control units; and
- $5.8 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

Payments to the Health Care Trust Funds

The FY 2024 request for Payments to the Health Care Trust Funds account totals $476.7 billion, a decrease of $71.4 billion below the FY 2023 Enacted 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 2024 request, when compared to the FY 2023 estimate level, is driven by a $60,376.0 million decrease for the General Fund contributions for the SMI Trust Fund and a $10,995.0 million decrease for General Revenue for the Part D Drug Benefit.

Key Initiatives

Opioid and Substance Use Disorders: The opioid crisis continues to be a pressing public health challenge, impacting many Americans, and CMS is 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. CMS continues 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: In FY 2024, CMS will continue to advance health equity by addressing the health disparities that underlie our health system. Working from our 'Framework for Health Equity' – a ten-year agency approach to promote health equity – CMS has five priority areas that we will use to develop and initiate policies to incorporate health equity into our programs. CMS is striving to fuse health equity into our very DNA, so that everything we do comes with health equity as a foundational piece. CMS will lead the way within the health care system to ensure health equity is engrained into the health care fabric that covers so many Americans.

Nursing Homes: Based on this Administration's commitment to nursing home safety, quality, and transparency, CMS is requesting funding to take significant steps to address the backlog of survey complaints, increase the inspection of specific focus facilities, and expand the financial penalties for substandard facilities to adequately fund nursing home inspections. The CMS Nursing Home Cross-Cutting Initiative makes nursing homes safer for their residents.

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 align 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. 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 is extremely useful in shaping policy and management choices in both the short and long term.

The CMS FY 2024 Performance section format is designed to create a more complete presentation of performance commitments, accomplishments, and trends.

Conclusion

CMS's FY 2024 request for Program Management totals $4,550.1 million. This funding allows CMS to continue its traditional activities in the Medicare, Medicaid, CHIP and Marketplace programs and address key budgetary initiatives that 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 $937.0 million in discretionary HCFAC funds for CMS, DOJ, HHS/OIG, and ACL. This funding maintains and improves oversight programs related to early detection and prevention, reducing improper payments, and funding for the Senior Medicare Patrol program.

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

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

	FY 2022 Final	FY 2023 Enacted /1	FY 2024 President's Budget	FY 2024 +/- FY 2023
Program Operations	$ 2,834.823	$ 2,914.823	$ 3,130.187	$ 215.364
Federal Administration	$ 772.533	$ 782.533	$ 854.023	$ 71.490
State Survey & Certification	$ 397.334	$ 407.334	$ 565.860	$ 158.526
Research /2	$ 20.054	$ 20.054	$ -	$ (20.054)
Subtotal, Appropriation/BA Current Law (Discretionary; 0511)	**$ 4,024.744**	**$ 4,124.744**	**$ 4,550.070**	**$ 425.326**
MIPPA (Mandatory; P.L. 110-275)	$ 2.914	$ 2.829	$ 2.829	$ -
PAMA (P.L. 113-93)	$ 4.857	$ 4.715	$ 1.886	$ (2.829)
IMPACT (P.L. 113-185)	$ 5.464	$ 5.304	$ 5.304	$ -
BBA (P.L. 115-123)	$ 4.857	$ 4.715	$ 4.715	$ -
Consolidated Appropriations Act, 2021 (P.L. 116-260)	$ 45.657	$ 49.036	$ 16.031	$ (33.005)
Postal Services Reform Act (P.L. 117-108)	$ 7.500	$ -	$ -	$ -
Bipartisan Safer Communities Act (P.L. 117-159)	$ 8.000	$ 5.000	$ 4.715	$ (0.285)
Inflation Reduction Act (P.L. 117-169)	$ 3,046.500	$ 90.000	$ 44.321	$ (45.679)
Consolidated Appropriations Act, 2023 (P.L. 117-328)	$ -	$ 36.000	$ -	$ (36.000)
Total, Mandatory Appropriation/BA C.L. (Mandatory; 0511)	**$ 3,125.749**	**$ 197.599**	**$ 79.801**	**$ (117.798)**
Total, Appropriation/BA Current Law (0511)	**$ 7,150.493**	**$ 4,322.343**	**$ 4,629.871**	**$ 307.528**
Proposed Law Appropriation (Mandatory)	$ -	$ -	$ 300.000	$ 300.000
Total, Appropriation/BA Proposed Law (0511)	**$ 7,150.493**	**$ 4,322.343**	**$ 4,929.871**	**$ 607.528**
Est. Offsetting Collections from Non-Federal Sources: /3				
User Fees and Reimbursements	$ 357.730	$ 354.448	$ 358.921	$ 4.473
Marketplace User Fees (FFM)	$ 1,780.401	$ 1,986.340	$ 2,073.887	$ 87.547
Risk Adjustment User Fees (RA)	$ 70.558	$ 60.674	$ 60.000	$ (0.674)
Recovery Audit Contracts /4	$ 693.929	$ 209.544	$ 238.409	$ 28.865
Total, Offsetting Collections	**$ 2,902.618**	**$ 2,611.006**	**$ 2,731.217**	**$ 120.211**
Subtotal, New BA, Current Law	**$ 10,053.111**	**$ 6,933.349**	**$ 7,361.088**	**$ 427.739**
Proposed Law Discretionary	$ -	$ -	$ -	$ -
Program Level, Proposed Law (0511)	**$ 10,053.111**	**$ 6,933.349**	**$ 7,661.088**	**$ 727.739**
HCFAC Discretionary	**$ 873.000**	**$ 893.000**	**$ 937.000**	**$ 44.000**
Non-CMS Administration /5	**$ 3,098.000**	**$ 3,339.000**	**$ 3,700.000**	**$ 361.000**
CMS FTEs:				
Discretionary (Federal Administration)	4,102	4,230	4,330	100
Reimbursable (CLIA, CoB, RAC, Marketplace)	532	619	619	0
Mandatory (Direct Appropriations)	47	223	267	44
Subtotal, Program Management FTEs	**4,681**	**5,072**	**5,216**	**144**
Program Management, Proposed Law	0	0	0	0
Total, Program Management FTEs	**4,681**	**5,072**	**5,216**	**144**
HCFAC Mandatory	506	570	570	0
Medicaid Integrity (State Grants; Mandatory)	238	278	278	0
Affordable Care Act Section 3021 (Mandatory)	506	612	624	12
Quality Improvement Organizations	262	297	297	0
Demonstrations	7	9	9	0
No Surprises Act	44	70	70	0
Subtotal, Other Sources FTEs	**1,563**	**1,836**	**1,848**	**12**
Total, CMS FTEs	**6,244**	**6,908**	**7,064**	**156**

/1 FY 2023 Enacted included $455 million for Additional Medicare Operations Funding. CMS has tentatively allocated $435 million to Program Operations, $10 million to Federal Administration, and $10 million to State Survey and Certification, all of which will support Medicare programs.

/2 In FY 2024, CMS proposes to request Research funding within the Program Operations account.

/3 Amounts are net of sequester and pop-up authority, as applicable.

/4 Beginning in FY 2023, anticipated RAC collections into the Program Management account reflects the amount needed to offset annual operations, remaining balances will stay in the Trust Fund.

/5 Includes discretionary funds only for the SSA, DHHS/OS, MedPac, and the SHIPs.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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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 **[**$3,669,744,000**]** *$4,550,070,000* 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**]** *2024* 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, **[**$397,334,000**]** *$565,860,000* shall remain available until September 30, **[**2024**]** *2025*, and shall be available for the Survey and Certification Program: **[**Provided further, That amounts available under this heading to support quality improvement organizations (as defined in section 1152 of the Social Security Act) shall not exceed the amount specifically provided for such purpose under this heading in division H of the Consolidated Appropriations Act, 2018 (Public Law 115-141).**]**

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 **[**$3,669,744,000**]** *$4,550,070,000*, 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**]** *2024* 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, **[**$397,334,000**]** *$565,860,000*, shall remain available until September 30, **[**2024**]** *2025* and shall be available for the Survey and Certification Program.	Extends the period of availability of Survey and Certification funding to two-year.

CMS Program Management
Amounts Available for Obligation
(Dollars in Thousands)

	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS) /1	$4,024,744	$4,124,744	$4,550,070
Trust Fund Mandatory Appropriation:			
PAMA/SGR (PL 113-93)	$4,857	$4,715	$1,886
IMPACT Act (PL 113-185)	$5,464	$5,304	$5,304
BBA (PL 115-123)	$4,857	$4,715	$4,715
Consolidated Appropriations (PL 116-260)	$45,657	$49,036	$16,031
Postal Services Reform Act (PL 117-108)	$7,500	$0	$0
Bipartisan Safer Communities Act (PL 117-159)	$8,000	$5,000	$4,715
Inflation Reduction Act (PL 117-169)	$3,046,500	$90,000	$44,321
Consolidated Appropriations Act, 2023 (PL 117-328)	$0	$36,000	$0
Subtotal, trust fund mand. Appropriation /2	$3,122,835	$194,770	$76,972
Mandatory Appropriation:			
MIPPA (PL 110-275)	$2,914	$2,829	$2,829
Subtotal, trust fund mand. Appropriation /2	$2,914	$2,829	$2,829
Offsetting Collections from Non-Federal Sources:			
Sale of data user fees	$37,077	$30,000	$35,000
Independent dispute resolution (IDR) fees	$0	$800	$1,600
Intra-Agency Agreement (IAA) reimbursements	$37,935	$53,233	$53,233
Marketplace user fees (FFM)	$1,780,401	$1,986,340	$2,073,887
Risk Adjustment user fees (RA)	$70,558	$60,674	$60,000
Recovery audit contracts /3	$693,929	$209,544	$238,409
CLIA user fees	$72,664	$66,010	$66,010
Part D COB user fees	$51,068	$47,150	$47,150
MA/PDP user fees	$106,079	$105,531	$109,354
Provider enrollment user fees	$25,000	$29,799	$24,342
Civil Monetary Penalties	$27,907	$21,925	$22,232
Subtotal, offsetting collections /4	$2,902,618	$2,611,006	$2,731,217
Total Budget Authority /5	**$10,053,111**	**$6,933,349**	**$7,361,088**

/1 Includes funding provided in the appropriation under Section 227, which includes $355 million in FY 2022 and $455 million in FY 2023 to support Program Management activity related to the Medicare Program.
/2 Current law display. Net of sequester.
/3 Beginning in FY 2023, anticipated RAC collections into the Program Management account reflects the amount needed to offset annual operations, remaining balances will stay in the Trust Fund.
/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

(Dollars in Millions)

FY 2023 Enacted	
Total estimated budget authority 1/	$4,124.744
(Obligations) 1/	($4,124.744)
FY 2024 President's Budget	
Total estimated budget authority 1/	$4,550.070
(Obligations) 1/	($4,550.070)
Net Change	**$425.326**

	FTE	FY 2023 Enacted	FTE	FY 2024 President's Budget	FTE	FY 2024 +/- FY 2023
Increases:						
A. Program:						
1. Program Operations		$2,914.823		$3,130.187		$215.364
2. Federal Administration	4,230	$782.533	4,330	$854.023	100	$71.490
3. State Survey & Certification		$407.334		$565.860		$158.526
Subtotal, Program Increases 1/		**$4,104.690**		**$4,550.070**		**$445.380**
Total Increases 1/						**$445.380**
Decreases:						
A. Program:						
1. Research 2/		$20.054		$0		($20.054)
Subtotal, Program Decreases 1/		**$20.054**		**$0**		**($20.054)**
Total Decreases 1/						**($20.054)**
Net Change 1/						**$425.326**

1/ Reflects enacted discretionary funds, only. Excludes budget authority and staffing from mandatory funds.
2/ Funding for Research is included within the FY 2024 total for Program Operations.

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

	FY 2022 Final	FY 2023 Enacted /1	FY 2024 President's Budget
1. Program Operations	$2,479,823	$2,479,823	$3,130,187
Additional Medicare Operations Funding	$355,000	$435,000	$0
MIPPA (PL 110-275)	$3,000	$3,000	$3,000
PAMA/SGR (PL 113-93)	$5,000	$5,000	$2,000
BBA (PL 115-123)	$5,000	$5,000	$5,000
Consolidated Appropriations Act (PL 116-260)	$37,000	$42,000	$7,000
Postal Services Reform Act (PL 117-108)	$7,500	$0	$0
Bipartisan Safer Communities Act (PL 117-159)	$8,000	$5,000	$5,000
Inflation Reduction Act (PL 117-169)	$3,046,500	$90,000	$47,000
Consolidated Appropriations Act, 2023 (PL 117-328)	$0	$36,000	$0
Sequester	($1,429)	($3,135)	($3,933)
Subtotal, Program Operations	**$5,945,394**	**$3,097,688**	**$3,195,254**
(Obligations) /2	($3,479,360)	($3,248,660)	($3,218,249)
2. Federal Administration	$772,533	$772,533	$854,023
Additional Medicare Operations Funding	$0	$10,000	$0
Sequester	$0	$0	$0
Subtotal, Federal Administration	**$772,533**	**$782,533**	**$854,023**
(Obligations) /3	($769,505)	($782,533)	($854,023)
3. State Survey & Certification	$397,334	$397,334	$565,860
Additional Medicare Operations Funding	$0	$10,000	$0
IMPACT Act (PL 113-185)	$5,625	$5,625	$5,625
Consolidated Appropriations Act (116-260)	$10,000	$10,000	$10,000
Sequester	($447)	($891)	($891)
Subtotal, State Survey & Certification	**$412,512**	**$422,068**	**$580,594**
(Obligations)	($403,563)	($422,068)	($580,594)
4. Research, Demonstration & Evaluation /4	$20,054	$20,054	$0
Sequester	$0	$0	$0
Subtotal, Research, Demonstration & Evaluation	**$20,054**	**$20,054**	**$0**
(Obligations)	($20,044)	($20,054)	$0
5. Reimbursables	$2,947,566	$2,646,134	$2,760,204
Sequester	($141,735)	($146,040)	($154,267)
Sequester Pop-Up	$96,787	$110,912	$125,280
Subtotal, User Fees	**$2,902,618**	**$2,611,006**	**$2,731,217**
(Obligations)	($2,398,476)	($2,233,306)	($2,014,223)
Total, Budget Authority /5	**$10,053,111**	**$6,933,349**	**$7,361,088**
(Obligations)	**($7,070,948)**	**($6,706,621)**	**($6,667,089)**
FTE	**4,681**	**5,072**	**5,216**

/1 FY 2023 Enacted included $455 million for Additional Medicare Operations Funding. CMS has tentatively allocated $435 million to Program Operations, $10 million to Federal Administration, and $10 million to State Survey and Certification, all of which will support Medicare programs.

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

/3 FY 2022 obligations include administrative cost reimbursements from external agencies.

/4 Research is appropriated its own PPA in FYs 2022 and 2023. In FY 2024, CMS proposes to request this funding within the Program Operations account.

/5 Reflects CMS's current law request. Totals may not add due to rounding.

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 2023 Funding Level in the Authorization**	**FY 2024 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	N/A	N/A	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, P.L. 109-432	N/A	N/A	Permanent	Program Authority

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($14,089,000)
Subtotal				$178,911,000
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
2016				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ARRA (PL 111-5)	$0	$0	$0	$65,000,000
Sequestration	$0	$0	$0	($4,624,000)
Subtotal				$63,376,000
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
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
Bipartisan Budget 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

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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
Bipartisan Budget 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
Bipartisan Budget 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
2021				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
American Rescue Plan (PL 117-2) **3/**	$0	$0	$0	$500,000,000
Consolidated Appropriations Act, '21 (PL 116-260)	$0	$0	$0	$37,000,000
Sequestration	$0	$0	$0	$0
Subtotal				$540,000,000
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
Bipartisan Budget Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Consolidated Appropriations Act, '21 (PL 116-260)	$0	$0	$0	$61,000,000
Sequestration	$0	$0	$0	$0
Subtotal	$3,693,548,000	$3,984,744,000	$3,974,744,000	$4,044,436,000
2022				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Postal Services Reform Act (PL117-108)	$0	$0	$0	$7,500,000
Bipartisan Safer Communities Act (PL 117-159)	$0	$0	$0	$8,000,000
Inflation Reduction Act (PL 117-169)	$0	$0	$0	$3,046,500,000
Sequestration	$0	$0	$0	($85,734)
Subtotal				$3,064,914,266
Trust Fund Appropriation:				
Base **1/**	$4,315,843,000	$4,315,843,000	$4,250,843,000	$4,024,744,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$5,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
Bipartisan Budget Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Consolidated Appropriations Act, '21 (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	$4,085,579,298

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2023				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Bipartisan Safer Communities Act (PL 117-159)	$0	$0	$0	$5,000,000
Inflation Reduction Act (PL 117-169)	$0	$0	$0	$90,000,000
Consolidated Appropriations Act, '23 (PL 117-328)				$26,000,000
Sequestration	$0	$0	$0	($171,000)
Subtotal				$123,829,000
Trust Fund Appropriation:				
Base **1/**	$4,346,985,000	$4,346,985,000	$0	$4,124,744,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$5,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
Bipartisan Budget Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Consolidated Appropriations Act, '21 (PL 116-260)	$0	$0	$0	$52,000,000
Consolidated Appropriations Act, '23 (PL 117-328)				$10,000,000
Sequestration	$0	$0	$0	($3,854,625)
Subtotal	$4,346,985,000	$4,346,985,000	$0	$4,198,514,375
2024				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Bipartisan Safer Communities Act (PL 117-159)	$0	$0	$0	$5,000,000
Inflation Reduction Act (PL 117-169)	$0	$0	$0	$47,000,000
Sequestration	$0	$0	$0	($3,135,000)
Subtotal				$51,865,000
Trust Fund Appropriation:				
Base **4/**	$4,550,070,000	$0	$0	$0
PAMA/SGR (PL 113-93)	$0	$0	$0	$2,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
Bipartisan Budget Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Consolidated Appropriations Act, '21 (PL 116-260)	$0	$0	$0	$17,000,000
Sequestration	$0	$0	$0	($1,688,625)
Subtotal	$4,550,070,000	$0	$0	$27,936,375

1/ Base appropriation includes $305 million through FY 2021, $355 million in FY 2022, and $455 million in FY 2023 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 and Prevention (CDC).

4/ 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 2023

CMS Program Management has no appropriations not authorized by law.

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Program Operations [1]

(Dollars in Thousands)

FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
$2,834,823	$2,914,823	$3,130,187	$215,364

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 2023 Authorization – One Year/Multi-Year P.L. 117-328

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 access to health care,

[1] FY 2022 includes $355 million in additional Medicare Operations funding from the General Provision. In FY 2023, CMS has tentatively allocated $435 million to Program Operations, $10 million to Federal Administration, and $10 million to State Survey and Certification, all of which will support Medicare programs.

reforming the health care delivery system, providing affordable health care, investing in health equity, 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 67 million beneficiaries in FY 2024. 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 2020 [2]	$2,774,823,000
FY 2021 [3]	$2,772,890,000
FY 2022 Final	$2,834,823,000
FY 2023 Enacted	$2,914,823,000
FY 2024 President's Budget	$3,130,187,000

Budget Request: $3,130.2 Million

CMS's FY 2024 Budget Request for Program Operations is $3,130.2 million, an increase of $215.4 million above the FY 2023 Enacted level. This requested funding is critical to maintain the administration of the Medicare, Medicaid, CHIP, and private insurance programs. The funding increase also supports continuation of implementing directives from new Executive Orders (EOs); including activities fostering diversity, equity, and inclusion in healthcare, the creation of data services and products to modernize operations, and an increased investment for IT security. In addition, this budget invests in several critical administration initiatives including, but not limited to, the opioid crisis, operational funding to support unfunded sections of the Inflation Reduction Act (IRA). The budget includes an adequate funding level to support state use of the Federal Marketplace Data Services Hub to determine Medicaid eligibility and to support ongoing Medicare Administrative Contractor operations, which are both essential for proper operations of Medicare and Medicaid.

Assuming present policy assumptions impacting CMS, if future annual appropriations flatline, CMS's budget deficit will continue to grow annually. Over the past few fiscal years, CMS has experienced unprecedented cost growth for ongoing workloads, primarily due to inflation, in addition to unfunded new workloads (Executive Orders, new legislation, and other priorities, etc.). The requested budget amount is needed to maintain the operational integrity of CMS programs and administrative tasks supporting our health plan offerings.

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

Program Operations
(Dollars in Thousands)

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
I. Medicare Parts A&B				
Ongoing Operations	$811,618	$756,630	$861,972	$105,342
FFS Operations Support	$42,398	$50,157	$51,589	$1,432
Claims Processing Investments	$86,099	$86,821	$87,093	$272
DME Competitive Bidding	$4,446	$2,161	$9,440	$7,278
QIC Appeals	$59,649	$62,029	$60,631	($1,398)
II. Medicare Parts C&D				
Oversight and Management of Health Plans	$56,839	$44,144	$46,336	$2,192
Medicare Parts C and D Appeals	$32,626	$32,810	$33,550	$739
Medicare Parts C and D IT Systems Investments	$35,784	$38,930	$38,716	($214)
III. Medicaid & CHIP				
MACBIS	$84,697	$71,088	$92,226	$21,138
MAC Scorecard	$5,151	$5,200	$6,200	$1,000
Section 1115 Waivers	$21,141	$16,696	$28,000	$11,304
Medicaid Oversight and Support	$92,301	$192,973	$226,818	$33,845
IV. Private Health Insurance				
Market Oversight and Support	$11,604	$8,985	$11,424	$2,438
Federal Marketplaces	$119,685	$121,000	$137,003	$16,003
V. Outreach & Education				
NMEP	$294,817	$365,388	$359,428	($5,960)
Targeted Outreach and Enrollment	$41,345	$21,728	$19,850	($1,878)
VI. Improving Health Care Quality				
Health Care Quality Initiatives	$38,410	$51,634	$53,892	$2,259
Quality Surveys and Qualitative Reporting	$21,344	$14,591	$15,931	$1,340
Quality Payment Program	$42,605	$42,708	$42,000	($708)
VII. Enterprise Operations				
Accounting and Audits	$100,323	$101,326	$100,702	($624)
HIPAA Administrative Simplification	$34,127	$32,320	$36,284	$3,963
IT Systems and Support	$654,665	$658,387	$681,428	$23,042
Operational Support	$113,101	$94,033	$66,726	($27,307)
Opioid Support Services	$6,144	$5,064	$8,032	$2,968

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Research, Demonstrations, and Evaluation	$0	$0	$20,297	$20,297
Health Equity/Rural Health	$17,236	$14,902	$25,000	$10,098
Data Automation and Operations Modernization	$6,666	$4,466	$0	($4,466)
Inflation Reduction Act (IRA) Support	$0	$18,650	$9,618	($9,032)
TOTAL	**$2,834,823**	**$2,914,823**	**$3,130,187**	**$215,364**

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 CMS contractors 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 2021 Actual	FY 2022 Actual	FY 2023 Estimate	FY 2024 Estimate
Part A (in thousands)	221,090	227,968	230,248	232,550
Part B (in thousands)	959,148	1,040,023	1,050,423	1,060,928
Total	**1,180,238**	**1,267,991**	**1,280,671**	**1,293,478**

Budget Request: $862.0 Million

The FY 2024 Budget Request for Ongoing Operations is $862.0 million, an increase of $105.3 million above the FY 2023 Enacted level. With this funding, the MACs can continue processing Medicare claims accurately, in a timely manner, and in accordance with CMS's program requirements. The funding supports a one percent increase in MAC workloads and covers additional costs due to inflation. All possible savings for the MAC contracts have already been maximized due to years of contract spend optimization. CMS expects MAC costs to continue growing annually assuming present CMS policy, inflationary cost growth for services, and Agency specific actuarial assumptions that impact programmatic cost.

In FY 2024, 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 2024, 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 2024, contractors are expected to respond to 11.5 million telephone inquiries and 300,000 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 2021 Actual	FY 2022 Actual	FY 2023 Estimate	FY 2024 Estimate
Completed Calls	12.6	11.5	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 CMS's Office of Program Operations and Local Engagement (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 2024, CMS has scheduled the contract re-procurements for Jurisdiction J A/B MAC and Jurisdiction A DME MAC.

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: $51.6 Million

The FY 2024 Budget Request for FFS Operations Support is $51.6 million, an increase of $1.4 million above the FY 2023 Enacted level. The increase in funding supports ongoing operations and standard annual increases such as increased postage costs for mailing and inflation. 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 aid 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 2023 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. 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: $87.1 Million

The FY 2024 Budget Request for Claims Processing Systems is $87.1 million, an increase of $0.3 million above the FY 2023 Enacted level. At this funding level, CMS will be able to continue ongoing maintenance and operations for these systems.

- *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). The MEPBS is a portfolio of mission critical applications systems/services for CMS that manage Medicare Beneficiary Demographics, Part A & B Entitlement and Premium, Part D Eligibility, Direct Billing, Premium Collection, Third Party, and Low Income Subsidy.

- *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: $9.4 Million

The FY 2024 Budget Request for DME Competitive Bidding is $9.4 million, an increase of $7.3 million above the FY 2023 Enacted level. 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. The FY 2024 budget request continues funding ongoing operations and maintenance and includes additional funding to prepare for the upcoming FY 2024 Competitive Bidding Survey Contract (CBSC) re-competition.

- *Competitive Bidding Survey Contractor (CBSC)*: The FY 2024 request will fund the contract to conduct remaining baseline surveys via telephone and/or electronically to key stakeholders (i.e., beneficiaries, suppliers, and referral agents), analyze baseline survey results, and memorialize the baseline survey findings. Additionally, it will cover transitions costs if this contract is awarded to another contractor when re-competed.

- *DME Bidding Systems (DBidS)*: DBids allows for entities to submit an online application to participate Medicare's DMECB Program. The FY 2024 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: $60.6 Million

The FY 2024 Budget Request for QIC Appeals (BIPA section 521) is $60.6 million, a decrease of $1.4 million below the FY 2023 Enacted level. Funding supports ongoing QIC processing of 2nd level appeals (non-Recovery Audit contractor related) and related workloads within the statutorily mandated 60-day timeframe. The table below includes the updated appeals estimates.

- *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. 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 2024 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 2021 Actual	FY 2022 Actual	FY 2023 Estimate	FY 2024 Estimate
Non-RAC QIC Appeals	177,966	177,909	176,084	177,820
% Increase from Previous Year	-18.24%	-0.03%	-1.03%	0.99%

- *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: $46.3 Million

The FY 2024 Budget Request for Oversight and Management of Health Plans is $46.3 million, an increase of $2.2 million above the FY 2023 Enacted level. CMS funds a contract to assist OACT in reviewing prescription drug and Medicare Advantage bids submitted by plans. The FY 2024 increase is due to an approximately three percent increase in the contractor's hourly rate and an increase in the volume of reviews.

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

Section 1852(g)(4) of the Social Security Act, as amended by Title II of the Medicare Modernization Act, requires CMS to contract with an independent review entity (IRE) to conduct standard and expedited reconsiderations of adverse organization determinations and reconsiderations issued by Medicare health plans. Additionally, the IRE conducts reconsiderations of coverage denials made by Program of All-inclusive Care for the Elderly (PACE) organizations. 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: $33.6 Million

The FY 2024 Budget Request for Medicare Parts C and D Appeals is $33.6 million, an increase of $0.7 million above the FY 2023 Enacted level. CMS budgeted for a 3 percent increase in appeals volume for Part C. Funding supports the annual operational costs to timely adjudicate Parts C and D appeals and includes an increase to review adverse reconsiderations made by Part C plans and non-contract provider payment disputes. It is difficult to estimate the potential changes in workload and funding needs for FY 2024 due to a growing percentage of

beneficiaries choosing to enroll in MA plans over Original Medicare. The funding request supports the workload projections presented in this section, and actual FY 2024 workloads may outpace these projections.

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

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

	FY 2021 Actual	FY 2022 Actual	FY 2023 Estimate	FY 2024 Estimate
Part C Appeals	126,647	160,428	206,000	211,000
Part D Benefit Appeals	30,317	38,047	33,000	34,000
Part D LEP Appeals	49,352	46,629	53,000	54,000

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: $38.7 Million

The FY 2024 Budget Request for Parts C and D IT Systems Investments is $38.7 million, a decrease of $0.2 million below the FY 2023 Enacted level. The request allows CMS to effectuate 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 91 million, or 1 in 4, Americans are expected to be enrolled in Medicaid and CHIP in FY 2024.

Medicaid and CHIP Business Information Solution (MACBIS)

The Medicaid and CHIP Business Information Solution (MACBIS) helps CMS 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 providing infrastructure, automated tools, and data analytics to drive improved operations for Medicaid and CHIP, which provides care to millions of individuals across 56 states and territories. MACBIS consists of services and related product development efforts designed to deliver an integrated set of modern digital products and data management strategy aimed at ensuring CMS protects access to coverage and care, advances healthy equity, and

drives innovation and whole person care in Medicaid and CHIP. Through MACBIS, CMS, stakeholders, states, and researchers are provided the ability to gather and analyze data to support program integrity activities, improving monitoring, oversight, and evaluation of Medicaid and CHIP overall.

Budget Request: $92.2 Million

The FY 2024 Budget Request for MACBIS is $92.2 million, an increase of $21.1 million above the FY 2023 Enacted level. The funding increase supports MACFin and data analytic work. MACFin is continuing its evolution as the modernized solution for CMS and States to improve the accuracy of over $620 billion in annual state-reported budget and expenditure data, and is essential for Federal and state administration of the Medicaid and CHIP programs. Funding supports continued development, redesign, and operations of systems that support this program including cloud computing costs (AWS). Additionally, the increase will support sharing, using and improving MACBIS data which aligns to the goal of data adoption. Through MACBIS data, CMS will enhance its ability to conduct Medicaid and CHIP program monitoring and oversight, provide technical assistance to states, inform policy and program development, support research and evaluation and public reporting.

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. 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. Additionally, starting with the 2020 Scorecard, users were 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. Because the COVID-19 public health emergency (PHE) had far-reaching impacts on Medicaid and CHIP programs and data, CMS decided not to add new measures to the 2021 MAC Scorecard in an effort to minimize any new reporting burden due to the PHE. As a result, the 2021 MAC Scorecard included updated data, minor changes to how certain existing measures are displayed but no new measures were added. 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 the following areas:

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

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

Budget Request: $6.2 Million

The FY 2024 Budget Request for the MAC Scorecard is $6.2 million, an increase of $1.0 million above the FY 2023 Enacted level. Activities include operational support to Medicaid.gov since that is where the Scorecard site is located as well as other Medicaid and CHIP programs that produce performance metrics and data analytics that are used in the Scorecard.

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. This level of funding will 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, continued improvements to user experience via usability testing, and working with interested states on 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 expand coverage, integrate behavioral and physical heath, address health related social needs, and improve the quality of service delivery to improve health outcomes and close health disparity gaps, and to increase the value of federal government and state investments in these programs. Over ninety percent of states have at least one section 1115 demonstration and many run the lion share of their Medicaid program through this authority, representing nearly forty percent of federal outlays in the Medicaid program. This activity provides policy and operational technical assistance to CMS for states' Section 1115 demonstration implementation, data reporting, oversight and evaluation.

Budget Request: $28.0 Million

The FY 2024 Budget Request for Section 1115 Waivers is $28.0 million, an increase of $11.3 million above the FY 2023 Enacted level. CMS is requesting additional funds to improve capacity for and to make more robust state and federal monitoring and evaluation of these demonstrations. These activities provide technical assistance in the design of performance measurement, data development, and methods for and review of evaluations to support policy advancement in Medicaid and CHIP. This includes developing implementation plan and monitoring plan templates, performance metric sets, and evaluation guidance, providing direct technical assistance to states and reviewing reports to focus on closing health disparity gaps, and to understand what policies and implementation approaches actually successfully address health related social needs, improve maternity outcomes, improve health outcomes for people transitioning out of the carceral system, and provide more comprehensive and better integrated care delivery. CMS will use this funding to re-compete the contract in FY 2024.

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: $226.8 Million

The FY 2024 Budget Request for Medicaid Oversight and Support is $226.8 million, an increase of $33.8 million above the FY 2023 Enacted level. The increase supports Medicaid eligibility determinations transaction costs made via the Federal Data Services Hub by states. CMS projects the volume of state Medicaid/CHIP agency transaction requests will increase to support Medicaid redeterminations and renewals as a result, in large part, of the end of the continuous enrollment condition and transitioning from the flexibilities under the COVID-19 Public Health Emergency. The requested amount includes the per-transaction annual rate increase built into the Commercial Sources of Income contract.

Medicaid Oversight and Support funding is necessary to fulfill ongoing statutory requirements of Sec. 1139B of the Affordable Care Act (ACA) to improve quality of and equitable access to care for Medicaid adults, as demonstrated through performance on the Adult Core Set measures. ACA section 2701 funding is expected to exhaust in FY 2024; therefore, CMS is requesting funding for Adult Health Quality work out of this account in FY 2024.

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 would support a contractor providing this service. In FY 2024, this contractor would: 1) provide approximately 22.1 million income data transactions for Medicaid and CHIP programs (including initial determinations and redeterminations/renewals); and 2) provide monthly project management and conduct ongoing service maintenance to support this body of work. These

income data transactions will be requested across 23 state Medicaid/CHIP programs, in order to determine applicants' 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.

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: $11.4 Million

The FY 2024 Budget Request for Market Oversight and Support is $11.4 million, an increase of $2.4 million above the FY 2023 Enacted level. The FY 2024 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: $137.0 Million

The FY 2024 Budget Request for the Marketplaces is $137.0 million, an increase of $16.0 million above the FY 2023 Enacted level. 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 160 million people and is focused on providing quality care. As such, outreach and education are 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: $359.4 Million

The FY 2024 Budget Request for NMEP is $359.4 million, a decrease of $6.0 million below the FY 2023 Enacted level. To accommodate cost increases for the Medicare & You Handbook and the beneficiary call center, the request reduces the multi-media education outreach campaign for several market segments. CMS will adjust its community-based outreach efforts

to reflect a sufficient level of effort for direct response marketing and outreach to underserved populations, within the budget request.

As for the other activities funded under the NMEP program, The Medicare & You Handbook costs have risen exponentially due to inflation and supply chain constraints. CMS expects to spend over $100.0 million in FY 2023 to mail handbooks and over $140.0 million in FY 2024 as required by statute[4]. Funding levels also allow CMS to maintain approximately a 5-minute ASA for the 1-800-MEDICARE call center. Within this funding request, CMS will also have ongoing operational funding to continue eMedicare self-service transactions using personalized Medicare data as requested by beneficiaries.

[4] Under Title XVIII of the Social Security Act (SSA), the Balanced Budget Act (BBA) of 1997 and the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.

National Medicare Education Program Budget Summary
(Dollars in Millions)

NMEP Category/Description of Activity	Funding Source	FY 2022 Final	FY 2023 Enacted	FY 2024 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	$46.60	$78.00	$84.00
	Postage	$41.09	$49.60	$58.90
	Total	**$90.69**	**$127.60**	**$142.90**
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	$142.34	$174.14	$185.00
	User Fees	$93.43	$108.60	$109.40
	Total	**$235.77**	**$282.74**	**$294.40**
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	$54.15	$53.50	$50.50
	Total	**$54.15**	**$53.50**	**$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 aid Medicare beneficiaries in their communities.	PM	$3.24	$15.86	$6.35
	Total	**$3.24**	**$15.86**	**$6.35**
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	$45.49	$43.89	$33.58
	Total	**$45.49**	**$43.89**	**$33.58**
Funding Source Breakout Total	**PM**	**$294.82**	**$365.39**	**$359.43**
	User Fees [5]	**$93.43**	**$108.60**	**$109.40**
	Postage	**$41.09**	**$49.60**	**$58.90**
	Total	**$429.34**	**$523.59**	**$527.73**

[5] The FY 2022 Final amount reflects actual obligations. FY 2023 and FY 2024 amounts reflect total collections.

- *Beneficiary Materials*: The total FY 2024 request for the handbook is $142.9 million, of which $84.0 million is discretionary budget authority to mail 53 million handbooks. Handbook costs began increasing at a higher than normal rate towards the end of FY 2021. Contractor rates are updated annually and bids are collected every spring for the fall mailing. Therefore, CMS estimates outyear costs based on current market conditions. It should be noted that this handbook estimate is based on current market conditions and expected contract terms for FY 2024. Although the increased funding is due to many reasons, inflationary cost adjustments for materials and services as well as increases in postage are the main drivers. There are also fewer printing companies large enough that bid for this work which limits CMS's options.

  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 emailed to them each fall. Less than 4 percent of beneficiaries have opted out despite CMS promoting this option in recent years. 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 2021 and the estimated distribution for FY 2022 through FY 2024. 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. This table show estimates under current law.

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

	FY 2021 Actual	FY 2022 Actual	FY 2023 Estimate	FY 2024 Estimate
Number of Handbooks Distributed	48.7	50.0	52.0	53.0

- *1-800-MEDICARE*: The total FY 2024 request is $294.4 million, of which $185.0 million is discretionary budget authority. The request reflects the contract's operational need supporting the estimated FY 2024 workload under current law. Additional funding supports increased costs for historical workloads and funding to support Inflation Reduction Act (IRA) related inquiries from beneficiaries. 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 2021 and the number of calls CMS expects to receive in FY 2022 through FY 2024. 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 2024 request level, CMS anticipates an average speed to answer of approximately 5 minutes.

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

	FY 2021 Actual	FY 2022 Actual	FY 2023 Estimate	FY 2024 Estimate
Number of Calls	23.9	23.9	24.0	23.9

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.

  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 2021 Actual	FY 2022 Actual	FY 2023 Estimate	FY 2024 Estimate
Number of Page Views for http://www.Medicare.gov	530.2	550.0	575.0	600.0

- *Community-Based Outreach*: $6.4 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 2024 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*: $33.6 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.

In addition to the Program Management budget authority request, the NMEP budget request assumes $109.4 million in user fees and $58.9 million in postage funding, bringing the total FY 2024 Budget Request for NMEP to $527.7 million, an increase of $4.1 million above the total FY 2023 Enacted level.

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: $19.8 Million

The FY 2024 Budget Request for Targeted Outreach and Enrollment is $19.8 million, a decrease of $1.9 million below the FY 2023 Enacted level. Funding would provide updates to existing outreach materials, strategic planning, policy analysis support, and other programs including Coverage 2 Care (C2C). The scope also includes support for minorities, rural populations, linguistically "challenged", the disabled, and other identified vulnerable populations.

- *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 mailing Medicare Beneficiary Identifier (MBI) cards 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, 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* funding request is included in the "Health Equity" section later in the chapter.

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: $53.9 Million

The FY 2024 Budget Request for Health Care Quality Initiatives is $53.9 million, an increase of $2.3 million above the FY 2023 Enacted level. Funding supports ongoing operations for the activities included in this request.

Additional details for this request are included below:

- *Medicare Shared Savings Program (MSSP)*: In FY 2024, approximately 500 Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) will serve over 10.7 million Medicare Fee-for-Service beneficiaries. In FY 2021, the Program Analysis and CAHPS Survey Administration contracts were awarded for five years with two-year base periods and three optional periods. 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.

- *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. The Qualified Entity (QE) contractor is scheduled for a re-compete in FY 2024.

Quality Surveys and Qualitative Reporting

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. The quality of services is measured clinically, administratively, and through the use of patient experience of care surveys.

Budget Request: $15.9 Million

The FY 2024 Budget Request for Quality Surveys is $15.9 million, an increase of $1.3 million above the FY 2023 Enacted level. The FY 2024 request continues ongoing operations for FY 2023 workloads and includes a slight increase for inflationary contract cost growth. The work is 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. 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 policy analysis, product development, product enhancement, and 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: $42.0 Million

The FY 2024 Budget Request for the Quality Payment Program (QPP) is $42.0 million, a decrease of $0.7 million below the FY 2023 Enacted level. At this funding level, CMS will continue ongoing operational support for MIPS, including maintenance of current MIPS measures, providing responses to stakeholder inquiries, data analytics to support policy decisions, and strategic analysis of CMS's policies on clinician value-based payment programs consistent with the FY 2023 level of effort.

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: $100.7 Million

The FY 2024 Budget Request for Accounting and Audits is $100.7 million, a decrease of $0.6 million below the FY 2023 Enacted level. 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's 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 6, 2023, CMS has recouped $1.485 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 2024 Budget Request for HIPAA Administrative Simplification is $36.3 million, an increase of $4.0 million above the FY 2023 Enacted level. This request supports ongoing operations and maintenance. 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 2024, CMS expects the migration to the cloud will be completed.

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.

Budget Request: $681.4 Million

The FY 2024 Budget Request for Information Technology Systems and Support activities is $681.4 million, an increase of $23.0 million above the FY 2023 Enacted level. 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 continuing the enhancement of Medicare's outdated fee-for service claims processing systems and proactive disaster recovery efforts. CMS continues to find efficiencies in cloud migration and looks to continue to maximize the cost savings of these investments.

The following are priorities within the IT systems and support category:

- *IT Security*: CMS faces a daily cybersecurity threat due to the value of the data it safeguards and the increased technical capability of "bad actors" across the globe. Threats continue to intensify and CMS must enhance its IT Security program to meet potential threats. In recent years, CMS's IT Security program worked to streamline the enterprise wide authority to operate process, increased cyber threat identification and improved cybersecurity training. In FY 2024, CMS will be tailoring its response to EO 14028 (Improving the Nation's Cybersecurity) which will include establishing Zero Trust Architecture (ZTA) as a pilot for batCAVE (Continuous Authorization and Verification

Engine).[6] The program will also continue limited ongoing development efforts associated with batCAVE and the Security Data Lake.

- *Continuity of Operations Disaster Recovery (COOP/DR*)*:* CMS continues to build the agency-wide COOP and DR program following audit findings in 2019 that determined the programs and systems that support CMS mission-essential functions require increased capabilities to meet federal requirements. Most recently, CMS's COOP and DR program completed the establishment of Enterprise Disaster Recovery hosting. In addition, the program migrated several CMS systems to the COOP/DR environment and established data replication for various vital virtual data centers in the new disaster recover sites. The program also migrated the workload and DR services for a variety of End User IT and Unified Communication services. In FY 2024, CMS will continue migrating the remaining systems to the COOP/DR environment through a scaled approach. CMS will also continue the build-out of COOP/DR services with the future goal of fulfilling all of the Agency's needs at the enterprise level.

- *Medicare Payment Systems Modernization (MPSM) Initiative*: This program enhances Medicare's outdated fee-for-service claims processing systems so that CMS can fulfill its duty to be a reliable first-class Medicare payer. CMS's MPSM program reached many milestones that provide valuable services to Medicare beneficiaries, providers, and claims processors. CMS has completed the modernization of all ten Institutional Claims Pricers and has transitioned all eight-claim payment estimating tools from a localized software to a web-based service. CMS also began replicating claims and claims processing-related data from the mainframe to the cloud. In FY 2024, the program will be fully functioning in its newly completed architecture, as outlined in the "Strategic Roadmap". It will also launch design sessions for modernizing beneficiary-centric functionality and data that supports all Medicare claim adjudication. MPSM will continue its iteration on current product lines such as provider data services, beneficiary API, pricing and coding service, and data replication to the cloud.

  In addition, CMS is conducting user research and initiating development for the recently mandated initiative of accepting Dental claims (*a new claim type for CMS*) by January 1st, 2024. The flexibility of CMS's strategic roadmap is highlighted by the integration of Dental Services Modernization into MPSM's product portfolio, insuring CMS will be able to receive, process, and pay for covered dental services on ADA claim forms in a way that supports the larger Medicare Payment System Modernization effort.

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, decreases administrative cost, 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.

[6] For more information on CMS's response to EO 14028 and Zero Trust, please refer to the Security section of the Information Technology narrative.

Budget Request: $66.7 Million

The FY 2024 Budget Request for Operational Support is $66.7 million, a decrease of $27.3 million below the FY 2023 Enacted level. The decrease considers that CMS's acquisition system upgrades and development work will be completed, some innovation and modernization efforts will halt, and access to services described in this section will be scaled back to reflect funding availability. CMS will continue to invest in high priority activities and seek efficiencies to maximize resources.

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. In addition, funding is necessary to support enterprise-wide contract closeout support efforts, as well as conduct background investigations on all CMS contractors in order to comply with the HSPD-12 directive.

- *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.

- *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 provisions of the SUPPORT Act that address improved behavioral health; access to SUD prevention, treatment and recovery services; and data for effective actions and impact.

Budget Request: $8.0 Million

CMS's FY 2024 Budget Request for Opioid and SUD Support is $8.0 million, an increase of $3.0 million above the FY 2023 Enacted level. In FY 2024, CMS will require funding to support section 2003 of the SUPPORT Act, which requires Medicare Part D prescriptions for Schedules II through V controlled substances (controlled substances) to be transmitted electronically in accordance with an electronic prescription drug program effective January 1, 2021. As part of our ongoing SUD support efforts, CMS will continue to develop IT infrastructure to process EPCS (Electronic prescribing of controlled substances) waivers, and enforce compliance. CMS must develop the system which will accept waivers/hardship applications for compliance, send non-compliance letters and notifications to prescribers, and fund other contracts necessary to perform the duties as required by law.

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 2024 Budget Request for RDE is $20.3 million, an increase of $20.3 million above the FY 2023 Enacted level in Program Operations. CMS is requesting to permanently move the

Research PPA into the Program Operations budget to provide funding flexibility for these activities and programs. The Research budget has remained flat for almost a decade and all contract efficiencies have been maximized. Maintaining the existing level of effort for this body of work is becoming increasingly difficult due to inflationary cost increases such as inflation and personnel wage growth.

- *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 2024, 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 and underserved 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.

CMS recently released its Framework for Health Equity, which outlines a ten-year agency approach to promote health equity and enhance initiatives that are focused on mitigating health

disparities for all disadvantaged or underserved populations. The Framework incorporates 5 priority areas that CMS will use to develop and initiate policies and programs to support health for all people served by Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplaces. The priority areas include expanding the collection, reporting, and analysis of standardized data; assessing the causes of disparities within CMS's programs and addressing inequities in policies and operations to close gaps; building the capacity of health care organizations and the workforce to reduce health and health care disparities; advancing language access, health literacy, and the provision of culturally tailored services; and increasing all forms of accessibility to health care services and coverage.

Budget Request: $25.0 Million

The FY 2024 Budget Request for Health Equity and Rural Health is $25.0 million, an increase of $10.1 million above the FY 2023 Enacted level. In FY 2024, CMS will continue strengthening its efforts and build upon the necessary agency infrastructure to drive equity across all of its programs and policies.

A few highlights for this request are described below:

- *Health Equity Policy Collaborative*: This effort provides insights and tools to help states, territories, and tribes with identifying barriers and opportunities to advance health equity through the CMS programs that they are implementing. These initiatives include, but are not limited to, environmental scans, literature reviews, and interviews with researchers, scientific experts, and advocates at the state, territories, and tribes. Funding will also support any operational needs related to state, territories, and tribe initiatives when requested. This work aligns with the goals laid out in the CMS 2022-2032 Equity Plan.

- *Health Equity Data Analysis System (HEDAS)*: This activity is established to support EO 13985. CMS achieves its mission and vision through core functions that include facilitating management and improvement of CMS minority health data in order to serve as a resource to other CMS components, providing subject matter expertise on minority health disparities and interventions for addressing them. Currently, CMS has limited ability to respond quickly to data requests to inform decision makers. This activity is focused on building a strong analytic environment that integrates data related to underserved populations in order to query data across all of CMS programs and develop dashboards and other reports to support CMS needs. This environment will allow CMS to identify opportunities to conduct predictive and descriptive models to identify disparities and trends over time to ensure that CMS is able to capture the current demographic shifts in the US population, which has implications on health and health care of this country.

- *Policy Analysis and Development*: This activity will provide CMS with the resources to ensure that CMS policies align with priorities outlined in EO 13985 on advancing racial equity to ensure policies and programs are equitable meeting the needs of underserved and disadvantaged communities. Funds will also allow CMS to enhance research opportunities to improve minority health and eliminate health disparities for beneficiaries, foster innovative approaches in planning, development, implementation and evaluation of CMS' programs and policies, and allow CMS to continue to advance its equity portfolio.

Inflation Reduction Act (IRA) Support

On August 16, 2022, the Inflation Reduction Act (P.L. 117-169) was passed into law by Congress. The Inflation Reduction Act provides meaningful financial relief for millions of people with Medicare by improving access to affordable treatments and strengthening the Medicare Program both now and in the long-run. The new law makes improvements to Medicare that will expand benefits, lower drug costs, keep prescription drug premiums stable, and improve the strength of the Medicare program.

Budget Request: $9.6 Million

The FY 2024 Budget Request for IRA Support is $9.6 million, a decrease of $9.0 million below the FY 2023 Enacted level. The request supports the full, successful, and timely implementation of the IRA to deliver lower drug costs for the Medicare population and reduced healthcare costs for millions of other Americans. The budget supports provisions of the law that did not receive direct appropriations, such as vaccine benefits for Medicaid and CHIP enrollees. It also supports CMS enterprise-wide activities necessary to implement the law, such as new information technology infrastructure and upgrades.

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Federal Administration

(Dollars in Thousands)

	FY 2022 Final	FY 2023 Enacted[1]	FY 2024 President's Budget	FY 2024 +/- FY 2023
Budget Authority	$772,533	$782,533	$854,023	$71,490
Indirect Costs	$184,757	$207,000	$207,000	$0
Program Level	**$957,290**	**$989,533**	**$1,061,023**	**$71,490**
FTE	4,102	4,230	4,330	100

Authorizing Legislation – Reorganization Act of 1953

FY 2023 Authorization – Public Law 117-328

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 and programs. This account provides funding for employee compensation, rent and utilities, administrative information technology and contractual services, as well as providing for business needs such as supplies, equipment, printing, training, and travel. Many of these costs are impacted by annual inflationary factors, such as increased costs for benefits paid on behalf of the employee and annual cost of living adjustments (COLA).

CMS is deployed throughout the country and provides oversight for the health care coverage for our large beneficiary and consumer populations. Our organizational structure is designed to focus on facilitating cohesion and integration to carry out the Agency's mission. Employees accomplish the CMS mission by: developing and implementing health care policies and regulations; setting payment rates; providing contractor oversight; delivering education and outreach to beneficiaries, consumers, employers, and providers; fighting fraud, waste, and abuse; and assisting law enforcement agencies in the prosecution of fraudulent activities.

CMS employees also work with State surveyors within health care facilities to ensure compliance with CMS health and safety standards as well as 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.

[1] FY 2023 Enacted included $455.0 million for Additional Medicare Operations Funding. CMS has tentatively allocated $435.0 million to Program Operations, $10.0 million to Federal Administration, and $10.0 million to State Survey and Certification, all of which will support Medicare programs.

Funding History

Fiscal Year	Amount
FY 2020[2]	$782,533,000
FY 2021	$772,533,000
FY 2022 Final	$772,533,000
FY 2023 Enacted[3]	$782,533,000
FY 2024 President's Budget	$854,023,000

Personnel and associated costs for programs and activities, where specific funding sources including mandatory sources 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: $854.0 million

The FY 2024 budget request for Federal Administration is $854.0 million, an increase of $71.5 million above the FY 2023 Enacted level. In addition, CMS projects $207.0 million will be available from the administrative cost allocation; bringing the total program level to $1,061.023 million.

Federal Administration Program Level Summary Table[4]
(Dollars in Thousands)

Objects of Expense	**FY 2022 Final**	**FY 2023 Enacted**	**FY 2024 President's Budget**	**FY 2024 +/- FY 2023**
Personnel Compensation and Benefits	$735,089	$796,100	$854,426	$58,326
Travel	$1,675	$4,200	$8,437	$4,237
Rent, Communications and Utilities	$33,181	$34,182	$34,200	$18
Printing and Postage	$4,597	$2,412	$3,511	$1,099
Contractual Services	$179,932	$148,763	$156,520	$7,757
Service and Supply Fund (non-add)	*$34,886*	*$41,857*	*$43,640*	$1,783

[2] The FY 2020 Final level includes $50.0 million in reprogrammed funds from Program Operations.
[3] The FY 2023 Enacted level includes a tentative $10.0 million from the Medicare programs General Provision 227.
[4] 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 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Administrative Services (non-add)	*$40,785*	*$10,283*	*$12,299*	*$2,016*
Administrative IT (non-add)	*$48,606*	*$39,625*	*$43,199*	*$3,574*
Administrative Contracts and Inter/Intra-Agency Agreements (non-add)	*$55,5655*	*$56,998*	*$57,382*	*$384*
Supplies	$399	$687	$701	$14
Training	$2,488	$3,189	$3,228	$39
Total, Federal Administration	**$957,290**	**$989,533**	**$1,061,023**	**$71,490**

Personnel Compensation and Benefits

Personnel compensation and benefits provides funding for CMS's staff payroll and benefit costs. Beyond payroll, this category provides funding for both CMS's Civilian and Commissioned Corps staff, within-grade increases, awards and overtime, as well as fringe benefits. Commissioned Corps staff are entitled to additional benefits including housing and other allowances. Moreover, this funding provides payroll and benefits for staff to continue to support the development and execution of policies and enhances our ability to meet our Agency's mission. CMS administers programs that provide health care coverage for over a 160 million people through Medicare, Medicaid, CHIP, and the Marketplace across the country. In addition to our core work, CMS continues to advance health equity, improve our customer experience, expand access to health care and drive innovation which will contribute to continuous improvements within our healthcare system and assist with addressing health care challenges. With the requested level of funding, CMS will have the capability to accomplish today's mission, while preparing for tomorrow.

Budget Request: $854.0 million

The FY 2024 budget request includes $854.0 million in discretionary funding for payroll and benefit costs, an increase of $71.5 million over the FY 2023 Enacted level. The requested funding will support 4,330 direct Full-Time Equivalents (FTEs), an increase of 100 FTEs compared to the FY 2023 Enacted level.

Historically, our payroll and benefits increase as a result of annual inflationary costs associated with cost of living adjustments (COLA) and increased benefit costs. Included in the FY 2024 FTE request is a 5.2 percent COLA assumption for civilian, 5.2 percent COLA assumption for Commissioned Corps and a 1.0 percent increase in benefits costs. These assumptions for payroll inflation are projected to result in a $50.0 million increase, which is assumed in this request. The FY 2023 Enacted level invested in CMS's future by elevating our workforce, and this FY 2024 request will maintain this investment. CMS's staffing levels, tied with related compensation and benefits expenses, are largely workload-driven. These staffing levels will enable CMS to execute the Administration's priorities and increased workload, while maintaining and improving the performance of our traditional

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, the Federal Marketplace, and mandatory funding such as that provided by the Inflation Reduction Act. These accounts will cover FTE costs required to execute their specific workload required to meet the Agency's needs. The FY 2024 budget request also includes $5.0 million to support United States Digital Service (USDS) costs at 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.

CMS's responsibilities have grown, including impacts from COVID, legislative mandates, and various coverage expansion and access initiatives. However, our administrative budget has not kept pace with this growth, creating a gap in staffing levels and skillsets. The projected FTE level is vital to bring CMS up to staffing levels that have been decreased by a history of strained staffing resources and will provide flexibility for the Agency to quickly adapt to emerging public health and Administration needs.

Travel

Travel enables CMS to continue our mission by conducting site visits on location at contractor sites, healthcare facilities, and with providers in any State. CMS administers its programs primarily through contractors, which makes site visits and receiving adequate funding a crucial need.

Budget Request: $8.4 million

The FY 2024 budget request includes $8.4 million in program level funding, an increase of $4.2 million above the FY 2023 Enacted level. Travel directly places our staff on the ground to identify and address contract and other issues. These site visits are critical to allow CMS to effectively manage and evaluate programs and to ensure 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. This level of funding also allows for changes in CMS's workforce of the future, which provides various workplace arrangements.

Rent, Communications, & Utilities

Budget Request: $34.2 million

The FY 2024 budget request includes $34.2 million in program level funding, a slight increase above the FY 2023 Enacted level. This object class provides funding for CMS's offices, including rent and operational costs, as calculated by the General Services Administration. CMS's leased locations include CMS Central Office Headquarters in Woodlawn, offices in Washington, D.C. and Bethesda, MD, ten Regional Offices, and outlying offices. CMS is in the middle of a multi-year Real Estate Consolidation effort that is working to reduce the amount of space we rent/lease. Through this process, we expect to realize reductions in our overall rent/lease costs, as the project matures. Other items in this category include certain contract labor costs, such as grounds maintenance, cleaning, and trash and snow removal.

Printing and Postage

Budget Request: $3.5 million

The FY 2024 budget request includes $3.5 million in program level funding, an increase of $1.1 million above our FY 2023 Enacted level. 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

Contractual Services funding covers some financial operations expenses and facility expansion services (e.g., facilities operations maintenance support and major projects) which are funded within administrative services. Contractual Services also include costs for our day-to-day operations via contracts and interagency agreements (IAAs). This category also supports critical information technology infrastructure and services, which provide CMS employees with a secure and technologically efficient workplace.

Budget Request: $156.5 million

The FY 2024 budget request includes $156.5 million in program level funding, an increase of $7.8 million above the FY 2023 Enacted level.

- ***Service and Supply Fund: $43.6 million***

  Funding within this category provides support for CMS share of the HHS's Program Support Center and other shared expenses, including payroll and financial management services required for CMS's daily operations.

- ***Administrative Services: $12.3 million***

  Funding within this category supports Commissioned Corp relocation expenses, facilities major projects and its operations maintenance and support, equipment and furniture maintenance and HSPD-12 program support.

  Although funding is not requested in FY 2024, the Real Estate Consolidation (REC) project remains on schedule in phase completion and is allowing CMS to reduce its overall rent/leases.

- ***Information Technology: $43.2 million***

  Within the contractual services contract lines are IT products and services which support, among other enterprise services, projects focused on modernizing CMS's human resource operations. Funding will allow CMS 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.

- ***Contracts and Intra/Inter-Agency Agreements (IAAs): $57.4 million***

  Essential IAAs, such as legal services with the HHS's Office of General Counsel and security services with the Department of Homeland Security, are funded within this category and are crucial in supporting CMS operations. This funding will also support IAAs with agencies such as the Department of Labor and the Office of Personnel Management to conduct contractor background investigations. Background investigations, provided via IAAs to the servicing Federal Agency, support the HSPD-12 credentialing, which is partially funded within this category. These resources provide support for continuous credentialing of employees and contractors to meet the requirements of Federal policies. In FY 2024, 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. This category also includes support for other aspects of our operations such as mailroom, interpreter services, and warehouse operations.

Supplies

Budget Request: $0.7 million

The FY 2024 budget request includes $0.7 million in program level funding, a slight increase above the FY 2023 Enacted level. As we continue to revamp the CMS work environment, fluctuations in these costs could occur based on employees' needs for resources.

Training

Budget Request: $3.2 million

The FY 2024 budget request includes $3.2 million in program level funding, a slight increase above the FY 2023 Enacted level. 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 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2023 +/- FY 2024
Discretionary				
State Survey and Certification[1]	$397,334	$407,334	$565,860	$158,526
Nursing Home Cross-Cutting Initiative (non-add)	*$0*	*$0*	*$20,000*	*$20,000*
Subtotal, Discretionary	**$397,334**	**$407,334**	**$565,860**	**$158,526**
Mandatory				
IMPACT Act[2]	$5,464	$5,304	$5,304	$0
Consolidated Appropriation Act	$9,714	$9,430	$9,430	$0
Grants to States for Medicaid (S&C)	$318,000	$328,000	$338,000	**$10,000**
Subtotal, Mandatory	**$333,178**	**$342,734**	**$352,734**	**$10,000**
Total	**$730,512**	**$750,068**	**$918,594**	**$168,526**

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 2023 Authorization – Public Law 117-328

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 minimum quality standards through objective, outcome-based verification activities carried out by qualified surveyors. The S&C program serves Long-Term Care (LTC) residents and other individuals who receive care from approximately 66,757 Medicare and Medicaid-certified facilities.

CMS accomplishes its quality assurance functions through collaboration with States and their respective State Survey Agencies (SAs), private accrediting organizations (AOs), and contracted private-sector survey organizations, who conduct specialized surveys and investigations. CMS takes progressive enforcement action when quality standards are not met or maintained by participating facilities. Remedies, based on the scope and severity of the

[1] FY 2023 Enacted included $455 million for Additional Medicare Operations Funding. CMS has tentatively allocated $435 million to Program Operations, $10 million to Federal Administration, and $10 million to State Survey and Certification, all of which will support Medicare programs.
[2] Funding provided through the Improving Medicare Post-Acute Care Transformation (IMPACT) and Consolidated Appropriations Acts are net of sequester. The FY 2024 request assumes the same sequestration amount as FY 2023.

non-compliance, may range from State monitoring and directed in-service training to the imposition of civil monetary penalties (CMPs) and termination from the Medicare and Medicaid programs.

The S&C program is funded by multiple sources. The Program Management discretionary appropriation ($407.3 million in FY 2023) supports the majority of the S&C program's ongoing oversight efforts. The S&C program is also supported by mandatory funding from the Improving Medicare Post-Acute Care Transformation Act (P.L.113-185; IMPACT Act; $5.5 million in FY 2023) and the Consolidated Appropriations Act of 2021 (P.L. 116-260; CAA; $9.6 million in FY 2023), both targeted to help keep hospice survey frequencies at every three years. CMS also expects to obligate approximately $21.5 million in CARES Act funding to support ongoing pandemic-related efforts in FY 2023. However, this funding expires at the end of FY 2023, providing no additional funding in FY 2024. The Grants to States for Medicaid account also provides mandatory funds ($328 million in FY 2023) to support the oversight of Medicaid and dually participating (Medicare/Medicaid) provider types.

CMS prioritizes survey activities within the S&C program starting with those which are required by law, and then prioritizing non-statutory surveys based on policies developed in part through an evidence-based approach incorporating recommendations by the Government Accountability Office (GAO) and the Office of the Inspector General (OIG). The recommendations aim to ensure the quality and safety of patients seeking care in CMS-certified facilities. The GAO has placed oversight of nursing homes and dialysis facilities into a high-risk category, indicating a greater vulnerability of fraud, waste, abuse, and mismanagement. The OIG has also published reports that stress the need for regular oversight of hospitals and Ambulatory Surgical Centers to avoid adverse events. Reports from both the GAO and OIG indicate that maintaining survey and certification frequency rates at or above the levels guided by statute and policy is critical to ensuring federal dollars support high quality care. Accordingly, CMS prioritizes surveys as follows:

1. Investigation of complaints triaged as immediate jeopardy (IJ) and actual harm;
2. Conducting statutorily required initial and recertification surveys (i.e., nursing homes, home health agencies (HHAs), and hospices);
3. Survey and recertification of non-statutory facilities as capacity enables.

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 contracts for other programmatic activities, such as online surveyor training, AO oversight, process improvement including nursing home surveys, and the identification of new methods for collecting and reporting data used to evaluate survey variation, performance and strengthening state oversight.

To improve CMS's existing data systems, including the Internet Quality Improvement and Evaluation System (iQIES), funding is used to support a broad array of information technology efforts that make program information more effective for program operations and emergency response as well as transparent and accessible to the public. 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 focused infection control (FIC) surveys in response to the COVID-19 public health emergency (PHE) and two Program

priorities, highlighted below, that seek to ensure continued quality and safety for the Nation's health care services. The FIC surveys have been absorbed into standard recertification surveys, as infection control is part of every survey. CMS had established benchmarks for completion of separate FIC surveys tied to the CARES Act.

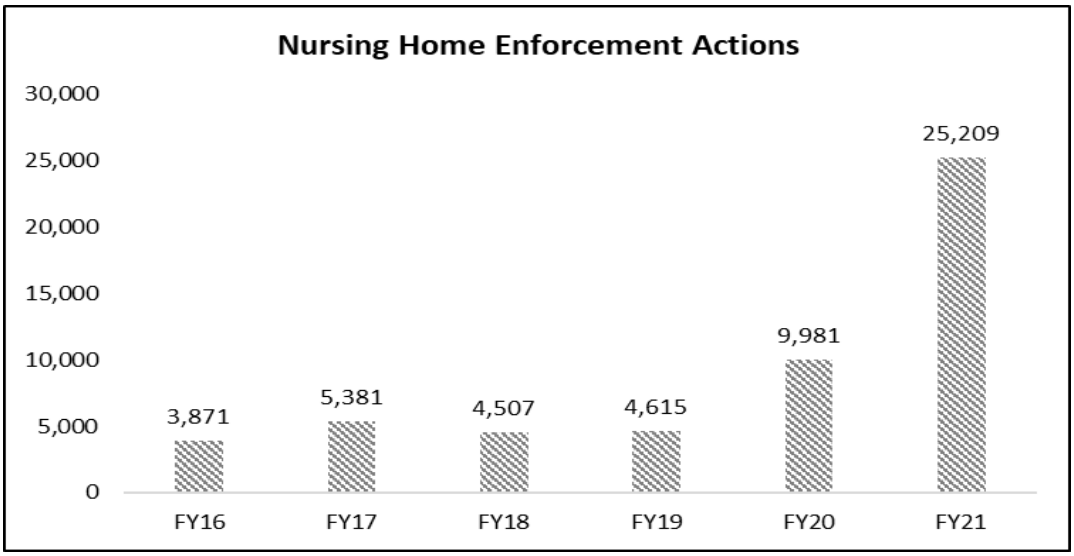
Long-Term Care Facilities

Given the number of Long-Term Care (LTC) facilities and the vulnerability of its patients, CMS places high programmatic priority on maintaining 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. CMS created its LTC initiative 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.

Although these milestones over the past six years were achieved, the ability of CMS to do much more beyond maintaining statutory support is not realistic. Staffing shortages, inflation, and no increase to the Enacted budget is forcing CMS to set realistic expectations about what is truly achievable within existing resources. For example, the table below highlights the significant growth in enforcement actions from the last few fiscal years which resulted in additional needs for oversight and the resources to better manage this work. To help improve this situation, and to align with the commitments announced by President Biden in February of 2022 to improve the safety and quality of nursing home care, an increase in funding is imperative.



Improve Oversight of Accrediting Organizations (AOs)

AOs receive deeming authority from CMS to affirm that their health and safety standards meet or exceed those of Medicare. There are currently 9 CMS-approved AOs, each of which survey one or more different types of facilities including hospitals, critical access hospitals (CAHs), psychiatric hospitals, HHAs, hospices, ambulatory surgical centers, rural health clinics, and ESRD facilities. Facilities surveyed and certified through CMS-approved AOs are considered "Deemed" to meet (or exceed) CMS's Conditions of Participation (COPs).

In response to ongoing concerns, such as disparities between the number of AO identified deficiencies in deemed facilities and the number of identified deficiencies cited by the state survey agency during the 60-day validation surveys, CMS developed a 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 facilities? Has increased oversight improved disparity findings? And, how has CMS improved partnerships and communications with AOs? CMS has proposed crucial milestones to implement this strategic initiative:

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

While several factors determine the overall quality of care in healthcare settings, CMS is committed to significantly reducing the number of serious health and safety violations in accredited facilities 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 survey and certification program. Additionally, CMS has proposed a rule to strengthen the oversight of AOs and prevent AO conflict of interest (CMS-3367-P), which is published on the unified agenda. The proposed rule sets forth provisions to strengthen AO oversight by addressing conflicts of interest, establishing consistent standards, processes and definitions, and updating the validation and performance standards systems.

CMS's Response to COVID-19

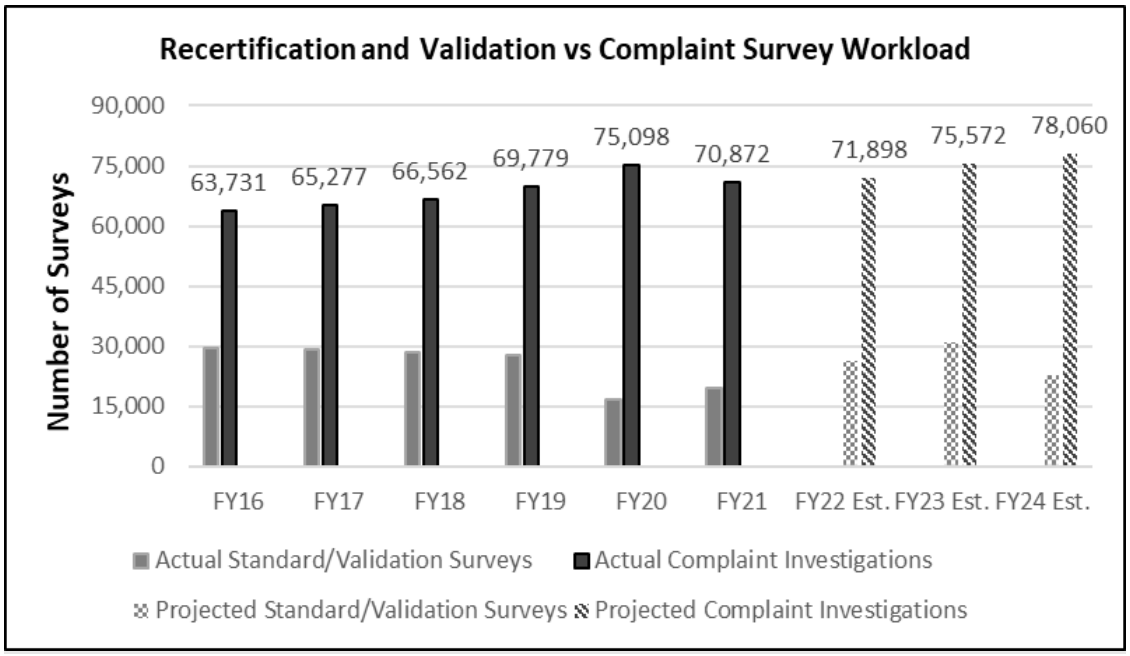
The CARES Act provided CMS with $200 million in multi-year Program Management funding available through FY 2023 to "prevent, prepare for, and respond to the Coronavirus (COVID-19) domestically and internationally." Of this amount, the CARES Act held that no less than $100 million was provided to cover the necessary expenses of CMS's S&C program. CMS leveraged its oversight role to increase focus on infection control in facilities to help prevent the spread of COVID-19. 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, combined with pre-existing shortfalls in base Program Management funding and SA staffing, has exacerbated the backlog of complaint and recertification surveys, which is addressed in the FY 2024 Budget request. Compounding this, the $100 million CARES Act funding expires in FY 2023, leaving continuing COVID-related workloads and related enforcement action workloads started under the PHE to continue through existing base funds.

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. Data as of May 2022 indicate that the percentage of nursing home residents and staff who are fully vaccinated are 88% and 87% respectively.

Programmatic Stress Points

The S&C program annual discretionary appropriation has remained relatively flat since FY 2015, which, over time, has limited the program's capacity to perform standard initial, recertification and validation surveys. This dynamic, compounded by the effects of the PHE, has fueled the loss and availability of SA surveyor resources and resulted in ongoing growth in complaints, with adverse effects on programmatic efficiency, quality and ultimately beneficiary safety. This has reframed the environment in which the S&C program operates. Staffing limitations associated with flat budgets creates an atmosphere where ongoing complaint workloads, and their continued growth, inhibits the SAs' ability to address noncompliance proactively and more efficiently through standard certification and recertification surveys. As a result, complaint surveys have become the primary oversight mechanism for most provider types.

The following graph 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 2022 through FY 2024 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 a 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.



As a result of the COVID-19 PHE which began in FY 2020, the standard survey workload and non-urgent complaints were de-prioritized to allow SAs to target infection control resulting in a historically lower number of actual recertification and validations surveys performed. During this time, SAs conducted FIC surveys and continued to respond to immediate jeopardy complaints. The results for FY 2021 show a drop in the number of complaints surveyed as compared to FY 2020; however, this is due, in part, to staffing shortages and funding constraints as the backlog continued to increase.

Complaints are categorized into four levels of severity: Immediate Jeopardy (IJ), Non-IJ High (NIJH), Non-IJ Medium (NIJM), and Non-IJ Low (NIJL). IJ and NIJH complaints are considered the top priority to ensure the safety and well-being of the beneficiary community. The standard timeline for IJ complaints requires SAs to complete an onsite assessment within two days of such a complaint. The next level of complaint, NIJH, although not as severe, requires the SAs to complete an assessment within 10 days of the complaint.

With a backlog of over 30,000 complaints, CMS forecasts an associated number of complaint surveys pending and overdue for investigation across all provider types, including some immediate jeopardy complaints.

CMS released QSO-22-02-ALL to the states in November of 2021 with updated guideline requirements associated with COVID-survey activities to address the backlog of complaint survey activities. In order to promote efficiency in addressing the backlog of survey activities, CMS's instructions for the investigation of backlogged complaints/Facility Reported Incidents (FRIs) include the prioritization of LTC Complaints/FRIs triaged as IJ and NIJH, and Continuing and Acute Care provider complaints triaged as IJ. Additional instructions direct the states to investigate the Continuing and Acute Care provider complaints triaged as NIJH within an average of 90 calendar days, not to exceed 120 calendar days. Lastly, any LTC complaints/FRIs triaged at a NIJM level may be investigated at the next scheduled standard survey.

Funding History

Fiscal Year	Amount
FY 2020	$397,334,000
FY 2021	$397,334,000
FY 2022 Final	$397,334,000
FY 2023 Enacted	$407,334,000
FY 2024 President's Budget	$565,860,000

Budget Request: $565.9 million

The FY 2024 Program Management discretionary budget request for the S&C program is $565.9 million, an increase of $158.5 million above the FY 2023 Enacted Budget level. This additional funding is requested to make up for the loss of CARES Act funds at the end of FY 2023, address the nursing home complaint backlog, and address inflationary pressures in state staffing salaries and other expenses, as well as funding to improve non-statutory surveys frequencies. We project that this level of funding will help us make some inroads toward addressing the backlog and increasing number of complaint surveys and will keep statutorily mandated survey levels at 100 percent. The requested funding level provides additional resources needed for states to hire and retain surveyor staff at wage levels competitive with private industry. With the CARES Act funding ending, this increase will also help to offset the funding needed to sustain work initiated as a result of this fund source.

The FY 2024 budget request also helps to offset the rise in operating costs for the S&C program. The S&C program has faced increased costs due, in part, from growth in complaints and other cost drivers including the number of beneficiaries (which has created a demand for more deemed facilities), surveyor wage growth, overall economic inflation, and improvements in quality standards. From FY 2019 to FY 2024, participating facilities are projected to grow by 6 percent, or approximately 3,900 facilities. During this time, deemed facilities are projected to account for a majority of this growth, with an increase of nearly 32 percent, whereas the total number of non-deemed facilities are expected to decrease by 1.5 percent.

The S&C program also receives approximately $5.6 million through FY 2025 from the IMPACT Act, and starting in FY 2022, an additional $10.0 million from the CAA to maintain hospice survey frequencies at a three-year rate. The CAA Act of 2021 required CMS to establish a special focus program for hospice agencies. An interim plan has been developed to oversee poor performing hospices pending the implementation of the Hospice SFP. A workgroup is in the process of reviewing the recent survey findings with results expected in October 2022. Under the Hospice SFP, low performing hospices would be subject to be surveyed every six months. The following table summarizes each funding source and its respective breakout per fiscal year.

	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
State Direct Survey	$361,097	$370,698	$521,793
Mandatory Surveys (Nursing Homes/Home Health/Hospice) (non-add)	$322,970	$329,813	$437,516
Non-Statutory Surveys Non-Deemed and Deemed (non-add)	$38,127	$40,885	$84,277
Federal Direct Surveys	$6,240	$6,812	$14,084
Support Contract and Information Technology	$29,997	$29,824	$29,982
Total S&C PM Discretionary	**$397,334**	**$407,334**	**$565,860**
IMPACT Act, Hospice Surveys[3]	$5,464	$5,304	$5,304
Consolidated Appropriations Act of 2021, Hospice Surveys	$9,714	$9,430	$9,430
Grants to States for Medicaid - S&C	$318,000	$328,000	$338,000

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: $521.8 million

The total discretionary State Direct Survey budget request is $521.8 million, an increase of $151.1 million above the FY 2023 Enacted level. This increase includes $437.5 million to inspect, survey, and certify statutory facilities, and $84.2 million to inspect, survey, and certify non-statutory facilities. These projections are based on FY 2021 actual data; however, it should be noted that the data behind the projections may be somewhat skewed due to variances in workload as a result of the PHE.

With this level of funding, CMS projects that states will have the resources to complete the recertification surveys for statutory facilities, survey projected complaints in all facility types at an Actual Harm, IJ, and Non-IJ High levels, address a portion of the current complaint backlog, and a proportional recertification survey frequency rate for non-statutory facilities with a focus on those facility types with higher beneficiary risks. This funding level will also allow CMS to maintain Conditions of Participation in covered facilities.

As states continue to return to a normal working environment, having these additional funds will enable the states to have long-term certainty to retain and hire additional workforce to handle the increased workload. Increased, long-term baseline funding to states will provide them with the security to hire adequate resources to better complete the backlog of survey work, as well as be able to better anticipate/react to any future PHE's that may arise.

The cost to reach the projected survey frequency completion rate and workload for each

[3] Funding provided through the Improving Medicare Post-Acute Care Transformation (IMPACT) and Consolidated Appropriations Acts are net of sequester.

provider type displayed in the following table is funded by all sources shown in the above table. Please note that the percentages represented below are based on modeling from a national average perspective and may not represent the actual workload results from individual states. 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, on average, 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. Deemed provider types on the other hand are surveyed on intervals by CMS approved Accrediting Organizations. These validation surveys serve as an effort of oversight of AO's survey workload.

Nursing Home Cross-Cutting Initiative - $20 million (non-add)

Based on White House commitment to nursing home transparency, CMS is taking significant steps to address backlog complaints, increase the inspection of special focus facilities, and expand the financial penalties for substandard facilities to adequately fund nursing home inspections. For over eight years, funding to conduct health and safety inspections has been held at a flat-line level, even as the volume of complaints in nursing homes has risen. To crack down on unsafe nursing homes and help residents, CMS is requesting an additional $20 million, within the State Survey and Certification topline, to address the worst performing nursing homes to improve care within the poorest performing facilities.

Provider Survey Frequency Rate Completion Projections

Provider Status and Type	Survey Frequency Intervals	FY 2022 Enacted Level	FY 2023 Enacted	FY 2024 President's Budget[4]
Statutory				
Nursing Facilities (NF)	100% Surveyed 12.9-15.9 mo.	100%	75%	100%
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	100% Surveyed 12.9-15.9 mo.	100%	75%	100%
Special Focus Facility Nursing Homes (SFF)	100% Surveyed 6 mo.	100%	75%	100%
Skilled Nursing Facilities (SNF)	100% Surveyed 12.9-15.9 mo.	100%	75%	100%
ICF/IID	100% Surveyed 12.9-15.9 mo.	100%	75%	100%
Home Health Agencies (HHAs)	100% Surveyed 36.9 mo.	100%	75%	100%
Hospice Agencies	100% Surveyed 36.9 mo.	100%	100%	100%
Special Focus Facility Hospice Agencies (SFF) [5]	100% Surveyed 6 mo.			100%
Non-Statutory Non-Deemed				
Ambulatory Surgical Centers (ASCs)	100% Surveyed 72 mo.	26%	10%	10%
Community Mental Health Centers (CMHCs)	100% Surveyed 72 mo.	28%	10%	10%
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	100% Surveyed 72 mo.	36%	10%	10%
End Stage Renal Disease (ESRD)	100% Surveyed 36 mo.	28%	10%	70%
Hospitals[6]	100% Surveyed 36 mo.	25%	10%	70%
Outpatient Physical Therapy (OPT)	100% Surveyed 72 mo.	30%	10%	10%
Portable X-Ray Suppliers	100% Surveyed 72 mo.	24%	10%	10%
Rural Health Clinics (RHCs)	100% Surveyed 72 mo.	28%	10%	10%
Transplant Centers	100% Surveyed 60 mo.	15%	10%	10%
Non-Statutory Deemed				
Ambulatory Surgical Centers (ASCs)	5% of Validation Surveys	9%	10%	20%
End Stage Renal Disease (ESRD)	5% of Validation Surveys	0%	0%	70%
Home Health Agencies (HHAs)	5% of Validation Surveys	29%	10%	20%
Hospice Agencies	5% of Validation Surveys	3%	100%	100%
Hospitals	5% of Validation Surveys	15%	10%	70%
Outpatient Physical Therapy (OPT)	5% of Validation Surveys	0%	0%	20%
Rural Health Clinics (RHCs)	5% of Validation Surveys	0%[6]	10%	20%

[4] The additional $20M for the NHCCI does not change these frequency levels as these reference recertification levels only.
[5] Surveys of Special Focus Facility for Hospice Agencies will start in FY 2024.
[6] FY 2023 Enacted Budget completion rates were based off older data and do not reflect current estimates.

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 by provider type. 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 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Statutory	**$322,970**	**$329,813**	**$437,516**
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	$291,939	$306,726	$404,962
Special Focus Facility Nursing Homes (SFF)	$2,445	$1,454	$4,575
Skilled Nursing Facilities (SNF)	$14,371	$13,481	$17,285
Home Health Agencies (HHAs)	$14,215	$8,152	$10,694
Hospice Agencies	$0	$0	$0
Special Focus Facility Hospice Agencies (SFF)	$0	$0	$0
Non-Statutory Non-Deemed	**$10,125**	**$13,351**	**$39,581**
Ambulatory Surgical Centers (ASCs)	$1,379	$1,336	$3,173
Community Mental Health Centers (CMHCs)	$28	$51	$141
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	$6	$23	$89
End Stage Renal Disease (ESRD)	$5,527	$8,275	$22,750
Hospitals	$2,807	$3,193	$12,104
Outpatient Physical Therapy (OPT)	$97	$104	$418
Portable X-Ray Suppliers	$16	$25	$52
Rural Health Clinics (RHCs)	$205	$189	$680
Transplant Centers	$61	$155	$173
Non-Statutory Deemed	**$28,002**	**$27,534**	**$44,696**
Ambulatory Surgical Centers (ASCs)	$25	$186	$648
End Stage Renal Disease (ESRD)	$0	$0	$303
Home Health Agencies (HHAs)	$17	$179	$358
Hospice Agencies	$0	$0	$0
Hospitals	$27,960	$27,118	$43,246
Outpatient Physical Therapy (OPT)	$0	$0	$7
Rural Health Clinics (RHCs)	$0	$51	$133
Total State Direct Survey Budget	**$361,097**	**$370,698**	**$521,793**
IMPACT Act, Hospice Surveys	$5,464	$5,304	$5,304
Consolidated Appropriations Act, Hospice Surveys	$9,714	$9,430	$9,430

With the level of funding from the FY 2024 request, CMS estimates SAs can complete the initial, recertification, and complaint surveys as shown below. These estimates represent fully funding the statutory workload for recertification surveys, however with complaint surveys becoming a larger driver of the workload, the actuals for complaints may be higher with the result of a corresponding decrease in recertification surveys.

The tables below continue to show that the majority of surveys and complaint visits are projected to be in nursing homes, illustrating the challenges discussed above. Additionally, it should be noted that the rise in economic inflation has created a corresponding rise in survey

costs, which has forced CMS to lower the assumptive level of survey activity from previous FY's.

FY 2024 Projected Survey and Complaint Visit Table

	Facilities Beginning of Year	Complaint Survey	Recertification Survey[7]	Initial Survey	Total Surveys
Total State Direct Survey Budget	**67,667**	**86,487**	**26,720**	**337**	**113,207**
Statutory	**29,299**	**81,075**	**23,953**	**124**	**105,152**
Nursing Facilities (NF)	275	1,023	275	14	1,312
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	14,207	73,517	14,207	0	87,724
Special Focus Facility Nursing Homes (SFF)	88	0	258	0	258
Skilled Nursing Facilities (SNF)	566	1,040	566	0	1,606
ICF/IID	5,583	4,165	5,583	27	9,775
Home Health Agencies (HHAs)	6,335	808	2,110	0	3,136
Hospice Agencies	2,333	522	778	83	1,614
Special Focus Facility Hospice Agencies (SFF)	88	0	176	0	176
Non-Statutory Non-Deemed	**19,391**	**1,690**	**2,293**	**213**	**4,132**
Ambulatory Surgical Centers (ASCs)	3,891	145	65	0	210
Community Mental Health Centers (CMHCs)	134	4	3	0	7
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	151	2	3	0	5
End Stage Renal Disease (ESRD)	7,435	1,168	1,706	213	3,087
Hospitals	1,809	269	415	0	684
Outpatient Physical Therapy (OPT)	1,620	7	27	0	34
Portable X-Ray Suppliers	537	2	9	0	11
Rural Health Clinics (RHCs)	3,576	23	60	0	83
Transplant Centers	238	6	5	0	11
Non-Statutory Deemed	**18,977**	**3,722**	**474**	**0**	**4,196**
Ambulatory Surgical Centers (ASCs)	2,355	39	24	0	63
End Stage Renal Disease (ESRD)	714	20	25	0	45
Home Health Agencies (HHAs)	5,230	218	52	0	270
Hospice Agencies	3,805	231	190	0	421
Hospitals	4,681	3,209	161	0	3,370
Outpatient Physical Therapy (OPT)	435	2	4	0	6
Rural Health Clinics (RHCs)	1,757	3	18	0	21

[7] Recertification column includes validation survey activity in deemed facilities.

FY 2021 Survey and Complaint Visit Table – Actual

	Facilities Beginning of Year	Complaint Survey	Recertification Survey[8]	Initial Survey	Total Surveys
Total State Direct Survey Budget	**65,056**	**71,377**	**19,480**	**745**	**128,186**
Statutory	**30,222**	**65,889**	**15,340**	**242**	**118,055**
Nursing Facilities (NF)	314	1,041	153	11	1,447
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	14,287	58,504	6,543	53	65,100
Focused Infection Control Surveys (SNF/NF)		N/A	35,386	N/A	35,386
Special Focus Facility Nursing Homes (SFF)	88	N/A	176	N/A	176
Skilled Nursing Facilities (SNF)	661	1,033	278	12	1,323
Focused Infection Control Surveys (SNF)		N/A	956	N/A	956
ICF/IID	5,773	4,031	3,726	29	7,786
Home Health Agencies (HHAs)	6,752	741	2,458	36	3,235
Hospice Agencies	2,347	539	2,006	101	2,646
Special Focus Facility Hospice Agencies (SFF)	0	0	0	0	0
Non-Statutory Non-Deemed	**19,046**	**1,624**	**4,140**	**503**	**6,267**
Ambulatory Surgical Centers (ASCs)	3,771	129	963	49	1,141
Community Mental Health Centers (CMHCs)	125	5	9	5	19
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	162	3	15	3	21
End Stage Renal Disease (ESRD)	7,511	1,150	1,747	171	3,068
Hospitals	1,377	296	195	101	592
Outpatient Physical Therapy (OPT)	1,732	7	266	31	304
Portable X-Ray Suppliers	502	3	51	17	71
Rural Health Clinics (RHCs)	3,630	21	860	125	1,006
Transplant Centers	236	10	34	1	45
Non-Statutory Deemed	**15,788**	**3,864**	**0**	**0**	**3,864**
Ambulatory Surgical Centers (ASCs)	2,105	39	0	0	39
End Stage Renal Disease (ESRD)	216	20	0	0	20
Home Health Agencies (HHAs)	4,620	220	0	0	220
Hospice Agencies	2,788	231	0	0	231
Hospitals	4,702	3,349	0	0	3,349
Outpatient Physical Therapy (OPT)	327	2	0	0	2
Rural Health Clinics (RHCs)	1,030	3	0	0	3

[8] Does not include FIC survey counts.

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: $14.1 million

The FY 2024 budget request for Federal Direct Surveys is $14.1 million, which is an increase of $7.7 million above the FY 2023 Enacted level. This increase represents an increased need for federal surveyors to complete portions of the required COVID oversight surveys for states unable to complete in the current environment.

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: $30.0 million

The FY 2024 budget request for Support Contracts and IT is $30.0 million, an increase of $0.2 million above the FY 2023 Enacted Budget level. This amount includes $23.5 million for support contracts and $6.6 million for IT contracts. This increase is primarily due to having initiatives that were previously funded by the CARES Act are now being absorbed into this funding request.

Grants to States Mandatory Appropriation: $338.0 million

The FY 2024 mandatory appropriation for the Grants to States for Medicaid is $338.0 million, $10 million above the FY 2023 Enacted level. This funding will allow states to conduct surveys, certifications, investigations, and a portion of the survey backlog of Medicaid eligible facilities. With this funding, CMS is projected to meet all statutory requirements of the S&C program, including responding to IJ complaints and adherence to statutorily required survey frequencies.

	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Medicaid Grants to States	**$318,000**	**$328,000**	**$338,000**
Statutory	**$317,239**	**$326,430**	**$336,921**
Nursing Facilities (NF)	$9,730	$9,659	$8,008
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	$243,566	$251,874	$270,201
Special Focus Facility Nursing Homes (SFF)	$2,001	$2,051	$1,575
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	$47,678	$48,439	$47,005
Home Health Agencies (HHAs)	$14,264	$14,407	$10,132
Non-Statutory Deemed	**$761**	**$1,570**	**$1,079**
Home Health Agencies (HHAs)	$761	$1,570	$1,079
Total Medicaid S&C Funding	**$318,000**	**$328,000**	**$338,000**

Clinical Laboratory Improvement Amendments Program (CLIA)
(dollars in thousands)

	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
CLIA Lab Obligations	**$77,550**	**$78,000**	**$80,344**

The CLIA program is entirely funded by user fees that are charged to the laboratories regulated by the program. The FY 2024 budget projection for CLIA is $80.3 million in obligations, which is $2.3 million above the FY 2023 Enacted Budget 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 2019 to FY 2024, CMS is expecting the number of labs to grow by 30 percent, with waived labs making up majority of this growth at approximately 41 percent.

Lab Type	FY 2019 Actual	FY 2020 Actual	FY 2021 Actual	FY 2022 Actual	FY 2023 Projected	FY 2024 Projected
Compliance Labs	17,717	17,404	17,411	17,934	19,256	19,256
Accredited Labs	16,035	15,746	15,656	15,907	16,168	16,168
Waived Labs	184,458	189,410	193,146	233,909	259,928	259,928
PPMP Labs	32,578	31,254	30,248	29,826	30,895	30,895
Total	**250,788**	**253,814**	**256,461**	**297,576**	**326,247**	**326,247**

The table below provides the projected CLIA Survey Workload from FY 2019 to FY 2024, and directly following is a table showing what the actual CLIA Survey workload was between FY 2019 to FY 2021.

Type of Survey	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Compliance: Initial and Recertification	8,858	8,702	8,620	9,508	9,542	9,542
Complaint/Follow-up	229	207	155	132	237	237
Validation Surveys	428	420	418	430	431	431
Total	**9,515**	**9,329**	**9,193**	**10,070**	**10,210**	**10,210**

Type of Survey	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Compliance: Initial and Recertification	7,858	4,818	8,127	TBD	TBD	TBD
Complaint/Follow-up	75	333	1,212	TBD	TBD	TBD
Validation Surveys	27	21	69	TBD	TBD	TBD
Total	**7,960**	**5,172**	**9,408**	**TBD**	**TBD**	**TBD**

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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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] *$406,956,850,000,* to remain available until expended.

In addition, for carrying out such titles after May 31, [2023] *2024*, for the last quarter of fiscal year [2023] *2024* 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] *2025,* [$197,580,474,000] *$245,580,414,000,* 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] *$406,956,850,000,* to remain available until expended.	This section provides a no-year appropriation for Medicaid for FY 2024. This appropriation is in addition to the advance appropriation of $197.6 billion for the first quarter of FY 2024. 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]*2024*, for the last quarter of fiscal year [2023] *2024*, 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 2024 to meet unanticipated costs for carrying out titles XI and XIX, including the costs of the Vaccines for Children program. "For carrying out" is substituted for consistency throughout the appropriations language. "To remain available until expended" is included for alignment with other Medicaid appropriations provided in this language.

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] *2025,* [$197,580,474,000] *$245,580,414,000,* to remain available until expended.	This section provides an advance appropriation for the first quarter of FY 2025 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 2025 is not enacted by October 1, 2024.
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 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Mandatory Appropriation:				
Advanced Appropriation.....	$148,732,315	$165,722,018	$197,580,474	$31,858,456
Annual Appropriation.....	$368,666,106	$367,357,090	$406,956,850	$39,599,760)
Indefinite Annual Appropriation..	$91,221,590	$73,544,552	$0	($73,544,552)
Subtotal, Mandatory Appropriation	**$608,620,011**	**$606,623,660**	**$604,537,324**	**($2,086,336)**
Offsetting Collections from Federal Sources:				
Collection Authority: Medicare Part D……..	$0	$5,000	$5,000	$0
Collection Authority: Medicare Part B……..	$1,596,470	$1,586,748	$1,553,000	($33,748)
Subtotal, Collections Authority	$1,596,470	$1,591,748	$1,558,000	($33,748)
Total New Budget Authority	**$610,216,481**	**$608,215,408**	**$606,095,324**	**($2,120,084)**
Unobligated Balances:				
Unobligated balance of appropriation withdrawn……..	($29,501,446)	$0	$0	$0
Unobligated balance, Start of year.....	$417,596	$311,282	$0	($311,282)
Unobligated balance, Recoveries of Prior Year Obligations (Unpaid)……	$67,255,142	$54,835,000	$0	($54,835,000)
Recoveries of Prior Year Obligations (Paid)……..	$12,260,340	$0	$0	$0
Subtotal, Unobligated Balances.....	$50,431,632	$55,146,282	$0	($55,146,282)
Total Budgetary Resources (Amounts Available for Obligation)	**$660,648,113**	**$663,361,690**	**$606,095,324**	**($57,266,366)**
Unobligated balance, end of year……..	$0	$0	$0	$0
Total, Gross Obligations.....	**$660,336,831**	**$663,361,690**	**$606,095,324**	**($57,266,366)**
Net Obligations:				
Unobligated balance of appropriation withdrawn……	($29,501,446)			
Gross Obligations.....	$660,336,831	$663,361,690	$606,095,324	($57,266,366)
Actual Collections: Medicare Part D……..	$0	($5,000)	($5,000)	$0
Actual Collections: Medicare Part B……..	($1,596,470)	($1,586,748)	($1,553,000)	$33,748
Unobligated balance, Start of year.....	($417,596)	($311,282)	$0	$311,282
Unobligated balance, Recoveries of Unpaid and paid Obligations.....	($79,515,482)	($54,835,000)	($54,092,343)	$742,657
Total Net Obligations	**$549,305,837**	**$606,623,660**	**$550,444,980**	**($56,178,680)**

Funding History

Fiscal Year	Amount
FY 2021 [1]	$519,483,858,000
FY 2022 [2]	$608,620,011,000
FY 2023 [3]	$606,623,660,000
FY 2024	$604,537,324,000

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

	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
CMS - Grants to States			
Grants to States, Subsidies	$603,781,275	$600,280,474	($3,500,801)
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance[4]	$4,434,133	$5,814,850	$1,380,717
Total Budget Authority	**$608,215,408**	**$606,095,324**	**($2,120,084)**

[1] Includes $65.7 billion in indefinite funding authority obligated during FY 2021.
[2] Includes $91.2 billion in indefinite funding authority obligated during FY 2022.
[3] Includes an estimate of $73.5 billion in indefinite authority to be obligated during FY 2023.
[4] Reflects Vaccines for Children estimates under current law.

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

	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
1. Medical Assistance Payments				
Medical Assistance Payments.....	$630,924,932	$580,957,737	$527,272,547	($53,685,190)
Benefits Due and Payable (IBNR)	$0	$54,092,343	$48,385,927	($5,706,416)
Subtotal, Benefits	**$630,924,932**	**$635,050,080**	**$575,658,474**	**($59,391,606)**
2. Vaccine for Children				
Vaccines for Children.....	$5,540,089	$4,434,133	$5,814,850	$1,380,717
Subtotal, Vaccine for Children	**$5,540,089**	**$4,434,133**	**$5,814,850**	**$1,380,717**
3. State Administration				
State and Local Administration.....	$22,793,826	$23,159,418	$23,877,000	$717,582
HIT- Provider.....	$50,361	$1,000	$0	($1,000)
HIT- Administration.....	$292,912	$23,059	$0	($23,059)
State Survey and Certification.....	$299,900	$328,000	$338,000	$10,000
State Fraud Control Units.....	$306,641	$346,000	$357,000	$11,000
MMIS Planning for Territories…….	$70,127			
E&E for Territories	$58,043			
BSCA Sec. 11003 - Admin		$20,000	$50,000	$30,000
Subtotal, State Administration	**$23,871,810**	**$23,877,477**	**$24,622,000**	**$744,523**
Total Mandatory Appropriation……..	$608,620,011	$606,623,660	$604,537,324	($2,086,336)
Total Offsetting Collection Authority [4,5]……..	$1,596,470	$1,591,748	$1,558,000	($33,748)
Total, Budget Authority	**$610,216,481**	**$608,215,408**	**$606,095,324**	**($2,120,084)**
Recoveries and unobligated balances	$50,431,632	$55,146,282	$0	($55,146,282)
Total, Budgetary Resources	**$660,648,113**	**$663,361,690**	**$606,095,324**	**($57,266,366)**

Authorizing Legislation – Social Security Act, title XIX, Section 1901 and Public Law 111-5, Public Law 111-148, Public Law 111-152
FY 2022 Authorization – Public Laws 116-450, 117-43
FY 2023 Authorization – Public Laws 117-328, 117-403
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 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Program Activity				
Medical Assistance Payments.....	$487,986,522	$504,767,498	$574,100,474	$69,332,976
State and Local Administration.....	$23,871,810	$23,877,477	$24,622,000	$744,523
Vaccines for Children.....	$5,540,089	$4,434,133	$5,814,850	$1,380,717
Subtotal, Medicaid Program Level	**$517,398,421**	**$533,079,108**	**$604,537,324**	**$71,458,216**
Less funds advanced in prior year.	$148,732,315	$165,722,018	$197,580,474	$31,858,456
Total, Grants to States for Medicaid	**$368,666,106**	**$367,357,090**	**$406,956,850**	**$39,599,760**
New advance 1st quarter of subsequent FY.....	$165,722,018	$197,580,474	$245,580,414	$47,999,940

[6] Funding represented in the chart equals the respective FY 2024 President's Budget estimates. FY 2022 does not include $91.2 billion in indefinite funding authority obligated during FY 2022. FY 2023 does not include projected indefinite funding need of $73.5 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 2024.

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

Program Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Medical Assistance Payments	$487,986,522	$578,312,050	$574,100,474	($4,211,576)
State and Local Administration	$23,871,810	$23,877,477	$24,622,000	$744,523
Vaccines for Children	$5,540,089	$4,434,133	$5,814,850	$1,380,717
Total Mandatory Appropriation Request[7]	**$517,398,421**	**$606,623,660**	**$604,537,324**	**($2,086,336)**

FY 2024 Mandatory Appropriation Request: $604.5 billion

CMS' FY 2024 mandatory appropriation request for the Grants to States for Medicaid account is $604.5 billion, a decrease of $2.1 billion relative to the FY 2023 request level of $606.6 billion[8]. This appropriation is composed of $197.6 billion in an authorized advance appropriation for FY 2023 and a remaining appropriation of $406.9 billion for FY 2024.

Resources will help fund $606.1 billion in anticipated FY 2024 Medicaid obligations. CMS also anticipates budget authority from offsetting collections from the Supplementary Medical Insurance trust fund and Medicare Part D account in the amount of $1.5 billion to fund the remaining anticipated obligations. These estimated obligations include:

- $575.7 billion in Medicaid medical assistance payments (MAP);
- $24.6 billion for Medicaid state and local administrative functions including funding for Medicaid state survey and certification and the state Medicaid fraud control units; and
- $5.8 billion for the Centers for Disease Control and Prevention's Vaccines for Children (VFC) program.

[7] Numbers may not add due to rounding. Vaccines for Children totals reflect estimates under current law.
[8] FY 2023 includes projected indefinite funding need of $73.5 billion.

This submission is based on projections from state-submitted estimates and CMS using Medicaid expenditure data as recent as the third quarter of FY 2022. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget (OMB) for the FY 2024 President's Budget.

Under current law, the federal share of Medicaid net outlays is estimated to be $556.1 billion in FY 2024, a decrease of $51.6 billion from the FY2023 level of $607.7 billion.

The FY 2024 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.

Improve Healthcare for Americans in Puerto Rico and Other Territories
The President supports eliminating Medicaid funding caps for Puerto Rico and other Territories while aligning their matching rate with States.

Grants to States for Medicaid

Medical Assistance Payments

(Dollars in Thousands)

	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Medical Assistance Payments	$487,986,522	$578,312,050	$574,100,474	($4,211,576)

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 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Aged	7.0	7.2	7.2	0.0
Disabled	10.7	10.8	10.8	0.0
Adults	20.3	21.0	17.0	(4.0)
Children	33.8	34.3	31.2	(3.1)
Expansion Adult	17.9	18.8	15.6	(3.2)
Territories	1.6	1.6	1.6	0.0
Total [9]	**91.3**	**93.7**	**83.5**	**(10.2)**

According to CMS projections of Medicaid enrollment, 83.5 million Americans will be enrolled in Medicaid for the equivalent of a full year during FY 2024. In FY 2024, 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 decrease by 10.2 million in FY 2024, due in part to the end of the continuous enrollment condition enacted in the Families First Coronavirus Response Act (P.L. 116-127).

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.

[9] 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 2024 Estimate

Budget Estimate: $574.1 Billion

CMS' Medical Assistance Payments (MAP) budget estimate is $574.1 billion, a $4.2 billion decrease below the FY 2023 request. The following language provides additional detail on CMS' FY 2024 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 2024 using the three quarters of FY 2022 state-reported expenditures as a base. Expenditures for FY 2022, FY 2023, and FY 2024 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 2024 estimate of $48.4 billion represents the entire liability for Medicaid medical services incurred but not paid from October 1, 2023 to September 30, 2024. 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 2024 is estimated to be $1.5 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.

Consolidated Appropriations Act of 2021 (P.L. 116-160)

Section 210 of this Act promotes access to life-saving therapies for Medicaid enrollees by ensuring coverage of routine patient costs for items and services furnished in connection with participation in qualifying clinical trials.

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.

Special Immigrants Visas (SIVs) Act (P.L. 117-31)

The Emergency Security Supplemental Appropriations Act, 2021 (P.L. 117-31), enacted in July 2021 during the U.S. military withdrawal from Afghanistan, includes provisions to facilitate admissions under the special immigrant visa (SIV) program for Afghans who worked for or on behalf of the U.S. government.

Afghan Refugees (P.L. 117-43)

On September 30, 2021, Congress passed the Afghanistan Supplemental Appropriations Act, 2022 (Public Law 117-43). Section 2502 of the legislation provided that Afghan humanitarian parolees are eligible to receive federal benefits, including Medicaid and TANF, from the date of enactment.

Additional Ukraine Supplemental Appropriation (P.L. 117-128)

The Additional Ukraine Supplemental Appropriations Act provides provided that Ukrainian humanitarian parolees are eligible to receive federal benefits, including Medicaid.

Bipartisan Safer Communities Act (P.L. 117-159)

This Act provides funding for the expansion of community mental health services demonstration programs. Discretionary grant funding to states will also be used in support of implementing, enhancing, or expanding the provision of medical assistance through school-based entities under Medicaid or CHIP.

Inflation Reduction Act (P.L. 117-169)

The Inflation Reduction Act lowers prescription drug costs, health care costs, and energy costs. Provisions impacting Medicaid include providing for lower prices for certain high priced single source drugs, prohibiting implementation of rule relating to eliminating the anti-kick-back statute safe harbor for prescription drug rebates, and improving access to adult vaccines under Medicaid.

Consolidated Appropriations Act of 2023 (P.L. 117-328)

The Act provides consolidated appropriations for the fiscal year ending September 30, 2023, which include 12 months of continuous eligibility for children under Medicaid, permanent extension of enhanced to the 12-month postpartum coverage state option under Medicaid, and the extension of Medicaid protections against spousal impoverishment for recipients of home and community based services.

Administrative Actions

Amendment of Safe Harbor Regulation Concerning Discounts for Prescription Pharmaceutical Products.

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.

Part C&D Duals/DIR Final Rule

This final rule will revise the Medicare Advantage (MA) (Part C) program and Medicare Prescription Drug Benefit (Part D) program regulations to implement changes related to marketing and communications, past performance, Star Ratings, network adequacy, medical loss ratio reporting, special requirements during disasters or public emergencies, and pharmacy price concessions. This final rule will also revise regulations related to dual eligible special needs plans (D-SNPs), other special needs plans, and cost contract plans.

SHO 22-002 Medicaid and CHIP Coverage of Stand-alone Vaccine Counseling

Expands Medicaid coverage for stand-alone vaccine counseling, including coverage for beneficiaries eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes

This rulemaking proposes changes to simplify the processes for eligible individuals to enroll and retain eligibility in Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program. This proposed rule would remove barriers and facilitate enrollment of new applicants, particularly those dually eligible for Medicare and Medicaid; align enrollment and renewal requirements for most individuals in Medicaid; establish beneficiary protections related to returned mail; create timeliness requirements for redeterminations of eligibility in Medicaid and CHIP; make transitions between programs easier; eliminate access barriers for children enrolled in CHIP by prohibiting premium lock-out periods, waiting periods, and benefit limitations; and modernize recordkeeping requirements to ensure proper documentation of eligibility and enrollment.

Grants to States for Medicaid

Vaccines for Children

(Dollars in Thousands)

	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY2023
Vaccines for Children	$5,540,089	$4,434,133	$5,814,850	$1,380,717

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 provides 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.[10]

FY 2024 Budget Estimate: $5.8 Billion

CMS' Vaccine for Children (VFC) estimate under current law is $5.8 billion, a $1.4 billion increase above the FY 2023 estimated level.

This current law 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

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

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 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 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
State and Local Administration	$23,871,810	$23,877,477	$24,622,000	$744,523

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.

FY 2024 Budget Estimate: $24.6 Billion

CMS' State Administration estimate is $24.6 billion, a $744.5 million dollar increase compared to the FY 2023 estimated level.

This estimate is composed of $338.0 million for Medicaid state survey and certification, $357 million for state Medicaid Fraud Control Units, $50.0 million for Section 11003 of the Bipartisan Safer Communities Act, and $23.9 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 2024 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2024 estimate for Medicaid state survey and certification is $338.0 million. This represents an increase of $10.0 million above the FY 2023 estimated amount of $328.0 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 2024, 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 $357.0 million. This represents an increase of $11.0 million over the FY 2023 estimate of $346.0 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.

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

The current FY 2024 estimate for this transfer is $5.0 million, a flatline from the FY 2023 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 2024.

All Other Medicaid State and Local Administration

The CMS estimate for FY 2024 is $23.9 billion. CMS adjusted the FY 2023 state-submitted estimates of $23.1 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 2024 MANDATORY STATE/FORMULA GRANTS[11]

(Dollars in Thousands)

CFDA No/Program Name: 93.778 Medical Assistance Program

State or Territory	FY 2022 Final	Estimated FY 2023 obligations from:		FY 2023 (Enacted)	FY 2024 President's Budget	FY 2024 +/- FY 2023
		Previous Authority	New Authority			
States						
Alabama	$5,685,190	$0	$5,974,827	$5,974,827	$5,913,793	($61,035)
Alaska	$1,910,982	$0	$2,329,668	$2,329,668	$2,718,828	$389,160
Arizona	$16,932,453	$0	$17,723,658	$17,723,658	$15,431,042	($2,292,616)
Arkansas	$7,022,132	$0	$7,241,712	$7,241,712	$7,160,164	($81,548)
California	$80,386,136	$0	$82,047,031	$82,047,031	$70,240,455	($11,806,576)
Colorado	$7,965,896	$0	$7,742,890	$7,742,890	$7,789,097	$46,207
Connecticut	$6,285,019	$0	$6,161,652	$6,161,652	$5,989,606	($172,047)
Delaware	$2,254,575	$0	$2,184,938	$2,184,938	$2,196,160	$11,223
District of Columbia	$2,902,370	$0	$2,742,690	$2,742,690	$2,715,580	($27,110)
Florida	$22,212,285	$0	$20,652,917	$20,652,917	$19,085,555	($1,567,362)
Georgia	$10,664,008	$0	$10,543,386	$10,543,386	$10,082,367	($461,019)
Hawaii	$2,130,218	$0	$2,193,008	$2,193,008	$2,165,467	($27,540)
Idaho	$2,550,899	$0	$3,098,641	$3,098,641	$3,124,349	$25,709
Illinois	$17,224,731	$0	$16,748,217	$16,748,217	$15,680,702	($1,067,515)
Indiana	$13,042,313	$0	$13,411,246	$13,411,246	$13,076,594	($334,652)
Iowa	$4,905,797	$0	$4,841,476	$4,841,476	$4,561,019	($280,457)
Kansas	$2,956,850	$0	$3,395,956	$3,395,956	$3,359,240	($36,716)
Kentucky	$12,164,024	$0	$13,732,279	$13,732,279	$14,038,859	$306,580
Louisiana	$11,790,080	$0	$14,032,712	$14,032,712	$12,782,206	($1,250,505)
Maine	$2,879,338	$0	$2,714,207	$2,714,207	$2,589,569	($124,639)
Maryland	$9,608,859	$0	$9,244,873	$9,244,873	$9,027,266	($217,607)
Massachusetts	$13,427,709	$0	$13,808,373	$13,808,373	$12,301,540	($1,506,833)
Michigan	$16,123,107	$0	$17,253,977	$17,253,977	$16,747,872	($506,105)
Minnesota	$10,707,751	$0	$11,654,456	$11,654,456	$10,109,574	($1,544,882)

[11] Obligation estimates for FY 2023 and 2024 reflect the State-reported estimates of Medicaid needs available to CMS in November 2022 and do not account for recently enacted legislation, regulations, or guidance.

State or Territory	FY 2022 Final	Estimated FY 2023 obligations from:		FY 2023 (Enacted)	FY 2024 President's Budget	FY 2024 +/- FY 2023
		Previous Authority	New Authority			
Mississippi	$5,062,431	$0	$5,551,174	$5,551,174	$4,965,414	($585,760)
Missouri	$10,302,976	$0	$13,680,503	$13,680,503	$12,513,462	($1,167,040)
Montana	$1,929,139	$0	$1,931,710	$1,931,710	$1,968,101	$36,392
Nebraska	$2,353,801	$0	$2,484,732	$2,484,732	$2,442,932	($41,800)
Nevada	$3,976,461	$0	$4,224,449	$4,224,449	$3,961,744	($262,706)
New Hampshire	$1,600,540	$0	$1,499,267	$1,499,267	$1,284,281	($214,986)
New Jersey	$14,229,181	$0	$14,653,945	$14,653,945	$15,455,641	$801,696
New Mexico	$7,073,874	$0	$7,608,131	$7,608,131	$7,131,212	($476,918)
New York	$52,155,447	$0	$56,139,720	$56,139,720	$52,539,703	($3,600,017)
North Carolina	$13,966,538	$0	$14,273,126	$14,273,126	$13,249,253	($1,023,874)
North Dakota	$1,076,071	$0	$1,159,561	$1,159,561	$1,180,177	$20,615
Ohio	$23,179,262	$0	$24,838,958	$24,838,958	$23,758,242	($1,080,715)
Oklahoma	$6,353,456	$0	$7,160,702	$7,160,702	$6,701,269	($459,434)
Oregon	$10,174,122	$0	$10,966,694	$10,966,694	$10,906,341	($60,353)
Pennsylvania	$28,126,388	$0	$28,564,753	$28,564,753	$27,711,298	($853,456)
Rhode Island	$2,394,075	$0	$2,251,113	$2,251,113	$2,190,013	($61,100)
South Carolina	$5,887,062	$0	$5,786,580	$5,786,580	$5,248,106	($538,474)
South Dakota	$886,078	$0	$820,908	$820,908	$782,449	($38,460)
Tennessee	$8,322,880	$0	$9,055,812	$9,055,812	$8,929,776	($126,036)
Texas	$37,497,430	$0	$32,837,059	$32,837,059	$30,597,671	($2,239,388)
Utah	$3,304,229	$0	$3,532,510	$3,532,510	$3,103,848	($428,662)
Vermont	$1,303,581	$0	$1,242,890	$1,242,890	$1,192,923	($49,967)
Virginia	$12,251,933	$0	$13,963,090	$13,963,090	$14,267,989	$304,899
Washington	$12,133,362	$0	$16,485,538	$16,485,538	$16,996,299	$510,761
West Virginia	$4,389,215	$0	$4,181,217	$4,181,217	$4,041,215	($140,002)
Wisconsin	$7,981,661	$0	$8,165,143	$8,165,143	$7,278,440	($886,703)
Wyoming	$409,526	$0	$405,461	$405,461	$394,895	($10,566)
Territories/Other[12]						
American Samoa	$58,559	$0	$96,049	$96,049	$89,649	($6,400)
Guam	$149,574	$0	$140,401	$140,401	$155,993	$15,592
Northern Mariana Islands	$65,583	$0	$69,086	$69,086	$69,529	$444
Puerto Rico	$3,368,230	$0	$3,506,299	$3,506,299	$2,993,947	($512,351)
Freely Associated States	$0	$0	$0	$0	$0	$0
Virgin Islands	$120,901	$0	$131,572	$131,572	$159,829	$28,256
Indian Tribes	$0	$0	$0	$0	$0	$0
Undistributed[13]	94,520,541	$0	$74,478,747	$74,478,747	$52,946,782	($21,531,965)
Total	**$660,336,831**	**$0**	**$663,361,690**	**$663,361,690**	**$606,095,324**	**($57,266,366)**

[12] Total obligations to territories account for all funding sources, some of which are appropriated outside of the allotment caps under section 1108 of the Social Security Act. For this reason, obligations listed for some territories exceed the allotment cap amount. FY 2024 reflect territory estimates at the time of publishing and are therefore subject to change.

[13] Includes grants to states for survey and certification, Medicaid Fraud Control Units, the Vaccines for Children program, and other adjustments. FY 2024 undistributed amounts also capture increased amounts anticipated to be available for obligation to states consistent with legislative proposals in the Budget.

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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, **[**$548,130,000,000**]** *$476,725,000,000.* 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.

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.

Annual Budget Authority by Activity
(Dollars in Thousands)

	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Budget Authority	$497,862,000	$548,130,000	$476,725,000	($71,405,000)

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. CMS has updated its methodology for budgeting the Payments to the Health Care Trust Funds costs in response to GAO concerns regarding the practice of incorporating a precautionary high-end estimate. CMS will now incorporate its lowest estimated budgetary needs and rely upon its indefinite authority if it is determined additional funding is needed.

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 2024 estimated request of $374.0 billion is a net decrease of $60.4 billion over the FY 2023 estimated amount of $434.3 billion.

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 2024 estimated request of $44.0 million for Hospital Insurance for Uninsured Federal Annuitants is a net decrease of $8.0 million from the FY 2023 estimated amount of $52.0 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 2024 budget estimate of $1.0 billion to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare trust fund activities is the same estimate as FY 2023, $1.0 billion.

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 2024 budget estimate of $100.8 billion for General Revenue for Part D (Benefits) is a net decrease of $11.0 billion over the FY 2023 estimated amount of $111.8 billion.

The FY 2024 budget estimate of $523.0 million request for General Revenue for Part D Federal Administration is a net decrease of $77.0 million over the FY 2023 estimate of $600.0 million.

The FY 2024 budget estimate 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 2024 budget estimate of $375.0 million for reimbursement of HCFAC is a net increase of $51.0 million over the FY 2023 estimate of $324.0 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 2024 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.

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

	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Supplementary Medical Insurance	$384,646,000	$434,349,000	$373,973,000	($60,376,000)
Hospital Insurance for Uninsured Federal Annuitants	$82,000	$52,000	$44,000	($8,000)
Program Management Administrative Expenses	$929,000	$1,000,000	$1,000,000	$0
General Revenue for Part D Benefit	$100,968,883	$111,800,000	$100,805,000	($10,995,000)
Indefinite Annual Appropriation, Part D Benefits	$10,000,000	$0	$0	$0
General Revenue for Part D Federal Administration	$882,000	$600,000	$523,000	($77,000)
Part D: State Low-Income Determination	$5,000	$5,000	$5,000	$0
Reimbursement for HCFAC	$349,117	$324,000	$375,000	$51,000
Total Budget Authority	**$497,862,000**	**$548,130,000**	**$476,725,000**	**($71,405,000)**

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 continuing to work 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

Fiscal Year	Budget Authority
FY 2020	$410,796,100,000
FY 2021	$439,514,000,000
FY 2022 Final	$497,862,000,000
FY 2023 Enacted	$548,130,000,000
FY 2024 President’s Budget	$476,725,000,000

Permanent Budget Authority
(Dollars in Thousands)

	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Tax on OASDI Benefits	$32,775,000	$35,436,000	$40,327,000	$4,891,000
HCFAC, FBI	$152,924	$161,216	$164,924	$3,708
HCFAC, Asset Forfeitures	$33,000	$34,000	$35,000	$1,000
HCFAC, Criminal Fines	$34,447	$18,798	$22,178	$3,380
HCFAC, Civil Penalties and Damages: Administration	$52,500	$53,500	$54,000	$500
Total Budget Authority	**$33,047,871**	**$35,703,514**	**$40,603,102**	**$4,899,588**

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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Health Care Fraud and Abuse Control

Appropriations Language

In addition to amounts otherwise available for program integrity and program management, **[**$893,000,000**]** *$937,000,000*, to remain available through September 30, **[**2024**]** *2025*, 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 **[**$665,648,000**]** *$667,359,000* shall be for the Centers for Medicare & Medicaid Services program integrity activities, of which **[**$105,145,000**]** *$112,434,000* 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 $122,207,000 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act, *and of which not less than $35,000,000, together with amounts made available for fiscal year 2024 under section 1817(k)(3)(A) of the Social Security Act, shall be for the Administration for Community Living for the Senior Medicare Patrol program to combat health care fraud and abuse*: *Provided*, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year **[**2023**]** *2024* 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, **[**$317,000,000**]** *$325,000,000* is provided to meet the terms of a concurrent resolution on the budget in the Senate, and **[**$576,000,000**]** *$612,000,000* is additional new budget authority specified for purposes of a concurrent resolution on the budget **[**in the Senate and section 1(h) of H. Res. 1151 (117th Congress), as engrossed in the House of Representatives on June 8, 2022**]** for additional health care fraud and abuse control activities**[**: *Provided further*, That the Secretary shall provide not less than $35,000,000 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, **[**$893,000,000**]** *$937,000,000*, to remain available through September 30, **[**2024**]** *2025*, 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 **[**$665,648,000**]** *$667,359,000* 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 **[**$105,145,000**]** *$112,434,000* 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 $122,207,000 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.
and of which not less than $35,000,000, together with amounts made available for fiscal year 2024 under section 1817(k)(3)(A) of the Social Security Act, shall be for the Administration for Community Living for the Senior Medicare Patrol program to combat health care fraud and abuse:	Provides funding for the Administration for Community Living to conduct the Senior Medicare Patrol program to combat healthcare fraud and abuse.
Provided, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year **[**2023**]** *2024* 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.

Language Provision	Explanation
Provided further, That of the amount provided under this heading, **[**$317,000,000**]** *$325,000,000* is provided to meet the terms of a concurrent resolution on the budget in the Senate, and **[**$576,000,000**]** *$612,000,000* is additional new budget authority specified for purposes of a concurrent resolution on the budget **[**in the Senate and section 1(h) of H. Res. 1151 (117th Congress), as engrossed in the House of Representatives on June 8, 2022**]** for additional health care fraud and abuse control activities**[**: *Provided further*, That the Secretary shall provide not less than $35,000,000 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**]**.	Specifies $325,000,000 for ongoing base healthcare fraud and abuse control activities, and $612,000,000 is available as additional budget authority to meet the terms of a concurrent resolution on the budget to pay for additional healthcare fraud and abuse control activities in FY 2024.

Health Care Fraud and Abuse Control
(Dollars in Thousands)

	FY 2022	FY 2023	FY 2024	
	Final	**Enacted**	**President's Budget**	**+/- FY 2023 Enacted**
Discretionary				
CMS Program Integrity	$658,648	$665,648	$667,359	$1,711
ACL	$0	$0	$35,000	$35,000
OIG	$102,145	$105,145	$112,434	$7,289
DOJ	$112,207	$122,207	$122,207	$0
Subtotal, Discretionary	**$873,000**	**$893,000**	**$937,000**	**$44,000**
Mandatory, Current Law[1]				
CMS Program Integrity	$963,369	$1,024,715	$1,081,275	$56,560
OIG	$214,631	$224,811	$237,175	$12,364
HHS Wedge	$41,051	$42,998	$45,363	$2,365
DOJ Wedge	$67,014	$70,192	$74,053	$3,861
FBI	$152,924	$160,178	$168,987	$8,809
Subtotal, Mandatory, Current Law	**$1,438,989**	**$1,522,894**	**$1,606,853**	**$83,959**
Total	**$2,311,989**	**$2,415,894**	**$2,543,853**	**$127,959**
Mandatory, Proposed Law[2]				
CMS Program Integrity	$0	$0	$138,757	$138,757
OIG	$0	$0	$30,529	$30,529
HHS Wedge	$0	$0	$4,209	$4,209
DOJ Wedge	$0	$0	$10,051	$10,051
FBI	$0	$0	$21,650	$21,650
Subtotal, Mandatory, Proposed Law	**$0**	**$0**	**$205,196**	**$205,196**

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

FY 2023 Authorization – Public Law (P.L.) 104-191 and P.L. 117-328

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 healthcare 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

[1] All mandatory amounts are net of sequester.
[2] All mandatory amounts are net of sequester. Amounts for FY 2024 reflect the proposed increase to mandatory HCFAC resources.

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 healthcare programs. Since their inception in March 2007, Strike Force prosecutors have charged more than 5,000 defendants who have collectively billed federal healthcare programs and private insurers approximately $24.7 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 3,200 cases reviewed at MCC, and law enforcement partners have made over 2,000 requests for CMS to refer reviewed cases.

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 $4.00 to $1.00 return on investment for law enforcement and detection efforts over a three-year period (2019-2021).

Medicare Integrity Program

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 Organizations (MAOs) 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 2022, CMS triaged more than 25,000 complaints from consumers who alleged they were enrolled in FFM policies without their consent or that incorrect information was submitted on an application by an agent or broker, or that other misconduct had occurred. Issuers confirmed that over 11,000 of these policies met the unauthorized enrollment criteria and subsequently cancelled the policies. Furthermore, issuers identified more than 23,000 additional policies attributable to allegations of fraud through their own investigations resulting in more than 34,000 overall policies being cancelled for allegations of fraud in FY 2022. CMS also performed over 700 license verifications to identify agents and brokers potentially noncompliant with states' licensure statutes and regulations.

Funding History[3]

Fiscal Year	Amount
FY 2020	$2,163,363,000
FY 2021[4]	$2,220,011,000
FY 2022 Final	$2,311,989,000
FY 2023 Enacted	$2,415,894,000
FY 2024 President's Budget	$2,543,853,000

[3] Includes both mandatory and discretionary resources; mandatory amounts are net of sequester.
[4] FY 2021 includes $2.423 million in HHS Secretary's Transfer Authority.

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: $937.0 million

The FY 2024 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2024 request for discretionary funding is $937.0 million, $44.0 million above the FY 2023 Enacted level. The total post-sequester FY 2024 current law mandatory funding level is $1,606.9 million, $84.0 million above the FY 2023 Enacted 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 2024, of the $937.0 million in discretionary HCFAC funding, $612.0 million is additional new budget authority for the allocation adjustment.

Over ten years, the Budget invests $1.4 billion in additional new discretionary HCFAC budget authority. The entire allocation adjustment yields $14.3 billion in healthcare savings to Medicare and Medicaid over the ten-year budget window, for an over $2:1 return-on-investment. The FY 2024 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 for the Marketplaces.

HCFAC Allocation Adjustment (outlays in millions)										
	2024	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**
New HCFAC discretionary spending, allocation adjustment	$44	$65	$86	$108	$130	$153	$176	$201	$225	$250
Savings to Medicare and Medicaid, entire allocation adjustment	$1,178	$1,243	$1,313	$1,383	$1,425	$1,468	$1,512	$1,557	$1,605	$1,652

The FY 2024 CMS allocation of the discretionary HCFAC request is $667.4 million, which is $36.7 million above the FY 2023 Enacted level[5] and reflects activities that support the emerging needs across all healthcare 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 prior authorization, modeling and analytics support, and strengthening program integrity in Medicaid and the Marketplace.

Current HCFAC funding levels to combat fraud, waste, and abuse are helping to safeguard Federal Health programs, but more could be done to ensure the government is keeping pace with the size, scope, and complexity of the healthcare industry and federal programs. Without additional resources, HHS may have to forgo investigating serious instances of fraud, waste, and abuse. Aging of the American population in the next few decades will lead to more older adults in nursing homes or home and community-based care settings,

[5] Note that the FY 2023 Enacted level includes $35.0 million for ACL's SMP program. The Budget proposes to provide ACL with a separate earmark in FY 2024.

increasing the risk of fraud, waste and abuse for this vulnerable population. Top priorities that require additional funding for CMS include:

- Increasing Medicare fee-for-service medical review, including the possible adoption of artificial intelligence and natural language processing technologies;
- Conducting Risk Adjustment Data Validation (RADV) audits on multiple payment years concurrently;
- Addressing vulnerabilities identified by the Vulnerability Collaboration Council, report recommendations from the Government Accountability Office (GAO) and OIG, and emerging issues;
- Increasing nursing home enforcement (e.g., ownership reporting validation, reviewing Part D data of beneficiaries who reside in nursing facilities, and supporting DOJ in cases brought under the False Claims Act related to quality of care); and
- Quickly addressing fraud scams, as needed, above current levels.

CMS Program Integrity – HCFAC Funding by Authority

(Dollars in Thousands)

Activity	FY 2024 Discretionary Request	FY 2024 Mandatory Funding	FY 2024 Total
Provider Enrollment & Screening	$67,873	$33,286	$101,159
Technical Assistance, Outreach & Education	$41,950	$37,186	$79,136
Medical Review	$58,500	$261,193	$319,693
Medicare Secondary Payer	$0	$114,054	$114,054
PI Investigation, Systems & Analytics	$165,649	$191,148	$356,797
Audits & Appeals	$108,940	$171,466	$280,406
Provider & Plan Oversight	$38,514	$29,000	$67,514
Error Rate Measurement	$88,113	$26,523	$114,635
Program Support & Administration	$97,821	$217,420	$315,240
Total[6]	**$667,359**	**$1,081,275**	**$1,748,634**

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 healthcare 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.

[6] Totals reflect budget authority; activity amounts may not add due to rounding.

Budget Request: $67.9 million

The discretionary request for Provider Enrollment & Screening activities is $67.9 million, an increase of $9.3 million above the FY 2023 Enacted level. Funding will support provider enrollment operations, with increased funding for operations of the new PECOS 2.0 system and a re-compete of the Advanced Provider Screening (APS) system.

- *Provider Enrollment, Chain, and Ownership System (PECOS):* $31.0 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 feeds information 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.

  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 expects PECOS 2.0 to begin operations by mid-FY 2023. Correspondingly, the original PECOS system will be decommissioned and will not require funding support in FY 2024.

- *Advanced Provider Screening (APS):* $34.8 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 2022, APS resulted in more than 7.6 million screenings which generated more than 38,000 potential licensure alerts and more than 3,000 criminal alerts for potentially fraudulent providers and suppliers for further review by CMS. Such review resulted in approximately 134 criminal revocations and over 300 licensure revocations. In FY 2024, CMS will require additional funds as it plans to award a new 12-month contract, as well as a transition period for the incumbent contractor. [This activity will be supplemented with $9.8 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. Additional funding is needed to provide sufficient contractor resources to handle the increased workload. [This activity will be funded with $16.0 million in mandatory HCFAC funds.]

- *Provider Ownership Verification:* This funding supports CMS efforts to validate ownership information submitted by providers enrolled in Medicare. The contractor will work with Medicare provider enrollment data and any available state data sources to compare and identify ownership discrepancies—typically the state's secretary of state database. The contractor will report discrepancies to CMS for follow up with providers. [This activity will be funded with $7.5 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 2022, CMS received 2,797 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 healthcare 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: $42.0 million

The discretionary request for Technical Assistance, Outreach & Education activities is $42.0 million, a decrease of $26.5 million below the FY 2023 Enacted level. CMS proposes to create a separate earmark under discretionary HCFAC for the Senior Medicare Patrol (SMP) program; as a result, that funding request is not included under this heading as it had been in previous years.

- *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 $30.5 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 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):* $19.9 million. The HFPP is a voluntary, public-private partnership between the Federal Government, state and local agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations to identify and reduce fraud, waste, and abuse across the healthcare 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. The HFPP currently has a total membership level of 279 partner organizations, comprised of federal agencies, associations, private payers, and state and local partners.

The FY 2024 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 additional funding in FY 2024 will cover a re-compete of the TTP contract, which would include the base 12 months of work as well as a transition period.

- *Medicaid Enterprise System:* $14.1 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. 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:* $8.0 million. This funding supports ongoing needs for the Local Coverage Determination Database, states' use of Medicare data for program integrity purposes, and CMS efforts to provide 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: $58.5 million

The discretionary request for MR activities is $58.5 million, an increase of $7.0 million above the FY 2023 Enacted level. Additional funding in FY 2024 would primarily support the prior authorization activities.

- *Medical Review - Ongoing Operations (MACs):* 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 2024 request supports ongoing MR operations, including Targeted Probe and Educate (TPE). MR helps reduce the error rate and is also used in vulnerabilities management. TPE reviews were suspended for the majority of FY 2021 due to the COVID PHE. The TPE process resumed September 1, 2021. In FY 2022, the MACs completed pre-payment review on approximately 329,865 claims.

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, which is substantially lower than private health insurers. CMS proposes to use additional mandatory resources for this important activity in FY 2024. [This activity will be funded with $213.7 million in mandatory HCFAC funds.]

- *Supplemental Medical Review Contractor (SMRC):* $15.4 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 and encounter data are paid correctly. In FY 2022, the SMRC reviewed approximately 285,915 claims. [This activity will be supplemented with $28.2 million in mandatory HCFAC funds.]

- *Prior Authorization:* $18.0 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. Funding will also support an evaluation contractor to test whether prior authorization and pre-claim review models and demonstrations show evidence of reduced fraud, improper payments, and overutilization without decreasing beneficiary access and quality of care, and whether refinements in the demonstration or model design are needed. CMS is researching contracting vehicles for this acquisition and anticipates making an award in the second quarter of FY 2024.

  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 2024 to meet the growing workload related to prior authorization.

- *Accuracy Reviews:* $2.8 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 2022 standard average accuracy review percentage was 98.5 percent. As of January 2023, the MRAC completed 2,500 reviews with an accuracy rate of 98.96 percent. CMS expects approximately 10,000 accuracy reviews to be completed in FY 2023. CMS is in the process of recompeting the contract; the anticipated award date is June 2023. [This activity will be supplemented with $2.9 million in mandatory HCFAC funds.]

- *MR Systems:* $18.8 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. Increased funding for FY 2024 will support the Electronic Submission of Medical Documentation (esMD) system through improved data interoperability and cloud services. [This activity will be supplemented with $7.8 million in mandatory HCFAC funds.]

- *Other MR Activities:* $3.5 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 $8.7 million in mandatory HCFAC funds.]

Medicare Secondary Payer

The Medicare Secondary Payer (MSP) program protects the Medicare Trust Funds by ensuring that Medicare does not pay for items and services where other health insurance or coverage has primary payment responsibility. The related statute and regulations require all entities that bill Medicare determine whether Medicare is the primary payer for those items or services, that Medicare not make payments where another primary payer is identified, and that Medicare recovers its payments where another party should have paid. MSP annually saves nearly $9 billion through cost avoidance and recoveries.

In FY 2024, this activity will be funded with $114.1 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.

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: $165.6 million

The discretionary request for PI Investigation, Systems & Analytics activities is $165.6 million, an increase of $0.3 million above the FY 2023 Enacted level.

- *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 operational activities of the MACs in identifying and reducing payment errors. [This activity will be funded with $22.9 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. The increase for FY 2024 is due to increasing workload and negotiating contract extensions for three UPIC jurisdictions. [This activity will be funded with $97.5 million in mandatory HCFAC funds.]

- *PI Modeling & Analytics Support:* $25.7 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. This activity includes monitoring and data quality efforts relating to beneficiary enrollment data received from state Medicaid agencies.

  Funding for this activity will allow CMS to continue supporting Medicaid fraud analytics using T-MSIS data, monitoring of providers who may have exploited the waivers and flexibilities promulgated as a result of the COVID-19 PHE, and 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 also fund contractor support to provide statistical expertise on estimation and extrapolation of overpayments, as well as expert evaluation and guidance through the appeals process. [This activity will be supplemented with $25.6 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 2022, the FPS generated alerts

that resulted in 960 new leads for program integrity contractors and augmented information for 759 existing program integrity contractor leads or investigations. [This activity will be funded with $32.2 million in mandatory HCFAC funds.]

- *One PI:* $20.0 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 2023 as well as a transition period for the incumbent contractor. The FY 2024 decreased request will support ongoing operations. [This activity will be supplemented with $1.0 million in mandatory HCFAC funds.]

- *Case Management:* $20.1 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 2024 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. The new system is expected to begin operations in FY 2024, and the legacy system will be decommissioned. Increased funding for FY 2024 support efforts to validate the data in the new system as well as a recompete of the contract, including a transition period. [This activity will be supplemented with $12.0 million in mandatory HCFAC funds.]

- *Application Programming Interface (API) Gateway:* $11.5 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.

  Fewer resources will be required in FY 2024. Data center costs will decrease with the migration to cloud-based services, and the software needs for the data strategy are less than originally anticipated.

- *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 2022, the I-MEDIC initiated 653 investigations; submitted 77 recommendations for provider revocations; submitted 170 referrals to law enforcement, including 31 immediate advisements; and submitted 138 referrals to other entities, such as state pharmacy boards, Medicare quality improvement organizations, and other Medicare contractors.

In FY 2022, the PPI MEDIC implemented six Self-Audits, six National Audits, and four Program Integrity (PI) Audits, and supported additional education and outreach initiatives for plan sponsors. For FY 2023 and FY 2024, the PPI MEDIC is tentatively scheduled to implement six Self-Audits, six National Audits, and four PI Audits. The PPI MEDIC will continue to conduct outreach and education efforts to plan sponsors.

- *Encounter Data Collection System:* $21.5 million. MA organizations and Medicare-Medicaid Plans submit on average 3.2 million encounter data records per day via the Encounter Data Front-End System (EDFES) and the Encounter Data Processing System (EDPS). 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):* $8.7 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). Increased funding in FY 2024 will allow CMS to expand and enhance the new unified dashboard, improve the review and processing of managed care contracts and rates, and continue to improve and expand data collection processes for future reporting.

- *Transformed Medicaid Statistical Information System (T-MSIS):* $10.8 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. T-MSIS provides tools to monitor the quality of state data submissions against priority reporting areas, in addition to expanded data quality checks, allowing CMS to review data for policy making and for program integrity

purposes. Funding supports operations, efforts to continue data quality improvement, cloud computing resources to handle ongoing operations of files and the needs of a growing data user base, and a pilot to improve data submission and interoperability with states.

- *MACBIS Data Analytics:* $5.9 million. CMS works closely with states to ensure that CMS and oversight bodies have access to the best, most complete, and accurate Medicaid data to support program integrity activities. This data improves monitoring, oversight, and evaluation of the Medicaid and CHIP programs aimed at protecting coverage, health equity, and driving innovation and whole person care for the beneficiaries served by the program. MACBIS data analytics support the sharing, using, and improvement of the MACBIS data set through the alignment of federal and state data sources. Specific areas of focus include 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; 4) providing analytic support to the user community; 5) strengthening the data set through data integration such as geo-coding provider and beneficiary addresses used as foundation to create imputed race and ethnicity data; and 6) monitoring beneficiary eligibility after the continuous enrollment condition period ends as a result of the PHE. 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:* $18.5 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: $108.9 million

The discretionary request for Audit & Appeals activities is $108.9 million, an increase of $4.2 million above the FY 2023 Enacted level. This funding will continue CMS's auditing functions and appeals initiatives in FY 2024, with most of the additional funding focused on appeals initiatives relating to Risk Adjustment Data Validation (RADV) activities.

- *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 2022, the MACs received and accepted approximately 53,001 Medicare cost reports, which included initial as well as amended cost report filings; approximately 25,501 cost reports were desk reviewed and tentatively settled; and approximately 622 audits were completed. [This activity will be funded with $144.7 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. Less funding is required for FY 2024, as CMS anticipates combining multiple streams of work under a single contract while removing activities relating to audit overflow work and risk assessment development. [This activity will be funded with $18.0 million in mandatory HCFAC funds.]*Risk Adjustment Data Validation (RADV):* $37.3 million. CMS uses diagnostic information submitted by MAOs to risk-adjust payments to plans for a given year. CMS conducts RADV audits for a sample of enrollees and MAO 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 finalized a regulation on January 30, 2023 that codifies our long-term RADV methodology. In FY 2023, CMS expects to begin the collection of overpayments for past RADV audits, as well as similar audits conducted by the OIG. This activity will include the processing of appeals made by MAOs to those overpayment determinations. CMS will also begin planning of future RADV audit years, the next of which will likely begin in early-mid FY 2024.

- *Cost Plan Audits:* $4.0 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:* $7.6 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 220 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:* $18.6 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:* $4.0 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:* $4.0 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 2024 request supports efforts to review and streamline audit resolution activities as well as develop recommendations for increasing accountability and improving financial integrity of CMS and state Medicaid and CHIP 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:* $18.0 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 $7.7 million in mandatory HCFAC funds.]

- *Appeals Initiatives:* $12.8 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 expected increased workload from RADV appeals.

  Additionally, this request will allow Qualified Independent Contractors (QICs) to participate as a party in approximately 2,400 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: $38.5 million

The discretionary request for Provider & Plan Oversight activities is $38.5 million, a decrease of $0.8 million below the FY 2023 Enacted level. Funding will support ongoing operations for oversight activities.

- *Open Payments:* The Open Payments program provides the public with information regarding the financial relationships between the healthcare industry (pharmaceutical and medical device manufacturers and their distributors) and healthcare 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 2024 request supports ongoing operations with increased needs for system modernization and cloud migration efforts. [This activity will be funded with $29.0 million in mandatory HCFAC funds.]

- *Part C & D Payment Analysis, Validation and Reconciliation:* $8.0 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. This funding also supports contractor responsibilities for several key functions, including serving as the primary point of contact for the Part D and Coverage Gap Discount Program (CGDP) reconciliations, analyzing Direct and Indirect Remuneration data, monitoring Plan to Plan payments, performing data quality reviews on Prescription Drug Event records, and supporting the CGDP dispute process through analysis and sponsor outreach. As of February 2023, the monthly payments average $39.2 billion representing 52.5 million beneficiaries.

- *Part C & D Review of Plans and Performance:* $20.2 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 network marketing and communications, formulary, enrollment guidelines, and appeals processes. Review and analysis 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. CMS also conducts actuarial review of bids

submitted by plans.

- *Rate Reviews:* $6.4 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 rates are financially sound, ensuring that states are in compliance with the HCBS assurances as defined in section 1915(c) of the Social Security 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:* $1.8 million. Section 1115(a) of the SSA provides authority to CMS and states under Medicaid to design, implement, and test new approaches to coverage, payment, and service delivery. CMS requests funding to improve the Agency's oversight of section 1115 demonstrations, including refinement of the budget neutrality policy, which includes the development and monitoring of state budget neutrality model formulations and estimations. 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. The funding also supports the evaluation of existing tools, the development of a suite of tools and training materials for project officer and monitoring and evaluation analysts.

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 healthcare 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: $88.1 million

The discretionary request for Error Rate Measurement activities is $88.1 million, an increase of $4.7 million above the FY 2023 Enacted level. This funding supports ongoing activities, with increased resources for improper payment rate measurement activities in Medicaid as well as Medicare Part C and Part D.

- *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 $26.5 million in mandatory HCFAC funds.]

- *Part C & D Error Rate Measurement:* $13.9 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):* $48.9 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. Additional funding in FY 2024 will support artificial intelligence (AI) initiatives that are expected to improve accuracy, decrease provider burden, and reduce the time contractors need to complete work.

- *Marketplace Improper Payment Assessment:* $25.4 million. CMS reported an improper payment rate for the Advance Premium Tax Credit (APTC) program for the first time in the FY 2022 Agency Financial Report (AFR). This funding supports the ongoing measurement and reporting of estimated improper payments in the Federally-facilitated Marketplace (FFM). It will also support the development of an improper payment measurement program for the State-based Marketplaces (SBMs), including pre-testing and assessment activities. Funding in FY 2024 will support the Review and Statistical contractors, as well as expansion of the Risk Assessment program to achieve compliance with the Payment Information Integrity Act of 2019 and Office of Management and Budget (OMB) requirements.

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: $97.8 million

The discretionary request for Program Integrity Support and Administration activities is $97.8 million, an increase of $3.5 million above the FY 2023 Enacted level. Increased funding will allow CMS to focus its efforts to improve Medicaid program integrity, as well as satisfy the HCFAC allocation towards CMS enterprise services.

- *Administrative Costs:* This funding will cover employee compensation, rent, utilities, information technology, contracts, supplies, equipment, training, and travel. [This activity will be funded with $167.9 million in mandatory HCFAC funds.]

- *Medicaid PI Improvements:* $9.5 million. This funding will support continued efforts to improve program integrity in the Medicaid program. With this funding, CMS will continue to effectively identify and mitigate program vulnerabilities in Medicaid and reduce risks. Funding will also support the Agency's oversight of state Medicaid managed care programs, including the development of risk mitigation strategies, tools and analysis relating to MLR reporting, and state directed payments. Funding in FY 2024 would allow CMS to increase its efforts to reduce state errors relating to eligibility and enrollment policies, as well as assist states with value-based purchasing (VBP) strategies and price transparency in their Medicaid drug programs.

- *Risk Management Support:* $4.0 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.

- *PI Process Improvements:* $9.0 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 $22.8 million in mandatory HCFAC funds.]

- *Ongoing Systematic Support for all PI Programs:* $30.8 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 activity will be supplemented with $25.0 million in mandatory HCFAC funds.]

- *Enterprise Services:* $44.5 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 $1.6 million in mandatory HCFAC funds.]

Administration for Community Living (ACL)

Program Description and Accomplishments

ACL supports the 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 healthcare fraud, errors, and abuse through outreach, counseling, and education. In calendar year 2021, SMP activities reached an estimated 556,980 people through 12,660 group outreach and education events and held 239,625 individual interactions with, or on behalf of, a Medicare beneficiary. The COVID-19 public health emergency (PHE) limited the SMP program's outreach efforts in 2021, and as a result, the performance data do not reflect a normal year of activities for the SMP program.

Budget Request: $35.0 million

The FY 2024 ACL discretionary request is $35.0 million, which represents an increase of $35.0 million above the FY 2023 Enacted level. This request is the same as what was appropriated out of the HCFAC discretionary amount for FY 2023. The displayed increase is attributable to the proposal to create a separate earmark for ACL for FY 2024.

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 healthcare system to HHS policymakers, program officials, and Congress. As described in the FY 2021 HCFAC Report to Congress, in FY 2021, HHS-OIG's Medicare and Medicaid oversight efforts in resulted in 504 criminal actions and 669 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 1,689 individuals and entities from participation in Federal healthcare programs. For FY 2021, 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 $2.7 billion.

Budget Request: $112.4 million

The FY 2024 HHS-OIG discretionary request is $112.4 million, which represents an increase of $7.3 million above the FY 2023 Enacted level. In addition, current law mandatory resources total $237.2 million for a total operating budget of $349.6 million.

DEPARTMENT OF JUSTICE (DOJ)

Program Description and Accomplishments

The United States Attorneys and the DOJ's Civil Division, Criminal Division, and Civil Rights Division receive HCFAC program funds to support civil and criminal healthcare fraud and abuse investigation and litigation. These offices dedicate substantial resources to combating healthcare 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 healthcare fraud cases. DOJ also provides additional funding to the FBI for Strike Force and other healthcare fraud investigations, and to the DOJ Office of the Inspector General for audits and investigations.

Budget Request: $122.2 million

The FY 2024 DOJ discretionary request is $122.2 million, which is the same as the FY 2023 Enacted level. In addition, current law mandatory resources total $74.1 million for a total operating budget of $196.3 million.

FEDERAL BUREAU OF INVESTIGATION (FBI)

Program Description and Accomplishments

The FBI is responsible for detecting and investigating healthcare 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 healthcare fraud matters. FBI special agents, intelligence analysts, and professional staff members at headquarters and in the field, work proactively to identify and target healthcare fraud in all its forms. As described in the FY 2021 HCFAC Report to Congress, in FY 2021, the FBI opened 593 new healthcare fraud investigations. At the end of FY 2021, 2,947 investigations were pending. Investigative efforts throughout the fiscal year produced 470 criminal healthcare fraud convictions, 526 indictments, and 281 prosecutors' informations. In addition, investigative efforts resulted in over 559 operational disruptions of criminal fraud organizations and the dismantlement of more than 107 healthcare fraud criminal enterprises. The FBI's efforts in combatting healthcare 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 healthcare fraud, are crucial to the success and sustainability of the healthcare system that so many Americans depend upon.

The FY 2024 FBI budget includes current law mandatory resources in the amount of $169.0 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 2022, negotiated amounts were $40.5 million for distribution among HHS components and $66.0 million for DOJ. The HHS portion of the wedge awards funded the following activities during FY 2022:

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. Funding has also enabled ACL to advance equity in the administration and implementation of the SMP program by supporting an initial SMP program equity assessment, data analytics, and the development of action plans to address findings from the assessment. This Wedge funding has supplemented ACL's base funding.

Office of the Assistant Secretary for Planning and Evaluation (ASPE): ASPE requested a third installment of $5 million to complete a five-year 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 and an additional $3 million in FY 2021. The Family First Prevention Services Act authorized healthcare 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 $626.2 million to date in FY 2022.

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 321 criminal HCFAC investigations. In FY 2022 FDA's thirteenth fiscal year of HCFAC Program activity, OCI, through its PFP, opened 13 criminal investigations, with two related to COVID-19.

FY 2022 Wedge funds have also supported two new projects: partnering with the Guam Department of Environmental Health to strengthen their import screening process for medical products; and improving FDA's Health Fraud Automated Surveillance Program by integrating the latest artificial intelligence and machine learning strategies to address public health threats stemming from the growth in online products regulated by the FDA.

HHS Office of Inspector General (OIG): FY 22 Wedge funds have supported four new HHS/OIG projects that aim to improve HHS/OIG's ability to conduct oversight of the Medicare and Medicaid programs. These projects include: modernizing data sharing practices and repositories of publicly shared Medicare and Medicaid program integrity data; updating the Digital Investigation Branch's cloud infrastructure to increase access to a growing volume of digital evidence; developing a comprehensive portal of Medicaid data sources and risks; and creating a system that continuously monitors and alerts OIG to Medicaid-related patient abuse and neglect risk indicators..

HHS Wedge Budget: $43.0 Million

The FY 2023 HHS Wedge request includes post-sequester mandatory funding of $43.0 million, which is an increase of $1.9 million above the FY 2022 Final 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.

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Children's Health Insurance Program

Current Law
(Dollars in Thousands)

	FY 2022 Final	FY 2023 Estimate	FY 2024 Estimate[1]	FY 2024 +/- FY2023
State Allotments (Healthy Kids Act P.L. 115-120, ACCESS Act P.L. 115-123)	$25,900,000	$25,900,000	$19,640,031	($6,259,969)
Additional State Allotment Carry-Forward (MACRA P.L. 114-10, Healthy Kids Act P.L. 115-120)	$3,185,187	$3,185,187	$10,295,363	$7,110,176
CHIP Performance Bonus Payments Fund (P.L. 111-3, P.L. 113-235)	$4,179,630	$7,480,368	$10,804,892	$3,324,524
Transfer from the CHIP Contingency Fund	$3,300,738	$3,324,524	$16,396,295	$13,071,771
Redistribution Pool	$3,413,812	$3,559,387	$3,559,387	$0
Child Health Quality Improvement (P.L. 111-3,114-10, 115-123)	$107,385	$101,022	$147,849	$46,827
Total Budgetary Resources[2]	**$40,086,752**	**$43,550,488**	**$60,843,817**	**$17,293,329**
CHIP State Allotment Outlays	$16,663,137	$17,689,000	$18,305,000	$616,000
Performance Bonus Payments Outlays	$0	$0	$0	$0
Redistribution Pool Payments	$0	$0	$0	$0
Child Health Quality Improvement Outlays	$5,215	$13,173	$18,000	$4,827
Redistribution Payments	$0	$0	$0	$0
Total Outlays[3]	**$16,670,269**	**$17,702,173**	**$18,323,000**	**$620,827**

[1] The Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act extended funding for each of fiscal years 2024 through 2026, and the Consolidated Appropriations Act, 2023, further extended through FY 2028, such sums as are necessary to fund allotments to States. This table provides CMS's current estimation on amounts needed to fund CHIP state allotments in FY 2024 according to the formula in the Social Security Act.

[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] FY2022 total includes $1.9 million in outlays that were used to resolve a settlement with Alabama on Performance Bonus Fund overpayments from FY 2009 – FY 2013. This involved a recalculation to decrease the overpayment in some years, and an net recovery of overpayments. No new obligations were made from the Performance Bonus Fund in FY 2022. No obligations for new Performance Bonus Payments have been issued since FY 2013.

Child Enrollment
Contingency Fund
Current Law
(Dollars in Thousands)

	FY 2022 Final	FY 2023 Estimate	FY 2024 Estimate	FY 2024 +/- FY 2023
Child Enrollment Contingency Fund, Budget Authority[4]	$21,159,738	$19,092,524	$20,324,301	$1,231,777
Temporarily Unavailable[5]	($12,679,000)	($14,628,000)	$0	$14,628,000
Transfer to CHIP Performance Bonus Fund	($3,300,738)	($3,324,524)	($16,396,295)	$13,071,771
Payments to Shortfall States	$0	$0	$0	$0
Interest Estimate	$93,524	$628,295	$168,904	($459,391)
Total Budgetary Resources, end of year[6]	**$5,273,524**	**$1,768,295**	**$4,096,910**	**$2,328,615**
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)
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).
Consolidated Appropriations Act, 2023 (P.L. 117-328).

Allocation Method – Formula grants

[4] Reflects both carryover resources and deposits into the Fund.
[5] The Consolidated Appropriations Act, 2022 (P.L.117-328) made $14.6 billion not available for obligation in FY 2023.
[6] Funding levels reflect new appropriations and carry-forward balances from prior year's net of enacted rescissions and amounts made temporarily unavailable for obligation.

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. The HEALTHY KIDS Act (P.L. 115-120) appropriated funding to CHIP for six years from FY 2018 through FY 2023, with an additional $20.2 billion in budget authority over the baseline for FY 2023. The Bipartisan Budget Act (BBA) (P.L. 115-123) extended CHIP funding through FY 2027, and the Consolidated Appropriations Act (P.L. 117-328) further extended CHIP funding through FY 2029 with additional funding above the baseline in FY 2029 to fund state allotment payments under 2104(b) of the Social Security Act.

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

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, the Bipartisan Budget Act of 2018 authorized the Fund through FY 2027, and the Consolidated Appropriations Act (P.L. 117-328) extended the Fund through FY 2029.

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. Territories are

not eligible to receive Contingency Fund payments.

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.

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 $3.6 billion in funding will be available for redistribution in FY 2023.

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, and the HEALTHY KIDS Act provided $90.0 million for child health quality activities for FYs 2018 through 2023. The ACCESS Act provided $60 million for FYs 2024 through 2027, and makes annual state reporting on the Child Core Set measures mandatory starting in FY 2024. The Consolidated Appropriations Act (P.L. 117-328) provides $15 million for each year in FY 2028 and FY 2029 for pediatric quality measures.

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 2022, 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 2023 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, the expected completion date was pushed to FY 2022. The implementation of the state pilots was 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 2020 [6]	$20,530,000,000
FY 2021 [7]	$23,800,000,000
FY 2022	$25,900,000,000
FY 2023	$25,900,000,000
FY 2024 [8]	$19,640,031,000

[6] 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).

[7] 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).

[8] The Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act extended funding for each of fiscal years 2024 through 2026, such sums as are necessary to fund allotments to States. As such, this amount is subject to change.

Mandatory State/Formula Grants[9]
State Children's Health Insurance Program
CFDA NUMBER/PROGRAM NAME: 93.767
(Dollars in Thousands)

STATE/TERRITORY	FY 2022[12] Actual	FY 2023[13] Estimate	FY 2024[14] Estimate	FY 2024 +/- FY 2023
Alabama	$390,033	$434,581	$457,626	$23,045
Alaska	$27,206	$20,344	$21,422	$1,079
American Samoa	$6,702	$8,208	$8,643	$435
Arizona	$263,995	$375,025	$394,912	$19,887
Arkansas	$221,210	$216,844	$228,343	$11,499
California	$3,545,882	$3,289,718	$3,464,164	$174,446
Colorado	$296,259	$265,485	$279,563	$14,078
Connecticut	$77,849	$63,402	$66,764	$3,362
Delaware	$39,587	$28,718	$30,241	$1,523
District of Columbia	$65,216	$56,297	$59,283	$2,985
Florida	$829,051	$670,813	$706,385	$35,572
Georgia	$493,812	$519,392	$546,934	$27,542
Guam	$32,505	$1,475	$1,553	$78
Hawaii	$58,569	$56,695	$59,701	$3,006
Idaho	$91,174	$101,872	$108,330	$6,458
Illinois	$567,905	$552,613	$581,916	$29,304
Indiana	$288,565	$240,608	$253,367	$12,759
Iowa	$184,949	$146,699	$154,478	$7,779
Kansas	$155,119	$152,499	$160,586	$8,087
Kentucky	$293,852	$387,467	$408,013	$20,546
Louisiana	$417,148	$462,627	$487,159	$24,532
Maine	$37,844	$39,593	$41,693	$2,100
Maryland	$302,351	$341,141	$359,231	$18,090
Massachusetts	$722,738	$679,666	$715,707	$36,041
Michigan	$287,657	$299,711	$315,604	$15,893
Minnesota	$121,599	$81,227	$85,535	$4,307
Mississippi	$286,916	$195,454	$205,818	$10,364
Missouri	$346,332	$325,388	$342,643	$17,255

[9] Represents proposed law baseline projections of obligations
[12] FY2022 Projected CHIP Allotments do not include FY 2022 CHIP ARP as relates to section 9821. Amounts are subject to change.
[13] FY2023 Projected CHIP allotments do not include FY 2023 CHIP ARP as relates to section 9821. Amounts are subject to change.
[14] FY2024 Projected CHIP Allotments do not include amount of increase, if any, determined under section 2104(m)(7) of the Act and the FY2023 Allotment Increase Factor (AIF) is used as a proxy since FY 2024 AIF is not available at this time. Amounts are subject to change.

STATE/TERRITORY	FY 2022[12] Actual	FY 2023[13] Estimate	FY 2024[14] Estimate	FY 2024 +/- FY 2023
Montana	$91,994	$98,768	$104,143	$5,375
Nebraska	$18,249	$18,737	$19,730	$994
Nevada	$86,511	$91,925	$96,799	$4,875
New Hampshire	$87,643	$92,474	$97,378	$4,904
New Jersey	$50,626	$53,794	$56,646	$2,853
New Mexico	$651,303	$642,394	$676,459	$34,065
New York	$122,274	$123,095	$129,623	$6,527
North Carolina	$1,699,383	$1,393,963	$1,467,882	$73,919
North Dakota	$589,003	$690,494	$727,109	$36,615
Northern Mariana Islands	$19,613	$21,102	$22,221	$1,119
Ohio	$552,186	$611,211	$643,622	$32,411
Oklahoma	$278,286	$258,639	$272,354	$13,715
Oregon	$455,233	$510,900	$537,992	$27,092
Pennsylvania	$736,628	$556,298	$585,798	$29,499
Puerto Rico	$124,412	$204,496	$215,340	$10,844
Rhode Island	$80,120	$104,988	$110,556	$5,567
South Carolina	$220,684	$207,457	$218,513	$11,056
South Dakota	$31,241	$30,922	$32,561	$1,640
Tennessee	$322,595	$360,828	$379,962	$19,134
Texas	$1,437,049	$1,416,976	$1,492,115	$75,139
Utah	$12,907	$2,994	$3,152	$159
Vermont	$134,902	$115,325	$121,440	$6,115
Virgin Islands	$21,989	$17,474	$18,401	$927
Virginia	$401,147	$400,773	$422,025	$21,252
Washington	$262,452	$248,710	$261,898	$13,189
West Virginia	$83,615	$83,114	$87,521	$4,407
Wisconsin	$265,385	$271,415	$285,808	$14,393
Wyoming	$12,915	$7,001	$7,372	$371
TOTAL RESOURCES	$19,302,373	$18,649,824	$19,640,031	$990,207

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 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Medicaid Integrity Program	$90,525	$93,513	$100,900	$7,387
CPI-U	$2,987	$7,387	$5,550	($1,838)
Sequester	($5,330)	($5,751)	($6,068)	($316)
MIP Total	**$88,182**	**$95,149**	**$100,382**	**$5,233**
Money Follows the Person (MFP)	$450,000	$450,000	$450,000	**$0**
Sequester	($25,650)	($25,650)	($25,650)	**$0**
MFP Total	**$424,350**	**$424,350**	**$424,350**	**$0**
Money Follows the Person (MFP TA/Evaluation)	$0	$5,000	$0	**($5,000)**
Sequester	$0	($285)	$0	**$285**
MFP TA/Evaluation Total	**$0**	**$4,715**	**$0**	**($4,715)**
Grants to Improve Outreach and Enrollment	$0	$0	$48,000	$48,000
Sequester	$0	$0	($2,736)	($2,736)
Outreach and Enrollment Total	**$0**	**$0**	**$45,264**	**$45,264**
Community Mental Health Grants	$0	$40,000	$0	**($40,000)**
Total Appropriation	**$512,532**	**$564,214**	**$569,996**	**$5,782**

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; Consolidated Appropriations Act, 2021 (P.L. 116-260); ACCESS Act of 2018 (P.L. 115-123); Bipartisan Safer Communities Act (P.L. 117-159); Consolidated Appropriations Act, 2023 (P.L. 117-328)

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, 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.

State Grants and Demonstrations
Net Outlays[3]
(Dollars in Thousands)

Program	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Money Follows the Person (MFP) Demonstration-Grants	$213,189	$247,269	$213,012	**($34,257)**
MFP Research & Evaluation	$612	$633	$583	**($50)**
MFP Best Practices	$266	$69	$0	**($69)**
MFP QA/Tech Asst/Oversight	$824	$466	$750	**$283**
Medicaid Integrity Program	$99,860	$90,566	$97,322	**$6,755**
Grants to Improve Outreach and Enrollment	$17,965	$12,977	$13,049	**$72**
Demonstration Programs to Improve Community Mental Health Services (PAMA 223)	$206	$16	$0	**($16)**
Demonstration Programs to Improve Community Mental Health Services (BSCA 11001)	$0	$38,000	$700	**($37,300)**
Demonstration Project to Increase Substance Use Provider Capacity (Sec 1003)	$14,720	$7,894	$1,128	**($6,766)**
Community-Based Mobile Crisis Intervention Services	$3,865	$4,050	$5,700	**$1,650**
Incentives for Prevention of Chronic Diseases in Medicaid	$18	$0	$0	**$0**
Administrative - Postage Penalty Mail	$0	$60,000	$0	**($60,000)[4]**
Total Outlays for State Grants and Demonstrations	**$351,525**	**$461,941**	**$332,243**	**($129,698)**

[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.
[4] Administrative Postage Penalty Mail represents outlays for mailed materials including printing, postage, and distribution. Budget Authority from P.L. 108-173, Sec. 1011 and P.L. 111-148, Sec. 4108

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[5]

Fiscal Year	Amount
FY 2020	$421,508,189
FY 2021	$525,816,455
FY 2022 Final	$512,532,410
FY 2023 Enacted	$564,213,819
FY 2024 President's Budget	$569,996,003

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, the Consolidated Appropriations Act, 2023, 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.

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

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

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) 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 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.

Between 2008 and 2020, states transitioned 107,128 people to community living through the MFP program.

Budget Overview

Section 6071 of the Deficit Reduction Act (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) added $1.253 billion ($1.201 billion after sequestration) and included statutory changes to enhance and extend the program through September 30, 2023. The Consolidated Appropriations Act, 2023 (P.L.117-328) added $1.8 billion ($1.697 billion after sequestration) and extends the program through September 30, 2027. The Consolidated Appropriations Act, 2023 (P.L.117-328) also amended the availability of funding until "September 30 of the subsequent fiscal year." This

change applies to all amounts appropriated under the Consolidated Appropriations Act, 2023, and to previous appropriations. Under the reauthorization in the Consolidated Appropriations Act, 2021, funding was available until 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/sites/default/files/2019-12/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 $3.0 million (until expended) for quality assurance and improvement; technical assistance and oversight. Sec. 5114 of the Consolidated Appropriations Act, 2023 included $5.0 million in fiscal year 2023 ($4,715,000 after sequestration) and for each subsequent 3-year period through fiscal year 2029 for Quality Assurance and Improvement; Technical Assistance; Oversight and Research and Evaluation.

As of December 31, 2022, CMS obligated approximately $4.5 billion in grants to 45 grantee states, two (2) territories and the District of Columbia (DC). Grantees have transitioned approximately 107,128 individuals as of December 31, 2020, based on individual state reporting. Currently, there are 38 states, two (2) territories and DC participating in the MFP demonstration.

State	*Cumulative Award Total*	*Initial Award Date*
Alabama	$25,424,244	September 27, 2012
American Samoa	$4,753,644	September 1, 2022
Arkansas	$68,256,438	January 1, 2007
California	$223,926,239	January 1, 2007
Colorado	$31,943,894	April 1, 2011
Connecticut	$280,497,914	January 1, 2007
Delaware	$13,304,857	May 1, 2007
District of Columbia	$44,057,769	May 1, 2007
Georgia	$173,103,277	May 1, 2007
Hawaii	$9,316,450	May 1, 2007
Idaho	$28,921,301	April 1, 2011
Illinois	$41,173,445	September 1, 2022
Indiana	$81,928,627	January 1, 2007
Iowa	$101,425,571	January 1, 2007
Kansas	$68,867,330	September 1, 2022
Kentucky	$59,601,005	May 1, 2007
Louisiana	$108,565,613	May 1, 2007
Maine	$13,239,658	April 1, 2011
Maryland	$173,070,208	January 1, 2007
Massachusetts	$97,538,327	April 1, 2011
Michigan	$79,802,401	January 1, 2007
Minnesota	$104,305,873	April 1, 2011
Mississippi	$29,183,470	April 1, 2011
Missouri	$89,287,035	January 1, 2007
Montana	$12,564,847	September 27, 2012
Nebraska	$17,419,791	January 1, 2007
Nevada	$17,694,870	April 1, 2011
New Hampshire	$18,753,793	September 1, 2022
New Jersey	$164,832,185	May 1, 2007
New Mexico	$49,205	April 1, 2011
New York	$277,808,412	January 1, 2007
North Carolina	$72,869,597	May 1, 2007
North Dakota	$45,420,867	May 1, 2007
Ohio	$464,011,389	January 1, 2007
Oklahoma	$62,470,039	January 1, 2007
Oregon	$22,655,153	May 1, 2007
Pennsylvania	$180,947,204	May 1, 2007
Puerto Rico	$4,998,037	September 1, 2022
Rhode Island	$22,954,380	April 1, 2011
South Carolina	$7,542,828	April 1, 2011
South Dakota	$17,926,234	September 27, 2012

State	*Cumulative Award Total*	*Initial Award Date*
Tennessee	$83,948,612	April 1, 2011
Texas	$409,874,795	January 1, 2007
Vermont	$30,195,647	April 1, 2011
Virginia	$70,866,895	May 1, 2007
Washington	$294,930,714	January 1, 2007
West Virginia	$32,087,589	April 1, 2011
Wisconsin	$77,753,186	January 1, 2007
Total	**$4,362,070,859**	

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). On September 1, 2022, planning grant awards were made to American Samoa, Illinois, Kansas, New Hampshire and Puerto Rico. Totals above for Illinois, Kansas, New Hampshire are cumulative to 2007.

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.

<u>Medicaid Program Integrity</u>

The Government Accountability Office (GAO) has included Medicaid on its list of high-risk programs since 2003, acknowledging that the size, complexity, and diversity of Medicaid

make the program particularly challenging to oversee at the federal level.[6] 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.[7] Building on 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. Continued levels of funding will be required through FY 2024 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. CMS operates a robust state-specific PERM corrective action plan process that provides enhanced technical assistance and guidance to states. CMS works with states to develop corrective action plans to address each error and deficiency identified during the PERM cycle. After a corrective action plan has been submitted, CMS monitors each state's progress in implementing effective corrective actions and provides a number of training opportunities to ensure compliance with CMS policies.
- Medicaid Eligibility Quality Control (MEQC) Program: Under the MEQC program, states design and conduct pilots to evaluate the processes that determine an individual's eligibility for Medicaid and CHIP benefits. The MEQC program also reviews eligibility determinations that are not reviewed under PERM, such as denials and terminations. States have flexibility in designing pilots to focus on suspected or known areas of vulnerability. MEQC pilots are conducted during the 2-year intervals ("off-years") that occur between states' triennial PERM review years, allowing states to implement prospective improvements in eligibility determination processes prior to their next review.

Medicaid Claiming and Financial Reporting

- A key component of CMS' managed care program integrity work is to conduct targeted audits of selected states' Medicaid Managed Care Plans' (MCPs) financial reporting, including Medical Loss Ratios (MLRs). As part of this effort, CMS most recently conducted an audit of the Medical Loss Ratio (MLRs) reported by the 15 Coordinated Care Organizations (CCOs) contracted with Oregon during calendar year (CY) 2019. The primary objectives were to determine if the CCOs submitted annual MLR reports to the state as required by federal regulations, and

[6] Dodaro, Gene L. (GAO), Medicaid: Actions Needed to Mitigate Billions in Improper Payments and Program Integrity Risks, (GAO-18-598T), Testimony before the United States Senate Committee on Homeland Security and Governmental Affairs, June 27, 2018. Available at https://www.gao.gov/assets/gao-18-598t.pdf.

[7] Available at: https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

if the annual MLR reporting and minimum MLR remittance calculations reported were supported by the underlying data and supporting documentation. The audit identified several recommendations and observations.

Medicaid and CHIP Collaboration

- 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. These TAG calls are focused on such areas as general fraud, waste and abuse concerns; provider enrollment; beneficiary eligibility; data analytics; and concerns specific to small states.
- CMS' Medicaid Integrity Institute (MII) provides training and education to state Medicaid program integrity staff throughout the year. MII courses cover such topics as provider enrollment; Medicaid risk assessments; managed care; program integrity reviews; and fraud, waste, and abuse data analytics. Despite a transition to all-virtual offerings as a result of the COVID-19 PHE, state interest and participation in the MII has remained strong. More information on the MII is located on the Medicaid Integrity Institute website at https://www.cms.gov/medicaid-integrity-institute.
- CMS fosters a collaborative relationship with states by providing one-on-one technical assistance and educational materials (such as toolkits) on various high-risk program integrity issues. For example, CMS previously announced certain Medicaid and CHIP waivers and flexibilities to allow states to best respond to the COVID-19 PHE. CMS continuously provides 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.
- As of December 31, 2022, the Healthcare Fraud Prevention Partnership (HFPP) had 47 State Medicaid partners. The HFPP held a virtual State Information Sharing Session on March 24, 2022. During the event, 84 partners from across 35 state health care and Medicaid Fraud Control Units (MFCU) organizations acquired the latest information on COVID-19, law enforcement activities, investigative strategies, and trending schemes to assist with -fraud fighting efforts. The next State Information Session is scheduled for March 23, 2023. The HFPP continues to engage state partners through a variety of means including producing study results, releasing 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 strengthen 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. As these materials are developed for specific demonstration types, they are being piloted and refined with state input and then fully implemented. In addition, CMCS uses a highly integrated team-based approach to ensure all staff working on section 1115 demonstrations are informed about a state's performance under its demonstration program.
- 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 data trends. Upcoming releases will also support application intake from states and the review and approval cycles of the section 1115 workflows.

Medicaid Data Analysis

- It is an Administration priority for CMS to work closely with states and territories to ensure CMS and oversight bodies have access to the best, most complete, and accurate Medicaid data to support program integrity activities, improve monitoring, oversight and evaluation of Medicaid and CHIP aimed at protecting coverage, health equity and driving innovation and whole person care for the beneficiaries served by the program. All 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands are submitting data on their programs on an ongoing basis to the Transformed Medicaid Statistical Information System (T-MSIS). Guam is working to begin submitting data, and American Samoa and Northern Mariana Islands do not participate in T-MSIS. Each year, CMS partners with states to improve the quality of the overall dataset, and holds states accountable for correcting high priority data areas. As a result of these efforts with states to improve the data, historical T-MSIS data can now be used for analysis and inform program integrity.
- As Data quality continues to improve, T-MSIS enhancements to strengthen data quality have expanded in areas such as improving insight on Managed Care data patterns, improving on the ability to identify data anomalies earlier in the ingestion process by comparing historical data, and keys essential for identifying and tracking a unique beneficiary, especially as beneficiaries move across States. In addition, the T-MSIS data set in the near future will be expanded to provide more visibility to sub-capitation payments and sub-capitated encounter records, the ability to collect more diagnosis codes, and to improve reporting of financial transactions typically lumped into a single category that historically creates challenges in performing analytics.
- CMS releases a research version of T-MSIS data called the T-MSIS Analytic Files (TAF), with data for calendar years 2014-2020 to federal partners and stakeholders, and publicly released research files for calendar years 2014-2020. To allow for users to explore the data, CMS also releases the Data Quality (DQ) Atlas. This interactive, web-based tool helps policymakers, analysts, researchers, and other stakeholders explore the quality and usability of the TAF to determine whether the data can meet their analytic needs.
- T-MSIS continues to support the public release of the annual substance use disorder data book, maternal and infant health data tables, monthly enrollment trend snapshots, annual state-level Medicaid per capita expenditures for the Medicaid, Modified Adjusted Gross Income (MAGI) application and processing time, COVID service utilization, and CHIP Scorecard, and the Non-Emergency Medicaid Transportation report.

  CMS continues to strengthen the T-MSIS data set by integrating other sources of data, such as expenditure data, state plan amendment/waiver data, and data on Medicare-Medicaid Dual Eligibility status allowing for future validation of areas such as services rendered against expenditures claimed, or evaluating expenditure changes in state programs. A federally Assigned Service Category (FASC) now provides TAF users with an alternative method to identify, select, and consistently categorize claims data across states' TAF files. As of 2023, T-MSIS

data is geo-coded for all provider and beneficiary addresses for calendar years 2016-2020. Geo-coded data provided the foundation for creating imputed race and ethnicity data that is now available in the TAF Race and Ethnicity Imputations (REI) file for calendar years 2016-2020. This data allows CMS to conduct accurate equity-related analyses for the first time in agency history. Using this data, the CMS team is working towards an internal Equity Dashboard to provide transparency and accountability on progress towards closing priority equity gaps among Medicaid and CHIP beneficiaries. Output from this dashboard will be publicly released in the future via a series of data briefs.

- CMS is conducting increasingly complex analyses to strengthen the Medicaid and CHIP programs, particularly around bundled payments for pregnancy-related services and opioid use and prescribing. This includes progression toward inferential statistics and analysis.
- 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. Analysis of expenditure data has led to enhancements in both data quality and an enhanced ability to support program integrity efforts.

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 2024, 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 2022, the UPICs initiated Medicaid provider investigations and audits in 43 states. The most common collaborative investigations and audits have involved hospitals, pharmacies, clinics, physicians, durable medical equipment suppliers, community mental health centers, and hospices. Each of these investigative areas includes both fee for service and managed care providers. In FY 2023, CMS is continuing to collaborate with states to conduct investigations and audits in high priority areas, with special emphasis on managed care plans' program integrity efforts and activities.

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 2022 through the continued efforts of these specialists, CMS removed an estimated $1.3 billion (with approximately $874 million recovered and $408 million resolved) of approximately $9.6 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 and CHIP Budget (Submission and new Review process with automated workflow); Upper Payment Limit for state demonstrations; Tracking Accountability in Government Grants System (TAGGS) to track grants awarded; initial and supplemental Grant awards, and many other improvements that enhanced MACFin system processes and the end-user experience. In addition, other enhancements to the federal systems supporting Medicaid and 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

CMS conducts oversight of state program integrity efforts through program integrity reviews of high-risk areas of fraud, waste and abuse. Reviews are conducted to determine if state policies and practices comply with federal regulations; identify program vulnerabilities that may lead to fraud, waste and abuse; identify program integrity promising practices that can be shared with other states; monitor state corrective action plans developed as a result of previous reviews; and identify areas that would benefit from technical assistance from CMS.

CMS' focused program integrity reviews target specific areas that have been identified as high-risk of fraud, waste and abuse in the Medicaid program. Focused reviews in recent years have focused on such topics as state managed care oversight, managed care organizations' oversight of their own programs, and personal care services. CMS conducts approximately 10-12 focused program integrity reviews each year.

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. CMS conducts approximately 50-60 program integrity desk reviews each year.

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 2022 budget authority was $88.2 million. The FY 2023 budget authority is $93.5 million with an estimated CPI-U adjustment of 7.9 percent, bringing the adjusted budget authority to $100.9 million. The FY 2023 budget authority is reduced by 5.7 percent due to sequestration, bringing the FY 2023 budget authority to $95.1 million. The FY 2024 budget authority is $100.9 million with an estimated CPI-U adjustment of 5.5 percent, bringing the adjusted budget authority to $106.4 million. The FY 2024 budget authority is reduced by 5.7 percent due to sequestration, bringing the estimated FY 2024 budget authority to $100.4 million. The CPI-U adjustments are based on the most current FY 2024 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 the 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, 330 awards to eligible entities have been issued for approximately $265.0 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. In 2019, CMS awarded $48.0 million to 39 organizations in 25 states for general outreach in FY 2019 through FY 2022. On July 19, 2022, CMS awarded and additional $49.0 million in cooperative agreements to 36 organizations in 20 states for general outreach and added pregnant individuals as an optional targeted population under the grants. Because babies born to pregnant individuals covered by Medicaid or CHIP are deemed eligible for Medicaid or CHIP, CMS believes that including pregnant individuals as a target population supports the statutory goal of enrolling more children in Medicaid and CHIP. The project period for this project is three years, from FY 2022 through 2024.

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 October 17, 2022, CMS issued another Notice of Funding Opportunity to make available the remaining $6.0 million for outreach and enrollment grants targeting AI/AN children, parents, and pregnant individuals 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 June 2023. A new multi-year task order will be awarded in June 2023 and will run through June 2027 with HEALTHY KIDS Act and ACCESS Act of 2018 funding. 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, producing public service announcements, developing a series of animated digital videos and conducting paid digital and earned media outreach to eligible but unenrolled consumers. All National Campaign materials can be found on InsureKidsNow.gov where there is a robust Outreach Tool Library, including some materials in 23 different languages which also contains all the languages under CMS' Strategic Language Access Plan. During the COVID-19 Public Health Emergency (PHE), the National Campaign created the "Peace of Mind" campaign and a mental health campaign, which included digital videos as a way to continue to promote Medicaid and CHIP benefits during the PHE when parents were concerned about the health and well-being of their families but were quarantined at home. Additional digital series were created into other topics such as 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 10 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 for FY 2024 through FY 2027, with the combined total of $168.0 million for outreach and enrollment activities for FY 2018 through FY 2027.

Recently, Section 5111 of the Consolidated Appropriations Act, 2023 (referred to as CAA, 2023 and included in P.L. 117-328) provided an additional $48.0 million to extend all outreach and enrollment activities, including the National Campaign, for FY 2028 and FY 2029. 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 (PAMA) 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.

On June 25, 2022, the Bipartisan Safer Communities Act (BSCA) (P.L. 117-159) was enacted under which section 11001 expands the existing CCBHC Demonstration authorized under section 223 of the Protecting Access to Medicare Act of 2014, and appropriates $40.0 million for awarding additional planning grants to new states to launch CCBHC behavioral health programs beginning July 1, 2024 with selection of up to10 additional states every two years until all funds are expended.

The legislation also extends the end date and enhanced FMAP of the original eight Demonstration states to September 30, 2025 and extends the length and enhanced FMAP for the two most recent states added to the Demonstration under the Consolidated Appropriations Act of 2020 from two years to six years.

Also, as authorized under the BCSA, the deadline for the recommendation report to Congress was extended to September 30, 2025 with continued annual Congressional reports. A final report is due to Congress two years after all Demonstration have ended and a final evaluation is required 24 months after the conclusion of all Demonstrations in states.

On October 18, 2023, SAMHSA released a Notice of Funding Opportunity (NOFO) to award the first round of 15 million in Planning Grants to up to 15 states for use during the 1-year planning phase of the Demonstration. The purpose of CCBHC Planning Grants is to

support states to develop and implement certification systems for CCBHCs, establish Prospective Payment System (PPS) reimbursement rates, and prepare an application to participate in a four-year CCBHC Demonstration program. SAMHSA expects that the program will meaningfully involve consumers, youth, family members, and communities in the development, implementation, and ongoing monitoring of the state's planning efforts to develop CCBHCs and prepare to apply for the CCBHC Demonstration. With the planning grants, SAMHSA aims to further expand opportunities for states to improve access to and delivery of coordinated, comprehensive behavioral health care through Certified Community Behavioral Health Clinics. SAMHSA in conjunction with CMS may announce the 15 awardee states around spring 2023.

Budget Overview

Section 223 of PAMA 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. Section 11001 of the BSCA authorized and appropriated $40.0 million to award additional planning grants in FY 2023; provide technical assistance (TA) to states applying for grants and carry out Demonstration programs. CMS, SAMHSA and ASPE subdivided $10.0 million of the $40.0 million toward TA, continued program evaluations and Reports to Congress.

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 quarterly 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 statutory timeline was pushed back to allow adequate time for statutorily required collaboration and clearances. The *Initial Report to Congress* is currently in clearance.

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.

Pursuant to section 1135(b)(5) of the Social Security Act (Act), CMS modified the deadlines and timeline set forth in section 1903(aa) of the Act (which was added by section 1003 of the SUPPORT Act) 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. 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 six 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. The AHRQ report to Congress, a summary of the experiences of states awarded planning grants, is currently under development.

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. The authorization directed CMS to select up to five states. 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 continues to monitor state community-based mobile crisis intervention services program planning and implementation, including oversight of state grant 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 $15.0 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.

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Information Technology

(Dollars in Thousands)

Information Technology Portfolio	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY2023
Program Management	**$2,027,879**	**$2,194,413**	**$2,244,911**	**$50,498**
Coronavirus Supplemental	$818	$160	$ -	$(160)
Federal Administration	$ -	$1,997	$ 2,177	$180
Program Operations	$1,363,685	$1,456,693	$1,535,134	$78,441
Research	$6,235	$ 6,215	$ -	$(6,215)
Survey & Certification	$7,871	$6,413	$6,450	$37
Subtotal: Discretionary Appropriation	**$1,378,609**	**$1,471,478**	**$1,543,761**	**$72,283**
Medicaid and Medicare (4201)	$2,593	$3,588	$963	$(2,625)
PAMA Section 210 & 216	$3,280	$3,400	$3,400	$ -
No Surprises Act	$40,590	$49,682	$44,159	$(5,523)
Consolidated Appropriations Act	$6,317	$7,250	$6,750	$(500)
Inflation Reduction Act	$6,677	$30,607	$10,000	$(20,607)
Subtotal: Mandatory Appropriation	**$59,457**	**$94,527**	**$65,272**	**$(29,255)**
CLIA	$68	$49	$50	$1
COB User Fees	$26,988	$36,314	$28,730	$(7,584)
Marketplace Risk Adjustment User Fees	$13,072	$17,655	$18,590	$935
Marketplace User Fees	$518,466	$559,985	$575,103	$15,118
RAC MSP & Parts A/B	$19,536	$ -	$ -	$ -
Sale of Data	$11,683	$14,405	$13,405	$(1,000)
Subtotal: Offsetting Collections	**$589,813**	**$628,408**	**$635,878**	**$7,470**
Quality Improvement Organizations	**$283,317**	**$302,914**	**$316,006**	**$13,092**
Innovation Center	**$196,886**	**$206,592**	**$207,765**	**$1,173**
Health Care Fraud & Abuse	**$498,502**	**$481,634**	**$473,308**	**$(8,326)**
Total Information Technology	**$3,006,584**	**$3,185,553**	**$3,241,990**	**$56,437**

Program Description

The Information Technology (IT) portfolio includes funding for all technological segments of CMS's operations. These functions stem from many of the agency's different funding sources, but it is best to examine CMS's IT portfolio by investment category. CMS's IT spending is broken out into seven categories:

- **Medicare Parts A and B:** Supports provider enrollment, claims processing, and incentive payment programs for Fee-For-Service (FFS) and durable medical equipment (DME) operations.
- **Medicare Parts C and D:** Aids with beneficiary enrollment, balancing risk, and issuer compliance across issuers in the Medicare Advantage and Prescription Drug programs.
- **Medicare Outreach and Education:** Systems aimed to educate beneficiaries on the most efficient ways to use CMS's resources.
- **Medicaid and CHIP:** Supports databases of standardized enrollment, eligibility, and claims, which provides statistical reports and supports research.

- **Private Insurance:** Maintains oversight and advises consumers on where to find the appropriate insurance coverage.
- **Health Care Quality:** Aims to improve the quality and value of health care provided to beneficiaries and consumers.
- **Enterprise Information Technology:** CMS-wide systems and support to ensure operating and security standards are applied across the enterprise.

Nearly every facet of CMS uses the resources funded out of this portfolio to complete mission critical functions on a daily basis. Below are a few of CMS's main priorities within the IT portfolio:

IT Security: CMS faces daily cybersecurity threats due to the value of the data it safeguards and the increased technical capability of "bad actors" across the globe. These threats continue to intensify and CMS must enhance its IT security program to meet these risks.

This program has accomplished many goals to help ensure the safety of CMS's networks and data. For example, CMS developed an initial prototype for its new security approval process platform, batCAVE (Continuous Authorization and Verification Engine). Under this prototype, 83 percent of the Acceptance Risk Safeguard (ARS) controls have been mapped and a portion of the infrastructure has been implemented for the platform. Once batCAVE is fully functional, CMS can streamline its security approval process for new IT efforts. Secondly, a new User Behavior Analytics (UBA) tool was implemented, which leverages targeted machine learning models to identify baselines of user activity and subsequent outliers that may be indicative of risky changes to the user. This enables CMS to identify potential cases of insider risk and manage them appropriately. In addition, the program began testing various tools and trainings to help mitigate cybersecurity threats, which includes piloting an enhanced phishing program, modernized enterprise cybersecurity and privacy training programs and creating CyberGeek (https://security.cms.gov). Furthermore, the IT Security Program implemented Red Team activities to test the various security architecture and provide feedback to system and business owners on how and where security can be enhanced.

This request will allow CMS's IT Security program to begin tailoring its response to EO 14028 (Improving the Nation's Cybersecurity) as well as continue the ongoing efforts of development for the batCAVE and Security Data Lake. As part of CMS's response to the Executive Order, the program will establish Zero Trust Architecture (ZTA) as a pilot for batCAVE and integrate it with a hardware security product. This will allow for the batCAVE environment to function as a hardware device multi-factor authentication (MFA) process. ZTA is centered on the idea that access to data should not be solely made based on network location.

Medicare Payment Systems Modernization (MPSM): This priority work enhances Medicare's outdated fee-for-service claims processing systems so that CMS can fulfill its duty to be a reliable first-class Medicare payer. MPSM's goal supports agency policy initiatives that drive innovation to tackle our health systems challenges, promote value-based care and protect CMS's sustainability for future generations by serving as a responsible steward of public funds.

CMS reached many milestones that provide valuable services to Medicare beneficiaries, providers, and claims processors. Most recently, CMS completed the modernization of all ten Institutional Claims Pricers, which includes updating program language from legacy COBOL to Java and converting the system to a cloud-based service. These updates allow for a single instance of the Pricers to be used for all claims processing. In addition, CMS has modernized all eight claim payment estimating tools by transitioning the program from a localized software to a web-based service which allows providers, Medicare Administrative Contractors (MACs), and Medicaid State Agencies to easily access data that previously had a limited end user scope. CMS also began replicating claims and claims processing-related data from the mainframe to the cloud, which when complete, will provide end users instant access to the most up to date claims status information.

In FY 2024, MPSM will be functioning off of its newly created "Strategic Roadmap" which will allow implementation speeds of modernization efforts to increase. This "Strategic Roadmap" will also support CMS's newly mandated initiative of accepting dental claims. The flexibility of the roadmap will allow for MPSM to integrate dental services modernization into its product portfolio. CMS will continue its iteration on current product lines such as provider data services, beneficiary API, pricing and coding service, and data replication to the cloud. With all of these efforts, CMS is laying important groundwork for continued modernization while delivering improved services to Medicare beneficiaries, providers, and claims processors.

Continuity of Operations and Disaster Recovery (COOP/DR): CMS continues to build the agency-wide COOP and DR program following audit findings in 2019 that determined the programs and systems supporting CMS mission-essential functions require increased capabilities to meet federal requirements.

CMS has completed the establishment of Enterprise Disaster Recovery hosting, which includes the completion of the East and West Coast disaster recover sites in Ashburn (VA) and Kent (WA). In addition, the program migrated over twelve CMS systems to the COOP/DR environment and established data replication for two virtual data centers in the new disaster recovery sites. Furthermore, the COOP/DR program migrated the workload and DR services for a variety of End User IT and Unified Communication services.

This request will allow CMS to continue the build out of a COOP/DR program that will provide the entire center with hybrid cloud hosting services. This includes the adoption and migration of legacy system hosting services to CMS hybrid cloud services which will lead to increased optimization of CMS's computing capabilities. CMS's hybrid cloud hosting services will be built out of the East and West Coast disaster recover sites in Ashburn (VA) and Kent (WA). CMS anticipates completion of the build out of these services by fiscal year FY 2025.

Agency Cloud Migration Efforts: CMS currently operates on Amazon Web Services and Microsoft Azure Government as the two primary cloud service providers to host our systems and data. Efforts to build-out and adopt cloud computing began in 2013 in response to the 2010 Federal Data Center Consolidation Initiative (FDCCI) and 2011 Federal Cloud Computing Strategy (now the updated 2018 Cloud Smart Strategy).

As part of this effort, CMS set an ambitious goal to make cloud computing a primary hosting solution for the majority of existing and new CMS applications. From the start, CMS has seen a continually increasing demand to move CMS applications from on-premise data

centers to cloud hosting for all CMS systems that would benefit (fiscally or operationally) from being moved into the cloud. This includes moving data, applications, entire systems, and other business elements to a cloud computing environment or making applications cloud-ready. This benefits CMS' IT in several ways such as cost to operate, performance, and security. It allows CMS to take advantage of benefits such as greater elasticity, self-service provisioning, redundancy, and a flexible pay-per-use model. CMS has migrated over 90 systems to date and plans to continue migrating applications and services to the cloud as long as funding is available to support this effort.

Funding History

Fiscal Year	Amount
FY 2020	$2,994,080,000
FY 2021	$2,907,306,000
FY 2022 Final	$3,006,584,000
FY 2023 Enacted	$3,185,553,000
FY 2024 President's Budget	$3,241,990,000

FY 2024 IT Funding Level: $3,242.0 million

The FY 2024 President's Budget for CMS-wide IT is $3,242.0 million, an increase of $56.4 million above the FY 2023 Enacted level.

Information Technology Portfolio Budget
By Investment Category
(Dollars in Thousands)

IT Funding by Category	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Medicare Parts A & B	$273,832	$270,398	$256,518	$(13,880)
Medicare Parts C & D	$150,266	$180,837	$154,283	$(26,554)
Medicare Outreach & Education	$94,964	$91,416	$87,034	$(4,382)
Medicaid and CHIP	$199,182	$284,293	$326,419	$42,126
Private Insurance	$631,469	$676,429	$708,498	$32,069
Health Care Quality	$336,022	$357,816	$368,565	$10,749
Enterprise IT	$1,320,849	$1,324,364	$1,340,673	$16,309
Total IT Portfolio	**$3,006,584**	**$3,185,553**	**$3,241,990**	**$56,437**

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 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: $256.5 million

The FY 2024 President's Budget for Medicare Parts A and B investments is $256.5 million, a decrease of $13.9 million below the FY 2023 Enacted Level. CMS expects PECOS 2.0 to begin operations by mid-FY 2023. Correspondingly, the original PECOS system will be decommissioned and will not require funding support in FY 2024.

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 and establishing billing relationships.

- *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.

- *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.

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.

- *The Part A Processing System* - The Part A Processing system processes Medicare FFS claims for medical services furnished in institutional settings, such as hospitals or skilled nursing facilities, or services provided by a home health agency or hospice. This supports the PMA Improve Financial Performance, as it is an essential component ensuring that accurate payments are made for medically necessary services and are provided to eligible beneficiaries by qualified providers of care.

- *Durable Medical Equipment (DME) Claims Processing System* - 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.

- *Multi-Carrier System (MCS)* - The MCS system processes claims for physicians and other practitioner services. This system directly supports the PMA Improve Financial Performance, as it is an essential component ensuring that accurate payments are made for medically necessary services and are provided to eligible beneficiaries by qualified providers of care.

- *Common Working File (CWF)* - The Common Working File (CWF) is a single data source for Fiscal Intermediaries and Carriers to verify beneficiary eligibility and conduct prepayment review and approval of claims from a national perspective. It is the only place in the fee for service (FFS) claims processing system where full individual beneficiary information is housed.

- *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.

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)* - Serves as the front-end gateway for all Medicare providers eligible to participate in Merit Based Incentive Payment System (MIPS) or Alternative Payment Models (APMs) to avoid MIPS Payment Adjustment on Medicare claims. MIPS/APM front end system maintains following data: MIPS/APM Eligibility, APM/APE/Provider Relationships, Qualifying APM Participant Status for each Eligible Professionals (EP), MIPS measure specifications and benchmarks, clinician submissions, final scores and Feedback Reports Core Function.

- *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. ACO's primary goal is to ensure patients receive the right care at the right time all while spending health care dollars more wisely.

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: $154.3 million

The FY 2024 President's Budget for Medicare Part C and D IT investments is $154.3 million, a decrease of $26.6 million below the FY 2023 Enacted Level. This decrease can be attributed to the influx of funding in FY 2023 from the Inflation Reduction Act for the Health Plan Management (HPMS), Prescription Drug Event Front-End (PDFS), and Part D Transaction Facilitator (PDTransFac) Systems.

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.

- *Medicare Advantage and Prescription Drug System (MARx)* - MARx is the primary interface for plan sponsor organizations and is the source for the enrollment and disenrollment information on the Common Medicare Environment (CME) tables. MARx supports calculating beneficiary-level payments for plans, maintaining an electronic process for receiving Part C & Part D premiums; and processing calculation of beneficiary-level premiums.

- *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. There are approximately 60 software modules supporting the MA and Part D functions. 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 Data Processing System (DDPS)* - 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.

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.

- *The Risk Adjustment Suite of Systems (RASS)* - RASS was implemented to receive, process, and store risk adjustment data, and use the HCC and Part D models developed by CMS, to calculate risk scores used to risk-adjust MA plan payments. RASS produces the risk adjustment factors for use by the Medicare Advantage and Prescription Drug System (MARx) to calculate beneficiary level payments, and provides these critical risk adjustment factors to MARx for payment calculations. This suite of systems is made up of Risk Adjustment Processing System (RAPS), Risk Adjustment System (RAS), RAPS User Interface (UI) and Encounter Data Risk Adjustment (EDRA).

- *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.

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: $87.0 million

The FY 2024 President's Budget for Medicare Outreach and Education IT is $87.0 million, a decrease of $4.4 million below the FY 2023 Enacted Level. This decrease takes into account that the additional software and hardware upgrades for improving services online will have concluded in FY 2023. The FY 2024 request will only fund operations and maintenance of eMedicare and medicare.gov.

- *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.[1] 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.

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: $326.4 million

The FY 2024 President's Budget for Medicaid and CHIP IT is $326.4 million, an increase of $42.1 million above the FY 2023 Enacted Level. This increase is attributed to additional funding for the use of the Federal Data Services Hub as well as additional funding for MACBIS.

- *Medicaid and CHIP Business Information Solutions (MACBIS)* - An enterprise-wide initiative providing infrastructure, automated tools, and data analytics to drive improved operations for Medicaid and CHIP, which provides care to millions of individuals across 56 states and territories. MACBIS consists of services and several related product development efforts designed at delivering an integrated set of modern digital products and data management strategy aimed at ensuring CMS protects access to coverage and care, advances healthy equity, and drives innovation and whole person care in Medicaid and CHIP. Through MACBIS, CMS, stakeholders, and states are provided the ability to gather and analyze data to support program integrity activities, improving monitoring, oversight and evaluation of Medicaid and CHIP overall. The program provides operational, financial,

[1] Funding for the Next Generation Desktop (NGD) is also included in the Private Insurance Investment line as the system also assists in the management of questions from consumers about the Federally Facilitated Marketplace.

pharmacy, quality, and business performance data through products and services such as the Transformed-Medicaid Statistical Information System (T-MSIS), Medicaid and CHIP Program (MACPRO), Medicaid and CHIP Financial (MACFin), and the Medicaid Drug Program.

- *Sources of Income for Medicaid Eligibility* - Income data transactions that CMS anticipates will be requested by state Medicaid and CHIP agencies. This includes an estimated 22.1 million income data transactions for Medicaid and CHIP eligibility determinations.

- *Medicaid.gov* - Provides a central resource for low income children and adults to register and learn about their coverage.

Private Insurance

CMS is responsible for facilitating access to reliable and affordable private health insurance throughout the United States. Through the Federally-Facilitated Marketplace (FFM), individuals are able to compare health plan options, received eligibility determinations for a number of health insurance programs, and obtain financial assistance with premiums and cost-sharing. In addition, the No Surprises Act protects individuals from out-of-network surprise medical bills and removes them from payment disputes between a provider or health care facility and their health plan. As the United States health care system changes, the programs and systems below help CMS maximize its level of care to those we serve.

Funding Level: $708.5 million

The FY 2024 President's Budget for Private Insurance IT request is $708.5 million, an increase of $32.1 million above the FY 2023 Enacted Level. The increase in funding supports Marketplace eligibility verification activities and is primarily attributed to increased cost and enrollment expectations.

Marketplace: The FFM is used by 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, and obtain financial assistance with premiums and cost-sharing.

- *Federal Data Services Hub (FDSH)* - 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 FFM 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.

- *Eligibility Appeals Case Management System (EACMS)* - Serves as the data repository of the Eligibility Appeals Operations Support Contractors (EAOS) and supports their work in processing Marketplace eligibility appeals. EACMS receives, stores, displays and processes appeal requests and supporting documentation submitted by consumers and large employers.

Market Reform: CMS is devoted to helping consumers receive the health care they need while also educating them about the protections they are entitled to and the financial impacts of their health care decisions.

- *IT systems supporting the No Surprises Act* - CMS leverages existing IT systems, such as the Integrated Data Repository (IDR), Health Insurance Casework System (HICS) and Plan Finder to support the Independent Dispute Resolution process, complaints system, help desk, and various data collections from health plans, issuers, providers, and facilities across the individual, small group, and large group markets.

Health Care Quality

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through a variety of initiatives.

Funding Level: $368.6 million

The FY 2024 President's Budget for Health Care Quality IT is $368.6 million, an increase of $10.8 million above the FY 2023 Enacted Level. This increase can be attributed to the cost of data initiatives tied to the Hospital Quality Reporting and End Stage Renal Disease (ESRD) Quality Reporting systems.

- *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.

- *Internet Quality Improvement and Evaluation System (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.

- *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.

- *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.

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: $1,340.7 million

The FY 2024 President's Budget for Enterprise IT is $1,340.7 million, an increase of $16.3 million above the FY 2023 Enacted Level. The FY 2024 request will allow CMS to begin its response to EO 14028: Improving the Nation's Cybersecurity, as well as continue ongoing IT operations. The majority of this increase includes making necessary investments in existing systems that support the effectiveness and efficiency of CMS's operations, in addition to providing operational support to manage CMS's enterprise-wide data environment. These solutions continue to maximize operational efficiencies through IT modernization and cloud migration.

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. Provides vital services to CMS employees, researchers, contractors, and beneficiaries, including unified voice, video, and data technologies. This category 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. Final this category supports data lifecycle management by providing guidance and technical assistance in the development, maintenance, administration, and enforcement of data asset reuse and metadata standards

- *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.

- *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.

- *Integrated Data Repository (IDR)* - The IDR is a multi-platform and high-volume data warehouse comprising integrated views of data across Medicare Parts A, B, C, and D, Beneficiary Entitlement, Enrollment and Utilization data, Provider reference information, Drug data, Contracts for Plans, and Medicaid and CHIP. The data in the IDR is leveraged by various components across the agency and outside such as FBI, OIG and DOJ to facilitate investigative and litigious efforts focused on fighting Medicare and Medicaid fraud, waste and abuse. Users of the IDR leverage the robust suite of Enterprise BI tools made available to them to conduct in-depth analysis of risk adjustment policies, Medicare-Medicaid program comparisons, payment models, and prescription drug cost trends, among many other areas of importance. The data maintained in the IDR includes: Claims and "claim-like" Data, Plan Payment Data, Beneficiary Data, Provider Data, Drug Reference Data, Contract/Plan Data, and other Reference Data.

- *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.

- *Artificial Intelligence (AI) Explores Program* - Creates opportunities for all CMS components to explore AI by using small investments to deliver proof-of-concept implementation to validate business use cases.

Shared Services: 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.

- *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.

- *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.

- *Advanced Provider Screening (APS)* - 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.

- *Electronic Submission of Medical Documentation (ESMD)* - Allows providers to electronically submit medical documentation in support of medical review and audit efforts in Medicare.

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Federal Marketplace Programs
(Dollars in Thousands)

Treasury Account	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Program Management	**$2,066,898**	**$2,343,586**	**$2,263,744**	**($79,842)**
Discretionary Appropriation	$143,977	$147,729	$165,122	$17,393
Program Operations (non-add)	*$119,685*	*$121,000*	*$137,003*	*$16,003*
Federal Administration (non-add)	*$24,292*	*$26,729*	*$28,119*	*$1,390*
Offsetting Collections	$1,899,955	$2,163,585	$2,060,800	($102,785)
Federally-facilitated Marketplace User Fee (non-add)	*$1,853,605*	*$2,106,081*	*$2,001,736*	*($104,345)*
Risk Adjustment User Fee (non-add)	*$46,350*	*$57,504*	*$59,064*	*$1,560*
Other	$22,966	$32,272	$37,822	$5,550
Heath Care Fraud and Abuse Control	**$18,446**	**$39,398**	**$43,821**	**$4,423**
Discretionary Appropriation	$18,446	$39,398	$43,821	$4,423
Total Program Level	**$2,085,344**	**$2,382,984**	**$2,307,565**	**($75,419)**

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 ACA'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 keep high quality healthcare coverage accessible and affordable for all Americans. The Inflation Reduction Act extended enhanced premium tax credits to consumers through plan year 2025, making coverage accessible and affordable for more consumers. During the 2023 Marketplace Open Enrollment Period, which ran from November 1, 2022 to January 15, 2023, 16.3 million consumers selected plans, including 12.2 million consumers in the FFM, the highest number of plan selections in the program to date. Total nationwide plan selections include 3.6 million consumers who were new to the Marketplaces for 2023. Four out of five consumers were able to find a Marketplace plan for $10 or less per month after tax credits.

CMS also awarded $109 million to the Navigator program in FY 2022 to support plan year 2023 enrollment, the single largest funding award to date. This was a strategic investment to help consumers in the FFM navigate enrollment through the Marketplace, Medicaid, and the Children's Health Insurance Program (CHIP) and make health coverage more equitable and accessible. Navigator awardees continue to focus on outreach to particularly underserved communities, and the FY 2022 award included additional funds to support direct outreach, education, and enrollment activities aimed at helping eligible individuals transition from Medicaid/CHIP to Marketplace coverage. This award allowed Navigator organizations to retain and add to the more than 1,500 existing Navigators who were trained and certified to assist consumers for the 2022 plan year.

In FY 2024, 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 2020	$1,655,775,000
FY 2021	$1,963,746,000
FY 2022 Final	$2,085,344,000
FY 2023 Enacted	$2,382,984,000
FY 2024 President's Budget	$2,307,565,000

Budget Request

The FY 2024 Budget request for FFM programs is $2,307.6 million at the program level, of which $2,263.7 million is funded from several Program Management and other sources and $43.8 million from the discretionary Health Care Fraud and Abuse Control (HCFAC) appropriation. This budget reflects a two-and-a-half-month Open Enrollment Period, includes funding for the Navigator program to support additional direct outreach, education, and enrollment activities aimed at helping eligible individuals transition from Medicaid/CHIP to Marketplace coverage, and supports year-round outreach and education efforts. Year-round outreach will consist of efforts to raise awareness of Marketplace coverage options during the unwinding of the Medicaid continuous coverage condition; 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:* $53.3 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 6,350 QHPs and approximately 690 SADPs in 2023. CMS also oversees the standards and strategic growth of programs that are related to issuer and web-broker associated enrollment and is responsible for onboarding, supporting, and overseeing the conduct of licensed agents and brokers.

- *Payment and Financial Management:* $57.6 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), External Data Gathering Environment (EDGE) servers, and other Marketplace infrastructure. Marketplace-related payments leverage CMS's Healthcare Integrated General Ledger Accounting System (HIGLAS) 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:* $417.9 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:* $976.0 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 assist potential and existing enrollees. CMS outreach efforts focus on building public awareness of the Marketplaces, Open Enrollment Periods, and other important dates and deadlines. CMS also works to support year-round consumer needs by promoting information about coverage and enrollment opportunities. Outreach and engagement strategies also focus on reaching historically underinsured and uninsured communities that experience lower access to health care, and health equity continues to be a central component of marketing and outreach campaigns.

  Navigators provide year-round community-based support 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. Navigator awardees continue to

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.

Through the Government Printing Office, CMS prints and mails pertinent consumer notices and provides educational publications on a wide variety of topics

- *Information Technology (IT):* $561.7 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 2024.

- *Marketplace Quality:* $8.3 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:* $43.8 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 will continue implementing a methodology to measure and report estimated improper payments for APTC in the FFM and will continue to strengthen oversight of the FFM and State Marketplace operations. CMS reported an improper payment rate of 0.62 percent for the FFM component of the APTC program for the first time in the FY 2022 Agency Financial Report (AFR), and will develop an improper payment measurement program for the SBMs. 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:* $19.8 million. CMS supports general planning and oversight of Marketplace activities to ensure integration and coordination across CMS with issuers and Federal partners.

- *Administration:* $168.9 million. This funding supports staffing and administration expenses for work across the Federal Marketplace, State-based Marketplaces, and payment programs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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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 2022 Estimates	FY 2023 Estimates	FY 2024 Estimates
Drug Resources by Decision Unit and Function/Program			
Medicaid Treatment	$9,050.0	$9,660.0	$8,400.0
Total Decision Unit #1 Medicaid	**$9,050.0**	**$9,660.0**	**$8,400.0**
Medicare Treatment	$3,090.0	$3,310.0	$3,530.0
Total Decision Unit #2 Medicare	**$3,090.0**	**$3,310.0**	**$3,530.0**
Total Funding	**$12,140.0**	**$12,970.0**	**$11,930.0**
Drug Resources Personnel Summary			
Total FTEs (direct only)	--	--	--
Drug Resources as a Percent of Budget			
Total Agency Budget (in billions)[1]	$1,214.0	$1,297.0	$1,193.0
Drug Resources Percentage	1.2%	1.3%	1.2%

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 2021 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 2024 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 SUDs are based on the FY 2024 President's Budget baseline. These projections reflect estimated Part A and Part B spending into FY 2024 and are based on an analysis of historical fee-for-service claims through 2021, 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 2023 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 SUD 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 SUDs are often also used to treat other conditions.

Budget Summary

The total FY 2024 drug control outlay estimate for CMS is $11,930.0 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 2024 outlay estimate: $8,400.0 million
(Reflects $1,260.0 million decrease from FY 2023)

The decrease in Medicaid substance use spending from FY 2023 to FY 2024 stems from the decrease in Medicaid enrollment projected due to the end of continuous enrollment condition on March 31, 2023 and the phase-out of the temporary FMAP increases.

[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.

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 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 2024 outlay estimate: $3,530.0 million
(Reflects $220.0 million increase from FY 2023)

The increase in Medicare SUD spending from FY 2023 to FY 2024 is due to normal program growth, reflecting the impact of changes in enrollment and utilization of health care services. This growth is consistent with the increase in the overall Medicare baseline projections.

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.

Health Equity

CMS is committed to advancing health equity by reducing the health disparities within our health system, including disparities in access and to quality of 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 of any changes to SUD-related programs or policies, including all of the CMS programs under the HHS Overdose Prevention Strategy.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Object Classification - Direct Budget Authority
CMS Program Management
(Dollars in Thousands)

Object Class	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Direct Budget Authority			
Personnel compensation:			
Full-time permanent (11.1)	$ 397,814	$ 443,346	$ 462,564
Other than full-time permanent (11.3)	$ 10,905	$ 11,945	$ 11,808
Other personnel compensation (11.5)	$ 7,486	$ 7,700	$ 7,700
Military personnel (11.7)	$ 19,896	$ 18,459	$ 21,846
Special personnel services payments (11.8)	$ -	$ -	$ -
Subtotal personnel compensation	**$ 436,101**	**$ 481,450**	**$ 503,918**
Civilian benefits (12.1)	$ 189,277	$ 199,798	$ 206,747
Military benefits (12.2)	$ 2,430	$ 2,430	$ 3,905
Benefits to former personnel (13.0)			
Subtotal Pay Costs	**$ 627,808**	**$ 683,678**	**$ 714,570**
Travel and transportation of persons (21.0)	$ 1,675	$ 4,200	$ 8,437
Transportation of things (22.0)	$ -	$ -	$ -
Rental payments to GSA (23.1)	$ 33,181	$ 34,182	$ 34,200
Communication, utilities, and misc. charges (23.3)	$ -	$ -	$ -
Printing and reproduction (24.0)	$ 4,096	$ 2,412	$ 3,511
Other Contractual Services:			
Advisory and assistance services (25.1)	$ 2,124,940	$ 2,022,353	$ 2,358,631
Other services (25.2)	$ -	$ -	$ -
Purchase of goods and services from	$ -	$ -	$ -
government accounts (25.3)	$ 3,699	$ 2,045	$ 2,187
Operation and maintenance of facilities (25.4)	$ -	$ -	$ -
Research and Development Contracts (25.5)	$ 20,054	$ 20,054	$ -
Medical care (25.6)	$ 1,208,952	$ 1,355,133	$ 1,427,833
Operation and maintenance of equipment (25.7)	$ -	$ -	$ -
Subsistence and support of persons (25.8)	$ -	$ -	$ -
Subtotal Other Contractual Services	**$ 3,357,645**	**$ 3,399,585**	**$ 3,788,651**
Supplies and materials (26.0)	$ 339	$ 687	$ 701
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	**$ 3,396,936**	**$ 3,441,066**	**$ 3,835,500**
Total Direct Budget Authority /1	**$ 4,024,744**	**$ 4,124,744**	**$ 4,550,070**
Average Cost per FTE			
Civilian FTEs	3,997	4,125	4,225
Civilian Average Salary	$ 150	$ 159	$ 161
Percent change	0%	6%	2%
Military FTEs	105	105	105
Military Average Salary	$ 213	$ 199	$ 245
Percent change	0%	-6%	23%
Total OPDIV FTEs	4,102	4,230	4,330
Total OPDIV Average Salary	$ 153	$ 162	$ 165
Percent change	0%	6%	2%

/1 Includes funding provided in the appropriation under Section 227, which includes $355 million in FY 2022 and $455 million in FY 2023 to support Program Management activity related to the Medicare Program. Indirect costs are excluded.

CMS Program Management
Salaries and Expenses
(Dollars in Thousands)

	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$ 397,814	$ 443,346	$ 462,564
Other than full-time permanent (11.3)	$ 10,905	$ 11,945	$ 11,808
Other personnel compensation (11.5)	$ 7,486	$ 7,700	$ 7,700
Military personnel (11.7)	$ 19,896	$ 18,459	$ 21,846
Special personnel services payments (11.8)	$ -	$ -	$ -
Subtotal personnel compensation	**$ 436,101**	**$ 481,450**	**$ 503,918**
Civilian benefits (12.1)	$ 189,277	$ 199,798	$ 206,747
Military benefits (12.2)	$ 2,430	$ 2,430	$ 3,905
Benefits to former personnel (13.0)	$ -	$ -	$ -
Total Pay Costs	**$ 627,808**	**$ 683,678**	**$ 714,570**
Travel and transportation of persons (21.0)	$ 1,675	$ 4,200	$ 8,437
Transportation of things (22.0)	$ -	$ -	$ -
Rental payments to GSA (23.1)	$ 33,181	$ 34,182	$ 34,200
Rental payments to Others (23.2)	$ -	$ -	$ -
Communication, utilities, and misc. charges (23.3)	$ -	$ -	$ -
Printing and reproduction (24.0)	$ 4,096	$ 2,412	$ 3,511
Other Contractual Services:			
Advisory and assistance services (25.1)	$ 2,124,940	$ 2,022,353	$ 2,358,631
Other services (25.2)			
Purchase of goods and services from	$ -	$ -	$ -
government accounts (25.3)	$ 3,699	$ 2,045	$ 2,187
Operation and maintenance of facilities (25.4)	$ -	$ -	$ -
Research and Development Contracts (25.5)	$ 20,054	$ 20,054	$ -
Medical care (25.6)	$ 1,208,952	$ 1,355,133	$ 1,427,833
Operation and maintenance of equipment (25.7)	$ -	$ -	$ -
Subsistence and support of persons (25.8)	$ -	$ -	$ -
Subtotal Other Contractual Services	**$ 3,357,645**	**$ 3,399,585**	**$ 3,788,651**
Supplies and materials (26.0)	$ 339	$ 687	$ 701
Total Non-Pay Costs	**$ 3,396,936**	**$ 3,441,066**	**$ 3,835,500**
Total Salary and Expense /1	**$ 4,024,744**	**$ 4,124,744**	**$ 4,550,070**
Direct FTE	4,102	4,230	4,330

/1 Includes funding provided in the appropriation under Section 227, which includes $355 million in FY 2022 and $455 million in FY 2023 to support Program Management activity related to the Medicare Program. Indirect costs are excluded.

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2022 Actual Total	2023 Est. Total	2024 Est. Total
Office of the Administrator			
Direct FTEs	40	27	27
Reimbursable FTEs	0	0	0
Subtotal	40	27	27
Center for Clinical Standards and Quality			
Direct FTEs	444	432	438
Reimbursable FTEs	53	81	81
Subtotal	497	513	519
Center for Consumer Information and Insurance Oversight			
Direct FTEs	132	141	141
Reimbursable FTEs	306	341	341
Subtotal	438	482	482
Center for Medicaid and CHIP Services			
Direct FTEs	526	559	559
Reimbursable FTEs	0	0	0
Subtotal	526	559	559
Center for Medicare			
Direct FTEs	638	640	646
Reimbursable FTEs	4	6	6
Subtotal	642	646	652
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	149	152	162
Reimbursable FTEs	16	15	15
Subtotal	165	167	177
Office of the Actuary			
Direct FTEs	85	82	82
Reimbursable FTEs	0	0	0
Subtotal	85	82	82
Office of Communications			
Direct FTEs	191	201	211
Reimbursable FTEs	62	72	72
Subtotal	253	273	283
Office of Information Technology			
Direct FTEs	392	395	440
Reimbursable FTEs	4	4	4
Subtotal	396	399	444
Office of Equal Opportunity and Civil Rights			
Direct FTEs	26	32	32
Reimbursable FTEs	0	0	0
Subtotal	26	32	32
Federal Coordinated Health Care Office			
Direct FTEs	29	31	31
Reimbursable FTEs	0	0	0
Subtotal	29	31	31

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2022 Actual Total	2023 Est. Total	2024 Est. Total
Office of Financial Management			
Direct FTEs	198	199	209
Reimbursable FTEs	10	10	10
Subtotal	208	209	219
Office of Hearings and Inquiries			
Direct FTEs	95	96	101
Reimbursable FTEs	26	29	29
Subtotal	121	125	130
Office of Legislation			
Direct FTEs	56	63	63
Reimbursable FTEs	0	0	0
Subtotal	56	63	63
Digital Service at CMS			
Direct FTEs	0	21	21
Reimbursable FTEs	0	0	0
Subtotal	0	21	21
Office of Minority Health			
Direct FTEs	25	28	30
Reimbursable FTEs	0	0	0
Subtotal	25	28	30
Office of Human Capital			
Direct FTEs	155	160	162
Reimbursable FTEs	0	0	0
Subtotal	155	160	162
Office of Strategic Operations and Regulatory Affairs			
Direct FTEs	149	154	154
Reimbursable FTEs	4	4	4
Subtotal	153	158	158
Office of Enterprise Data and Analytics			
Direct FTEs	69	77	77
Reimbursable FTEs	0	0	0
Subtotal	69	77	77
Office off Burden Reductions & Health Informatics			
Direct FTEs	36	43	43
Reimbursable FTEs	0	0	0
Subtotal	36	43	43
Office of Program Operations & Local Engagement			
Direct FTEs	532	540	544
Reimbursable FTEs	16	25	25
Subtotal	548	565	569
Emergency Preparedness & Response Operations			
Direct FTEs	8	12	12
Reimbursable FTEs	0	0	0
Subtotal	8	12	12
Office of Security, Facilities and Logistics Operations			
Direct FTEs	92	99	99
Reimbursable FTEs	1	1	1
Subtotal	93	100	100
Office of Strategy, Performance, and Results			
Direct FTEs	35	46	46
Reimbursable FTEs	0	0	0
Subtotal	35	46	46
Total, CMS Program Management FTE 1/ 2/	**4,634**	**4,849**	**4,949**
Total, CMS Military Staffing - Disc. (Non-Add) 2/	*105*	*105*	*105*
Total, CMS Military Staffing - Reimbursable (Non-Add) 2/	*19*	*20*	*20*

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2022 Actual Total	2023 Est. Total	2024 Est. Total
American Recovery and Reinvestment Act (ARRA)	*11*	*1*	*1*
CMS Military Staffing - Direct	*2*	*0*	*0*
ACA Directly Appropriated	*14*	*14*	*6*
CMS Military Staffing - Direct	*0*	*0*	*0*
Consolidated Appropriation Act	*11*	*23*	*4*
CMS Military Staffing - Direct	*0*	*1*	*1*
Inflation Reduction Act	*0*	*174*	*245*
CMS Military Staffing - Direct	*0*	*0*	*0*
PAMA/IMPACT/MACRA	*9*	*10*	*10*
CMS Military Staffing - Direct	*0*	*0*	*0*
Total, CMS Program Management FTE	***47***	***223***	***267***

1/ FY 2022 reflects actual FTE consumption.

2/ Includes FTEs funded from Program Management Federal Administration and Reimbursables only.

Average GS Grade

FY 2020	**13.7**
FY 2021	**13.7**
FY 2022	**13.5**
FY 2023	**13.7**
FY 2024	**13.9**

CMS Program Management
Detail of Positions
(Dollars in Thousands)

	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Subtotal, EX	1	1	1
Total - Exec. Level Salary	$168	$174	$182
Subtotal	85	83	83
Total - ES Salaries	$16,702	$17,283	$18,138
GS-15	564	582	595
GS-14	656	676	692
GS-13	2,041	2,105	2,154
GS-12	522	538	551
GS-11	146	150	154
GS-10	0	0	0
GS-9	123	126	129
GS-8	1	1	1
GS-7	41	42	43
GS-6	2	2	2
GS-5	4	4	4
GS-4	3	3	4
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal 1/	4,102	4,230	4,330
Total - GS Salary 1/	$499,130	$550,105	$593,985
Average GS Grade 1/	13.5	13.7	13.9
Average GS Salary 1/	$127.622	$135.795	$143.094

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 2013			FY 2014			FY 2015			FY 2016		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated													
Health Insurance Consumer Information	1002		0			0			0			0	
Rate Review Grants	1003		0			0			0				
Pre-existing Condition Insurance Plan Program	1101		12			7			5			0	
Reinsurance for Early Retirees	1102		11			4			4			0	
Affordable Choices of Health Benefit Plans	1311	$ 2,147,742	56		$ 784,491	51		$ 469,624	49		$ 20,163	34	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322	$ (2,275,588)	18			15			0			0	
Adult Health Quality Measures 2/	2701	$ 56,940	10		$ 40,680	9			11			11	
Medicaid Emergency Psychiatric Demonstration	2707					0			1			0	
Quality Measurement 2/	3014	$ 18,980	6		$ 18,560	9			9			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		258			355			479			521	
Independence At Home Demonstration 2/	3024	$ 4,745	2		$ 4,640	1		$ 4,635	1			1	
Community Based Care Transitions	3026		1			0			0			1	
Treatment of Certain Complex Diagnostic Lab Tests	3113		1			0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		1			1			1			0	
Community Prevention and Wellness	4202		1			0			0			0	
Graduate Nurse Education 2/	5509	$ 47,450	0		$ 46,400	0		$ 46,350	1			1	
Sunshine Act	6002	$ 16,050	11		$ 1,024	14		$ 21,399	16		$ 4,211	17	
LTC National Background Checks	6201		4			5			5			6	
Provider Screening & Other Enrollment Requirements 1/	6401	$ 5,000	10			12		$ 18,035	13		$ 3,509	14	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 13,000	1		$ 3,000	1		$ 27,377	2		$ 468	2	
Expansion of the Recovery Audit Contractor Program 1/	6411	$ 3,300	1		$ 3,783	2		$ 3,975	2		$ 468	2	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323	$ 417,560	1		$ 316,448	1		$ 548,548	1		$329	1	
Total ACA Direct Appropriated FTEs			**405**			**487**			**600**			**611**	

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%), FY 2023 (-5.7%) and FY 2024 (-5.7%).

FTEs Funded by the Affordable Care Act
Centers for Medicare & Medicaid
(Dollars in Thousands)

Program	Section	FY 2017			FY 2018			FY 2019			FY 2020		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated													
Health Insurance Consumer Information	1002		0			0			0			0	
Rate Review Grants	1003					0			0			0	
Pre-existing Condition Insurance Plan Program	1101		0			0			0			0	
Reinsurance for Early Retirees	1102		0			0			0			0	
Affordable Choices of Health Benefit Plans	1311	$ 18,221	25		$ 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			0	
Adult Health Quality Measures 2/	2701		8			6			10			10	
Medicaid Emergency Psychiatric Demonstration	2707		0			0			0			0	
Quality Measurement 2/	3014		0			0			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		551			540			600		$10,000,000	528	
Independence At Home Demonstration 2/	3024		1			1			0			0	
Community Based Care Transitions	3026		0			0			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		0			0			0			0	
Community Prevention and Wellness	4202		0			0			0			0	
Graduate Nurse Education 2/	5509		2			2			0			0	
Sunshine Act	6002	$ 5,615	22			0			0			0	
LTC National Background Checks	6201		6			4			6			6	
Provider Screening & Other Enrollment Requirements 1/	6401	$ 3,509	9			0			0			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 468	1			0			0			0	
Expansion of the Recovery Audit Contractor Program 1/	6411		0			0			0			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323		0			0			0			0	
Total ACA Direct Appropriated FTEs			**625**			**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%), FY 2023 (-5.7%) and FY 2024 (-5.7%)

FTEs Funded by the Affordable Care Act
Centers for Medicare & Medicaid
(Dollars in Thousands)

Program	Section	FY 2021			FY 2022			FY 2023			FY 2024		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated													
Health Insurance Consumer Information	1002		0			0			0			0	
Rate Review Grants	1003		0			0			0			0	
Pre-existing Condition Insurance Plan Program	1101		0			0			0			0	
Reinsurance for Early Retirees	1102		0			0			0			0	
Affordable Choices of Health Benefit Plans	1311		0			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			0	
Adult Health Quality Measures	2701		10			9			8			0	
Medicaid Emergency Psychiatric Demonstration	2707		0			0			0			0	
Quality Measurement	3014		0			0			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		523			506			612			624	
Independence At Home Demonstration	3024		0			0			0			0	
Community Based Care Transitions	3026		0			0			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		0			0			0			0	
Community Prevention and Wellness	4202		0			0			0			0	
Graduate Nurse Education	5509		0			0			0			0	
Sunshine Act	6002		0			0			0			0	
LTC National Background Checks	6201		10			5			6			6	
Provider Screening & Other Enrollment Requirements 1/	6401		0			0			0			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402		0			0			0			0	
Expansion of the Recovery Audit Contractor Program 1/	6411		0			0			0			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards	10323		0			0			0			0	
Total ACA Direct Appropriated FTEs			**543**			**520**			**626**			**630**	

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%), FY 2023 (-5.7%) and FY 2024 (-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.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

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 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
3a) Number of Physicians Receiving PCAs	31	34	32
3b) Number of Physicians with One-Year PCA Agreements	0	1	1
3c) Number of Physicians with Multi-Year PCA Agreements	31	33	31
4a) Average Annual PCA Physician Pay (without PCA payment)	$176,300	$183,500	$183,500
4b) Average Annual PCA Payment	$27,000	$23,955	$30,000

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.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

Legislation over the past several years, such as the CARES Act, No Surprises Act and the most recent Inflation Reduction Act, requires CMS to implement new health care related work. 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 experience with the many hurdles of recruiting 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 vary as physicians enter or leave the program. There are currently 34 Physicians in CMS receiving PCA, 15 at the maximum PCA amount of $30,000.

Resources for Cyber Activities
Centers for Medicare & Medicaid Services

(Dollars in Millions)

Cyber Category	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Cyber Human Capital	--	--	--	--
Sector Risk Management Agency (SRMA)	--	--	--	--
Securing Infrastructure Investments	--	--	--	--
Other NIST CSF Capabilities	$ 129.21	$ 125.97	$ 144.08	$ 18.11
Detect	$ 19.38	$ 18.89	$ 21.61	$ 2.72
Identity	$ 77.52	$ 75.59	$ 86.44	$ 10.86
Protect	$ 25.84	$ 25.19	$ 28.82	$ 3.63
Recover	$ 3.23	$ 3.15	$ 3.60	$ 0.45
Respond	$ 3.23	$ 3.15	$ 3.60	$ 0.45
Total Cyber Request	**$ 129.21**	**$ 125.97**	**$ 144.08**	**$ 18.11**
Technology Ecosystems	$ -	$ -	$ -	$ -
Zero Trust Implementation	$ 1.27	$ 1.27	$ 1.27	$ -

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 our 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, 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. HHS will focus on training, hiring, and tools that drive the communication culture change necessary to successfully implement IDEA.

Over the next year, HHS Agencies and Offices will work 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
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SIGNIFICANT ITEMS AND REPORTS TO CONGRESS FOR INCLUSION IN THE FY 2024 CONGRESSIONAL JUSTIFICATION

Joint Explanatory Statement:

Evaluation and Management Services (E/M) - The agreement requests an update in the fiscal year 2024 Congressional Justification on a process to evaluate E/M services more regularly and comprehensively.

Action Taken or To Be Taken

The Social Security Act directs the Secretary to conduct a periodic review of the relative value units (RVUs) established under the physician fee schedule (PFS) not less than every 5 years. The Secretary is also required to periodically identify potentially misvalued services using certain criteria and to review and make appropriate adjustments to the relative values for those services as well as to develop a process to validate the RVUs of certain potentially misvalued codes and to make appropriate adjustments.

Each year CMS develops appropriate adjustments to the RVUs taking into account recommendations provided by the American Medical Association (AMA) Resource-Based Relative Value Scale Update Committee (RUC), MedPAC, and other interested parties. For many years, the RUC has provided us with recommendations on the appropriate relative values for new, revised, and potentially misvalued PFS services. We review these recommendations on a code-by-code basis and consider these recommendations in conjunction with analyses of other data, such as claims data, to inform the decision-making process as authorized by statute. We may also consider analyses of RVU inputs using other data sources, such as Department of Veteran Affairs. In addition to considering the most recently available data, we assess the results of physician surveys and specialty recommendations submitted to us by the RUC for our review.

Over the past several years, CMS has engaged in a multi-year effort with the AMA and other interested parties to update coding and payment for evaluation and management (E/M) visits, so that `they better reflect the current practice of medicine, are less administratively complex, and are paid more accurately under the PFS. In a step-wise approach, the AMA CPT Editorial Panel revised the office/outpatient E/M visit code family and E/M guidelines first, which CMS generally adopted effective January 1, 2021.

For Calendar Year 2023, the AMA CPT Editorial Panel has revised the rest of the E/M visit code families (except critical care services) to match the general framework of the office/outpatient E/M visits, including inpatient and observation visits, emergency department visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment, which CMS generally adopted effective January 1, 2023.

Transitional Coverage for Emerging Technologies -The agreement requests an update in the fiscal year 2024 Congressional Justification on this program and related CMS resources.

Action Taken or To Be Taken

The Centers for Medicare & Medicaid Services (CMS) is committed to making sure Medicare beneficiaries are able to access emerging technologies. CMS plans to do this in the coming months by exploring policy options that would create an accelerated approval pathway. This pathway would build off of prior initiatives, including coverage with evidence development, and would meet the following principles:
1) Manufacturers may enter the process on a voluntary basis. This process will be limited to medical devices that fall within the Medicare statute and that are relevant to the Medicare population.
2) CMS may conduct early evidence review (before the device secures FDA market authorization) and discuss with the manufacturer the best Medicare coverage pathway, depending upon the strength of the evidence collected.
3) At the manufacturer's request, CMS may initiate the coverage process before FDA market authorization, which could require developing an additional evidence development plan and confirming that there are appropriate safeguards and protections for Medicare beneficiaries.
4) If CMS determines that further evidence development is the best coverage pathway, the agency would explore how to reduce the burden on manufactures, clinicians and patients while maintaining rigorous evidence requirements.

As CMS develops this pathway, the agency will work closely with stakeholders.

House Report:

Advancements in Breast Reconstruction —The Committee notes that reconstruction after mastectomy can have a significant, positive impact on the quality of life for breast cancer survivors. For this reason, the Women's Health and Cancer Rights Act (WHCRA) was enacted in 1998 to provide insurance protections to women choosing breast reconstruction after a mastectomy. The number of breast reconstructions performed in the U.S. has steadily increased over the past two decades. Over the same timeframe, significant technological procedure advancements have shifted the focus beyond cosmetic-only results to include the restoration of typical breast functions, such as sensation. Sensory restoration as a part of breast reconstruction can ultimately improve the overall physical and emotional health, safety, and quality of life for breast cancer survivors. The Committee directs CMS, in collaboration with other HHS agencies with necessary expertise, to study the landscape of surgical techniques and other procedures for breast reconstruction, and whether gaps exist in the insurance coverage provided by the WHCRA. The Committee requests an update in the fiscal year 2024 Congressional Budget Justification on this study.

Action Taken or To Be Taken

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy.

If WHCRA applies to a patient and that patient is receiving benefits in connection with a mastectomy and they elect breast reconstruction, coverage must be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

This law applies to two different types of coverage:

1. Group health plans (provided by an employer or union);
2. Individual health insurance policies (not based on employment).

Group health plans can either be "insured" plans that purchase health insurance from a health insurance issuer, or "self-funded" plans that pay for coverage directly. How they are regulated depends on whether they are sponsored by private employers, or state or local ("non-federal") governmental employers. Private group health plans are regulated by the Department of Labor. State and local governmental plans, for purposes of WHCRA, are regulated by CMS. If any group health plan buys insurance, the insurance itself is generally regulated by the State's insurance department, and in some cases CMS. Individual health insurance coverage is generally regulated by the State's insurance department, and in some cases, CMS. In Alabama, Texas, and Wyoming the requirements of in WHCRA are regulated by CMS for individual and small group market health insurance coverage.

Lowering the Cost of Care —The agreement continues to encourage CMMI to consider creative pilot projects that lower the cost of care among older Americans and enable individuals who retire overseas to retain and utilize their Medicare primary healthcare benefits. The pilot should consider potential cost savings involving international collaborations where the quality of care is comparable and less expensive. The Committee requests an update on this effort in the fiscal year 2024 Congressional Budget Justification.

Action Taken or To Be Taken

The Center for Medicare and Medicaid Innovation released a Strategy Refresh Whitepaper[1], where it discussed the goal that all Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030. The statutory purpose of the Innovation Center is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals. A barrier to the development of a model in this space is the operational concerns of trying to establish an accountable care model due to the small number of Medicare beneficiaries living overseas in various countries. For example, in 2020, the Social Security Administration reported that the number of retired workers receiving Social Security and living in foreign countries is 441,268 (table 5.J11 at https://www.ssa.gov/policy/docs/statcomps/supplement/2021/5j.html). Another barrier to the development of a model in this space is that overseas primary care costs would not typically be incurred by the Medicare program otherwise, with few exceptions. As such, it would be difficult to design a model that would reduce program expenditures.

[1] https://innovation.cms.gov/strategic-direction-whitepaper

Some Medicare Advantage plans may offer worldwide emergency/urgent coverage for health care services outside of the U.S. and its territories, as supplemental benefits. Under this benefit, Medicare Advantage enrollees may obtain only services that would be classified as emergency and urgently needed services had they been covered inside the U.S. More discussion can be found in the Medicare Managed Care Manual on page 47, Section 30.3, Chapter 4, Benefits and Beneficiary Protections. In addition, Medigap plans C, D, F, G, M, and N offer coverage for foreign travel emergency health care coverage outside of the U.S. Plans E, H, I and J also provide foreign travel emergency coverage outside of the U.S, but these 4 plans are no longer sold. However, enrollees who bought these plans before June 1, 2010 are able to keep them.

All of the Medigap plans listed above cover foreign travel emergency care if the care begins during the first 60 days of the trip, and if Medicare doesn't otherwise cover the care. These Medigap policies pay 80 percent of the billed charges for certain medically necessary emergency care outside the U.S. after a $250 annual deductible is met. Additionally, foreign travel emergency coverage with Medigap policies has a lifetime limit of $50,000. Information is available in the 2022 Medigap policy guidance and the Medigap & travel webpage on Medicare.gov, at https://www.medicare.gov/supplements-other-insurance/medigap-travel.

Medicare Advantage Coverage of Substance Use Services — The Committee is aware that enrollees of Medicare Advantage (MA) plans may face barriers to accessing timely and appropriate care for substance use disorder (SUD) compared to enrollees of other insurers. The Committee urges CMS to review how MA plans can improve access to care for SUD, including by measuring provider availability as part of network adequacy standards, such as by maintaining sufficient networks of providers for SUD and mental health care. The Committee also urges CMS to review how MA plans can improve access to care for SUD, including through reviewing level of care assessment tools that reflect generally accepted standards of care and informing beneficiaries of the plan's responsibility to arrange for medically necessary care outside of the network, but at in-network cost sharing, if the covered service is not provided in network. The Committee requests a report in the fiscal year 2024 Congressional Budget Justification on updates since the October 2020 report required by P.L. 115–271 on SUD treatment services that are provided by MA plans as supplemental benefits.

Action Taken or To Be Taken

CMS is committed to ensuring that Medicare Advantage (MA) enrollees have access to provider networks sufficient to provide covered services, including access to behavioral health service providers. In the "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications" proposed rule, CMS proposed to strengthen network adequacy requirements for access to behavioral health care, including Substance Use Disorder (SUD), in MA plans. Specifically, CMS proposes to add Clinical Psychologists, Licensed Clinical Social Workers, and Prescribers of Medication for Opioid Use Disorder as specialty types for which specific minimum standards are set and on which MA networks are evaluated.

In this proposed rule, CMS is also proposing to amend general access to services standards to explicitly include behavioral health services; codify standards for appointment wait times for both primary care and behavioral health services; clarify that emergency medical services that must

not be subject to prior authorization include behavioral health services to evaluate and stabilize an emergency medical condition; require that MA organizations notify enrollees when the enrollee's behavioral health or primary care provider(s) are dropped midyear from networks; and require MA organizations to establish care coordination programs, including coordination of community, social, and behavioral health services to help move towards parity between behavioral health and physical health services and advance whole-person care.

Medicare Advantage plans continue to offer a wide range of supplemental benefits in 2023. These supplemental benefits may include those related to the prevention or treatment of substance use disorders.

Medicare Coverage of Behavioral Health Services — The Committee is concerned there is insufficient Medicare coverage of community-based behavioral health services for individuals in crisis. The Committee requests a report in the fiscal year 2024 Congressional Budget Justification on addressing the scope of Medicare coverage of behavioral health services for outpatient behavioral and mental health services.

This report should include information on the total amount of Medicare spending on behavioral and mental health services in calendar years 2019 through 2021 by site of service, the amount spent on each code for services that could be furnished to individuals in behavioral or mental health crisis, and the provider types that billed for these services.

Action Taken or To Be Taken

Medicare covers a range of behavioral health services, typically referred to as mental health and substance use services, in the outpatient setting such as a hospital or a physician's office. Example of these services include alcohol treatment, detoxification, outpatient hospital treatment, and rehabilitative services; behavioral health integration by clinical staff to assess, monitor, and plan care; opioid use disorder management and counseling; diagnostic psychological and neuropsychological tests; individual and group psychotherapy; and medication-assisted treatment. Medicare also covers partial hospitalization program services when furnished by a hospital or community mental health center. A list of these services and information on partial hospitalization program services are described in this MLN Matters booklet on Medicare Mental Health Services: https://www.cms.gov/files/document/mln1986542-medicare-mental-health.pdf.

In addition, beginning on January 1, 2020, Medicare covers opioid use disorder treatment services when furnished by an opioid treatment program. Information on opioid treatment programs is in this MLN fact sheet: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/MLN8296732-print-friendly.pdf

We note that the Consolidated Appropriations Act, 2023 (CAA) included provisions that will further expand Medicare coverage of and access to additional behavioral health services beginning January 1, 2024. These include adding coverage of intensive outpatient services furnished in hospitals outpatient departments and certain other settings, allowing payment to be made directly to marriage and family therapists and mental health counselors for services they furnish, and enhancing payment for crisis care services furnished in certain settings, such as a mobile unit or home or other residence. The CAA also requires HHS to conduct several provider outreach and education efforts to improve access to community-based mental health and substance use disorder care that are already covered under Medicare.

Data on: (1) the number and types of services (including behavioral health and mental health services) furnished by specific Medicare providers/suppliers, as well as average Medicare payment amounts for each service, aggregated by each specific Medicare provider/supplier and service and (2) the number of services (including behavioral health and mental health services) furnished by Medicare providers/suppliers, as well as average Medicare payment amounts for each service, aggregated by geography and service are available at https://data.cms.gov/provider-summary-by-type-of-service. Data on total Medicare payments for Part B services, such as those furnished by physicians for behavioral health care or mental health care, is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Part-B-National-Summary-Data-File/Overview. A data highlight available at https://www.cms.gov/files/document/data-highlight-jan-2022-opiod.pdf describes and compares sociodemographic, health condition characteristics, and health care utilization, including use of telehealth, among patients enrolled in Medicare Fee-for-Service who have opioid use disorder, examining the data before and after the onset of the COVID-19 pandemic and implementation of the CARES Act. Another data highlight available at https://www.cms.gov/files/document/data-highlight-jan-2022.pdf compares access to medication treatment for Medicare enrollees diagnosed with opioid use disorder before and after COVID-19 telehealth expansion was implemented.

Obesity and Comorbidities — The Committee notes obesity is a disease, and it leads to serious and costly health issues, including diabetes, heart disease, stroke, certain chronic liver diseases like nonalcoholic steatohepatitis, and some types of cancer. Comprehensive management of obesity requires both lifestyle changes and physician-guided support including access to innovative pharmacological treatments. The Committee requests additional information in the fiscal year 2024 Congressional Budget Justification on how policies in Medicare could be improved to help reduce obesity and its comorbidities for those Americans who require clinical interventions and reduce the racial and ethnic disparities in health care outcomes for beneficiaries suffering from obesity.

Action Taken or To Be Taken

As detailed by the White House National Strategy of Hunger, Nutrition, and Health[2], the Biden-Harris Administration set a goal of ending hunger and increasing healthy eating and physical activity by 2030 so fewer Americans experience diet-related diseases— while reducing related health disparities. Integrating nutrition and health can optimize Americans' well-being and reduce healthcare costs. The FY 2024 President's Budget includes two legislative proposals to address these important issues for Medicare beneficiaries.

Expand and Enhance Access to Medicare Coverage of Nutrition and Obesity Counseling
Currently, only a limited number of Medicare beneficiaries are seeking these nutrition and obesity counseling services. This proposal expands access to additional beneficiaries with nutrition or obesity-related chronic diseases and makes additional providers eligible to furnish services.

Conduct a Subnational Medicare Medically-Tailored Meal Demonstration
Currently, original Medicare does not cover home delivery of meals. Beginning in 2024, this proposal establishes a three-year demonstration to test Medicare coverage of medically tailored meals. Eligibility for this demonstration includes Medicare fee-for-service beneficiaries with a

[2] https://www.whitehouse.gov/wp-content/uploads/2022/09/White-House-National-Strategy-on-Hunger-Nutrition-and-Health-FINAL.pdf

diet-impacted disease (such as kidney disease, congestive heart failure, diabetes, chronic obstructive pulmonary disease) likely to trigger an inpatient hospital stay and who have at least one activity of daily living limitation. The demonstration will operate in at least 20 hospitals across ten different States. This demonstration design is similar to the introduced bill, the Medically Tailored Home-Delivered Meals Demonstration Pilot Act of 2021. The Secretary has the discretion to consider certain modifications as it relates to implementation and execution of this demonstration.

Pediatric ESRD Services — The Committee recognizes that children with end stage renal disease (ESRD) have unique care needs and require services that are not typically required by adult ESRD patients, including specialized nursing care, nutritional support, social workers, and child life specialists. The Committee commends CMS for focusing on pediatric case-mix adjustment in its December 2020 technical expert panel and requesting information on the adequacy of reimbursement for pediatric services in the request for information included in the calendar year 2022 End Stage Renal Disease Prospective Payment System Proposed Rule. The Committee requests an update in the fiscal year 2024 Congressional Budget Justification on progress towards establishing adequate bundled payments for pediatric ESRD services.

Action Taken or To Be Taken

Compared to the Medicare dialysis adult population, the Medicare dialysis pediatric population is much smaller, comprising approximately 0.14 percent of the total ESRD patient population in 2019. Pediatric facilities have higher direct patient care labor expenditures than adult facilities. CMS has continued to hear concerns from organizations associated with pediatric dialysis about underpayment of pediatric renal dialysis services under the current ESRD Prospective Payment System (PPS) payment model.

In order to obtain necessary cost report data for the pediatric dialysis population, the following changes have been made to the ESRD facility cost reports:

- Inclusion of line reporting of supplies unique to the pediatric dialysis population in the ESRD PPS independent facility and hospital- based facility cost reports
- Inclusion of line reporting of unique labor categories to the pediatric dialysis population in the independent ESRD facility cost report. The hospital-based cost reports include separating out some pediatric labor costs, but not in the same way as with the independent ESRD facilities.

In addition to the data described above, we are also considering other potential changes to the ESRD facility cost reports.

In the Calendar Year (CY) 2023 ESRD PPS proposed rule, we requested comments on improving CMS's ability to detect and reduce health disparities within the ESRD PPS for pediatric patients receiving renal dialysis services. Our goal in publishing the Request for Information (RFI) in the CY 2023 ESRD PPS proposed rule was to solicit input on topics such as circumstances and health inequities unique to the pediatric dialysis population, possible refinements to the ESRD PPS payment policy to mitigate health disparities for this population, the possible inclusion of a specific payment modifier on the claim indicating pediatric dialysis, and putting more emphasis on pediatric comorbidities. A summary of the responses that we received to this RFI are found at: https://www.cms.gov/files/document/cy-2023-esrd-pps-equity-

rfi-summary-comments.pdf (the comments focusing on pediatric begin on page 23). CMS is considering the comments we received from the public to potentially inform future rulemaking.

Telehealth and Health Care Access —The Committee requests a report in the fiscal year 2024 Congressional Budget Justification on the impact of telehealth on health care access, utilization, cost, and outcomes, broken down by race, ethnicity, sex, age, disability status, and zip code under the Medicaid program and CHIP.

Telehealth can be a cost-effective service delivery method to furnish care and services to Medicaid and CHIP beneficiaries, and states have broad flexibility in designing the parameters of telehealth delivery methods to furnish services. Although telehealth services have been available in many states for decades, the COVID-19 public health emergency (PHE) accelerated states' interest in incorporating telehealth services in their Medicaid and CHIP programs to help combat COVID-19 and increase beneficiaries' access to care. To monitor the impact of the COVID-19 PHE, CMS continues to conduct extensive data analyses to provide insight into the impact of COVID-19 on Medicaid and CHIP beneficiaries and their service utilization. These analyses include evaluations of Medicaid and CHIP beneficiaries' utilization of telehealth services during the PHE. The most recent preliminary data show rates of Medicaid and CHIP services delivered through telehealth peaked in April 2020, stabilized from June 2020 through March 2021, and then decreased through April 2022. This data also suggests that such services delivered through telehealth increased for beneficiaries of all age groups during the PHE, but were highest among the 19 to 64 age group. Given the variability across states in reporting of demographic data, CMS does not have sufficiently complete data to evaluate many of the variables described above.

These data analyses are available at: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/medicaid-and-chip-resources/data-releases/index.html.

With respect to more broadly examining the impact of telehealth, we note that states are primarily responsible for monitoring and overseeing the quality of care provided to Medicaid beneficiaries, and several states have undertaken activities such as surveys and service use analyses, to assess the quality of services provided via telehealth. At the federal level, CMS utilizes the Medicaid and CHIP Child and Adult Core Sets to monitor the overall quality of care Medicaid and CHIP beneficiaries receive and their access to care. However, measure stewards, which are often external stakeholders, are responsible for maintaining measure specifications for quality measures; current reporting on all of the Core Sets measures does not allow CMS to differentiate between services delivered in-person versus those delivered via telehealth. To the extent the measure steward for a given measure determined that services delivered via telehealth can be included, the data that states report to CMS will reflect the quality of services delivered via telehealth as well as in-person.

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 the Consolidated Appropriations Act of 2023 (Public Law 117-328) (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 2024.

Health Insurance Marketplaces Transparency Table

Dollars in Thousands

Activity	FY 2018 Actual	FY 2019 Actual	FY 2020 Actual	FY 2021 Actual	FY 2022 Actual	FY 2023 Enacted	FY 2024 President's Budget
Health Plan Bid Review, Management and Oversight	**$37,910**	**$45,797**	**$45,480**	**$38,841**	**$54,255**	**$56,219**	**$53,319**
Payment and Financial Management	**$45,141**	**$50,220**	**$39,178**	**$49,821**	**$47,780**	**$57,600**	**$57,600**
Eligibility and Enrollment [3]	**$392,660**	**$348,488**	**$371,802**	**$350,482**	**$391,341**	**$391,627**	**$417,907**
Consumer Information and Outreach	**$591,948**	**$579,088**	**$503,271**	**$843,729**	**$903,220**	**$1,090,299**	**$975,981**
Call Center (non-add)	*$525,326*	*$499,053*	*$440,000*	*$477,247*	*$535,219*	*$504,500*	*$489,500*
Navigators Grants & Enrollment Assisters (non-add) [3]	*$12,720*	*$19,499*	*$19,689*	*$91,233*	*$133,293*	*$141,747*	*$141,200*
Consumer Education and Outreach (non-add)	*$10,744*	*$11,231*	*$14,082*	*$245,749*	*$211,592*	*$382,250*	*$280,750*
Information Technology	**$767,413**	**$504,283**	**$549,369**	**$515,388**	**$511,706**	**$552,830**	**$561,713**
Quality	**$7,240**	**$7,334**	**$7,063**	**$6,391**	**$6,706**	**$7,777**	**$8,282**
SHOP and Employer Activities	**$4,418**	**$2,117**	**$200**	**$197**	**$195**	**$195**	**$195**
Other Marketplace	**$31,196**	**$40,290**	**$63,579**	**$38,827**	**$35,400**	**$62,267**	**$63,644**
Federal Payroll and Other Administrative Activities	**$70,892**	**$77,750**	**$85,833**	**$120,071**	**$134,741**	**$164,170**	**$168,924**
Total	**$1,948,818**	**$1,655,367**	**$1,665,775**	**$1,963,746**	**$2,085,344**	**$2,382,984**	**$2,307,565**

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.

[3] Funding for Enrollment Assisters under Eligibility and Enrollment ended in FY 2017. Starting in FY 2022, this activity is funded under Navigator Grants and Enrollment Assisters.

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	FY 2017 Actual
Health Plan Bid Review, Management and Oversight	$0	**$300**	**$21,936**	**$40,595**	**$33,497**	**$43,960**	**$40,520**	**$39,846**
Payment and Financial Management	$0	**$1,698**	**$24,998**	**$25,832**	**$49,615**	**$43,733**	**$51,325**	**$47,640**
Eligibility and Enrollment [4]	$0	**$2,218**	**$3,433**	**$275,501**	**$339,754**	**$363,768**	**$445,249**	**$484,144**
Consumer Information and Outreach	$0	**$2,427**	**$32,610**	**$701,075**	**$704,136**	**$753,238**	**$805,833**	**$640,232**
Call Center (non-add)	*$0*	*$0*	*$22,000*	*$505,446*	*$545,600*	*$566,178*	*$563,638*	*$540,197*
Navigators Grants & Enrollment Assisters (non-add) [4]	*$0*	*$0*	*$0*	*$107,513*	*$97,152*	*$75,996*	*$99,677*	*$51,166*
Consumer Education and Outreach (non-add)	*$0*	*$0*	*$7,043*	*$77,436*	*$49,334*	*$54,897*	*$101,048*	*$16,599*
Information Technology	**$2,346**	**$92,672**	**$166,455**	**$402,553**	**$770,957**	**$798,648**	**$664,083**	**$710,867**
Quality	**$0**	**$0**	**$0**	**$0**	**$17,189**	**$15,634**	**$11,736**	**$7,301**
SHOP and Employer Activities	**$0**	**$366**	**$18,479**	**$25,076**	**$30,541**	**$42,717**	**$34,520**	**$16,500**
Other Marketplace	**$1,879**	**$14,906**	**$13,738**	**$4,400**	**$6,728**	**$3,614**	**$12,032**	**$49,584**
Federal Payroll and Other Administrative Activities	**$429**	**$10,805**	**$43,493**	**$68,429**	**$80,000**	**$80,000**	**$85,000**	**$79,602**
Total	**$4,654**	**$125,392**	**$325,142**	**$1,543,461**	**$2,032,418**	**$2,145,312**	**$2,150,297**	**$2,075,714**

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.

[4] Funding for Enrollment Assisters under Eligibility and Enrollment ended in FY 2017. Starting in FY 2022, this activity is funded under Navigator Grants and Enrollment Assisters.

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CMS Program Management and HCFAC 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.

- **Require Medicaid Adult and Home and Community-Based Services Quality Reporting**

  This proposal provides CMS $15 million annually for the Adult Quality Measurement and Improvement Program and requires annual reporting on the Adult Core Set four years after enactment. It also establishes and funds a Home and Community Based Services Measurement Program at $10 million annually and requires reporting on a core set four years after enactment. Currently, it is voluntary for states to report on the Adult Core Set and reporting on home and community-based services measures varies. As such, this voluntary and inconsistent reporting has stifled the ability of CMS and states to assess and improve quality and outcomes within and across their Medicaid and home and community-based services programs. This funding and authority align reporting requirements with those of the Child Health and Behavioral Health Core Sets, and provide the funding needed for CMS to continue supporting health equity and value-based care models through this work. [$278 million in administrative costs over 10 years]

- **State Health Insurance Assistance Program**

  The budget proposes to reauthorize the Medicare Improvements for Patients and Providers Act programs at $50 million annually from FY 2024 to FY 2028. In addition to supporting the National Benefits Outreach and Enrollment Assistance Center, the act makes additional funding available to State Health Insurance Assistance Programs, area agencies on aging and aging and disability resource centers to provide more intensive health care counseling for people who are eligible for both Medicare and Medicaid and those who qualify for low-income subsidies.

- **Refine the Quality Payment Program: Measure Development Funding for the Quality Payment Program**

  The current inventory of Merit-based Incentive Payment System quality and cost measures in Medicare's physician payment system is insufficient to fully transition to Merit-based Incentive Payment System Value Pathways. Introduced for the 2023 performance year, Merit-based Incentive Payment System Value Pathways is a voluntary reporting structure intended to help clinicians participate in the Merit-based Incentive Payment System by easing the reporting burden and developing more meaningful measures grouped by specialty. Development of new measures is currently driven by third-party measure developers and stewards, except for CMS-funded development of a limited number of cost measures and quality outcome measures. This proposal renews the expired funding appropriation for quality measure development for FYs 2024 through 2028, generating new measures for use

in the transition to Merit-based Incentive Payment System Value Pathways and expanding the types of measures that may be developed to include cost performance measures. Measure development aimed at improving the value of healthcare services, including specialty services, will allow CMS to address health priorities, improve clinical services, and reduce health inequities. [Budget Neutral]

- **Adjust Survey Frequency for High-Performing and Low-Performing Facilities**

  CMS requires long-term care facilities to be recertified annually for participation in the Medicare program regardless of the overall quality of the facility. By contrast, CMS currently uses a risk-based approach for other facility types, such as ambulatory surgical centers and outpatient physical therapy centers, based on risk of poor care. A risk-based approach for long-term care facilities allows CMS to survey high-performing facilities less frequently and redirect resources to strengthen oversight and quality improvement for low-performing facilities, where they are most needed. [Budget Neutral]

- **Provide Authority for the Secretary to Collect and Expend Re-Survey Fees**

  Current law requires that CMS pay states a reasonable cost for conducting surveys, on behalf of CMS, of healthcare providers to certify their compliance with federal health and safety standards. The law prohibits CMS from imposing fees on providers or suppliers for the purpose of conducting these surveys. This proposal permits the Secretary to charge long-term facilities "re-survey fees" after a third visit is required to validate the correction of deficiencies that were identified during prior survey visits. The intent of these fees is to repurpose them to cover the associated costs necessary to perform these revisit surveys. CMS has discretion in developing and adjusting fee levels. This fee will help ensure quality of care in historically poor performing facilities when revisit surveys are required. [Budget Neutral]

- **Increase Investment in Mandatory HCFAC and Other Mandatory HCFAC Modifications**

  The budget grows all but one mandatory Health Care Fraud and Abuse Control (HCFAC) funding stream by 20 percent over current law baseline levels; the HHS Wedge stream would grow by 10 percent. The additional mandatory HCFAC investment will support top priorities, such as Medicare fee-for-service medical review, addressing emerging fraud schemes, fraud and abuse audits and investigations, increased staffing for oversight and enforcement, cutting-edge data analytics to detect trends and outliers, and fraud and abuse law enforcement and prosecution activities. This additional investment is projected to total $3.8 billion over the 10-year budget window and yield $5.4 billion in net savings over 10 years.

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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	2024	90%	October 31, 2024
	2023	90%	October 31, 2023
	2022	90%	99% (Target Exceeded)
	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)
MCR9.1b: Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment	2024	90%	October 31, 2024
	2023	90%	October 31, 2023
	2022	90%	99% (Target Exceeded)
	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)

Measure	FY	Target	Result
MCR9.1c: Quality Standards: Minimum of 90 percent meets expectations for Knowledge Skills Assessment	2024	90%	October 31, 2024
	2023	90%	October 31, 2023
	2022	90%	96% (Target Exceeded)
	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)
MCR9.3: Minimum of 90 percent pass rate for the Customer Satisfaction Survey	2024	90%	October 31, 2024
	2023	90%	October 31, 2023
	2022	90%	94% (Target Exceeded)
	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)

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	2024	Maintain an unmodified opinion	November 15, 2024
	2023	Maintain an unmodified opinion	November 15, 2023
	2022	Maintain an unmodified opinion	Target Met
	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

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 2022 target of maintaining an unmodified opinion on four out of the six principal financial statements. During FY 2022, 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 2022 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)	2024	17.5%	April 30, 2024 (based on CY 2022 data)
	2023	17.5%	April 30, 2023 (based on CY 2021 data)
	2022	17.5%	17.8% (Target Not Met) (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" refers to an unplanned hospitalization that occurs after a patient has recently been discharged from a hospital. A thirty-day period between the discharge day and the readmission day 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 based on excess unplanned Medicare inpatient hospital readmissions for patients admitted with the following 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 unplanned 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 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 beginning with 2019 payment, CMS penalize hospitals that perform poorly on their HRRP measures, 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 demonstrate that these reports can help target disparities by reducing hospital readmissions among members of under-served and under-resourced communities. CMS provides hospitals with annual confidential feedback reports on HRRP readmission measure performance for dual-eligible beneficiaries. Hospitals can review their readmission measure performance among dual-eligible relative to non-dual-eligible beneficiaries, and relative to other hospitals treating similar proportion of dual-eligible beneficiaries. In CY 2022, CMS targeted to expand its health equity confidential feedback to hospitals by stratifying readmission measure performance by race and ethnicity.

CMS did not meet its targets for CYs 2019-CY 2022, 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 appeared 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 keeps its target for CY2023 at 17.5 percent for two reasons: 1) In March 2022, the Food and Drug Administration authorized the second booster dose of two COVID-19 vaccines for people over the age of 50 and immunocompromised individuals[1]; and 2) On April 27, 2022, Dr. Anthony Fauci, former Chief Medical Advisor to President Biden, stated that the U.S. is transitioning out from the pandemic and attributed that to

[1] Food and Drug Administration. U.S. Department of Health and Human Services. (3/29/2022). Coronavirus (COVID-19) Update: FDA Authorizes Second Booster Dose of Two COVID-19 Vaccines for Older and Immunocompromised Individuals | FDA

a higher level of collective immunity across the nation[2]. CMS expects that the effectiveness of the second booster and a higher collective immunity would enable hospitals to reduce readmissions, especially among Medicare beneficiaries. Thus, the target of 17.5 percent is reasonable and appropriate for the purpose of risk management.

Based on results from 2016-2022 for this measure remaining relatively constant, CMS recommends retiring this goal as a measure to see a national reduction in the raw Readmission Rate. CMS programs such as Quality Reporting and Hospital Value Based Purchasing look at a comparison of one hospital to another and not at the National rate. The Quality Improvement Organization Program uses a population-based measure to assess the change in readmissions per 1000 beneficiaries as compared to the raw readmission rate (number of readmissions/number of admissions) used for this GPRA performance measure. Readmission rates are difficult to impact due to the fact that interventions used to reduce the number of readmissions also tend to reduce the number of admissions. When both the numerator and the denominator decrease when interventions are working, as is the case with the readmission rate, the readmission rate stays static. It may be beneficial to explore using other measures to assess readmissions reductions and coordination of care for patients discharging from the hospital in future GPRA performance measures.

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. While the number of admissions and readmissions decreased across the board in both Medicare Fee-for-Service (FFS) and Medicare Advantage (MA) from 2019 to 2020, the readmissions rates have remained relatively stable.

[2] Achenbach, J., and B. Pietsch (4/27/2022) Fauci says U.S. is out of coronavirus 'pandemic phase' - The Washington Post

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	2024	55%	December 15, 2025
	2023	47%	December 15, 2024
	2022	40%	December 15, 2023
	2021	40%	24.8% (Target Not Met)
	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 for volume and towards paying for value and outcomes, CMS launched 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). In November 2022, CMS published a one-year update on progress made achieving this vision, including measures for success against key objectives (Person-Centered Innovation - An Update on the Implementation of the CMS Innovation Center's Strategy). 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 (see newly developed measure CMMI6).

CMS did not meet its FY 2021 target because of the unprecedented impact of the COVID-19 pandemic (e.g. significant uncertainty around and fluctuations in patient utilization, how patients received care, and availability of clinical labor), more limited opportunities for enrollment in new CMMI models, and a plateauing of participation in the Medicare Shared Savings Program.

MCR37: Increase Patient Choice in Dialysis Treatment

Measure	CY	Target	Result
MCR37: Increase the percentage of new dialysis patients who choose home dialysis modalities	2024	24.62%	June 30, 2025
	2023	23.60%	June 30, 2024
	2022	22.57%	June 30, 2023
	2021	19.92%	21.5% (Target Exceeded)
	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 result for CY 2021 is 21.5%, which exceeded the target rate of 19.92%. 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 2022 yields a target of 22.57 percent. Similarly, a 15 percent relative increase between 2020 and 2023 yields a target of 23.60 percent. A 20 percent relative increase from 2020 to 2024 yields a target of 24.62 percent. 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 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. The ESRD Networks will ensure health inequities information and education are provided in an equitable manner to

reach all patients. The ESRD National Coordinating Center (NCC) will review high performers and include how the Networks have provided outreach and support to all of their patients. The Networks will also 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 2020 home dialysis was still underutilized in the U.S. with approximately 14.7 percent of the dialysis patients undergoing renal replacement therapy at home versus approximately 85.3 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 more 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.[3] Another barrier noted is inadequate number of trained home dialysis staff. 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 percent of ESRD patients use a home dialysis modality which is an increase of 1.2 percentage points from 2019. This increase in the number of patients using of home dialysis

[3] 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

instead of in-center hemodialysis represented an approximate cost savings of $60 million in 2020. 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 July 2022, the COVID-19 pandemic continues with vulnerabilities that may negatively impact the agency's ability to meet performance targets in a timely manner. Note, initiating home dialysis with new ESRD patients could be protective, and reduce the chances of contracting COVID-19, as compared to in-center hemodialysis. 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 percent increase in the number of incident patients starting dialysis with a home modality, and;
- 30 percent 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)	2024	0.75% Reduction From 2019 Actual	April 20, 2026
	2023	0.50% Reduction From 2019 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	70.7 per 1000 (Target Met) 16.4% below 2019 actual
	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.
*Due to the COVID-19 impact on the measure, the target reduction for 2023 readmissions will be anchored to 2019 data, the last full year before the onset of COVID-19 in the U.S.

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 2021, 12.9 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, CMS 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). The greatest declines occurred between 2012-2014 followed by a period of stability from 2015-2019 with only slight movement in either direction. Similarly, in MCR26: *Reduce All-Cause Hospital Readmission Rates for Medicare Beneficiaries by One Percent over the Previous Year's Actual Rate* measure, CMS found the greatest declines in the readmission rate from 2010-2015 followed by a period of stability from 2016-2019.

This CMS performance measure, MMB2, showed declines in admissions and readmissions and a steep decline in the readmission rate for the target dually eligible population and the non-dually eligible comparison group from 2019-2020 of 16.4 percent (from 84.6 to 70.7 per 1000 beneficiaries) and 21.5 percent (from 30.4 to 23.9 per 1000 beneficiaries), respectively, as compared to 1.0 percent increase (from 83.7to 84.6 per 1000 beneficiaries in readmission rates for dually eligible individuals and 2 percent reduction (from 31.0 to 30.4 per 1000 beneficiaries) for the non-dually eligible group, from 2018-2019.[4] The steep reductions in 2020 are likely related to changes in utilization patterns related to the COVID-19 public health emergency (PHE) in 2020 and the fact that hospital index admissions with a primary diagnosis code of COVID-19 are excluded from the measure.

There is evidence that COVID-19 infection worsens the severity of existing comorbidities resulting in an increased rate of readmission.[5] Two of these comorbidities, pneumonia and COPD, captured in MMB2 data when coded as primary diagnoses on index admissions, are linked with worse outcomes in individuals who contract respiratory viruses such as COVID-19.[6] MMB2 data showed a small increase in readmissions for these diagnoses from 2019-2020, contrary to the sharp drop overall.

Although these findings are not very well understood yet, it seems the bulk of the reduction could be attributed to the exclusion of COVID-19 as a primary diagnosis upon index admission. At least two other scenarios may have contributed to this result in the MMB2 population:

[4] CMS calculates the readmissions data each year from 2012 to current measurement year to account for any minor changes in systems coding from version-to-version and/or any other changes in the underlying measure methodologies. Therefore, slight variations in past years' rates may be observed.
[5] Atalla E, Kalligeros M, Giampaolo G, Mylona EK, Shehadeh F, Mylonakis E. Readmissions among patients with COVID-19. Int J Clin Pract. 2021;75:e13700. 10.1111/ijcp.13700
[6] Anastasio F, Barbuto S, Scarnecchia E, et al. Medium-term impact of COVID-19 on pulmonary function, functional capacity and quality of life. Eur Respir J. 2021;58:2004015. 10.1183/13993003.04015-2020

1) Those who had admissions for an included diagnosis may have taken great care to avoid COVID-19 exposure (and other risks) post-discharge and avoided readmission during the 30-day timeframe necessary for inclusion in the rate; or
2) Given the scarcity of hospital beds in 2020, individuals who may have otherwise been admitted may have had to wait for an open bed in observation or elsewhere before being admitted, possibly missing the 30-day timeframe.

Accounting for COVID-19 in other CMS readmissions measures, MCR26 similarly showed across the board reductions (FFS v. MA and dual v. non-dual) in the number of admissions and readmissions from 2019-2020, but the readmission rates remained relatively stable (between 17.6-17.8 percent during 2016-2020).

CMS recommends increasing the target reduction rate to 0.75 percent for CY 2024 as compared to 2019 actual data in consideration of the instability in readmission rates that has resulted from the PHE which began in 2020. We do not believe that the significant readmission rate reduction observed between 2019 and 2020 would serve to predict future readmission rates due to the confounding variables brought on by the continuing PHE. Although these findings are not very well understood yet, we believe that a significant portion of the reduction could potentially be attributed to the exclusion of COVID-19 as a primary diagnosis upon index admission. At least two other scenarios may also have contributed to this result in the MMB2 population:

1) Those who had admissions for an included diagnosis may have taken great care to avoid COVID exposure (and other risks) post-discharge and avoided readmission during the 30-day timeframe necessary for inclusion in the rate; or
2) Given the scarcity of hospital beds in 2020, individuals who may have otherwise been admitted may have had to wait for an open bed in observation or elsewhere before being readmitted, possibly missing the 30-day timeframe.

We do not yet have any indication of how the end of the PHE will impact the readmission rate for dually eligible individuals.

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. CMS continues to focus on readmissions 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 initiatives, including the Medicare Shared Savings Program (MSSP), incorporate financial incentives to reduce utilization and readmissions and use readmission and admission quality outcome measures (Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate and Risk-standardized Hospital

Admission Rates for Patients with Multiple Chronic Conditions) as part of the quality measure set that impacts shared savings and losses determinations; and

- An array of CMS Innovation Center models with financial incentives to reduce utilization and readmissions, including the Bundled Care Improvement (BCPI-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	2024	Contextual Measure	November 30, 2024
	2023	Contextual Measure	November 30, 2023
	2022	Contextual Measure	1,750,006
	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 May 2022, the Contract Year 2023 Policy and Technical Changes to

the Medicare Advantage and Medicare Prescription Drug Benefit Programs Rule included provisions to further improve integration of Medicare and Medicaid programs for dually eligible individuals enrolled in D-SNPs. These provisions 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 codified 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 1,750,006. In 2022, about 21 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.

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 antipsychotic medication*	2024	14.3%	July 31, 2025
	2023	14.7%	July 31, 2024
	2022	15.0%	July 31, 2023
	2021	15.3%	14.5% (Target Exceeded)
	2020	15.4%	14.5% (Target Exceeded)
	2019	15.5%	14.0% (Target Exceeded)
	2018	16.0%	14.6% (Target Exceeded)
	2017	16.0%	15.4% (Target Exceeded)
	2016	16.7%	16.7% (Target Met)

*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 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; 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.

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 website, 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 of 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 39.1 percent to a national prevalence of 14.5 percent in 2021 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)	2024	98%	December 31, 2024
	2023	98%	December 31, 2023
	2022	97.5%	96.7% (Target not met)
	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. Fiscal Year results are available by the end of December each calendar year.

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 an 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 Payroll-Based Journal (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, future target predictions are 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.

On December 11, 2021, Ultimate Kronos Group (UKG), a workforce management software company used by many nursing homes for their PBJ submission, was the victim of a ransomware attack. This prevented many nursing homes from being able to submit their PBJ data which impacted the overall result for FY2022. Additionally, in January 2022, CMS began posting weekend staffing and staff turnover measures on Nursing Home Care Compare (QSO-22-08-NH). As part of this effort, CMS added new weekend staffing exclusion criteria. Facilities that meet these exclusion criteria are not included in the PBJ public use file and are not included in the percentage reported above. We believe these new staffing measures will draw new attention causing facilities to focus on their submissions and they will improve over time. On June 29, 2022, CMS added new requirements for surveyors to incorporate the use of PBJ staffing data for their inspections. State Survey Agencies (SSAs) can use PBJ data to identify nursing homes at risk of insufficient nurse staffing. For example, the PBJ data that will be leveraged by SSAs includes nursing homes that reported

excessively low weekend staffing, staffing below 8 RN hours, or 24 licensed-nurse hours during a quarter.

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	2024	Work with States to ensure that 95% of States report on at least seventeen quality measures in the CHIPRA children's core set of quality measures.	June 1, 2025
	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	June 1, 2023

Measure	FY	Target	Result
	2020	Work with States to ensure that 90% of States report on at least <u>twelve</u> quality measures in the CHIPRA children's core set of quality measures	92% of States reported on at least twelve measures (Target Exceeded)
	2019	Work with States to ensure that 90% of States report on at least <u>eleven</u> 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 <u>eleven</u> 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 <u>eleven</u> 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.

* When reporting becomes mandatory in FY 2024, the denominator will increase from 51 (states and DC) to 54 (states, DC, Guam, Puerto Rico, and Virgin Islands). Although the percentage of states reporting remains the same in the targets for FYs 2023 and 2024, the FY 2024 target reflects an increase in reporting due to the increase in the denominator.

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.[7] Due to the development of a new quality measurement

[7] Currently the definition of states includes the 50 states and D.C. When reporting becomes mandatory in FY 2024, the definition of states will include the 50 states, D.C., Puerto Rico, U.S. Virgin Islands, and Guam.

reporting system, updated Child Core Set data for FY 2021 will not be available until June 2023. The FY 2024 target is that 95 percent of states will report on at least seventeen quality measures. Beginning in FY 2024, reporting on the Child Core Set measures will become mandatory as required by the Bipartisan Budget Act of 2018 (P.L. 115-123), also referred to as the ACCESS Act. While CMS expects that there will be an uptick in Child Core Set reporting as the result of this requirement, CMS expects that not all states will be able to report on all Child Core Set measures. CMS will provide technical assistance to states to assist with mandatory reporting requirements.

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 2021 Child Core Set contains 23 measures, the 2022 Child Core Set contains 25 measures, and the 2023 Child Core Set contains 27 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.

CMS 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.

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/.

As noted above, CMS has developed a new quality measure reporting system, which has impacted the timing of FY 2021 state core set reporting and the release of data. State reporting of FY 2021 and 2022 core set data will be complete in early January

2023 and CMS expects to provide both the FY 2021 and 2022 updates in June 2023, after working with States to ensure data quality meets CMS standards.

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%	2024*	+10 percentage points over 2011 baseline	October 15, 2025
	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	46% (Target Not Met)
	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.
*We are holding the 2024 goal at the same level of the 2023 goal to help states recover progress lost to the COVID-19 public health emergency.

CMS did not meet the FY2021 target. There was a significant disruption in state performance 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– April 2022 to the pre-pandemic period, the data shows about 20 percent fewer dental services being provided per 1,000 beneficiaries. 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 24 of the Medicaid and CHIP and the COVID-19 Public Health Emergency: Preliminary Medicaid and CHIP Data Snapshot. Performance in FY 2021 improved by 3 percentage points over FY 2020, and CMS engages with states on dental access issues, including addressing foregone care, in the course of reviewing State Plan Amendments, managed care waivers, and section 1115 demonstrations. CMS fosters improvement through its learning collaborative focused on oral health care for young children, and shares best practices on access initiatives (e.g. for tribal populations) through the Oral Health Technical Advisory Group.

The pandemic presented a setback from the last decade of sustained, gradual improvement in 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. However, even in FY 2019, only 52 percent of all enrolled children nationally received a preventive dental or oral health service in FY 2019. This highlights the continued need for focus on access to dental care.

CMS' current focus on oral health began with 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 in 2010. 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 initiative staff are assisting California in applying lessons learned from this concluded demonstration to its ongoing State Plan and managed care waiver authorities.

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 the 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. In 2023, CMS' technical assistance contractor will be convening an expert work group to provide input on strategic priorities for the next five years of the Oral Health Initiative.

MCD8: Improve Adult Health Care Quality across Medicaid

Measure	FY	Target	Result
MCD8: Improve Adult Health Care Quality Across Medicaid	2024*	Work with States to ensure that 90% of States report on at least fourteen quality measures in the Adult Medicaid core set of quality measures	June 1, 2025
	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	June 1, 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)

Measure	FY	Target	Result
	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

* When reporting becomes mandatory in FY 2024, the denominator will increase from 51 (states and DC) to 54 (states, DC, Guam, Puerto Rico, and Virgin Islands). Although the percentage of states reporting remains the same in the targets for FYs 2023 and 2024, the FY 2024 target reflects an increase in reporting due to the increase in the denominator.

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.[8] Due to the development of a new quality measurement reporting system, updated Adult Core Set data for FY 2021 will not be available until June 2023. The FY 2024 target is that 90 percent of states will report on at least 14 quality 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.

Beginning in FY 2024, reporting on the behavioral health measures on the Adult Core Set and the Child Core Set will become mandatory. While CMS expects an uptick in the reporting of the behavioral health measures on Adult Core Set, CMS anticipates that states may prioritize certain voluntary core measures to target improvement strategies rather than reporting on a large volume of measures. CMS provides technical assistance to states to assist with reporting requirements for both mandatory and voluntary reporting.

[8] Currently the definition of states includes the 50 states and D.C. Starting in FY 2024, the definition of states will include the 50 states, D.C., Puerto Rico, U.S. Virgin Islands, and Guam.

Section 1139B of the Social Security Act established a national adult quality measures program for Medicaid. The 2021 Adult Core Set contains 32 measures, the 2022 Adult Core Set contains 33 measures, and the 2023 Adult Core Set contains 34 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.

CMS 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.

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.

As noted above, CMS has developed a new quality measure reporting system, which has impacted the timing of FY 2021 state core set reporting and the release of data. State reporting of FY 2021 and 2022 core set data will be complete in early January 2023 and CMS expects to provide both the FY 2021 and 2022 updates in June 2023, after working with States to ensure data quality meets CMS standards.

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	Reports from 26 states submitted (Target Exceeded)
	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 approved1115 SUD demonstrations on use of the instrument and system
MCD9.3 Reduce Emergency Department (ED) Use Under Substance Use Disorder (SUD)1115 Demonstration	2024	The percent of states that either demonstrate a decrease or remain consistent in their ED utilization for SUD will be similar to the 2023 baseline.	September 30, 2024
	2023	Baseline – Percent of states that demonstrate a decrease or remain consistent in their ED utilization for SUD from the base year of each state's demonstration to their most recent monitoring report (as of June 1, 2023)	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). In addition, we have assessed this measure for its relevance to the current strategic plan which includes a pillar to improve behavioral health by increasing access to prevention and treatment of SUD. As such, this metric simultaneously supports the goals of strengthening performance measurement under section 1115 demonstrations and advancing comprehensive care delivery for SUD.

States are using Section 1115 demonstration authority to achieve Medicaid reform through innovative approaches to achieve the following goals: expand coverage, and make improvements in service delivery, and in quality of care and health outcomes, with a significant emphasis on closing gaps in health disparities. Initiatives include: 1) addressing health related social needs, 2) integrating physical and behavioral health (including comprehensive service delivery for SUD, and serious mental illness / serious emotional disturbance (SMI/SED), 3) providing transition services for people being released from carceral settings, and expanding post-partum care. CMS is making significant investments in these types of demonstrations and their effective monitoring and evaluation, including developing and requiring states to report on initiative-specific standardized metric sets, largely drawing from nationally approved and Medicaid core metrics, to be submitted through PMDA, 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 SUD and 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 is working 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 July 30, 2022, there are 34 approved SUD demonstrations. These 33 states and the District of Columbia (together referred to as 34 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 September 30, 2022, 26 of the 34 states submitted monitoring reports using the SUD templates to CMS.[9]

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 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[10], which can result in resource constraints for health systems[11]. 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.

[9] 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 30, 2022, 22 of these 27 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.
[10] 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/
[11] 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	2024	TBD	
	2023	TBD	April 30, 2025
	2022	TBD	April 30, 2024
	2021	Historical Actual	April 30, 2023
	2020	84.5% Historical Actual	Oct 1, 2022
	2019	84.3% 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.12 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. As of April 2022, we are considering an approach that captures the percentage of Medicaid LTSS users who received HCBS in each state. We will calculate the percentages by dividing the number of unduplicated Medicaid beneficiaries who received any HCBS by the number of unduplicated Medicaid beneficiaries who received any LTSS (either institutional service or HCBS). For this purpose, HCBS would encompass Medicaid services described in Appendix B of the State Medicaid Director Letter SMD# 21-003 Implementation of American Rescue Plan Act of 2021, Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency.[13] 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. Initial results support continuing use of the TAF for FY 2020 and FY 2021 data and to establish targets for FY 2022 through 2024.

[12] https://www.kff.org/medicaid/issue-brief/potential-impact-of-additional-federal-funds-for-medicaid-hcbs-for-seniors-and-people-with-disabilities/
[13] https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf

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.[14] 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.[15]

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 most 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.[16] 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*.[17] 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 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

[14] Kim, Min-Young, Edward Weizenegger, and Andrea Wysocki. "Medicaid Beneficiaries Who Use Long-Term Services and Supports: 2019." Chicago, IL: Mathematica, July 16, 2021.
[15] 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/
[16] https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf
[17] https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/21/executive-order-ensuring-an-equitable-pandemic-response-and-recovery/

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 established a baseline for FY 2019, by April 30, 2022, and has reported historical data for FY 2020. CMS continues to 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. 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 Medicare Fee-for-Service (FFS) Program	2024	TBD	November 15, 2024
	2023	7.36%	November 15, 2023
	2022	6.16%	7.46%* (Target Not Met)
	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)

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 2022 HHS AFR. Starting in FY 2017, per OMB guidance, CMS establishes improper payment rate targets only for the next fiscal year. CMS develops the following year's target error rate using a unique approach each year. For instance, the 2023 Medicare FFS target takes into consideration:

1) Reduced sample size;

2) PHE waiver and flexibilities provide by CMS;

3) Policy changes; and

4) Behavior of providers and suppliers complying with documentation requests during and after the COVID-19 PHE.

Therefore, the FY 2024 target will be established in the FY 2023 HHS AFR.

In August 2020, CMS resumed CERT program activities that had been paused due to COVID-19, thus impacting the FY 2022 reporting period. As a result, the improper

payment rate reflects processes that had a 2-month delay in contacting providers and suppliers for documentation and an adjusted sample size. In addition, the waivers and flexibilities provided by CMS for providers and suppliers during COVID-19 apply to all claims in the FY 2022 reporting period.

The Medicare FFS improper payment estimate for FY 2022 is 7.46 percent, or $31.46 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:

- 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 7.79 percent in FY 2021 to 15.10 percent in FY 2022. The primary reasons for these errors are missing documentation to support the level of care requirements and missing documentation to support the required components for the billed code.

- 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 4.57 percent in FY 2021 to 5.43 percent in FY 2022; however, this 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.

- Hospice: Both insufficient documentation and medically unnecessary were the major error reasons for hospice claims. The improper payment estimate for hospice claims increased from 7.77 percent in FY 2021 to 12.04 percent in FY 2022. The primary reasons for these errors are missing or insufficient documentation to support the certification or recertification and the hospice coverage criteria for medical necessity was not met.

- Home Health: Medically unnecessary was the major error reason for home health claims. The improper payment estimate for home health claims decreased from 10.24 percent in FY 2021 to 10.15 percent in FY 2022; however, this change is not statistically significant. The primary reason for these errors is that the home health coverage criteria for medical necessity was not met.

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 2022 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%	2024	TBD	November 15, 2024
	2023	5.77%	November 15, 2023
	2022	9.69%	5.42%* (Target Exceeded)
	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)

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 2022, CMS reported an improper payment estimate of 5.42 percent of total outlays or $13.94 billion. CMS finalized a policy regarding treatment of spontaneous "additionals" in the improper payment rate calculation. Diagnoses that were not submitted to CMS for payment have been excluded from the payment error calculation to get a true measure of payment error. In previous years, these potential payments were reflected in the underpayment rate and overall payment error calculation; however, including the spontaneous "additionals" in the gross underpayment portion resulted in an overstatement of the overall improper payment rate. The implemented policy contributed to a decrease in the projected Part C improper payment rate, representing a new baseline improper payment rate for Part C and is not directly comparable with prior reporting years. Moreover, FY 2021 also represented a new baseline due to various methodology changes, most significantly, a refined denominator calculation.

The Part C 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 Organizations. To calculate the projected error rate, CMS selects a random sample of enrollees with one or more CMS-HCCs and requests medical records to support each condition. If medical records do not support the diagnoses submitted to HHS the risk scores may be inaccurate and result in payment errors.

In FY 2022, CMS selected a stratified random sample of beneficiaries with a risk adjusted payment in Payment Year 2020 and reviewed medical records of the diagnoses submitted by plans for the sample beneficiaries. CMS establishes improper payment rate targets only for the next fiscal year; therefore, the FY 2024 target will be established in the FY 2023 HHS AFR.

The primary error type of Medicare Part C improper payments consists of medical record discrepancies (4.74 percent in overpayments and 0.49 percent in underpayments), with a smaller portion of improper payments resulting from insufficient documentation to determine whether proper or improper (0.19 percent). Improper payments due to medical record discrepancies occur when medical record documentation submitted by the MAO 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 MAO 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 2022 HHS AFR. CMS recently published a rule that finalized the policies for the MA Risk Adjustment Data Validation program, which is CMS's primary audit and oversight tool of MA program. This rule will allow CMS to continue to focus its audits on those MAOs identified as being at the highest risk for improper payments in the Medicare Advantage program.

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%	2024	TBD	November 15, 2024
	2023	1.64%	November 15, 2023
	2022	1.20%	1.54%* (Target Met)
	2021	1.14% (target in FY 2020 AFR)	1.33% (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)

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 2022, CMS reported an improper payment estimate of 1.54 percent of total outlays or $1.36 billion. The improper payment estimate due to missing or insufficient documentation is 1.21 percent or $1.07 billion, representing 78.49 percent of total improper payments. The increase from the prior year's estimate of 1.33 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 types and amounts can cause minor shifts in the total estimated error rate. Per OMB guidance, CMS establishes improper payment rate targets only for the next fiscal year, therefore the FY 2024 target will be established in the FY 2023 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 2022 Medicare Part D improper payment error categories are drug or drug pricing discrepancies (0.29 percent in Overpayments and 0.04 percent in Underpayments) and insufficient documentation to determine whether proper or improper (1.21 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) indicate 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 2022 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	2024	TBD	November 15, 2024
	2023	12.68%	November 15, 2023
	2022	18.94%	15.62% (Target Exceeded)
	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)	2024	TBD	November 15, 2024
	2023	21.04%	November 15, 2023
	2022	27.88%	26.75% (Target Exceeded)
	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 FFS, managed care, and eligibility components of both Medicaid (MIP9.1) and 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 2022 HHS AFR are based on measurements that were conducted in FYs 2020, 2021, and 2022. Information on the Medicaid and CHIP statistical sampling process and review period can be found in the FY 2022 HHS AFR. Per OMB guidance, CMS establishes improper

payment targets only for the next fiscal year, therefore the FY 2024 target will be established in the FY 2023 HHS AFR.

The national Medicaid improper payment estimate for FY 2022 is 15.62 percent or $80.57 billion. The national Medicaid component rates are 10.42 percent for Medicaid FFS, 0.03 percent for Medicaid managed care, and 11.89 percent for the Medicaid eligibility component.

The national Medicaid improper payment estimate reflects reviews that accounted for certain flexibilities afforded to states during COVID-19, such as postponed eligibility determinations and reduced requirements around provider enrollment or revalidations. CMS published the 2022 Medicaid & CHIP Supplemental Improper Payment Data on the CMS website following AFR publication.

The areas driving the Medicaid improper payment estimate are:

- **Insufficient Documentation:** Represents 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 that the verification process was completed. This includes situations where medical records were either not submitted or were missing required documentation to support the medical necessity of the claim.

- **State Non-Compliance:** Represents noncompliance with federal eligibility redetermination requirements; enrolled providers not appropriately screened by the state; providers not appropriately rescreened at revalidation; providers not enrolled; and/or providers without the required National Provider Identifier on the claim. State compliance with provider enrollment or screening requirements has improved as the Medicaid FFS component improper payment estimate decreased from 13.90 percent in RY 2021 to 10.42 percent in RY 2022. COVID-19 review flexibilities afforded to states should also be considered in the identified decrease in the Medicaid FFS and eligibility components between RY 2021 and RY 2022.

The national CHIP improper payment estimate for FY 2022 is 26.75 percent or $4.30 billion. The national CHIP component rates are 11.23 percent for CHIP FFS, 0.62 percent for CHIP managed care, and 24.01 percent for the CHIP eligibility component.

The national CHIP improper payment estimate reflects reviews that accounted for certain flexibilities afforded to states during COVID-19, such as postponed eligibility determinations and reduced requirements around provider enrollment or revalidations. CMS published the 2022 Medicaid & CHIP Supplemental Improper Payment Data posted on the Payment Error Rate Measurement page of the CMS website following AFR publication.

The areas driving the CHIP improper payment estimate are as follows:

- **Insufficient Documentation:** Represents 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 that the verification process was completed. This includes situations where medical records were either not

submitted or were missing required documentation to support the medical necessity of the claim.

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

- **State Non-Compliance:** Represents noncompliance with federal eligibility redetermination requirements; enrolled providers not appropriately screened by the state; providers not appropriately rescreened at revalidation; providers not enrolled; and/or providers without the required National Provider Identifier on the claim. State compliance with provider enrollment or screening requirements has improved as the CHIP FFS component improper payment estimate decreased from 13.67 percent in RY 2021 to 11.23 percent in RY 2022. COVID-19 review flexibilities afforded to states should also be considered in the identified decrease in the CHIP FFS and eligibility components between RY 2021 and RY 2022.

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 2022 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%	2024	60%	April 30, 2025
	2023	56%	April 30, 2024
	2022	52%	April 30, 2023
	2021	50%	62.57% (Target Exceeded)
	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 CY Q2 2023, the PECOS system will be in a transition out phase, which is the reason for the increase

of 2 percent for that year and will return to 4 percent 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 2021 result was 62.57 percent, which exceeds the target of 50 percent. Targets set for CY 2022 (52 percent), CY 2023 (56 percent) and CY 2024 (60 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 *	2024	$65.0 million	April 30, 2025
	2023	$62.0 million	April 30, 2024
	2022	$45.0 million	April 30, 2023
	2021	$40.0 million	$86.4 million (Target exceeded)
	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 several new edits have been 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.	2024	85% QIO Satisfaction	January 15, 2025
	2023	85% QIO Satisfaction	January 15, 2024
	2022	83% QIO Satisfaction	78.3 (Target Not Met)
	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)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.

The primary focus of the Beneficiary and Family Centered Care (BFCC) program is to improve health care 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. Overall beneficiary positive experience with the QIO Quality of Care (QOC) complaint review process has been decreasing. Two potential reasons for this decrease are:

1) The BFCC-QIOs have been making increased use of Immediate Advocacy to resolve beneficiary complaints resulting in fewer QOC cases overall. The decreased number of cases results in fewer surveys collected and this can cause increased variability in scores due to the effect of extreme low or high scores; and
2) The possible effect of the COVID-19 pandemic that has lowered overall beneficiary positive experience and satisfaction with health care services in general.
3) 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. 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 process with mail follow-up to randomly chosen Medicare beneficiaries who file an Appeal and all eligible beneficiaries who file a Quality of Care Complaint. Beneficiaries share their experiences with the Medicare Complaint or Appeal process in the following three domains.

(1) Communication with the BFCC-QIO at complaint initiation;
(2) Support provided by the BFCC-QIO with preparing the necessary documentation for the Quality of Care Complaint and keeping the beneficiary informed about their case status; and
(3) From the beneficiary's perspective, did the conduct of the BFCC-QIO meet the beneficiary's expected levels of satisfaction of courtesy, respect, and communication with both the beneficiary and their family.

BFCC QIOs continue to sustain good levels of performance. The FY 2022 target was not met.

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	2024	20% reduction from baseline	January 31, 2025
	2023	15% reduction from baseline	January 31, 2024
	2022	10% reduction from baseline	13.49% (Target Exceeded)
	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 expectation 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.

As of March 2022, more than 1.1 million residents live in approximately 15,216 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), 82.5% or 14,742 from 2019 through 2021, and 71.4% or 13,250 from 2020 through 2021. Recently, nursing homes have been the site of many 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. Due to the important work of reducing infections in nursing homes, CMS intends to carry this measure forward into the 13th SOW, and sets the FY 2024 target at 20% from the developmental baseline.

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 disease specialists. 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 based on the fiscal year cycle.

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	0.585 (Target Not Met)
	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	0.766 (Target Met)
	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 and decreased in 2021 to 0.585. Notable about 2020 was the global pandemic, COVID-19, which led to increased hospitalizations across the United States including patients who became ventilator-dependent for long periods of time; consequently, it would be typical for these patients 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 CAH CAUTI rates the during 2020-2021 time period, which was 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.[18,19,20]
2) Urinary irritation and frequency are 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).[21]

[18] 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

[19] 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.

[20] 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.

[21] 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;[22] 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.

[22] 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	2024	Contextual Indicator	December 31, 2024
	2023	Contextual Indicator	December 31, 2023
	2022	Contextual Indicator	90%
	2021	Contextual Indicator	91%
	2020	Contextual Indicator	Not Available**
	2019	Contextual Indicator	92%
	2018	Contextual Indicator	91%
	2017	Contextual Indicator	91%
MCR1.1b: Maintain or exceed percent of beneficiaries in Medicare Advantage (MA) who report access to care	2024	Contextual Indicator	December 31, 2024
	2023	Contextual Indicator	December 31, 2023
	2022	Contextual Indicator	90%
	2021	Contextual Indicator	91%
	2020	Contextual Indicator	Not Available**
	2019	Contextual Indicator	90%
	2018	Contextual Indicator	91%
	2017	Contextual Indicator	91%

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.
** Survey data was not available due to survey administration being curtailed as a result of the Coronavirus (COVID-19) pandemic.
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CMS has monitored Medicare FFS and MA access to care through measures of patient experiences of care 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, CMS uses 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. 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%	2024	25%	April 30, 2026
	2023	25%	April 30, 2025
	2022	25%	April 30, 2024
	2021	25%	April 30, 2023
	2020	25%	25% (Target Met)
	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 2023, beneficiaries reach this phase when total drug costs amount to $4,660 and stay in this phase until they pay $7,400 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	2024	44,538,869 children (Medicaid- 35,391,786/CHIP – 9,147,083)	March 31, 2025
	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)	46,000,408 children (Medicaid- 37,371,414/CHIP- 8,628,994) (Target Not Met)
	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 2024. Our enrollment target for FY 2024 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. Additionally, the FY 2024 Medicaid and CHIP

enrollment target accounts for potential declines in Medicaid and CHIP child enrollment that may result from states resuming normal operations after the end of the continuous enrollment condition initially authorized in section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA), which required states to maintain enrollment for most individuals enrolled in Medicaid since March 2020, as a condition of receiving a 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP). For example, state renewal processing after the end of the continuous enrollment condition will impact individuals that have retained their coverage during the COVID-19 PHE in Medicaid because of the FFCRA continuous coverage requirement, and in CHIP for states that elect the optional flexibilities to temporarily delay acting on changes in circumstances that would impact eligibility, and delay timely processing of renewals in CHIP. These changes will lead to terminations of coverage for children that are determined to be ineligible for Medicaid or CHIP at renewal during the eligibility period after the continuous enrollment condition ends. The FY 2024 enrollment target is set at the same enrollment projections for FY 2023. We anticipate this to be a reasonable goal for FY 2024 given that states will continue to process renewals from the COVID-19 PHE at the start of FY 2024, which will result in terminations of enrollees that do not complete renewals, or are otherwise no longer eligible for Medicaid and CHIP. These terminations will likely be reflected in the FY 2024 results as a decline in Medicaid and CHIP enrollment. After the continuous enrollment condition ends on March 31, 2023, there will be a great focus on retention of eligible child enrollment in Medicaid and CHIP, however, we do not expect to see returns to pre-pandemic levels of Medicaid and CHIP child enrollment until FY 2025. Additionally, a 2021 analysis by the Urban Institute reveals that 91.9% of eligible children were enrolled in Medicaid and CHIP in 2019. The remaining eligible but uninsured children are the hardest to reach.

The data for this goal comes from state's submission of required quarterly and annual child enrollment data, which include 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.

Measurement and reporting on this measure align with the CMS Strategic Plan pillar to expand access to quality, affordable health coverage and care, and supports the CMCS Blueprint objectives of ensuring all youth have access to a full breadth of physical and behavioral health services, and maximizing coverage retention across CMS programs as the COVID-19 PHE unwinds.

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.

CHIP, including the Connecting Kids to Coverage Outreach and Enrollment Program, is currently funded through FY 2029. 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 Consolidated Appropriations Act of 2023 further extends CHIP funding through FY 2029. These laws also include provisions related to

the extension and reduction of federal financial participation for CHIP, maintenance of effort for children's Medicaid and CHIP coverage, and the extension of express lane eligibility. The Connecting Kids to Coverage Outreach and Enrollment grants and National Campaign received $120 million in funding for outreach and enrollment activities through FY 2023, $48 million for FY 2024 to FY 2027, and $48 million for FY 2028 to FY 2029.

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. Most recently, on July 19, 2022, CMS awarded 36 new cooperative agreements, with awarded amounts ranging from $664,179 to $1,500,000. These grants have a 3-year period of performance which began on July 19, 2022. On October 17, 2022, CMS published a Notice of Funding Opportunity for an additional $6 million of HEALTHY KIDS Act funding that is available to enroll and retain AI/AN children in Medicaid and CHIP. The award date for these cooperative agreements is scheduled for April 2023. 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.

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%	2024	Contextual Indicator	November 30, 2024
	2023	Contextual Indicator	November 30, 2023
	2022	Contextual Indicator	16%
	2021	Contextual Indicator	17%
	2020	Contextual Indicator	13%
	2019	Contextual Indicator	15%
	2018	Contextual Indicator	17%
	2017	Contextual Indicator	13%
CMMI3.3: Number of providers participating in Innovation Center models Baseline: < 60,000	2024	Contextual Indicator	November 30, 2024
	2023	Contextual Indicator	November 30, 2023
	2022	Contextual Indicator	91,950
	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

Measure	FY	Target	Result
CMMI3.5: Percentage of Model awardees participating in learning activities	2024	54%	November 30, 2025
	2023	54%	November 30, 2024
	2022	52%	November 30, 2023
	2021	50%	51.7% (Target Exceeded)
	2020	50%	54% (Target Exceeded)
	2019	50%	54.2% (Target Exceeded)
	2018	Baseline	61%

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.

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 2022 result was 16 percent. 7 CMMI models ended in 2021 through mid-2022, while 2 new FFS models started in 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. The FY 2022 result was 91,950. The Medicare ACO Track 1+ Model ended in 2021 and is no longer under Section 1115A of the SSA. As such, providers from that model who remained in Medicare Shared Savings Program ACOs in 2022 participated in the permanent part of that Program. Therefore, the CMMI3.3 measure no longer includes such participants.

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). In FY2021, CMMI3.5 achieved 51.7 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	2024	60%	November 30, 2025
	2023	50%	November 30, 2024
	2022	45%	November 30, 2023
	2021	Baseline	44%

The CMS Innovation Center conducted a strategic refresh in 2021 to support and help execute CMS' strategic plan and priorities. In the fall of 2022, the Innovation Center released a 1-year Status Update Report that provides an update on the Innovation Center's progress implementing the new strategy, describes areas of focus for the coming year, and begins the process of measuring progress against the five objectives to drive accountable care, advance health equity, support care innovations, address affordability, and partner to achieve system transformation (Innovation Strategy Refresh). This measure aligns to the Administration's priority to reduce care fragmentation by aligning beneficiaries to 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. CMS commits to using FY 2021 data for the baseline, and created targets through FY 2024 based on the following current programs, models and demonstrations.

- Medicare Shared Savings Program
- Comprehensive Primary Care Plus Model
- Primary Care First Model
- Maryland Primary Care Track 2
- Kidney Care Choices Model (both Kidney Care First and Comprehensive Kidney Care Contracting options)
- Comprehensive ESRD Care Model
- Next Generation ACO Model
- Global and Professional Direct Contracting/ACO REACH Model
- Vermont All Payer ACO Model
- Maryland Total Cost of Care Model
- Oncology Care Model
- Independence at Home Demonstration

CMS continues to assess whether new metrics are needed and the potential for these shifts to impact data sources as well as the methods used to calculate metric denominators,

baselines, and targets by regularly monitoring and analyzing the metrics to identify any issues that may warrant revisiting baselines and targets in future years.

CMS DISCONTINUED PERFORMANCE MEASURES

Medicare Survey & Certification Program Discontinued Measures

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 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	*86.6% (Target Not Met)
	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 targets for FY 2020 and FY 2021 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[23] [24].

[23] https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html
[24] 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%	62.5% (Target Not Met)
	2019	63%	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%)*	35 States and District of Columbia 70.6% (Target Not Met)
	2019	37 States and District of Columbia (74.5%)*	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.

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%	1.5* (Target Not Met)
	2020	Baseline	9.4% (based on 4Q 2018- 3Q 2019 data)

*Note: The result reported is based on the newer methodology and not consistent with the previously reported target. Due to the change in calculation methodology, data for FY 2021 is a percentage of 1 Star nursing homes against the total number of nursing homes. This percentage was compared to the same data from 2018 – 2019. As expected, the reduction in one-star nursing homes is extremely low, and the result is unmet.