DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2025

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) 2025 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 2025, over 160 million, or roughly 1 in 2 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 support affordable health coverage, address health disparities to promote health equity, and inform policymaking through community and partner engagement. CMS will continue to support a highly competitive Marketplace that benefits consumers, while implementing innovative approaches to improving quality, affordability, and accessibility.

With the enactment of the Inflation Reduction Act (IRA) in 2022, CMS has continued to 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. A few of the specific accomplishments impacting millions of Americans includes saving Marketplace consumers an average of $800 per year, driving the nation's uninsured rate to historic lows, and lowering insulin costs for 4 million seniors and other Medicare beneficiaries. 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 responsible stewardship, and improving maternal and behavioral health outcomes, highlights CMS's continuation of striving to promote excellence in all aspects of operations.

The investments proposed in FY 2025 will keep CMS on the leading edge of providing the high-quality health benefits that all Americans deserve. At the same time, CMS is pursuing innovative program integrity efforts to further prevent fraud, waste, and abuse.

On behalf of our beneficiaries and consumers, I thank you for your continued support of CMS and its FY 2025 performance budget.

Administrator Chiquita Brooks-LaSure

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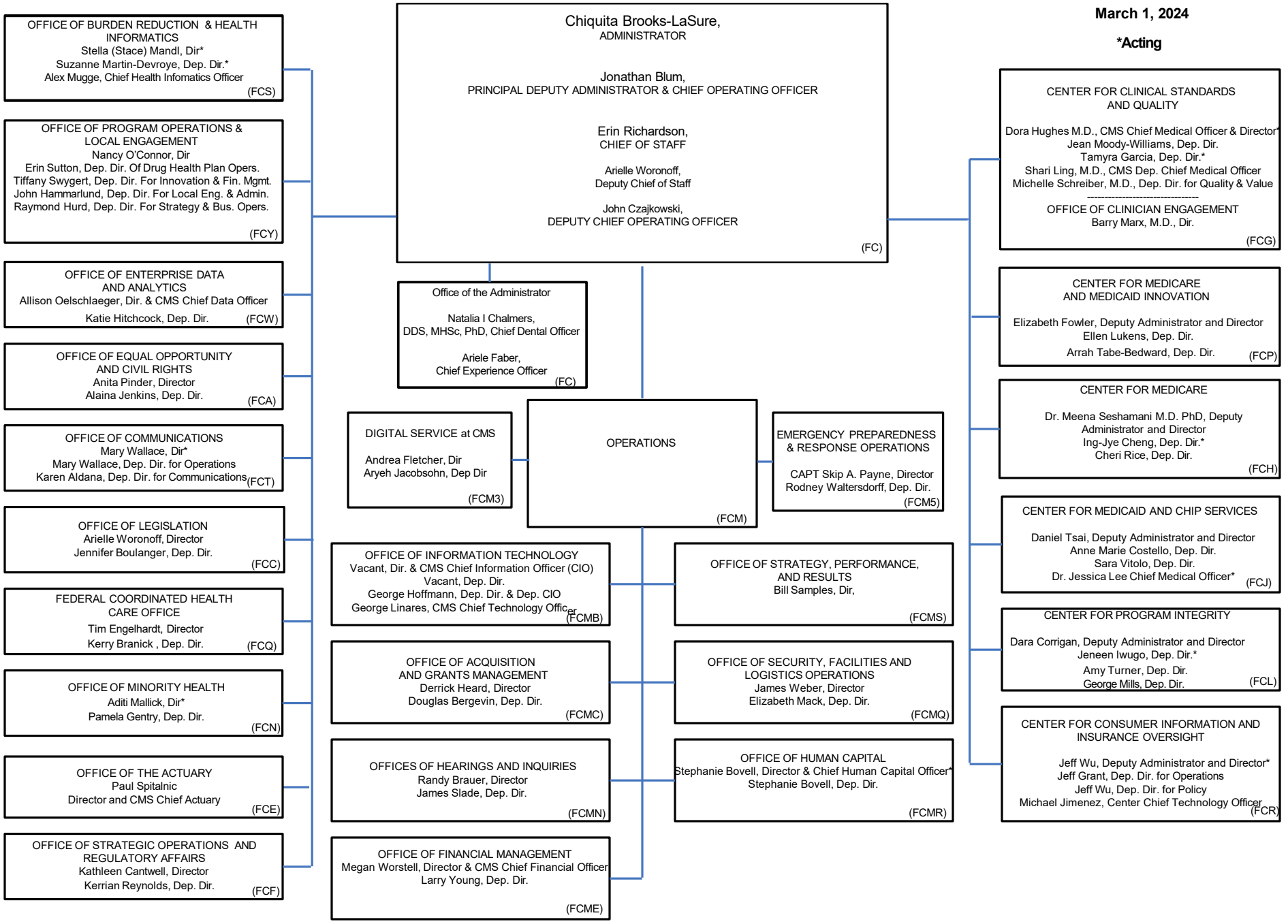
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED LEADERSHIP As of

March 1, 2024

***Acting**



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EXECUTIVE SUMMARY

Introduction and Mission

The Centers for Medicare & Medicaid Services (CMS) is an Operating Division within the Department of Health and Human Services (HHS) responsible for administering the largest Federal health care 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 we expect to serve in FY 2025.

CMS's budget request reflects our vision to serve the public as a trusted partner and steward, dedicated to advancing health equity, lowering costs, 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. 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.

The customer experience is one driver behind our operational excellence and engagement with our partners. Accordingly, CMS is working to amplify the voice of all we serve, using their experience to improve how we do business. CMS is aligned with the Federal vision of customer experience[1], where there is a focus on delivering excellent, equitable, and secure Federal Services and Customer Experience. We also acknowledge the unique context in which our mission sits within the nation's broader health ecosystem. Given this, we are emphasizing our ability to design more consistent, connected, and sustainable experiences. CMS is striving to embed a customer-centric approach across our organization so we can deliver more human-centered products, services, programs, and policies to the public, while continuously improving our employee experience and alleviating administrative burden. In FY 2025, we aim to scale our enterprise efforts to listen and engage the voice of the customers to drive improved public-facing service delivery including our High Impact Services; advance our voice of the employees for actionable insights (e.g., pulse-based feedback); formalize our customer experience organization through a sustainable staffing model; and scale best practices and relevant elements of the CMS customer experience model.

Our ability to listen, communicate, and engage with people across the country, from all walks of life, enables us to build trust locally, while delivering results a national scale. Through these interactions, we 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 healthcare 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.

[1] "The Federal Government must deliver a simple, seamless, and secure customer experience, on par with or more effective than leading consumer experiences" - President's Management Agenda, Priority 2 https://www.performance.gov/pma/cx/

Assuming present policy assumptions impacting CMS and if future annual appropriations flatline, CMS's budget deficit will continue to grow annually. In FY 2023, CMS's total administrative costs were $11.62 billion, or 0.67%, of the total obligations of $1.75 trillion. Over the past few fiscal years, CMS has experienced cost growth for ongoing workloads, primarily due to inflation, in addition to unfunded new workloads (Executive Orders, new legislation, and other priorities, etc.). CMS's requested budget is needed to maintain the operational integrity of CMS programs and to successfully achieve the agency's goals to advance health equity, lower costs, expand coverage, and improve health outcomes for all our beneficiaries and consumers.

Overview of FY 2025 President's Budget Request

CMS requests funding for its annually-appropriated discretionary accounts, including Program Management (PM) and discretionary Health Care Fraud and Abuse Control (HCFAC), as well as Grants to States for Medicaid and Payments to the Health Care Trust Funds. The table below displays CMS's funding for Fiscal Year (FY) 2023 Enacted level, the FY 2024 CR level, and FY 2025 President's Budget.

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 affordable access to care. The FY 2025 request reflects a level of funding that will not only allow CMS to maintain base operations, but also improve its traditional activities throughout its various programs to better serve the millions of Americans that rely on CMS. This investment will allow us to fund critical core operations, such as our basic oversight responsibilities supporting Medicare, Medicaid, CHIP; to provide enhanced customer service to beneficiaries, health care providers, and other key stakeholders; to protect our seniors; and to sustain our current workforce.

CMS Annually-Appropriated Accounts

(Dollars in Millions)

Account	FY 2023 Enacted	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Program Management[2]	**$4,124.744**	**$4,124.744**	**$4,329.000**	**$204.256**
Program Operations	*$2,914.823*	*$2,914.823*	*$2,979.051*	*$64.228*
Federal Administration	*$782.533*	*$782.533*	*$857.615*	*$75.082*
Survey & Certification	*$407.334*	*$407.334*	*$492.334*	*$85.000*
Research [3]	*$20.054*	*$20.054*		*($20.054)*
HCFAC	**$893.000**	**$893.000**	**$941.000**	**$48.000**
Discretionary Subtotal	**$5,017.740**	**$5,017.740**	**$5,270.000**	**$252.260**
Grants to States (Medicaid)	**$611,245.154**	**$622,280.940**	**$633,474.512**	**$22,229.358**
Payments to Health Care Trust Funds	**$557,729.683**	**$476,725.000**	**$521,757.000**	**($35,972.683)**
Total	**$1,173,992.577**	**$1,104,023.680**	**$1,160,501.512**	**(13,491.065)**

FY 2025 Summary of the Request

Program Management

CMS requests $4,329.0 million in Budget Authority appropriated funding for Program Management. 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 2025 Budget request, CMS can appropriately execute core Agency functions, maintain public-facing services, address congressional mandates, and accomplish the priorities of the Administration as described below.

- Program Operations:

  CMS's FY 2025 Budget request is $2,979.1 million, an increase of $64.2 million above the FY 2023 Final Level. This request incorporates the Research funding into Program Operations (see above table). This funding level will allow CMS to address statutorily mandated Medicare workloads, keep our systems running, and maintain expected customer service levels for our 1-800-MEDICARE call centers. In addition to supporting the administration of Medicare, the request level supports ongoing operations for Medicaid, CHIP, private insurance programs, cybersecurity, health equity, and efforts to address opioid use. CMS aims to design consistent, connected, secure, and sustainable care experiences across the country, that are delivered with dignity.

[2] The $455 million in additional Medicare programs funding provided by General Provision in Sec. 227 is included in the Program Management line and allocated across activities as later described.
[3] Research funding requested in Program Operations for FY 2025

The budget assumes that costs related to Medicaid and CHIP eligibility determination transactions for the Verify Current Income (VCI) service through the Federal Data Services Hub will be shifted to the states, rather than funded in Program Management. State-based Marketplaces will be charged for their usage of the Verify Current Income (VCI) service through the Federal Data Services Hub, as well. This proposal is described in detail in the HHS Notice of Benefit and Payment Parameters Proposed Rule for 2025.

CMS will spend all remaining mandatory funding supporting ACA Section 2701 (Adult Health Quality Measures) by the end of FY 2024, and the No Surprises Act (NSA) implementation funding will expire at the end of CY 2024. CMS proposes to continue supporting these important activities with mandatory funding. As described in the Proposed Law section, "Require Medicaid Adult and Home and Community-Based Services Quality Reporting" would continue ACA Section 2701 and "Replenish and Extend No Surprises Implementation Fund" would continue NSA and Title II Transparency- related activities that are ineligible to be funded from independent dispute resolution administrative fees. These legislative budget proposals would extend mandatory resources to continue operations for both programs.

- Federal Administration:

  CMS's request is $857.6 million, an increase of $75.1 million, above the FY 2023 Enacted level. This request will support 4,205 direct Full-Time Equivalents (FTEs), an increase of 46 FTE over FY 2023. To meet the needs of over 163 million Americans relying on CMS programs, our workforce is our greatest asset, which is why we are requesting restoring these resources to improve customer experience, advance health care quality, ensure adequate oversight of taxpayer dollars, and support providers, states, and other stakeholders.

- Survey and Certification:

  CMS's request is $492.3 million, an increase of $85.0 million, above the FY 2023 Enacted level. With the requested level of funding, CMS projects to be able to complete 85% of the mandatory survey levels and 10% of the non-statutory level. In addition, the requested funding provides for continued administration and oversight of the survey and certification activities at the federal level. The budget includes a proposal, effective in FY 2026, to create a new mandatory funding stream to ultimately achieve 100% survey and certification frequency for nursing homes. The budget also includes other mandatory proposals to strengthen nursing home and long-term care facility inspections and fulfill our mission to protect the most vulnerable.

Health Care Fraud and Abuse Control

In FY 2025, CMS requests $941.0 million in discretionary HCFAC funding, which would be allocated among CMS, Department of Justice (DOJ), and HHS Office of Inspector General (HHS-OIG). The request provides CMS and its federal partners resources to continue investing in activities that reduce fraud in Medicare, Medicaid, CHIP, and the Marketplaces. CMS funding supports ongoing operations for a wide range of program integrity activities such provider enrollment and screening, medical review, auditing, and investigations and data analytics work. In addition, the request focuses increased

discretionary resources on activities such as prior authorization, Marketplace improper payment measurement, and strengthening program integrity in Medicare Part C and Part D.

Grants to States for Medicaid

The FY 2025 Medicaid mandatory appropriations request is $633.5 billion, an increase of $11.2 billion relative to the FY 2024 request level of $622.3 billion. This appropriation is comprised of $249.9 billion in an authorized advance appropriation for FY 2024 and a remaining appropriation of $383.6 billion for FY 2025.

Resources will help fund $638.2 billion in anticipated FY 2025 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 $1.6 billion to fund the remaining anticipated obligations. These estimated obligations include:

- $604.1 billion in Medicaid medical assistance payments (MAP);
- $26.4 billion for Medicaid state and local administrative functions including funding for Medicaid state survey and certification and the state Medicaid fraud control units; and
- $7.7 billion for the Centers for Disease Control and Prevention's Vaccines for Children (VFC) program.

Payments to the Health Care Trust Funds

The FY 2025 request for Payments to the Health Care Trust Funds account totals $521,757.000 million, a decrease of $(35,972.683) million below the FY 2023 estimate level. This account transfers payments from the General Fund to the trust funds 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.

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 actively tracks its established performance measures and continues to introduce improvements that reflect the Administration's priorities and reinforces the FY 2022-2026 HHS Strategic Plan. Thus,

any of our currently proposed performance goals may be subject to change and may be 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 2025 Performance section format is designed to create a more complete presentation of performance commitments, accomplishments, and trends.

Conclusion

CMS's $4,329.0 million request for Program Management allows CMS to continue its traditional activities in the Medicare, Medicaid, CHIP, and Marketplace programs in a constrained budget environment without degradation of service. The $941.0 million in requested discretionary HCFAC funds 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 2023 Final	FY 2024 CR	FY 2025	
			President's Budget	+/- FY 2023 Final
Program Operations	$ 2,914.823	$ 2,914.823	$ 2,979.051	$ 64.228
Federal Administration	$ 782.533	$ 782.533	$ 857.615	$ 75.082
State Survey & Certification	$ 407.334	$ 407.334	$ 492.334	$ 85.000
Research /1	$ 20.054	$ 20.054	$ -	$ (20.054)
Subtotal, Appropriation/BA Current Law (Discretionary; 0511) /2	**$ 4,124.744**	**$ 4,124.744**	**$ 4,329.000**	**$ 204.256**
MIPPA (Mandatory; P.L. 110-275)	$ 2.829	$ 2.829	$ 2.829	$ -
PAMA (P.L. 113-93)	$ 4.715	$ 1.886	$ 1.886	$ (2.829)
IMPACT (P.L. 113-185)	$ 5.304	$ 5.304	$ 5.304	$ -
BBA (P.L. 115-123)	$ 4.715	$ 4.715	$ 4.715	$ -
Consolidated Appropriations Act, 2021 (P.L. 116-260)	$ 49.036	$ 16.031	$ 16.031	$ (33.005)
Bipartisan Safer Communities Act (P.L. 117-159)	$ 5.000	$ 4.715	$ 0.943	$ (4.057)
Inflation Reduction Act (P.L. 117-169)	$ 90.000	$ 44.321	$ 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	**$ 197.599**	**$ 79.801**	**$ 76.029**	**$ (121.570)**
Total, Appropriation/BA Current Law (0511)	**$ 4,322.343**	**$ 4,204.545**	**$ 4,405.029**	**$ 82.686**
Proposed Law Appropriation (Mandatory)	$ -	$ -	$ 335.000	$ 335.000
Total, Appropriation/BA Proposed Law (0511)	**$ 4,322.343**	**$ 4,204.545**	**$ 4,740.029**	**$ 417.686**
Est. Offsetting Collections from Non-Federal Sources: /3				
User Fees and Reimbursements	$ 396.968	$ 416.815	$ 469.129	$ 72.161
Marketplace User Fees (FFM)	$ 2,130.824	$ 2,041.317	$ 2,021.228	$ (109.596)
Risk Adjustment User Fees (RA)	$ 75.357	$ 70.318	$ 70.000	$ (5.357)
Recovery Audit Contracts (RACs) /4	$ 189.121	$ 207.245	$ 256.100	$ 66.979
Total, Offsetting Collections	**$ 2,792.270**	**$ 2,735.695**	**$ 2,816.457**	**$ 24.187**
Subtotal, New BA, Current Law (0511)	**$ 7,114.613**	**$ 6,940.240**	**$ 7,221.486**	**$ 106.873**
Proposed Law Discretionary	$ -	$ -	$ -	$ -
Program Level, Proposed Law (0511)	**$ 7,114.613**	**$ 6,940.240**	**$ 7,556.486**	**$ 441.873**
HCFAC Discretionary (8393)	**$ 893.000**	**$ 893.000**	**$ 941.000**	**$ 48.000**
Non-CMS Administration /5	**$ 3,339.000**	**$ 3,339.000**	**$ 4,155.000**	**$ 816.000**
NEF /6	**$ -**	**$ 20.000**	**$ 45.000**	**$ 45.000**
CMS FTEs:				
Discretionary (Federal Administration)	4,159	4,080	4,205	46
Reimbursable (CLIA, CoB, RAC, Marketplace)	559	634	634	75
Mandatory (Direct Appropriations)	219	275	266	47
Program Management, Proposed Law (non-add)	*0*	*0*	*9*	*9*
Subtotal, Current Law Program Management FTEs	**4,937**	**4,989**	**5,105**	**168**
HCFAC (Mandatory)	546	617	617	71
Medicaid Integrity (State Grants; Mandatory)	250	278	278	28
Affordable Care Act Section 3021 (Mandatory)	545	626	626	81
Quality Improvement Organizations	260	299	299	39
Demonstrations	9	9	9	0
No Surprises Act	58	70	0	(58)
Bipartisan Safer Communities Act	4	4	4	0
Other Sources, Proposed Law (non-add)	*0*	*0*	*70*	*70*
Subtotal, Current Law Other Sources FTEs	**1,672**	**1,903**	**1,833**	**161**
Total, Current Law CMS FTEs	**6,609**	**6,892**	**6,938**	**329**

/1 In FY 2025, CMS requests Research funding within Program Operations.

/2 FY 2023 and 2024 includes $455 million in additional Medicare Operations funding from the FY 2023 annual appropriation, Public Law 117-328, General Provision Section 227. CMS has 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.

/3 Displayed amounts reflect current law, net of sequester and pop-up authority as applicable.

/4 Beginning in FY 2023, RAC balances remained in the Trust Fund to accrue interest and will continue to do so until the unobligated balance in the non-interest bearing Program Management account is obligated down.

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

/6 FY 2023 Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on September 23, 2022. FY 2024 Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on October 19, 2023. FY 2025 level indicates the amount HHS intends to notify for CMS's investments in 2025. Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.

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Program Management

Appropriations Language

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare & Medicaid Services, not to exceed ~~$4,550,070,000~~ $4,329,000,000 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 ~~2024~~ 2025 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, ~~$565,860,000~~ $492,334,000, shall remain available until September 30, ~~2025~~ 2026, and shall be available for the Survey and Certification Program.

Program Management

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare & Medicaid Services, not to exceed ~~$4,550,070,000~~ $4,329,000,000 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 ~~2024~~ 2025 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, ~~$565,860,000~~ $492,334,000, shall remain available until September 30, ~~2025~~ 2026, 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 2023 Final	FY 2024 CR	FY 2025 President's Budget
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS) /1	$4,124,744	$4,124,744	$4,329,000
Trust Fund Mandatory Appropriation:			
PAMA/SGR (PL 113-93)	$4,715	$1,886	$1,886
IMPACT Act (PL 113-185)	$5,304	$5,304	$5,304
BBA (PL 115-123)	$4,715	$4,715	$4,715
Consolidated Appropriations (PL 116-260)	$49,036	$16,031	$16,031
Consolidated Appropriations Act, 2023 (PL 117-328)	$10,000	$0	$0
Subtotal, Trust Fund Mand. Appropriation /2	$73,770	$27,936	$27,936
General Fund Mandatory Appropriation:			
MIPPA (PL 110-275)	$2,829	$2,829	$2,829
Bipartisan Safer Communities Act (PL 117-159)	$5,000	$4,715	$943
Inflation Reduction Act (PL 117-169)	$90,000	$44,321	$44,321
Consolidated Appropriations Act, 2023 (PL 117-328)	$26,000	$0	$0
Subtotal, Other Mand. Appropriation /2	$123,829	$51,865	$48,093
Offsetting Collections from Non-Federal Sources:			
Sale of data user fees	$37,815	$35,000	$35,000
Independent dispute resolution (IDR) fees	$23,015	$20,000	$25,737
Intra-Agency Agreement (IAA) reimbursements	$53,104	$89,987	$131,313
Marketplace user fees (FFM)	$2,130,824	$2,041,317	$2,021,228
Risk Adjustment user fees (RA)	$75,357	$70,318	$70,000
Recovery audit contracts /3	$189,121	$207,245	$256,100
CLIA user fees	$66,734	$66,010	$66,010
Part D COB user fees	$51,060	$47,150	$47,150
MA/PDP user fees	$107,511	$112,397	$118,630
Provider enrollment user fees	$29,866	$24,346	$24,000
Civil Monetary Penalties	$27,863	$21,925	$21,289
Subtotal, offsetting collections /4	$2,792,270	$2,735,695	$2,816,457
Total Budget Authority /5	**$7,114,613**	**$6,940,240**	**$7,221,486**

/1 FY 2023 and 2024 includes $455 million in additional Medicare Operations funding from the FY 2023 annual appropriation, Public Law 117-328, General Provision Section 227. CMS has 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 Displayed amounts reflect current law, net of sequester and pop-up authority as applicable.
/3 Beginning in FY 2023, RAC balances remained in the Trust Fund to accrue interest and will continue to do so until the unobligated balance in the non-interest bearing Program Management account is obligated down.
/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)

	Dollars	FTE
FY 2023 Final		
Total estimated budget authority /1	$4,125	4,159
FY 2025 President's Budget		
Total estimated budget authority /1	$4,329	4,205
Net Change	**$204**	46

	FY 2023 Final		FY 2025 President's Budget		FY 2025 +/- FY 2023	
	BA	FTE	BA	FTE	BA	FTE
Increases:						
A. Program:						
1. Program Operations	$2,915		$2,979		$64	0
2. Federal Administration	$783	4,159	$858	4,205	$75	46
3. State Survey & Certification	$407		$492		$85	0
Subtotal, Program Increases /1	**$4,105**		**$4,329**		**$224**	**46**
Total Increases /1					**$224**	**46**
Decreases:						
A. Program:						
1. Research 2/	$20		$0		($20)	0
Subtotal, Program Decreases /1	**$20**		**$0**		**($20)**	**0**
Total Decreases /1					**($20)**	**0**
Net Change /1					**$204**	**46**

/1 Reflects enacted discretionary funds, only. Excludes budget authority and staffing from mandatory funds.
/2 Funding for Research is included within the FY 2025 total for Program Operations.

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

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
1. Program Operations	$2,479,823	$2,479,823	$2,979,051
Additional Medicare Operations Funding /1	$435,000	$435,000	$0
MIPPA (PL 110-275)	$3,000	$3,000	$3,000
PAMA/SGR (PL 113-93)	$5,000	$2,000	$2,000
BBA (PL 115-123)	$5,000	$5,000	$5,000
Consolidated Appropriations Act (PL 116-260)	$42,000	$7,000	$7,000
Bipartisan Safer Communities Act (PL 117-159)	$5,000	$5,000	$1,000
Inflation Reduction Act (PL 117-169)	$90,000	$47,000	$47,000
Consolidated Appropriations Act, 2023 (PL 117-328)	$36,000	$0	$0
Sequester	($3,135)	($3,933)	($3,705)
Subtotal, Program Operations	**$3,097,688**	**$2,979,890**	**$3,040,346**
(Obligations) /2	($3,126,648)	($2,702,758)	($2,757,591)
2. Federal Administration	$772,533	$772,533	$857,615
Additional Medicare Operations Funding /1	$10,000	$10,000	$0
Sequester	$0	$0	$0
Subtotal, Federal Administration	**$782,533**	**$782,533**	**$857,615**
(Obligations) /3	($768,823)	($782,533)	($857,615)
3. State Survey & Certification	$397,334	$397,334	$492,334
Additional Medicare Operations Funding /1	$10,000	$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	($891)	($891)	($891)
Subtotal, State Survey & Certification	**$422,068**	**$422,068**	**$507,068**
(Obligations)	($394,283)	($422,068)	($507,068)
4. Research, Demonstration & Evaluation	$20,054	$20,054	$0
Sequester	$0	$0	$0
Subtotal, Research, Demonstration & Evaluation	**$20,054**	**$20,054**	**$0**
(Obligations)	($19,967)	($20,054)	$0
5. Reimbursables	$2,825,115	$2,736,653	$2,824,066
Sequester	($143,757)	($135,912)	($135,427)
Sequester Pop-Up	$110,912	$134,953	$127,818
Subtotal, User Fees	**$2,792,270**	**$2,735,694**	**$2,816,457**
(Obligations) /2	($2,861,560)	($2,386,104)	($2,456,546)
Total, Budget Authority /4	**$7,114,613**	**$6,940,239**	**$7,221,486**
(Obligations)	**($7,171,281)**	**($6,313,517)**	**($6,578,821)**
FTE	**4,937**	**4,989**	**5,105**

/1 FY 2023 and 2024 includes $455 million in additional Medicare Operations funding from the FY 2023 annual appropriation, Public Law 117-328, General Provision Section 227. CMS has 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 2023 obligations include administrative cost reimbursements from external agencies.

/4 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 2024 Funding Level in the Authorization**	**FY 2025 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
	Independent Dispute Resolution	Consolidated Appropriations Act of 2021, P.L. 116-260, Division BB, Title I (No Surprises Act), Section 103 & 105.	42 U.S.C. 300gg-111-112	Consolidated Appropriations Act of 2021, P.L. 116-260	N/A	N/A	Permanent	Program Authority

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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
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

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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	$3,326,690,000	$4,124,744,000	$4,124,744,000
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	$3,326,690,000	$4,124,744,000	$4,152,680,375
2025				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Bipartisan Safer Communities Act (PL 117-159)	$0	$0	$0	$1,000,000
Inflation Reduction Act (PL 117-169)	$0	$0	$0	$47,000,000
Sequestration	$0	$0	$0	($2,907,000)
Subtotal				$48,093,000
Trust Fund Appropriation:				
Base **/5**	$4,329,000,000	$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	$4,329,000,000	$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 FY 2024 Appropriation is based on an annualized CR.
/5 Based on Current Law Request

CMS Program Management
Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2024

CMS Program Management has no appropriations not authorized by law.

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Program Operations [1]

(Dollars in Thousands)

FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
$2,914,823	$2,914,823	$2,979,051	$64,228

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 2024 Authorization – One Year/Multi-Year P.L. 118-22

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 and pregnant women 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. CMS remains highly efficient. In FY 2023, CMS's total administrative costs were $11.62 billion, or 0.67%, of the total obligations of $1.75 trillion.

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

[1] FY 2023 and 2024 includes $455 million in addition Medicare Operations funding from the FY 2023 annual appropriation, Public Law 117-328, General Provision Section 227. CMS has 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.

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, 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 aged 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 69 million beneficiaries in FY 2025. 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

Medicaid, authorized in 1965 under title XIX of the Social Security Act, and CHIP, authorized under title XXI of the Social Security Act, are means-tested health care entitlement programs financed jointly by states and the federal government. CMS anticipates that approximately 87 million individuals, or 1 in 4 Americans, will be enrolled in Medicaid and CHIP in FY 2025. Together, these programs provide health care coverage for some of America's most vulnerable populations, including low-children, pregnant women, aged, blind, and disabled individuals, and other eligible adults. Medicaid also provides home and community-based services and support to seniors and individuals with disabilities, as well as institutional long-term care services. Congress annually appropriates funding for the federal share of Medicaid services and state administration, and funding for capped CHIP state allotments are appropriated through FY 2029. Medicaid and CHIP funding in this chapter covers certain federal administrative expenses, such as Medicaid and CHIP systems support, managed care review and oversight, demonstration management, and other program-related initiatives.

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 determinations, 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). Working in concert with the Departments of Labor and the Treasury, along with the Office of Personnel Management (OPM), CMS is also responsible for protecting consumers from surprise medical bills and administering an independent dispute resolution process to resolve certain out-of-network payment disputes between providers and facilities and plans and issuers, as required by the No Surprises Act (NSA). Funding for the No Surprises Act is appropriated through a separate implementation fund that is available through the end of CY 2024.

Funding History

Fiscal Year	Amount
FY 2021 [2]	$2,772,890,000
FY 2022	$2,834,823,000
FY 2023 Final	$2,914,823,000
FY 2024 CR	$2,914,823,000
FY 2025 President's Budget	$2,979,051,000

Budget Request: $2,979.1 Million

CMS's FY 2025 Budget Request for Program Operations is $2,979.1 million, an increase of $64.2 million above the FY 2023 Final 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, competition, and inclusion in healthcare, and an increased investment for IT security. In addition, this budget includes funding for critical administration initiatives including, but not limited to, the opioid crisis and operational funding to support unfunded sections of the Inflation Reduction Act (IRA), such as an outreach and education campaign to encourage enrollment in Medicare's low-income programs.

The budget also assumes that costs related to Medicaid eligibility determination transactions for the Verify Current Income (VCI) service through the Federal Data Services Hub will be shifted to the states, rather than funded in Program Management. State-based Marketplaces will be charged for their usage of the Verify Current Income (VCI) service through the Federal Data Services Hub, as well.

Due to budget constraints resulting from mostly flat appropriations, inflationary cost pressure, and emerging priorities that lack a new funding stream to perform the work, the discretionary budget has been stretched thin in recent years. Since FY 2015 alone, this budget has absorbed work from exhausted/expiring mandatory sources including the Quality Payment Program (MACRA of 2015), SUPPORT Act of 2018, and the Consolidated Appropriations Act of 2021 and 2023, which has crowded out funding for important operational needs. Adding to this, CMS now expects to obligate all remaining mandatory funding supporting ACA Section 2701 (Adult Health Quality Measures) by the end of FY 2024, and No Surprises Act implementation funding will expire in CY 2024. As a result, mandatory funding is requested for several activities: "Require Medicaid Adult and Home and Community-Based Services Quality Reporting" to continue ACA Section 2701 (Adult Health Quality Measures) and "Replenish and Extend No Surprises Implementation Fund" to continue required surprise billing and price transparency-related activities ineligible to be funded by Independent Dispute Resolution user fees. In the absence of sufficient discretionary funds, the workloads associated with these functions are at risk without dedicated mandatory resources to continue operations.

[2] FY 2021 includes $11.933 million in HHS Secretary's Transfer Authority.

Assuming present policy assumptions impacting CMS and if future annual appropriations flatline, CMS's budget deficit will continue to grow annually. Over the past few fiscal years, CMS has experienced 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.

Described below are a few notable examples that illustrate the impact of how multiple years of flat budgets have not kept pace with rising costs and workloads (comparing end of FY 2023 to end of FY 2014):

- Program Operations funding has increased by 3% whereas there is a corresponding 23% loss of purchasing power over the same timeframe due to inflation.
- Handbook mailings grew by 16% due to increased Medicare enrollees. Single-piece First-Class Mail pricing, effective Jan. 26, 2014, was $0.49. The equivalent rate today is $0.68. This increase alone adds nearly $10 million in costs as compared to today's workload volume. The Handbook is one example of the many mailings CMS is statutorily required to perform.
- There has been a 107% increase in total Parts C and D workloads largely driven by new beneficiaries enrolling into MA/PDP plans.

Based on current law, CMS expects the following anticipated trends through FY 2025 (comparing FY 2025 President's Budget to end of FY 2023). These workload increases will create additional demand on the budget for several reasons as explained below:

- Medicare Part C enrollment growth continues to outpace FFS. As a result, CMS anticipates substantial increases in workloads, such as a 37% growth in Part C appeals, as discussed further in the Medicare Parts C and D Appeals section.
- CMS expects a 4% increase in FFS claims processing due to workloads returning to pre-pandemic levels.
- Assuming current law, paper/print M&Y Handbook mailing workloads will increase by 4% due to growth in FFS enrollment.

The budget includes several legislative proposals that seek to reduce costs beyond CMS's control, while maintaining service levels.

Program Operations
(Dollars in Thousands)

Activity	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
I. Medicare Parts A&B				
Ongoing Operations	$775,424	$831,971	$839,072	$63,648
FFS Operations Support	$43,393	$54,983	$51,569	$8,177
Claims Processing Investments	$80,593	$86,734	$87,915	$7,322
DME Competitive Bidding	$1,486	$1,689	$2,161	$675
QIC Appeals	$57,612	$59,098	$62,069	$4,457
II. Medicare Parts C&D				
Oversight and Management of Health Plans	$37,391	$40,451	$44,296	$6,905
Medicare Parts C and D Appeals	$32,109	$32,056	$38,883	$6,774
Medicare Parts C and D IT Systems Investments	$41,148	$36,087	$43,312	$2,164
III. Medicaid & CHIP				
MACBIS	$72,511	$70,605	$92,818	$20,307
MAC Scorecard	$4,837	$5,350	$6,475	$1,638
Section 1115 Demonstrations	$17,484	$15,571	$16,696	($787)
Medicaid Oversight and Support	$153,960	$113,698	$35,199	$(118,761)
IV. Private Health Insurance				
Market Oversight and Support	$9,226	$10,513	$8,985	($241)
Federal Marketplaces	$119,243	$121,052	$125,945	$6,702
V. Outreach & Education				
NMEP	$409,608	$357,048	$385,382	($24,226)
Targeted Outreach and Enrollment	$22,710	$23,928	$22,850	$140
VI. Improving Health Care Quality				
Health Care Quality Initiatives	$51,890	$56,164	$53,892	$2,002
Quality Surveys and Qualitative Reporting	$17,572	$15,620	$15,931	($1,641)
Quality Payment Program	$43,497	$44,055	$42,000	($1,497)
VII. Enterprise Operations				
Accounting and Audits	$95,292	$102,081	$101,819	$6,527
HIPAA Administrative Simplification	$31,283	$33,919	$34,303	$3,020
IT Systems and Support	$646,886	$656,757	$743,808	$96,922
Operational Support	$106,713	$111,901	$71,523	($35,190)
Opioid Support Services	$5,057	$5,423	$5,657	$600

Activity	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Research, Demonstration, and Evaluation (RDE) [3]	$0	$0	$20,054	$20,054
Inflation Reduction Act (IRA) Support	$23,475	$12,000	$11,535	($11,940)
Health Equity/Rural Health	$9,538	$11,786	$14,902	$5,364
Data Automation and Operations Modernization	$4,889	$4,283	$0	($4,889)
TOTAL [4]	**$2,914,823**	**$2,914,823**	**$2,979,051**	**$64,228**

I. MEDICARE - PARTS A AND B

Program Description and Accomplishments

CMS administers Medicare Parts A and B (otherwise known as FFS or Original Medicare). Over 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 2022 Actual	FY 2023 Actual	FY 2024 Estimate	FY 2025 Estimate
Part A (in thousands)	203,080	207,229	211,463	215,784
Part B (in thousands)	957,366	976,927	996,888	1,017,257
Total	**1,160,466**	**1,184,156**	**1,208,351**	**1,233,041**

[3] CMS is requesting for Research to be funded under the Program Operations account in FY 2025. Research was appropriated as its own PPA in FY 2023 and 2024 at $20.054 million, respectively.
[4] Totals may not add due to rounding.

Budget Request: $839.1 Million

The FY 2025 Budget Request for Ongoing Operations is $839.1 million, an increase of $63.6 million above the FY 2023 Final Level. The FY 2025 request will fund MAC contracts for 12-months, accounting for growth in MACs claims volume and labor expenses for a full year. With this funding, the MACs will continue processing Medicare claims accurately, in a timely manner, and in accordance with CMS's program requirements. CMS expects a four percent increase in MAC workloads over FY 2023 as workloads are expected to return to pre-pandemic levels. CMS expects MAC costs to continue growing annually, assuming present CMS policy, and projected inflationary cost growth for services.

In FY 2025, MACs are expected to:

- Process over 1.2 billion claims.
- Handle 2.5 million Medicare first-level appeal redeterminations; and
- Answer 12.3 million provider toll-free inquiries.

MAC ongoing operations include:

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 several 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 added 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 2025, the MACs are expected to process 2.5 million redeterminations.

Participating Physician/Supplier Program (PARDOC) – This program helps reduce health care burden 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 2025, contractors are expected to respond to 12.3 million telephone inquiries and 300,000 written inquiries (which include rare walk-in inquiries) from 2 million FFS providers. 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 2022 Actual	FY 2023 Actual	FY 2024 Estimate	FY 2025 Estimate
Completed Calls	12.1	12.3	12.3	12.3

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.

MAC Transition Cost – CMS must support the transition, termination, and implementation costs associated with transitioning from incumbent MACs to their successor MACs. In FY 2025, CMS has scheduled the contract re-procurements for A/B MAC Jurisdictions JA and JF.

Other Ongoing Operations not handled by MACs include:

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.

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 (FFS) 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 2025 Budget Request for FFS Operations Support is $51.6 million, an increase of $8.2 million above the FY 2023 Final Level. The increased funding will support expanded data analytics to enhance CMS's capacity to respond to the Consolidated Appropriations Act (CAA) of 2023 requirements after mandatory funds are exhausted, such as to develop the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) policy and payment methodologies, new reporting capabilities for thousands of new codes and hundreds of new manufacturers who have never been reported in the system before, and funding will also support these manufacturers with improved editing, search capabilities, resources, and to respond to interested parties.

FFS Operations Support 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 the 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 20 percent 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 percent 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. CMS's increased investment supports updated IPF PPS data collection requirements (CAA Section 4125), makes certain changes to the definition of Partial Hospitalization Services and directs CMS to establish coverage for Intensive Outpatient (IOP) services (CAA Section 4124).

Claims Processing Systems

CMS's claims processing systems process over 1.2 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 200 million Medicare Part A claims, including outpatient claims submitted under Part B.

- *Multi Carrier System (MCS)*: MCS is used to process nearly 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: $87.9 Million

The FY 2025 Budget Request for Claims Processing Systems is $87.9 million, an increase of $7.3 million above the FY 2023 Final Level. The increase supports sustainability modernization necessary to maintain ongoing operations and systems maintenance as well as necessary analysis and design modernization efforts to ensure the long-term sustainability of CMS's claims processing systems. CMS's systems must reflect annual Medicare updates and legislative mandates to ensure the proper payment of claims when Medicare payment policy changes.

Claims Processing Systems include the following:

- *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. 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.

There is a temporary gap period for the DMEPOS Competitive Bidding Program (CBP) starting January 1, 2024. CMS will start bidding for the next round of the DMEPOS CBP after it completes a formal public notice and comment rulemaking process and implements the necessary changes to the program.

Budget Request: $2.2 Million

The FY 2025 Budget Request for DME Competitive Bidding is $2.2 million, an increase of $0.7 million above the FY 2023 Final Level. This request funds operations and maintenance costs for the DMEPOS Bidding Systems (DBidS).

- *DMEPOS Bidding Systems (DBidS)*: The DMEPOS Bidding System, DBidS, is the system bidding suppliers submit their bid information to be considered for a DMEPOS CBP contract.

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 can 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: $62.1 Million

The FY 2025 Budget Request for QIC Appeals (BIPA section 521) is $62.1 million, an increase of $4.5 million above the FY 2023 Final 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.

- *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 2025 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 2022 Actual	FY 2023 Actual	FY 2024 Estimate	FY 2025 Estimate
Non-RAC QIC Appeals	177,909	199,978	196,277	197,367
% Increase from Previous Year	-0.03%	8.90%	-0.98%	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 are entitled to from our programs.

Budget Request: $44.3 Million

The FY 2025 President's Budget Request for Oversight and Management of Health Plans is $44.3 million, an increase of $6.9 million above the FY 2023 Final Level. CMS requests additional funds to assist the actuaries in reviewing prescription drug and Medicare Advantage bids submitted by plans and Part C/D policy and program support as required by law in the Social Security Act §1854. Funding supports annual notices to over 1.5 million beneficiaries whose drug coverage may change due to a new plan assignment because of plan termination or premium increases. CMS expects an approximate six percent increase in the volume of bid reviews, development policy regulation level of effort, fee increases, and inflationary cost increases.

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, and Rule Support*: 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 for low-income subsidy (LIS). Approximately 95,000 subsidy-eligible beneficiaries will be informed of their plan assignment and annual notices sent to as many as 1.5 million LIS eligible beneficiaries whose copay level will change in the next calendar year. Two million LIS-eligible beneficiaries reassigned to a new plan by CMS due to plan termination or premium increase, and as many as 2.5 million beneficiaries will receive the annual fall 'Chooser' notice.

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: $38.9 Million

The FY 2025 Budget Request for Medicare Parts C and D Appeals is $38.9 million, an increase of $6.8 million above the FY 2023 Final Level. CMS requests funding to support a thirty-seven percent increase in appeals volume for Part C as illustrated in the below table as compared to FY 2023. Per beneficiary enrollment projections, it's expected that new beneficiaries choosing Parts C and D plans over Original Medicare will continue to grow rapidly, which is directly correlated with Parts C and D claims growth. As Parts C and D claims increase, second level appeals are also expected to increase. Funding also 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.

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

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

	FY 2022 Actual	FY 2023 Actual	FY 2024 Estimate	FY 2025 Estimate
Part C Appeals	160,428	195,750	239,000	268,000
Part D Benefit Appeals	38,047	38,579	41,000	45,000
Part D LEP Appeals	46,629	48,000	50,000	52,000

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 Part D Manufacturer Discount Program (MDP).

- *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 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: $43.3 Million

The FY 2025 Budget Request for Parts C and D IT Systems Investments is $43.3 million, an increase of $2.2 million above the FY 2023 Final Level. This level of funding represents the cost to maintain ongoing operations and maintenance.

- *MA/Part D Help desk*: This funding supports enrollment-related beneficiary requests applications. CMS supports, facilitates, and coordinates customer interaction with various help desks operating in parallel to ensure seamless technical support for CMS's business partners. Funding provides help desk and business operations support to CMS for its programs including but not limited to operations, reporting, and information for payment and service delivery.

- *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 Manufacturer 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). CMS operations includes but are not limited to collecting and analyzing data to accelerate quality improvement, reporting CHIP enrollment and goals, development of appropriate education and outreach materials and learning collaboratives and supports website development and management. These efforts help to improve the quality of life for our beneficiaries and Federal/State partnership strategies to sustain and improve performance.

<u>Medicaid and CHIP Business Information Solution (MACBIS)</u>

The Medicaid and CHIP Business Information Solution 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 improve operations for the Medicaid and CHIP programs, which provide care to millions of individuals across 56 states and territories. These improvements drive innovation and value, reduce reporting burden, and improve customer service. 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 health 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: $92.8 Million

The FY 2025 Budget Request for MACBIS is $92.8 million, an increase of $20.3 million above the FY 2023 Final Level. The funding increase supports the Medicaid Drug programs, MACBIS data operational work, and MACPRO - a suite of products supporting the partnership with states in the Medicaid & CHIP programs ensuring that state plans, waivers, and reporting align with CMS policies and federal regulations. The requested increase supports investing in new contractor services that will maintain and ensure scalability for operating the Medicaid Drug programs that includes managing the over $39 billion Medicaid Drug Rebate program and ensuring Medicaid drug expenses comply with federal regulations and statutes. Funding also invests in maturing MACBIS data operations to support a growing user community by integrating new data sources for enhanced analytic capabilities and developing self-service and public facing data tools for users to explore Medicaid and CHIP data. Through MACBIS data efforts, CMS will enhance its ability to conduct Medicaid and CHIP program monitoring and oversight, provide technical assistance to states, inform policy and program development, and support research and evaluation and public reporting. This request also supports advancements in automating burdensome manual processes for State Plan amendments, Waivers, Managed Care Contract and Rate submissions, as well as implement state data collection enhancements because of regulatory changes released.

Medicaid and CHIP Scorecard

The Medicaid and CHIP Scorecard increases public transparency and accountability for these programs' administration and outcomes. This CMS dashboard draws from over 30 datasets derived from state and federal reporting efforts, and the Scorecard measures represent key data points that reflect CMS's priorities across different facets of Medicaid and CHIP. The 2023 Scorecard release features an updated measure set and fully redesigned website that includes new ways to help the public find and use key Medicaid and CHIP metrics.

Highlights of the 2023 Scorecard redesign:

- Full redesign that allows searches for measures by name, keywords, or category.
- Display of information by both overview and disaggregated data for each measure.
- Capacity to download measure information into files and export to images.
- Interactive display of measure data, including sortable bar graphs, line graphs, tables, or maps; and
- Longitudinal displays of data for certain measures to show change over time.

The Medicaid and CHIP Scorecard is also supported by work in the Adult Medicaid Quality Measurement Program, authorized under Section 1139B of the Social Security Act. The remaining mandatory funding for the Adult Medicaid Quality Measurement Program will be fully expended in FY 2024 and CMS will need alternative funding to support these ongoing, statutorily required activities. The Budget includes a legislative proposal to provide mandatory funding for this work beginning in FY 2025: "Require Medicaid Adult and Home and Community-Based Services Quality Reporting."

Budget Request: $6.5 Million

The FY 2025 Budget Request for the Medicaid and CHIP Scorecard is $6.5 million, an increase of $1.6 million above the FY 2023 Final Level. Activities include costs to:

- maintain operations and improve functionality and usability of the Scorecard online platform, including user experience and usability testing.
- collaborate with interested states to support performance and explore new areas of application for the Scorecard.
- support annual production of the Scorecard, which includes contributing to stakeholder engagement processes that assist with selecting measures, conducting analysis, designing the national context and measure overviews on the Scorecard, and overall Scorecard content development.

Section 1115 Demonstrations

Section 1115 of the Social Security Act provides broad authority to CMS and states under Medicaid and CHIP to design, implement, and test demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. These demonstrations aim to demonstrate and evaluate state-specific policy approaches to better serve Medicaid populations, including expanding coverage, integrating behavioral and physical heath, addressing health related social needs, and improving the quality-of-service delivery to improve health outcomes and close health disparity gaps, all while increasing the value of federal government and state investments in these programs. Over 90 percent of states have at least one Section 1115 demonstration and many run a substantial portion (in some states nearly all) of their Medicaid program through this authority, representing a third of all federal outlays in the Medicaid program. This activity provides policy and operational technical assistance to CMS for states' Section 1115 demonstration implementation, data reporting, and oversight and evaluation.

Budget Request: $16.7 Million

The FY 2025 Budget Request for Section 1115 Demonstrations is $16.7 million, a decrease of $0.8 million below the FY 2023 Final Level. This request will allow CMS to continue robust state and federal monitoring and evaluation of these demonstrations. These activities provide technical assistance in the design of performance measurement, data development, and evaluation methodology 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. Together, these efforts help build an understanding of what policies and implementation approaches 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.

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, and the Basic Health Program.

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: $35.2 Million

The FY 2025 President's Budget Request for Medicaid Oversight and Support is $35.2 million, a decrease of $118.8 million below the FY 2023 Final Level. The large decrease is due to the proposed shift in costs to the states for the Verify Current Income services related to Medicaid eligibility determinations transactions made via the Federal Data Services Hub. This request includes $0.650 million to drive customer experience improvements for Medicaid.gov and continue to fund a HISP metrics contract. The funding supports implementation of the 21st Century IDEA Act implementation and the Federal Digital Strategy by ensuring customer research helps modernize websites, digitize services, and improve customer experience. These efforts will focus on the Medicaid.gov consumer journey to improve the website and our communications including comprehensive journey mapping and user persona analysis. Improvements will be designed to increase accessibility, reduce consumer burden, increase access to eligibility and enrollment systems, and further instill trust in the Medicaid health care system.

Other activities funded in this section are included below:

- *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. (1) 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 can live in the community and have equal access to community support. All states were required to be compliant with the 2014 regulations in March 2023 and monitoring activities will continue for several years post implementation. (2) In addition, CMS provides technical assistance to increase states' compliance with the federal Preadmission Screening & Resident Review 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. (3) This work also supports maintenance and continued endorsement of HCBS and managed Long-Term Services and Supports quality measures. This helps to strengthen HCBS quality measurement and reporting activities by CMS, states, managed care organizations, and providers and to facilitate comparisons across states, plans, and providers. (4) This project also allows CMS to track and retain the information reported by states in their spending plans and narratives for American Rescue Plan Act of 2021 section 9817, increased federal

medical assistance percentage for HCBS. This is critical to meet commitments made to various stakeholders to provide transparency in the implementation of this legislation.

- *Sources of Income for Medicaid Eligibility*: States use the Federal Data Services Hub, a contractor managed IT system, to make Medicaid and CHIP eligibility determinations. In FY 2025, the contractor will: 1) provide an estimated 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 35 state Medicaid and CHIP programs to help determine applicants' eligibility. CMS projects the volume of state Medicaid and CHIP agency transaction requests will decrease, in large part, due to the end of the COVID-19 public health emergency and the unwinding of the Medicaid continuous enrollment condition. As stated above, CMS is not requesting Medicaid discretionary funding for the costs of using this system, anticipating a regulatory shift of cost responsibility to user states. This section is included for informational purposes only.

- *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 managed care programs covering roughly 77 million individuals. CMS implemented this activity to increase its monitoring, oversight, and technical assistance to address program vulnerabilities created by the growth of managed care, as well as HHS OIG and GAO concerns. Under this activity, CMS performs several critical functions including directed technical assistance to states; development and implementation of monitoring, oversight, and reporting tools for states including a data strategy and related data analyses; and the development of assistance toolkits.

- *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. The states may use the NADAC files to meet the new Actual Acquisition Cost reimbursement requirements in the Covered Outpatient Drug final rule (CMS 2345-FC), and 45 states are currently using the NADAC as their approved State Plan reimbursement methodology. 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 implementing insurance market reforms and works closely with state regulators, consumers, and other stakeholders to ensure that the law best serves the American people. In conjunction with the Departments of Labor and the Treasury, as well as the Office of Personnel Management (OPM), CMS enforces the No Surprises Act, which has already prevented as many as 1 million surprise bills every month. This work is currently supported by the No Surprises Implementation Fund, which expires at the end of CY 2024, in addition to IDR administrative fees. Mandatory funding is requested through the "Replenish and Extend No Surprises Implementation Fund" legislative proposal to continue and enhance enforcement of provisions of the No Surprises Act and Title II Transparency Provisions that are ineligible to be funded by IDR administrative fees. Without additional funding, CMS may need to phase-down or phase-out these activities.

The following details other activities that CMS is charged with administering.

Market Oversight and Support

CMS works with states to ensure compliance with market reforms, including 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 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 based on price and quality.

Budget Request: $9.0 Million

The FY 2025 President's Budget Request for Market Oversight and Support is $9.0 million, a decrease of $0.2 million below the FY 2023 Final Level. The FY 2025 request fully funds ongoing operations for the following activities:

- *Consumer Support and Information*: CMS holds health insurance companies accountable for compliance with market reforms, increases industry transparency, and supports competition based on price and quality. 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.

- *Insurance Market Reforms*: CMS enforces 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 issuers 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 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*: The 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 to increase transparency.

Federal Marketplaces

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

Budget Request: $125.9 Million

The FY 2025 President's Budget Request for the Marketplaces is $125.9 million, an increase of $6.7 million above the FY 2023 Final 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 163 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, the Affordable Care Act, and the Inflation Reduction 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 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, the Social Security Administration (SSA), 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: $385.4 Million

The FY 2025 Budget Request for NMEP is $385.4 million, a decrease of $24.2 million below the FY 2023 Final Level. In FY 2025, CMS requests funding to support website updates, content management, alterations to beneficiary service tools, and operational support for enrollment outreach efforts.

The Medicare & You Handbook costs rose exponentially due to inflation and supply chain constraints in FY 2021 and FY 2022. Raw material costs to produce the handbook decreased following the end of the pandemic which account for variance in handbook funding requests in recent fiscal years. CMS projects to spend $140.1 million in FY 2025 to mail beneficiaries' handbooks as required by statute[5]. Additional funding is needed to maintain approximately a 3-5-minute Average Speed to Answer (ASA) for the 1-800-MEDICARE call center.

[5] 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 2023 Final	FY 2024 CR	FY 2025 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	$73.63	$73.90	$75.30
	Postage	$49.60	$44.94	$64.80
	Total	**$123.23**	**$118.84**	**$140.10**
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. (FY 2025 average cost per month is ~$25 million)	PM	$227.74	$155.37	$180.28
	User Fees	$100.00	$100.00	$119.00
	Total	**$327.74**	**$255.37**	**$299.28**
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	$53.38	$60.25	$61.25
	Total	**$53.38**	**$60.25**	**$61.25**
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	$7.84	$16.13	$14.97
	Total	**$7.84**	**$16.13**	**$14.97**
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	$47.02	$51.40	$53.58
	Total	**$47.02**	**$51.40**	**$53.58**
Funding Source Breakout Total	**PM**	**$409.61**	**$357.05**	**$385.38**
	User Fees [6]	**$100.00**	**$100.00**	**$119.00**
	Postage	**$49.60**	**$44.94**	**$64.80**
	Total	**$559.21**	**$501.98**	**$569.18**

[6] The FY 2024 NMEP user fee amount reflects planned obligations and FY 2025 reflects estimated collections.

- *Beneficiary Materials*: The total FY 2025 request for the handbook is $140.1 million, of which $75.3 million is discretionary budget authority to mail 52 million handbooks. 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 2025.

  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 September. Beneficiaries currently have the option to opt out of receiving a hard copy of the handbook by signing up at Medicare.gov/go-digital/ for an electronic copy that gets emailed to them each fall. Approximately 6 percent of beneficiaries are estimated to opt-out in FY 2025. 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 2022 through FY 2023 and estimated distribution for FY 2024 through FY 2025. The yearly distribution includes the number of handbooks mailed to beneficiary households in September, 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 2022 Actual	FY 2023 Actual	FY 2024 Estimate	FY 2025 Estimate
Number of Handbooks Distributed	49.5	50.4	51.4	52.4

- *1-800-MEDICARE*: The total FY 2025 request is $299.3 million, of which $180.3 million is discretionary budget authority. The request reflects the contract's operational need supporting the estimated 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 2022 and FY 2023 the number of calls CMS expects to receive in FY 2024 through FY 2025. 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 2025 request level, CMS anticipates an average speed to answer of approximately 3-5 minutes.

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

	FY 2022 Actual	FY 2023 Actual	FY 2024 Estimate	FY 2025 Estimate
Number of Calls	24.0	23.0	23.3	23.5

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*: $61.3 million. The Internet budget funds operations and maintenance for three websites. Additional funding will support the successful implementation of several enhancements to improve customer service that align with Executive Order 14058, Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government. CMS also requests funding to perform updates for the Medicare Plan Finder tool due to Part D Benefit changes made in the IRA.

  The http://www.cms.gov website is CMS's public website for communicating with public stakeholders including providers, professionals, researchers, and the press daily. 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 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 2022 Actual	FY 2023 Actual	FY 2024 Estimate	FY 2025 Estimate
Number of Page Views for http://www.Medicare.gov	613.8	650.0	675.0	700.0

- *Community-Based Outreach*: $15.0 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 2025 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 increase supports the Medicare direct response program (email, message center, SMS/text) during annual enrollment periods, special enrollment periods, and other ad hoc/off-season/year-round outreach efforts as well as additional support for LIS Direct Marketing because of the IRA's expansion of the program (includes data purchases and mail production and postage costs).

- *Program Support Services*: $53.6 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. A portion of the FY 2025 increase will be used to expand campaign outreach to those that have traditionally lower access to care, particularly those that are in the Asian Americans Native Hawaiians and Pacific Islanders (AANHPI) community. This would also increase investment in outreach to the African American and Latino audiences.

In addition to the Program Management budget authority request, the NMEP budget request assumes $119.0 million in user fees and $64.8 million in postage funding, bringing the total FY

2025 President's Budget Request for NMEP to $569.2 million, an increase of $10.0 million above the total FY 2023 Final 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: $22.9 Million

The FY 2025 Budget Request for Targeted Outreach and Enrollment is $22.9 million, an increase of $0.1 million above the FY 2023 Final Level. The request maintains ongoing operations for the work described below. Production and mailing of initial and replacement paper Medicare Beneficiary Identifier (MBI) cards is increasing slightly due to fraud-related reissues.

- *Beneficiary Enrollment and Validation*: Funding will support for the production and mailing of the Initial Enrollment Period (IEP) packages, which include the initial Medicare card and a second mailing to all IEP beneficiaries who received the initial IEP package. This funding request also supports mailing MBI cards and other enrollment verification costs such as the Minimum Essential Coverage (MEC) notices. Fraudulent activities in recent years have led to an increase in CMS and beneficiary-initiated change MBI requests, requiring CMS to reissue cards and other notices, which has impacted the program budget.

- *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 to help beneficiaries understand their health coverage and to connect to the right primary care and preventative services deemed most appropriate. In addition, funding 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 to remove barriers that cause disparities in health care. 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 2025 Budget Request for Health Care Quality Initiatives is $53.9 million, an increase of $2.0 million above the FY 2023 Final Level. The funding supports the expansion of the Medicare Shared Savings Program (MSSP) operations and technical assistance and compliance monitoring for new Advance Investment Payments and enhancements in the CAHPS for MIPs contract. The CAHPS Clinician and Group Survey replaces the Physician Quality Reporting System (PQRS) Survey and funding for testing and implementation of new survey completion modalities is required.

Additional details for this request are included below:

- *Medicare Shared Savings Program (MSSP)*: In FY 2025, over 456 Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) will serve over 10.9 million Medicare Fee-for-Service beneficiaries. The funding request supports operations for multiple contracts that conduct beneficiary assignment, claims data analysis for purposes of calculating financial benchmarks and annual financial reconciliation including shared savings payments and shared losses owed, generating and disseminating quarterly and annual financial, expenditure, utilization, demographic and quality data/reports, and technical assistance (e.g., user guides, templates) to implement the Shared Savings Program, established by Section 3022 of the Affordable Care Act. A new Clinical Quality Measure (CQM) collection type for ACOs will be established to align the MSSP and the merit-based Incentive Payment System (MIPS) to promote interoperability requirements beginning January 1st, 2025. In FY 2025, CMS requests additional funding for the implementation of new policies finalized in the 2023 PFS final rule including Advance Investment Payments to grow accountable care in underserved and rural areas, to provide technical assistance to ACOs, and to implement benchmark improvements to strengthen incentives for new ACOs to join the program and existing ACOs to continue participation in the program. These policies are projected to increase by up to 4 million the number of Medicare FFS beneficiaries getting care from provider in an accountable care relationship over the next several years.

  The Shared Savings Program is estimated the save the Medicare Trust Fund $14.8 billion over 12 years. (Reg cite 87 FR 70193) https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

- *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 claim 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 FY 2025 request supports ongoing operations and includes a nominal increase due to inflation.

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 2025 President's Budget Request for Quality Surveys is $15.9 million, a decrease of $1.6 million below the FY 2023 Final Level. The FY 2025 request continues ongoing operations and maintenance. The activities in this section are necessary to collect and report the patient experience of care data from MA and PDP contracts as part of the Part C and D Star Ratings as required by regulation and statute for MA Quality Bonus Payments. Other FFS data collection efforts are also funded in this section as required in statute. 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 while others are necessary to provide Part C and D Star ratings which impact MA payment rates. 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 2025 Budget Request for the Quality Payment Program (QPP) is $42.0 million, a decrease of $1.5 million below the FY 2023 Final 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 these programs are managed by in-house staff and systems supporting the Agency. Enterprise Operations activities support CMS's staff in all our efforts and initiatives as well as managing and directing the health care industry.

Accounting and Audits

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

Budget Request: $101.8 Million

The FY 2025 Budget Request for Accounting and Audits is $101.8 million, an increase of $6.5 million above the FY 2023 Final Level. FY 2023 funding need was lower than usual as a result of HIGLAS being re-competed in FY 2023. The FY 2025 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 and accounts for approximately $2.1 trillion in outlays annually thus making it the largest Oracle Federal Financials System. HIGLAS continues to enhance CMS's oversight of financial operations, 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 recover identified Medicare overpayments efficiently. 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. Since program inception through January 5, 2024, CMS has recouped $1.69 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: $34.3 Million

The FY 2025 Budget Request for HIPAA Administrative Simplification is $34.3 million, an increase of $3.0 million above the FY 2023 Final Level. The increased funding request supports the contract re-compete and transitioning to a new NPPES contractor developer which supports the NPPES application, Identity and Authorization (I&A), and Help Desk (Enumerator). The remaining request supports ongoing operations and maintenance. Funding is requested for the following activities:

- *HIPAA Eligibility Transaction System (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 6 million individual NPIs have been assigned and over 1.5 million organization NPIs have been assigned in NPPES. In FY 2023, CMS completed the NPPES migration to the cloud.

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: $743.8 Million

The FY 2025 Budget Request for Information Technology Systems and Support activities is $743.8 million, an increase of $96.9 million above the FY 2023 Final Level. This request is necessary to continue ongoing IT operations in a safe and secure environment, 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, proactive disaster recovery efforts, and ensuring the safety of CMS's IT ecosystem. CMS continues to find efficiencies in cloud migration and looks to continue to maximize the cost savings of these investments without compromising its cybersecurity.

The following are priorities within the IT systems and support category:[7]

- *IT Security*: CMS faces daily cybersecurity threats and as the cyber landscape intensifies, CMS must enhance its IT Security efforts to combat potential hazards. This request will enable CMS to maintain its current cybersecurity posture while also providing the necessary funding to make strides towards complying with Executive Order 14028, and Memorandums 21-31 and 23-18. This funding level will also support work on batCAVE (Continuous Authorization and Verification Engine), the security data lake, and Governance Risk Management and Compliance (GRC) tooling along with other mission critical functions.

- *Continuity of Operations Disaster Recovery (COOP/DR):* CMS continues to construct the agency-wide COOP/DR effort following OIG audit findings in 2019 that determined the programs and systems that support CMS mission-essential functions require increased capabilities to meet federal requirements. This funding will allow CMS to complete the build out and optimization of its hosting and COOP/DR services and integrate with the public cloud services. This request will also support the optimization, modernization and maintenance of various processes, applications, and architectures that are required to support the COOP/DR effort.

- *Medicare Payment Systems Modernization (MPSM):* This effort 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. This request will allow MPSM to support claims payment processing, enable data that is timely and accurate, and refine current claims processing systems. In addition, the MPSM effort will be able to continue its ongoing operations such as building infrastructure in both the Cloud and Mainframe environments and further developing a modern claims processing platform for the dental initiative along with other crucial work.

[7] For more information on these priorities, please refer to the Information Technology chapter.

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 several complex operational issues, merging often conflicting systems, policies, financing, monitoring and oversight protocols, and data requirements across Medicare and Medicaid, and at times private insurance.

Budget Request: $71.5 Million

The FY 2025 Budget Request for Operational Support is $71.5 million, a decrease of $35.2 million below the FY 2023 Final Level. The decrease assumes several CMS initiatives will be discontinued due to funding constraints. There will not be enhancements made to current contract support/portfolio management functionality within CMS's contracting system in awarding and managing contracts. Other critical support contracts will be held to the FY 2023 level of effort or even reduced further.

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 CALM acquisition system. 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 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.

- *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: $5.7 Million

CMS's FY 2025 Budget Request for Opioid and SUD Support is $5.7 million, an increase of $0.6 million above the FY 2023 Final Level. In FY 2025, 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 that went into effect January 1, 2021. Funding also supports outreach and education, monitoring prescriber compliance, analyzing root causes for non-compliance, developing appropriate non-compliance actions, and supporting analyses for policy and rulemaking development.

Research, Demonstration, and Evaluation (RDE)

The program supports CMS's key role as a beneficiary-centered purchaser of high-quality health care at reasonable costs. The work has evolved to include most of the CMS's data collection and data storage efforts, which is used in the development, implementation, and evaluation of a variety of research and data activities. This data is used to conduct research

about the communities CMS serves to improve the efficiency of payment, delivery, access, and quality of our health care programs.

Budget Request: $20.1 Million

The FY 2025 Budget Request for RDE is $20.1 million, an increase of $20.1 million above the FY 2023 Final Level in Program Operations, but zero increase over RDE funding in the Research PPA. CMS largely relies other funding sources, such as ACA Section 3021 (Innovation Center) funding to support RDE activities, where appropriate, so very little funding remains in the Research PPA. For that reason, CMS is requesting to shift the remaining RDE activities from the Research PPA into the Program Operations budget to reduce complexity and provide the same funding flexibility for these activities as for other Program Operations activities and programs. The budget includes necessary funding amounts to continue operations and maintenance of the Medicare Current Beneficiary Survey and to fulfill physical data requests supporting internal and external Virtual Research Data Center users via the Chronic Condition Warehouse database. At this funding level, CMS will continue to maintain the Minority Research Grant Program with the intention of achieving health equity through conscientious research at minority serving institutions. The MRGP is imperative to provide technical assistance to support U.S. States, U.S. Territories, and Tribal Nations in building local capacity and infrastructure to advance health equity and remove barriers to CMS-supported services, benefits, and coverage among those they serve.

- *Medicare Current Beneficiary Survey (MCBS)*: The Medicare Current Beneficiary Survey (MCBS) is the most comprehensive and complete survey available on the Medicare population and is essential in capturing data not otherwise collected through CMS operations. The survey's design aids CMS's administration in monitoring and evaluating the Medicare program. The survey captures beneficiary information including those who are aged or disabled, live in a community or facility, and are serviced by managed care or fee-for-service. Data produced as part of the MCBS is enhanced with CMS administrative data 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):* Section 723 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) requires CMS to improve quality of care and reduce the cost of care for chronically ill Medicare beneficiaries, including through the collection of data into a data warehouse. The CCW contains Medicare and Medicaid enrollment and claims data, assessment data, encounter data, Part D drug event data, and a unique identifier for each beneficiary or Medicaid recipient. Researchers accessing the data in the CCW identify ways to improve the quality and effectiveness of care for chronically ill Medicare beneficiaries. These research projects evaluate possible changes or alternatives to the current Medicare and Medicaid programs that can lead to improvements in patient outcomes. The funding request supports maintenance of data sources, research and public use files, ad hoc requests, loading future data sources, and the creation of new research files.

- *Other Research*: Other innovative research projects include program evaluations, prospective payment systems evaluation, refinement and monitoring, and health service research capacity building and improvement. This funding supports these efforts and includes activities such as 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.

Inflation Reduction Act (IRA) Support

On August 16, 2022, the Inflation Reduction Act (P.L. 117-169) was signed into law and 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 future. The new law makes improvements to Medicare that expand benefits, lower drug costs, and improve the strength of the Medicare program.

Budget Request: $11.5 Million

The FY 2025 Budget Request for IRA Support is $11.5 million, a decrease of $11.9 million below the FY 2023 Final Level. The request supports the implementation of the law to deliver lower drug costs for the Medicare population and reduced healthcare costs for millions of other Americans. The budget supports statutorily required provisions of the law that did not receive direct appropriations. Funding will be used for an outreach and education campaign to encourage enrollment in Medicare's low-income programs, including the expansion of low-income subsidy (LIS) eligibility because of changes included in the IRA.

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 (OMH). 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 its programs and policies.

CMS 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: $14.9 Million

The FY 2025 Budget Request for Health Equity and Rural Health is $14.9 million, an increase of $5.4 million above the FY 2023 Final Level. CMS requests an increase in funding for the Health Equity Data Analytic Strategy (HEDAS) activity, which focuses on building a strong analytic

environment that integrates data related to underserved populations to query data across all of CMS programs. This will allow CMS to identify opportunities to conduct predictive and descriptive modeling to identify disparities and trends over time.

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 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 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.

  This funding will also support the maintenance and operations of the Mapping Medicare Disparities (MMD Tool), an external interactive map that provides user friendly way to explore and better understand disparities in chronic diseases, and allows users to: 1) visualize health outcome measures at a national, state, or county level; 2) explore health outcome measures by age, race and ethnicity, sex; 3) compare differences between two geographic locations (e.g., benchmark against the national average); and 4) compare differences between two racial and ethnic groups within the same geographic area. The MMD Tool has been a popular and helpful tool to all types of public users, such as researchers, policy makers, enrollees, academic institutions, providers, states, and many more, to use to identify areas of disparities. The MMD Tool provides a means to operate EO 13985 to assess equity from the national level down to the county level, and when appropriate, down to the census track level.

- *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.

- *Data and Policy to Reduce Disparities in Health and Health Care:* This funding will support CMS OMH activities to develop papers, resources, policy solutions, and action plans with emphasis on evidence-based and confirmatory analyses to identify and eliminate disparities, measure quality and health equity, and improve policies and programs targeting CMS's focus populations across all CMS programs, such as Medicaid, CHIP, and the Marketplaces. Examples of product development are policy analyses, issue briefs, public-facing educational resources, data highlights, reports, manuscript, guides, equity score, and equity measure focusing on improving the quality of care and increasing access for underserved populations, increase partnering and supporting the health care workforce, eliminating health disparities and working with partner organizations to develop appropriate interventions to achieve health equity, evaluating the effects of health care delivery system and payment model reform, enhancing language access, exploring disparity-sensitive conditions, diseases, and measures, exploring social determinants of health associated with quality of care, and strengthening population health.

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Federal Administration

(Dollars in Thousands)

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority [1]	$782,533	$782,533	$857,615	$75,082
Indirect Costs	$203,403	$230,313	$222,353	$18,950
Program Level	**$985,936**	**$1,012,846**	**$1,079,968**	**$94,032**
FTE	**4,159**	**4,080**	**4,205**	**46**

Authorizing Legislation – Reorganization Act of 1953

Authorization Status – Permanent

FY 2024 Authorization – Public Law 118-35, Further Continuing Appropriations and Other Extensions Act, 2024

Allocation Method – Direct Federal/Intramural, 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 is also pursuing activities to advance our customer engagements and improve our use of digital technologies and methodologies. This request includes funding to support our Customer Service Center of Excellence which aims to improve our ongoing, Agency-wide service delivery. This budget will also support our Digital Services team, which coordinates the best-in-class private sector practices, talent, and technology to transform the way the IT products are built and delivered within and across the CMS and HHS. To that end, the budget includes $3 million for reimbursable FTEs to continue supporting ongoing projects that focus on improving

[1] FY 2023 and 2024 includes $455 million in additional Medicare Operations funding from the FY 2023 annual appropriation, Public Law 117-328, General Provision Section 227. CMS has 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.

customer experience and service delivery.

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.

Funding History

Fiscal Year	Amount
FY 2021	$772,533,000
FY 2022	$782,533,000
FY 2023 Final	$782,533,000
FY 2024 CR	$782,533,000
FY 2025 President's Budget	$857,615,000

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. To ensure indirect administrative 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: $857.6 million

The FY 2025 Budget request for Federal Administration is $857.6 million, an increase of $75.1 million above the FY 2023 Final level. In addition, CMS projects $222.4 million will be available from the administrative indirect cost allocation, bringing the total program level to $1,080.0 million.

Federal Administration Program Level Summary Table[2]

(Dollars in Thousands)

Objects of Expense	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Personnel Compensation and Benefits	$796,122	$826,960	$877,016	$80,894
Rent, Maintenance, and Building Loans	$33,421	$34,550	$34,590	$1,169
Service and Supply Fund	$39,931	$44,936	$44,936	$5,005
Administrative Services	$3,554	$5,343	$6,213	$2,659
Administrative IT	$51,140	$43,199	$43,080	($8,060)
Supplies and Equipment	$252	$308	$715	$463

[2] This table and corresponding narrative, below, reflect program level funding, which includes appropriated resources in addition to funds from CMS indirect cost allocations.

Objects of Expense	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Administrative Contracts and Inter/Intra-Agency Agreements	$49,717	$46,629	$58,472	$8,755
Training	$3,067	$3,164	$3,164	$97
Travel	$4,406	$5,361	$7,100	$2,694
Printing and Postage	$4,326	$2,396	$4,682	$356
Total, Federal Administration	**$985,936**	**$1,012,846**	**$1,079,968**	**$94,032**

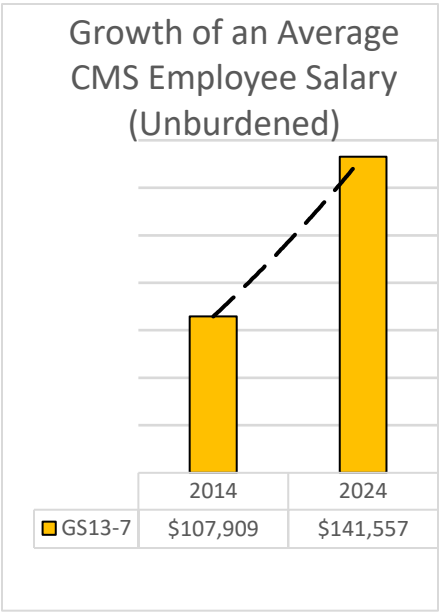
Personnel Compensation and Benefits

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.

CMS administers programs that provide health care coverage for over 163 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: $877.0 million

The FY 2025 Budget request includes $877.0 million in discretionary funding for payroll and benefit costs, an increase of $80.9 million above the FY 2023 Final level. Payroll and benefits are impacted annual by cost increases associated with cost-of-living adjustments (COLA) and increased benefit costs. The requested funding will support 4,205 direct FTEs, which is 46 more FTEs as compared to the FY 2023 Final level.



The FY 2025 request assumes COLA increases of 2.0 percent for civilian employees and a 4.5 percent Commissioned Corps, with a 1.0 percent increase in benefits costs for both. These assumptions are projected to result in an approximate $25.0 million increase above FY 2024 alone. To illustrate the impact COLA increases have on this account, the graph shows the growth of CMS' average employee, a GS-13 Step 7. From 2014 to 2024, the unburdened salary of a GS-13 Step 7 increased from $107,909 to $141,557, a $33,648 increase. To be clear, this graph displays salary increases alone and does not show the added costs of increases in benefits per employee.

In FY 2024, 4,080 FTEs will be supported by this account. Even using this low point FTE level, the scale of the COLA impact over this time period reaches $137.0 million, as an average. During the same time period, this account experienced a largely flat-lined budget. In order to keep pace with the rise in payroll costs during this period, CMS' Federal Administration FTE level has had to decrease.

CMS's staffing levels, tied with related compensation and benefits expenses, are largely workload-driven. The budgeted 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 the Inflation Reduction Act. These accounts cover FTE costs required to execute their specific workload required to meet the Agency's needs.

CMS's responsibilities have grown, including impacts from new legislative mandates and various coverage expansion activities. However, our administrative budget has not kept pace with this growth, creating a gap in staffing levels and skillsets. The projected FTE level in our FY 2025 President's Budget request is vital for CMS to maintain minimum staffing levels, recouping FTEs lost since FY 2023.

FY 2025 Other Objects of Expense: $203.0 million

Rent, Maintenance, & Building Loans

CMS utilizes rented and leased building space to conduct its operations. These facilities provide work and meeting areas, housing for infrastructure, and places where engagement with stakeholders can occur. In FY 2024, CMS went through a multiphase process that returned our workforce to our physical locations using a flexible hybrid work approach, moving away from the pandemic-induced posture of remote work.

Budget Request: $34.6 million

The FY 2025 Budget request includes $34.6 million in program level funding, a $1.1 million increase above the FY 2023 Final level. While this slight increase trends with annual yearly cost increases, CMS is constantly evaluating our space usage, to align our real estate foot print to our operations. 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. Other items in this category include certain contract labor costs, such as grounds maintenance, cleaning, and trash and snow removal.

Service and Supply Fund

At the HHS organizational level, certain administrative services and supplies are provided to CMS. Consolidation, at the HHS level, allows for better pricing, oversight of certain processes, and continuity in some shared services.

Budget Request: $44.9 million

The FY 2025 Budget request includes $44.9 million in program level funding, a $5.0 million increase above FY 2023 Final level. 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

CMS has a sizable operation that requires several internal services to maintain day-to-day continuity. This makes it necessary for administrative services such as facility improvement projects, employee badging, and even heating and air conditioning (HVAC).

CMS is in the process of a multi-year Real Estate Consolidation effort to consolidate rented and leased space. As the project matures, CMS expects to realize reductions across multiple funding sources in our overall costs. Funding for this effort is not requested in FY 2025.

Budget Request: $6.2 million

The FY 2025 Budget request includes $6.2 million in program level funding, an increase of $2.7 million above the FY 2023 Final level. The increase covers rise in energy costs as well as other costs impacted by annual inflation.

Administrative Information Technology (IT)

Enterprise IT services include CMS's Unified Communication(s), Agency SharePoint, Enterprise Mobile Device Management, and notably Hosting Operations and End User support. Various other line items exist under Administrative IT, all of which serve as the nervous system of CMS.

Budget Request: $43.1 million

The FY 2025 Budget request includes $43.1 million in program level funding, a $8.0 million decrease below the FY 2023 Final level. Although a decrease, this request will still enable CMS to provide a user-friendly IT environment for employees with integrated data, voice, and video services that provide seamless connections between meeting rooms, workstations, and remote locations. These services are critical to CMS's operation as the workplace continues to evolve.

Supplies and Equipment

Every component of CMS needs the basic instruments of business to conduct its work. This category includes items such as office and facility supply and equipment need throughout the Agency.

Budget Request: $0.7 million

The FY 2025 Budget request includes $0.7 million in program level funding, a $0.5 million increase above the FY 2023 Final level. The increase is largely based on CMS's shift towards a greater in-office presence and is tied to the administrative business needs of each component.

Contracts and Intra/Inter-Agency Agreements (IAAs)

CMS holds a number of enterprise contracts and IAAs which provide services throughout our operations. These contracts include services for background investigations, Equal Employment Opportunities, translation, mailroom and security. These and other contracted services allow CMS employees to work in a safe, supportive environment regardless of personnel circumstances. IAAs are economic ways we partner with our colleagues form other agencies across government. These partnerships allow CMS access to subject matter experts for specific engagement. CMS also supports Tribal Resources which enhance our relationship with Native Americans and Alaska Natives (AI/AN).

Budget Request: $58.5 million

The FY 2025 Budget request includes $58.5 million in program level funding, a $8.8 million increase above the FY 2023 Final level. This increase largely reflects inflationary impacts over a two-year period and will allow CMS to maintain current service levels.

Training

The Training costs support continuous learning of technical, professional, and general business skills. Technical and professional continuing education provided under this object class include 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.

Budget Request: $3.2 million

The FY 2025 Budget request includes $3.2 million in program level funding, relatively flat as compared to the FY 2023 Final level.

Travel

Travel enables CMS to continue our mission by conducting site visits at contractor operations, healthcare facilities, and places us with health providers in every State and U.S. Territory. As CMS administers its programs primarily through contractors, site visits are a critical method of oversight and contract management. Travel directly places our staff on the ground to identify and address contract and other issues. Site visits also allow CMS to oversee the level of care our beneficiaries and consumers are receiving. 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.

Budget Request: $7.1 million

The FY 2025 Budget request includes $7.1 million in program level funding, a $2.7 million increase above the FY 2023 Final level. This increase will allow CMS to provide additional oversight of key contracts and visit more facilities throughout the US.

Printing and Postage

CMS as the nation's largest health insurer has the administrative need to print and also mail a large volume. Specifically, 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.

Budget Request: $4.7 million

The FY 2025 Budget request includes $4.7 million in program level funding, relatively flat as compared to the FY 2023 Final level.

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State Survey and Certification

(Dollars in Thousands)

	FY 2023 Final	FY 2024 CR [1]	FY 2025 President's Budget	FY 2025 +/- FY 2023
Discretionary				
State Survey and Certification	$407,334	$407,334	$492,334	$85,000
Nursing Home Cross-Cutting (NHCC) (non-add)	*$0*	*$0*	*$20,000*	*$20,000*
Subtotal, Discretionary	**$407,334**	**$407,334**	**$492,334**	**$85,000**
Mandatory				
IMPACT Act [2]	$5,304	$5,304	$5,304	-
Consolidated Appropriation Act	$9,430	$9,430	$9,430	-
Grants to States for Medicaid (S&C)	$327,384	$351,000	$362,000	$34,616
Subtotal, Mandatory	**$342,118**	**$365,734**	**$376,734**	**$34,616**
Total	**$749,452**	**$773,068**	**$869,068**	**$119,616**

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

Authorization Status – Permanent

FY 2024 Authorization – Public Law 118-35, Further Continuing Appropriations and Other Extensions Act, 2024

Allocation Method – Direct Federal/Intramural, Contract, Formula Grant/Co-operative agreement

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 68,000 Medicare and Medicaid-certified facilities.

[1] FY 2024 CR 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 2025 request assumes the same sequestration amount as FY 2024.

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 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 via FY 2024 CR) 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; $5.3 million in FY 2024) and the Consolidated Appropriations Act of 2021 (P.L. 116-260; CAA; $9.4 million in FY 2024), both targeted to help keep hospice survey frequencies at every three years. The Grants to States for Medicaid account also provides mandatory funds ($351 million in FY 2024) to support the oversight of Medicaid and dually participating (Medicare/Medicaid) provider types.

With years of flat funding, the Survey and Certification program can no longer meet statutory frequency requirements or adequately guarantee the safety and quality of care for patients receiving care in CMS certified facilities. HHS has developed a conceptual proposal (Reclassify discretionary nursing home Survey and Certification activities as mandatory) for identifying a stable, mandatory source of funding for nursing home oversight that ensures patients' basic health and safety, protects the most vulnerable patients from abuse, neglect, and harm, and enables the federal government to meet its legal and fiduciary responsibilities.

CMS prioritizes survey activities within the S&C program starting with those that most acutely impact health and safety of Americans (i.e., serious quality complaints), those that 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), end stage renal disease initials, and hospices); and
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, 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 used in the S&C program, 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. Another example of data improvement efforts that S&C program has supported 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

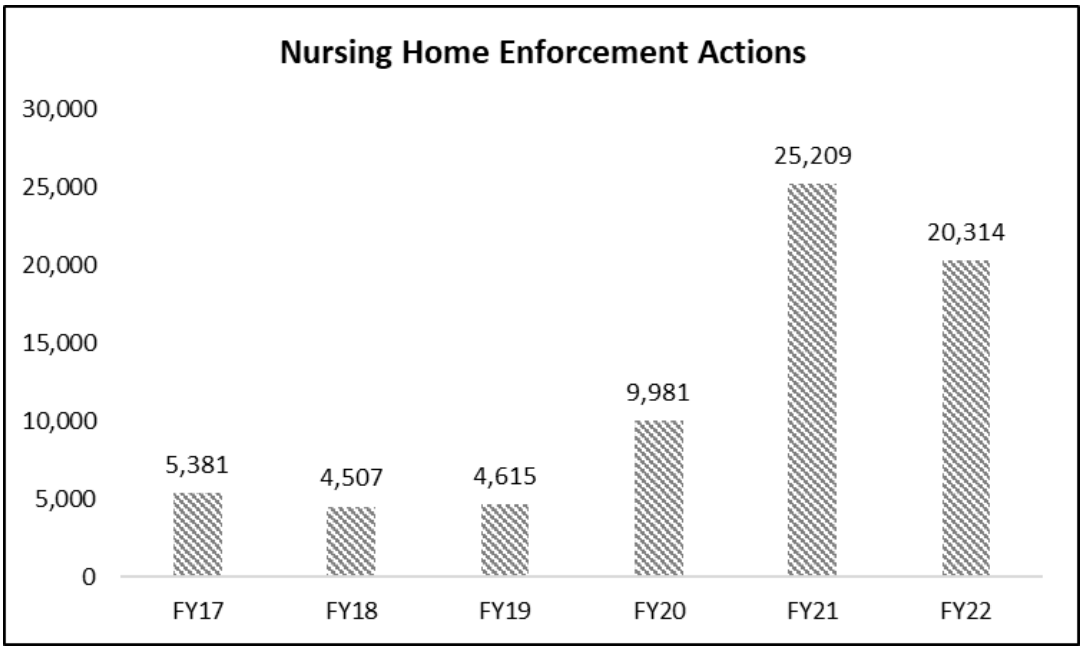
Given the number of Long-Term Care (LTC) facilities and the vulnerability of its patients, CMS places high programmatic priority on maintaining the quality of care and transparency in these facilities. In FY 2025, CMS projects, based on historical trends, that LTC facilities will account for over 90 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 LTC residents? How will survey effectiveness and efficiency improve?

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

- 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;
- Revised Special Focus Facility standards to address poorly performing facilities;
- Revised State Performance Standards System measurement and process to address areas of improvement needed by states through corrective action plans.
- Improved monitoring of health, safety and emergency preparedness compliance and events;
- 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;
- Reinvested 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;
- Established data on Care Compare that identifies quality across multiple nursing homes with common ownership (e.g., nursing home chains);
- Increased efforts to monitor and audit reported Payroll-Based Journal data; and
- Analyzed survey findings to improve and address issues of under-citation in nursing home deficiencies.

CMS's ability to expand and improve on its survey and certification activities in LTC facilities even at the statutorily required level is compromised as a result of nearly nine years of flat funding, despite CMS facing the increase in mandatory costs, including pay raise and inflation, and growing survey workloads, which has led to staffing shortages. At the 2024 CR level, state survey agencies would complete just 65% of statutorily required nursing home surveys in FY 2024, down from 100% in FY 2022. Continued flat funding the S&C program will put nursing home residents at heightened risk of harm and degrades the ability to respond to complaints of health and safety violations, such as abuse or neglect. Specifically, the current backlog of 30,000 nursing home complaints will continue to grow, increasing the likelihood of harm for our most vulnerable beneficiaries.

For example, the table below highlights the significant growth in enforcement actions, where the display shows the historical average of around 5,000 annual cases doubled going into FY 2020 which then more than doubled again in FY 2021. The Program has seen the enforcement action workload increased a staggering 20,000 cases over historical norms. While FY 2022 retreated a little from this high-water mark, the additional need for oversight and the resources to better manage this four-fold work increase is clear and compelling. To address the increasing workloads and align with the Administration's commitments to improve the safety and quality of nursing home care, the budget requests an increase in funding as well as legislative proposals for FY 2025. In addition, the Administration's proposal to shift survey and certification funding for LTC facilities from discretionary to mandatory effective in FY 2026, would allow for sustained and reliable oversight and enforcement in the nation's nursing homes and ensure that Americans receive high quality, safe services within these facilities.



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.

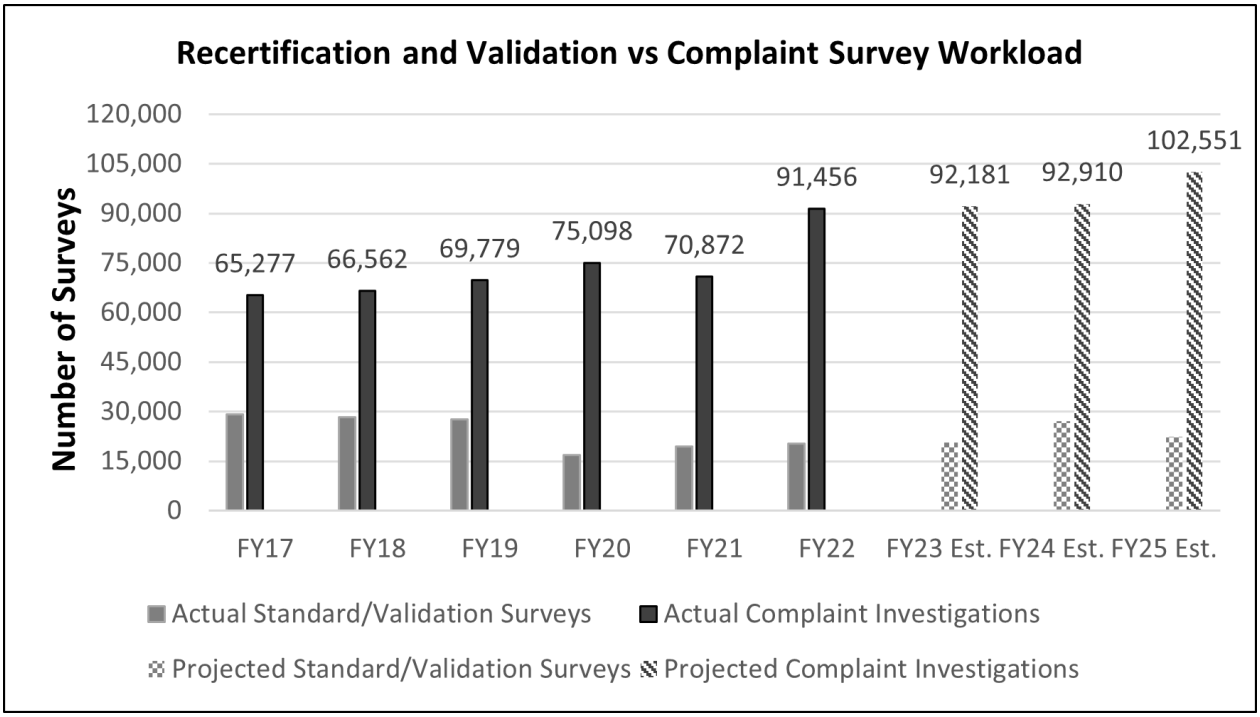
While several factors determine the overall quality of care in healthcare settings, CMS is committed to significantly reducing the number of serious health and safety violations in accredited facilities each year. A number of important steps have been taken to improve the survey processes and oversight 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). 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.

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 lasting effects of the PHE, has fueled the loss and availability of State Survey Agency (SA) resources and resulted in ongoing growth in complaints, with adverse effects on programmatic efficiency, quality, and ultimately beneficiary safety and basic care. The flat funding level for the program has hampered states' ability to maintain competitive compensation rates as compared to the standard wage inflation for existing and new surveyor staff, and seek additional positions due to capped federal funding leading to many vacant positions that have gone unfilled. These staffing constraints create 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 2025 respectively. While the program was experiencing steady growth in the complaint survey workload (a 13 percent increase just between FY 2018 to FY 2020), the more recent jump in actual workload is about 20,000 more investigations, or 28%, over the historical average. Moreover, the projections going forward sustains this higher level of complaint investigations suggesting the upward trend will continue. Due to the continued flat funding,

CMS has had to prioritize funds to pay for the rise in complaint surveys by reducing support to standard surveys, resulting in a year-over-year decrease in the number of recertification and validation surveys. Each complaint case represents a beneficiary or family member calling CMS or their SA directly for help when they are at their most vulnerable, such as a beneficiary facing negligence and poor quality of care.



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 validation 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 already a backlog of over 30,000 nursing home complaints, CMS forecasts an increased number of complaint surveys pending and overdue for investigation across all provider types, including some immediate jeopardy complaints. The concern with the backlog is further confounded by the aforementioned increasing number of complaints being reported as well as surveyors finding more serious quality of care issues when conducting onsite surveys. These findings result in longer surveys and possible onsite revisit surveys. They also indicate a general worsening in the quality of services being provided to patients and residents.

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. On May 1, 2023, CMS released QSO-23-13-ALL, outlining initial guidance for the expiration of the PHE. With the current backlog of surveys, the complaint priority guidelines above are still in effect, however as this backlog is reduced, CMS will reevaluate this guidance.

Funding History

Fiscal Year	Amount
FY 2021	$397,334,000
FY 2022	$397,334,000
FY 2023 Final	$407,334,000
FY 2024 CR	$407,334,000
FY 2025 President's Budget	$492,334,000

Budget Request: $492.3 million

The FY 2025 Budget request for the S&C program is $492.3 million, an increase of $85 million above the FY 2023 Enacted level. This funding level will allow for an 85% completion rate of statutorily mandated surveys. The 2025 funding request represents a 20% increase over projected completion rates in FY 2024. To address this, the Budget includes a proposal, effective FY 2026, to create a new mandatory funding stream to ultimately achieve 100% frequency for nursing home survey and certification activities. The budget request also includes a $20 million within the $492 million total for the Nursing Home Cross-Cutting Initiative which will help in making inroads toward addressing the complaint backlog.

The S&C program continues to experience 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 2020 to FY 2025, participating facilities are projected to grow by 4.3 percent, or approximately 2,800 facilities. During this time, deemed facilities are projected to account for a majority of this growth, with an increase of nearly 30 percent, whereas the total number of non-deemed facilities are expected to decrease by 2.5 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, not including sequester. The CAA Act of 2021 required CMS to establish a special focus program for hospice agencies. The Special Focus Program (SFP) was codified in the CY 2024 Home Health Payment Final rule effective January 1, 2024. In conjunction with establishing the SFP through rulemaking, CMS is establishing a multi-year contract to support the SFP activities that include, but is not limited to, support and management of the methodology/algorithm used to identify poor performers; establish a dedicated national

SFP survey team; and establish and maintain an SFP website page and updates to Compare Site.

The following table summarizes each funding source for the Survey and Certification account and its respective breakout per fiscal year.

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
State Direct Survey	$368,239	$363,419	$447,876	$79,637
Mandatory Surveys (Nursing Homes/Home Health/Hospice) (non-add)	$327,354	$315,719	$399,507	$72,153
Non-Statutory Surveys Non-Deemed and Deemed (non-add)	$40,885	$47,700	$48,369	$7,484
Federal Direct Surveys	$9,809	$9,985	$10,157	$348
Support Contract and Information Technology	$29,286	$33,930	$34,301	$5,015
Total S&C PM Discretionary	**$407,334**	**$407,334**	**$492,334**	**$85,000**
IMPACT Act, Hospice Surveys [3]	$5,304	$5,304	$5,304	-
Consolidated Appropriations Act of 2021, Hospice Surveys	$9,430	$9,430	$9,430	-
Grants to States for Medicaid - S&C	$327,384	$351,000	$362,000	$34,616

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: $447.9 million

The Budget request is $447.9 million, an increase of $79.6 million above the FY 2023 Enacted Level. This increased total amount reflects $399.5 million to inspect, survey, and certify statutory facilities, and $48.4 million to inspect, survey, and certify non-statutory facilities. These projections are based on FY 2022 actual data which may be 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 approximately 85% of 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. At this level, CMS will maintain 10% survey completion rate of non-statutory facilities. At this level, Hospice and ESRD facilities will have funding to perform initial surveys on new providers wanting to enter the program to gain Medicare and/or Medicaid certification.

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

If adopted, CMS's budget proposals lay the path towards enabling the states to have long-term certainty to retain and hire additional workforce to handle the increased workload and provide states with the much-needed 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 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.

Provider Survey Frequency Rate Completion Projections

Provider Status and Type	Survey Frequency Intervals	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Statutory				
Nursing Facilities (NF)	100% Surveyed 12.9-15.9 mo.	75%	65%	85%
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	100% Surveyed 12.9-15.9 mo.	75%	65%	85%
Special Focus Facility Nursing Homes (SFF)	100% Surveyed 6 mo.	75%	100%	100%
Skilled Nursing Facilities (SNF)	100% Surveyed 12.9-15.9 mo.	75%	65%	85%
ICF/IID	100% Surveyed 12.9-15.9 mo.	75%	65%	100%
Home Health Agencies (HHAs)	100% Surveyed 36.9 mo.	75%	65%	85%
Hospice Agencies	100% Surveyed 36.9 mo.	100%	100%	100%
Special Focus Program Hospice Agencies (SFP)	100% Surveyed 6 mo.		100%	100%
Non-Statutory Non-Deemed				
Ambulatory Surgical Centers (ASCs)	100% Surveyed 72 mo.	10%	10%	10%
Community Mental Health Centers (CMHCs)	100% Surveyed 60 mo.	10%	10%	10%
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	100% Surveyed 72 mo.	10%	10%	10%
End Stage Renal Disease (ESRD)	100% Surveyed 36 mo.	10%	10%	10%
Hospitals	100% Surveyed 36 mo.	10%	10%	10%
Outpatient Physical Therapy (OPT)	100% Surveyed 72 mo.	10%	10%	10%
Portable X-Ray Suppliers	100% Surveyed 72 mo.	10%	10%	10%
Rural Health Clinics (RHCs)	100% Surveyed 72 mo.	10%	10%	10%
Transplant Centers	100% Surveyed 60 mo.	10%	10%	10%
Non-Statutory Deemed				
Ambulatory Surgical Centers (ASCs)	5% of Validation Surveys	10%	10%	10%
End Stage Renal Disease (ESRD)	5% of Validation Surveys	10%	10%	10%
Home Health Agencies (HHAs)	5% of Validation Surveys	10%	10%	10%
Hospice Agencies	5% of Validation Surveys	100%	100%	100%
Hospitals	5% of Validation Surveys	10%	10%	10%
Outpatient Physical Therapy (OPT)	5% of Validation Surveys	10%	10%	10%
Rural Health Clinics (RHCs)	5% of Validation Surveys	10%	10%	10%

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. Hospice survey work is covered by supplemental funding provided through the IMPACT Act, and the Consolidated Appropriations Act of 2021.

Medicare PM Discretionary Survey and Complaint Visit Cost Projections

(Dollars in Thousands)

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget [4]
Statutory	**$327,355**	**$315,719**	**$399,507**
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	$304,268	$293,140	$370,402
Special Focus Facility Nursing Homes (SFF)	$1,454	$1,462	$2,039
Skilled Nursing Facilities (SNF)	$13,481	$12,062	$15,244
Home Health Agencies (HHAs)	$8,152	$9,055	$11,822
Hospice Agencies	$0	$0	$0
Special Focus Program Hospice Agencies (SFP)	$0	$0	$0
Non-Statutory Non-Deemed	**$13,351**	**$14,925**	**$15,434**
Ambulatory Surgical Centers (ASCs)	$1,336	$1,477	$1,642
Community Mental Health Centers (CMHCs)	$51	$56	$46
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	$23	$17	$24
End Stage Renal Disease (ESRD)	$8,275	$8,414	$8,451
Hospitals	$3,193	$4,292	$4,590
Outpatient Physical Therapy (OPT)	$104	$153	$157
Portable X-Ray Suppliers	$25	$29	$29
Rural Health Clinics (RHCs)	$189	$331	$341
Transplant Centers	$155	$156	$154
Non-Statutory Deemed	**$27,533**	**$32,775**	**$32,936**
Ambulatory Surgical Centers (ASCs)	$186	$159	$159
End Stage Renal Disease (ESRD) [5]	$0	$0	$0
Home Health Agencies (HHAs)	$179	$159	$163
Hospice Agencies	$0	$0	$0
Hospitals	$27,117	$32,408	$32,565
Outpatient Physical Therapy (OPT) [5]	$0	$0	$0
Rural Health Clinics (RHCs)	$51	$49	$49
Total State Direct Survey Budget	**$368,239**	**$363,419**	**$447,876**
IMPACT Act, Hospice Surveys	$5,304	$5,304	$5,304
Consolidated Appropriations Act, Hospice Surveys	$9,430	$9,430	$9,430

[4] Total Statutory amounts include $17.5M for survey backlog and $0.5M for NH SFF from $20M NHCC Non-Add

[5] New validation survey type being completed by Contract

With the level of funding from the FY 2025 request, CMS estimates SAs can complete the initial, recertification, and complaint surveys as shown below. These estimates represent funding the statutory workload for recertification surveys at an approximate 85% completion rate. The additional $20 million within the State Survey and Certification topline, will be used to work towards addressing the complaint backlog.

The tables on the following pages continue to show that the majority of surveys and complaint visits are projected to be in nursing homes, illustrating the challenges discussed above.

FY 2025 Projected Survey and Complaint Visit Table

	Facilities Beginning of Year	Complaint Survey	Recertification Survey [6]	Initial Survey	Total Surveys
Total State Direct Survey Budget	**68,043**	**102,048**	**22,190**	**219**	**124,460**
Statutory	**29,548**	**97,032**	**21,440**	**83**	**118,558**
Nursing Facilities (NF)	274	1,164	274	7	1,446
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	14,172	89,421	12,245	0	101,666
Special Focus Facility Nursing Homes (SFF)	N/A	N/A	120	N/A	120
Skilled Nursing Facilities (SNF)	578	1,236	499	0	1,735
ICF/IID	5,530	4,039	5,530	26	9,596
Home Health Agencies (HHAs)	6,677	825	1,912	0	2,737
Hospice Agencies	2,317	347	772	50	1,170
Special Focus Program Hospice Agencies (SFP)	N/A	N/A	50	N/A	50
Non-Statutory Non-Deemed	**19,354**	**1,656**	**458**	**136**	**2,250**
Ambulatory Surgical Centers (ASCs)	3,869	206	64	0	270
Community Mental Health Centers (CMHCs)	113	2	2	0	4
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	145	1	2	0	4
End Stage Renal Disease (ESRD)	7,248	1,031	242	136	1,409
Hospitals	2,110	374	49	0	423
Outpatient Physical Therapy (OPT)	1,546	9	26	0	35
Portable X-Ray Suppliers	534	2	9	0	10
Rural Health Clinics (RHCs)	3,550	25	59	0	84
Transplant Centers	239	6	5	0	11
Non-Statutory Deemed	**19,141**	**3,360**	**292**	**0**	**3,652**
Ambulatory Surgical Centers (ASCs)	2,278	0	11	0	11
End Stage Renal Disease (ESRD)	603	0	3	0	3
Home Health Agencies (HHAs)	4,845	0	24	0	24
Hospice Agencies	4,379	0	219	0	219
Hospitals	4,775	3,360	24	0	3,384
Outpatient Physical Therapy (OPT)	375	0	2	0	2
Rural Health Clinics (RHCs)	1,886	0	9	0	9

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

FY 2022 Survey and Complaint Visit Table – Actual

	Facilities Beginning of Year	Complaint Survey	Recertification Survey	Initial Survey	Total Surveys
Total State Direct Survey Budget	**66,757**	**91,456**	**20,007**	**1,649**	**113,112**
Statutory	**30,004**	**86,323**	**16,572**	**120**	**103,015**
Nursing Facilities (NF)	304	1,242	183	3	1,428
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	14,336	78,764	8,707	27	87,498
Focused Infection Control Surveys (SNF/NF)	N/A	N/A	9,970	N/A	9,970
Special Focus Facility Nursing Homes	N/A	N/A	176	N/A	176
Skilled Nursing Facilities (SNF)	630	1,348	414	4	1,766
Focused Infection Control Surveys (SNF)	N/A	N/A	203	N/A	203
ICF/IID	5,704	3,937	4,193	26	8,156
Home Health Agencies (HHAs)	6,661	824	2,204	37	3,065
Hospice Agencies	2,369	208	695	23	926
Special Focus Program Hospice Agencies (SFP)	N/A	N/A	0	N/A	0
Non-Statutory Non-Deemed	**19,878**	**1,629**	**3,435**	**392**	**5,456**
Ambulatory Surgical Centers (ASCs)	3,829	236	704	40	980
Community Mental Health Centers (CMHCs)	129	1	23	3	27
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	159	1	16	2	19
End Stage Renal Disease (ESRD)	7,506	910	1,683	89	2,682
Hospitals	2,198	438	319	11	768
Outpatient Physical Therapy (OPT)	1,680	10	184	24	218
Portable X-Ray Suppliers	512	1	58	26	85
Rural Health Clinics (RHCs)	3,626	27	384	197	608
Transplant Centers	239	5	64	0	69
Non-Statutory Deemed	**16,875**	**3,504**	**0**	**1,137**	**4,641**
Ambulatory Surgical Centers	2,198	0	0	159	159
End Stage Renal Disease	357	0	0	7	7
Home Health Agencies	4,829	0	0	286	286
Hospice Agencies	3,173	0	0	406	406
Hospitals	4,691	3,504	0	55	3,559
Outpatient Physical Therapy	359	0	0	33	33
Rural Health Clinics (RHCs)	1,268	0	0	191	191

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.

For example, CMS has had significant interest in improving the performance of Organ Procurement Organizations (OPO) through updated regulatory performance metrics and data transparency. For FY 2025 and based on historical data, CMS expects that there may be some complaints that require onsite surveys. We expect a significant uptick in FY 2026 when all OPOs will be required to undergo a recertification survey and will be assessed using the updated performance metrics.

Budget Request: $10.2 million

The FY 2025 Budget request for Federal Direct Surveys is $10.2 million, which is an increase of $0.3 million above the FY 2023 Enacted Level. This level represents continued funding for the Federal oversight of State surveys with a small inflationary increase, as well as the OPT surveys.

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: $34.3 million

The FY 2025 Budget request for Support Contracts and IT is $34.3 million, an increase of $5.0 million above the FY 2023 Enacted Level. This amount includes $25.9 million for support contracts and $8.4 million for IT contracts.

Grants to States Mandatory Appropriation: $362.0 million

The FY 2025 Mandatory appropriation for the Grants to States for Medicaid is $362.0 million, $34.6 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.

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Medicaid Grants to States	**$327,384**	**$351,000**	**$362,000**
Statutory	**$325,814**	**$349,921**	**$359,808**
Nursing Facilities (NF)	$9,659	$7,887	$8,135
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	$251,258	$279,188	$287,376
Special Focus Facility Nursing Homes (SFF)	$2,051	$1,575	$2,186
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	$48,439	$49,733	$51,291
Home Health Agencies (HHAs)	$14,407	$11,538	$10,820
Non-Statutory Deemed	**$1,570**	**$1,079**	**$2,192**
Home Health Agencies (HHAs)	$1,570	$1,079	2,192
Total Medicaid S&C Funding	**$327,384**	**$351,000**	**$362,000**

Clinical Laboratory Improvement Amendments Program (CLIA)

(Dollars in thousands)

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
CLIA Lab Obligations	**$77,500**	**$78,000**	**$79,800**

The CLIA program is entirely funded by user fees that are charged to the laboratories regulated by the program. The FY 2025 budget projection for CLIA is $79.8 million in obligations, which is $2.3 million above the FY 2023 Enacted 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 2020 to FY 2022, the number of labs grew by 17 percent. By FY 2025, CMS is expecting the number of labs to grow by an additional 7 percent, with waived labs making up majority of this growth.

Lab Type	FY 2020 Actual	FY 2021 Actual	FY 2022 Actual	FY 2023 Projected	FY 2024 Projected	FY 2025 Projected
Compliance Labs	17,404	17,411	17,934	19,256	18,516	18,516
Accredited Labs	15,746	15,656	15,907	16,168	16,234	16,234
Waived Labs	189,410	193,146	233,909	259,928	256,745	256,745
PPMP Labs	31,254	30,248	29,826	30,895	28,070	28,070
Total	**253,814**	**256,461**	**297,576**	**326,247**	**319,565**	**319,565**

The table below provides the projected CLIA Survey Workload from FY 2020 to FY 2025, and directly following is a table showing what the actual CLIA Survey workload was between FY 2020 to FY 2022.

Original projected workload

Type of Survey	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**
Compliance: Initial and Recertification	8,702	8,620	9,508	9,542	9,172	9,172
Complaint/Follow-up	207	155	132	668	642	642
Validation Surveys	420	418	430	431	433	433
Total	**9,329**	**9,193**	**10,070**	**10,641**	**10,247**	**10,247**

Note: FY 2023-2025 estimates as of January 2024.

Actual workload

Type of Survey	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
Compliance: Initial and Recertification	4,818	8,127	8,266	TBD
Complaint/Follow-up	333	1,212	981	TBD
Validation Surveys	21	69	148	TBD
Total	**5,172**	**9,408**	**9,395**	**TBD**

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, ~~$406,956,850,000~~ $383,609,399,000, to remain available until expended. In addition, for carrying out such titles after May 31, ~~2024~~ 2025, for the last quarter of fiscal year ~~2024~~ 2025 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 ~~2025~~ 2026, ~~$245,580,414,000~~ $261,063,820,000, 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, ~~*$406,956,850,000*~~ *$383,609,399,000,* to remain available until expended.	This section provides a no-year appropriation for Medicaid for FY 2025. This appropriation is in addition to the advance appropriation of $249.9 billion for the first quarter of FY 2025. 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, ~~*2024*~~ *2025*, for the last quarter of fiscal year ~~*2024*~~ *2025*, 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 2025 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 ~~2025~~ *2026, ~~$245,580,414,000~~ $261,063,820,000,* to remain available until expended.	This section provides an advance appropriation for the first quarter of FY 2026 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 2026 is not enacted by October 1, 2025.
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 2023 Final	FY 2024 Estimate	FY 2025 President's Budget	FY 2025 +/- FY 2024
Mandatory Appropriation:				
Advanced Appropriation.....	$165,722,018	$197,580,474	$249,865,113	$52,284,639
Annual Appropriation.....	$367,357,090	$424,700,466	$383,609,399	($41,091,067)
Indefinite Annual Appropriation..	$78,166,046	$0	$0	$0
Subtotal, Mandatory Appropriation	**$611,245,154**	**$622,280,940**	**$633,474,512**	**$11,193,572**
Offsetting Collections from Federal Sources:				
Collection Authority: Medicare Part D……..	$0	$5,000	$5,000	$0
Collection Authority: Medicare Part B……..	$1,586,748	$1,718,393	$1,587,000	($131,393)
Subtotal, Collections Authority	$1,586,748	$1,723,393	$1,592,000	($131,393)
Total New Budget Authority	**$612,831,902**	**$624,004,333**	**$635,066,512**	**$11,062,179**
Unobligated Balances:				
Unobligated balance of appropriation withdrawn……..	$0	$0	$0	$0
Unobligated balance, Start of year[1].....	$361,282	$50,348	$3,150,153	$3,099,805
Unobligated balance, Recoveries of Prior Year Obligations (Unpaid)……	$32,243,598	$0	$0	$0
Recoveries of Prior Year Obligations (Paid)……..	$19,996,780	$0	$0	$0
Subtotal, Unobligated Balances.....	$52,601,660	$50,348	$3,150,153	$3,099,805
Total Budgetary Resources (Amounts Available for Obligation)	**$665,433,562**	**$624,054,681**	**$638,216,665**	**$14,161,984**
Unobligated balance, end of year……..	$0	$0	$0	$0
Total, Gross Obligations.....	**$665,383,214**	**$620,904,529**	**$638,196,665**	**$17,292,136**
Net Obligations: Unobligated balance of appropriation withdrawn……				
Gross Obligations.....	$665,383,214	$620,904,529	$638,196,665	$17,292,136
Actual Collections: Medicare Part D……..	$0	($5,000)	($5,000)	$0
Actual Collections: Medicare Part B……..	($1,586,748)	($1,718,393)	($1,587,000)	$131,393
Unobligated balance, Start of year.....	($361,282)	($50,348)	($3,150,153)	($3,099,805)
Unobligated balance, Recoveries of Unpaid and paid Obligations.....	($52,240,378)	($55,507,125)	($52,028,000)	$3,479,125
Total Net Obligations	**$611,194,806**	**$563,623,663**	**$581,426,512**	**$17,802,849**

[1] Includes $50 million of Discretionary funding carried forward from FY 2023 from the Bipartisan Safer Communities Act (P.L. 117-159)

Funding History

Fiscal Year	Amount
FY 2021 [2]	$519,483,858,000
FY 2022 [3]	$608,620,011,000
FY 2023 [4]	$611,245,154,000
FY 2024	$622,280,940,000
FY 2025	$633,474,512,000

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

	FY 2024 Estimate	FY 2025 President's Budget	FY 2025 +/- FY 2024
CMS - Grants to States			
Grants to States, Subsidies	$616,791,590	$627,354,794	$10,563,204
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance[5]	$7,212,743	$7,711,718	$498,975
Total Budget Authority	**$624,004,333**	**$635,066,512**	**$11,062,179**

[2] Includes $65.7 billion in indefinite funding authority obligated during FY 2021.
[3] Includes $91.2 billion in indefinite funding authority obligated during FY 2022.
[4] Includes $78.2 billion in indefinite funding authority obligated during FY 2023.
[5] Reflects Vaccines for Children estimates under current law.

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

	FY 2023 Final	FY 2024 Estimate	FY 2025 President's Budget	FY 2025 +/- FY 2024
1. Medical Assistance Payments				
Medical Assistance Payments.....	$635,707,858	$535,392,590	$554,050,580	$18,657,990
Benefits Due and Payable (IBNR)	$0	$52,028,000	$50,022,367	($2,005,633)
Subtotal, Benefits	**$635,707,858**	**$587,420,590**	**$604,072,947**	**$16,652,357**
2. Vaccine for Children				
Vaccines for Children.....	$5,216,952	$7,212,743	$7,711,718	$498,975
Subtotal, Vaccine for Children	**$5,216,952**	**$7,212,743**	**$7,711,718**	**$498,975**
3. State Administration				
State and Local Administration.....	$23,631,063	$25,497,196	$25,600,000	$102,804
HIT- Provider.....	$3,307	$0	$0	$0
HIT- Administration.....	$57,650	$0	$0	$0
State Survey and Certification.....	$327,384	$351,000	$362,000	$11,000
State Fraud Control Units.....	$330,210	$373,000	$380,000	$7,000
BSCA Sec. 11003 - Admin	$0	$40,000	$50,000	$10,000
MMIS Planning for Territories	$74,858			
Eligibility and Enrollment	$33,932			
Subtotal, State Administration	**$24,458,404**	**$26,261,196**	**$26,392,000**	**$130,804**
Total Mandatory Appropriation……..	$611,245,154	$622,280,940	$633,474,512	$11,193,572
Total Offsetting Collection Authority [6,7]……..	$1,586,748	$1,723,393	$1,592,000	($131,393)
Total, Budget Authority	**$612,831,902**	**$624,004,333**	**$635,066,512**	**$11,062,179**
Recoveries and unobligated balances	$52,601,660	$50,348	$3,150,153	$3,099,805
Total, Budgetary Resources	**$665,433,562**	**$624,054,681**	**$638,216,665**	**$14,161,984**

Authorizing Legislation – Social Security Act, title XIX, Section 1901 and Public Law 111-5, Public Law 111-148, Public Law 111-152
FY 2023 Authorization – Public Laws 117-328, 117-403
FY 2024 Authorization – Public Laws 117-403
Allocation Method – Formula Grants

[6] Budget authority authorized and appropriated through offsetting collection authority under Social Security Act, title XIX, Section 1933(f).
[7] 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 [8]

(Dollars in Thousands)

	FY 2023 Final	FY 2024 Estimate	FY 2025 President's Budget	FY 2025 +/- FY 2024
Program Activity				
Medical Assistance Payments.....	$581,569,798	$588,807,001	$599,370,794	$10,563,793
State and Local Administration.....	$24,458,404	$26,261,196	$26,392,000	$130,804
Vaccines for Children.....	$5,216,952	$7,212,743	$7,711,718	$498,975
Subtotal, Medicaid Program Level	**$533,079,108**	**$622,280,940**	**$633,474,512**	**$11,193,572**
Less funds advanced in prior year.	$165,722,018	$197,580,474	$249,865,113	$52,284,639
Total, Grants to States for Medicaid	**$367,357,090**	**$424,700,466**	**$383,609,399**	**($41,091,067)**
New advance 1st quarter of subsequent FY.....	$197,580,474	$249,865,113	$261,063,820	$11,198,707

[8] Funding represented in the chart equals the respective FY 2025 President's Budget estimates. FY 2023 does not include $78.2 billion in indefinite funding authority.

Grants to States for Medicaid

Authorized under title XIX of the Social Security Act, Medicaid provides health care 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. Medicaid also 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 2025.

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

Program Activity	FY 2023 Final[9]	FY 2024 Estimate	FY 2025 President's Budget	FY 2025 +/- FY 2024
Medical Assistance Payments	$581,569,798	$588,807,001	$599,370,794	$10,563,793
State and Local Administration	$24,458,404	$26,261,196	$26,392,000	$130,804
Vaccines for Children	$5,216,952	$7,212,743	$7,711,718	$498,975
Total Mandatory Appropriation Request[10]	**$611,245,154**	**$622,280,940**	**$633,474,512**	**$11,193,572**

FY 2025 Mandatory Appropriation Request: $633.5 billion

CMS's FY 2025 mandatory appropriation request for the Grants to States for Medicaid account is $633.5 billion, an increase of $11.2 billion relative to the FY 2024 request level of $622.3 billion. This appropriation is composed of $249.9 billion in an authorized advance appropriation for FY 2024 and a remaining appropriation of $383.6 billion for FY 2025.

Resources will help fund $638.2 billion in anticipated FY 2025 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 $1.6 billion to fund the remaining anticipated obligations. These estimated obligations include:

- $604.1 billion in Medicaid medical assistance payments (MAP);
- $26.4 billion for Medicaid state and local administrative functions including funding for Medicaid state survey and certification and the state Medicaid fraud control units; and
- $7.7 billion for the Centers for Disease Control and Prevention's Vaccines for Children (VFC) program.

[9] FY 2023 includes indefinite funding of $78.2 billion.
[10] Numbers may not add due to rounding. Vaccines for Children totals reflect estimates under current law.

This submission is based on projections from state-submitted estimates and CMS using Medicaid expenditure data as recent as the third quarter of FY 2023. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget (OMB) for the FY 2025 President's Budget.

Under current law, the federal share of Medicaid net outlays is estimated to be $586.6 billion in FY 2025, an increase of $19.5 billion from the FY2024 level of $567.1 billion.

The FY 2025 estimate will be discussed in further detail by the major program activities of the Grants to States for Medicaid account; Medical Assistance Payments, Vaccines for Children, and State and Local Administration.

Grants to States for Medicaid

Medical Assistance Payments

(Dollars in Thousands)

	FY 2023 Final	FY 2024 Estimate	FY 2025 President's Budget	FY 2025 +/- FY 2024
Medical Assistance Payments	$581,569,798	$588,807,001	$599,370,794	$10,563,793

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 2023 Final	FY 2024 Estimate	FY 2025 President's Budget	FY 2025 +/- FY 2024
Aged	7.4	7.3	7.4	0.1
Disabled	10.7	10.8	10.9	0.1
Adults	22.2	17.8	16.5	(1.3)
Children	34.7	29.8	28.5	(1.3)
Expansion Adult	19.4	15.8	14.7	(1.1)
Territories	1.7	1.7	1.7	0.0
Total [11]	**96.1**	**82.9**	**79.5**	**(3.5)**

According to CMS projections of Medicaid enrollment, 79.5 million Americans will be enrolled in Medicaid for the equivalent of a full year during FY 2025. In FY 2025, 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 3.5 million in FY 2025, due in part to the end of the continuous enrollment condition enacted in the Consolidated Approrpiations Act, 2023 (P.L. 116-160.

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.

[11] Totals may 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 2025 Estimate

Budget Estimate: $599.4 Billion

CMS's Medical Assistance Payments (MAP) budget estimate is $599.4 billion, a $10.6 billion increase above the FY 2024 request. The following language provides additional detail on CMS's FY 2025 estimate: In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to reflect actuarial estimates developed by CMS's 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's OACT has found that state-submitted estimates of the grant awards tend to be higher than actual expenditures and, because of this, CMS's OACT relies more on actual expenditure data than the state-submitted estimates. CMS's OACT developed the MAP estimate for FY 2025 using the three quarters of FY 2023 state-reported expenditures as a base. Expenditures for FY 2023, FY 2024, and FY 2025 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's 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 2025 estimate of $50.0 billion represents the entire liability for Medicaid medical services incurred but not paid from October 1, 2024 to September 30, 2025. 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's OACT, which for FY 2025 is estimated to be $1.6 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's 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.

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 the extension of Medicaid protections against spousal impoverishment for recipients of home and community based services. Continuous enrollment from the Families First Coronavirus Response Act (FFCRA) has ended and the temporary enhanced FMAP is being phased down.

Regulatory Actions

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; 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. The rule also included provisions to simplify processes for eligible individuals to enroll and retain eligibility in the Medicare Savings Programs (MSPs) which were separately finalized in September 2023.

Grants to States for Medicaid

Vaccines for Children

(Dollars in Thousands)

	FY 2023 Final	FY 2024 Estimate	FY 2025 President's Budget	FY 2025 +/- FY2024
Vaccines for Children	$5,216,952	$7,212,743	$7,711,718	$498,975

Program Activity Description and Accomplishments

The Vaccines for Children (VFC) program is funded by the Medicaid appropriation and operated by the Centers for Disease Control (CDC) and Prevention. This program provides vulnerable children access to vaccines recommended by the Advisory Committee on Immunization Practices 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 receive vaccines through the VFC program, 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 CDC 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.

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 decline significantly. In addition to the health benefits of immunization, vaccines also provide significant economic value. Millions of children have benefited from vaccination since the VFC Program began in 1994. Among children born during 1994-2021, vaccination will prevent an estimated 472 million illnesses, 29.8 million hospitalizations, and help avoid 1,052,000 deaths, at a net savings of $479 billion in direct costs to federal programs, and $2.2 trillion in total societal costs.[12]

FY 2025 Budget Estimate: $7.7 Billion

CMS's Vaccine for Children (VFC) estimate under current law is $7.7 billion, a $499.0 million increase above the FY 2024 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 for the nation's immunization system that is used to fight outbreaks of VPDs and mitigate

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

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 2023 Final	FY 2024 Estimate	FY 2025 President's Budget	FY 2025 +/- FY 2024
State and Local Administration	$24,458,404	$26,261,196	$26,392,000	$130,804

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 2025 Budget Estimate: $26.4 Billion

CMS's State Administration estimate is $26.4 billion, a $130.8 million dollar increase compared to the FY 2024 estimated level.

This estimate is composed of $362.0 million for Medicaid state survey and certification, $380 million for state Medicaid Fraud Control Units, $50.0 million for Section 11003 of the Bipartisan Safer Communities Act, and $25.6 billion 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 2025 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2025 estimate for Medicaid state survey and certification is $362.0 million. This represents an increase of $11.0 million above the FY 2024 estimated amount of $351.0 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 2025, 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 $380.0 million. This represents an increase of $7.0 million over the FY 2024 estimate of $373.0 million. 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 2023, MFCUs were responsible for 1,143 convictions, 436 civil settlements and judgments, and expected monetary recoveries for both civil and criminal cases of $1.2 billion. MFCU cases in FY 2023 were also responsible for the exclusion of 850 individuals and entities from participation in Medicaid and other federal funding health care programs.

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

The current FY 2025 estimate for this transfer is $5.0 million, a flatline from the FY 2024 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 2025.

All Other Medicaid State and Local Administration

The CMS estimate for FY 2025 is $25.6 billion. CMS adjusted the FY 2024 state-submitted estimates of $25.5 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 2025 MANDATORY STATE/FORMULA GRANTS[13]

(Dollars in Thousands)

CFDA No/Program Name: 93.778 Medical Assistance Program

State or Territory	FY 2023 Final	Estimated FY 2024 obligations from:		FY 2024 Estimate	FY 2025 Estimate	FY 2025 +/- FY 2024
		Previous Authority	New Authority			
States						
Alabama	$6,231,576	$0	$6,447,098	$6,447,098	$6,579,634	$132,536
Alaska	$2,079,606	$0	$2,179,049	$2,179,049	$2,297,102	$118,054
Arizona	$18,102,132	$0	$18,484,368	$18,484,368	$18,432,270	($52,099)
Arkansas	$7,305,767	$0	$7,223,781	$7,223,781	$7,348,578	$124,796
California	$84,955,195	$0	$94,902,732	$94,902,732	$89,244,695	($5,658,037)
Colorado	$8,632,863	$0	$8,956,066	$8,956,066	$9,023,093	$67,027
Connecticut	$6,811,848	$0	$6,759,563	$6,759,563	$6,757,805	($1,758)
Delaware	$2,484,901	$0	$2,319,053	$2,319,053	$2,244,875	($74,178)
District of Columbia	$3,346,428	$0	$3,142,271	$3,142,271	$3,162,931	$20,660
Florida	$22,696,803	$0	$18,586,034	$18,586,034	$18,429,876	($156,158)
Georgia	$11,783,233	$0	$11,074,705	$11,074,705	$10,073,980	($1,000,725)
Hawaii	$2,265,400	$0	$2,114,869	$2,114,869	$2,073,221	($41,648)
Idaho	$2,348,323	$0	$2,828,961	$2,828,961	$2,759,153	($69,807)
Illinois	$21,689,976	$0	$19,570,462	$19,570,462	$19,184,751	($385,711)
Indiana	$13,362,559	$0	$14,548,808	$14,548,808	$16,761,407	$2,212,599
Iowa	$5,017,125	$0	$4,879,277	$4,879,277	$4,752,412	($126,865)
Kansas	$3,521,462	$0	$3,314,264	$3,314,264	$3,504,164	$189,899
Kentucky	$13,536,874	$0	$14,983,040	$14,983,040	$15,162,882	$179,841
Louisiana	$13,156,295	$0	$14,148,721	$14,148,721	$12,911,899	($1,236,822)
Maine	$3,085,834	$0	$2,991,794	$2,991,794	$2,939,508	($52,286)
Maryland	$11,147,912	$0	$10,476,295	$10,476,295	$10,550,469	$74,174
Massachusetts	$14,851,214	$0	$14,061,213	$14,061,213	$13,578,940	($482,272)
Michigan	$17,959,216	$0	$19,510,953	$19,510,953	$20,865,595	$1,354,642
Minnesota	$11,876,319	$0	$11,667,614	$11,667,614	$12,097,015	$429,400

[13] Obligation estimates for FY 2024 and 2025 reflect the State-reported estimates of Medicaid needs available to CMS in November 2023 and do not account for recently enacted legislation, regulations, or guidance.

State or Territory	FY 2023 Actual	Estimated FY 2024 obligations from:		FY 2024 (Estimated Obligation)	FY 2025 (Estimated Obligation)	FY 2025 +/- FY 2024
		Previous Authority	New Authority			
Mississippi	$5,371,461	$0	$5,699,192	$5,699,192	$5,806,664	$107,472
Missouri	$12,758,758	$0	$15,411,367	$15,411,367	$15,361,703	($49,664)
Montana	$1,943,520	$0	$1,978,688	$1,978,688	$2,016,899	$38,211
Nebraska	$2,728,846	$0	$2,723,315	$2,723,315	$2,716,155	($7,160)
Nevada	$4,418,969	$0	$3,516,280	$3,516,280	$3,774,102	$257,822
New Hampshire	$1,598,855	$0	$1,467,844	$1,467,844	$1,466,400	($1,444)
New Jersey	$14,925,546	$0	$14,946,548	$14,946,548	$15,550,360	$603,812
New Mexico	$6,959,319	$0	$7,806,355	$7,806,355	$7,714,003	($92,352)
New York	$58,257,924	$0	$63,150,829	$63,150,829	$59,359,578	($3,791,251)
North Carolina	$14,779,203	$0	$21,409,639	$21,409,639	$22,217,926	$808,287
North Dakota	$1,068,632	$0	$1,095,835	$1,095,835	$1,071,693	($24,142)
Ohio	$24,160,463	$0	$25,899,756	$25,899,756	$27,093,173	$1,193,417
Oklahoma	$7,194,943	$0	$7,923,604	$7,923,604	$8,356,113	$432,508
Oregon	$11,466,243	$0	$11,931,456	$11,931,456	$12,380,712	$449,256
Pennsylvania	$28,552,616	$0	$29,064,557	$29,064,557	$30,914,905	$1,850,348
Rhode Island	$2,434,908	$0	$2,471,634	$2,471,634	$2,566,513	$94,880
South Carolina	$6,638,976	$0	$6,459,597	$6,459,597	$5,793,720	($665,878)
South Dakota	$860,760	$0	$1,167,214	$1,167,214	$1,232,252	$65,038
Tennessee	$9,533,008	$0	$9,944,718	$9,944,718	$10,324,275	$379,557
Texas	$38,075,142	$0	$33,910,784	$33,910,784	$34,441,439	$530,655
Utah	$3,548,347	$0	$3,269,874	$3,269,874	$3,388,174	$118,300
Vermont	$1,424,838	$0	$1,410,139	$1,410,139	$1,426,250	$16,111
Virginia	$14,363,091	$0	$14,792,095	$14,792,095	$15,904,525	$1,112,430
Washington	$9,897,699	$0	$15,349,388	$15,349,388	$16,032,968	$683,580
West Virginia	$4,642,385	$0	$4,434,904	$4,434,904	$4,280,752	($154,151)
Wisconsin	$8,157,432	$0	$7,980,031	$7,980,031	$7,890,739	($89,292)
Wyoming	$464,314	$0	$478,385	$478,385	$479,609	$1,224
Territories/Other[14]						
American Samoa	$54,173	$0	$91,783	$91,783	$91,783	($0)
Guam	$163,055	$0	$175,347	$175,347	$175,361	$14
Northern Mariana Islands	$78,571	$0	$75,967	$75,967	$71,851	($4,116)
Puerto Rico	$3,446,142	$0	$3,633,898	$3,633,898	$3,749,404	$115,507
Freely Associated States	$0	$0	$0	$0	$0	$0
Virgin Islands	$157,506	$0	$156,415	$156,415	$176,103	$19,689
Indian Tribes	$0	$0	$0	$0	$0	$0
Undistributed[15]	$57,008,708	$0	($14,103,902)	($14,103,902)	$5,955,304	$20,059,206
Total	**$665,383,214**	**$0**	**$620,894,529**	**$620,894,529**	**$640,517,665**	**$19,623,136**

[14] 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 2025 reflects territory estimates at the time of publishing and are therefore subject to change.

[15] Includes grants to states for survey and certification, Medicaid Fraud Control Units, the Vaccines for Children program, and other adjustments. FY 2025 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, ~~$476,725,000,000~~ $521,757,000,000. 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, ~~$476,725,000,000~~ $521,757,000,000.	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 2023 Final	FY 2024 Estimate	FY 2025 President's Budget	FY 2025 +/- FY 2024
Budget Authority	$557,729,683	$476,725,000	$521,757,000	$45,032,000

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

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

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

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

Federal Contribution for SMI:

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

The FY 2025 estimated request of $408.9 billion is a net increase of $35.0 billion over the FY 2024 amount of $374.0 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 2025 estimated request of $37.0 million for Hospital Insurance for Uninsured Federal Annuitants is a net decrease of $7.0 million from the FY 2024 amount of

$44.0 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's administrative costs, initially borne by the 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 2025 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 2024.

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

The Medicare Prescription Drug Plan program was created as a result of the enactment of Public Law 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 2025 budget estimate of $110.8 billion for General Revenue for Part D (Benefits) is a net increase of $10.0 billion over the FY 2024 amount of $100.8 billion.

The FY 2025 budget estimate of $613.0 million request for General Revenue for Part D Federal Administration is a net increase of $90.0 million over the FY 2024 amount of $523.0 million.

The FY 2025 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 2025 budget estimate of $377.0 million for reimbursement of HCFAC is a net increase of $2.0 million over the FY 2024 amount of $375.0 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 2025 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 2023 Final	FY 2024 Estimate	FY 2025 President's Budget	FY 2025 +/- FY 2024
Supplementary Medical Insurance*	$434,353,300	$373,973,000	$408,939,000	$34,966,00
Hospital Insurance for Uninsured Federal Annuitants	$52,000	$44,000	$37,000	($7,000)
Program Management Administrative Expenses	$1,000,000	$1,000,000	$1,000,000	$0
General Revenue for Part D Benefit	$111,800,000	$100,805,000	$110,786,000	$9,981,000
Indefinite Annual Appropriation, Part D Benefits	$9,595,383	$0	$0	$0
General Revenue for Part D Federal Administration	$600,000	$523,000	$613,000	$90,000
Part D: State Low-Income Determination	$5,000	$5,000	$5,000	$0
Reimbursement for HCFAC	$324,000	$375,000	$377,000	$2,000
Total Budget Authority	**$557,729,683**	**$476,725,000**	**$521,757,000**	**$45,032,000**

*This includes a one-time transfer in FY 2023 for the Intravenous Immune Globulin Demonstration for $4.3M per H.R. 2617-1462 Section 4134.

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

The SSA'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 2021	$439,514,000,000
FY 2022	$497,862,000,000
FY 2023 Final	$557,729,683,000
FY 2024 Estimate	$476,725,000,000
FY 2025 President’s Budget	$521,757,000,000

Permanent Budget Authority
(Dollars in Thousands)

	FY 2023 Final	FY 2024 Estimate	FY 2025 President's Budget	FY 2025 +/- FY 2024
Tax on OASDI Benefits	$34,968,000	$39,454,000	$42,698,000	$3,244,000
HCFAC, FBI	$160,178	$168,347	$173,734	$5,387
HCFAC, Asset Forfeitures	$119,000	$35,000	$36,000	$1,000
HCFAC, Criminal Fines	$13,000	$21,045	$22,254	$1,209
HCFAC, Civil Penalties and Damages: Administration	$25,000	$43,475	$39,370	($4,105)
Total Budget Authority	**$35,258,178**	**$39,721,867**	**$42,969,358**	**$3,247,491**

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, ~~$937,000,000~~$941,000,000, to remain available through September 30, ~~2025~~2026, 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 ~~$667,359,000~~$703,868,000 shall be for the Centers for Medicare & Medicaid Services program integrity activities, of which ~~$112,434,000~~$111,508,500 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, of which ~~$122,207,000~~$125,623,500 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 ~~2024~~2025 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, ~~$325,000,000~~$311,000,000 is provided to meet the terms of ~~a concurrent resolution on the budget in the Senate~~section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, and ~~$612,000,000~~$630,000,000 is additional new budget authority specified for purposes of ~~a concurrent resolution on the budget for additional health care fraud and abuse control activities~~section 251(b)(2)(C) of such Act: 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 2025 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, ~~$937,000,000~~$941,000,000, to remain available through September 30, ~~2025~~2026, 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 ~~$667,359,000~~$703,868,000 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 ~~$112,434,000~~$111,508,500 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.
of which ~~$122,207,000~~$125,623,500 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~~:	Provides funding for the Department of Justice, and limits activities to those authorized under the original HIPAA statute.
Provided, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year ~~2024~~2025 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, ~~$325,000,000~~$311,000,000 is provided to meet the terms of ~~a concurrent resolution on the budget in the Senate~~section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, and ~~$612,000,000~~$630,000,000 is additional new budget authority specified for purposes of ~~a concurrent resolution on the budget for additional health care fraud and abuse control activities~~section 251(b)(2)(C) of such Act:	Specifies the $311 million base amount, necessary for the incremental cap adjustment funds to be appropriated, consistent with the Fiscal Responsibility Act of 2023. Additionally, specifies that once the $311 million base amount is met, that $630 million is available for appropriation as additional budget authority in FY 2025.
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 2025 under section 1817(k)(3)(A) of the Social Security Act 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 health care fraud and abuse and flexibility to fund through either discretionary or mandatory HCFAC funds.

Health Care Fraud and Abuse Control
(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	**CR**	**President's Budget**	**+/- FY 2024**
Discretionary				
CMS Program Integrity	$665,648	$665,648	$703,868	$38,220
OIG	$105,145	$105,145	$111,509	$6,364
DOJ	$122,207	$122,207	$125,624	$3,417
Subtotal, Discretionary	**$893,000**	**$893,000**	**$941,000**	**$48,000**
Mandatory, Current Law[1]				
CMS Program Integrity	$1,024,715	$1,076,310	$1,110,766	$34,456
OIG	$224,811	$236,276	$243,837	$7,561
HHS Wedge	$42,998	$45,191	$46,637	$1,446
DOJ Wedge	$70,192	$73,772	$76,133	$2,361
FBI	$160,178	$168,347	$173,734	$5,387
Subtotal, Mandatory, Current Law	**$1,522,894**	**$1,599,896**	**$1,651,107**	**$51,211**
Total	**$2,415,894**	**$2,492,896**	**$2,592,107**	**$99,211**
Mandatory, Proposed Law[2]				
CMS Program Integrity	$0	$0	$141,346	$141,346
OIG	$0	$0	$31,452	$31,452
HHS Wedge	$0	$0	$4,191	$4,191
DOJ Wedge	$0	$0	$10,019	$10,019
FBI	$0	$0	$22,602	$22,602
Subtotal, Mandatory, Proposed Law	**$0**	**$0**	**$209,610**	**$209,610**

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

FY 2024 Authorization – Public Law (P.L.) 104-191 and P.L. 118-35

Allocation Method – Other

Program Description and Accomplishments

Title II of the Health Insurance Portability and Accountability Act of 1996 established the Health Care Fraud and Abuse Control (HCFAC) program to detect, prevent, and combat health care fraud, waste, and abuse. The HCFAC account is structured to ensure

[1] All mandatory amounts are net of sequester.
[2] All mandatory amounts are net of sequester and reflect the proposed increases to mandatory HCFAC resources.

resources provided to the Department of Health and Human Services (HHS) Office of Inspector General (OIG), the Department of Justice (DOJ), and CMS allow for these entities to coordinate oversight and law enforcement efforts to target bad actors efficiently and effectively.

Discretionary HCFAC resources have been critical to the success of the federal partners over the years in addressing health care fraud. Additional discretionary investments in FY 2025 will strengthen the integrity and sustainability of the Medicare, Medicaid, and Marketplace programs through prevention and law enforcement efforts.

In addition to discretionary resources, mandatory funding also supports CMS and its federal partners. CMS receives funding to carry out the Medicare Integrity Program, as described in section 1893 of the Social Security Act, including the Medicare-Medicaid Data Match Program (Medi-Medi). Section 1817 of the Social Security Act describes amounts that the Secretary of HHS and the Attorney General jointly certify as necessary to finance anti-fraud activities, up to a maximum specified in the appropriation (the HHS and DOJ Wedge funds); certain portions of this funding are set aside for HHS-OIG's Medicare and Medicaid activities. Additionally, the Federal Bureau of Investigation (FBI) receives funding for its health care fraud enforcement efforts.

Collaboration Among Federal Partners

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 Health Care Fraud Strike Force teams, which investigate and track down individuals and entities that are defrauding Medicare and other government health care programs. Since FY 2020 alone, Strike Force prosecutors have charged more than 1,200 defendants who have collectively billed federal health care programs and private insurers approximately $8.6 billion.

CMS also coordinates with its law enforcement partners through the Major Case Coordination (MCC) initiative, 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 more than 4,000 cases reviewed at MCC, and law enforcement partners have made more than 2,600 requests for CMS to refer reviewed cases.

The federal partners target areas with high incidence of fraud to carry out the synchronized efforts to reduce fraud and recover taxpayer dollars. Together, activities like 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 $2.90 to $1.00 return on investment for law enforcement and detection efforts over a three-year period (2020-2022). Notably, the return on investment has been adversely impacted by COVID-19. Court closures as well as interrupted or slowed enforcement activities all contributed to lower recoveries, disallowances, and restitutions for FYs 2020-22.

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 for 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. CMS is taking steps to address program integrity efforts with the current legislative authorities and financial resources available, which include: more stringent scrutiny of applicants seeking to bill the Medicare program; increased collaboration with law enforcement; enhanced oversight of Medicare Advantage (MA) organizations 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

Medicaid is a federal-state partnership, and this partnership is central to the program's success. CMS provides states with guidance to use in meeting statutory and regulatory requirements; technical assistance, including tools and data; federal matching funds for their expenditures; and other resources. States fund their share of the program, and, within federal and state guidelines, operate their individual program through activities including setting rates, paying claims, enrolling providers and beneficiaries, contracting with private plans, improving service quality, and claiming expenditures. States and CMS share responsibility for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse.

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. CMS exercises appropriate oversight over Medicaid expenditures as well as states' enterprise systems. HCFAC funding also supports efforts to reduce improper payments through the Payment Error Rate Measurement (PERM) program. In addition to HCFAC funding, CMS conducts its Medicaid program integrity efforts using Medicaid Integrity Program resources, described in greater detail in the State Grants and Demonstrations chapter.

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 advance premium tax credits (APTCs), 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. CMS annually measures and reports the estimated improper payments for the APTC program in the FFM. CMS reported an improper payment rate for the APTC program for the first time in the FY 2022 Agency Financial Report (AFR).

In FY 2023, CMS triaged more than 73,000 complaints from consumers who alleged they were enrolled in FFM policies without their consent, that incorrect information was submitted on an application by an agent or broker, or that other misconduct had occurred. As a result of these investigations and our own data analytics, in FY 2023, CMS suspended 28 agent/broker agreements to participate in the FFM, 22 of which were terminated for a period of 3 years after they failed to demonstrate the suspected fraudulent enrollments were valid.

Funding History[3]

5 Year Funding Table	
FY 2021[4]	$2,220,011,000
FY 2022	$2,311,989,000
FY 2023 Final	$2,415,894,000
FY 2024 CR	$2,492,896,000
FY 2025 President's Budget[5]	$2,592,107,000

Since its inception in 1997, HCFAC has been financed from the Federal Hospital Insurance Trust Fund, which provides both mandatory and discretionary funding.[6]

In FY 2011, the Budget Control Act of 2011 (BCA) created a discretionary cap adjustment for HCFAC funding for 10 years, from FY 2012 through FY 2021. In FY 2023, the Fiscal Responsibility Act of 2023 (FRA) established cap adjustments for HCFAC in FY 2024 and FY 2025. These cap adjustments allow HHS and DOJ to enhance existing, successful health care fraud prevention and law enforcement efforts by investing in proven anti-fraud and abuse strategies.

Budget Request: $941.0 million

The FY 2025 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2025 request for discretionary funding is $941.0 million, $48.0 million above the FY 2024 CR Level and in line with the increase included in the FRA. The total post-sequester FY 2025 current law mandatory funding level is $1,651.1 million, $51.2 million above the FY 2024 CR Level.

The FY 2025 budget assumes discretionary HCFAC spending will continue over the 10-year budget window through dedicated program integrity discretionary investments,

[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.
[5] Amount based on current law.
[6] The Trust Fund is reimbursed for discretionary HCFAC activities properly chargeable to the general fund, such as Part D and Medicaid activities. Additional detail can be found in the Payments to the Health Care Trust Funds chapter.

pursuant to the Congressional Budget Act in the Congressional Budget Resolution. Of the $941.0 million in discretionary HCFAC funding for FY 2025, $630.0 million is additional new budget authority pursuant to the FRA.

HCFAC Discretionary Investments and Savings (Amounts in Millions)										
	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
HCFAC Discretionary Investments (BA) [Non-add]	*$630*	*$649*	*$668*	*$668*	*$709*	*$730*	*$752*	*$775*	*$798*	*$822*
HCFAC Discretionary Investments (Outlays)	$442	$602	$622	$640	$659	$679	$700	$721	$742	$765
Federal Health Care Savings from HCFAC Discretionary Investments	-$1,215	-$1,287	-$1,362	-$1,441	-$1,485	-$1,529	-$1,575	-$1,623	-$1,671	-$1,722
Net Federal Health Care Savings from HCFAC Discretionary Investments	-$773	-$685	-$740	-$801	-$826	-$850	-$875	-$902	-$929	-$957

The FY 2025 CMS allocation of the discretionary HCFAC request is $703.9 million, which is $38.2 million above the FY 2024 CR Level and reflects activities that support the emerging needs across all health care programs under CMS's jurisdiction. In addition to ongoing operations for a wide array of program integrity activities, the request focuses increased discretionary resources on activities such as prior authorization, Medicaid systems, Marketplace improper payment measurement, and strengthening program integrity in Medicare Part C and Part D.

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. 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, increasing the risk of fraud, waste, and abuse for this vulnerable population.

Without additional resources, HHS may have to forgo investigating serious instances of fraud, waste, and abuse. Top priorities that require additional funding for CMS include:

- Increasing Medicare fee-for-service medical review, including the possible adoption of artificial intelligence (AI) and natural language processing technologies;
- Addressing vulnerabilities identified by the Vulnerability Collaboration Council, report recommendations from the Government Accountability Office (GAO) and HHS-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 enforcement of home and community-based services (HCBS); and
- Quickly addressing fraud scams, as needed, above current levels.

CMS Program Integrity – HCFAC Funding by Authority

(Dollars in Thousands)

Activity	FY 2025 Discretionary Request	FY 2025 Mandatory Funding	FY 2025 Total
Provider Enrollment & Screening	$63,392	$24,170	$87,562
Technical Assistance, Outreach & Education	$81,670	$42,320	$123,990
Medical Review	$71,135	$225,192	$296,326
Medicare Secondary Payer	$0	$121,504	$121,504
PI Investigation, Systems & Analytics	$166,024	$216,416	$382,440
Audits & Appeals	$99,830	$189,709	$289,539
Provider & Plan Oversight	$38,273	$28,733	$67,006
Error Rate Measurement	$81,425	$26,390	$107,815
Program Support & Administration	$102,120	$236,332	$338,451
Total[7]	**$703,868**	**$1,110,766**	**$1,814,634**

Provider Enrollment & Screening

Provider enrollment is the gateway to the Medicare and Medicaid programs and is the key to preventing ineligible providers and/or suppliers from entering either program. Medicare and Medicaid providers and suppliers are required to undergo screening, including enhanced screening for certain high-risk providers and suppliers, and may be deemed ineligible to participate in CMS's health care programs or have their enrollment revoked and consequently, ineligible for continued participation.

Through investments in provider screening and enrollment, CMS continues to prevent and reduce fraud, waste, and abuse in the Medicare and Medicaid programs and ensure that only eligible providers are caring for beneficiaries and receiving payment.

Budget Request: $63.4 million

The discretionary request for Provider Enrollment & Screening activities is $63.4 million, an increase of $5.0 million above the FY 2024 CR Level. Funding will support ongoing operations, including the Advanced Provider Screening (APS) system and the launch of PECOS 2.0.

- *Provider Enrollment, Chain, and Ownership System (PECOS):* $27.0 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

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

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 in FY 2024.

- *Advanced Provider Screening (APS):* $35.0 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 2023, APS resulted in more than 10 million screenings which generated more than 55,000 potential licensure alerts and more than 700 criminal alerts for potentially fraudulent providers and suppliers for further review by CMS. Such review resulted in approximately 237 criminal revocations, 284 licensure revocations, and more than 23,000 licensure deactivations. In FY 2025, funding will support normal operations after a contract recompete in FY 2024. [This activity will be supplemented with $2.1 million in mandatory HCFAC funds.]

- *National Supplier Clearinghouse (NSC):* Enrollment plays an important program integrity role for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers. In FY 2023, the NSC was replaced by two National Provider Enrollment contractors. The National Provider Enrollment East and West contractors process all Medicare enrollment applications for DMEPOS suppliers as well as provide state Medicaid agencies with the option of having Medicare complete their DMEPOS provider screening. [This activity will be funded with $12.2 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 works 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. Additional resources in FY 2025 will cover an expected contract recompete. [This activity will be funded with $9.9 million in mandatory HCFAC funds.]

- *Medicaid Provider Enrollment:* $1.4 million. The Medicaid Data Exchange (DEX) system shares provider termination and revocation data among CMS and the state 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 2023, CMS received 2,015 termination submissions through the DEX system from states.

Technical Assistance, Outreach & Education

CMS uses a variety of strategies and communication channels to offer Medicare providers and suppliers a broad spectrum of information about the Medicare program to promote

appropriate billing and reducing improper payments. The activities detailed below also include effective tools in reaching beneficiaries with ways to protect against health care fraud, waste, and abuse.

CMS also maintains key relationships with relevant federal and state agencies, and other stakeholders impacted by CMS's program integrity activities.

Budget Request: $81.7 million

The discretionary request for Technical Assistance, Outreach & Education activities is $81.7 million, an increase of $2.8 million above the FY 2024 CR Level. This funding will support ongoing operations, with greater resources directed towards oversight of state Medicaid systems.

- *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 $33.6 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 supports a strong media delivery to ensure beneficiaries are educated on how to protect their Medicare number and to expand outreach in communities that are particularly susceptible to scammers. [This activity will be funded with $7.0 million in mandatory HCFAC funds.]

- *Healthcare Fraud Prevention Partnership (HFPP):* $21.2 million. The HFPP is a voluntary, public-private partnership between the Federal Government, state and local agencies, law enforcement, private health insurance plans, and health care anti-fraud associations to identify and reduce fraud, waste, and abuse across the health care sector. The HFPP allows for the exchange of data and information, leveraging various analytic tools using claims and other data provided by HFPP partners, and providing a forum for leaders and subject matter experts to share successful practices and effective methodologies. The HFPP currently has a broad membership comprised of 303 Partners. The FY 2025 request will support the recompete of the Trusted Third Party (TTP), ongoing operations of the Data Analytics contractor, and the medical review conducted by the Supplemental Medical Review Contractor (SMRC).

- *Senior Medicare Patrol (SMP):* $35.0 million. CMS requests $35.0 million in discretionary resources to support the Administration for Community Living (ACL) SMP program. The mission of the SMP program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. In calendar year 2022, SMP activities reached an estimated 1,000,240 people through 18,274 group outreach and education events and held 246,722 individual counseling sessions with, or on behalf of, Medicare beneficiaries. The COVID-19 public health emergency (PHE) continued to present challenges that limited the SMP program's in-person activities in 2022.

- *Medicaid Enterprise System:* $17.5 million. CMS provides over $13 billion annually in federal financial participation for state Medicaid systems that determine Medicaid

beneficiary 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 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. Additional funding in FY 2025 will allow for greater capacity to meet the growing workload associated with state Medicaid systems.

- *Other Targeted Outreach, Education and Assistance:* $8.0 million. This funding supports the Medicare Coverage 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 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. Medical review 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: $71.1 million

The discretionary request for medical review activities is $71.1 million, an increase of $14.3 million above the FY 2024 CR Level. This funding supports ongoing operations, with additional funding for prior authorization and the Supplemental Medical Review Contractor (SMRC) as well as the development of a decision support tool to assist in the review of DMEPOS orders.

- *Medical Review - Ongoing Operations (MACs):* The MACs 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 2025 request supports ongoing medical review operations, including Targeted Probe and Educate (TPE). Medical review helps reduce the error rate and is also used in vulnerabilities management. In FY 2023, the MACs completed pre-payment review on approximately 464,398 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. [This activity will be funded with $176.4 million in mandatory HCFAC funds.]

- *Supplemental Medical Review Contractor (SMRC):* $20.4 million. The SMRC conducts nationwide medical review of Medicare claims, as directed by CMS. This funding supports Specialty Reviews for issues identified by Federal agencies such as HHS-OIG, GAO, and other CMS groups as well as Program Integrity Reviews that focus on ensuring claims and encounter data are paid correctly. In FY 2023, the SMRC reviewed approximately 124,936 claims. [This activity will be supplemented with $25.6 million in mandatory HCFAC funds.]

- *Prior Authorization:* $26.8 million. Prior authorization is a key corrective action towards lowering improper payments. In recent years, CMS has increased the number of DMEPOS items and hospital outpatient department services subject to prior authorization. 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.

  The MACs review prior authorization requests, perform work related to appeals, conduct customer service operations, provide outreach and education, and create reports. CMS is requesting additional funding in FY 2025 to meet the growing prior authorization workload.

- *Accuracy Reviews:* $3.2 million. The Medical Review Accuracy Contractor (MRAC) conducts medical review of review determinations made by contractors (e.g., MACs and SMRC). The results allow CMS to develop an accuracy score for each contractor and determine where inconsistencies may exist. The FY 2023 standard average accuracy review percentage was 99.7 percent. In FY 2023, the MRAC completed 13,436 standard workload claim reviews. CMS expects approximately 12,000 accuracy reviews to be completed in FY 2024. [This activity will be supplemented with $2.9 million in mandatory HCFAC funds.]

- *Medical Review Systems:* $15.9 million. This funding supports IT operations for multiple medical review activities including the National Correct Coding Initiative (NCCI) for Medicare and Medicaid, the Services Tracking Analysis and Reporting System (STARS), and the Electronic Submission of Medical Documentation (esMD). These systems ensure proper coding of claims, control overpayments, and assist in detecting, analyzing, investigating, coordinating, and documenting cases of fraud, waste, and abuse. [This activity will be supplemented with $7.2 million in mandatory HCFAC funds.]

- *Other Medical Review Activities:* $4.8 million. This funding provides operational support for medical review 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 also addresses inappropriate prescribing and/or diagnoses of schizophrenia relating for beneficiaries in skilled nursing facilities.

CMS continues to explore the use of 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. For example, CMS is developing a decision support tool to assist with real-time approvals of certain DMEPOS items based on Medicare guidelines. [This activity will be supplemented with $13.0 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 over $9 billion through cost avoidance and recoveries.

In FY 2025, this activity will be funded with $121.5 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: $166.0 million

The discretionary request for PI Investigation, Systems & Analytics activities is $166.0 million, an increase of $5.1 million above the FY 2024 CR Level. This funding supports ongoing operations, with additional funding to support the Medicare Drug Integrity Contractors (MEDICs) as well as systems supporting encounter data collection.

- *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, GAO, HHS-OIG, the Medicare FFS Recovery Audit Contractors, 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 $25.2 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. The UPICs conduct reviews of Medicare and Medicaid claims payments to ensue payments are appropriate and consistent with coverage coding regulations and policies, and also identify, prevent, or correct potential fraud

waste and abuse. [This activity will be funded with $111.3 million in mandatory HCFAC funds.]

- *PI Modeling & Analytics Support:* $26.7 million. 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. These efforts include supporting CMS's law enforcement partners and expanding the use of innovative analytical tools such as AI. CMS also plans to significantly expand its efforts in Medicaid by adding all Medicaid claims data to FPS and conducting new work in managed care.

  This activity includes other program integrity activities such as the Medicare Exclusion Database, the Medicaid support for the National Plan and Provider Enumeration System (NPPES) application, transparency and other analysis efforts with provider enrollment data, and support to provide statistical expertise on the estimation and extrapolation of overpayments. [This activity will be supplemented with $31.9 million in mandatory HCFAC funds.]

- *Fraud Prevention System (FPS):* FPS is the predictive analytics technology required under the Small Business Jobs Act of 2010. FPS applies proven and effective predictive modeling tools into the Medicare claims processing system to stop payment on high-risk claims and perform analysis on paid claims to generate alerts of potentially fraudulent providers for further investigation. During FY 2023, the FPS generated alerts that resulted in 1,137 new leads for program integrity contractors and augmented information for 1,994 existing leads or investigations. [This activity will be funded with $33.7 million in mandatory HCFAC funds.]

- *One PI:* $20.0 million. One PI provides CMS staff, program integrity contractors, and law enforcement with centralized access to data from the Integrated Data Repository and analytical tools. Users can access and analyze enterprise Medicare and Medicaid data that will help combat fraud, waste, and abuse. Reduced discretionary costs reflect a new contract after a recompete in FY 2024, as well as increased funding with mandatory resources. [This activity will be supplemented with $4.5 million in mandatory HCFAC funds.]

- *Case Management:* $20.0 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; capture and manage workflow; report workload metrics; report the status of administrative actions and referrals to law enforcement; and record the outcomes or disposition of audit and investigative actions. The UCM 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 to an open source, cloud-based solution. [This activity will be supplemented with $9.9 million in mandatory HCFAC funds.]

- *Application Programming Interface (API) Gateway:* $10.7 million. The API Gateway is a full lifecycle API management platform that will be used to develop, deploy, and manage APIs for various program integrity systems. 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. CMS's program integrity partners (e.g., law enforcement and contractors) depend on these systems and related data for fraud, waste, and abuse activities.

- *Medicare Drug Integrity Contractors (MEDICs):* $26.6 million. CMS supports ongoing program integrity efforts in Medicare Part C and Part D using two MEDICs. The Investigations MEDIC (I-MEDIC) conducts investigations, recommends administrative actions, and submits case referrals to law enforcement. The Plan Program Integrity MEDIC (PPI MEDIC) analyzes Part C and Part D data, conducts audits of plan sponsors, and provides outreach and education support. The additional funds in FY 2025 will allow the MEDICs to better meet the oversight needs in these programs.

  In FY 2023, the I-MEDIC initiated 695 investigations; submitted 73 recommendations for provider revocations; submitted 174 referrals to law enforcement, including 63 immediate advisements; and submitted 157 referrals to other entities, such as state pharmacy boards, Medicare quality improvement organizations, and other Medicare contractors.

  In FY 2023, the PPI MEDIC implemented six Self-Audits (in addition to four ongoing audits), three National Audits (in addition to six ongoing audits), and three Program Integrity (PI) Audits (in addition to four ongoing audits) and supported additional education and outreach initiatives for plan sponsors. For FY 2024 and FY 2025, the PPI MEDIC is tentatively scheduled to work on 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:* $23.0 million. MA organizations and Medicare-Medicaid Plans submit, on average, 4.1 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. Additional funding will cover costs relating to supplemental benefits and dental claims data collection.

- *Medicaid and CHIP Program System (MACPRO):* $11.6 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 2025 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:* $9.5 million. T-MSIS is a data ingestion application and reporting tool that collects state 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. T-MSIS develops and uses tools to monitor the quality of state data submissions against priority reporting areas as well as to expanded data quality checks. This national dataset is important to multiple aspects of operations, including policy making, program monitoring, program integrity oversight, program evaluation, auditing, and other investigations. Funding supports operations, continued efforts to further improve data quality, 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:* $6.1 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:* $11.8 million. CMS continues to safeguard the Health Insurance Marketplaces using a range of program integrity activities. This includes data analytics and investigations to prevent, identify, and address allegations of fraud and abuse, as well as efforts to identify and mitigate program vulnerabilities. CMS also reviews and evaluates 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: $99.8 million

The discretionary request for Audit & Appeals activities is $99.8 million, an increase of $7.5 million above the FY 2024 CR Level. This funding will continue CMS's auditing functions and appeals initiatives in FY 2025, with increased funding for Risk Adjustment Data Validation (RADV) audits and appeals as well as program audits of MA organizations.

- *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 2023, the MACs received and accepted approximately 54,061 Medicare cost reports, which included initial as well as amended cost report filings; approximately 43,740 cost reports were desk reviewed and tentatively settled; and approximately 515 audits were completed. [This activity will be funded with $159.6 million in mandatory HCFAC funds.]

- *Targeted Provider Cost Report Audits:* $3.0 million. This activity addresses a wide range of other cost report auditing activities, such as appeals support and risk assessments. CMS is responsible for evaluating Medicare, Medicaid, and other private plan sponsors' performance in the delivery of health and drug services and ensure that beneficiaries receive appropriate services for which these sponsors have already been paid to provide. [This activity will be funded with $19.0 million in mandatory HCFAC funds.]

- *Risk Adjustment Data Validation (RADV):* $30.0 million. CMS uses enrollee diagnoses information submitted by MA organizations to risk-adjust payments to plans each payment year. CMS conducts RADV audits for a sample of enrollees and MA organizations' contracts to verify that enrollee diagnoses are supported by medical record documentation and identify overpayments. CMS will continue using advanced analytics to focus audits on high-risk areas, reducing the burden of audits that comply with CMS rules on MA organizations, improving the timeliness of audits, and exploring ways to improve audit efficiency. CMS published a final regulation on February 1, 2023, that codifies the Agency's long-term RADV methodology. In FY 2024, CMS expects to begin collecting overpayments resulting from past CMS and HHS-OIG RADV audits, processing appeals submitted by MA organizations related to these overpayment determinations, and initiating RADV audits of additional MA payment years. These activities will continue into FY 2025, and CMS will continue to explore ways of strengthening and streamlining RADV audit processes. [This activity will be supplemented with $1.5 million in mandatory HCFAC funds.]

- *Cost Plan Audits:* $3.1 million. As part of its fiscal oversight over Medicare managed care organizations, CMS supports audits of managed care cost reports to ensure costs are allowable and in accordance with contract requirements and CMS regulations. Audit activities include cost report examinations performed by independent audit contractors as well as medical review performed by medical coders. Funding also supports modules within the Health Plan Management System (HPMS) used for audit tracking, administration, communication, and storage.

- *Part C & D Audits:* $7.3 million. Sections 1857(d)(1) and 1860D-12(b)(3)(c) of the Social Security Act require audits of financial records of MA organizations and PDPs. CMS performs approximately 240 audits annually, as well as resolution of the audit issues noted in the audit reports. Prompt audits of the financial data permit CMS to evaluate and refine its plan oversight, which assures accurate bidding and enhances

payment accuracy.

- *Targeted Programmatic Compliance Audits:* $23.8 million. CMS conducts 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. The increased funding would allow CMS to increase the number of audits of MA organizations that may be particularly risky, including evaluating new requirements related to utilization management in MA.

- *Medical Loss Ratio (MLR) Audits:* $1.2 million. CMS conducts targeted audits of Medicaid Managed Care Organizations' (MCOs') compliance with Medicaid MLR requirements in high-risk states. This work includes conducting analyses to identify the states most at risk as well as 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 findings from single state agency audits and HHS-OIG audits of state Medicaid and CHIP 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 2025 request supports financial management oversight activities to assist CMS in researching and analyzing data to create recommendations to better manage and oversee Medicaid funding to increase accountability and improve financial integrity of CMS and state Medicaid and CHIP programs.

- *Appeals Initiatives:* $12.8 million. CMS conducts 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 and the administrative adjudicative process established for MA organizations to appeal RADV determinations to a CMS Hearing Officer. Increased funding is requested to handle the growing number of expected 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. Historically, the ALJ cases in which the QIC has participated as a party generally have lower ALJ overturn rates.

- *Internal Controls Audits:* $2.8 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. This 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 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:* $11.9 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 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 $8.6 million in mandatory HCFAC funds.]

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: $38.3 million

The discretionary request for Provider & Plan Oversight activities is $38.3 million, an increase of $1.1 million above the FY 2024 CR Level. Funding will support ongoing operations for oversight activities.

- *Open Payments:* The Open Payments program is a statutorily required national disclosure program that promotes transparency and accountability by providing the public with information regarding the financial relationships between the health care industry (pharmaceutical and medical device manufacturers and their distributors) and health care providers (physicians, physician assistants, certain advanced practice nurses, and teaching hospitals). In Program Year 2022, reporting entities collectively reported $12.6 billion in publishable payments and ownership and investment interests. These payments are comprised of 14.1 million payment records attributable to 588,514 physicians, 271,682 non-physician practitioners, and 1,240 teaching hospitals. The FY 2025 request supports ongoing operations along with the go-live for system modernization efforts and cloud migration. [This activity will be funded with $28.7 million in mandatory HCFAC funds.]

- *Part C & D Payment Analysis, Validation and Reconciliation:* $5.2 million. CMS maintains several controls to ensure that Part C and Part D payments are correct. CMS conducts a routine monthly Beneficiary Payment Validation (BPV) process prior to payment authorization to confirm that the calculated payments for MA, Part D, Cost Plan, PACE, and demonstration plans are accurate regarding using the appropriate source data and consistent application of the current payment rules. This work also includes validating and processing retroactive requests for enrollment and related transactions. The decrease in funding reflects a shift to mandatory funding resources for certain reconciliation activities. As of January 2024, the monthly payments average $49.2 billion representing 55.4 million beneficiaries.

- *Part C & D Review of Plans and Performance:* $23.9 million. CMS conducts activities that support the monitoring and oversight strategy for the Part C and Part D programs,

including sponsors' compliance with CMS marketing, formulary, and enrollment guidelines, and appeals processes. 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. CMS develops and collects MA Healthcare Effectiveness Data and Information Set (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 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 and monitors the reasons beneficiaries leave their plans.

- *Rate Reviews:* $6.3 million. This funding supports CMS's efforts to ensure proper billing and rate reimbursement in Home and Community-Based Services (HCBS) waiver and state plan programs and improve oversight of rate setting and financial reporting for PACE. 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, providing technical assistance, and the detection and prevention of fraud and abuse in the delivery of personal care and other HCBS services.

- *Section 1115:* $3.0 million. Section 1115(a) of the Social Security Act 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 oversight efforts to enhance the review and monitoring of 1115 demonstrations.

Error Rate Measurement

Under the Payment Integrity Information Act of 2019, CMS is required to estimate the amount of improper payments, submit those estimates to Congress, and report on actions the agency is taking to reduce improper payments. Through this work, CMS better understands not only the amount of improper payments in its health care programs but also the drivers of those improper payments. CMS currently measures improper payments in Medicare, Medicaid, CHIP, and the APTC program in the FFM. Additional information on these programs can be found in the HHS Agency Financial Report.

Budget Request: $81.4 million

The discretionary request for Error Rate Measurement activities is $81.4 million, an increase of $4.6 million above the FY 2024 CR Level. This funding supports ongoing operations, including additional funding to implement measurement in the State-based Marketplaces (SBMs).

- *Comprehensive Error Rate Testing (CERT):* CMS annually estimates the Medicare FFS improper payment rate through the CERT program. The CERT program reviews a stratified random sample of Medicare FFS claims to determine if CMS properly paid

claims under Medicare coverage, coding, and billing rules. [This activity will be funded with $26.4 million in mandatory HCFAC funds.]

- *Part C & D Error Rate Measurement:* $12.7 million. CMS annually calculates the improper payment rates for the Part C and Part D programs. The Part C methodology estimates improper payments resulting from errors in beneficiary risk scores while the Part D methodology measures payment error relating to prescription drug event data.

- *Payment Error Rate Measurement:* $46.9 million. CMS annually measures the improper payment rates for Medicaid and CHIP through the PERM program. The improper payment rates are based on reviews of the FFS, managed care, and eligibility components of Medicaid and CHIP. In FY 2025, development will continue on PERM program system/process improvement efforts and AI initiatives that are expected to improve accuracy, decrease provider burden, and reduce the time contractors need to complete work.

- *Marketplace Improper Payment Assessment:* $21.9 million. CMS annually measures the improper payment rate for the APTC program in the FFM. In FY 2025, CMS will continue measurement in the FFM as well as development of an improper payment measurement program for the SBMs, including pre-testing and assessment activities. This increased funding would allow CMS to begin implementing the improper payment measurement methodology for an initial group of SBMs in FY 2025.

Program Support and Administration

CMS depends on several programmatic and operational support activities that are critical to achieving the Agency's program integrity goals. This includes program support to help achieve CMS's program integrity goals, critical enterprise-level services, and the CMS federal staff carrying out HCFAC activities. These activities achieve economies of scale and allow for business owners to reuse existing processes to reduce cost.

Budget Request: $102.1 million

The discretionary request for Program Integrity Support and Administration activities is $102.1 million, a decrease of $2.2 million below the FY 2024 CR Level. This funding will support ongoing operations; fewer resources will be needed as certain Medicaid activities will be completed in FY 2024.

- *Administrative Costs:* This funding covers employee compensation, rent and utilities, and other administrative expenses that support HCFAC activities. [This activity will be funded with $183.0 million in mandatory HCFAC funds.]

- *Medicaid PI Improvements:* $10.3 million. CMS supports a number of efforts to support state Medicaid programs in reducing improper payments, promoting regulatory compliance, and addressing program vulnerabilities. With this funding, CMS will continue to identify and mitigate vulnerabilities in Medicaid and CHIP. Funding will support the Agency's oversight of state Medicaid managed care programs and program monitoring, including reporting associated with the Managed Care Annual Program Report (MCPAR) and Network Adequacy and Access Assurances Report (NAAAR), and activities associated with state use of in lieu of services and supports (ILOSs) as well as state plan amendments and other state actions. CMS will continue its efforts to reduce state errors relating to eligibility and enrollment policies. Less funding will be

needed in FY 2025 after efforts supporting states' Medicaid drug programs will be completed in FY 2024.

- *Risk Management Support:* $2.7 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:* $11.0 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), modeling and analytics support developers, and an HPMS module. This funding will also support Integrated Data Repository infrastructure to support law enforcement access to data. [This activity will be funded with $21.3 million in mandatory HCFAC funds.]

- *Ongoing Systematic Support for all PI Programs:* $36.8 million. This funding supports operations and maintenance for the Common Working File, the Single Testing Contract, the CMS Analysis Reporting and Tracking System, 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 program integrity efforts, tracking detailed financial activity, deliverables and the performance of contracts, and other electronic data interchanges. [This activity will be supplemented with $27.2 million in mandatory HCFAC funds.]

- *Enterprise Services:* $41.3 million. HCFAC activities benefit from investments that span multiple program areas or provide CMS-wide services. These enterprise services include shared IT services, HSPD-12, contract closeout support, and litigation and enforcement support from the Office of General Counsel. [This activity will be supplemented with $4.8 million in mandatory HCFAC funds.]

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 health care-related offenses accountable through criminal and civil actions, while providing recommendations for improving the health care system to HHS policymakers, program officials, and Congress. As described in the FY 2022 HCFAC Report to Congress, in FY 2022, HHS-OIG's Medicare and Medicaid oversight efforts in resulted in 661 criminal actions and 726 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties settlements and administrative recoveries related to provider self-disclosure matters. In addition, HHS-OIG excluded a total of 2,332 individuals and entities from participation in Federal health care programs. For FY 2022, 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 $2.9 billion.

Budget Request: $111.5 million

The FY 2025 HHS-OIG discretionary request is $111.5 million, an increase of $6.4 million above the FY 2024 CR Level. In addition, current law mandatory resources total $243.8 million for a total operating budget of $355.3 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 health care fraud and abuse investigation and litigation. These offices dedicate substantial resources to combating health care fraud and abuse. HCFAC funding builds on those resources by providing dedicated positions for attorneys, paralegals, auditors, and investigators, as well as funds for electronic discovery, data analysis, and litigation of resource-intensive health care fraud cases. DOJ also provides additional funding to the FBI for Strike Force and other health care fraud investigations, and to the DOJ Office of the Inspector General for audits and investigations.

Budget Request: $125.6 million

The FY 2025 DOJ discretionary request is $125.6 million, an increase of $3.4 million above the FY 2024 CR Level. In addition, current law mandatory resources total $76.1 million for a total operating budget of $201.7 million.

FEDERAL BUREAU OF INVESTIGATION (FBI)

Program Description and Accomplishments

The FBI is responsible for detecting and investigating health care fraud in the United States and has jurisdiction over crimes targeting Federal health insurance programs and private health insurance plans. Each of the FBI's 56 field offices have personnel assigned to investigate health care fraud matters. FBI special agents, intelligence analysts, and professional staff members at headquarters and in the field, work proactively to identify and target health care fraud in all its forms. In FY 2022, the FBI opened 625 new health care fraud investigations. At the end of FY 2022, 3,103 investigations were pending. Investigative efforts throughout the fiscal year produced 495 criminal health care fraud convictions, 389 indictments, and 190 prosecutors' informations. In addition, investigative efforts resulted in over 499 operational disruptions of criminal fraud organizations and the dismantlement of more than 132 health care fraud criminal enterprises. The FBI's efforts in combatting health care fraud, in coordination with the efforts of our Federal, state, and local law enforcement and regulatory partners, as well as our partners in the private sector, are crucial to the success and sustainability of the health care system that so many Americans depend upon.

The FY 2025 FBI budget includes current law mandatory resources in the amount of

$173.7 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 2023, negotiated amounts were $43.0 million, not including carryover from the prior year, for distribution among HHS components and $70.2 million for DOJ. The HHS portion of the wedge awards funded the following activities during FY 2023:

Administration for Community Living (ACL): Wedge funds have allowed ACL to fund Senior Medicare Patrol (SMP) projects in each state, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. SMP projects provide education to Medicare beneficiaries and the public through in-person and virtual outreach events, media activities, and one-on-one assistance to those who contact the program with questions or suspected cases of Medicare fraud. This Wedge funding has supplemented ACL's base funding.

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 $453 million to date in FY 2023.

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 made 104 arrests, brought 72 convictions, and collected $435,878,583 million in fines, restitution, and forfeiture. Additionally, FDA uses HCFAC funds to establish a presence in Guam and support a collaborative partnership with the Guam Department of Environmental Health to stop the importation of fraudulent, misbranded or adulterated medical products.

Office of Civil Rights (OCR): OCR uses HCFAC funds to support efforts to combat health care fraud and abuse by ensuring entities that HHS funds through Medicare, Medicaid, the Affordable Care Act, and other health care programs do not use funds in a discriminatory manner by unlawfully institutionalizing individuals in costly and unnecessary nursing homes and other segregated congregate facilities.

Assistant Secretary for Financial Resources, Office of Finance (ASFR OF): ASFR OF uses HCFAC funds to improve HHS's overall Fraud Risk Management approach. ASFR OF works with HHS Divisions to complete fraud risk assessments, identifies and implements fixes to the information technology infrastructure to support future fraud risk assessments and develops user guides on fraud risk assessment.

Centers for Medicare & Medicaid Services: CMS uses HCFAC funds to develop advanced analytic solutions and workflows to review skilled nursing facilities and any deficiency findings for not meeting the minimum standards of care to be a Medicare/Medicaid-

certified provider.

HHS Office of Inspector General: FY 2023 Wedge funds have supported several HHS/OIG projects that aim to improve HHS/OIG's ability to conduct oversight of the Medicare and Medicaid programs. These projects include developing an innovative data and analytics portal that would provide a comprehensive view of Medicaid data and risks and; developing a centralized intelligence platform of web-based analysis tools to support healthcare fraud investigations nationwide.

HHS Wedge Budget: $46.6 Million

The FY 2025 HHS Wedge request includes post-sequester mandatory funding of $46.6 million, which is an increase of $1.4 million above the FY 2024 CR Level. The HHS Wedge is subject to agreement between the Secretary of HHS and the Attorney General. Funding allocations are determined after HHS and DOJ complete negotiations.

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Children's Health Insurance Program

Current Law
(Dollars in Thousands)

	FY 2023 Final	FY 2024 Estimate	FY 2025 Estimate	FY 2025 +/- FY 2024
State Allotments (Healthy Kids Act P.L. 115-120, ACCESS Act P.L. 115-123)[1]	$25,900,000	$19,655,239	$18,025,000	($1,630,329)
Additional State Allotment Carry-Forward (MACRA P.L. 114-10, Healthy Kids Act P.L. 115-120)	$3,185,187	$10,120,920	$10,120,920	$0
CHIP Performance Bonus Payments Fund (P.L. 111-3)	$7,480,368	$10,804,892	$27,251,651	$16,446,759
Transfer from the CHIP Contingency Fund	$3,324,524	$16,446,759	$4,147,255	($12,299,504)
Redistribution Pool	$3,413,812	$3,559,387	$3,559,387	$0
Child Health Quality Improvement (P.L.111-3, 114-10, 115-120,115-123)	$101,341	$157,952	$142,522	($15.430)
Total Budgetary Resources[2]	**$43,405,232**	**$60,745,149**	**$63,246,735**	**$2,501,586**
CHIP State Allotment Outlays	$17,579,355	$17,229,000	$18,408,000	$1,179,000
Performance Bonus Payments Outlays	$0	$0	$0	$0
Redistribution Pool Payments	$2,727	$0	$0	$0
Child Health Quality Improvement Outlays	$5,987	$15,430	$15,000	($430)
Redistribution Payments	$0	$0	$0	$0
Total Outlays	**$17,588,069**	**$17,244,430**	**$18,423,000**	**$1,178,570**

[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 estimation for the President's FY 2025 Budget on aggregate amounts needed to fund CHIP state allotments in FY 2024 and FY 2025 according to the formula outlined in the Social Security Act.

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

Child Enrollment
Contingency Fund
Current Law
(Dollars in Thousands)

	FY 2023 Final	FY 2024 Estimate	FY 2025 Estimate	FY 2025 +/- FY 2024
Child Enrollment Contingency Fund, Budget Authority[3]	$19,092,524	$20,377,807	$7,752,255	($12,625,552)
Temporarily Unavailable[4]	($14,628,000)	$0	$0	$0
Transfer to CHIP Performance Bonus Fund	($3,324,524)	($16,446,759)	($4,147,255)	$12,299,504
Payments to Shortfall States	$0	$0	$0	$0
Interest Estimate	$678,759	$216,207	$160,423	($55,784)
Total Budgetary Resources, end of year[5]	**$1,818,759**	**$4,147,255**	**$3,765,423**	**($381,832)**
Total Outlays	**$309**	**$0**	**$0**	**$0**

Authorizing Legislation –
The Balanced Budget Act of 1997 (P.L. 105-33), The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3),
The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10),
The HEALTHY KIDS Act (P.L. 115-120),
Advancing Chronic Care, Extenders, and Social Security (ACCESS) Act (P.L. 115-123)
Consolidated Appropriations Act, 2023 (P.L. 117-328).

Allocation Method – Formula grants

[3] Reflects both carryover resources and deposits into the Fund.
[4] The Consolidated Appropriations Act, 2023 (P.L.117-328) made $14.6 billion unavailable for obligation in FY 2023.
[5] 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 (P.L. 105-33) authorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act (The Act). CHIP is a federal-state matching program with capped federal funding that provides health care coverage to targeted low-income children. The objective of CHIP is to enable states to maintain and expand child health care coverage to uninsured, low-income children and low-income pregnant women. This program has improved access to health care and quality of life for millions of vulnerable children under 19 years of age. There are currently over 7 million children enrolled in CHIP. Under Title XXI of the Act, states have the option to operate a separate CHIP program, expand eligibility for children under their state Medicaid program, or operate a combination of these two options.

Since September 1999, all states, territories, and the District of Columbia have an approved CHIP plan. 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 through FY 2013, and increased funding by $68.9 billion above the baseline. The Patient Protection and Affordable Care Act (P.L 111-148) extended CHIP funding 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) extended CHIP funding through FY 2023, with an additional $20.2 billion in budget authority over the baseline for FY 2023. The Bipartisan Budget Act (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 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. This fund was initially authorized by the CHIPRA. MACRA extended the Child Enrollment Contingency Fund authorization through FY 2017, the HEALTHY KIDS Act through FY 2023; the Bipartisan Budget Act of 2018 through FY 2027, and the Consolidated Appropriations Act, 2023 through FY 2029.

The Contingency Fund receives an appropriation equal to 20 percent of the CHIP total state allotment appropriation under Section 2104(a) of the Act. Any amounts exceeding the aggregate cap are transferred annually to the CHIP Performance Bonus Fund upon enactment of a full-year appropriations bill. 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 CHIP. 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 from FY 2009 - 2013. 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 in CHIPRA, and transfers of any unobligated state 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 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 fiscal 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 and was ultimately returned to the redistribution fund upon enactment of a full-year appropriation. Approximately $3.4 billion in funding is currently available for redistribution in FY 2024.

Child Health Quality Improvement in Medicaid and CHIP– Section 1139A of the Act, as amended by CHIPRA, requires the Secretary to identify and annually publish a recommended core set of child health quality measures for Medicaid and CHIP (the Child Core Set), establish the Pediatric Quality Measures Program, and to encourage successful quality improvement strategies. The Bipartisan Budget Act of 2018 further amended the Act to make state reporting on the Child Core Set of quality health measures mandatory beginning in FY 2024.

CHIPRA initially appropriated a total of $225 million at $45 million per year for FYs 2009-2013, to be available until expended. Section 210 of the Protecting Access to Medicare Act of 2014 (P.L. 113-3) transferred $15 million from the Medicaid Adult Health Quality funding to this program. MACRA (P.L. 114-10) appropriated an additional $20 million in FY 2016, the HEALTHY KIDS Act appropriated $90 million in FY 2018, the ACCESS Act appropriated $60 million in FY 2024, and most recently the Consolidated Appropriations Act, 2023 (P.L. 117-328) appropriated $15 million for each year in FY 2028 and FY 2029.

These sources of Medicaid and CHIP health quality funding support the Pediatric Quality Measures Program, including annual updates to the Medicaid and CHIP Child Core Set of quality measures, significant technical assistance to states to assist them in reporting the measures and applying promising practices for improving performance in these critical health care areas, and the Electronic Health Record Program discussed below.

CHIPRA Pediatric Quality Measures Program -- Funds for the Pediatric Quality Measures Program support child health quality activities, including collecting, reporting, and analyzing data on the child quality measures, and conducting quality improvement work and accountability with state agencies and managed care organizations through the Medicaid and CHIP Scorecard. With mandatory state reporting on the Child Core Set beginning in FY 2024, CMS will have access to more data to assess access and quality of care furnished by state Medicaid and CHIP programs as part of its ongoing efforts to advance health equity for low-income adults, children, and people with disabilities. Under the Mandatory Medicaid and CHIP Core Set Reporting final rule, states will be required to report certain stratified data on Child Core Set measures beginning in FY 2025, to be fully phased in over five years. (See: https://www.federalregister.gov/documents/2023/08/31/2023-18669/medicaid-program-and-chip-mandatory-medicaid-and-childrens-health-insurance-program-chip-core-set). The CHIPRA Pediatric Quality Measures Program also includes a collaboration between CMS and the Agency for Healthcare Research and Quality to assess and address gaps on the Medicaid and CHIP Child Core Set through new measure development.

CHIPRA Electronic Health Record Program -- HHS jointly released development standards, including data elements and standards for electronic health record developers, to ensure relevant elements are captured in a consistent manner. The standards are found at https://ushik.ahrq.gov/mdr/portals/cehrf?system=cehrf. The children's format helps bridge the gap between the functionality present in most electronic health records currently available and the functionality that would more optimally support the care of children.

In FY 2019, CMS began implementation of the next phase of the model electronic health record format, in collaboration with the Office of the National Coordinator for Health Information, by initiating activities that will connect immunization data from state immunization information systems with existing consumer-based portals. As of January 2024, six states have used the app developed through this collaboration to provide consumer access to immunization data.

History of Funding for CHIP State Allotments

Fiscal Year	Amount
FY 2021 [6]	$23,800,000,000
FY 2022	$25,900,000,000
FY 2023	$25,900,000,000
FY 2024 [7]	$19,655,239,029
FY 2025 [8]	$18,025,000,000

[6] Reflects rescission of $1.0 billion in funding from Section 2104(a)(24) of the Social Security Act enacted in the Consolidated Appropriations Act, 2021 (P.L. 116-260).

[7,8] The Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act and Consolidated Appropriations Act, 2023 together extended funding for each of fiscal years 2024 through 2028, such sums as are necessary to fund allotments to States. As such, this amount is subject to change.

FY 2025 MANDATORY STATE/FORMULA GRANTS[9]
Centers for Medicare and Medicaid Services
CFDA NUMBER/PROGRAM NAME: 93.767
State Children's Health Insurance Program
(Dollars in Thousands)

STATE/TERRITORY	FY 2023 Final[10]	FY 2024 CR[11]	FY 2025 Estimate[12]	FY 2025 +/- FY 2024
Alabama	$434,931	$457,731	$501,279	$43,548
Alaska	$20,344	$21,388	$23,062	$1,674
American Samoa	$8,888	$9,344	$9,824	$480
Arizona	$375,025	$394,280	$371,079	($23,201)
Arkansas	$216,844	$228,309	$200,740	($27,569)
California	$3,294,138	$3,463,271	$5,317,690	$1,854,418
Colorado	$265,742	$279,386	$239,307	($40,079)
Connecticut	$63,990	$67,276	$167,268	$99,993
Delaware	$28,718	$30,358	$40,486	$10,128
District of Columbia	$56,297	$59,298	$85,916	$26,618
Florida	$671,583	$714,733	$808,567	$93,835
Georgia	$519,396	$546,639	$488,410	($58,229)
Guam	$1,475	$1,551	$33,643	$32,092
Hawaii	$56,695	$59,606	$55,063	($4,542)
Idaho	$101,872	$107,619	$107,297	($322)
Illinois	$552,613	$580,986	$432,227	($148,759)
Indiana	$241,178	$253,561	$288,204	$34,643
Iowa	$146,699	$154,231	$144,731	($9,500)
Kansas	$152,499	$160,329	$132,601	($27,728)
Kentucky	$387,467	$407,361	$426,017	$18,656
Louisiana	$462,627	$486,380	$639,276	$152,896
Maine	$39,593	$41,626	$36,150	($5,476)
Maryland	$341,141	$358,656	$386,753	$28,097
Massachusetts	$679,866	$714,773	$719,405	$4,632
Michigan	$299,711	$315,099	$345,989	$30,890
Minnesota	$81,235	$85,406	$342,655	$257,248

[9] Represents proposed law baseline projections of obligations.
[10] FY2023 actual CHIP allotment figures do not include FY 2023 CHIP state allotment increases authorized under Section 9821 of the American Rescue Plan Act (P.L. 117-2).
[11] FY2024 projected CHIP allotment figures: do not include allotment increases authorized under Section 9821 of the American Rescue Plan Act (P.L. 117-2); and use the FY 2023 Allotment Increase Factor (AIF) as a proxy since the FY 2024 AIF was not available at time of publishing. Amounts are subject to change.
[12] FY2025 projected CHIP allotment figures: do not include amount of increase, if any, for approved program expansions as allowed under Section 2104(m)(7) of the Act; use: The FY2024 state-projected expenditures from the November 2023 budget submission as a proxy; and use the FY2023 AIF as a proxy since FY 2025 AIF was not available at the time of publishing. Amounts are subject to change.

STATE/TERRITORY	FY 2023 Final	FY 2024 CR	FY 2025 Estimate	FY 2025 +/- FY 2024
Mississippi	$195,647	$205,692	$180,164	($25,528)
Missouri	$325,587	$342,304	$381,020	$38,716
Montana	$98,768	$104,282	$86,424	($17,859)
Nebraska	$91,925	$96,644	$88,591	($8,053)
Nevada	$92,474	$97,222	$76,080	($21,142)
New Hampshire	$53,794	$56,555	$60,087	$3,532
New Jersey	$643,023	$676,039	$572,613	($103,426)
New Mexico	$123,198	$129,523	$116,545	($12,978)
New York	$1,393,963	$1,465,534	$1,728,952	$263,418
North Carolina	$690,794	$729,694	$714,370	($15,324)
North Dakota	$21,102	$22,185	$23,435	$1,250
Northern Mariana Islands	$18,737	$19,699	$20,710	$1,011
Ohio	$611,211	$642,593	$654,639	$12,046
Oklahoma	$258,642	$272,634	$256,379	($16,255)
Oregon	$510,900	$537,131	$602,595	$65,464
Pennsylvania	$558,987	$587,687	$597,359	$9,672
Puerto Rico	$204,496	$214,995	$122,873	($92,123)
Rhode Island	$104,988	$110,379	$117,054	$6,676
South Carolina	$207,457	$220,097	$171,644	($48,453)
South Dakota	$30,922	$32,705	$33,596	$891
Tennessee	$361,291	$381,905	$364,102	($17,803)
Texas	$1,416,976	$1,499,314	$968,381	($530,933)
Utah	$115,325	$121,246	$125,786	$4,540
Vermont	$17,474	$18,371	$33,833	$15,462
Virgin Islands	$2,994	$3,147	$21,349	$18,202
Virginia	$400,773	$421,350	$424,329	$2,979
Washington	$250,726	$263,599	$176,009	($87,591)
West Virginia	$83,114	$87,381	$88,971	$1,590
Wisconsin	$271,415	$285,351	$323,395	$38,045
Wyoming	$7,001	$7,360	$7,684	$323
TOTAL RESOURCES[13]	$18,664,267	$19,651,818	$21,482,610	$1,830,792

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

[13] This table displays current anticipated state-by-state obligations per the allotment formula in Section 2104 of the Social Security Act. As such, totals in this table do not align with those in the President's Budget baseline for projected total CHIP obligations, as the President's Budget was developed prior to final state reporting for FY 2023.

State Grants and Demonstrations
Budget Authority[1] [2] [3]
(Dollars in Thousands)

Program	FY 2023 Enacted	FY 2024 Estimated	FY 2025 Estimated	FY 2025 +/- FY 2024
Medicaid Integrity Program	$93,513	$100,900	$106,046	$5,146
CPI-U	$7,387	$5,146	$3,393	($1,752)
Sequester	($5,751)	($6,045)	($6,238)	($193)
MIP Total	**$95,149**	**$100,001**	**$103,201**	**$3,200**
Money Follows the Person (MFP) Grants	$450,000	$450,000	$450,000	**$0**
Sequester	($25,650)	($25,650)	($25,650)	**$0**
MFP Grants Total	**$424,350**	**$424,350**	**$424,350**	**$0**
MFP-Technical Assistance (TA)	$5,000	$0	$0	**$0**
Sequester	($285)	$0	$0	**$0**
MFP TA Total	**$4,715**	**$0**	**$0**	**$0**
Grants to Improve Outreach and Enrollment	$0	$48,000	$0	($48,000)
Sequester	$0	($2,736)	$0	$2,736
Outreach and Enrollment Total	**$0**	**$45,264**	**$0**	**($45,264)**
Community Mental Health Services Demonstration Program	$40,000	$0	$0	**$0**
Total Appropriation	**$564,214**	**$569,615**	**$527,551**	**($42,064)**

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

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[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.

[3] Division B, Title I, Sec. 2(34) of the Fiscal Responsibility Act (FRA) of 2023 rescinds all unobligated balances as added by section 9813 of Public Law 117-2. The amount rescinded was $737,082 of the original FY 2021 budget authority.

State Grants and Demonstrations
Net Outlays[4]
(Dollars in Thousands)

Program	FY 2023 Enacted	FY 2024 Estimated	FY 2025 Estimated	FY 2025 +/- FY 2024
Medicaid Integrity Program	$93,609	$98,136	$98,629	**$493**
Money Follows the Person (MFP) Demonstration-Grants	$354,545	$294,313	$277,896	**($16,417)**
MFP Research & Evaluation	$1,159	$486	$330	**($156)**
MFP Best Practices	$53	$16	$0	**($16)**
MFP QA/Tech Asst/Oversight	$1,381	$969	$1,700	**$731**
Grants to Improve Outreach and Enrollment	$17,664	$20,310	$16,571	**($3,739)**
Demonstration Project to Increase Substance Use Provider Capacity	$4,592	$1,733	$378	**($1,356)**
Community-based Mobile Crisis Intervention Services[5]	$7,308	$3,090	$0	**($3,090)**
Community Mental Health Services Demonstration Program	$1,191	$6,898	$8,858	**$1,960**
Administrative - Postage Penalty Mail[6]	$0	$52,963	$0	**($52,963)**
Total Outlays for State Grants and Demonstrations	**$481,503**	**$478,914**	**$404,362**	**($74,552)**

[4] Amounts on this table include outlays from obligations made in previous fiscal years. These outlay estimates are based on the most recent baseline estimates.
[5] The outlays on this table are adjusted based on the rescinded amounts.
[6] 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 in FY 2024..

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[7]

Fiscal Year	Amount
FY 2021	$525,816,455
FY 2022	$512,532,410
FY 2023	$564,213,819[8]
FY 2024	$569,615,409
FY 2025	$527,551,454

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 states' 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 individuals 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.

[7] Reflects new appropriations in a given fiscal year. Does not include balances from previous appropriations.
[8] This includes the FRA rescission of unobligated balances in the amount of $737,082.

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

The CMS MFP Tribal Initiative (TI) offers existing MFP state grantees and tribal partners the resources to build sustainable HCBS specifically for Tribal communities. The TI may be used to advance the development of an infrastructure required to implement HCBS 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.

On September 23, 2020, CMS announced the CMS MFP Capacity Building Initiative, a supplemental funding opportunity available to the MFP demonstration states currently operating MFP funded transition programs. Under this supplemental funding opportunity, up to $5 million in MFP grant funds was made available to each eligible state for planning and capacity building activities to strengthen the 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. CMS awarded a total of $154,414,948.47 to 33 grantees for the initiative. The amounts in the table on the following page are inclusive of these supplemental awards.

Between 2008 and 2021, states transitioned 112,883 people to community living through the MFP program[9].

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

[9] Peebles, Victoria, and Johanna Dolle. "Money Follows the Person: Updated State Transitions as of December 31, 2020." Chicago, IL: Mathematica, July 20, 2022, https://www.medicaid.gov/sites/default/files/2022-08/mfp-2020-transitions-brief.pdf

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 MFP 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 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.[10] 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. Further, the Consolidated Appropriations Act, 2021 allowed CMS to open MFP to states and territories that were not existing MFP grant recipients. 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, 2023, CMS obligated approximately $4.84 billion in grants to 45 grantee states, two (2) territories and the District of Columbia (DC). Grantees have transitioned approximately 112,883 individuals as of December 31, 2021, based on individual state reporting. Currently, there are 38 states, two (2) territories and DC participating in the MFP demonstration.

[10] "Report to the President and Congress: The Money Follows the Person (MFP) Rebalancing Demonstration", June 2017, https://www.medicaid.gov/sites/default/files/2019-12/mfp-rtc.pdf

State	*Cumulative Award Total*	*Initial Award Date*
Alabama	$28,850,055	September 27, 2012
American Samoa	$4,753,644	September 1, 2022
Arkansas	$70,394,841	January 1, 2007
California	$248,865,521	January 1, 2007
Colorado	$43,538,893	April 1, 2011
Connecticut	$330,396,989	January 1, 2007
Delaware	$13,304,857	May 1, 2007
District of Columbia	$46,774,240	May 1, 2007
Georgia	$182,171,227	May 1, 2007
Hawaii	$10,980,314	May 1, 2007
Idaho	$30,467,521	April 1, 2011
Illinois	$41,173,445	September 1, 2022
Indiana	$126,100,687	January 1, 2007
Iowa	$113,589,417	January 1, 2007
Kansas	$68,867,330	September 1, 2022
Kentucky	$61,103,251	May 1, 2007
Louisiana	$118,984,689	May 1, 2007
Maine	$13,915,967	April 1, 2011
Maryland	$176,527,878	January 1, 2007
Massachusetts	$147,879,522	April 1, 2011
Michigan	$79,802,401	January 1, 2007
Minnesota	$132,635,077	April 1, 2011
Mississippi	$29,183,470	April 1, 2011
Missouri	$93,045,432	January 1, 2007
Montana	$14,628,627	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	$180,051,120	May 1, 2007
New Mexico	$49,205	April 1, 2011
New York	$296,724,684	January 1, 2007
North Carolina	$81,955,156	May 1, 2007
North Dakota	$53,755,774	May 1, 2007
Ohio	$480,799,739	January 1, 2007
Oklahoma	$65,383,098	January 1, 2007
Oregon	$22,655,153	May 1, 2007

State	*Cumulative Award Total*	*Initial Award Date*
Pennsylvania	$222,742,462	May 1, 2007
Puerto Rico	$4,998,037	September 1, 2022
Rhode Island	$25,554,699	April 1, 2011
South Carolina	$8,287,924	April 1, 2011
South Dakota	$20,657,498	September 27, 2012
Tennessee	$90,037,370	April 1, 2011
Texas	$429,484,418	January 1, 2007
Vermont	$33,775,676	April 1, 2011
Virginia	$70,866,895	May 1, 2007
Washington	$356,454,807	January 1, 2007
West Virginia	$37,948,295	April 1, 2011
Wisconsin	$79,785,037	January 1, 2007
Total	**$4,843,770,796**	

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 dedicated 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 Medicaid recipients.

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 while other details are included in the HCFAC chapter.

Medicaid Program Integrity

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.[11] 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, covering FYs 2006 through 2010. CMS released the most recent CMIP in July 2020 for FYs 2019 through 2023.[12] Building on CMS' existing program integrity efforts, the CMIP for FYs 2019 through 2023 includes new and enhanced Medicaid program integrity initiatives that target seven high-risk areas. CMS is also currently developing the next CMIP for FYs 2024 through 2028. In FY 2025, continued funding will be required to meet the program goals outlined in the CMIP. CMS's 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 several training opportunities to ensure compliance with CMS policies. To assist states' PERM efforts, CMS will modernize reporting and oversight through the implementation of the Medicaid and CHIP Program Integrity Reporting Portal. This portal will reduce the burden on states and CMS, while allowing for more effective oversight, monitoring, and trend analysis to better reduce future Medicaid and CHIP improper payments.
- 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 certain 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

[11] 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.

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

determination processes prior to their next review. To assist states' MEQC efforts, CMS will modernize reporting and oversight through the implementation of the Medicaid and CHIP Program Integrity Reporting Portal. This portal will reduce the burden on states and CMS, while allowing for more effective oversight, monitoring, and trend analysis to better reduce future Medicaid and CHIP improper payments.

- Beneficiary Eligibility Reviews: CMS conducts audits of beneficiary eligibility determinations in high-risk states. CMS recently completed audits in Connecticut, Kansas, Missouri, and Pennsylvania, which were identified based on a risk assessment that reviewed states with higher eligibility improper payment rates, eligibility errors based on GAO or OIG reports, issues identified by states through the MEQC program, and issues identified through HHS's various corrective action plan oversight processes. CMS is currently conducting audits in Texas, Idaho, Florida, and Georgia, which focus on children terminated from Medicaid and CHIP during the unwinding period. CMS expects additional unwinding audits to begin over the course of FY 2024.

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 released the audit findings 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 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. CMS is currently conducting MLR audits in Washington, Ohio, and Arizona, with an audit of Texas beginning later in FY 2024.
- CMS supports a project that focuses on Rate Review and Health & Welfare in Home and Community Based Services (HCBS). It supports CMS in ensuring proper billing and rate reimbursement in HCBS waiver and state plan programs and improving oversight of rate setting & financial reporting for Programs of All-inclusive Care for the Elderly (PACE). Tasks include: Rate methodology and rate fiscal integrity systems review; Compilation of data for benchmarking and trending analyses; TA to states and CMS, and maintenance of the HCBS Rates, EVV & Quality Collaborative Tool, an internal tool that tracks state rate methodologies; and health & welfare projects including environmental scans, scorecard reports, survey & certification reports and Quarterly Learning Collaborative Meetings for Health & Welfare.

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 Medicaid provider enrollment; program integrity risk assessments; managed care oversight; provider auditing and investigations; medical coding; beneficiary/provider payment integrity; and fraud schemes/trends. Starting in FY24, CMS will provide these opportunities through hybrid (virtual and in-person) trainings. More information on the MII is located on the Medicaid Integrity Institute website at https://www.cms.gov/medicaid-integrity-institute.
- CMS conducts a Learning Collaborative focused on Value Based Purchasing in the Medicaid Drug Program. It assists in the development of products, toolkits, and guidance documents to support state implementation of VBP strategies in their Medicaid drug programs. It also includes a process to increase the public transparency of drug pricing through public forums with drug manufacturers.
- 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, recently released four managed care toolkits focused on fraud referrals, overpayment recoveries, compliance plans, and payment suspensions. Additional toolkits are under development for release in FY 2024.
- As of March 31, 2023, the Healthcare Fraud Prevention Partnership (HFPP) had 49 State Medicaid partners. The HFPP held a virtual State Information Sharing Session on March 23, 2023. During the event, 168 partners from across 58 state Medicaid agencies and Medicaid Fraud Control Units (MFCU) organizations acquired the latest information from HHS-OIG on opioids, data analytics review of HFPP studies on allergy services and providers of interest, and trending schemes to assist with fraud fighting efforts. 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 continues 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. CMCS continues to refine the monitoring performance metrics specific to emerging 1115 policies such as for transition services for incarcerated individuals returning to their communities (reentry), and the implementation of Health-Related Social Needs (HRSN) to understand how these important but new services are being implemented. In addition, to better target limited oversight resources, CMCS is embarking on standardizing 1115 program monitoring reporting across all demonstration types and right sizing the cadence of state reporting that is better aligned with an assessment of risk. Similarly, CMCS is modifying the standardized 1115 budget neutrality workbook that states report in to reflect recent revisions to the 1115 budget neutrality policy approach and is developing a budget neutrality formulation workbook to support a more efficient and reliable development of the budget neutrality parameters for each demonstration. The development of these improved templates will require state engagement to complete them, and staff and states will need to be trained on their use. CMCS is

also revising its state-specific team-based approach to monitoring of 1115 demonstrations and related more general state oversight to be more efficient and to better target areas of potential and real vulnerability.

- 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, 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 the use of 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 improved reporting of financial transactions typically lumped into a single category.
- CMS releases a research version of T-MSIS data called the T-MSIS Analytic Files (TAF), with data for calendar years 2014-2023 to federal partners and stakeholders, and publicly released research files for calendar years 2014-2023. 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 (SUD) data book, maternal and infant health data tables, monthly enrollment trend snapshots, annual state-level Medicaid per capita expenditures for the Medicaid and CHIP Scorecard, Modified Adjusted Gross Income (MAGI) application and processing time, 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 2016-2021. 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 2016-2021. This data allows CMS to conduct accurate equity-related analyses for the first time in agency history. Using this data, the CMS team has developed 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 is used to create and iteratively publish a series of health equity data briefs on Medicaid.gov.

- 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 its 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 that 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 2023, the UPICs initiated Medicaid provider investigations and audits in collaboration with 49 state Medicaid agencies that includes the District of Columbia, Guam, and the Virgin Islands. 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. 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 2023 through the continued efforts of these specialists, CMS removed an estimated $765 million (with approximately $393 million recovered and $372 million resolved) of approximately $9 billion identified in questionable Medicaid costs.

Furthermore, an estimated $1.2 billion in questionable reimbursement was 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, 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 notable enhancements on its journey to improve the budget and expenditure reporting processes and retire legacy systems, 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 manage 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' program integrity reviews target specific areas that have been identified as high-risk of fraud, waste and abuse in the Medicaid program. Program integrity reviews have targeted such topics as state managed care oversight, managed care organizations' oversight of their own programs, personal care services, non-emergent medical transportation, and telehealth. In FY 2025, CMS will continue to refine the program integrity reviews to allow CMS to adapt more quickly to a changing Medicaid and CHIP program integrity landscape and identify emerging high-risk areas.

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 2023 budget authority was adjusted to $95.1 million. The FY 2024 budget authority is $100.9 million with an estimated CPI-U adjustment of 5.1 percent, bringing the adjusted budget authority to $106.0 million. The FY 2024 budget authority is reduced by 5.7 percent due to sequestration, bringing the estimated FY 2024 budget authority to $100.0 million. The FY 2025 budget authority is $106.0 million with an estimated CPI-U adjustment of 3.2 percent, bringing the adjusted budget authority to $109.4 million. The FY 2025 budget authority is reduced by 5.7 percent due to sequestration, bringing the estimated FY 2025 budget authority to $103.2 million. The CPI--U adjustments are based on the most current FY 2025 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 but uninsured children in Medicaid and the Children's Health Insurance Program (CHIP) with a particular focus on children who are the most difficult to reach and enroll, and improve retention of eligible and enrolled children. Recognizing that traditional methods of outreach were not having the desired effect, Congress appropriated funding to CMS to develop specialized strategies and partner with organizations that have access to and credibility with families in the communities with high counts of eligible but uninsured children.

Since the Connecting Kids to Coverage Outreach and Enrollment grant funding initiatives began in 2009, CMS has issued 337 awards to eligible entities for approximately $270.9 million in total grant funding. CMS awards grants through two award cycles that last three years each. One award cycle targets American Indian/Alaska Native child enrollment, and the other the general child population. These outreach and enrollment grants all share the common goal of reducing the number of children who are eligible for Medicaid and CHIP but are not enrolled.

Overview and Background of Funding

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.

Congress initially authorized and appropriated funding in the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3) for these outreach and enrollment grants. Of amounts appropriated, Congress set aside 10 percent for outreach and enrollment grants for American Indian/Native Alaskan children, 10 percent for the National Campaign, and beginning in FY 2024, 10 percent for evaluation and technical assistance.

The Advancing Chronic Care, Extenders and Social Services (ACCESS) Act (P.L. 115-123) appropriated $48 million for these grants for FY's 2024 through 2027. Of this, $33.6 million goes to general grants for outreach and enrollment, $4.8 million for American Indian/Alaska Native outreach and enrollment grants, $4.8 million for the National Campaign, and $4.8 million evaluation and technical assistance. The Consolidated Appropriations Act, 2023 (P.L. 117-328) appropriated an additional $40 million in funding for these activities in FY's 2028 and 2029.

In FY 2022, CMS awarded $49 million in cooperative agreements to 36 organizations for general child population, lasting three years through FY 2025. CMS awarded an additional $5.9 million to 7 organizations to target American Indian/Alaska Native child enrollment, lasting three years through FY 2026. These most recent grant cycles added pregnant individuals as an optional targeted population under the grants as babies born to pregnant individuals covered by Medicaid or CHIP are deemed automatically eligible for Medicaid or CHIP. These previous award cycles were funded by the $120 million appropriated in the

HEALTHY KIDS Act (P.L. 115-120).

CMS anticipates announcing the next round of awards in FY 2025 totaling $31.6 million for the general child population, and $4.52 million in FY 2026 for American Indian/Native Alaskan children. In FY 2025, CMS also anticipates using $4.52 for evaluating and providing technical assistance to grantees.

National Enrollment Campaign

The statute sets aside 10 percent of appropriated funding to develop and implement a national enrollment campaign to increase the enrollment of eligible but uninsured children. This includes culturally-appropriate activities and materials that target American Indian/Native Alaskan populations. With the funding appropriated under the HEALTHY KIDS Act, CMS awarded a multi-year contract for this work beginning in 2019, and most recently extended through June 2025. CMS plans to award a new contract for 2025 through 2027 with funding appropriated in the ACCESS Act.

The National Campaign informs families that eligible children can enroll in Medicaid and CHIP any time of the year and includes a website and call number for additional information. Under the 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. All National Campaign materials are available at InsureKidsNow.gov including some materials in 24 different languages.

The National Campaign also supports continuity of coverage for children as states return to routine operations after the end of the continuous enrollment condition in Medicaid. The National Campaign developed tools and materials to encourage beneficiaries to update their contact information to receive important renewal information from their state Medicaid agency. Additional digital series were created into other topics such as oral health, flu and vaccinations, maternal health, renewals as well as corresponding social media graphics.

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 Medical Assistance Percentages (FMAP) rates to be equivalent to the Children's Health Insurance Program (CHIP) enhanced FMAP 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 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 providing recommendations for continuation, expansion, modification, or termination of the demonstration.

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 July 22, 2019, ASPE released the second CCBHC report for Congressional review. The 2018 report can be found on ASPE's website. 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 September 12, 2020, ASPE released the third annual CCBHC report for Congressional review. The 2019 report is located on ASPE's website..
In addition, ASPE released the following CCBHC detailed cost and quality evaluation reports, also located on their website here and here.

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 here. 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.

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 a CCBHC interim cost and quality evaluation report. In addition, on December 23, 2021, ASPE released the fourth annual CCBHC report for Congressional review. The 2021 report is located on ASPE's website.

The fourth annual CCBHC Report to Congress focuses 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 (available until expended) for awarding additional planning grants to new states to launch CCBHC behavioral health programs beginning July 1, 2024 and the selection of up to10 additional states every two years for the demonstration program.

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 November 1, 2022, ASPE released the fifth annual Report to Congress which builds on interim evaluation reports, which provide detailed information on implementation progress and the costs and quality of care.
On October 18, 2022, 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.

On March 16, 2023, SAMHSA announced the selection of 15 planning grant states to participate in the one-year planning phase of the CCBHC Demonstration expanded under the BSCA. The following states were selected from among states that responded to the 10/18/2022 Notice of Funding Opportunity Announcement. The 15 states selected are Alabama, Delaware, Georgia, Iowa, Kansas, Maine, Mississippi, Montana, North Carolina, New Hampshire, New Mexico, Ohio, Rhode Island, Vermont, West Virginia. In 2024, up to 10 of those will participate in the CCBHC Medicaid demonstration program and receive enhanced Medicaid reimbursement.

On May 12, 2023, CMS posted to Medicaid.gov for public comment, a request for information (RFI), summary-level "crosswalk" of proposed updates to the Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System (PPS) Technical Guidance. The crosswalk of proposed changes took into consideration feedback from earlier listening sessions held with states, providers, and other stakeholders on suggested program improvements through the BSCA expansion of the CCBHC demonstration. Based on stakeholder feedback regarding the need to address the high-cost and specialized care delivered through mobile and on-site crisis intervention services, the crosswalk introduced for public comment, new CCBHC Special Crisis Services (SCS) PPS rates that allow for calculation of up to three separate PPS rates for

1. Mobile crisis services as authorized under section 9813 of the American Resue Plan Act at the 85% FMAP rate;
2. Mobile crisis services as authorized under section 223 of the Protecting Access to Medicare Act (PAMA) for CCBHC services at the 75% enhanced FMAP rate; and
3. Onsite Mobile Crisis also authorized under the PAMA matched at 75%.

Final Updates to the CCBHC PPS Guidance will assist states with developing clinic specific PPS rates, cost reporting, and claiming Medicaid expenditures at the statutory enhanced Federal Medical Assistance Percentage (FMAP) rate throughout the extension and expansion of the Demonstration program as authorized under section 11001 of the Safer Communities Act (BSCA).

The BSCA effectively extends the enhanced FMAP to September 30, 2025 for the original eight Demonstration states authorized under section 223 of the 2014 Protecting Access to Medicare Act (PAMA), provides the two states authorized under the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 with the increased FMAP for 24 quarters, and authorizes the enhanced FMAP for 16 quarters for each of the ten additional Demonstration states added to the program every two years, starting in 2024.

On July 7, 2023, ASPE released the sixth report to Congress which describes specific findings related to the topics of access to care and scope of services and describes how states and CCBHCs adapted during the COVID-19 public health emergency. The report also provides information on demonstration payment rates and costs for the first four demonstration years for states with available data.

On February 15, 2024, CMS published Updated CCBHC PPS Technical Guidance. Most notably, updates to the 2016 CCBHC PPS Technical Guidance allow participating states to develop new special crisis services (SCS) PPS rates to address the high-cost of specialized care delivered through mobile and on-site crisis intervention services provided directly to individuals who are experiencing a substance use-related or mental health crisis. As such, the updated guidance provides assistance to states with developing clinic specific PPS rates, cost and quality reporting including implementation of value-based bonus payment systems and claiming Medicaid expenditures at the statutory enhanced Federal Medical Assistance Percentage (FMAP) rate throughout the statutory BSCA extension and expansion of the CCBHC demonstration program.

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 and every two years thereafter; to 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;
- 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; and

- improved reimbursement for and expansion of, through the provision of education, training, and technical assistance, the number or treatment capacity of providers participating under the Medicaid state plan or waiver.

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 demonstration. 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 disorder treatment provider capacity in the Medicaid program on June 25, 2019.

CMS 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* was released in May 2023. The *Interim Report to Congress* is currently under development.

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 amended 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 period of the demonstration by 6 months to September 29, 2021. CMS also delayed the start of the 36-month post-planning period by six months to September 30, 2021.

The Agency for Healthcare Research and Quality (AHRQ) and the Substance use and Mental Health Services Administration (SAMHSA) 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, was released in May 2023.

Post-Planning Period

States participating in the 36-month post-planning period of the demonstration will receive enhanced federal reimbursement for eligible increases in Medicaid expenditures for substance use disorder treatment and recovery services. CMS issued a limited competition, notice of funding opportunity (NOFO) for the post-planning period of the demonstration project on July 9, 2021. The statutory language 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. States participating in the 36-month demonstration will receive enhanced federal reimbursement for eligible increases in Medicaid expenditures for substance use disorder treatment and recovery services.

Budget Overview

In FY 2019, Section 1003 authorized and appropriated $50.0 million for the planning grants and $5.0 million to support the administration of the demonstration. 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.

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. In addition, 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 12-month 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 State Health Officials (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 monitored state community-based mobile crisis intervention services program planning and implementation, including oversight of state grant expenditures, and continues to provide technical assistance to states on implementation of community-based mobile crisis intervention services and review state submissions, as needed. To date, CMS has approved Medicaid state plan amendments authorizing enhanced federal reimbursement for mobile crisis services in the following states: Oregon, Arizona, North Carolina, New York, California, Wisconsin, Kentucky, District of Columbia, West Virginia, Massachusetts, Indiana, Washington, Montana, Colorado, and Alabama. In addition, New Mexico, Nevada, and Louisiana have submitted state plan amendments to CMS.

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.

Grant awards ranged from $381,331 to $953,336. After the initial 12-month period, 16 states received a 1-year no-cost extension to continue implementing their plans through September 2023. All Section 9813 planning grants were completed and Division B, Title I, Sec. 2(34) of the Fiscal Responsibility Act of 2023 rescinded all unobligated balances in Sec. 9813 which amounted to $737,082.

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Information Technology
(Dollars in Thousands)

Information Technology Portfolio	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2024
Program Management	**$2,263,165**	**$2,242,434**	**$2,290,375**	**$47,941**
Coronavirus Supplemental	$136	$0	$0	$0
Federal Administration	$1,997	$2,177	$490	$(1,687)
Program Operations	$1,384,888	$1,378,978	$1,410,140	$31,162
Research	$4,211	$4,357	$0	$(4,357)
Survey & Certification	$6,782	$6,782	$8,392	$1,610
Subtotal: Discretionary Appropriation	**$1,398,014**	**$1,392,294**	**$1,419,022**	**$26,728**
Medicaid and Medicare (4201)	$2,678	$250	$250	$0
PAMA Section 210 & 216	$3,380	$2,564	$3,000	$436
No Surprises Act [1]	$44,230	$23,698	$23,698	$0
Consolidated Appropriations Act	$1,693	$0	$0	$0
Inflation Reduction Act	$8,989	$15,979	$18,390	$2,411
Other Mandatory Appropriations	$9,274	$7,076	$7,022	$(54)
Subtotal: Mandatory Appropriation	**$70,244**	**$49,567**	**$52,360**	**$2,793**
CLIA	$49	$50	$51	$1
COB User Fees	$36,090	$30,730	$32,730	$2,000
Marketplace Risk Adjustment User Fees	$17,822	$16,700	$18,575	$1,875
Marketplace User Fees	$632,162	$656,503	$676,977	$20,474
Recovery Audit Contractors	$23,784	$21,837	$25,633	$3,796
Sale of Data	$66,638	$27,406	$17,680	$(9,726)
Independent Dispute Resolution [2]	$18,362	$47,347	$47,347	$0
Subtotal: Offsetting Collections and Reimbursables	**$794,907**	**$800,573**	**$818,993**	**$18,420**
Quality Improvement Organizations [3]	**$302,960**	**$331,549**	**$388,547**	**$56,998**
Innovation Center	**$197,544**	**$184,502**	**$185,505**	**$1,003**
Health Care Fraud & Abuse	**$468,001**	**$463,738**	**$459,612**	**$(4,126)**
Nonrecurring Expense Fund [4]	**$52,032**	**$0**	**$0**	**$0**
Total Information Technology	**$3,283,702**	**$3,222,223**	**$3,324,039**	**$101,816**

[1] Funding levels are subject to change. FY 2025 is contingent on the passage of the "Replenish and Extend No Surprises Implementation Fund" legislative proposal.
[2] Funding levels are contingent on rate of fee collections and are subject to change.
[3] FY 2025 funding level is an estimate and subject to change, pending approval of QIO 13th Scope of Work.
[4] FY 2024 and 2025 estimates are unknown until funding is awarded.

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 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 daily. 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 efforts to meet these risks.

CMS has accomplished many goals to help ensure the safety of its IT ecosystem. For example, CMS's new security approval process platform, Continuous Authorization and Verification Engine (batCAVE), is now fully functional with eight applications on the platform. A fully functional batCAVE allows CMS to reduce duplicative security development and implementation while increasing the speed in which CMS can deploy and update security countermeasures. Secondly, the effort has nearly completed CMS's Zero Trust evaluation and recommendation process. Furthermore, CMS developed a hospital cyber resiliency landscape analysis which highlights findings and issues affecting the cybersecurity resiliency of U.S. hospitals.

This request prioritizes the IT Security effort so that CMS can make strides towards complying with Executive Order 14028 and Memorandums 21-31 and 23-18. This request also allows CMS to continue increasing system utilization of batCAVE and continue analysis and expansion of the security data lake. In addition, CMS will invest in Governance Risk Management and Compliance (GRC) tooling which will assist the agency to keep pace with new security threats and compliance challenges.

Medicare Payment Systems Modernization (MPSM): MPSM is priority work that 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.

MPSM has reached many milestones that have provided valuable services to Medicare beneficiaries, providers, and claims processors. Most recently, CMS created a solution that provides end-users with 24/7 real-time read access to Provider Specific File (PSF) data. This solution allows Medicare Administrative Contractors (MACs), external users and internal CMS teams to obtain up-to-date inpatient and outpatient PSF data 24/7 instead of quarterly. In addition, the MPSM effort created a proof-of-concept that will reduce workload burden on end users by allowing CMS to use one Fee Schedule file for all MACs regardless of institutional or noninstitutional status. CMS has also leveraged MPSM's Strategic Roadmap to begin implementation of the Dental Services required by regulatory changes CMS issued to expand dental coverage for Medicare beneficiaries. CMS has made significant progress with building a new claims processing system in the cloud to support Dental Services and plans to launch the system later in CY 2024.

This request will assist CMS in reaching its strategic goals by ensuring that the agency can support claims payment processing, enable data that is timely and accurate, and enhance current claims processing systems. This funding aids MPSM's approach to incrementally modernize the claims processing systems, deploy and manage Application Programing Interfaces and develop data replications. In addition, this request also supports the further development of a modern claims processing platform for the dental initiative and allows CMS to continue to utilize tools to foster innovation and building infrastructure in both the Cloud and Mainframe environments.

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

The CMS COOP/DR effort is continuing to make progress toward migrating all Virtual Data Centers (VDCs) to the Disaster Recovery as a Service (DRaaS) environment. As part of this effort, CMS is building out CMS Hybrid Cloud ecosystem to completely transform and integrate private and public cloud for hosting CMS mission essential functions. CMS is in a final phase of migrating to the DRaaS environment and the agency continues to make progress in achieving its goal of improving Hosting & COOP/DR capabilities from an enterprise perspective.

CMS plans to complete the integration of its Hosting & COOP/DR services with cloud services. In addition, funding will support the operations, optimizations, and maintenance of the Kent and Ashburn Data Center's architecture and allow the effort to assess and modernize the applications within these data centers. Lastly, CMS will be able to use the Rapid Cloud Migration Program to help streamline and support cloud migrations by utilizing and implementing repeatable and automated processes.

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 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 an increased demand to move its applications from on-premises data centers to cloud hosting. 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 lower cost to operate, better performance, and tightened security. It also allows CMS to take advantage of benefits such as greater elasticity, self-service provisioning, reduced redundancy, and flexible pay-per-use model. CMS 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 2021	$2,897,822,000
FY 2022	$3,006,189,000
FY 2023 Final	$3,283,702,000
FY 2024 CR	$3,222,223,000
FY 2025 President's Budget	$3,324,039,000

FY 2025 IT Funding Level: $3,324.0 million

The FY 2025 President's Budget Level for CMS-wide IT is $3,324.0 million, an increase of $101.8 million above the FY 2024 CR Level.

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

IT Funding by Category	FY 2023 Final	FY24 CR Level	FY 2025 President's Budget	FY 2025 +/- FY 2024
Medicare Parts A & B	$274,371	$279,209	$260,746	$(18,463)
Medicare Parts C & D	$162,792	$156,714	$169,101	$12,387
Medicare Outreach & Education	$89,652	$96,841	$97,325	$484
Medicaid and CHIP	$264,584	$213,333	$155,454	$(57,879)
Private Insurance	$763,357	$791,947	$819,219	$27,272
Health Care Quality	$355,064	$381,677	$442,693	$61,016
Enterprise IT	$1,373,882	$1,302,502	$1,379,501	$76,999
Total IT Portfolio	**$3,283,702**	**$3,222,223**	**$3,324,039**	**$101,816**

Medicare Parts A & B

Medicare Parts A & B investments support the FFS and 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 several incentive payment programs that reward eligible providers for improving quality, reducing unnecessary resource utilization, and adopting new technologies.

Funding Level: $260.7 million

The FY 2025 President's Budget Level for Medicare Parts A and B investments is $260.7 million, a decrease of $18.5 million below the FY 2024 CR Level. CMS anticipates the Provider Enrollment, Chain, and Ownership System (PECOS) 2.0 will begin operations in FY 2024. As a result, the original PECOS system will be decommissioned and no longer require funding.

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)* – 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) – DbidS is a* web application for 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 system is an essential component in ensuring that accurate payments are made for medically necessary services and are provided to eligible beneficiaries by qualified providers of care.

- *DME Claims Processing System* – The 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)* – HETS allows providers to check beneficiary eligibility for Medicare Part A and B services using Health Insurance Portability and Accountability Act (HIPAA) compliant Accredited Standards Committee (ASC) X12 transactions.

- *Medicare Appeals System (MAS)* – MAS provides a unified appeals case-tracking system that facilitates maintenance and transfer of case-specific data regarding 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 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 FFS claims processing system where full individual beneficiary information is housed.

- *Medicare Secondary Payer System (MSPS)* – 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)* – The 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/Alternative Payment Model Entities/Provider Relationships, Qualifying APM Participant Status for each Eligible Professionals, MIPS measure specifications and benchmarks, clinician submissions, final scores and Feedback Reports Core Function.

- *Accountable Care Organizations (ACOs)* – 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 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: $169.1 million

The FY 2025 President's Budget Level for Medicare Part C and D IT investments is $169.1 million, an increase of $12.4 million above the FY 2024 CR Level. This increase is a result of the continuation of Inflation Reduction Act work that includes but is not to limited to efforts supporting the Part D Coverage Gap work and the Prescription Drug Event support activities.

Beneficiary and Plan Management: Ensures that beneficiaries can 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 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 (Part C) and Prescription Drug (Part D) programs. There are approximately 60 software modules supporting the Part C and 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)* – 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 Hierarchical Condition Category coding 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 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, Risk Adjustment System, Risk Adjustment Processing System User Interface, and Encounter Data Risk Adjustment.

- *Encounter Data System* – The 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. 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: $97.3 million

The FY 2025 President's Budget Level for Medicare Outreach and Education IT is $97.3 million, an increase of $0.48 million above the FY 2024 CR Level. This increase supports ongoing operations.

- *Beneficiary e-Services* – Beneficiary e-Services provide 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, who 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.[5] 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* – 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: $155.5 million

The FY 2025 President's Budget Level for Medicaid and CHIP IT is $155.5 million, a decrease of $57.9 million below the FY 2024 CR Level. This decrease is a result of CMS's rulemaking effort that would shift the financial responsibility for income verifications via the Verify Current Income (VCI) service through the Federal Data Services Hub to the states.

- *Medicaid and CHIP Business Information Solutions (MACBIS)* – 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 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, 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.

[5] 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.

- *Sources of Income for Medicaid Eligibility* – This work will continue in FY 2025; however, funding has not been requested in anticipation of a future funding policy change related to the Federal Data Services Hub, as described above.

- *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 affordable and quality private health insurance throughout the United States. Through the Federally-Facilitated Marketplace (FFM) and State-based Marketplaces that use Federal Platforms (SBM-FP), individuals are able to compare health plan options, received eligibility determinations for health insurance programs, and obtain financial assistance with premiums and cost-sharing. CMS also enforces certain provisions of the No Surprises Act, which 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[6]. 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: $819.2 million

The FY 2025 President's Budget Level for the Private Insurance IT request is $819.2 million, an increase of $27.3 million above the FY 2024 CR Level. Increased funding is required due to an estimated increase in FFM enrollment and data transactions, as well as the continuing development efforts related to the Eligibility and Enrollment and Plan Management Module.

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 certain health insurance programs, and obtain financial assistance with premiums and cost-sharing.

- *Federal Data Services Hub (FDSH) – 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)* – 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)* – MIDAS provides a central repository for capturing, organizing, and aggregating data for the

[6] No Surprises Act (NSA) implementation funding will expire at the end of CY 2024. Funding and narrative related to NSA represents CMS's funding needs assuming the "Replenish and Extend the No Surprises Implementation Fund" legislative proposal is enacted.

Marketplaces.

- *Federal Health Care Marketplace (HIX)* – 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)* – EACMS serves as the data repository of the Eligibility Appeals Operations Support Contractors 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 helps consumers receive the health care they need while 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: $442.7 million

The FY 2025 President's Budget Level for Health Care Quality IT is $442.7 million, an increase of $61.0 million above the FY 2024 CR Level. Additional funds are needed for improving the quality of data submissions while implementing data standardization, increasing integrity and simplifying ingestion processes supporting electronic Clinical Quality Measures, Digital Quality Measures, and the Quality Improvement Organization (QIO) 13th Statement of Work.

- *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 QIOs 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.

- *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 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 beneficiaries that qualify for both the Medicare and the Medicaid programs, 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: $1,380.0 million

The FY 2025 President's Budget Level for Enterprise IT is $1,380.0 million, an increase of $77.0 million above the FY 2024 CR Level. This increase will allow CMS to make strides toward strengthening CMS's cybersecurity in compliance with Executive Order 14028 "Improving the Nation's Cybersecurity" and Memorandums 21-31 and 23-18 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): 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 like private cloud technologies, standardized 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. Finally, 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 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)* – 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.

<u>*Shared Services*</u>: Provides CMS with cost-effective solutions that eliminate duplication by providing services that can be accessed across the various investments. These solutions provide standardized interfaces and reusable processes.

- *Enterprise Identity Management (EIDM)* – 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)* – The MDM 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.

Crosscutting Program Integrity: 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)* – The HFPP provides an opportunity for private and public payers to collaborate on health care fraud identification and prevention activities.

- *One Program Integrity (One PI) – 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)* – FPS provides state-of-the-art analytical tools to help predict and prevent potentially wasteful, abusive, or fraudulent payments before they occur. Before Medicare FFS 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)* – The 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)* – The 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 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2024
Program Management	**$2,412,472**	**$2,433,889**	**$2,306,495**	**($127,394)**
Discretionary Appropriation	$119,243	$121,052	$125,945	$4,893
Program Operations (non-add)	*$119,243*	*$121,052*	*$125,945*	*$4,893*
Offsetting Collections	$2,293,229	$2,266,405	$2,154,216	($112,189)
Federally-facilitated Marketplace User Fee (non-add)	*$2,237,915*	*$2,205,463*	*$2,087,100*	*($118,363)*
Risk Adjustment User Fee (non-add)	*$55,314*	*$60,942*	*$67,116*	*$6,174*
Other[1]	$0	$46,432	$26,334	($20,098)
Penalty Mail	*$0*	*$35,359*	*$26,334*	*($9,025)*
Health Insurance Reform Implementation Fund (HIRIF)	*$0*	*$11,073*	*$0*	*($11,073)*
Heath Care Fraud and Abuse Control	**$28,274**	**$31,121**	**$33,705**	**$2,584**
Discretionary Appropriation	$28,274	$31,121	$33,705	$2,584
Total Program Level	**$2,440,746**	**$2,465,010**	**$2,340,200**	**($124,810)**

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).

Marketplaces provide millions of Americans access to affordable health insurance coverage. Since October 1, 2013, Marketplaces have helped individuals and small

[1] The FY 2023 Final level excludes Penalty Mail as the associated funding sources were not available for obligation. Beginning in FY 2024, Penalty Mail will be obligated through other expired sources.

employers better understand their insurance options by assisting them in shopping for, selecting, and enrolling in health insurance plans. 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.

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 2024 Marketplace Open Enrollment Period, which ran from November 1, 2023 to January 15, 2024, a record-breaking 21.3 million consumers selected plans as of January 24th, 2024. More than 90% of consumers were able to choose among three or more plans. This accomplishment follows the historic Open Enrollment Period in 2023, in which 16.3 million consumers selected plans, and is part of the Biden-Harris Administration's efforts to help connect people to coverage.

In FY 2023, CMS awarded $98.6 million in Navigator grants to 57 returning Navigator organizations for the 2024 Open Enrollment Period, to help consumers establish eligibility and enroll in coverage through the Marketplace, Medicaid, or the Children's Health Insurance Program (CHIP). These awards enable Navigator organizations to retain staff and add to the more than 2,300 existing Navigators who have been trained to help consumers find affordable, comprehensive health coverage.

In FY 2025, 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 2021	$1,963,746,000
FY 2022	$2,085,344,000
FY 2023 Final	$2,440,746,000
FY 2024 CR	$2,465,010,000
FY 2025 President's Budget	$2,340,200,000

Budget Request

The FY 2025 Budget request for FFM activities is $2,340.2 million at the program level, of which $2,306.5 million is funded from several Program Management sources and $33.7 million from the discretionary Health Care Fraud and Abuse Control (HCFAC) appropriation. This budget reflects a two-and-a-half-month Open Enrollment Period; fully funds the Navigator program; and supports year-round outreach and education efforts with a focus on underserved and minority populations. Year-round outreach raises awareness of Marketplace coverage during the unwinding of the Medicaid continuous coverage condition and beyond to support ongoing coverage transitions; raise awareness of an SEP for the uninsured; and supports educational campaigns for current enrollees.

- *Health Plan Bid Review, Management, and Oversight:* $63.5 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 over 690 SADPs each year.

- *Payment and Financial Management:* $63.1 million. States and issuers supply a range of enrollment, premium, and claims data to calculate financial payments across multiple Marketplace activities using the Health Insurance Oversight System (HIOS). Marketplace-related payments leverage CMS's Healthcare Integrated General Ledger Accounting System and financial management processes such as reporting and debt management.

- *Eligibility and Enrollment:* $423.7 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. The budget request assumes that SBM states will be charged for their usage of the Verify Current Income (VCI) service through the Data Services Hub starting on July 1st, 2024, but requests $24 million to cover SBM costs for the VCI service through the Data Services Hub during this transition.

- *Consumer Information and Outreach:* $938.1 million. CMS ensures applicants and enrollees are fully supported not only during Open Enrollment, but throughout the plan year using mail, phone, media campaigns, 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. This budget includes $46 million to bolster year-round outreach for Special Enrollment Periods with a focus on hard-to-reach health equity populations, as part of the Marketplace's High Impact Service Providers (HISP) customer experience activities.

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.

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):* $645.3 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 2025.

- *Marketplace Quality:* $6.9 million. CMS provides quality rating information using a five-star rating scale based on clinical quality measures and an enrollee satisfaction survey to give individuals and families easy-to-compare quality metrics on QHPs.

- *Program Integrity:* $33.7 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 reported an improper payment rate of 0.58 percent for the FFM component of the APTC program in the FY 2023 Agency Financial Report (AFR). CMS will continue measurement in the FFM as well as development of an improper payment measurement program for the SBMs, including pre-testing and assessment activities. This increased funding would allow CMS to begin implementing the improper payment measurement program methodology for an initial group of SBMs in FY 2025. 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:* $26.3 million. CMS supports general planning and oversight of Marketplace activities to ensure integration and coordination across CMS with issuers and Federal partners.

- *Administration:* $139.4 million. This funding supports staffing and administration expenses for work across the Federal Marketplace, State-based Marketplaces, and payment programs.

Nonrecurring Expenses Fund

Budget Summary
(Dollars in Thousands)

	FY 2023[1]	FY 2024[2]	FY 2025[3]
Notification[4]	--	$20,000	$45,000

Authorizing Legislation:
Authorization…….Section 223 of Division G of the Consolidated Appropriations Act, 2008
Allocation Method……..Direct Federal, Competitive Contract

Program Description and Accomplishments

The Nonrecurring Expenses Fund (NEF) permits HHS to transfer unobligated balances of expired discretionary funds from FY 2008 and subsequent years into the NEF account. Congress authorized use of the funds for capital acquisitions necessary for the operation of the Department, specifically information technology (IT) and facilities infrastructure acquisitions.

CMS is constantly looking for ways to improve our information technology and facilities infrastructure investments so that we may provide our staff and beneficiaries with innovative solutions to complex problems. NEF has provided CMS with the opportunity to continue this pursuit without utilizing funds that could otherwise be allocated to other mission critical functions.

Budget Allocation FY 2025

NEF will invest in IT and facilities infrastructure efforts. These investments will support the modernization of CMS to continue to foster improved quality, equity, and outcomes in the health care system. CMS continues to push for sustainability, continuity, and an enhanced customer experience. Moving towards these three objectives will bolster our ability to execute the CMS mission.

Budget Allocation FY 2024

In FY 2024, NEF is investing in Medicare and Medicaid IT systems and cybersecurity enhancements. These investments support the modernization of CMS's IT ecosystem so that the center may continue to foster improved quality, equity, and outcomes in the health care system.

[1] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on September 23, 2022.
[2] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on October 19, 2023.
[3] HHS has not yet notified for FY 2025.
[4] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.

CMS intends to primarily use NEF resources in FY 2024 for projects that will enhance, update, or otherwise improve our IT solutions. These projects represent capital investments that will advance CMS's abilities, modernize our systems, and/or increase IT functionality. The following is a listing of projects CMS is pursuing in FY 2024:

1. A system upgrade for the Fee-for-Service Data Collection system. This upgrade will allow CMS to enhance the complexity of calculations and support new information that is required by the new legislation to enhance the accuracy of reporting.
2. A Mainframe Solution project will install and configure software on all of the contracted mainframes in the data centers. CMS IT staff/contractors will then configure the detections and dashboards to highlight security issues we want to monitor.
3. A main thrust of CMS's modernization effort has been to move away from retired legacy coding. To further this aim, the Legacy Code Disentanglement and Retirement project will convert legacy COBOL pricing code/functionality to Java, so it can be stored and maintained in the cloud, a significant improvement for legacy systems.
4. Another effort will add necessary code functionality to the system to ensure effective dental claims adjudication and payment. This, in turn, will increase functionality to the Dental Claims Processing system.
5. CMS intends to modernize our workload architecture, optimize the utilization of the infrastructure resources, take advantage of hybrid offering, and refine our operational processes. This effort will complete the re-architecture of certain migrated systems from their current state to a new operational baseline that will be more resilient and efficient, potentially leading to a decrease in the necessary physical infrastructure, correlating software, and required Disaster Recovery footprint.
6. The Medicare Advantage and Prescription Drug System Application Programing Interface improvements will move from file-based data exchanges that use Electronic File Transfer services to Application Programming Interface based data exchanges. Moving to APIs will allow the real or near real-time exchange of information as well as direct system-to-system interactions for single or multiple queries, a marked improvement from the current state.
7. The final project is the Optimization of Enterprise Hosting Shared Services. This project will build out CMS's hybrid cloud ecosystem to completely transform and integrate private and public cloud for hosting CMS's mission essential functions, improve our hosting & disaster recovery capabilities from an enterprise perspective, and assess and modernize the applications within certain data centers to prepare them for migration to a CMS cloud offering.

Budget Allocation FY 2022 and Prior

In recent FYs, CMS utilized the NEF to improve our cybersecurity, enhance our Program's data processing capabilities, and take steps to right-size CMS's office space.

NEF resources allowed CMS to expand the Disaster Recovery as a Service East and West sites, build-out our cloud and Disaster Recovery as a Service western region, and create a hardware device phishing resistant multi-factor authentication process for batCAVE (Continuous Authorization and Verification Engine), which improves our cybersecurity posture.

NEF funds supported the modernization and cloud migration efforts of the Legacy Medicare Enrollment and Premium Billing System applications and the Medicare Claims Processing Systems. In addition, NEF funds assisted in building an IT product/system to accept, process, and pay certain dental claims.

Finally, NEF funds supported the right-sizing project to consolidate and modernize CMS's office space. This multi-year project is working to ensure that CMS is maximizing its office space, which can and has led to reducing our overall real estate footprint.

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 2023 Estimates	FY 2024 Estimates	FY 2025 Estimates
Drug Resources by Decision Unit and Function/Program			
Medicaid Treatment	$9,960.0	$8,510.0	$8,410.0
Total Decision Unit #1 Medicaid	**$9,960.0**	**$8,510.0**	**$8,410.0**
Medicare Treatment	$3,170.0	$3,390.0	$3,580.0
Total Decision Unit #2 Medicare	**$3,170.0**	**$3,390.0**	**$3,580.0**
Total Funding	**$13,130.0**	**$11,900.0**	**$11,990.0**
Drug Resources Personnel Summary			
Total FTEs (direct only)	--	--	--
Drug Resources as a Percent of Budget			
Total Agency Budget (in billions)[1]	$1,630.5	$1,590.6	$1,723.3
Drug Resources Percentage	0.8%	0.7%	0.7%

Program Summary

Mission

The Centers for Medicare & Medicaid Services (CMS) is strengthening and modernizing the nation's health care system to provide access to high quality care and improved health at lower cost. Through its coverage of substance use disorder (SUD) treatment services in Medicare and Medicaid, CMS helps support the goals of the Office of National Drug Control Policy (ONDCP) by providing SUD treatment to eligible beneficiaries.

Methodology

Medicaid

The projections provided in the above table were based on data from the Medicaid Analytic

[1] The total agency budget reflects only Medicare and Medicaid current law benefit costs as estimated by the CMS Office of the Actuary. The Medicaid total reflects the net outlays of Medical Assistance Payments benefit grants and the Vaccines for Children Program, administered by the Centers for Disease Control and Prevention. The Medicare total reflects gross benefit outlays.

eXtract (MAX) for Fiscal Year (FY) 2007 through 2013, based on expenditures for claims with SUDs as a primary diagnosis. Managed care expenditures were estimated based on the ratio of SUD expenditures to all expenditures for fee-for-service by eligibility group. The estimates were trended forward to FY 2022 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 2025 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 2025 President's Budget baseline. These projections reflect estimated Part A and Part B spending into FY 2025 and are based on an analysis of historical fee-for---service claims through 2022, 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 2024 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 2025 drug control outlay estimate for CMS is $11,990.0 million. This estimate reflects Medicaid and Medicare populations and an upward adjustment 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 2025 outlay estimate: $8,410.0 million
(Reflects $100.0 million decrease from FY 2024)

The decrease in Medicaid substance use spending from FY 2024 to FY 2025 stems from the decrease in projected Medicaid enrollment, impacted by the end of the continuous enrollment condition during the COVID-19 Public Health Emergency.

[2] Based on the International Classification of Diseases (ICD) coding system. The applicable ICD-9 codes for SUD treatment 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--based health care entitlement program financed by the States and the Federal Government. Mandatory Medicaid benefits 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. States may provide additional Medicaid SUD treatment services as optional benefits. 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 2025 outlay estimate: $3,580.0 million
(Reflects $190.0 million increase from FY 2024)

The increase in Medicare SUD spending from FY 2024 to FY 2025 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 addressing the health disparities that underlie the nations health system, including disparities in accessibility of SUD and related treatment and quality of those services. The CMS Framework for Health Equity includes behavioral health as an area of focus, and provides a strong foundation for advancing health equity, expanding coverage, and improving health outcomes. CMS continues work in this area of designing, implementing, and operationalizing policies and programs that support improving health outcomes for all the individuals served by our programs and provide the care and support that our enrollees need to thrive. This includes strengthening our infrastructure for assessment, creating synergies across the health care system to drive structural change, and identifying and working together to eliminate barriers to CMS-supported benefits, services, and coverage, including for people living with and at risk of developing behavioral health conditions such as SUD. The CMS Framework for Health Equity can be found at https://www.cms.gov/files/document/cms-framework-health-equity.pdf.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS Program Management
Object Classification - Direct Budget Authority /1
(Dollars in Thousands)

Object Class	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Direct Budget Authority				
Personnel compensation:				
Full-time permanent (11.1)	$ 422,977	$ 428,051	$ 454,432	$ 31,455
Other than full-time permanent (11.3)	$ 13,247	$ 13,406	$ 14,232	$ 985
Other personnel compensation (11.5)	$ 9,755	$ 9,872	$ 10,480	$ 725
Military personnel (11.7)	$ 16,836	$ 17,038	$ 18,088	$ 1,252
Special personnel services payments (11.8)	$ 36	$ 36	$ 39	$ 3
Subtotal personnel compensation	**$ 462,851**	**$ 468,403**	**$ 497,271**	**$ 34,420**
Civilian benefits (12.1)	$ 217,311	$ 219,919	$ 233,472	$ 16,161
Military benefits (12.2)	$ 2,113	$ 2,138	$ 2,270	$ 157
Benefits to former personnel (13.0)				$ -
Subtotal Pay Costs	**$ 682,275**	**$ 690,460**	**$ 733,013**	**$ 50,738**
Travel and transportation of persons (21.0)	$ 4,406	$ 5,361	$ 7,100	$ 2,694
Transportation of things (22.0)	$ -		$ -	$ -
Rental payments to GSA (23.1)	$ -	$ -	$ -	$ -
Communication, utilities, and misc. charges (23.3)	$ -		$ -	$ -
Printing and reproduction (24.0)	$ 4,326	$ 2,396	$ 4,682	$ 356
Other Contractual Services:				$ -
Advisory and assistance services (25.1)				$ -
Other services (25.2)	$ 2,230,673	$ 2,166,860	$ 2,252,084	$ 21,411
Purchase of goods and services from				$ -
government accounts (25.3)				$ -
Operation and maintenance of facilities (25.4)				$ -
Research and Development Contracts (25.5)	$ 20,054	$ 20,054	$ -	$ (20,054)
Medical care (25.6)	$ 1,182,758	$ 1,239,305	$ 1,331,406	$ 148,648
Operation and maintenance of equipment (25.7)				$ -
Subsistence and support of persons (25.8)	$ -		$ -	$ -
Subtotal Other Contractual Services	**$ 3,433,485**	**$ 3,426,219**	**$ 3,583,490**	**$ 150,005**
Supplies and materials (26.0)	$ 252	$ 308	$ 715	$ 463
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	**$ 3,442,469**	**$ 3,434,284**	**$ 3,595,987**	**$ 153,518**
Total Direct Budget Authority /2	**$ 4,124,744**	**$ 4,124,744**	**$ 4,329,000**	**$ 204,256**

/1 This table displays the Program Management Discretionary amounts only.

/2 FY 2023 and 2024 includes $455 million in additional Medicare Operations funding from the FY 2023 annual appropriation, Public Law 117-328, General Provision Section 227. CMS has 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.

CMS Program Management
Salaries and Expenses
(Dollars in Thousands)

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Personnel compensation:				
Full-time permanent (11.1)	$ 422,977	$ 428,051	$ 454,432	$ 31,455
Other than full-time permanent (11.3)	$ 13,247	$ 13,406	$ 14,232	$ 985
Other personnel compensation (11.5)	$ 9,755	$ 9,872	$ 10,480	$ 725
Military personnel (11.7)	$ 16,836	$ 17,038	$ 18,088	$ 1,252
Special personnel services payments (11.8)	$ 36	$ 36	$ 39	$ 3
Subtotal personnel compensation	**$ 462,851**	**$ 468,403**	**$ 497,271**	**$ 34,420**
Civilian benefits (12.1)	$ 217,311	$ 219,919	$ 233,472	$ 16,161
Military benefits (12.2)	$ 2,113	$ 2,138	$ 2,270	$ 157
Benefits to former personnel (13.0)	$ -	$ -	$ -	$ -
Total Pay Costs	**$ 682,275**	**$ 690,460**	**$ 733,013**	**$ 50,738**
Travel and transportation of persons (21.0)	$ 4,406	$ 5,361	$ 7,100	$ 2,694
Transportation of things (22.0)	$ -	$ -	$ -	$ -
Rental payments to GSA (23.1)	$ -	$ -	$ -	$ -
Rental payments to Others (23.2)	$ -	$ -	$ -	$ -
Communication, utilities, and misc. charges (23.3)	$ -	$ -	$ -	$ -
Printing and reproduction (24.0)	$ 4,326	$ 2,396	$ 4,682	$ 356
Other Contractual Services:				
Advisory and assistance services (25.1)	$ -	$ -	$ -	$ -
Other services (25.2)	$ 2,230,673	$2,166,860	$2,252,084	$ 21,411
Purchase of goods and services from government accounts (25.3)	$ -	$ -	$ -	$ -
Operation and maintenance of facilities (25.4)	$ -	$ -	$ -	$ -
Research and Development Contracts (25.5)	$ 20,054	$ 20,054	$ -	$ (20,054)
Medical care (25.6)	$ 1,182,758	$ 1,239,305	$ 1,331,406	$ 148,648
Operation and maintenance of equipment (25.7)	$ -	$ -	$ -	$ -
Subsistence and support of persons (25.8)	$ -	$ -	$ -	$ -
Subtotal Other Contractual Services	**$ 3,433,485**	**$3,426,219**	**$3,583,490**	**$ 150,005**
Supplies and materials (26.0)	$ 252	$ 308	$ 715	$ 463
Total Non-Pay Costs	**$ 3,442,469**	**$3,434,284**	**$3,595,987**	**$ 153,518**
Total Salary and Expense /1	**$ 4,124,744**	**$4,124,744**	**$4,329,000**	**$ 204,256**
Direct FTE	4,159	4,080	4,205	46

/1 FY 2023 and 2024 includes $455 million in additional Medicare Operations funding from the FY 2023 annual appropriation, Public Law 117-328, General Provision Section 227. CMS has 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.

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2023 Actual Total	2024 Est. Total	2025 Est. Total
Office of the Administrator			
Direct FTEs	26	30	30
Reimbursable FTEs	0	0	0
Subtotal	26	30	30
Center for Clinical Standards and Quality			
Direct FTEs	448	437	437
Reimbursable FTEs	71	83	83
Subtotal	519	520	520
Center for Consumer Information and Insurance Oversight			
Direct FTEs	131	124	130
Reimbursable FTEs	305	353	353
Subtotal	436	477	483
Center for Medicaid and CHIP Services			
Direct FTEs	552	532	567
Reimbursable FTEs	1	1	1
Subtotal	553	533	568
Center for Medicare			
Direct FTEs	780	780	820
Reimbursable FTEs	6	6	6
Subtotal	786	786	826
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	36	36	36
Subtotal	36	36	36
Office of Acquisition & Grants Management			
Direct FTEs	167	166	167
Reimbursable FTEs	14	15	15
Subtotal	181	181	182
Office of the Actuary			
Direct FTEs	82	82	82
Reimbursable FTEs	0	0	0
Subtotal	82	82	82
Office of Communications			
Direct FTEs	202	200	205
Reimbursable FTEs	64	64	64
Subtotal	266	264	269
Office of Information Technology			
Direct FTEs	398	395	403
Reimbursable FTEs	3	4	4
Subtotal	401	399	407
Office of Equal Opportunity and Civil Rights			
Direct FTEs	30	31	31
Reimbursable FTEs	0	0	0
Subtotal	30	31	31
Federal Coordinated Health Care Office			
Direct FTEs	29	28	30
Reimbursable FTEs	0	0	0
Subtotal	29	28	30

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2023 Actual Total	2024 Est. Total	2025 Est. Total
Office of Financial Management			
Direct FTEs	196	194	196
Reimbursable FTEs	10	10	10
Subtotal	206	204	206
Office of Hearings and Inquiries			
Direct FTEs	93	92	93
Reimbursable FTEs	27	32	32
Subtotal	120	124	125
Office of Legislation			
Direct FTEs	57	53	57
Reimbursable FTEs	0	0	0
Subtotal	57	53	57
Digital Service at CMS			
Direct FTEs	17	17	17
Reimbursable FTEs	0	0	0
Subtotal	17	17	17
Office of Minority Health			
Direct FTEs	34	32	34
Reimbursable FTEs	0	0	0
Subtotal	34	32	34
Office of Human Capital			
Direct FTEs	166	177	177
Reimbursable FTEs	0	3	3
Subtotal	166	180	180
Office of Strategic Operations and Regulatory Affairs			
Direct FTEs	157	157	157
Reimbursable FTEs	4	4	4
Subtotal	161	161	161
Office of Enterprise Data and Analytics			
Direct FTEs	63	68	68
Reimbursable FTEs	0	0	0
Subtotal	63	68	68
Office off Burden Reductions & Health Informatics			
Direct FTEs	40	49	49
Reimbursable FTEs	0	0	0
Subtotal	40	49	49
Office of Program Operations & Local Engagement			
Direct FTEs	565	575	575
Reimbursable FTEs	17	22	22
Subtotal	582	597	597
Emergency Preparedness & Response Operations			
Direct FTEs	8	8	8
Reimbursable FTEs	0	0	0
Subtotal	8	8	8
Office of Security, Facilities and Logistics Operations			
Direct FTEs	93	90	93
Reimbursable FTEs	1	1	1
Subtotal	94	91	94
Office of Strategy, Performance, and Results			
Direct FTEs	44	38	45
Reimbursable FTEs	0	0	0
Subtotal	44	38	45
Total, CMS Program Management FTE 1/ 2/	**4,937**	**4,989**	**5,105**
Total, CMS Military Staffing - Disc. (Non-Add) 2/	*100*	*94*	*94*
Total, CMS Military Staffing - Other (Non-Add) 2/	*21*	*18*	*18*

1/ FY 2023 reflects actual FTE consumption.

2/ Includes FTEs funded from Program Management only (discretionary, mandatory, and reimbursables).

CMS Program Management
Detail of Full Time Equivalents (FTE)

Average GS Grade	2023 Actual Total	2024 Est. Total	2025 Est. Total
FY 2021	**13.7**		
FY 2022	**13.5**		
FY 2023	**13.7**		
FY 2024	**13.8**		
FY 2025	**13.8**		

CMS Program Management
Detail of Positions
(Dollars in Thousands)

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Subtotal, EX	1	1	1
Total - Exec. Level Salary	$168	$168	$169
Subtotal	67	60	60
Total - ES Salaries	$14,987	$13,350	$12,301
GS-15	668	656	677
GS-14	701	689	710
GS-13	1,964	1,929	1,989
GS-12	466	458	472
GS-11	103	101	104
GS-10	0	0	0
GS-9	104	103	106
GS-8	0	0	0
GS-7	37	37	38
GS-6	3	2	3
GS-5	6	6	6
GS-4	4	4	4
GS-3	2	2	2
GS-2	0	0	0
GS-1	0	0	0
Subtotal 1/	4,059	3,986	4,111
Total - GS Salary 1/	$553,839	$574,480	$600,344
Average GS Grade 1/	13.7	13.8	13.8
Average GS Salary 1/	$136	$144	$146

1/ Reflects direct discretionary staffing within the Program Management account.
Note: This table does not include salaries for military/CoC personnel.

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 2015			FY 2016			FY 2017			FY 2018		
		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		5			0			0			0	
Reinsurance for Early Retirees	1102		4			0			0			0	
Affordable Choices of Health Benefit Plans	1311	$ 469,624	49		$ 20,163	34		$ 18,221	25		$ 11,698	24	
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		11			11			8			6	
Medicaid Emergency Psychiatric Demonstration	2707		1			0			0			0	
Quality Measurement 2/	3014		9			0			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		479			521			551			540	
Independence At Home Demonstration 2/	3024	$ 4,635	1			1			1			1	
Community Based Care Transitions	3026		0			1			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		1			0			0			0	
Community Prevention and Wellness	4202		0			0			0			0	
Graduate Nurse Education 2/	5509	$ 46,350	1			1			2			2	
Sunshine Act	6002	$ 21,399	16		$ 4,211	17		$ 5,615	22			0	
LTC National Background Checks	6201		5			6			6			4	
Provider Screening & Other Enrollment Requirements 1/	6401	$ 18,035	13		$ 3,509	14		$ 3,509	9			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 27,377	2		$ 468	2		$ 468	1			0	
Expansion of the Recovery Audit Contractor Program 1/	6411	$ 3,975	2		$ 468	2			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	$ 548,548	1		$329	1			0			0	
Total ACA Direct Appropriated FTEs			**600**			**611**			**625**			**577**	

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 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), FY 2020 (-5.9%), and FY 2021 - FY 2025 (-5.7%).

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

Program	Section	FY 2019			FY 2020			FY 2021			FY 2022		
		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 2/	2701		10			10			10			9	
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		600		$10,000,000	528			523			506	
Independence At Home Demonstration 2/	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 2/	5509		0			0			0			0	
Sunshine Act	6002		0			0			0			0	
LTC National Background Checks	6201		6			6			10			5	
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 2/	10323		0			0			0			0	
Total ACA Direct Appropriated FTEs			**616**			**544**			**543**			**520**	

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 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), FY 2020 (-5.9%), and FY 2021 - FY 2025 (-5.7%).

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

Program	Section	FY 2023			FY 2024			FY 2025		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Health Insurance Consumer Information	1002		0			0			0	
Rate Review Grants	1003		0			0			0	
Pre-existing Condition Insurance Plan Program	1101		0			0			0	
Reinsurance for Early Retirees	1102		0			0			0	
Affordable Choices of Health Benefit Plans	1311		0			0			0	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322		0			0			0	
Adult Health Quality Measures	2701		9			9			0	
Medicaid Emergency Psychiatric Demonstration	2707		0			0			0	
Quality Measurement	3014		0			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		545			626			626	
Independence At Home Demonstration	3024		0			0			0	
Community Based Care Transitions	3026		0			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		0			0			0	
Community Prevention and Wellness	4202		0			0			0	
Graduate Nurse Education	5509		0			0			0	
Sunshine Act	6002		0			0			0	
LTC National Background Checks	6201		6			6			6	
Provider Screening & Other Enrollment Requirements 1/	6401		0			0			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402		0			0			0	
Expansion of the Recovery Audit Contractor Program 1/	6411		0			0			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards	10323		0			0			0	
Total ACA Direct Appropriated FTEs			**560**			**641**			**632**	

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 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), FY 2020 (-5.9%), and FY 2021 - FY 2025 (-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 2023 Projected Actuals	FY 2024 Estimates	FY 2025 Estimates
3a) Number of Physicians Receiving PCAs	34	37	35
3b) Number of Physicians with One-Year PCA Agreements	5	5	3
3c) Number of Physicians with Multi-Year PCA Agreements	29	32	32
4a) Average Annual PCA Physician Pay (without PCA payment)	$181,863	$185,824	$185,824
4b) Average Annual PCA Payment	$22,985	$24,000	$25,000

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 programs. Some of these mandates require establishing additional new physician positions or quickly filling vacated physician positions to fill very specific needs. Even though CMS has experienced many hurdles trying to recruit physicians, the PCA is still necessary because the candidates with quality experience make significantly more money in the private sector compared to what CMS would be able to offer them without PCA. PCA has made the salary offers more comparable to give us the opportunity to attract and hire exceptional physicians. Without this allowance, CMS would not be able to attract and retain highly qualified physicians.

6) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

The average annual PCA physician pay (without PCA payment) may increase resultant of physicians being eligible for step increases during that timeframe. The average annual PCA amounts may increase slightly as a physician completes their 24 months as a government physician. There are currently 34 Physicians in CMS receiving PCA, 13 at the maximum PCA amount of $30,000.

Resources for Cyber Activities
Centers for Medicare & Medicaid Services

(Dollars in millions)

Cyber Category	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Cyber Human Capital	--	--	--	--
Planning Roles and Responsibilities	--	--	--	--
Sector Risk Assessment, Management, and Operations	--	--	--	--
Sector Coordination	--	--	--	--
Other NIST CSF Capabilities:				
Detect	16.80	18.96	28.86	12.06
Identify	67.19	75.83	115.44	48.25
Protect	22.40	25.28	38.49	16.09
Recover	2.80	3.16	4.81	2.01
Respond	2.80	3.16	4.81	2.01
Total Cyber Request	**111.99**	**126.39**	**192.41**	**80.42**
Technology Ecosystems (non-add)	--	--	--	--
Zero Trust Implementation (non-add)	*5.20*	*0.90*	*16.60*	*11.40*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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**

  State reporting on the Adult Core Set and home and community-based services measures under the Adult Quality Measurement Improvement Program is currently voluntary. As such, data on these measures remains inconsistent, which has stifled CMS and states' ability to assess and improve quality and outcomes within and across their Medicaid and home and community-based services programs. Additionally, existing funding for the Adult Quality Measurement and Improvement Program will be expended by early FY 2025 and CMS will need alternative funding to support these ongoing, statutorily-required activities. This proposal provides CMS $15 million annually for this program and requires state 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. This funding and authority align reporting requirements with those of the Child Health and Behavioral Health Core Sets, which are mandatory for state reporting beginning in FY 2024, and provide the resources needed for CMS to continue supporting health equity. [$299 million in administrative costs over 10 years]

- **Provide Measure Development Funding to Refine 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. This proposal renews the expired funding appropriation for quality measure development for FYs 2025 through 2029, making $10 million available for each year. This proposal also generates new measures for use in the transition to Merit-based Incentive Payment System Value Pathways and expands 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. [$50 million in administrative costs over 10 years]

- **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 highperforming 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]

- **Reclassify Discretionary Nursing Home Survey and Certification Activities as Mandatory**

  CMS's annual funding for health and safety surveys has remained flat for years, while the number of nursing home complaints have surged. Additionally, flat funding has made it difficult for many states to offer competitive wages to the healthcare personnel who work as surveyors, leading to surveyor workforce shortages in some areas. These factors make it challenging for states to complete all statutorily-required nursing home surveys and complaint visits, and can place nursing home residents at increased risk of abuse and neglect. This proposal will shift funds for nursing home surveys from a discretionary appropriation to a mandatory appropriation and increase the funding to a level necessary to achieve a 100% survey frequency, adjusted annually for inflation, effective in FY 2026. This proposal will guarantee sufficient funding to promote the health and safety of the Nation's nursing home residents. [Net cost of $346 million over 10 years]

- **Increase Mandatory HCFAC Funding**

  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 $4.1 billion over the 10-year budget window and yield $5.0 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	2025	90%	October 31, 2025
	2024	90%	October 31, 2024
	2023	90%	99% (Target Exceeded)
	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)
MCR9.1b: Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment	2025	90%	October 31, 2025
	2024	90%	October 31, 2024
	2023	90%	99% (Target Exceeded)
	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	2025	90%	October 31, 2025
	2024	90%	October 31, 2024
	2023	90%	96% (Target Exceeded)
	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)
MCR9.3: Minimum of 90 percent pass rate for the Customer Satisfaction Survey	2025	90%	October 31, 2025
	2024	90%	October 31, 2024
	2023	90%	96% (Target Exceeded)
	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)
MCR9.4a: Quality Standards: Minimum of 90 percent pass rate for Adherence to Privacy Act (Health Insurance Marketplace)	2025	90%	October 31, 2025
	2024	90%	October 31, 2024
	2023	90%	97% (Target Exceeded)

Measure	FY	Target	Result
MCR9.4b: Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment (Health Insurance Marketplace)	2025	90%	October 31, 2025
	2024	90%	October 31, 2024
	2023	90%	99% (Target Exceeded)
MCR9.4c: Quality Standards: Minimum of 90 percent meets expectations for Knowledge Skills Assessment (Health Insurance Marketplace)	2025	90%	October 31, 2025
	2024	90%	October 31, 2024
	2023	90%	96% (Target Exceeded)
MCR9.5: Minimum of 90 percent pass rate for the Customer Satisfaction Survey (Health Insurance Marketplace)	2025	90%	October 31, 2025
	2024	90%	October 31, 2024
	2023	90%	93% (Target Exceeded)

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

CMS is the largest purchaser of health insurance in the United States responsible for accurate, timely, relevant, understandable, and easily accessible information that will help individuals evaluate health plan options, nursing home options, and make decisions on their individual health care needs. CMS works to ensure high quality health care at a reasonable price and to provide information about benefits, health promotion, and choices.

The Contact Center Operations (CCO) environment provides customer service functions which can efficiently handle and answer inquiries with a high level of service across the United States and its territories. The operations include offering the same range of services and quality across multiple contact channels, such as telephone, mail, email, TDD/TTY, fax, and web chat, enabling multi-channel access.

The 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. 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.

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, while CMS's IQA contractor uses Quality Call Monitoring to assess quality from a universal customer service experience perspective. Both quality processes help to identify 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 its inception, this performance measure has relied 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 dedicated to fostering excellence and providing world class customer service for the Americans who receive their health insurance through Medicare or the Health Insurance Marketplace. In 2023, CMS expanded the Government Performance and Results Act (GPRA) goals to include metrics for the Health Insurance Marketplace call center. CMS will be using the same call center methodology outlined above to monitor the quality of the interactions, and evaluate the customer satisfaction rates collected.

These metrics continue to align with the measures provided as two of the High Impact Service Providers (HISPs) designated by OMB in the President's Management Agenda priority on customer service.

1-800-MEDICARE and the Federal Marketplace Call Center both strive to advance equity by providing 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's Improved Rating on Financial Statements

Measure	FY	Target	Result
MCR12: Maintain an unmodified opinion	2025	Maintain an unmodified opinion	November 15, 2025
	2024	Maintain an unmodified opinion	November 15, 2024
	2023	Maintain an unmodified opinion	Target Met
	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

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. The HHS Office of Inspector General is responsible for auditing these financial statements and hires an independent accounting firm to perform a financial statement audit, including a review of the financial operations, internal controls, and compliance with laws and regulations at CMS and its contractors.

This measure supports the Strategic Objective to Foster Financial Excellence/Stewardship for all of CMS's major programs (Medicare, Medicaid, and Health Insurance Marketplaces). This measure ensures CMS's compliance with applicable laws and regulations in accordance with Office of Management and Budget (OMB) Bulletin 21-04, Audit Requirements for Federal Financial Statements. In addition, it allows the Agency to submit to HHS an Annual Statement of Assurance on the effectiveness of CMS's internal controls meeting the objectives of the Federal Manager's Financial Integrity Act of 1982 (FMFIA). This measure also supports CMS's Strategic Objective to Engage Partners by providing financial transparency to our stakeholders around the programs we administer as we continue to service our beneficiary/recipient population and provider communities, This measure also supports the Strategic Objective to Protect Our Programs as we fulfill our fiduciary responsibilities to develop effective internal controls that safeguard the Medicare Trust Funds and the assets entrusted to us to administer our programs.

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, 2022, and September 30, 2022.

The measure met the FY 2023 target and is on track to achieve the FY 2024 estimates.

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	2025	60%	December 15, 2026
	2024	55%	December 15, 2025
	2023	47%	December 15, 2024
	2022	40%	30.4% (Target Not Met But Improved)
	2021	40%	24.8% (Target Not Met But Improved)
	2020	30%	24.2% (Target Not Met But Improved)
	2019	Baseline	20.21%

HHS and 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 almost 11 million people with Medicare receiving care from a health care provider in a Shared Savings Program ACO as of January 2023. These efforts drive innovative payment and service delivery models, which 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 toward 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 measure CMMI6).

While CMS did not meet its FY 2022 target, it demonstrated significant improvement towards the goal, making the largest annual jump in recent years (5.6 percentage points increase). Several factors contribute to CMS falling short of the designated goal, including lingering effects of the COVID-19 pandemic, such as practice staffing issues and comfort with risk-based arrangements, a limited number of new CMMI models in the preceding recent years, and stabilization of enrollment in the Medicare Shared Savings Program.

To continue working towards the goal of shifting Traditional Medicare dollars into APMs that include downside risk, CMMI announced several new innovative payment models in 2023. In June 2023, the Making Care Primary (MCP) model was announced, which aims to move primary care practices towards accepting prospective, population-based payments. Additionally, in September 2023 the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) was announced, which is a state-based total cost of care model. CMMI plans to continue to develop and test new alternative payment models in FY 2024 and beyond. The targets for FY 2023, FY 2024, and FY 2025 are 47%, 55%, and 60% respectively. These were set to align with CMMI's Strategic Refresh and the Health Care Payment Learning & Action Network (HCPLAN) goals for the percentage of health care spending tied to Alternative Payment Models (APMs) that incorporate downside risk.

MCR37: Increase Patient Choice in Dialysis Treatment

Measure	FY	Target	Result
MCR37: Increase the percentage of new dialysis patients who choose home dialysis modalities	2025	25.65%	June 30, 2026
	2024	24.62%	June 30, 2025
	2023	23.60%	June 30, 2024
	2022	22.57%	22.9% (Target Exceeded)
	2021	19.92%	21.5% (Target Exceeded)
	2020	19.02%	20.52% (Target Exceeded)
	2019	Baseline	18.11%

HHS has a goal of 80 percent of new ESRD patients either receiving dialysis at home or receiving a transplant by 2025. 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. 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. Data from the U.S. Renal Data System (USRDS) also indicates that annual cost of home dialysis is substantially less than in-center dialysis for qualified patients. USRDS 2022 Annual Data Report (Figure 9.11) shows the annual cost of peritoneal dialysis is substantially less than hemodialysis dialysis for Medicare Fee-For-Service (FFS) beneficiaries with ESRD. In 2020, as adjusted for inflation, the per person per year (PPPY) costs were approximately $95,932 for individuals receiving hemodialysis and $81,525 for those utilizing peritoneal dialysis as a treatment modality—a difference of $14,407 PPPY.

This measure focuses on increased patient choice to use home dialysis and direct support for this goal is included in the ESRD Network Program for the 12th Scope of Work (SOW), as one of our Objectives and Key Results (OKRs). 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.

This measure supports the CMS Strategic Plan Pillar for Advancing Equity. 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.

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 the 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. Home dialysis modalities include:

- 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.

There are a number of challenges 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. Another barrier noted is an inadequate number of trained home dialysis staff, which was exacerbated by the COVID-19 Public Health Emergency (PHE). Current ESRD Network projects focus efforts to mitigate these challenges.

The targets set for this measure through FY 2021 were calculated based on a 10 percent relative increase in the measure rate starting from the 2019 baseline. For example, the FY 2020 target was 19.02 percent (5 percent relative increase over baseline) and the FY 2021 target was 19.92 percent (10 percent relative increase over baseline). The targets for FY 2022 and beyond are based on the observed measure rate in 2020 and use a similar calculation. For example, the observed measure rate in 2020 was 20.52 percent, so a 10 percent relative increase over 2 years to 2022 yields a target of 22.57 percent which was exceeded at 22.9 percent.

The activities of the ESRD Network Program to drive the increases in incident and prevalent patients moving to a home dialysis modality directly support and contribute to not only meeting but exceeding the target goals set for this measure.

A 20 percent relative increase from 2020 to 2024 yields a target of 24.62 percent, and a 25 percent increase from 2020 to 2025 yields a target of 25.65 percent. The next result is scheduled to be reported by June 30, 2024. The program is expected to meet the FY 2023 target of 23.6 percent.

The ESRD Networks will continue to utilize the home dialysis change package, which is 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 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, the Office of Minority Health, and dialysis facilities to advance the work of health equity.

The FY 2024-2025 budget for the ESRD Network Program is directly tied to the number of required/performed dialysis treatments, whether provided through in-center dialysis or a home dialysis modality. Achievement of this measure does not impact the Program budget but could contribute to Medicare savings since the annual cost of home dialysis is substantially less than in-center dialysis for qualified patients.

MMB2: All-Cause Hospital Readmission Rate for Medicare-Medicaid Dually Eligible Individuals in Fee-for-Service (FFS) Medicare

Measure	FY	Target	Result
MMB2: All-Cause Hospital Readmission Rate for Medicare-Medicaid Enrollees in Fee-for-Service (FFS) Medicare Baseline: 92.7 (Readmissions per 1,000 Beneficiaries)	2025	1% Reduction from 2019 Actual	April 30, 2027
	2024	0.75% Reduction from 2019 Actual	April 30, 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	64.6 per 1000 (Target Exceeded) (8.6% below 2020 Actual)
	2020	0.5% Reduction from 2019 Actual	70.7 per 1000 (Target Exceeded) (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)

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.

This measure represents CMS's understanding of hospital readmission rates for individuals who are dually eligible for Medicare and Medicaid. During 2023, more than 13 million individuals concurrently enrolled in 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 within 30 days of an acute hospitalization per 1,000 eligible beneficiaries. Eligible beneficiaries are dually eligible individuals of any age.

This measure supports the CMS Strategic Plan Pillar for Advancing Equity. 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.

Dually eligible individuals face higher degrees of social risk, which can include housing, transportation, food, and technology access limitations, and they have higher rates of chronic conditions. They manage these challenges while navigating a health system with benefits under multiple payers that may not be integrated or coordinated.

The target was met in 2021. After several years of stabilization of readmission rates from 2015-2019[1], in 2021 MMB2 showed declines in readmissions per 1,000 eligible beneficiaries. It showed a steep decline in both 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. This significant decrease in readmissions is in contrast to the change between 2018 and 2019, when the measure showed a 1.0 percent increase in readmission rates for dually eligible individuals (from 83.7 to 84.6 per 1000 beneficiaries) and a 2 percent reduction for the non-dually eligible group (from 31.0 to 30.4 per 1000 beneficiaries) [2]. The steep reductions in 2020 are likely the result of changes in utilization patterns related to the COVID-19 public health emergency (PHE) in 2020 and 2021 and the fact that hospital index admissions with a primary diagnosis code of COVID-19 are excluded from the measure.

The readmission rate continued its decline from 2020 to 2021 by 8.6 percent (from 70.7 to 64.6 per 1000 beneficiaries). It should be noted that the steward of the underlying measure, which is used in the Medicare Hospital Readmissions Reduction Program (HRRP), implemented a measure specification change that impacted the 2021 measurement year. The change excluded admissions with a primary or secondary diagnosis of COVID-19 from the universe of hospitalizations captured. Admissions with a primary diagnosis of COVID-19 would not have previously been included in this GPRA metric, because it is not one of the nine diagnoses captured; however, exclusion of any admissions with one of the nine included primary diagnoses and a secondary diagnosis of COVID-19 is a change. The overall percentages of admissions with one of the nine primary diagnoses included in this metric and a secondary diagnosis of COVID-19 were quite small. The highest was for admissions in which pneumonia was the primary diagnosis of which only 4.5% were excluded from the universe of eligible admissions. The readmissions rate (readmissions/admissions) remained stable at 21% from 2020 to 2021 for the remaining denominator of admissions with a primary diagnosis of pneumonia. These percentages are not limited to dually eligible beneficiaries and not all would have resulted in a readmission that would have been captured in this metric. Given current data limitations, we are not able to accurately estimate the impact of this specification change on our GPRA metric, but based on the overall percentage exclusions, we assume it to be small.

There is evidence the COVID-19 infection worsens the severity of existing comorbidities resulting in an increased rate of readmission.[3] 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

[1] 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.
[2] 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.
[3] 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.

COVID-19.[4] MMB2 data showed a small increase in readmission rates for these diagnoses from 2019-2021, 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: 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 and 2021, 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.

There are a number of programs and innovations targeting Medicare and Medicaid beneficiaries more broadly, focusing on dually eligible individuals specifically, or reaching dually eligible individuals by nature of their target illnesses or program designs (e.g., ESRD, Medicare-Medicaid Plans) – all with at least one measure focused on impacting hospital readmissions. A risk for this measure is that we do not know whether improvements already achieved through overlapping programs will limit the ability to make significant gains.

CMS will analyze 2022 data when it becomes available in spring 2024. We recommend increasing the target reduction rate to 1 percent for FY 2025 as compared to 2019 actual data. We selected 2019 because it is a stable year against which we could measure our cumulative progress on this measure over time, rather than fluctuations in any given year which could give a misleading result. For example, if our performance on the measure worsened relative to the target in a given year and then, in the following year, improved against a target that was based on that poor performance, then it would appear that we had very good performance in the second year. In reality, such a result could even have been an overall decline in performance as measured against a stable historical target. Tracking performance on this measure against a stable target enables us to capture our sustained performance over time.

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:

- 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 and other measures;

- 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,

[4] 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.

All-Cause Unplanned Readmission (HWR) Rate for MIPS Groups and Clinicians 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 States Advancing Health Equity Approaches and Development (AHEAD) model, the Bundled Payments for Care Improvement (BPCI Advanced) initiative, the ACO REACH Model, the Medicare-Medicaid Financial Alignment Initiative managed fee-for-service model,]the Primary Care First model, and the Making Care Primary model.

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, especially 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	2025	Contextual Measure	November 30, 2025
	2024	Contextual Measure	November 30, 2024
	2023	Contextual Measure	1,988,037
	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

More than 13 million Americans were concurrently enrolled in both the Medicare and Medicaid programs during 2023. A lack of alignment between the Medicare and Medicaid programs can lead to fragmented 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 promote greater alignment between Medicare and Medicaid plans, 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. Promoting integrated care through these approaches, and maximizing their value to beneficiaries, supports the Expand Access CMS Strategic Plan Pillar and is a high priority for CMS.

Since 2011, the number of full-benefit dually eligible individuals in integrated care and/or financing models has increased from 161,777 to 1,988,037. In 2023, about 22 percent of full-benefit dually eligible individuals were enrolled in integrated care programs. Barriers to integrated care include state capacity, misaligned enrollment across Medicare and Medicaid health plans, and other factors.

The growth in enrollment in integrated care can be attributed to CMS regulatory actions and CMS's extensive work with states to help them understand, develop, and implement integrated care programs, increasing beneficiary access to quality integrated care. In 2023, CMS began implementing the 2023 Medicare Advantage (MA) and Part D Final Rule to advance CMS's strategic vision of expanding access to affordable health care and

improving health equity in MA and Part D. These provisions aim to further improve integration of Medicare and Medicaid programs for dually eligible individuals enrolled in D-SNPs. In 2023, CMS also released the 2024 Medicare Advantage & Part D Final Rule finalized amendments to the earlier regulations prohibiting D-SNP look-alikes and worked with D-SNP look-alike plans to transition dually eligible enrollees to integrated D-SNPs where available. Finally, to further reduce misaligned enrollment across Medicare and Medicaid programs, we have put forward proposals in the 2025 MA and Part D Notice of Proposed Rulemaking to further increase the percentage of dually eligible managed care enrollees who receive integrated Medicare and Medicaid services from the same health plan.

In addition to the regulatory actions taken in Medicare Advantage, CMS took the most significant action in a decade to make care for older adults and people with disabilities more affordable and accessible by issuing the first part of a final rule to remove barriers for dually eligible beneficiaries to enroll in (and maintain enrollment in) Medicare Savings Programs, improving access to integrated care options.

CMS also continues to invest in technical assistance to state Medicaid agencies on aspects of integrated care, including state-led strategies to align Medicare and Medicaid enrollment in managed care plans, through the Integrated Care Resource Center. As a result of these steps, we anticipate continued growth in the number of full-benefit dually eligible individuals in integrated care nationally in the coming years. We do not have specific targets as states have the flexibility to design and implement their own programs.

PHI8: Improve Access to Health Insurance Coverage by Increasing Marketplace Enrollment Nationwide

Measure	FY	Target	Result
PHI8: Improve access to Health Insurance Coverage by increasing Marketplace enrollment nationwide	2025	17.5 million	June 30, 2025
	2024	17 million	June 30, 2024
	2023	15 million	16.4 million (Target Exceeded)
	2022	13 million	14.5 million (Target Exceeded)

Ensuring Americans have access to health coverage is critical so that individuals can live longer and healthier lives, with improved health outcomes and protection from financial bankruptcy. CMS continues to employ multi-layered efforts to expand access to quality, affordable health coverage by applying a holistic approach, which includes improved policy, a better plan comparison experience, consumer education and outreach, and oversight of agent/broker practices. CMS also aims to improve the ease of coverage transitions and increase the percentage of consumers who enroll in Marketplace plans after being transferred to the Marketplace from Medicaid.

In line with the CMS Strategic Plan Pillar to Expand Access, CMS is building on the ACA by improving Qualified Health Plan coverage, access, and choice by implementing new requirements for network adequacy regarding time and distance and appointment wait times, reducing single issuer rural counties, and implementing standardized options on the Federally Facilitated Marketplace and State-based Marketplace using the federal platform. Additionally, CMS continues work to implement the No Surprises Act to help protect people from surprise medical bills and remove consumers from payment disputes between a provider or health care facility and their health plan.

The Marketplace experienced a substantial increase in enrollment during the 2022 Open Enrollment Period. The enhanced premium tax credits authorized in the American Rescue Plan expanded the affordability and accessibility of health coverage, with the number of consumers getting coverage for $10 or less per month, after tax credits, nearly doubling compared to beginning of the 2021 Open Enrollment Period. With the passage of the Inflation Reduction Act, the enhanced premium tax credits will continue to help people afford their premiums and connect to coverage through 2025.

The 2023 Open Enrollment Period also saw the Marketplace experience record-breaking enrollment. From 2014 to 2023, effectuated enrollment has doubled from 8 million to more than 16 million and continues to increase year over year. These coverage gains are the result of the combination of greater affordability due to the Inflation Reduction Act, robust plan options, an improved consumer experience, and large-scale outreach and enrollment assistance.

For FYs 2024 and 2025, the Marketplace aims to continue improvements in access to health coverage by increasing Marketplace enrollment nationwide to 17 million and 17.5 million, respectively. Due to the record-breaking enrollment period in 2023, CMS updated

the performance measure targets for FYs 2024 and 2025, as the prior targets fell below the achieved 2023 enrollment numbers. These targets were developed in consultation with CMS Senior Leadership and the Senior Data Analyst.

CMS will continue to expand access to affordable and quality health coverage by improving consumer protections and removing potential barriers to access by strengthening network adequacy, improving the ease of coverage transitions and re-enrollment, making health plan option and choice comparisons simpler, setting standards for health plan marketing names, and improving modified annual household income verification. CMS expects individuals and families losing Medicaid and Children's Health Insurance Plan (CHIP) coverage due to unwinding to continue to transition to Marketplace coverage, and has implemented a variety of improvements and flexibilities to ease coverage transitions, including a special enrollment period for those who lose Medicaid or Children's Health Insurance Plan (CHIP) coverage and door-to-door Assister outreach to help consumers enroll in coverage and large-scale outreach and advertising. CMS continues to make investments and improvements to its Navigator and assister programs, with $98.6 million in grant funding provided to 57 Navigator entities for the 2024 Open Enrollment Period, and a new policy for door-to-door Assister outreach to help consumers enroll in coverage. CMS also launched a $5 million pilot to conduct rural-focused outreach and health insurance enrollment activities during the 2024 Open Enrollment Period.

PHI9: Increase Federally-Facilitated Marketplace Enrollment Among Underrepresented Populations

Measure	FY	Target	Result
PHI9: Increase Federally-facilitated Marketplace enrollment among underrepresented populations	2025	3.1 million	March 15, 2025
	2024	3.0 million	March 15, 2024
	2023	2.1 million	2.9 million (Target Exceeded)
	2022	1.9 million	2.7 million (Target Exceeded)

Relative to the general population, lower enrollment among underrepresented populations may be due to a number of reasons, including high healthcare costs, discriminatory or misleading marketing practices, fear due to immigration-related policies, confusion about eligibility policies, language and literacy challenges, government distrust, and lack of outreach and enrollment assistance.

CMS employs multi-layered efforts to expand access to quality, affordable health coverage for underrepresented populations and advances health equity by applying a holistic approach, which includes improved policy, a better plan comparison experience, consumer education and outreach, and oversight of agent/broker practices. CMS is planning listening sessions and meetings with states, issuers, and providers on suggestions to address health equity and serve the underserved.

It is important to note that while CMS collects self-reported enrollees' demographic data, enrollees are not required to report this information and, as a result, CMS does not have accurate or complete data on enrollees' demographics. These data collection challenges may be difficult to remedy and may result in an underreporting of enrollment among underrepresented populations.

In line with the CMS Strategic Plan Pillar to Expand Access, CMS is building on the ACA by improving Qualified Health Plan coverage, access, and choice by implementing new requirements for network adequacy regarding time and distance and appointment wait times, reducing single issuer rural counties, and implementing standardized options on the Federally Facilitated Marketplace and State-based Marketplace using the federal platform. Additionally, CMS continues work to implement the No Surprises Act to help protect people from surprise medical bills and remove consumers from payment disputes between a provider or health care facility and their health plan.

The Marketplace experienced a substantial increase in enrollment during the 2022 Open Enrollment Period. The enhanced premium tax credits authorized in the American Rescue Plan expanded the affordability and accessibility of health coverage, with the number of consumers getting coverage for $10 or less per month, after tax credits, nearly doubling compared to beginning of the 2021 Open Enrollment Period. With the passage of the Inflation Reduction Act, the enhanced premium tax credits will continue to help people afford their premiums and connect to coverage through 2025.

The 2023 Open Enrollment Period also saw the Marketplace experience record-breaking enrollment, with over 16.3 million Americans signing up for health coverage, including 2.9 million enrollees from underrepresented populations. CMS made an investment of nearly $100 million in continuation grants to 59 Navigator entities. These investments — along with increased affordability thanks to the extended premium tax credits in the Inflation Reduction Act and new eligibility for families previously impacted by the family glitch — have resulted in these record-breaking numbers.

For FYs 2024 and 2025, CMS aims to increase Federally-facilitated Marketplace enrollment among underrepresented populations to 3 million and 3.1 million, respectively. These targets were developed in consultation with CMS Senior Leadership and the Senior Data Analyst.

CMS will continue to expand access to affordable and quality health coverage by improving consumer protections and removing potential barriers to access by strengthening network adequacy, improving the ease of coverage transitions and re-enrollment, making health plan option and choice comparisons simpler, setting standards for health plan marketing names, and improving modified annual household income verification. CMS expects individuals and families losing Medicaid and Children's Health Insurance Plan (CHIP) coverage due to unwinding to continue to transition to Marketplace coverage, and has implemented a variety of improvements and flexibilities to ease coverage transitions, including a special enrollment period for those who lose Medicaid or Children's Health Insurance Plan (CHIP) coverage and door-to-door Assister outreach to help consumers enroll in coverage and large-scale outreach and advertising. CMS continues to make investments and improvements to its Navigator and assister programs, with $98.6 million in grant funding provided to 57 Navigator entities for the 2024 Open Enrollment Period, and door-to-door Assister outreach to help consumers enroll in coverage. CMS also launched a $5 million pilot to conduct rural-focused outreach and health insurance enrollment activities during the 2024 Open Enrollment Period.

MEDICARE SURVEY & CERTIFICATION PROGRAM

MSC5: Decrease the Percentage of Long-stay Nursing Home Residents Receiving an Antipsychotic Medication

Measure	FY	Target	Result
MSC5: Decrease the population of long-stay nursing home residents receiving antipsychotic medication	2025	14.0%	July 31, 2026
	2024	14.3%	July 31, 2025
	2023	14.7%	July 31, 2024
	2022	15.0%	14.6% (Target Exceeded)
	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)

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

This performance measure aims 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.

Since 2012, through the work of the National Partnership to Improve Dementia Care in Nursing Homes, there has been improvement in the quality of dementia care and a significant reduction in the use of antipsychotic medications. CMS and its partners are committed to finding new ways to implement practices that enhance the quality of life for people with dementia, protect them from substandard care, and promote goal-directed, person-centered care for every nursing home resident.

A number of evidence-based, non-pharmacological interventions and approaches have been incorporated into clinical practice guidelines, and various tools and resources are posted on the CMS website at Quality Innovation Network-Quality Improvement Organization (QIN-QIO). Additionally, the Hand in Hand resource, the training for nursing home staff developed by CMS, is in the training catalog on the Quality, Safety & Education Portal (QSEP) website. Several meta-analyses have reviewed non-pharmacological approaches to behaviors in people with dementia. Studies have shown that these interventions may effectively reduce 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 to individualize and de-institutionalize the care environment. Person-centered care is the central theme of the Hand in Hand training.

In July 2012, CMS began posting on the Care Compare website quality measures of antipsychotic medication 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.

CMS released a Quality, Safety, and Oversight memo outlining actions taken to increase transparency of nursing home oversight enforcement and crack down on inappropriate prescribing. This performance measure supports this objective to foster excellence and stewardship in our nation's nursing homes. It emphasizes the necessity of an improved standard practice within each nursing home to create positive changes and better outcomes, dedicated to the care and quality of life of all residents.

For this goal, CMS reports the prevalence of antipsychotic use in the last three months of the calendar 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 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 14.6 percent in 2022 Q4. Success has varied by state and CMS location, with some states and locations having seen a reduction of greater than 40 percent.

CMS promotes non-pharmacologic approaches and person-centered dementia care practices by working with provider associations, nursing home resident advocates, and stakeholders, to decrease the use of antipsychotic medications when they are not clinically indicated. Some of this work includes developing and conducting training for nursing home providers, surveyors, and consumers; conducting research; raising public awareness; using regulatory oversight; improving surveyor guidance; and public reporting to increase transparency.

Due to growing concerns that some nursing homes have erroneously coded residents as having schizophrenia, which can mask the facilities' true rate of antipsychotic medication use, CMS released new interpretative guidance in June of 2022. This guidance includes new instructions for surveyors on situations where a nursing home resident has potentially been misdiagnosed with schizophrenia. CMS also released survey process revisions that will help surveyors better investigate and cite this issue.

The major programmatic challenge we have identified is that nursing homes must improve their standard practice to make significant meaningful changes in the prevalence of antipsychotic medication use.

CMS will continue to focus on reducing the use of antipsychotic medications and enhancing the use of non-pharmacologic approaches and person-centered dementia care practices in all nursing homes. Also, CMS will evaluate actions to address concerns about facilities using an inappropriate process to diagnose residents with schizophrenia to improve their quality measures artificially.

In January 2023, CMS and contracted auditors began conducting off-site audits of facilities' documentation for coding and diagnosing residents with schizophrenia. CMS provides states with the results of these audits to be used to help inform surveyors' investigations during the survey process. This contracted effort will continue, and CMS will closely monitor the outcomes of state's surveys related to these issues, policies, and initiatives. Additionally, we believe this initiative will help to address health disparities. As it was found that selected facilities generally have larger proportions of residents that are low-income and have a larger proportion of minorities. These facilities also have a poorer history of noncompliance and lower staffing levels.

MSC6: Percentage of Hospice Facilities that Have Been Surveyed within 36 Months

Measure	FY	Target	Result
MSC6.2: Percentage of facilities that are surveyed within the required 36 month timeframe	2025	98% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2026
	2024	98% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2025
	2023	98% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2024
	2022	98% of hospice facilities are surveyed within the required 36 month timeframe	87.1%* (Target Not Met But Improved)
	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 FYs 2020, 2021, and 2022 due to the COVID-19 Public Health Emergency (PHE) and reprioritization of survey activities based on guidance published throughout the PHE.

This measure aims to ensure that the statutory requirement for the hospice survey interval is met nationally. Although the CMS target is 100 percent compliance with the statutory requirement, the stated measure represents a realistic expectation, considering the effort required at the state-level to achieve the survey interval timeframe requirement.

A hospice is a public agency or private organization that is primarily engaged in providing care to terminally ill individuals. Hospice care is an approach to caring for terminally ill individuals that stresses palliative care (relief of pain and uncomfortable symptoms) as opposed to curative care. In addition to meeting the patient's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the patient, as well as the psychosocial needs of the patient's family/caregivers. The hospice program emphasizes keeping the hospice patient at home with family and friends as long as possible.

Although some hospices are part of a hospital, nursing home, or home health agency, all hospices must meet specific federal requirements and be separately certified and approved for Medicare participation. As of November 20, 2023, 7,084 Medicare certified hospice agencies in the U.S. provide care to over 1.5 million Medicare beneficiaries annually.

The Social Security Act (the "Act") mandates the establishment of minimum health and safety standards for all participating hospice providers. These standards are further defined in the Medicare Conditions of Participation (COPs), which establish the minimum requirements that a hospice agency must meet to participate in Medicare. State Survey Agencies (SAs), under agreements between the state and CMS, evaluate hospice compliance through the survey and certification process. However, approximately half of the Medicare-certified hospices participate through deemed status with a CMS-approved accrediting organization (AO) in lieu of oversight by SAs. Additionally, the Act allows health care facilities to demonstrate their compliance with the Medicare conditions through accreditation by a CMS-approved program of an AO, in lieu of being surveyed by SAs for certification. This is referred to as "deeming" accreditation and program standards must meet or exceed those of Medicare.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) 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. Annual targets for these surveys were established by agency policy based on available resources each year and had been every 72 months. In addition to mandating a 36-month frequency of hospice recertification surveys, the IMPACT Act provided funding to support CMS in meeting this requirement, through 2025. The shorter duration for hospice recertification surveys mandated by the IMPACT Act ensured hospice providers were more frequently assessed against the minimum requirements for quality of care, providing greater oversight of these providers by CMS.

The Consolidated Appropriations Act 2021, includes hospice survey and enforcement provisions requiring the survey frequency of 36 months, initially established in the IMPACT Act, a permanent mandate.

CMS believes that the goal is responsive to the requirement that all hospice agencies nationwide be surveyed every 36 months. CMS did not meet the FY 2020 – FY 2022 target of 98% due to the COVID-19 Public Health Emergency (PHE) and reprioritization of survey activities based on guidance published throughout the PHE. While Accrediting Organizations have eliminated backlog resultant from the PHE, SAs still face challenges. As SAs reduce the backlog, we anticipate meeting the target goal of hospice facilities surveyed within the required 36 months in the upcoming years.

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)	2025	98.0%	December 31, 2025
	2024	98.0%	December 31, 2024
	2023	98.0%	97.5% (Target Not Met But Improved)
	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's 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 long-term care facilities. This information is also very important to consumers when selecting or evaluating a long-term care facility.

As of July 1, 2016, long-term care 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. Reporting accurate staffing measures incentivizes facilities to improve their staffing which supports our strategic objective to improve safety and quality of care in the nation's nursing homes. Improving nursing home staffing also supports CMS's strategic pillar to expand access to quality health care. CMS continues to engage partners on this important topic by facilitating discussions with stakeholders. In 2023 CMS issued a proposed rule seeking to establish a comprehensive staffing requirement for nursing homes, including national minimum nurse staffing standards, to ensure access to safe, high-quality care for over 1.2 million nursing home residents.

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 long-term care 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.

CMS adjusts the targets (lower or higher) as needed to ensure realistic and appropriate goals. Results are 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.

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 FY 2022. 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. These factors impacted our ability to meet the FY 2022 goal, however, we believe these new staffing measures will draw new attention causing facilities to focus on their submissions and they will improve over time.

Also, 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.

FY 2024 results will be available by the end of December 2024. CMS adjusts the targets (lower or higher) as needed to ensure realistic and appropriate goals. In FY 2022, 96.7% of facilities submitted staffing data that met the new inclusion criteria for the PBJ public use file. This increased to 97.5% in FY2023. We anticipate submissions will continue to improve over time and are, therefore, keeping the FYs 2024 and 2025 goals at 98%. To help us achieve these goals and further incentivize facilities to submit accurate data, we plan to revise the staffing rating methodology so that any provider that fails to submit accurate staffing data receives the lowest score for corresponding staffing measures that are reported on Nursing Home Care Compare. Assigning the lowest score possible for these measures as a penalty will incentivize these nursing homes to submit accurate staffing data.

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	2025	Work with States to ensure that 100% of States report on at least twenty quality measures in the CHIPRA children's core set of quality measures.	June 1, 2026
	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	96% of States reported at least twelve quality measures (Target Exceeded)
	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	94% of States reported at least twelve quality measures (Target Exceeded)
	2020	Work with States to ensure that 90% of States report on at least twelve quality measures in the CHIPRA children's core set of quality measures	92% of States reported at least twelve quality measures (Target Exceeded)
	2019	Work with States to ensure that 90% of States report on at least eleven quality measures in the CHIPRA children's core set of quality measures	94% of States reported at least eleven quality measures (Target Exceeded)

Measure	FY	Target	Result
	2018	Work with States to ensure that 90% of States report on at least eleven quality measures in the CHIPRA children's core set of quality measures	86% of States reported 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.

This measure supports health quality work in Medicaid and the Children's Health Insurance Program (CHIP). It also supports the CMS Strategic Plan Pillars of Advancing Equity and Driving Innovation by providing data to identify disparities and achieve quality improvement.

Section 1139A of the Social Security Act established a national pediatric quality measures program for Medicaid and CHIP, and requires CMS to develop and periodically update a Core Set of health care quality measures (Child Core Set) for children enrolled in Medicaid or CHIP. The standardized reporting on the Child Core Set creates a foundation for a national system of quality measurement in Medicaid and CHIP that allows CMS to assess delivery of services and work with states to improve health outcomes for children enrolled in these programs. On January 1, 2024, reporting on all measures in the Child Core Set became mandatory for states, as required by the Bipartisan Budget Act of 2018 (P.L. 115-123).[5] Prior to this, state reporting on the Child Core Set was voluntary, and strongly encouraged by CMS

CMS's primary challenge to achieving targets for this measure is that state reporting on the Child Core Set was voluntary prior to 2024. Despite this, CMS has met or exceeded the target for Child Core Set reporting since 2019 due to consistent and significant technical assistance to states over the last decade. This guidance and technical assistance include the August 2023 final rule that outlined requirements for mandatory reporting on the Child Core Set and annual updates to the Child Core Set of measures. The 2021 Child Core Set contained 23 measures, the 2022 Child Core Set contained 25 measures, and the 2023 and 2024 Child Core Set contain 27 measures. CMS also provides technical assistance to help states understand how to use the data they collect to drive quality improvement at the state and programmatic levels.

Data for both 2021 and 2022 became available in August 2023 and results for the 2023 goal will be available in June 2024. Given the mandatory reporting requirement, CMS increased the FY 2025 target to 100 percent of states reporting on at least 20 quality measures. CMS will continue to provide technical assistance to states to assist with mandatory reporting requirements, which will support the ability to achieve the targets. This work is supported through CMS's multi-year Technical Assistance/Analytic Support contract, and is funded using no-year statutory funds directed to CMS for the Child Health Quality Measures Program.

[5] The definition of states for mandatory reporting beginning in 2024 includes the 50 states, D.C., Puerto Rico, U.S. Virgin Islands, and Guam.

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 2016 Baseline: 46%	2025	+3 percentage points over 2016 baseline	October 15, 2026
	2024	+2 percentage points over 2016 baseline**	October 15, 2025
	2023	+1 percentage points over 2016 baseline	October 15, 2024
	2022	+6 percentage points over 2016 baseline	47% (Target Not Met But Improved)
	2021	+5 percentage points over 2016 baseline	46% (Target Not Met But Improved)
	2020	+4 percentage points over 2016 baseline	43% (Target Not Met)
	2019	+3 percentage points over 2016 baseline	52% (Target Exceeded)
	2018	+2 percentage points over 2016 baseline	51% (Target Exceeded)
	2017	+1 percentage points over 2016 baseline	51% (Target Exceeded)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.
*CMS has adjusted the measure baseline from 2011 to 2016 to correct an HHS Data Analytics System issue. The target percentages are now reflected as increases against the 2016 baseline, but the FYs target amounts and target results are unchanged.
**CMS is holding the 2024 target at the same level of the 2023 target to help states recover progress lost to the COVID-19 public health emergency.

This measure supports the Medicaid program and the Children's Health Insurance Program (CHIP) and the CMS Oral Health Initiative (OHI). It also supports the CMS Strategic Plan Pillars of Advancing Equity (since there are persistent and significant disparities in oral health status) and Expanding Access, as well as directly supporting CMS's Cross-Cutting Initiative on Oral Health.

Oral health is essential to overall health, and appropriate preventive care can help children to avoid pain and adverse health outcomes. CMS launched the OHI in 2010 to help states improve performance related to children's access to dental care. This initiative engages with states through existing levers such as Section 1115 demonstrations, 1915(b) managed care waivers, state plan amendments, as well as providing significant technical support to states to promote oral health's importance within broader Medicaid and CHIP program objectives. For example, CMS was deeply engaged in California's dental-focused section 1115 demonstration from 2015-2021, and helped the state develop strategies that have been successfully implemented.

In 2021, CMS launched a two-year oral health technical assistance opportunity where 14 states received assistance in planning and implementation of quality improvement projects focused on increasing access to fluoride varnish in primary care settings and connecting children to ongoing dental care. CMS also hosts the 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.

The delivery of dental services was impacted more by the COVID-19 public health emergency (PHE) than most other types of services. Comparing March 2020–July 2022 to the pre-PHE period, the data shows about 19 percent fewer dental services were provided to children enrolled in Medicaid and Medicaid expansion CHIP. While state performance on this measure increased in both FY 2021 and FY 2022, with FY 2022 data showing an improvement of 4 percentage points over FY 2020, it has still not returned to the pre-PHE rates. CMS anticipates this recovery will continue in future years.

CMS continues to work with states to address foregone care during the PHE through technical assistance to states and monthly Oral Health Technical Advisory Group meetings. States' robust interest in the fluoride varnish technical assistance opportunity reflects a desire for continued efforts to improve access to oral health care.

In anticipation of a return to the pre-PHE trend of sustained, gradual improvement, the goals for FY23 – 25 are to achieve improvements of 1 - 3 percentage points above the 2016 baseline.

CMS will continue its strategy of engagement with states on oral health access issues in the context of state plan amendments, waivers, and demonstrations, as well as the development of targeted technical assistance opportunities. CMS's technical assistance contractor has convened an expert work group to provide input on strategic priorities and measurement strategy for the next five years of the Oral Health Initiative, with the workgroup report expected to be available in early 2024. This workgroup's input may result in changes to the measurement strategy for this GPRA goal.

The Oral Health Initiative's activities are supported through the Division of Quality and Health Outcomes' Technical Assistance/Administrative Support contract using no-year statutory Medicaid and CHIP children's quality measurement funds.

MCD8: Improve Adult Health Care Quality across Medicaid

Measure	FY	Target	Result
MCD8: Improve Adult Health Care Quality Across Medicaid	2025	Work with States to ensure that 90% of States report on at least fifteen quality measures in the Adult Medicaid core set of quality measures	June 1, 2026
	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 fourteen 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	90% (Target Exceeded)
	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	86% (Target Exceeded)
	2020	Work with States to ensure that 75% of States report on at least twelve quality measures in the Adult Medicaid core set of quality measures	86% (Target Exceeded)
	2019	Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures	84% (Target Exceeded)
	2018	Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures	76% (Target Exceeded)

Measure	FY	Target	Result
	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 on the behavioral health measures within the Adult Core Set 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.

This measure supports health quality work for adults enrolled in Medicaid. It also supports the CMS Strategic Plan Pillars of Advancing Equity and Driving Innovation by providing data to identify disparities and achieve quality improvement.

Section 1139B of the Social Security Act established a national adult quality measures program for Medicaid, and requires CMS to develop and annually update a Core Set of health care quality measures for adults enrolled in Medicaid (Adult Core Set). In 2024, state reporting on the behavioral health measures on the Adult Core Set becomes mandatory. While state reporting on the other measures in the Adult Core Set remains voluntary, CMS encourages all states to report on this entire set of measures to assess the delivery of services and to collect data that can be used in efforts to improve health outcomes for Medicaid beneficiaries.

CMS's primary challenge to achieving targets for this measure has been the voluntary nature of this program. Despite this, CMS has met or exceeded the target for Adult Core Set reporting since 2014 due to consistent and significant technical assistance to states over the last decade. CMS provides technical assistance to ensure consistent reporting across states and to help states understand how to use these data to drive quality improvement at the state and program levels. Guidance to states includes the August 2023 final rule that outlined state requirements for reporting on the behavioral health measures, and annual updates to the Adult Core Set of measures. The 2021 Adult Core Set contained 32 measures, the 2022 Adult Core Set contained 33 measures, the 2023 Adult Core Set contains 34 measures, and the 2024 Adult Core Set contains 33 measures. By encouraging states to report the core set measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid.

Data for both FYs 2021 and 2022 was available in August 2023, and result for the 2023 goal will be available in June 2024. While CMS expects an increase in reporting on the behavioral health measures on the Adult Core Set, CMS anticipates that states may prioritize mandatory reporting on the Child Core Set, and on certain voluntary core measures in the Adult Core Set to target improvement strategies rather than reporting on a large volume of measures. As such, the FY 2023 target decreases the target number from 15 to 14 quality measures, while increasing reporting to 90% of states. CMS will continue to provide technical assistance to states to assist with reporting requirements for both mandatory and voluntary reporting.

This work is supported through CMS's multi-year Technical Assistance/Analytic Support contract. The remaining mandatory funds for this program will be fully-expended in FY

2024 and CMS will need alternative funding to support these ongoing, statutorily-required activities, including reporting on this quality measure.

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.

MCD9: Improve Capacity to Collect Quality and Other Performance Data for Monitoring 1115 Demonstration Programs

Measure	FY	Target	Result
MCD9.3 Reduce Emergency Department (ED) Use Under Substance Use Disorder (SUD) 1115 Demonstration	2025	Sixty 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, 2025
	2024	Fifty 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)	87% (Baseline)

Section 1115 of the Social Security Act provides broad authority to the HHS Secretary to grant demonstrations to states for testing innovative reforms in Medicaid and CHIP. CMS has assessed this measure for its relevance to the current CMS Cross-Cutting Initiative 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), and 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 the Medicaid State Technical Advisory Groups. 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 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 submitted to CMS.

CMS is also 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 is providing states with technical assistance on these templates and metrics. As of September 2023, there are 35 approved SUD demonstrations. These 34 states and the District of Columbia (together referred to as 35 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, 2023, 28 of the 35 states submitted monitoring reports using the SUD templates to CMS.[6]

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, 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

[6] 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 September 30, 2023, 28 of these 35 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.

utilization over the course of the demonstration. The analysis will examine year over year progression compared to the baseline period.

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	2025	88.0%	July 1, 2027
	2024	87.8%	July 1, 2026
	2023	87.6%	July 1, 2025
	2022	87.4%	July 1, 2024
	2021	87.2% Historical Actual	April 30, 2023
	2020	84.5% Historical Actual	October 1, 2022
	2019	84.3% Baseline	April 30, 2022

Medicaid is the primary payer of Long-term Services and Supports (LTSS) in the United States, accounting for about 52 percent of national LTSS spending in 2019.[7] LTSS encompasses a wide range of medical and nonmedical services and supports for people with physical, cognitive, mental, or other disabilities or conditions. Medicaid covers various institutional and home and community-based LTSS, but the type of services, populations covered, and delivery models differ substantially across states.

Increasing the proportion of LTSS beneficiaries receiving home and community-based services supports the CMS Strategic Plan Pillar – "Expand Access: Build on the Affordable Care Act and expand access to quality, affordable health coverage and care". Further, this goal serves to help measure the impact of states' structural investments on strengthening home- and community-based services (HCBS) across all states, a Center for Medicaid and Children's Health Insurance Program Services (CMCS) Strategic Blueprint objective.

On January 21, 2021, President Biden issued an Executive Order on Ensuring an Equitable Pandemic Response and Recovery. 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 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.

This 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

[7] Kim, Min-Young, Edward Weizenegger, and Andrea Wysocki. "Medicaid Beneficiaries Who Use Long-Term Services and Supports: 2019." Chicago, IL: Mathematica, July 16, 2021.

disproportionate impact on older adults and people with disabilities, particularly those living in medical institutions such as nursing homes.[8] 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 final performance goal was informed by feedback from state associations, states, researchers, and other stakeholders. As of April 2023, we are reporting the results of 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.[9]

Based on three years of data, FY 2019 through FY 2021, we established annual target figures for achieving the measure for FY 2022 through FY 2025. The baseline is FY 2019, which occurred prior to the COVID-19 public health emergency and, CMS assumes, is likely to better reflect typical utilization of HCBS than the following year when the pandemic impacted reporting systems and the actual provision of all services. Subsequent reporting periods will look back two years to allow for T-MSIS TAF production schedules, reporting lags and adjustments related to data quality.

HCBS users as a percentage of total Medicaid LTSS users grew from 84.3 percent in 2019 to 84.5 percent in 2020 to 87.2 percent in 2021. This reflects a 2.9 percent increase nationwide from 2019 to 2021. However, the yearly percent increase from 2019 to 2020 was more modest at 0.2 percent. The larger percent increase from 2020 to 2021 may reflect changes in the delivery of care due to the COVID 19 pandemic. The proposed targets for FY2022 through FY2025 reflect the more modest annual percent increase from 2019 to 2020 of 0.2 percent.

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.[10]

Previous GPRA goals concerning the proportion of expenditures spent on HCBS, (MCD10.1 and 10.2; reporting 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 goal, CMS seeks to explore the capabilities of the Transformed Medicaid Statistical Information System Analytic File (TAF), to identify Medicaid users of 15 Medicaid LTSS

[8] https://www.kff.org/medicaid/issue-brief/potential-impact-of-additional-federal-funds-for-medicaid-hcbs-for-seniors-and-people-with-disabilities/
[9] https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf
[10] 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/

service categories. The identification of the Medicaid LTSS service categories and the Medicaid users was critical for developing the baseline assumptions. Annual targets for FY 2022 through FY 2025 were informed by trends based on this data. The next result will be reported by July 1, 2024.

As noted above, TAF, is the most comprehensive national dataset on beneficiary enrollment and service use for Medicaid and the Children's Health Insurance Program. Initial results supported continuing use of the TAF for FY 2020 and FY 2021 data and to establish targets for FY 2022 through FY 2025.

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, 2025, on activities aligned with the goals of section 9817 of the ARP, including to expand and sustain individuals' access to HCBS beyond 2025.[11] This 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.

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 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.

[11] https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf

MCD12: Improving Maternal Health: Postpartum-Related Quality Measure Reporting

Measure	FY	Target	Result
MCD12: Improving Maternal Health: Postpartum-Related Quality Measure Reporting	2025	Work with States to ensure that at least 47 States report on the Prenatal and Postpartum Care: Under age 21 and Age 21 and Older (PPC2-CH and PPC2-AD) measure and at least 42 states report on the Contraceptive Care: Postpartum Women Ages 21 to 44 (CCP-AD) measure in the Adult Medicaid Core Set of quality measures	June 1, 2026
	2024	Work with States to ensure that at least 46 states report on the Prenatal and Postpartum Care Age 21 and Older (PPC2-AD) measure and at least 41 states report on the Contraceptive Care: Postpartum Women Ages 21 to 44 (CCP-AD) measure in the Adult Medicaid Core Set of quality measures	June 1, 2025
	2023	Work with States to ensure that at least 45 states report on the Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD) measure and at least 40 states report on the Contraceptive Care: Postpartum Women Ages 21 to 44 (CCP-AD) measure in the Adult Medicaid Core Set of quality measures	June 1, 2024

This measure is new this year, and supports the Maternal and Infant Health Initiative (MIHI) and the adult quality measures program for Medicaid. To improve access to and quality of care for pregnant and postpartum people and their infants, CMS launched the MIHI in July 2014. MIHI also supports the CMS Strategic Plan Pillars of Advancing Equity (since there are persistent and significant disparities in maternal and infant health outcomes) and Expanding Access, as well as directly supporting CMS's Cross-Cutting Initiative on Maternal Health. Thirty-eight states, DC, and the US Virgin Islands have opted to extend postpartum coverage for individuals enrolled in Medicaid and CHIP through CMS-approved state plan amendments. This option was made possible by the American Rescue Plan.

In 2020, CMS launched the new phase of the MIHI which prioritized three areas of focus where Medicaid and CHIP have a significant opportunity to influence change through technical assistance: 1) increase the use and quality of postpartum care visits; 2) increase the use and quality of well-child visits; and 3) decrease the rates of cesarean section births in low-risk pregnancies, defined as nulliparous (first-time pregnancies), term (37 or more weeks gestation), singleton (one fetus), vertex (head facing down in the birth canal).

The postpartum-related quality measures are part of a subset of maternal health measures on the Medicaid Adult Core Set. 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 can be used in efforts to improve health outcomes. CMS also provides significant technical assistance and guidance to support state reporting on the Adult Core Set, and helps states understand how to use this data to drive quality improvement at the state and programmatic levels. (see MCD8 for additional information on the Adult Core Set)

Results for the new 2023 goal are expected in June 2024, and CMS anticipates meeting the target. CMS developed these targets using 2022 as a baseline for the number of states reporting, increasing the target number of reporting states by one per year for each measure. CMS will provide technical assistance to states to achieve these targets as part of its work on the Adult Core Set. As time progresses, CMS anticipates a few remaining states will be unable to report on these measures due to specific barriers. Therefore, CMS plans to devote more technical assistance work to help those few states troubleshoot reporting barriers, and reach our ultimate goal of all states reporting.

With the new mandatory reporting requirements on the behavioral health measures in the Adult Core Set, states using hybrid reporting methodology will need to do separate sampling to report Core Sets due to newly-required age stratification on the mandatory reporting measures. We do not yet know what this means for the postpartum and contraception care measures. CMS will continue to provide technical assistance to states on reporting requirements for both mandatory and voluntary quality measures.

This work is supported through CMS's multi-year Technical Assistance/Analytic Support contract. The remaining mandatory funds for the Adult Quality Measures Program, which include the Adult Core Set and this subset of maternal health measures, will be fully-expended in FY 2024. CMS will need alternative funding to support these ongoing, statutorily-require activities, including reporting on this maternal health measure.

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.

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	2025	TBD	November 15, 2025
	2024	7.28%	November 15, 2024
	2023	7.36%	7.38%* (Target Met)
	2022	6.16%	7.46%* (Target 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)

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 HHS Agency Financial Report (AFR) on an annual basis. The CERT program selects a statistically valid stratified random sample of Medicare FFS claims from a population of claims submitted for payment. CMS performs a complex medical review on the sample of Medicare FFS claims to determine if the claims were properly paid under Medicare coverage, coding, and billing rules.

The CMS improper payment measurement programs support our programs' sustainability for future generations by serving as a responsible steward of public funds. Specifically, the improper payment measurement programs support the: 1) HHS Strategic Plan Objective Goal 5: Promote effective and efficient management and stewardship, and 2) CMS Strategic Plan Pillar: Protect our programs' sustainability for future generations by serving as a responsible steward of public funds.

The Medicare FFS improper payment estimate for Fiscal Year (FY) 2023 is 7.38 percent, or $31.23 billion. Because the FY 2023 target of 7.36 percent is within the 95% confidence internal for the FY 2023 Medicare FFS improper payment estimate, the target was met. Information on the Medicare FFS improper payment methodology can be found in the FY 2023 HHS AFR.

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:

1) Skilled Nursing Facilities (SNF): The improper payment estimate for SNF claims decreased from 15.10 percent in Reporting Year(RY) 2022 to 13.76 percent in RY 2023; however, this change is not statistically significant. Insufficient documentation continues to be the major error reason for SNF claims. The primary reasons for these errors are missing or insufficient documentation to support the SNF coverage criteria requirements (e.g., level of care requirements, certification/recertification) and missing or insufficient documentation to support the required component(s) for the billed code.

2) Hospital Outpatient: The improper payment estimate for hospital outpatient claims decreased from 5.43 percent in RY 2022 to 5.20 percent in RY 2023; however, this change is not statistically significant. Insufficient documentation continues to be the major error reason for hospital outpatient claims. The primary reason for these errors is missing documentation to support the order, or the intent to order for certain services.

3) Inpatient Rehabilitation Facilities (IRF): The improper payment estimate for IRF claims increased from 19.22 percent in FY 2022 to 27.33 percent in FY 2023. The leading cause of errors in claims for IRF is the lack of medical necessity. These errors primarily occur because the documentation does not substantiate the beneficiary's requirement for an intensive rehabilitation program, close supervision by a rehabilitation physician, or sufficient stability to actively engage in an intensive rehabilitation therapy program.

4) Hospice: The improper payment estimate for hospice claims decreased from 12.04 percent in RY 2022 to 5.36 percent in RY 2023. Insufficient documentation is the major error reason for hospice claims. The primary reason for these errors is missing or insufficient documentation to support the certification or recertification.

CMS has developed corrective actions for specific service areas with high improper payment estimates, including SNF, hospital outpatient, hospice, and IRF. CMS believes these targeted corrective actions will prevent and reduce improper payments in these areas. Many of CMS's corrective actions center around prior authorization, medical review, and targeted probe and education efforts. CMS also uses automation, billing reviews, and the fraud prevention system to address improper payments. Detailed information on these corrective actions can be found in Section 7.1 of the FY 2023 HHS AFR.

The FY 2024 Medicare FFS improper payment rate will be reported in the FY 2024 HHS AFR published on November 15, 2024, with a target of 7.28 percent. In accordance with Office of Management and Budget guidance, CMS establishes improper payment rate targets only for the next fiscal year, and therefore the FY 2025 target will be established in the FY 2024 HHS AFR. To meet the FY 2024 and future targets, CMS reviews strategies and actions annually to ensure corrective actions address the root causes of the improper payments and increase the likelihood that programs meet targets, reduce improper payment estimates, or perform other activities to strengthen program integrity. If targets are not met, CMS develops new strategies, adjusts staffing and other resources, or revises

targets. Because actions vary and are implemented on a concurrent or continuous basis, it can be difficult to establish key milestones and target completion dates for individual activities. Despite these challenges, CMS evaluates the impact of mitigation strategies and corrective actions to refine program integrity activities.

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%	2025	TBD	November 15, 2025
	2024	6.38%	November 15, 2024
	2023	5.77%	6.01%*** (Target Met)
	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)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets and HHS AFRs.
*Due to a temporary medical record submission policy change enacted during the COVID-19 Public Health Emergency, significant changes were made to the sampling and estimation plan for FY 2020 Medicare Part C improper payment reporting. This impacted HHS's ability to set an aggressive, yet realistic, out-year target.
**Targets are re-established as of FY 2022. FY 2019-2021 results do not reflect all states under the new eligibility methodology
***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 Part C improper payment measurement (IPM) methodology estimates improper payments resulting from errors in beneficiary risk scores. Clinical diagnoses submitted by the Medicare Advantage Organizations (MAOs) are the primary component of most beneficiary risk scores (the CMS Hierarchical Condition Category [CMS-HCC]). To calculate the projected improper payment 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 CMS, the risk scores may be inaccurate and result in payment errors. For FY 2023 reporting, CMS selected a stratified random sample of beneficiaries with a risk adjusted payment in Payment Year 2021 and reviewed medical records of the diagnoses submitted by plans for the sample beneficiaries. CMS provides interim finding reports to MAOs during the documentation submission window, detailing preliminary results as well as suggested remedies for the potential discrepancies. CMS also conducts training and provides other educational materials to ensure MAOs understand the IPM medical review requirements. At the conclusion of the IPM sample cycle, CMS provides a Final Finding Report to each participating MAO, allowing them to validate discrepancies and make data corrections as appropriate.

The CMS improper payment measurement programs support our programs' sustainability for future generations by serving as a responsible steward of public funds. Specifically, improper payment measurement programs support the: 1) HHS Strategic Plan Objective

Goal 5: Promote effective and efficient management and stewardship, and 2) CMS Strategic Plan Pillar: Protect our programs' sustainability for future generations by serving as a responsible steward of public funds.

The Medicare Part C improper payment estimate for FY 2023 is 6.01 percent, or $16.55 billion. Because the FY 2023 target of 5.77 percent is within the 95% confidence internal for the FY 2023 Medicare FFS improper payment estimate, the target was met. Information on the Medicare Part C improper payment methodology can be found in the FY 2023 Department of Health and Human Services (HHS) Agency Financial Report (AFR).[12]

While the factors contributing to improper payments are complex and vary from year to year, the primary error type of Medicare Part C improper payments consists of medical record discrepancies (5.3 percent in overpayments and 0.69 percent in underpayments). An overpayment is identified when the medical record documentation submitted by the MAO does not substantiate the CMS-HCC for which it received payment. The underpayment component is comprised of CMS-HCCs identified during review of the medical records that were not submitted by the MAO for inclusion in the risk score calculation and therefore were not paid to the MAO as part of the risk adjustment payment. The improper payment estimate due to missing or insufficient documentation is 0.01 percent or $0.04 billion, representing 0.24 percent of total improper payments.

CMS has developed corrective actions the agency will implement to prevent and reduce improper payments in Medicare Part C. Most notably, CMS recently published a regulation that finalized the policies for the MA Risk Adjustment Data Validation (RADV) program, which is CMS's primary audit and oversight tool of the Medicare Advantage (MA) program. This rule will allow CMS to hold MAOs accountable for improper risk adjustment payments by extrapolating RADV audit findings beginning with the Payment Year 2018 audit. In addition to RADV audits, CMS also conducts training sessions and regularly audits MAOs to ensure meaningful steps are being taken by MAOs to reduce program integrity risks in MA. Detailed information on corrective actions can be found in Section 7.2 of the FY 2023 HHS AFR.

The FY 2024 Medicare Part C improper payment rate will be reported in the FY 2024 HHS AFR published on November 15, 2024, with a target of 6.38 percent. In accordance with Office of Management and Budget guidance, CMS establishes improper payment rate targets only for the next fiscal year, and therefore, the FY 2025 target will be established in the FY 2024 HHS AFR.

To meet the FY 2024 and future targets, CMS reviews strategies and actions annually to ensure corrective actions address the root causes of the improper payments and increase the likelihood that programs meet targets, reduce improper payment estimates, or perform other activities to strengthen program integrity. If targets are not met, CMS develops new strategies, adjusts staffing and other resources, or revises targets. Because actions vary and are implemented on a concurrent or continuous basis, it can be difficult to establish key milestones and target completion dates for individual activities. Despite these challenges,

[12] In FY 2023, CMS implemented a revised sample allocation methodology which yields a more precise overall error estimate. In FYs 2021 and FY 2022, CMS implemented methodology and policy changes, and FY 2023 establishes a baseline. The FY 2023 error rate calculation follows those previously implemented policy changes. While FY 2023 and FY 2022 are comparable, they are not directly comparable to earlier reporting years.

CMS evaluates the impact of mitigation strategies and corrective actions to refine program integrity activities.

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%	2025	TBD	November 15, 2025
	2024	TBD	November 15, 2024
	2023	1.64% (Target in FY 2022 AFR)	3.72% (Target Not Met)
	2022	1.20%** (Target in FY 2021 AFR)	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)

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.
** Targets are re-established as of FY 2022. FY 2019-2021 results do not reflect all states under the new eligibility methodology

The Part D IPM methodology estimates 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, including 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. CMS provides interim finding reports to Part D plan sponsors during the documentation submission window, detailing preliminary results. CMS also conducts training and provides other educational materials to ensure Part D plan sponsors understand the IPM clinical review requirements. At the conclusion of the IPM sample cycle, CMS provides a Final Finding Report to each participating Part D plan sponsor, allowing it to validate discrepancies and make data corrections as appropriate.

The CMS improper payment measurement programs support our programs' sustainability for future generations by serving as a responsible steward of public funds. Specifically, improper payment measurement programs support the: 1) HHS Strategic Plan Objective Goal 5: Promote effective and efficient management and stewardship, and 2) CMS Strategic Plan Pillar: Protect our programs' sustainability for future generations by serving as a responsible steward of public funds.

The Medicare Part D improper payment result for FY 2022 is 3.72 percent, or $3.35 billion. This does not meet the FY 2023 target of 1.64 percent. Information on the Medicare Part D improper payment methodology can be found in the 2023 Department of Health and Human Services (HHS) Agency Financial Report (AFR). The increase from the prior year's estimate of 1.54 percent is attributed to the multiple methodological changes implemented for the FY 2023 improper payment estimate.[13]

While the factors contributing to improper payments are complex and vary from year to year, the primary error type of Medicare Part D improper payments consist of two primary error types:

1) Drug or Drug Pricing Discrepancies: Improper payments due to drug or drug pricing discrepancies occur when the submitted prescription documentation indicates that an overpayment occurred. Underpayments result when prescription record hard copies (or medication orders) indicate that HHS should have paid a greater amount. The improper payment estimate due to drug or drug pricing discrepancies is 0.20 percent in overpayments and 1.13 percent in underpayments, or $1.2 billion, representing 1.33 percent of total improper payments.

2) Insufficient Documentation: The improper payment estimate due to missing or insufficient documentation to determine whether payments are proper or improper is 2.39 percent or $2.16 billion, representing 64.27 percent of total improper payments.

CMS has developed corrective actions the agency will implement to prevent and reduce improper payments in Medicare Part D. CMS regularly conducts trainings for Part D Plan Sponsors and continued formal outreach to plan sponsors for invalid or incomplete documentation. In addition to training, CMS conducts audits of Part D Plan Sponsors, focusing on drugs that are at high risk of improper payments. Detailed information on corrective actions can be found in Section 7.3 of the FY 2023 HHS AFR.

The FY 2024 Medicare Part D improper payment rate will be reported in the FY 2024 HHS AFR published on November 15, 2024. There is no target for FY 2024 because numerous methodology changes were implemented in the FY 2023 reporting period and a baseline has not yet been established. In accordance with Office of Management and Budget guidance, CMS establishes improper payment rate targets only for the next fiscal year; therefore, the FY 2025 target will be established in the FY 2024 HHS AFR.

To meet the FY 2025 and future targets, CMS reviews strategies and actions annually to ensure corrective actions address the root causes of the improper payments and increase the likelihood that programs meet targets, reduce improper payment estimates, or perform other activities to strengthen program integrity. If targets are not met, CMS develops new strategies, adjusts staffing and other resources, or revises targets. Because actions vary and are implemented on a concurrent or continuous basis, it can be difficult to establish key milestones and target completion dates for individual activities. Despite these challenges, CMS evaluates the impact of mitigation strategies and corrective actions to refine program integrity activities.

[13] CMS methodology changes included: adjusting the methodology to recognize payment errors resulting from the use of incorrect benefit parameters, using a more appropriate sampling unit, and applying more accurate parameter assumptions when benefit parameters are missing or incomplete. Due to the methodology changes introduced in FY 2023, the rates for FY 2022 and FY 2023 are not comparable.

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	2025	TBD	November 15, 2025
	2024	7.34%	November 15, 2024
	2023	12.68%	8.58% (Target Exceeded)
	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 Met)
MIP9.2: Reduce the Improper Payment Rate in the Children's Health Insurance Program (CHIP)	2025	TBD	November 15, 2025
	2024	10.28%	November 15, 2024
	2023	21.04%	12.81% (Target Exceeded)
	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 Met)

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

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 CMS improper payment measurement programs support our programs' sustainability for future generations by serving as a responsible steward of public funds. Specifically, improper payment measurement programs support the: 1) HHS Strategic Plan Objective Goal 5: Promote effective and efficient management and stewardship, and 2) CMS Strategic Plan Pillar: Protect our programs' sustainability for future generations by serving as a responsible steward of public funds.

The national Medicaid improper payment result for FY 2023 is 8.58 percent, or $50.33 billion, with national Medicaid component rates of 6.90 percent for Medicaid FFS, 0.00 percent for Medicaid managed care (see PERM for 2023), and 5.95 percent for the Medicaid eligibility component. The national CHIP improper payment result for FY 2023 is 12.81 percent, or $2.14 billion, with national CHIP component rates of 7.09 percent for CHIP FFS, 0.59 percent for CHIP managed care, and 10.86 percent for the CHIP eligibility component. These improper payment rates exceeded the FY 2023 targets of 12.68 percent and 21.04 percent, respectively. Information on the Medicaid and CHIP improper payment methodology can be found in 2023 Department of Health and Human Resources (HHS) Agency Financial Report (AFR).

While the factors contributing to improper payments are complex and vary from year to year, Medicaid improper payments consist of three primary error types:

- Insufficient Documentation: Insufficient documentation occurs when 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. The improper payment estimate due to insufficient documentation was 7.02 percent, or $41.19 billion, representing 81.84 percent of total improper payments.

- Improper Determinations: Improper payments due to improper determinations occurs when 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 21 percent or $0.41 billion of total errors cited in CHIP FFS, CHIP managed care and CHIP eligibility.

- State Non-Compliance: Improper payments due to state noncompliance with federal eligibility redetermination requirements occurs when enrolled providers not appropriately screened by the state, providers are not enrolled, and/or providers do not include 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 10.42 percent in RY 2022 to 6.9 percent in RY 2023. COVID-19 review flexibilities afforded to states should also be considered in the identified decrease in the Medicaid FFS and eligibility components between RY 2022 and RY 2023.

CMS has developed corrective actions the agency will implement to prevent and reduce improper payments in Medicaid and CHIP. CMS collaborates with states to establish an effective state-specific corrective action plan process, offering enhanced technical assistance and guidance. In addition, CMS conducts eligibility determination audits in high-risk states, provides training and support to state Medicaid program integrity officials through the Medicaid Integrity Institute, and provides resources and guidance to support states' provider enrollment processes. Detailed information on these corrective actions can be found in Sections 7.4 and 7.5 of the FY 2023 HHS AFR.

The FY 2024 Medicaid and CHIP improper payment rate will be reported in the FY 2024 HHS AFR published on November 15, 2024, with a target of 7.34 percent for Medicaid and 10.28 percent for CHIP. In accordance with Office of Management and Budget guidance, CMS establishes improper payment targets only for the next fiscal year, and therefore, the FY 2025 target will be established in the FY 2024 HHS AFR.

To meet the FY 2025 and future targets, CMS reviews strategies and actions annually to ensure corrective actions address the root causes of the improper payments and increase the likelihood that programs meet targets, reduce improper payment estimates, or perform other activities to strengthen program integrity. If targets are not met, CMS develops new strategies, adjusts staffing and other resources, or revises targets. Because actions vary and are implemented on a concurrent or continuous basis, it can be difficult to establish key milestones and target completion dates for individual activities. Despite these challenges, CMS evaluates the impact of mitigation strategies and corrective actions to refine program integrity activities.

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%	2025	64%	April 30, 2026
	2024	60%	April 30, 2025
	2023	56%	April 30, 2024
	2022	52%	74.65% (Target Exceeded)
	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)

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

The Provider, Enrollment, Chain and Ownership System (PECOS) is the online 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 supports the HHS strategic objective to reform, strengthen and modernize the nation's healthcare system by providing an online system to submit and maintain Medicare enrollments. This measure tracks the increase in number of providers submitting initial enrollments using online PECOS as a proportion of all applications.

The purpose of the measure is to drive innovation and increase online submission of enrollment applications and reduce the number of paper applications, thereby increasing operational efficiency. 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 most recent CY 2022 result was 74.65 percent, which exceeds the target of 52 percent. Continued system enhancements streamlined interfaces as well as continued provider outreach and engagement have contributed to the success and the ability to meet and exceed this measure. The only existing challenge is the reduced Operations and Maintenance budget due to the planned release of PECOS 2.0 in the upcoming year. The current version of PECOS will be retired and the new PECOS 2.0 will take over the

enrollment process.

Expected date for the next result is April 2024. Future targets are set for CY 2023 (56 percent), CY 2024 (60 percent) and CY 2025 (64 percent) with subsequent measurements available by April of the year following the calendar year measured.

The transition to the new PECOS 2.0 system in March 2024 should help to improve adaptation of the online enrollment process and continue to help reach and exceed the future targets. Based on the successful release of PECOS 2.0, future targets will be adjusted in future iterations of this document.

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 * Baseline: $32.1 million	2025	$68.0 million	April 30, 2026
	2024	$65.0 million	April 30, 2025
	2023	$62.0 million	April 30, 2024
	2022	$45.0 million	$103 million (Target Exceeded)
	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)

*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."

FPS edits support the CMS Strategic Plan Pillar to protect our programs sustainability for future generations by serving as a responsible steward of public funds. The use of FPS edits result in measurable savings to the Medicare Trust Fund through the screening of Medicare FFS claims prior to payment. FPS edits 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 FPS edits program significantly exceeded its target for FY 2022. Savings totaled $103 million, well over the target of $45 million. FPS edits are on track to do the same in FY 2023. As of the half-year savings evaluation, FPS edits have already resulted in $60 million in savings – already almost meeting the target for the entire year. The next result will be reported on April 30, 2024.

The performance of existing edits was enhanced by adding new codes based on updates to local or national coverage determinations and new edits were added to address emerging and highly impactful vulnerabilities related to potential improper billing and fraudulent activity.

Going forward, the target for the FPS edits program is to increase edits savings by approximately 5% each fiscal year. This target was chosen because edits savings have surpassed set dollar amount targets for the last several years. The FPS edits team will continue to research new vulnerability areas to determine if any clear CMS policy exists to support new edits. The team will also evaluate the performance of existing edits and identify any potential enhancements, such as new codes added by updates to local or national coverage determinations. The target and strategies for the FPS edits program are supported by a small but consistent increase in the budget for Medicare FFS program integrity activities.

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	2025	TBD	December 31, 2025
	2024	85% QIO Satisfaction	December 31, 2024
	2023	85% QIO Satisfaction	77.9% (Target Not Met)
	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)

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 Positive beneficiary experience with the QIO Quality of Care (QOC) complaint review process overall has been decreasing. One potential reason for this decrease is 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.

The FY 2023 target was not met. The estimate was 77.9 percent which fell short of the 85 percent target. BFCC-QIOs performed less than the target on the portions of the measures that assessed beneficiary experience received during case processing to ensure that the BFCC-QIOs were beneficiary and family-centered. Interventions that will be implemented to improve the failed measure portion, will include but not limited to closely monitoring the measure activities within the Beneficiary Experience survey to support quality adjustments as needed in the BFCC QIO case review process. This includes review of survey methods, technical issues, and the BFCC-QIO and beneficiary engagement.

The target for FY 2024 is 85%, and FY 2025 is TBD to revisit the survey methodology, historical data and align with CMS strategic priorities for the next scope of work.

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. Currently, 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.

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	2025	25% reduction from baseline	January 31, 2026
	2024	20% reduction from baseline	January 31, 2025
	2023	15% reduction from baseline	1.1% reduction from baseline (29.6%) (Target Not Met)
	2022	10% reduction from baseline	17.21% reduction from baseline (13.49%) (Target Exceeded)
	2021	5% reduction from baseline	9.73% reduction from baseline (20.97%) (Target Exceeded)
	2020	Developmental (Baseline)	30.7%

This goal supports CMS strategic pillars, White House initiatives, and specifically, *HHS's Strategic Plan FY 2022-2026*, Strategic Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes, Strategic Objective 2.2: Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines.

The most current data reveals more than 1.4 million residents live in 15,000+ Medicare and Medicaid certified Nursing Homes (NHs) in the United States. These certified NHs must meet federal standards (Federal participation requirements), including the establishment and maintenance of an infection control program. When a NH does not comply with infection control requirements, all residents are impacted. CMS forecasts that a focus on facility-based infection control will reduce risk for all residents, but especially residents with co-morbidities that increase their vulnerability to infection control deficiencies.

When a facility is out of compliance with infection prevention and control standards, they receive deficiency citations during surveys. CMS identifies cited NHs that have received assistance from Quality Innovation Network-Quality Improvement Organization (QIN-QIO) and analyzes if there was a further infection control deficiency after the QIN-QIO assistance.

CMS uses survey and infection control data to target NHs with infection control deficiencies and deploys the QIN-QIOs to provide timely education and technical

assistance (TA) through TR-QIIs. TA includes a complete assessment and root cause analysis, development of an implementation plan, implementation of best practice interventions, and monitoring of outcome metrics. The QIN-QIOs intervene with facilities to influence performance and improve compliance using tools created by CDC, QIN-QIOs, and other experts.

The target for FY 2023 was met, and we achieved a result above the goal. The goal was a 15% reduction of infection control survey deficiencies over the baseline established in FY 2020 (30.7%). The actual reduction was 29.6% over the 2020 baseline.

CMS data shows that infection prevention and control deficiencies were the most common type of deficiency cited in surveyed NHs through 2021, with most homes having an infection prevention and control deficiency cited in one or more years from 2013 through 2017 (13,299 NHs, or 82 percent of all surveyed homes), 82.5 percent or 14,742 from 2019 through 2021, and 71.4 percent or 13,250 from 2020 through 2021. In 2022, 14,862 NHs surveyed, only 3,863 (26.0%) received one or more citations related to infection control, demonstrating the impact of these infection control technical assistance referrals. Since FY 2020 there has been a steady reduction in the number of NHs cited for infection control deficiencies.

Throughout the pandemic, NHs have been the site of many U.S. 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. The targeted assistance for infection control included an assessment of infection prevention programs, recommendations to improve infection control practices, and direct education for NH administrators and staff. In 2023, the continuing effects of these efforts were realized in that of 14,924 NHs surveyed, only 2,960 (19.84%) received one or more citations related to infection control.

The CMS NH Command Center (NHCC) was an important factor in the reduction in infection control survey deficiencies. The NHCC monitored the CDC's National Healthcare Safety Network (NHSN) daily to identify NHs most in need of infection control assistance. Referrals for focused assistance were sent to QIN-QIOs, which then assessed nursing homes' infection control programs. Action plans were created to cover the program gaps, including staff coaching, training on use of personal protection equipment (PPE) and other infection control techniques, and working directly with NH infection preventions.

The targets for FYs 2024 and 2025 are reductions from the original baseline of 20% and 25%, respectively. The baseline for this measure was set by analyzing the universe of NHs that received a survey and identifying the NHs that received multiple infection control deficiencies using the Quality, Certification, and Oversight Reports. NHs that received additional infection control survey deficiencies after receiving a TR-QII constituted the numerator at baseline. CMS's 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 (SOW).

QIO13: Reduce Healthcare Associated Infections [HAIs] in Critical Access Hospitals (CAH)

Measure	FY	Target	Result
QIO13.1: Reduce CAUTI SIR in critical access hospitals	2025	5.6% reduction from baseline	June 30, 2026
	2024	4.5% reduction from baseline	June 30, 2025
	2023	3.3% reduction from baseline	June 30, 2024
	2022	Baseline*	67.8%
	2021	1.1% reduction from baseline	.50% reduction from baseline (58.5%) (Target Not Met But Improved)
	2020	Historical Actual	64.1%
	2019	Baseline	59%
QIO13.2: Reduce CDI SIR in critical access hospitals	2025	5.6% reduction from baseline	June 30, 2026
	2024	4.5% reduction from baseline	June 30, 2025
	2023	3.3% reduction from baseline	June 30, 2024
	2022	Baseline*	83.3%
	2021	1.1% reduction from baseline	4.4% reduction from baseline (76.6%) (Target Exceeded)
	2020	Historical Actual	70.9%
	2019	Baseline	81%

*The most recent 2022 data point will now be the baseline standardized infection ratio (SIR) for these two infections post the COVID-19 pandemic

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 the individuals they serve are at risk for increased comorbidities and mortality. These measures support the CMS's Quality Improvement, Patient Safety and Quality Reporting programs. They also serve to report HAI data to CMS's federal partner(s) such as the CDC.

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. The most recent 2022 data point will now be the baseline standardized infection ratio (SIR) for these two infections post the COVID-19 pandemic. It will be particularly important to follow the trajectory of data through 2025 to understand whether there is a decrease in these infections in a post-pandemic world. Following and reporting this data will help in understanding the variables responsible for improvements or lack thereof.
A urinary tract infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney. The Centers for Disease Control and Prevention (CDC) states, overall, among all acute care hospitals, between 15-25 percent of hospitalized patients receive urinary catheters during their hospital stay. The more days that a catheter is left in, the greater the risk of acquiring a CAUTI. Among UTIs acquired in the hospital, approximately 75 percent are associated with a urinary catheter.

Clostridium 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 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 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.

This GPRA goal supports several of the CMS Strategic Plan Pillars including: 1) Advance Equity: Examination and technical assistance in areas where HAIs standardized infection ratios are consistently higher due to socioeconomic determinants of health (SDOH). CMS led the development of the CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities, in recognition of the fact that CMS programs have a unique impact and role in meeting the care needs of individuals in rural, tribal, and geographically isolated communities, 2) Engage Partners: CMS collaborates with CDC through use of its data source, National Healthcare Safety Network (NHSN), and 3) Foster

Excellence through monitoring healthcare-associated infections in inpatient settings. Use evidence-based interventional strategies to ensure improvements in the SIR over time.

The FY 2022 Q4 CAUTI SIR data result of 0.678 was an increase of 14.91% from the 2019 baseline. Therefore, the target of a 2.2% reduction was not met. There was an observed increase in CAH CAUTI rates during 2020-2022 compared to 2019. These increases occurred during the intervals most impacted by COVID-19 and an uptick in other respiratory illnesses requiring increases in hospital stays. Likely contributors to this increase are:

- Although the pandemic was declared "over" by the World Health Organization (WHO) in May 2023, COVID-19 and other respiratory illnesses continued to require care episodes with known risk factors for both urinary catheter placement and CAUTI, including long hospital stays, long ICU stays, prolonged immobilization and ventilation.

- 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).

- Prone positioning changes, routine catheter care and requires staff training during a surge of critically ill patients, staff may not have been able to complete or practice or attain proficiency in new skills.

- 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.

The FY 2022 Q4 data reveals an SIR increase of 2.84% from the 2019 baseline. The FY 2019 CDI baseline was 0.81 went down steadily 0.710 in FY 2021. Therefore, this year reflects a change in the trend since FY 2020, reflecting a 17.34% increase in baseline from FY 2021 to the end of FY 2022.

Further evaluation is underway to look for a particular influential data point for CDI where CAHs are reporting small numbers. In this case, a few CAH CDI outbreaks could result in this elevation in the CDI SIR. Another trend may be increases in respiratory illnesses resulting in hospitalizations and increased antibiotic usage. CMS is assessing this upswing in CDI for this reporting period.

CMS's Hospital Quality Improvement Contractors (HQICs) continue to work with recruited CAH 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 post-coronavirus pandemic.

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 are embedded as a required element of support provided to hospitals. At a minimum, hospital quality improvement contractors shall provide technical assistance to

hospitals to 1) Improve the health of the general population including underserved sub-populations, 2) analyze Race, Ethnicity, Age, and Language (REAL) data to inform quality improvement, 3) customize interventions to improve the health of the general population including sub-populations, and 4) ensure the quality improvement program includes patient feedback for greater effectiveness.

CMS has had reporting challenges because reporting is not mandatory for CAHs. However, approximately 63% and 60% of CAHs report on CAUTI and CDI respectively. CMS contractors will need to work with these facilities to increase reporting while developing a system to look at multiple infection types for quality purposes.
It should be noted that the national calculation of these measures by CDC does not map exactly to the same CAHs to which CMS Quality Contractors are providing technical assistance. CMS is working with 44% of CAHs and won't be able to influence every CAH that reports to NHSN. In addition, to not working with all CAHs, CAHs do not represent the only kind of hospital that CMS will work with. CMS will also be working with other rural hospitals, which are not included in this statistic. Thus far, CDC does not routinely produce analytics specific to rural IPPS hospitals, and because of the way SIRs are constructed, CMS depends on CDC to perform a special set of analyses to obtain data for these other hospitals, which is not practical during the pandemic.

The upcoming CDI SIR targets will be a reduction (from 2019 baseline) of 3.3% in FY 2023 and 4.5% in FY 2024 which will be reported on June 30. 2024 and June 30, 2025, respectively. It has not been determined yet whether this GPRA goal will be retained in 2025. HAI measure tracking will likely continue to align with CMS quality improvement, quality reporting and patient safety programs based and prioritized using evolving HAI data. Also, infection control strategies and HAI measures will likely be in part, supported by the QIN-QIO 13th Scope of Work (SOW) funding.

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	2025	Contextual Indicator	December 31, 2025 (Pending funding availability)
	2024	Contextual Indicator	December 31, 2024
	2023	Contextual Indicator	89%
	2022	Contextual Indicator	90%
	2021	Contextual Indicator	91%
	2020	Contextual Indicator	Not Available**
	2019	Contextual Indicator	92%
	2018	Contextual Indicator	91%
MCR1.1b: Maintain or exceed percent of beneficiaries in Medicare Advantage (MA) who report access to care	2025	Contextual Indicator	December 31, 2025
	2024	Contextual Indicator	December 31, 2024
	2023	Contextual Indicator	89%
	2022	Contextual Indicator	90%
	2021	Contextual Indicator	91%
	2020	Contextual Indicator	Not Available**
	2019	Contextual Indicator	90%
	2018	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.

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. This contextual

indicator supports the CMS Strategic Plan Pillar to Expand Access. As part of this pillar, CMS is working to expand access to quality, affordable health coverage and care. This indicator monitors, from the beneficiary perspective, if they are getting needed care as quickly as they need it.

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 trends annually for these contextual measures to track beneficiary access to care. High performance has continued for this measure. For the survey conducted in 2023, the scores went down slightly, but that is not surprising given the continuing shortage of healthcare workers.

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.

The results for this measure are produced every December. Given the very high rates for these measures, it is very difficult to improve performance further. Our ability to measure performance through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey in future years for the FFS setting is pending budget availability to fund the FFS CAHPS Survey.

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%	2025	Discontinued	N/A
	2024	25%	April 30, 2026
	2023	25%	April 30, 2025
	2022	25%	April 30, 2024
	2021	25%	25% (Target Met)
	2020	25%	25% (Target Met)
	2019	28%	27% (Target Exceeded)
	2018	37%	36.7% (Target Exceeded)
	2017	43%	42% (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.

The Inflation Reduction Act of 2022 (IRA) makes significant changes to the Part D benefit design. Due to changes enacted by the IRA, the current GPRA goal will no longer be consistent with current law in 2025. Beginning in 2025, the IRA eliminates the coverage gap benefit phase, introduces manufacturer discounts in the initial and catastrophic coverage phases, changes enrollee and plan liability in the initial coverage phase, and changes plan and government reinsurance liability in the catastrophic phase. Because of the statutory design of the Coverage Gap Discount Program (CGDP), the target of 25% will continue until the CGDP sunsets in 2025.

Prior to the IRA, there were other changes to the Part D benefit that aimed to improve prescription drug coverage for Medicare beneficiaries. Before 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 was 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 2020 through 2023, non-LIS beneficiaries who

reached this phase of Medicare Part D coverage paid no more than 25 percent of costs for all covered Part D drugs. For 2024, beneficiaries reach this phase when total drug costs amount to $5,030 and stay in this phase until they pay $8,000 in qualified out-of-pocket costs. CMS's 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's 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 the Children's Health Insurance Program (CHIP) and Medicaid

Measure	FY	Target	Result
CHIP3.3: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in the Children's Health Insurance Program (CHIP) and Medicaid Baseline: 37,311,641 children	2025	35,800,000 children (Medicaid - 28,100,000/ CHIP - 7,700,000)	July 31, 2026
	2024	37,000,000 children (Medicaid - 29,500,000/ CHIP - 7,500,000)	July 31, 2025
	2023	41,900,000 children (Medicaid - 34,700,000/ CHIP - 7,200,000)	July 31, 2024
	2022	44,650,216 children (Medicaid - 35,720,173/ CHIP - 8,930,043)	46,418,101 children (Medicaid - 38,135,461/ CHIP - 8,282,640) (Target Exceeded)
	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 But Improved)
	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 - 7,152,321/ CHIP - 9,288,080)	45,919,430 children (Medicaid - 36,287,063/ CHIP - 9,632,367) (Target Not Met)

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

This measure assesses the progress of the Children's Health Insurance Program (CHIP) and Medicaid in providing affordable health coverage for low-income children and families by monitoring child enrollment trends for these programs over time. States are required to report child enrollment data for Medicaid and CHIP on a quarterly basis. These enrollment data are an important indicator of access to health coverage for children because over half of the nation's children obtain health coverage through Medicaid and CHIP. This measure aligns with the CMS Strategic Plan pillar to expand access to quality, affordable health coverage and care.

As of August 3, 2023:

- The final FY 2022 **combined Medicaid and CHIP** enrollment total for children is 46,396,724 children. This exceeds the FY 2022 GPRA target of 44,650,216 children enrolled in Medicaid and CHIP. The final FY 2022 CHIP and Medicaid enrollment total represents an increase of 1,654,072 or 3.7% in children's enrollment over the revised FY 2021 CHIP and Medicaid enrollment total of 44,742,652 children.

- The FY 2022 **Medicaid** enrollment total for children is 38,122,535 children. This exceeds the FY 2022 Medicaid child enrollment target of 35,720,173 children enrolled in Medicaid. The FY 2022 Medicaid child enrollment total reflects an increase of 1,811,047, or 5%, in child Medicaid enrollment over the revised FY 2021 Medicaid child enrollment total of 36,311,488 children.

- The FY 2022 **CHIP** enrollment total is 8,274,189 children, which does not meet the FY 2022 GPRA target of 8,930,043 children enrolled in CHIP. This represents a decrease of 156,975 or 1.94% in CHIP enrollment over the revised FY 2021 CHIP enrollment total of 8,431,164 children.

The FY 2022 result is largely attributed to temporary state policy changes in response to the Families First Coronavirus Response Act (FFCRA; P.L. 116-127), which enacted a 6.2 percentage point increase to the federal matching rate tied to the continuous enrollment condition in Medicaid for the period of January 1, 2020 through March 31, 2023. This resulted in significant growth in Medicaid child enrollment, as children that became ineligible for Medicaid during this period were not terminated from coverage. This continuous enrollment condition did not apply to CHIP, though some states opted to extend this policy to CHIP. Most states continued to terminate coverage for ineligible children from CHIP at renewal during this period, resulting in decreased CHIP enrollment for FY 2022.

The FY 2022 enrollment results are also influenced by the continued success of the Connecting Kids to Coverage Outreach and Enrollment Program and the National Campaign. These programs award funding for activities to reduce the number of children who are eligible but not enrolled in Medicaid and CHIP, and improve retention for eligible and enrolled children.

CMS's future targets for this measure account for residual impacts of states returning to routine operations after the end of the continuous enrollment condition on March 31, 2023. CMS developed the initial enrollment targets for FYs 2023 and 2024 prior to the end of the continuous enrollment condition. We now expect smaller enrollment totals for FYs 2023 and 2024 that will be lower than the targets set for these years. We adjusted our FY 2025 projection to account for anticipated enrollment losses from terminations following the end of the FFCRA continuous enrollment condition. The FY 2025 target also accounts for enrollment targets prior to FY 2022 not being met since FY 2017. For this reason, we propose a more modest and attainable target for FY 2025. Additionally, with most eligible children already enrolled in Medicaid and CHIP, we do not expect significant levels of growth in child enrollment for these programs going forward.

CMS's strategy to increase the availability and accessibility of health insurance coverage for children and meet future performance targets for this measure includes: collaborating with state and federal partners; implementing statutory provisions that encourage program simplification; supporting outreach and enrollment grantees; and issuing guidance to

states about new continuous eligibility requirements. CMS also engages in rulemaking and developing guidance for states to improve access to health care coverage and quality. Examples of these activities are outlined below.

- On July 19, 2022, CMS awarded over $49 million for 36 cooperative agreements, with award amounts ranging from $664,000 to $1,500,000, to advance Medicaid and CHIP enrollment and retention. On March 30, 2023, CMS awarded an additional $5.9 million in cooperative agreements to seven organizations to increase the participation of eligible, uninsured American Indian and Alaska Native children in Medicaid and CHIP, with award amounts ranging from $316,349 to $1,000,000. CMS provides extensive technical assistance to grantees to increase awareness of strategies to maintain coverage for Medicaid and CHIP beneficiaries as states return to routine operations following the end of the continuous enrollment condition. In FY 2025, we anticipate funding $40.7 million toward new outreach and enrollment cooperative agreements, and for National Campaign outreach activities.

- CMS published an NPRM on September 7, 2022 that proposes policy changes to simplify application; eligibility determination; enrollment; and renewal processes in Medicaid and CHIP. The proposed changes in the NPRM include eliminating policies that impose barriers to children's coverage in CHIP, such as waiting periods and premium lock-out periods. The NPRM also proposes changes to streamline coverage transitions between Medicaid and CHIP to make the process less burdensome for families and to prevent unnecessary gaps in coverage for children transitioning between programs. A final rule is under development by CMS that finalizes these and other proposed changes to improve access to coverage and reduce churn in Medicaid and CHIP.

- CMS issued guidance on January 5 and 31, 2023 about returning to routine operations for processing renewals in Medicaid and CHIP following the end of the continuous enrollment condition. CMS also specifically addressed ensuring that children maintain Medicaid and CHIP coverage, in the December 18, 2023 CMCS Information Bulletin. We continue to provide intensive technical assistance to states on this process to minimize potential losses in coverage during the current unwinding period.

- As outlined in SHO #23-004, states are required to provide 12 months of continuous eligibility for children under the age of 19 in Medicaid and CHIP, effective January 1, 2024. Section 5112 of the Consolidated Appropriations Act, 2023 (CAA, 2023) amended sections 1902(e)(12) and 2107(e)(1) of the Social Security Act to add this requirement.

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	2025	Contextual Indicator	November 30, 2025
	2024	Contextual Indicator	November 30, 2024
	2023	Contextual Indicator	26%
	2022	Contextual Indicator	16%
	2021	Contextual Indicator	17%
	2020	Contextual Indicator	13%
	2019	Contextual Indicator	15%
	2018	Contextual Indicator	17%
CMMI3.3: Number of providers participating in Innovation Center models Baseline: < 60,000	2025	Contextual Indicator	November 30, 2025
	2024	Contextual Indicator	November 30, 2024
	2023	Contextual Indicator	100,681
	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

Measure	FY	Target	Result
CMMI3.5: Percentage of Model awardees participating in learning activities	2025	54%	November 30, 2026
	2024	54%	November 30, 2025
	2023	54%	November 30, 2024
	2022	52%	50% (Target Not Met)
	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's 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.

CMS continues to look at models that increase access to advanced, high-quality, primary care, and further make multi-payer alignment possible, including Medicaid, to ensure a focus on underserved populations.

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.

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's model portfolio.

CMMI3.5 measures CMMI Learning System participation. CMMI Learning Systems provide extra support to model participants that are working to achieve better health, better care, and reduced costs. Learning Systems promote collaboration through virtual and in-person events to maximize partnerships across models that focus on the same core

improvement elements (e.g., waivers, health equity, beneficiary engagement, and provider engagement). CMS has created collaborative learning systems for providers and other model participants 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. Additionally, Learning Systems are advancing CMS priorities by supporting model participants as they work to improve equity, expand access, engage partners, drive innovation, and foster excellence/stewardship.

For measure CMMI3.1, the FY 2023 result was 26 percent. The FY 2023 percentage increase is due to the addition of the new Expanded Home Health Value-Based Purchasing (HHVBP) Model as well as beneficiary increases within the following models: Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model, Comprehensive Care for Joint Replacement (CRJ) Model, Emergency Triage, Treat and Transport (ET3) Model, Kidney Care Choices (KCC) Model, Maryland Total Cost of Care (MDTCOC) Model, Medicare Diabetes Prevention Program (MDPP) Expanded Model, Pennsylvania Rural Hospital Model (PARHM), Primary Care Model, and the Vermont All-Payer Accountable Care Organization (ACO) Model.

For measure CMMI3.3, the FY 2023 result was 100,681. The FY 2023 result increase is due to the addition of the new Expanded HHVBP Model as well as participation increases within the following models: ACO REACH Model, ET3 Model, Integrated Care for Kids (InCK) Model, KCC Model, MDTCOC Model, MDPP Expanded Model, Primary Care First Model, and the Vermont All-Payer ACO Model.

For measure CMMI3.5, CMS fell slightly short of meeting the 52 percent target for FY22 with a 50 percent learning system participation rate for 7 models. Learning system participation was high for InCK (93 percent), Maternal Opioid Misuse (MOM) Model (89 percent), and Oncology Care Model (OCM) (60 percent), but decreased for Bundled Payments for Care Improvement Advanced (BPCI-A) Model (21 percent), ET3 (24 percent), Global and Professional Direct Contracting (GPDC) Model (25 percent), and KCC (34 percent), thus bringing down the overall participation rate to 50 percent, which is 2 percent shy of the target 52 percent for FY22.

Lower than anticipated learning system participation for a subset of models was affected by a range of factors including: participant attrition/consolidation and model transitions or terminations. In early 2022, CMS announced that the GPDC model would transition to ACO REACH on January 1, 2023. This led to decreased engagement from model participants as they waited and applied for the new model. GPDC learning system activities were subsequently scaled back in response to the pending changes and to facilitate model participant transition to ACO REACH. In 2022, the decision to terminate the ET3 model altered the learning system approach and engagement. In the KCC model, there was significant consolidation among KCC entities, leading to less unique attendees at events. Finally, BPCI-A's low participation rates were due to attrition of many large convener organizations that often represented multiple participants in past learning events. Model participants reported seeking more asynchronous and smaller scale activities to facilitate deeper engagement with content and their peers, which the learning system responded to by decreasing the amount of large-scale learning events that would have previously garnered larger audiences and broader participation.

The target for FY24 and FY25 remains at 54 percent which is based on historical treads as well as refined recruitment methods that aim to yield a higher rate of engaged model participants.

As CMS moves into future model support, CMS will continue 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	2025	65%	November 30, 2026
	2024	60%	November 30, 2025
	2023	50%	November 30, 2024
	2022	45%	47% (Target Exceeded)
	2021	Baseline	44%

The CMS Innovation Center conducted a strategic refresh in 2021 to support and help execute CMS's strategic plan and priorities. In the fall of 2022, the Innovation Center released a 1-year Status Update Report that provided an update on the Innovation Center's progress implementing the new strategy, described areas of focus for the coming year, and began 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.

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.

The Innovation Center remains focused on expanding the foundation toward a health system that achieves equitable outcomes through high-quality, affordable, and person-centered care. To make this lasting change, it is incorporating patient and caregiver perspectives across the lifecycle of its models, implementing more patient-reported outcome measures (PROMs) to measure what matters to beneficiaries, and evaluating patient and caregiver experience in models.

With 47% of FY 2022 original Medicare beneficiaries aligned to a care relationship model that ensures accountability for quality and cost of care, the CMS Innovation Center surpassed its goal of 45%. This represents a 3% increase from the Innovation Center's FY 2021 baseline of 44%. CMS continues to drive innovation by promoting value based and person-centered care, including:

- Implementing the redesigned ACO Realizing Equity, Access, and Community Health (ACO REACH Model).
- Launching the Enhancing Oncology Model (EOM), which aims to bring enhanced services and coordinated care to beneficiaries with cancer.
- Finalizing proposal to scale successful features of the ACO Investment Model (AIM) in the Medicare Physician Fee Schedule Rule.
- Submitting a report outlining models to reduce drug costs for patients as

called for by Executive Order 14087 Lowering Prescription Drug Costs for Americans.
- Announcing Making Care Primary Model which is designed to improve care management and care coordination, provide a pathway for primary care clinicians with varying levels of experience in value-based care to gradually adopt prospective, population-based payments while building infrastructure to improve behavioral health and specialty integration, and address patients' health needs as well as their health-related social needs (HRSNs).
- Announcing the States Advancing All-Payer Health Equity Approaches & Development (AHEAD) Model. CMS's goal in this Model is to collaborate with states to curb health care cost growth; improve population health; and advance health equity by reducing disparities in health outcomes.

As new models become operational, CMS will integrate them into the numerator of the metric. Additional highlights of the Innovation Center's accomplishments in implementation of its strategic refresh are outlined in the Innovation Strategy Refresh document.

Using FY 2021 data for the baseline CMS created targets through FY 2025 (FY 2024 – 2025 targets: 60% and 65%, respectively) based on the following 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

Program Operations Discontinued Measures

MCR26: Reduce All-Cause Hospital Readmission Rates for Medicare Beneficiaries

MCR26 was implemented to monitor hospital readmissions, an important indicator of care quality that accounts for billions of dollars in annual Medicare spending. Over the last several years, CMS has undertaken several initiatives to reduce readmissions in the Medicare program. This included publicly reporting hospital readmission rates through Hospital Compare, funding hospital-level improvements through the Partnership for Patients program, changing payment policies through the Hospital Readmissions Reduction Program and the Medicare Physician Fee Schedule, and CMS's many shared savings initiatives.

CMS is discontinuing this measure since 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. 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. We believe this fact contributed to our CMS performance measure results remaining relatively constant from FY 2016 - FY 2022.

CMS will continue to monitor hospital readmission rates through the CMS GPRA MMB2 performance measure: All-Cause Hospital Readmission Rate for Medicare-Medicaid Enrollees in Fee-for-Service (FFS) Medicare.

Measure	FY	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	Discontinued	N/A
	2023	17.5%	17.8% (Target Not Met) (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)

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

*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.

Medicaid Discontinued Measures

MCD9: Improve Capacity to Collect Quality and Other Performance Data for Monitoring 1115 Demonstration Programs

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). This measure tracks the development of an automated infrastructure to support section 1115 Medicaid demonstrations by focusing on comprehensive treatment for substance use disorders (SUD) (MCD9.2).

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.[14]

CMS was refocusing 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[15], which can result in resource constraints for health systems.[16] 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. MCD9.3, Reduce Emergency Department (ED) Use Under Substance Use Disorder (SUD) 1115 Demonstration, will examine the percentage of states that either demonstrate a decrease or remain consistent in their ED utilization over the course of the demonstration.

[14] 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.

[15] 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/

[16] Weiss, A. Overview of Emergency Department Visits in the United States, 2011. Available at. https://www.ncbi.nlm.nih.gov/books/NBK235856/

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