DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2027

Centers for Medicare & Medicaid Services

Justification of Estimates for Appropriations Committees

This page intentionally left blank.

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

Message from the Administrator

It is my privilege to present the Centers for Medicare & Medicaid Services (CMS) Fiscal Year (FY) 2027 performance budget—a blueprint for the future of health care in America. As the nation's largest health insurance provider, CMS serves as a trusted partner and steward for more than 164 million Americans we plan to serve in FY 2027. This is a responsibility we embrace with compassion, resolve, and a deep commitment to public trust.

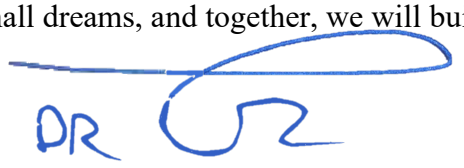
Great societies protect their most vulnerable, and at CMS, we take this calling to heart. Our work is rooted in competent service, accountability, and the belief that every American deserves access to high-quality, affordable care. CMS is more than a safety net—we are a driving force for change. We are empowering beneficiaries with better tools and greater transparency, incentivizing providers to deliver optimal care in real time, and modernizing our systems to tackle fraud, waste, and abuse with unprecedented precision.

This year, I am especially proud of how quickly CMS has adopted new, cutting-edge technologies, including artificial intelligence, to strengthen our operations and improve health outcomes. With the help of advanced analytics and innovative partners (including Artificial Intelligence-powered solutions), we are identifying savings, streamlining processes, and enhancing our ability to detect and crush fraud. These investments are not just about efficiency; they are about restoring public confidence and ensuring every taxpayer dollar delivers maximum value.

Our FY 2027 budget reflects these priorities. We are investing in modernization, enhancing oversight, and supporting our dedicated workforce that makes our mission possible. We are working side-by-side with doctors, providers, federal and state partners to address the root causes of chronic conditions, lowering prescription drug costs, unmasking unfair billing practices, and building a health care system that is proactive, transparent, and focused on prevention and wellness.

Our mission goes beyond numbers and technology. At CMS, we never lose sight of the human stories behind every policy and every program. Whether it's a new senior navigating Medicare, a young family relying on Medicaid, a working American finding coverage on the Exchanges, or an infant covered by the Children's Health Insurance Program, we are here to serve with compassion and integrity. We listen, we learn, and we adapt—because the health and well-being of our neighbors is the true measure of our success.

On behalf of our beneficiaries and the entire CMS team, I thank you for your continued support. America is too great for small dreams, and together, we will build a health care system worthy of every American.



Dr. Mehmet Oz

This page intentionally left blank.

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

This page intentionally left blank.

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

This page intentionally left blank.

EXECUTIVE SUMMARY

Introduction and Mission

The Centers for Medicare & Medicaid Services (CMS) is leading the transformation of health care as the preeminent expert, a trusted partner, and an unwavering steward of taxpayer dollars. We are committed to Making America Healthy Again (MAHA) by promoting innovation, conquering health care system challenges, and crushing fraud, waste, and abuse. CMS will Make America Healthy Again with curiosity, courage, competence, and compassion while guaranteeing program sustainability for future generations.

As an Operating Division within the Department of Health and Human Services (HHS), CMS is 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 Exchange. As a driving force in the health care industry, CMS recognizes the direct impact its programs have on over 164 million beneficiaries and consumers that we will serve in FY 2027. CMS delivers results for customers and stakeholders by demanding accountability and promoting collaboration. We center everything we do around those we serve and will continue to drive the country towards the best health outcomes in the world. The Agency ensures high-quality services are provided with respect and applies rigorous oversight to guarantee the best value for Americans.

CMS is coming off a historic year with many significant accomplishments, which showcase our steadfast commitment, stewardship, and value to America. To remain succinct, the following list notes some of our notable successes.[1]

- CMS announced $50 billion in awards to strengthen rural health in all 50 States
- CMS delivered savings for seniors on 15 major drugs for cancer and chronic diseases
- The White House, along with key technology leaders, committed to creating a Patient-Centric Health Technology Ecosystem
- National Health Care Fraud takedown resulted in 324 defendants charged in connection with over $14.6 billion in alleged fraud
- CMS announced several innovative, game-changing models such as GUARD, BALANCE, GENEROUS, GLOBE, ACCESS, and MAHA ELEVATE, which will pave the way for the future of our programs. [2]

These phenomenal headlines are MAHA policy in action. Gone are the days of wait and see; CMS is an agency of action that is delivering on promises made. This list of accomplishments also demonstrates our resolve and provides the foundation that we will build upon as we move towards a healthier America. Within this budget, CMS lays out our plan to drive down costs; increase quality of care and outcomes for patients through common sense policy decisions; root out fraud, waste, and abuse; drive strategic innovation; advance our technological capabilities; and strengthen our professional CMS staff.

[1] To learn more about these and the many more wins CMS had over the past year, please visit https://www.cms.gov/about-cms/contact/newsroom

[2] A listing of all CMS Innovation Models along with additional details about how these models aim to vastly improve America's health care can be found at https://www.cms.gov/priorities/innovation/models

Overview of FY 2027 Budget Request

The FY 2027 President's Budget request will ensure that CMS can sustain its core operations while also enhancing its traditional activities to better serve the millions of Americans who depend on our programs. Our objective is to focus on key areas for improvement, including the adoption of modern technologies and the implementation of innovative solutions to crush fraud, waste, and abuse across all CMS programs.

Beyond core operations, CMS' key priorities for FY 2027 will modernize and streamline our internal and external business practices. The key priorities are:

- **CMS Health Tech Ecosystem** – The Ecosystem is a transformational initiative designed to empower beneficiaries with seamless access to their health information, reduce provider administrative burden, and unlock innovation across the private sector. The request would allow CMS to continue its progress towards achieving milestones for this effort.

- **ClaimsCore** – ClaimsCore will replace Original Medicare's legacy shared systems and other aged infrastructure with a secure, real-time, enterprise platform deployed in the CMS Cloud to deliver sub-second adjudication, configuration-driven policy agility, pre-payment integrity controls, transparent APIs, and resilient operations for CMS, Medicare Administrative Contractors, providers, and beneficiaries. The request would enable CMS to plan and begin early implementation phases.

- **Medicaid Oversight** – CMS will continue to address growing risks in the Medicaid program. This initiative will involve tackling fraud schemes through additional investigations, data analysis, and law enforcement support; conducting audits related to Medicaid beneficiary eligibility and enrollment changes in the Working Families Tax Cut legislation; and expanding oversight of Medicaid managed care.

- **CMS Staffing Plan** – With an emphasis on hiring program integrity and technology positions (e.g., software/hardware engineers, data scientist, artificial intelligence and machine learning experts), CMS has a plan to onboard staff that will be the in-house subject matter experts needed to raise our internal capabilities. This staffing plan, in line with the President's guidance to crush fraud, focuses on modernization, oversight, and enforcement capabilities to further safeguard our programs. CMS leadership will provide oversight for each position, ensuring tactical decisions make strategic sense.

Concentrating on these strategic initiatives, CMS is dedicated to ensuring that every dollar is spent wisely to drive significant improvements, have a positive impact on health outcomes, and improve patient satisfaction. This budget presents a comprehensive approach that not only fortifies the Agency's commitment to current beneficiaries but also secures the future of America's health care system for generations to come. CMS is intensifying efforts to combat health care fraud. By leveraging advanced analytics and enhancing inter-agency collaboration, CMS is refining its ability to detect, prevent, and respond to fraudulent activities, with the goal of crushing fraud wherever we find it.

CMS requests funding for its annually appropriated discretionary accounts, including Program Management (PM) and discretionary Health Care Fraud and Abuse Control (HCFAC). The table on the next page displays CMS' funding for Fiscal Year (FY) 2025, FY 2026, and FY 2027.

CMS Annually Appropriated Accounts
(Dollars in Millions)

Account	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Program Management[3]	**$4,136.981**	**$3,681.981**	**N/A**	**N/A**
Program Administration (non-add)[4]	*$3,699.647*	*$3,284.647*	$3,213.493	($71.154)
Program Operations (non-add)[4]	*$2,838.460*	*$2,492.061*	*$2,461.378*	*($30.683)*
Federal Administration (non-add)[4]	*$843.533*	*$772.533*	*$734.061*	*($38.472)*
Research (non-add)[4]	*$17.654*	*$20.054*	*$18.054*	*($2.000)*
State Survey & Certification (non-add)[4]	*$437.344*	*$397.334*	$487.000	$89.666
Medicare Operations General Provision	*	*$455.000*	-	($455.000)
Subtotal, Appropriation/BA Current Law[5,6]	**$4,136.981**	**$4,136.981**	**$3,700.493**	**($436.488)**
HCFAC	**$941.000**	**$941.000**	**$976.000**	**$35.000**
Grants to States (Medicaid)	**$672,310.865**	**$779,651.906**	**$785,192.746**	**$5,540.840**
Payments to Health Care Trust Funds	**$588,782.000**	**$593,817.000**	**$686,855.000**	**$93,038.000**
Total, All Appropriated Accounts	**$1,266,170.847**	**$1,378,546.887**	**$1,476,724.239**	**$98,177.352**

Program Administration

CMS' FY 2027 President's Budget request for Program Administration is $3,213.5 million. CMS has reduced costs by driving efficiencies and internalizing workloads. The use of innovative solutions has been a key piece of containing operational costs. With cost savings efforts ongoing, CMS still recognizes the need for increased business flexibility. Therefore, in the FY 2027 President's Budget, CMS re-proposes to merge our Program Operations, Research, and Federal Administration accounts into a single Program Administration account. CMS made the same proposal in the FY 2026 President's Budget. By integrating funding of federal staff within program costs, CMS envisions better alignment with mission priorities and an increased flexibility in workforce planning. The merger of these accounts allows CMS to adjust the ratio of contractor and federal staffing levels, which is currently heavily weighted with contractor staff at 6:1. The flexibility gained through the Program Administration account shifts CMS towards business operations more like its peers and private industry – mission needs, not funding structure, will dictate business decisions.

This funding level will allow CMS to address statutorily mandated Medicare workloads, maintain legacy systems while modernizing CMS' architecture, and make strategic investments to prepare for the future. CMS aims to design consistent, secure, and sustainable care experiences across the country that are delivered with dignity. Funding is necessary to execute

[3] The FY 2027 Budget assumes the planned HHS Reorganization, which includes HRSA's Office of Pharmacy Affairs residing in CMS Program Management. This display comparably adjusts FY 2025 and FY 2026 columns to the FY 2027 Budget policy.

[4] Program Administration and Survey & Certification are non-adds for FY 2025 and FY 2026 only, but distinct proposed project, programs, and activities for the FY 2027 budget. Program Operations, Federal Administration, and Research are distinct project, programs, and activities for FY 2026 only, but displayed for FY 2025 and FY 2027 for comparison.

[5] The FY 2025 Enacted Level includes a $2.6 million Secretary's Transfer from CMS Program Management to the HHS Office of the Inspector General for Information Blocking.

[6] FY 2025 includes $455 million from the Medicare Operations general provision from the FY 2025 continuing resolution, Public Law 119-4. In FY 2025, CMS allocated $370 million to Program Operations, $45 million to Federal Administration, and $40 million to Survey & Certification.

today's mission while maintaining customer service levels, business operations, and employee productivity through new investments in federal technology modernization including automation and the use of AI. CMS continues to assess its contract footprint with the goal of insourcing expertise for many critical business functions. This funding level also supports our dedicated workforce of 3,576 FTEs funded through the discretionary appropriation who serve over 164 million Americans daily, the people who deliver exceptional service, advance innovative solutions, and build a more responsive health care system that benefits all Americans.

Planned HHS Reorganization

Within the MAHA structure, certain work elements that are currently completed by the Health Resources and Services Administration (HRSA) are planned to be strategically shifted. Particularly, the 340B Drug Pricing Program, which plays a crucial role in enhancing health care outcomes and ensuring affordability, is planned to reside within CMS.

The 340B Drug Pricing Program FY 2027 President's Budget request is $20.5 million, which will allow for fulfillment of statutory obligations and ensure program oversight. The program mandates drug manufacturers participating in Medicaid provide discounts on outpatient drugs to covered entities.

Survey and Certification

CMS' FY 2027 President's Budget request is $487.0 million to provide the resources to achieve 78% completion of mandatory surveys and 10% completion of non-statutory surveys of facilities that provide care to beneficiaries. This enhanced funding strengthens our ability to ensure quality care and safety standards across health care facilities while advancing comprehensive federal oversight that protects millions of most vulnerable Americans.

Health Care Fraud and Abuse Control

CMS' $976.0 million discretionary HCFAC funding request strengthens our partnerships with the Department of Justice and the HHS Office of Inspector General to aggressively crush fraud in Medicare, Medicaid, CHIP, and the Exchanges. Driven by our commitment to excellence and innovation, we are enhancing our provider screening, medical review, and data analytics capabilities while expanding investigation efforts across all programs. Further, this request will allow CMS to implement a more robust and effective program integrity strategy specifically targeting Medicaid, where we have seen pervasive fraud, waste, and abuse in state programs. This investment empowers CMS to identify and eliminate fraud, waste, and abuse, protect vulnerable patients and taxpayer dollars through targeted initiatives, and advance modeling techniques.

Grants to States for Medicaid

CMS' FY 2027 mandatory appropriation request for the Grants to States for Medicaid account is $785.2 billion, an increase of $16.0 billion relative to the FY 2026 request level of $769.2 billion.[7] This appropriation is composed of $316.5 billion in an authorized advance appropriation for FY 2026 and a remaining appropriation of $468.7 billion for FY 2027.

[7] The FY 2026 amount of $769.2 billion in the narrative does not include anticipated indefinite authority.

Resources will help fund $786.7 billion in anticipated FY 2027 Medicaid obligations. CMS also anticipates budget authority from offsetting collections from the Supplementary Medical Insurance trust fund and Medicare Part D account in the amount of $1.5 billion to fund the remaining anticipated obligations. These estimated obligations include:

- $744.8 billion in Medicaid medical assistance payments (MAP);
- $33.6 billion for Medicaid state and local administrative functions including funding for Medicaid state survey and certification and the state Medicaid fraud control units; and
- $6.8 billion for the Centers for Disease Control and Prevention's Vaccines for Children (VFC) program.

This submission is based on projections from state-submitted estimates and CMS using Medicaid expenditure data as recently as the third quarter of FY 2025. The projections incorporate the economic and demographic assumptions provided by the Office of Management and Budget (OMB) for the FY 2027 President's Budget.

Payments to the Health Care Trust Funds

The FY 2027 President's Budget request for Payments to the Health Care Trust Funds account totals $686.9 billion. This account transfers payments from the General Fund to the Trust Funds to make the Supplemental 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 include 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 our government more effective and efficient in managing and delivering HHS programs, by implementing the Government Performance and Results Act of 1993 (GPRA) and the GPRA Modernization Act of 2010 (GPRAMA).

CMS employs a comprehensive strategic approach to performance management that aligns program goals with its mission of ensuring vulnerable populations receive high-value care. The agency has implemented an Objectives and Key Results (OKR) framework that cascades from organizational priorities down to individual teams, with regular reviews ensuring continuous alignment and fostering data-driven decision making. CMS achieves effective performance measurement through continuous data analysis, monthly reporting, and quarterly performance reviews to identify trends and drive incremental progress.

In FY 2025, CMS achieved significant impact through the announcement of $50 billion in rural health investments, major drug savings for seniors, historic fraud enforcement actions, and the launch of innovative care delivery models in partnership with technology leaders. Looking ahead, the FY 2027 budget showcases CMS's strategic direction toward technological modernization, improved beneficiary experience, reduced administrative burden, and building internal technical capacity to address the current contractor-heavy workforce model.

However, CMS faces ongoing performance challenges including balancing aggressive performance targets with realistic expectations and adapting to evolving health care system challenges. The agency is addressing these challenges by leveraging innovative solutions such as advancing value-based care models and implementing innovative payment systems, while working to better balance its current 6:1 contractor-to-federal staff ratio for improved workforce flexibility and mission alignment. Further performance improvement actions implemented in FY 2025, including strategy refinements, system upgrades, and increased fraud, waste, and abuse combat activities, are expected to result in significant FY 2027 accomplishments while maintaining exceptional fiscal responsibility standards, customer service excellence, and program sustainability for future generations.

Conclusion

CMS' FY 2027 President's Budget request for Program Management is $3,700.5 million, which represents our unwavering commitment to excellence in serving over 164 million Americans through Medicare, Medicaid, CHIP, and the Exchanges. This strategic investment, combined with $976.0 million in discretionary HCFAC funds, positions us to not only maintain but enhance our oversight capabilities, strengthening early detection and prevention of fraud while strengthening care for beneficiaries.

With this request, CMS will modernize Medicare, Medicaid, CHIP, and the Exchanges to ensure Americans get the care they want, need, and deserve through these decisive actions:

- Empower Americans with personalized solutions so they can better manage their health and navigate the complex health care system. CMS will implement Executive Order 14221 on Pricing Transparency to give Americans the information they need about the actual prices of drugs, hospital care, and health insurance.

- Equip health care providers with better information about the patients they serve and hold them accountable for health outcomes rather than unnecessary paperwork that distracts them from their mission.

- Identify and eliminate fraud, waste, and abuse to stop unscrupulous individuals who are stealing from vulnerable patients and taxpayers.

- Shift the paradigm for health care from a system that focuses on sick care to one that fosters prevention, wellness, and chronic disease management. CMS will continue to operate and improve many programs that can be used to focus on improving holistic health outcomes.

As we look ahead, CMS will continue as a leader in the transformation of health care delivery to improve quality, access, and outcomes. We are confident that through our strategic investments, technological advancements, our expert staff, and strong focus on those we serve, we will continue to advance our mission of Making America Healthy Again. We will do this while ensuring the highest levels of service to our beneficiaries, health care providers, and all stakeholders.

Together, we are not just maintaining programs; we are actively shaping a better future of health care in America, making our programs more accessible, efficient, and responsive to the needs of Americans we serve.

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

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	+/- FY 2026
Program Management /1	$ 4,136.981	$ 3,681.981	N/A	N/A
Program Administration (non-add) /2	*$ 3,699.647*	*$ 3,284.647*	$ 3,213.493	$ (71.154)
Program Operations (non-add) /2	*$ 2,838.460*	*$ 2,492.061*	*$ 2,461.378*	*$ (30.683)*
Federal Administration (no-add) /2	*$ 843.533*	*$ 772.533*	*$ 734.061*	*$ (38.472)*
Research (non-add) /2	*$ 17.654*	*$ 20.054*	*$ 18.054*	*$ (2.000)*
State Survey & Certification (non-add) /2	*$ 437.334*	*$ 397.334*	$ 487.000	$ 89.666
Medicare Operations General Provision	*	$ 455.000	$ -	$ (455.000)
Subtotal, Appropriation/BA Current Law (Discretionary; 0511) /3 /4	**$ 4,136.981**	**$ 4,136.981**	**$ 3,700.493**	**$ (436.488)**
MIPPA (Mandatory; P.L. 110-275)	$ 2.829	$ 2.829	$ 2.829	$ -
PAMA (P.L. 113-93)	$ 1.886	$ 1.886	$ 1.886	$ -
IMPACT (P.L. 113-185)	$ 5.304	$ -	$ -	$ -
BBA (P.L. 115-123)	$ 4.715	$ 4.715	$ 4.715	$ -
Consolidated Appropriations Act, 2021 (P.L. 116-260)	$ 16.031	$ 11.316	$ 11.316	$ -
Bipartisan Safer Communities Act (P.L. 117-159)	$ 0.943	$ 0.943	$ 0.943	$ -
Inflation Reduction Act (P.L. 117-169)	$ 44.321	$ 44.321	$ 44.321	$ -
American Relief Act (P.L. 118-158)	$ 5.780	$ -	$ -	$ -
Full-Year Continuing Appropriations and Extensions Act (P.L. 119-4)	$ 10.500	$ -	$ -	$ -
Working Families Tax Cut Law (P.L. 119-21)	$ 200.000	$ 410.000	$ 11.316	$ (398.684)
Continuing Appropriations and Extensions Act, 2026 (P.L. 119-37)	$ -	$ 20.314	$ -	$ (20.314)
Consolidated Appropriations Act, 2026 (P.L. 119-75)	$ -	$ 367.900	$ 15.182	$ (352.718)
Total, Mandatory Appropriation/BA C.L. (Mandatory; 0511)	**$ 292.309**	**$ 864.224**	**$ 92.508**	**$ (771.716)**
Total, Appropriation/BA Current Law (0511)	**$ 4,429.290**	**$ 5,001.205**	**$ 3,793.001**	**$ (1,208.204)**
Est. Offsetting Collections from Non-Federal Sources: /5				
User Fees and Reimbursements	$ 924.459	$ 914.841	$ 669.598	$ (245.243)
Marketplace User Fees (FFM)	$ 1,889.446	$ 2,044.039	$ 2,018.630	$ (25.409)
Risk Adjustment User Fees (RA)	$ 80.278	$ 78.432	$ 65.758	$ (12.674)
Recovery Audit Contracts (RACs) /6	$ 238.373	$ 243.900	$ 301.019	$ 57.119
Total, Offsetting Collections	**$ 3,132.556**	**$ 3,281.212**	**$ 3,055.005**	**$ (226.207)**
Subtotal, New BA, Current Law (0511)	**$ 7,561.846**	**$ 8,282.417**	**$ 6,848.006**	**$ (1,434.411)**
HCFAC Discretionary (8393)	**$ 941.000**	**$ 941.000**	**$ 976.000**	**$ 35.000**
Non-CMS Administration /7	**$ 3,629.000**	**$ 3,893.000**	**$ 3,952.000**	**$ 59.000**
CMS FTEs:				
Discretionary (Program Management) /8	3,550	3,572	3,576	4
Reimbursable (CLIA, CoB, RAC, Marketplace)	684	722	722	0
Mandatory (Direct Appropriations)	213	395	395	0
Subtotal, Current Law Program Management FTEs	**4,447**	**4,689**	**4,693**	**4**
HCFAC (Mandatory)	594	634	651	17
Medicaid Integrity (State Grants; Mandatory)	268	268	268	0
Affordable Care Act Section 3021 (Mandatory)	507	577	615	38
Quality Improvement Organizations	256	260	260	0
Demonstrations	5	5	5	0
No Surprises Act	28	28	0	(28)
Subtotal, Current Law Other Sources FTEs	**1,658**	**1,772**	**1,799**	**27**
Total, Current Law CMS FTEs	**6,105**	**6,461**	**6,492**	**31**

/1 The FY 2027 Budget assumes the planned HHS Reorganization, which includes HRSA's Office of Pharmacy Affairs residing in CMS Program Management. This display comparably adjusts FY 2025 and FY 2026 columns to the FY 2027 Budget policy.

/2 Program Administration and Survey & Certification are non-adds for FY 2025 and FY 2026 only, but distinct proposed project, programs, and activities for the FY 2027 budget. Program Operations, Federal Administration, and Research are distinct project, programs, and activities for FY 2026 only, but displayed for FY 2025 and FY 2027 for comparison.

/3 The FY 2025 Enacted Level includes a $2.6 million Secretary's Transfer from CMS Program Management to the HHS Office of the Inspector General for Information Blocking.

/4 FY 2025 includes $455 million from the Medicare Operations general provision from the FY 2025 continuing resolution, Public Law 119-4. In FY 2025, CMS allocated $370 million to Program Operations, $45 million to Federal Administration, and $40 million to Survey & Certification.

/5 Displayed amounts reflect current law, net of sequester and pop-up authority as applicable.

/6 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.

/7 Includes discretionary funds only for the SSA, DHHS/OS, MedPac, and the SHIPs.

/8 FYs 2025 and 2026 each include 22 FTEs and FY 2027 includes 26 FTEs from HRSA to CMS for comparability per the planned HHS Reorganization.

This page intentionally left blank.

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

Program Management

Summary of Changes

(Dollars in Millions)

	Dollars	FTE
FY 2026 Enacted		
Total estimated budget authority /1 /2	$ 4,137	3,572
FY 2027 President's Budget		
Total estimated budget authority /1 /2	$ 3,700	3,576
Net Change	**$ (436)**	**4**

	FY 2026 Enacted		FY 2027 President's Budget		FY 2027 +/- FY 2026	
	BA	FTE	BA	FTE	BA	FTE
Increases:						
A. Program:						
1. Program Management /2	$ 397	3,572	$ 487	3,576	$ 90	4
a. Survey & Certification (non-add) /3	*$ 397*	-	$ 487	-	$ 90	-
Subtotal, Program Increases /1 /2	**$ 397**	**3,572**	**$ 487**	**3,576**	**$ 90**	**4**
Total Increases /1 /2					**$ 90**	**4**
Decreases:						
A. Program:						
1. Program Management	$ 3,285	-	N/A	-	N/A	-
a. Program Administration (non-add) /3	*$ 3,285*	-	$ 3,213	-	$ (71)	-
Program Operations (non-add) /3	*$ 2,492*	-	*$ 2,461*	-	$ (31)	-
Federal Administration (non-add) /3	*$ 773*	-	*$ 734*	-	$ (38)	-
Research (non-add) /3	*$ 20*	-	*$ 18*	-	$ (2)	-
2. Medicare Operations Anomaly	$ 455	-	$ -	-	$ (455)	-
Subtotal, Program Decreases /1	**$ 3,740**	-	**$3,213**		**$ (526)**	-
Total Decreases /1					**$ (526)**	-
Net Change /1 /2	$ 4,137	3,572	$ 3,700	3,576	**$ (436)**	**4**

/1 Reflects enacted discretionary funds, only. Excludes budget authority and staffing from mandatory funds.

/2 The FY 2027 Budget assumes the planned HHS Reorganization, which includes HRSA's Office of Pharmacy Affairs program residing in CMS Program Management. This display comparably adjusts FY 2026 to the FY 2027 Budget policy.

/3 Survey & Certification and Program Administration are non-adds for FY 2026 only, but distinct proposed projet, programs, and activities for the FY 2027 budget. Program Operations, Federal Administration, and Research are distinct project, programs, and activities for FY 2026 only, but displayed for FY 2027 for comparison.

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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**	$3,587,996,000	$3,451,141,000	$3,974,744,000	$3,974,744,000
HHS Secretary's Transfer Authority	$0	$0	$0	($9,864,000)
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**	$3,543,879,000	$3,502,024,000	$3,974,744,000	$3,974,744,000
HHS Secretary's Transfer Authority	$0	$0	$0	($8,948,000)
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
MACRA (PL 114-10)	$0	$0	$0	$115,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$18,625,000
Bipartisan Budget Act '18 (PL 115-123)	$0	$0	$0	$25,500,000
SUPPORT Act (PL 115-271)	$0	$0	$0	$83,000,000
Sequestration	$0	$0	$0	($8,904,750)
Subtotal	$3,543,879,000	$3,502,024,000	$3,974,744,000	$4,209,016,250
2020				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($103,008)
Subtotal				$2,896,992
Trust Fund Appropriation:				
Base **/1**	$3,579,427,000	$3,984,744,000	$3,974,744,000	$3,974,744,000
CARES Act Supplemental (PL 116-136)	$0	$0	$0	$200,000,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
MACRA (PL 114-10)	$0	$0	$0	$20,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
Bipartisan Budget Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Health Extenders (PL 116-59)	$0	$0	$0	$1,852,000
Further Health Extenders (PL 116-69)	$0	$0	$0	$1,033,000
Further Consolidated Appropriation (PL 116-94)	$0	$0	$0	$10,315,000
CARES Act (PL 116-136)	$0	$0	$0	$19,800,000
Sequestration	$0	$0	$0	($1,394,903)
Subtotal	$3,579,427,000	$3,984,744,000	$3,974,744,000	$4,246,974,097
2021				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
American Rescue Plan (PL 117-2) **/2**	$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**	$3,693,548,000	$3,984,744,000	$3,974,744,000	$3,974,744,000
HHS Secretary's Transfer Authority	$0	$0	$0	($11,933,000)
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

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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
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)	$0	$0	$0	$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)	$0	$0	$0	$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
Consolidated Appropriations Act, '24 (PL 118-42)	$0	$0	$0	$15,000,000
Sequestration	$0	$0	$0	($3,135,000)
Subtotal				$66,865,000
Trust Fund Appropriation:				
Base /1	$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
Consolidated Appropriations Act, '24 (PL 118-42)	$0	$0	$0	$27,750,000
Sequestration	$0	$0	$0	($1,688,625)
Subtotal	$4,550,070,000	$3,326,690,000	$4,124,744,000	$4,180,430,375
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
Working Families Tax Cut Act, '25 (PL 119-37)	$0	$0	$0	$200,000,000
Sequestration	$0	$0	$0	($2,907,000)
Subtotal				$248,093,000
Trust Fund Appropriation:				
Base /1	$4,329,000,000	$3,909,690,000	$4,194,744,000	$4,124,744,000
HHS Secretary's Transfer Authority	$0	$0	$0	($2,600,000)
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
American Relief Act, '25 (PL 118-158)	$0	$0	$0	$5,780,000
Full Year Continuing Approps and Extensions Act, '25 (PL 119-4)	$0	$0	$0	$10,500,000
Sequestration	$0	$0	$0	($1,688,625)
Subtotal	$4,329,000,000	$3,909,690,000	$4,194,744,000	$4,166,360,375

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2026				
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
Working Families Tax Cut Law (PL 119-21)	$0	$0	$0	$410,000,000
Consolidated Appropriations Act, '26 (PL 119-75)	$0	$0	$0	$333,500,000
Sequestration	$0	$0	$0	($2,907,000)
Subtotal				$791,593,000
Trust Fund Appropriation:				
Base **/1**	$3,464,391,000	$3,929,391,000	$4,124,744,000	$4,124,744,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$2,000,000
Bipartisan Budget Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Consolidated Appropriations Act, '21 (PL 116-260)	$0	$0	$0	$12,000,000
Continuing Appropriations Act, '26 (PL 119-37)	$0	$0	$0	$20,313,699
Consolidated Appropriations Act, '26 (PL 119-75)	$0	$0	$0	$34,400,000
Sequestration	$0	$0	$0	($1,083,000)
Subtotal	$3,464,391,000	$3,929,391,000	$4,124,744,000	$4,197,374,699
2027				
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
Working Families Tax Cut Law (PL 119-21)	$0	$0	$0	$12,000,000
Consolidated Appropriations Act, '26 (PL 119-37)	$0	$0	$0	$1,000,000
Sequestration	$0	$0	$0	($3,648,000)
Subtotal				$60,352,000
Trust Fund Appropriation:				
Base **/3**	$3,700,493,000	$0	$0	N/A
PAMA/SGR (PL 113-93)	$0	$0	$0	$2,000,000
Bipartisan Budget Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Consolidated Appropriations Act, '21 (PL 116-260)	$0	$0	$0	$12,000,000
Consolidated Appropriations Act, '26 (PL 119-37)	$0	$0	$0	$15,100,000
Sequestration	$0	$0	$0	($1,943,700)
Subtotal	$3,700,493,000	$0	$0	$32,156,300

/1 Base appropriation includes $305 million through FY 2021, $355 million in FY 2022, and $455 million beginning in FY 2023 to support Program Management activity related to the Medicare Program.
/2 The FY 2021 Enacted level for Sections 9402 and 9818 of the American Rescue Plan Act reflects the funding transferred from CMS to the Centers for Disease Control and Prevention (CDC).
/3 The FY 2027 Budget assumes the planned HHS Reorganization, which includes HRSA's Office of Pharmacy Affairs residing in CMS Program Management.

This page intentionally left blank.

Program Administration
(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Discretionary Budget Authority[1]	$3,699,647	$3,699,647	$3,213,493	($486,155)
Program Operations[2]	*$2,838,460*	*$2,492,061*	*$2,461,378*	*($30,683)*
Federal Administration	*$843,533*	*$772,533*	*$734,061*	*($38,472)*
Research	*$17,654*	*$20,054*	*$18,054*	*($2,000)*
Medicare Operations General Provision[3]	*	*$415,000*	-	*($415,000)*

Medicare Authorizing Legislation – Social Security Act, Title XVIII and the Medicare Prescription Drug Improvement and Modernization Act of 2003

Medicaid Authorizing Legislation – Social Security Act, Title XIX

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 2026 Authorization – One-Year/Multi-Year Public Law 119-75

Allocation Method – Contracts, Competitive Grants, Cooperative Agreements

Overview

The **Make America Healthy Again initiative**, led by HHS Secretary Robert F. Kennedy Jr., involves restructuring CMS to streamline operations, maximize taxpayer value, and improve health care outcomes through person-focused, efficient, and evidence-based health policies. The Agency is prioritizing process improvements across the health care continuum to enhance patient care, with the expectation that state governments, private insurers, and health care providers will follow CMS leadership in delivering high-quality, value-based care.

Optimizing Care Delivery: A Framework for Improving the Health Care Experience is CMS' five-year strategic framework designed to transform health care delivery by reducing administrative burdens and system inefficiencies. The framework focuses on technology integration through secure electronic health records, e-prescribing capabilities, integrated data repositories, and meaningful use of electronic records to enhance patient care quality. CMS recognizes that administrative burden limits patient access to timely care, reduces clinician time with patients,

[1] Program Operations, Federal Administration, and Research are distinct project, programs, and activities for FY 2026 only, but displayed for FY 2025 and FY 2027 for comparison.
[2] The FY 2027 Budget assumes the planned HHS Reorganization, which includes HRSA's Office of Pharmacy Affairs residing in CMS Program Management. This display comparably adjusts FY 2025 and FY 2026 columns to the FY 2027 Budget policy.
[3] FY 2025 includes $455 million from the Medicare Operations general provision from the FY 2025 continuing resolution, Public Law 119-4. In FY 2025, CMS allocated $370 million to Program Operations, $45 million to Federal Administration, and $40 million to Survey & Certification.

and negatively impacts health care workforce well-being. Through this comprehensive framework, CMS is advancing health care system efficiency and improving both the delivery and receipt of health care services.

CMS is building critical digital infrastructure to meet its own core operational responsibilities as the nation's largest health care payer, while deliberately designing that infrastructure to function as common rails that the broader health care ecosystem can rely on. CMS envisions a health care enterprise that operates seamlessly and equitably to improve patients' lives and support safe, high-quality care. **The Health Technology Ecosystem initiative** reflects the reality that CMS must modernize how it manages data security, provides information, and data exchange across programs, challenges that also drive fragmentation, limited data sharing, and lowers administrative burden across the market. By investing in shared services, uniform standards, and authoritative sources of provider and trust data, CMS is reducing duplication internally and enabling payers, providers, and technology partners to align around the same infrastructure. Customer engagement through interviews and Requests for Information ensures these capabilities are built using human-centered design and informed directly by those who must implement them. The result is a more connected, transparent, and efficient digital health ecosystem that strengthens CMS operations, lowers administrative burden across the market, and returns decision making to beneficiaries while rebuilding the foundation of the national health system.

Original Medicare claims processing systems process $460 billion of claims annually through mainframes using 1970s-era COBOL code. This aging, batch-oriented architecture is brittle and limiting. It cannot provide real time fraud prevention, requires 7-12 month release cycles to implement policy updates, provides little transparency to stakeholders, and limits timely analytics and interoperability. Additionally, as COBOL skills become scarce, the operational risk of outages and cyber security exposure grows. To strengthen stewardship of taxpayer dollars and secure the Medicare Trust Fund, CMS is advancing a best-in-class commercial claims processing effort, **ClaimsCore**, that will re-platform Original Medicare claims processing onto a secure, configurable, and modern foundation. CMS estimates it will save millions through this work, not including the additional billions that may be saved through improved program integrity. ClaimsCore is designed to support modern payment integrity controls, faster and more transparent policy execution, and advanced capabilities such as AI, while improving operational efficiency and care delivery over time.

CMS is also exploring the Modernization of Medicaid Systems and tools for States to support enhanced payment integrity controls, faster and more transparent policy execution, and advanced capabilities to improve operational efficiency and care delivery over time.

Medicaid operates through a complex and fragmented, state-based claims processing and beneficiary management environment that relies on aging and highly customized systems. These legacy platforms are costly to maintain, difficult to modernize, and often lack the flexibility needed to support evolving delivery models and program integrity efforts. Critically, they do not allow for real-time visibility into activity at the Federal level. Fragmented data and limited interoperability across each State and managed care organizations constrain oversight and slow claims adjudication. As part of CMS' ongoing efforts to combat fraud, waste, and abuse in Medicaid, the Budget provides CMS with $25 million to explore investing in a scalable and modernized Medicaid system and tools to support State systems with the goal of improving transparency in and access to Medicaid data; enhancing administrative efficiency; and serving as a critical capability in supporting States in managing fraud, waste, and abuse.

CMS also offers an operational solution to complement the IT modernization efforts presented above. Historically, CMS operated under four Program, Project, or Activity (PPA) lines that separated federal staff funding from program contract funding. This, in part, is driving the need to outsource work resulting in a 6:1 contractor-to-federal staff ratio which is substantially higher than other federal agencies. CMS requests to consolidate Program Operations, Federal Administration, and Research into a single **Program Administration PPA**, enabling more efficient operations and strategic business decisions. CMS can further reduce costs by prudently utilizing the workforce and resources to accomplish tasks and projects rather than outsourcing them to external vendors or contractors. CMS will shift its strategy from hiring overly expensive vendors to retraining and upgrading its workforce and recruiting skilled employees to meet evolving needs and achieve CMS' goals.

PPA consolidation provides cost savings, secures in-house knowledge and continuity, enables flexibility to respond to emerging priorities, and enhances accountability. The consolidation ensures administrative funding structure does not restrict business function, providing CMS with the flexibility to make strategic hiring decisions that best serve the Agency's mission.

Program Descriptions

The Agency has a broad set of responsibilities, all heavily reliant on the Program Administration budget, including setting health and safety standards for providers, overseeing compliance, and developing policies for benefits and payments. CMS also plays a crucial role in enforcing consumer protection and addressing fraud and abuse[4] within the health care system. Some of CMS' main responsibilities include:

- Administering the nation's major health care programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and Health Insurance Exchanges.
- Collecting and analyzing data, producing research reports, and working to eliminate instances of fraud and abuse within the health care system.
- Ensuring the most vulnerable populations receive the highest-value, appropriate care from leading payers and supporting providers.

Medicare

Authorized in 1965 under title XVIII of the Social Security Act, Medicare offers hospital and medical insurance to Americans aged 65+, disabled persons, and those with End Stage Renal Disease. It expanded in 2006 with Part D, a prescription drug benefit. Enrollment grew from 21 million in 1966 to a projected 72 million in FY 2027. Medicare benefits are permanently authorized, while administrative expenses are funded annually through CMS Program Management.

Medicaid and CHIP

Medicaid and CHIP, established under titles XIX and XXI of the Social Security Act, are means-tested health care entitlement programs funded by states and the federal government. CMS expects 87.4 million Americans to be enrolled in these programs by FY 2027. They provide coverage for vulnerable populations like low-income children, pregnant women, certain elderly individuals, and disabled individuals. This Congressional Justification discusses funding for

[4] Please refer to the Health Care Fraud and Abuse Control narrative.

associated federal administrative costs such as system support, managed care review, demonstration management, and other program-related initiatives.

Private Health Insurance Protections and Programs

CMS has significant oversight responsibilities for private health insurance, particularly for Qualified Health Plans (QHPs) and the Health Insurance Exchanges. CMS ensures compliance, enforces standards, and provides consumers with information about health coverage. The Health Insurance Exchanges were established under the Patient Protection and Affordable Care Act in 2010 as a place for consumers to purchase private health insurance coverage. CMS operates the Federally Facilitated Exchanges (FFEs) for states that do not operate their own State Based Exchanges (SBEs). SBEs can work with CMS to use federal platforms for certain activities such as enrollment. CMS oversees the review and certification of the majority of QHPs on the FFE, the implementation of Exchange eligibility and enrollment rules, including eligibility for financial assistance, and tracks and evaluates private health insurance market stability.

Funding History[5]

Fiscal Year	Amount
FY 2023	$2,914,823,000
FY 2024	$2,913,823,000
FY 2025 Final[6]	$3,699,647,000
FY 2026 Enacted	$3,699,647,000
FY 2027 President's Budget	$3,213,493,000

Budget Request: $3,213.5 Million

The 2027 budget request is $486.2 million below the comparable FY 2026 Enacted Level. The request aligns programmatic scope with CMS Administration priorities including funding for enrollment growth, increasing workload demands, while continuing base operations for statutorily mandated programs, and includes funding for HRSA's 340B drug pricing program. Ongoing operational efficiencies will be achieved through eliminating procedural duplication, procurement consolidation, accelerating technology modernization, a focus on providing the highest quality care for beneficiaries, and prioritizing administrative effort for statutory mandates. CMS continues to assess its federal contract footprint with the goal of insourcing expertise for many critical business functions.

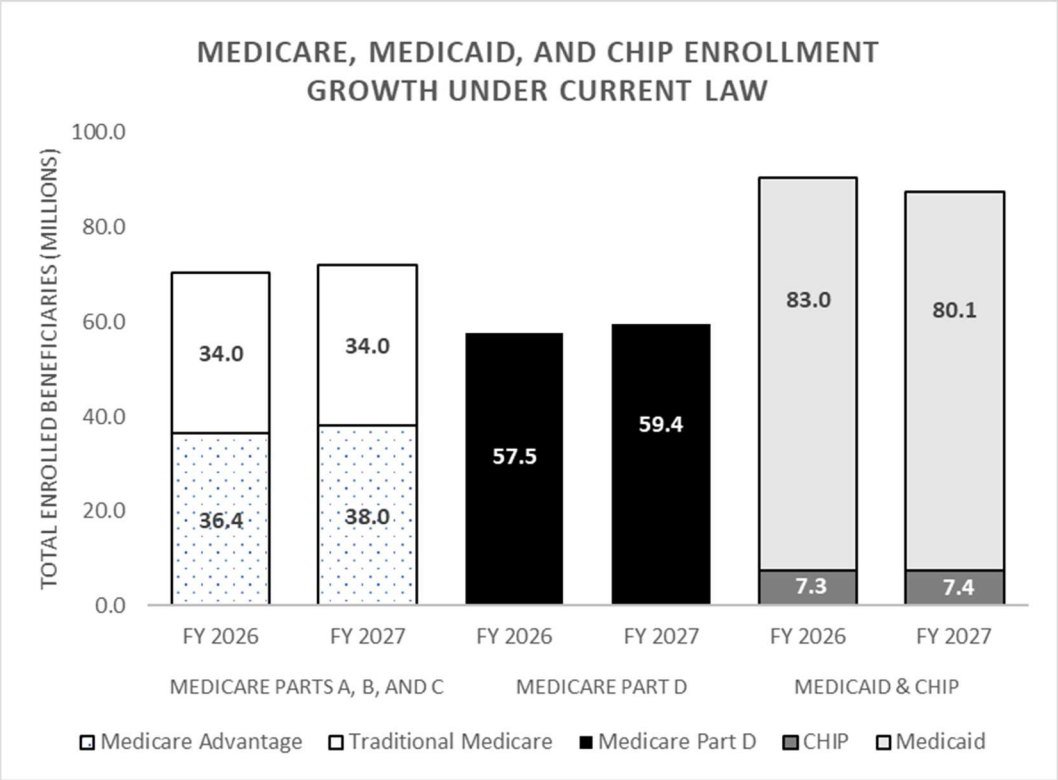
CMS' administrative budget totaled $12.0 billion in FY 2025 in Program Level funding, which represents 0.61% of $1.96 trillion in obligations that the Agency oversees. Program Administration's discretionary request accounts for one-fourth of the total Agency total operating budget. The President's Budget is critical to execute CMS' mission while maintaining customer service levels, business operations, employee productivity, and avoiding disruption to health care delivery.

[5] The FY 2027 budget request total reflects merging the Program Operations, Federal Administration, and Research accounts into a single Program Administration account.
[6] Consistent with the FY 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA in FY 2025 and includes comparable budget authority resulting from planned DHHS Reorganization.

Enrollment Status

As the population of 65+ grows, health care administration responsibilities are increasing in Medicare. Medicare enrollment is projected to rise by 2.3 percent from FY 2026 to FY 2027, with more beneficiaries opting for Part C plans. CMS actuaries project Medicaid enrollment will decrease by 3.5 percent and CHIP enrollment will increase by 0.2 percent from FY 2026 to FY 2027. Medicare, Medicaid, and CHIP enrollment are affected by health care policy changes, economic conditions, and enrollment provisions.

The beneficiary population is projected to be 164 million in FY 2027.[7]



[7] Includes Employer Subsidy Part D enrollment.

Program Administration
(Dollars in Thousands)

	FY 2025 Final[8]	FY 2026 Enacted	FY 2027 President's Budget
Program Administration Request	**$3,699,647**	**$3,699,647**	**$3,213,493**
I. Medicare Parts A&B			
MAC Operations	$630,041	$653,214	$620,183
Parts A/B Operational Support	$42,525	$48,941	$50,665
Parts A/B Claims Processing	$77,115	$77,550	$79,899
DME/B Competitive Bidding	$1,051	$20,876	$9,234
Parts A/B Appeals	$55,308	$60,450	$51,500
II. Medicare Parts C&D			
Parts C/D Oversight & Management	$72,070	$80,079	$73,096
Parts C/D Appeals	$39,130	$47,999	$38,671
III. Medicaid & CHIP Operations	**$134,161**	**$143,957**	**$154,611**
IV. Private Health Insurance			
Market Oversight and Support	$14,840	$16,841	$11,551
Exchanges	$88,567	$84,147	-
V. Outreach & Education			
National Medicare Education Program	$405,173	$361,847	$385,800
Tribal Outreach & Enrollment	$2,713	$3,097	$3,000
VI. Value-Based Care Initiatives	**$102,924**	**$102,763**	**$90,000**
VII. Enterprise Operations			
Accounting and Audits	$92,474	$97,503	$97,403
HIPAA Administrative Simplification	$31,393	$46,127	$27,426
IT Systems and Support	$860,804	$919,444	$657,058
Enterprise Operational Support	$144,724	$129,097	$89,305
Opioid Support Services	$873	$891	$1,471
Research, Demonstrations, and Evaluation	$17,635	$20,054	$18,054
VIII. Federal Administration[9]			
Compensation & Benefits	$604,859	$606,591	$606,998
Operating Expense	$230,906	$165,942	$127,063
IX. HRSA/340B Reorganization[10]	**$12,238**	**$12,238**	**$20,505**

[8] The FY 2025 total includes prior year contract adjustments ($35.5 million) and Secretary's transfer to HHS-Office of Inspector General for information blocking ($2.6 million) not shown at the activity level.

[9] Displays discretionary only; the Federal Administration program level also includes indirect cost pool funding.

[10] The FY 2027 Budget assumes the planned HHS Reorganization, which includes the HRSA 340B program. This display comparably adjusts FY 2025 to the FY 2027 Budget policy.

I. MEDICARE - PARTS A AND B

Original Medicare is a health insurance program that pays doctors, hospitals, and other health care providers a fee for each service they provide to Medicare beneficiaries. It includes Part A (hospital insurance) and Part B (medical insurance). The program's business functions are carried out by CMS, the **Medicare Administrative Contractors** (MACs), and a network of specialized contractors. The delineation of mission critical tasks optimizes the model for cost and operational effectiveness.

CMS business operations described below support all Medicare programs such as provider enrollment, independent appeal review, and integrated data management/validation support. Beneficiary claims are processed through the MACs, which are the primary CMS contractors for managing Original Medicare and are mission critical for the success of CMS operations.

MAC Operations

MACs are private health care insurers split by geographical jurisdictions to process Part A and B medical claims, and durable medical equipment claims for Original 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).

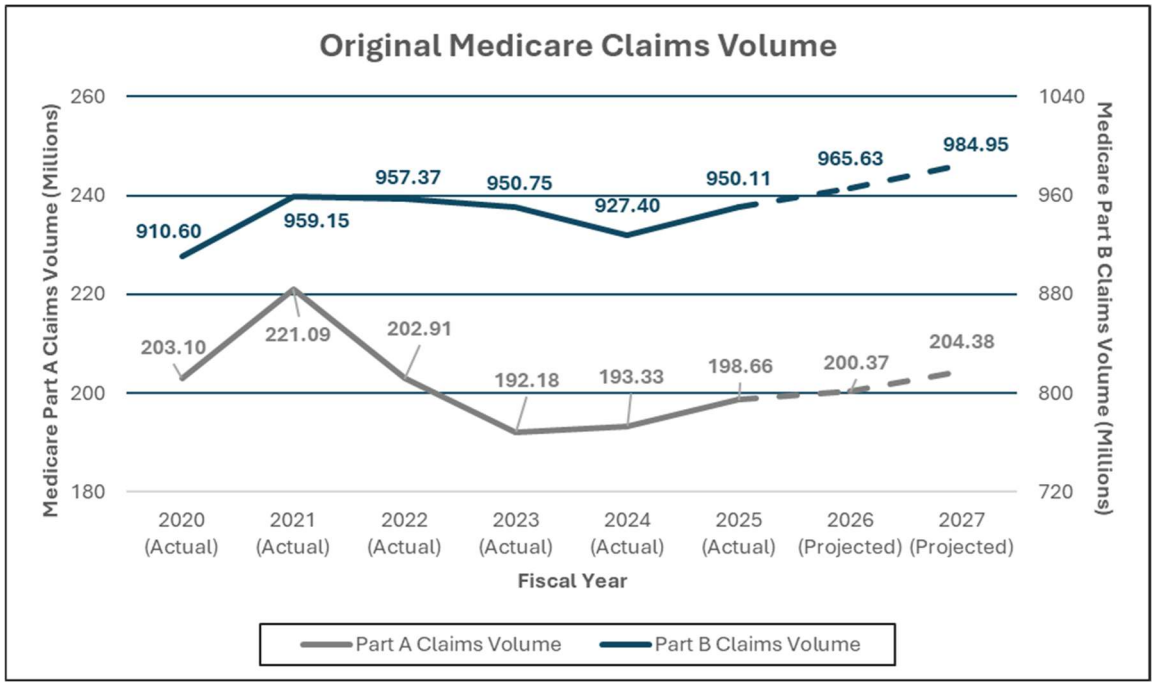
The MACs play a crucial role in ensuring the coordination of benefits within each jurisdiction and continuity of claims payment for providers. During disruption events, such as the Change Health care cyberattack, the CHOPD Accelerated and Advanced Payment Program allowed eligible providers and suppliers the option of interim payment options to alleviate cash flow strain from claim payment delays. These payments were managed by MACs, which concluded on July 12, 2024.

Budget Request: $620.2 Million

The budget request is a $33.0 million reduction below the FY 2026 Enacted Level, which assumes reduced Medicare Summary Notice (MSN) mailings in FY 2027. The discretionary request level assumes $45.0 million from penalty mail funding sources to cover MSN postage costs. The budget reflects the efficiency gained by descoping non-statutory workload and optimizing the level of effort.

Funding supports statutorily required MAC operations including:

- **Claims Processing:** MACs handle the review and payment of Original Medicare claims. Upon receipt, the MAC verifies that claims meet Medicare's coverage requirements and that the services provided are accurately coded. CMS expects the MACs to process 1.2 billion claims in FY 2027. Historical and projected claim workloads are shown in the table on the next page.



- **Appeals:** The MACs perform the first level of appeal, known as redeterminations, and are required to process the request within 60 days of receiving the Redetermination Request Form (CMS-20027). This process affords beneficiaries, providers, and suppliers the opportunity to dispute an adverse determination, including coverage and payment decisions[11] and is essential to maintain provider participation in Medicare. CMS anticipates processing 2.4 million redeterminations in FY 2027.

- **Provider/Supplier Services:** The MACs offer a range of services to health care providers, primarily focused on processing claims, managing payments, and ensuring compliance with Medicare rules. Critical services include but are not limited to provider enrollment, compliance monitoring for enrolled health care providers **PARDOC**, and addressing provider inquiries.

    - 1.7 million enrollment actions including new applications, status changes, and revalidations.
    - CMS issues approximately 500 change requests each year to ensure appropriate billing and processing, policies and procedures, new initiatives, and significant changes to Medicare.
    - Oversee and support for approximately 2.2 million total physicians, limited license physicians, non-physician practitioners and 35.2 thousand suppliers participating in Medicare.

- **Provider Contact Centers (PCC):** The MACs plan to answer over 10 million provider toll-free telephone inquiries based on historical trends. Costs for the PCC are primarily driven by the duration of each call. Approximately 46% of calls are handled through

[11] If the redetermination is unfavorable, appellants can proceed to higher levels of appeal within HHS, including a reconsideration by a Qualified Independent Contractor (QIC), a hearing before an Administrative Law Judge (ALJ), and potentially a review by the Departmental Appeals Board (DAB). Appeal progression is discussed further in the "QIC Operations" section of the chapter.

interactive voice response (IVR) systems. This increased use of automation frees up customer service representatives to handle more complex questions. PCC workloads are illustrated in the following table.

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

	FY 2023 Actual	FY 2024 Actual	FY 2025 Actual	FY 2026 Estimate	FY 2027 Estimate
Completed Calls	12.2	11.9	10.8	11.0	11.0
Written Inquiries	0.3	0.3	0.3	0.3	0.3
IVR (% Completed)	45%	46%	45%	45%	45%

- **Outreach and Education:** Medicare Learning Network® (MLN) serves as the official source of information for Original Medicare. CMS and the MACs are required to use MLN products to promote consistent outreach messaging. The request provides a wide range of materials, including publications, web-based training, and other educational products, to help providers understand Medicare policies, procedures, and compliance requirements. MLN aids providers in their billing, coding, and documentation practices, assisting them in preventing errors and ensuring prompt payments.

Parts A and B Operational Support

As the government Agency responsible for delivering the Original Medicare program, CMS is ultimately responsible to the beneficiaries and the public for its successful operations. CMS determines policy, establishes rules, allocates business functions to a variety of contractors, oversees contract execution, and provides funds both for administering the Original Medicare environment and paying providers for health care delivery. These activities create the foundation for Medicare administration and other statutorily mandated requirements across the organization.

CMS leverages Original Medicare business applications and operational responsibilities to benefit all Medicare stakeholders as permissible by law. Utilizing data, contract and system function, and synergistic business requirements for legislatively mandated CMS activities may present the opportunity for future operational efficiency gain. Through streamlining operations, bridging data and programs, informatics development, and modernizing health IT infrastructure, the Agency aims to reduce health care administrative burden leaving more time for patient care and improved outcomes.

Budget Request: $50.7 Million

The budget request is an increase of $1.7 million above the FY 2026 Enacted Level. The discretionary request level assumes $24.4 million from penalty mail funding sources to cover Medicare Premium Billing postage cost. CMS will sustain current planning baseline operations at the request level while continuing to assess leveraging existing staff capacity to support annual policy updates. The strategy involves transitioning annual rulemaking and data analytics tasks from external contractors to internal CMS staff, which are requested in the Federal Administration section. Funding supports statutorily required operations as described below.

CMS manages a comprehensive health care financing framework through the Medicare Physician Fee Schedule and Prospective Payment Systems, requiring annual updates in regulation. The request also supports analytics to identify and test alternative data sources to support the development of Medicare payment rates. The Agency processes approximately 200,000 new beneficiaries monthly, maintaining the Eligibility Enrollment Medicare Online (ELMO) Database as the authoritative source for Medicare enrollment information and handling premium billing.

CMS' operational infrastructure includes robust internal control systems (covering over 900 controls across operations, contractors, regional offices, and IT systems) and three key administrative IT systems including MAC/CMS Data Exchange Portal (MDX), Production Performance Monitoring System (PULSE), Enterprise Electronic Change Information Management Portal (eChimp), and the Common Electronic Data Interchange (CEDI). These systems work together to manage contractors, implement system changes, and standardize claims submission processes.

Additionally, the budget supports expanding telehealth and home infusion therapy for Medicare and hospice beneficiaries and the continuation of critical protective beneficiary services through the Medicare Beneficiary Ombudsman, Competitive Acquisition Ombudsman, and Pharmaceutical and Technology Ombudsman, which handle inquiries, complaints, and appeals. As the health care needs of the aging population continue to evolve, it is critical to meet the needs of seniors while also protecting them from harm.

Parts A and B Claims Processing

CMS operates several fragmented and outdated claim adjudication systems which were first deployed in the 1970's to process Medicare claims. These systems are designed to validate claims, determine coverage, apply payment rules, prevent fraud, waste, and abuse, and issue payments to health care providers. The CMS-owned and developed shared systems adjudicate approximately 1.2 billion Part A, Part B, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims each year, representing more than $460 billion in annual benefit payments. This claims infrastructure is the operational backbone of Original Medicare and is essential to ensuring accuracy, continuity, and responsible stewardship of taxpayer dollars.

The primary Original Medicare claims processing systems that will be replaced and consolidated include:

- 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 DMEPOS Part B services.
- ViPS Medicare System (VMS): VMS is used to process claims for DMEPOS.
- Common Working File (CWF): CWF serves as Medicare's benefit coordination and claim validation system that verifies beneficiary eligibility, entitlement, and utilization.

These expensive and outdated systems are estimated to cost more than $319 million per year to operate and maintain and result in inconsistent processes across CMS and MACs. The fragmented architecture and continued reliance on obsolete technology create a compounding burden: it is costly to maintain, difficult to update, and challenging to scale as

policy, operational demands, and external threats evolve. Presented in the introduction section, and in more detail within the IT Systems and Support section of this request, ClaimsCore will replace Original Medicare claims processing by replacing legacy "Shared Systems" including MCS, FISS, VMS, and CWF, with a more flexible, cost effective, interoperable, and secure platform. This is a foundational investment in the nation's Medicare payment infrastructure. It will strengthen payment accuracy and integrity, improve CMS and MAC operational efficiency, increase transparency for beneficiaries and providers, and restore policy agility so CMS can implement changes more rapidly, consistently, and safely in response to emerging needs.

Budget Request: $79.9 Million

The budget request is an increase of $2.3 million above the FY 2026 Enacted Level. This funding level is consistent with historical ongoing operations and maintenance costs. The increase supports sustainability modernization for current Original Medicare pay and supporting systems.

DMEPOS Competitive Bidding Program (CBP)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required Medicare to replace the fee schedule payment methodology for selected DMEPOS items with a competitive bidding program implemented in specific geographical areas throughout the country. The DMEPOS CBP helps Medicare establish sustainable prices, saves money for beneficiaries and taxpayers, and limits fraud, waste, and abuse in the Medicare program. In addition to the cost savings, there are several beneficiary protections that help to guarantee access to competitively bid DMEPOS including requiring contract suppliers to provide equal access to all DMEPOS items and services included in the supplier contract to every beneficiary residing in the competitive bidding area.

First launched in 2011 in nine metropolitan statistical areas and since expanded to 130 competitive bidding areas, Medicare has saved an estimated $11 billion from lower payment for 16 categories of DMEPOS items and services, with beneficiaries saving from lower cost sharing. In addition to the savings obtained in the competitive bidding areas, adjustments made to fee schedule amounts paid in non-competitive bidding areas based on pricing from the DMEPOS CBP has approximately doubled these savings. Payment has generally declined 40 percent compared to the traditional fee schedule methodology.

The most recent Round 2021 DMEPOS CBP contracts expired on December 31, 2023. As of January 1, 2024, there is a temporary gap period for the DMEPOS CBP. CMS will start bidding for the next round of the DMEPOS CBP after:

- Re-engineering and migrating the IT systems located within the Competitive Bidding Implementation Contractor’s IT environment into the CMS Cloud environment
- Completing the formal public notice and comment rulemaking process (in process)
- Implementing necessary DMEPOS CBP changes to:
    - Establish sustainable prices
    - Save money for Medicare beneficiaries and taxpayers
    - Help limit fraud, waste, and abuse in the Medicare Program
    - Ensure beneficiary access to quality items and services

Budget Request: $9.2 Million

The budget request is a reduction of $11.6 million below the FY 2026 Enacted Level. The budget request assumes planned FY 2026 programmatic restart activities, as described in the FY 2026 President's Budget, will be successfully completed. This request supports bidder registration, the bidding process, bid evaluation, and contracting activities to perform the Round 2028 restart. Maintaining adequate funding for DMECB is critical to successfully launch Round 2028, which is currently scheduled to begin on January 1, 2028.

Parts A and B 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, or "reconsiderations", resulting from an adverse redetermination of a claim by a MAC during the first level of appeal. BIPA requires Parts A and B claim appeal processing within 60 calendar days of receipt of the request. If a QIC is unable to complete the appeal within the 60-day timeframe, then it must notify the appellant and offer the appellant an opportunity to escalate the appeal to an Administrative Law Judge (ALJ) at the Office of Medicare Hearings and Appeals (OMHA).

Budget Request: $51.5 Million

The budget request is a reduction of $9.0 million below the FY 2026 Enacted Level. Funding supports QIC appeal processing costs as well as operations and maintenance for the Medicare Appeals System (MAS), CMS' system of record for Medicare appeals. CMS projects the need to process over 200,000 appeals (non-Recovery Audit Contractor (RAC) related) within the statutorily mandated 60-day timeframe.[12] Projections rely on historic workload; however, the appeals workload is variable by nature.

QIC A/B appeals reconsideration workload history and projections[13] are presented in the following table:

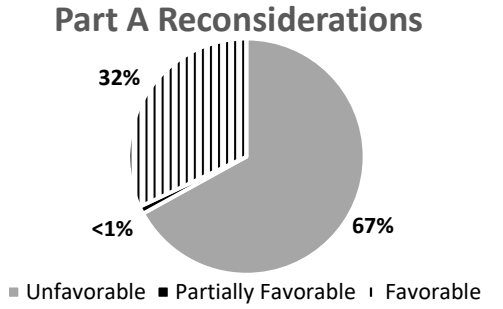
QIC Appeals Workload
(Volume in Appeals)

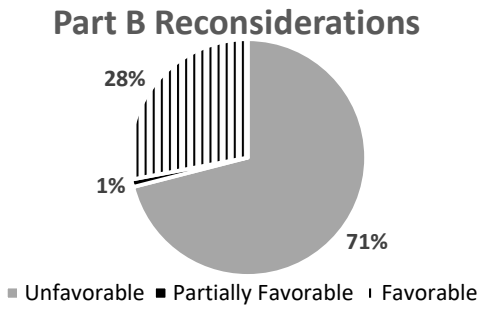
	FY 2023 Actual	FY 2024 Actual	FY 2025 Actual	FY 2026 Estimate	FY 2027 Estimate
Non-RAC QIC Appeals	199,978	203,587	203,857	203,208	203,128
% Increase from Previous Year	12.40%	1.80%	0.13%	-0.32%	-0.04%

The following charts illustrate claim dispositions (i.e., outcomes) for Medicare appeals processed by the QIC contractors in CY 2024.[14] "Favorable" disposition means the reconsideration decision sided with the appellant (health provider or beneficiary). If the QIC

[12] Section 1869(c) of the Social Security Act
[13] The FY 2026 and FY 2027 appeals (cases) projections were formulated based upon Original Medicare enrollment growth projections from CMS' Office of the Actuary. As in previous years, CMS will continue to review and analyze workload trends and adjust as necessary.
[14] Data sourced from the publicly available CY 2024 Original Medicare Appeals Fact Sheet and include claims originating from both non-RAC reviews and RAC reviews.

upholds the denial, the appellant is allowed an independent review at the Office of Medicare Hearings and Appeals (OMHA), the 3rd level in the appeals process.





II. MEDICARE – PARTS C AND D

Beneficiary options include choosing Medicare coverage offered by private health insurance companies through CMS-approved Medicare Advantage (MA or Part C) and Medicare prescription drug (Part D) plans. CMS has oversight and administrative responsibilities to ensure quality health care and service delivery for beneficiaries enrolled in these plans. Program administration includes, but is not limited to, reviewing formularies and benefits, plan bid management, value-based programs such as Star Ratings, public reporting of quality measures, regulatory oversight, data collection, and technical assistance. CMS continually updates these programs through rulemaking and annual guidance to improve beneficiary experience, promote quality of care, and enhance patient protection.

Oversight and Management

CMS is responsible for developing policies, maintaining critical systems for operations, and conducting oversight and auditing activities to run the Part C and Part D programs, which include MA plans, prescription drug plans, Special Needs Plans (SNPs), 1876 Cost Plans, and Program of All Inclusive Care for the Elderly (PACE) organizations. CMS performs a variety of functions to administer these programs including obtaining actuarial estimates, reviewing bids from the prescription drug and MA 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 low-income beneficiaries. CMS expects continued growth in this work due to increases in enrollment in the Part C and Part D programs and the statutory expanded eligibility for full benefits under the low-income subsidy program (LIS). Nearly 300,000 low-income Medicare beneficiaries are newly enrolled in LIS each year and receive expanded benefits, such as no deductible, no premium, and fixed or lower copayments for most medications.

Activities described in this section support the MA (Part C) and Prescription Drug (Part D) Annual Proposed and Final Rules, Advance Notice, and Rate Announcement, including technical assistance, sub-regulatory support, and the triage of public comments received in response to annually required rulemaking and payment and policy updates.

Budget Request: $73.1 Million

The budget request is a decrease of $7.0 million below the FY 2026 Enacted Level. The discretionary request level assumes $4.3 million from penalty mail funding sources to cover Part D plan reassignment notices for LIS beneficiaries. CMS has undertaken steps to reduce costs, streamline operations, and reduce redundancies, including reduced operational funding needs by terminating work supporting rescinded Executive Orders, descoping unmandated workloads, and reducing frequency for some workstreams (certain surveys and data collection).

Funding supports the following business critical requirements described below:

- Enrollment Operations and Policy Support: Collecting beneficiary demographic and entitlement information is a long-standing CMS practice. This is critical for general operational support, understanding of the Medicare population, and for targeting populations that qualify for special needs/subsidized plans as mandated by law. The Medicare Beneficiary Database Suite of Services (MBDSS), for example, stores LIS beneficiary status. It also derives Part D eligibility periods, processes state files, and assigns LIS beneficiaries to a Part D drug plan. In FY 2027, CMS expects:

    - An estimated 3% cost increase to produce and mail LIS annual notices, including up to 1.55 million for changes in copayment; 206,000 for plan assignment; 2.75 million for plan reassignments due to plan termination or premium increase; and as many as 3.1 million beneficiaries to receive the annual fall 'Chooser' notice, which informs impacted beneficiaries of what their plan premium will be the following year and that they will have to pay a portion of the premium each month unless they switch into a new plan by December 31.

- Plan Management System Operation and Maintenance: Ongoing administration support systems such as MARx (Medicare Advantage Prescription Drug System), PRS (Payment Reconciliation System), and RAS (Risk Adjustment System) provide mission critical infrastructure for administering the MA program, ensuring accurate payments to plans and appropriate coverage for beneficiaries. Other operational workloads are largely driven by external influences such as beneficiary decision making, health plan action, policy changes, and organizational direction.

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 reconsiderations (second level of appeal) of adverse organization payment and coverage determinations and redeterminations issued by private Medicare Part C and Part D health plans. Additionally, the IRE conducts reconsiderations of coverage denials made by PACE organizations. The IRE also conducts reconsiderations of late enrollment penalties (LEP). All CMS second level reviews/appeals are done by the IRE.

Budget Request: $38.7 Million

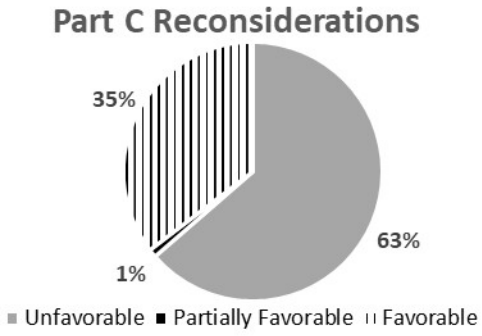
The budget request is a decrease of $9.3 million below the FY 2026 Enacted Level. CMS anticipates continued enrollment growth in the number of new beneficiaries choosing Part C and D plans. Higher plan enrollment drives higher Part C and D payment requests, subject to associated plan utilization management strategies that drive increases in second level appeals.

Under current law, approximately 80 percent of the FY 2027 estimated workloads will be adjudicated timely at the request level. CMS will explore opportunities to improve efficiency to keep pace with anticipated workload growth and maintain timely appeal adjudication.

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

	FY 2023 Actual	FY 2024 Actual	FY 2025 Actual	FY 2026 Estimate	FY 2027 Estimate
Part C Appeals	195,706	218,323	292,973	357,000	357,000
Part D Benefit Appeals	39,000	47,265	65,639	78,767	78,767
Part D LEP Appeals	42,938	43,495	55,969	65,000	65,000

The following chart illustrates claim dispositions (i.e., outcomes) for appeals processed in CY 2023.[15] "Favorable" disposition means the reconsideration decision side with the appellant (health provider or beneficiary).



III. MEDICAID AND CHIP

CMS serves as the operational and policy center for the formulation, coordination, and evaluation of all national program policies and operations relating to Medicaid, CHIP, and the Basic Health Program (BHP). This includes administering Medicaid policies for low-income children and adults, managing quality measurement and improvement work, and facilitating Tribal policy and outreach. Federal and state oversight of states' managed care programs and performance improves fiscal transparency and increases the provision of high-quality services to enrollees nationwide. Additionally, CMS monitors states' compliance with federal statutes and regulations in the administration of the Medicaid and CHIP programs.

Activities described in this section provide operational resources to:

- Partner with states to finance, implement, and certify state Medicaid Enterprise Systems as appropriate; collect, analyze, and report Transformed Medicaid Statistical Information System (T-MSIS) data; and operate digital services and support data management across programs.
- Perform financial management oversight activities, including targeted financial management reviews; review of state funding mechanisms and appropriateness of non-

[15] Data sourced from the publicly available CY 2023 Part C Appeals Fact Sheet.

federal sources of funding; developing financing policy; and making grant awards to states.
- Oversee and evaluate the design and implementation of state-led innovations in Medicaid via section 1115 demonstrations.

These efforts ensure effective and efficient operation of the Programs and enhance Federal/State partnership strategies to sustain and improve performance. Better programs ultimately result in the ability to meet beneficiary needs and provide high-quality care.

Modernizing Medicaid Claims Adjudication and Program Integrity

Medicaid operates through a complex and fragmented state-based claims processing and beneficiary management environment that relies on ageing and highly customized systems. These legacy platforms are costly to maintain, difficult to modernize, and often lack the flexibility needed to support evolving delivery models and program integrity efforts. Critically, they do not allow for real-time visibility into activity at the federal level. Fragmented data and limited interoperability across each state and managed care organizations constrain oversight and slow claims adjudication.

As part of CMS' ongoing efforts to combat fraud, waste, and abuse in Medicaid, the Budget provides CMS with $25 million to explore investing in a scalable and modernized Medicaid system and tools to support State systems with the goal of improving transparency in and access to Medicaid data; enhancing administrative efficiency; and serving as a critical capability in supporting States in managing fraud, waste, and abuse.

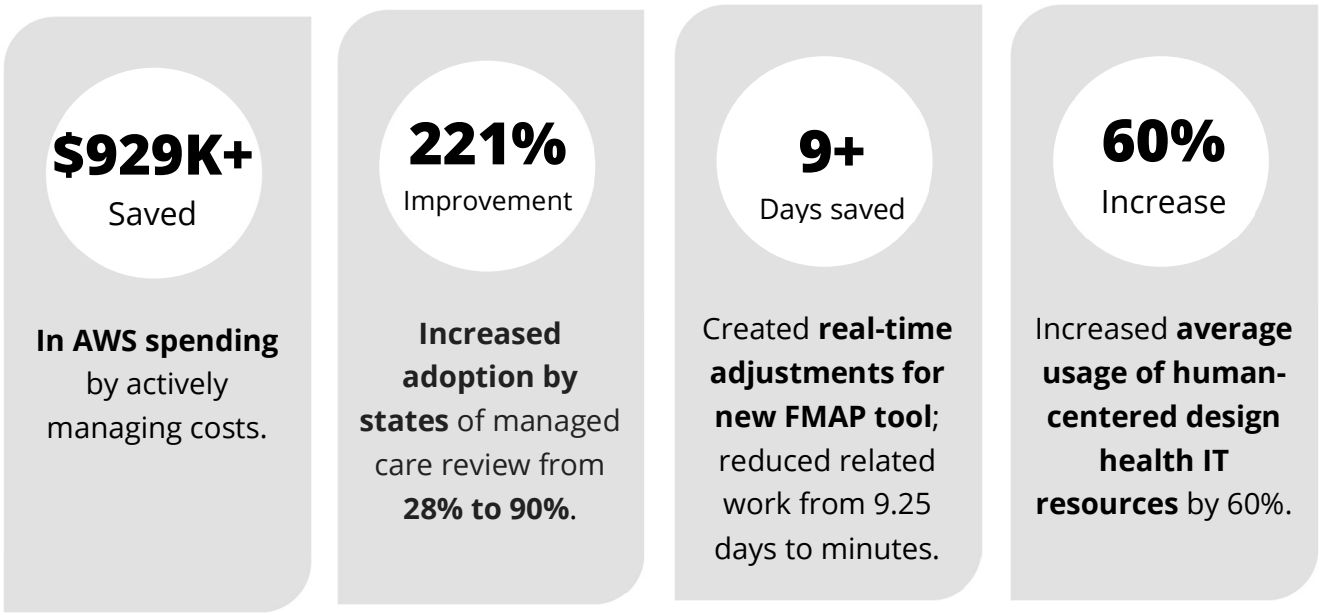
Budget Request: $154.6 Million

The budget request is an increase of $10.7 million above the FY 2026 Enacted Level. The largest portion of the Medicaid and CHIP budget request supports existing operations, systems, and tools that CMS uses to administer, oversee, and analyze the Medicaid and CHIP programs. In FY 2027, CMS plans to:

- Continue significant investment to expedite the transition from the out-of-date Medicaid Budget and Expenditure System (MBES) systems to the updated Medicaid and CHIP Financial (MACFin) System. Currently, CMS and states operate both systems, which require duplicate and manual data entry, resulting in budget and staffing inefficiencies, as well as financial, programmatic, and reputational risks.
- Increase investments in the Medicaid and CHIP Program (MACPro) Portal, the system used to execute state plan amendments (SPAs), which are contracts between the State Medicaid Agency and CMS concerning benefits and payment rates. Accepting, processing, and updating SPAs happens across several systems, requiring manual entry and disrupted workflows. Starting in FY 2026, CMS plans to initiate a multi-year initiative to consolidate the number of SPA processing systems, introduce streamlined workflows, and templates with structured data elements to enhance reporting and analysis.
- Invest in the tools CMS uses to ensure value and quality in Medicaid Managed Care. Over the next several years, CMS plans to develop a series of reporting templates and portals to further standardize the way states submit Managed Care data, develop internal and external facing dashboards and data analysis platforms to improve transparency and accountability, and build out CMS' monitoring and oversight procedures and capabilities.

- Continue to improve the quality, accessibility, and use of T-MSIS data. In addition to ongoing work to improve enrollment, encounter, and financial data, CMS anticipates exploring options to provide states with data when an individual is enrolled in more than one state.
- Refresh the outdated Performance Metrics Databases and Analytics (PMDA) system, which is used for Medicaid Section 1115 Demonstration reporting and monitoring. The new investment will build functionality to intake and analyze 1115 demonstration operational, financial, and programmatic data.

Overall, these investments reflect an effort to consolidate systems, create more efficient workflows, improve transparency and accountability, and increase access to data for decision-making, all geared toward ultimately improving outcomes for beneficiaries and the states that partner with CMS. The following infographic showcases the Medicaid and CHIP Business Information Solution (MACBIS) modernization successes and investment value returned over the past 2 years.[16]



The largest programmatic investments aim to ensure the right care, at the right time, in the right place, remove unnecessary burdens, root out Fraud, Waste, and Abuse in Medicaid and CHIP, and Make America Healthy Again.

In FY 2027, CMS anticipates:

- Refocusing and strengthening the Medicaid Section 1115 Demonstration innovation by maximizing efforts to support financial integrity. CMS anticipates prioritizing investments in 1115 budget neutrality policy and oversight, as well as monitoring and evaluation of demonstration financial and programmatic outcomes.
- Focusing program resources on a subset of key technical assistance and data reporting activities to meet core statutory requirements for the Adult Health Quality Measures Program.

[16] Amazon Web Services (AWS), Federal Medical Assistance Percentage (FMAP).

- Continuing, at a smaller scale, learning collaboratives and technical assistance activities focused on the highest priority topics, including chronic disease prevention, ensuring appropriate access to home and community-based services, and enrollment integrity.
- Ensuring the federal government is meeting its obligations to the tribes through the continued support of tribal consultation, training, and outreach.

IV. PRIVATE HEALTH INSURANCE

CMS plays a crucial role in the health insurance market, primarily by overseeing the Health Insurance Exchanges and enforcing regulations related to consumer protections. These protections aim to oversee market reforms, ensure continuous coverage, and promote transparency in health insurance to comply with the law. The Agency works closely with state regulators, consumers, and other stakeholders to ensure that the law best serves the American people.

Insurance Market Reform and Oversight

Market reform compliance, as statutorily required, ensures consumer protections such as prohibiting issuers from denying coverage for pre-existing conditions, prohibiting annual and lifetime dollar limits on essential health benefits, and certifying that health insurance issuers are complying with rating requirements. Insurance market reform oversight improves the health insurance system by promoting affordability, transparency, and accountability that promotes competition based on price and quality.

Budget: $11.6 Million

The budget request is a reduction of $5.3 million below the FY 2026 Enacted Level. Funding supports information standardization, conducting rate reviews, ensuring compliance with public reporting mandates, responding to inquiries, addressing complaints, and enforcing market conduct rules. CMS must perform market conduct examinations and analyses, data collection, and enforcement to successfully implement these statutory mandates.

Federal Exchanges

The Exchanges allow individuals to compare health plan options, determine eligibility for several health insurance programs, obtain financial assistance with premiums, and facilitate enrollment. The FY 2027 Budget includes a General Provision that would allow user fees collected to operate FFEs and federal platforms leveraged by State Based Exchanges to be made available for any federal administrative expenses the Secretary incurs for activities related to the Federal Exchange, including those activities that CMS conducts on behalf of all Exchanges.

Budget Request: $0.0 Million

For additional information, please refer to the “Federal Exchanges” section.

V. OUTREACH AND EDUCATION

CMS is responsible for conducting outreach efforts to educate beneficiaries, providers, and other key audiences about available programs and services. Activities include educational mailings and national communication campaigns to promote CMS programs. 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 is committed to educating beneficiaries on the programs and services available to them.

National Medicare Education Program (NMEP)

The NMEP was established to implement provisions of the Balanced Budget Act of 1997 and continues under the Medicare Modernization Act of 2003. This outreach helps people who are new to Medicare navigate their many choices between Part C (MA), Part D (Prescription Drug Coverage), and make decisions about when to enroll in Part B as more people delay their social security benefits past age 65. When people defer past the age of 65, they are not automatically enrolled and oftentimes need to know how and when to act. Furthermore, NMEP drives plan competition and provides customer service during the Annual Election Period (Open Enrollment) every fall.

In addition, the NMEP program aims to educate the public about Medicare benefits, rights, options, and requirements. In support of the MAHA movement, NMEP promotes healthy living, and the Medicare core benefits and supplemental benefits that assist beneficiaries in doing so.

An effective outreach strategy requires combining diverse communication channels to provide information and support to beneficiaries and the public.

- Education and Awareness: CMS provides print materials such as the "Medicare & You" handbook, websites (Medicare.gov), and a national toll-free line (1-800-MEDICARE).

- Outreach: CMS engages in publicity campaigns and supports state and community-based outreach efforts.

- Outreach and Collaboration: CMS collaborates with organizations, including beneficiary advocacy groups, health care providers, and community groups. A diversified engagement strategy enhances outreach impact.

CMS strives to empower beneficiary health care decisions by providing the official source of accurate and reliable Medicare program information, access to self-help and customer response options, and prioritizes informed and unbiased decision making for better health outcomes.

Budget Request: $385.8 Million

The budget request is an increase of $24.0 million above the FY 2026 Enacted Level to meet beneficiary customer service standards aligned with Executive Order 14058, “Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government.” The budget also assumes $124.4 million in Current-Law user fees from MA and Part D plans to share the cost of Medicare outreach, and $61.8 million in penalty mail funding to cover handbook and enrollment package postage costs. CMS must conduct annual reviews and update all NMEP content to ensure accuracy and relevance with such requested funds.

The NMEP performs several critical responsibilities to support Medicare beneficiaries. As statutorily required, the Agency mails approximately 53 million Medicare & You handbooks annually to existing and new beneficiaries. CMS empowers beneficiaries to make informed healthcare decisions through multiple channels, including Medicare Open Enrollment, online resources, and decision-support tools. To ensure timely assistance, CMS maintains the 1-800-MEDICARE helpline with a 5-minute average speed of answer target, supported by this request level. To offset growing beneficiary population needs, CMS is exploring the use of AI functionality to handle forecasted growth in call volume. CMS plans to enhance Medicare.gov with improved navigation, expanded claim data access, strengthened security measures, and streamlined functionality to increase online customer engagement and better serve beneficiaries.

Program details including workload history and projections are shown below.

- **Medicare & You handbook**: CMS is statutorily required to mail a handbook annually to each eligible beneficiary at least 15 days before the start of the annual election period ("open enrollment"). Beneficiaries have the option to opt out of receiving a hard copy by signing up at Medicare.gov/go-digital/ for an electronic copy. Approximately 5.3% of beneficiaries are estimated to opt-out of the mailed copy in FY 2027.

  CMS continues to explore and test methods to promote electronic resources adoption by Medicare beneficiaries. CMS continues its annual direct-to-beneficiary email campaign, which consists of a series of four emails designed to encourage beneficiaries to opt in to electronic resources. This initiative yields approximately 150,000 new sign-ups annually. To maximize reach and engagement, CMS promotes the campaign across CMS social media channels. In addition, CMS intends to target messaging and outreach to beneficiaries who are enrolled in Medicare Advantage plans (and therefore have diminished need for the content in paper communications like the Medicare & You handbook) to increase the percentage of eResource enrollees.

  The annual handbook mailing history and projection is presented below.

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

	FY 2023 Actual	FY 2024 Actual	FY 2025 Actual	FY 2026 Estimate	FY 2027 Estimate
Number of Handbooks Mailed	50.3	51.1	51.3	51.9	52.5
Number of eHandbooks Sent	2.8	3.0	3.4	3.6	3.8

- **1-800-MEDICARE**: The 1-800-MEDICARE national toll-free line provides beneficiaries with access to trained customer service representatives to answer questions regarding the Medicare program. Beneficiaries and their caregivers use the service to inquire about Medicare coverage, plan information, enrollment, report suspected fraud, and ask questions about their medical records, claims, or expenses.

  Efforts are underway to streamline costs and improve operations with the use of AI across customer experience. CMS is working with industry to improve call center tools and capabilities. In addition, CMS is working on short-term opportunities to assist

customer service representatives with efficiency in their call flow. These efficiencies will decrease call duration and enable the call center to handle the forecasted call volume, without increasing workforce.

All calls are initially answered by the Interactive Voice Response (IVR) system. IVR completely manages thirty percent of call volume. The following table illustrates annual call volume history and future estimates.

1-800-MEDICARE Call Volume
(in Millions)

	FY 2023 Actual	FY 2024 Actual	FY 2025 Actual	FY 2026 Estimate	FY 2027 Estimate
Number of Calls	23.0	23.9	24.2	24.6	24.8

- **Website Operations and Maintenance:** The official and most comprehensive website for Medicare is **Medicare.gov**. This website provides information on Medicare, including enrollment, benefits, costs, and private health and drug plans. The **Medicare Plan Finder**, available on Medicare.gov, allows individuals to compare different Medicare Advantage and Part D plans according to their location, specific medications, and pharmacies.

  Over 40% of traffic to the website is authenticated users or account holders with a Medicare Beneficiary Identifier (MBI). This is a 5% increase from the previous year, and CMS continues to see strong growth in authenticated traffic to the website. The www.Medicare.gov page view history and projection is presented below.

Medicare.gov Page Views
(in Millions)

	FY 2023 Actual	FY 2024 Actual	FY 2025 Actual	FY 2026 Estimate	FY 2027 Estimate
Number of Page Views for http://www.Medicare.gov	650.0	675.0	940.1	1,000.0	1,100.0

- **Beneficiary Enrollment and Validation:** Funding supports 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 the printing and mailing of MBI cards. Fraudulent activities in recent years have led to an increase in CMS and beneficiary-initiated MBI change requests, requiring CMS to reissue cards and other notices.

Tribal Outreach and Education

CMS performs outreach and education for rural communities, and outreach and education contracts reaching AI/AN's to remove barriers that cause disparities in health care.

Budget Request: $3.0 Million

The request level continues ongoing AI/AN outreach effort planned in FY 2026.

VI. VALUE-BASED HEALTH CARE

Value-based health care programs represent CMS' strategic shift to payment systems that reward quality over quantity of care. These initiatives include the Medicare Shared Savings Program (MSSP) and the Quality Payment Program (QPP). The Shared Savings Program enables groups of providers to form Accountable Care Organizations (ACOs) to coordinate care for Medicare beneficiaries while being held accountable for quality and costs. QPP offers two participation tracks: (the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)) to incentivize clinicians to improve outcomes while controlling expenses. These programs use sophisticated measurement tools to evaluate clinician performance, adjust payments based on quality metrics and cost efficiency, and ultimately drive health care transformation toward better patient outcomes at lower costs while improving the overall patient experience.

CAHPS surveys are integral to value-based health care programs by providing standardized patient experience data that directly informs quality measurement, payment adjustments, and performance improvement. These surveys capture critical patient perspectives on health care delivery (including access to care, provider communication, and care coordination) which are incorporated into multiple value-based payment models. In Medicare Advantage Star Ratings, CAHPS results impact plan ratings and bonus payments; in MIPS, results contribute to clinician quality scores affecting Medicare reimbursement; and in the Shared Savings Program, results impact performance assessments, potential shared savings payments, and shared losses owed.

Value-based health care seeks to change the health care system from one that incentivizes volume to one that incentivizes value, focusing on better care at lower costs with improved patient experiences.

Budget Request: $90.0 Million

The budget request is a reduction of $12.8 million below the FY 2026 Enacted Level. CMS descoped work in accordance with recent Executive Orders and discontinued non-essential workloads during FY 2025. Given MAHA's charge to enhance health outcomes, Agency support for value-based care programs will play a crucial role in helping to achieve the desired outcomes. Activities in this request are described below.

- **Medicare Shared Savings Program**: In 2026, 511 Shared Savings Program ACOs serve more than 12.6 million Original Medicare beneficiaries, a 12.3% increase[17] from 2025, and CMS expects continued growth in participation in the program for FY 2027. The funding request supports application and change cycles, benchmarking and

[17] https://www.cms.gov/newsroom/fact-sheets/2026-medicare-accountable-care-organization-initiatives-participation-highlights

financial calculations, program monitoring, compliance to reduce improper payments, policy development, rulemaking, education, outreach, and website services.

The Shared Savings Program is estimated to save the Medicare Trust Fund $10 billion over 10 years. (Reg cite 87 FR 70193)[18]

- **Quality Payment Program**: The request supports operations to facilitate Medicare clinicians' participation in value-based payment models, involving over 1.5 million eligible clinicians. CMS' ongoing operational needs include IT infrastructure maintenance, data management systems for processing MIPS/APM eligibility determinations, and technical capabilities to receive and score quality measures from thousands of clinicians nationwide.

  As QPP adapts to health care policy changes, continued investment is necessary to support its core functions of measure collection, scoring, and payment adjustment implementation that underpins CMS' value-based payment strategy.

- **Data Collection, Reporting, and Testing:** The request provides operational support to create robust data sets, including mandated CAHPS surveys, MSSP, QPP, and the MA Star Ratings Program. This activity is necessary to generate the Star Ratings data that is published on the Medicare Plan Finder (MPF), and part of the assessment of quality performance for Medicare Shared Savings Program ACOs. This data provides Medicare beneficiaries with information needed to compare available health and prescription drug plans based on cost, coverage, and quality, aiding their enrollment decisions.

VII. ENTERPRISE OPERATIONS

CMS requires funding to operate Medicare, partner with states on Medicaid and CHIP, and manage health insurance standards. Additionally, CMS handles privacy protections and financial reporting transparency. These programs are managed by internal staff and systems. Enterprise Operations support CMS staff in all initiatives and oversee 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' programs. The HIGLAS System processes approximately 4.5 million claims daily and manages roughly $1.5 trillion in annual outlays, making it the largest Oracle Federal Financials System in operation. This system has significantly strengthened Medicare's fiscal management by eliminating redundant financial record systems, improving debt collection activities, creating comprehensive audit trails for all transactions, enhancing financial audit capabilities, and accelerating the recovery of overpayments.

CMS conducts statutorily required CFO audits to ensure financial statements are reasonable, internal controls are adequate, and the Agency complies with applicable laws and regulations. These audits are mandated by the Government Management Reform Act of 1994 and OMB Bulletin No. 07-04 and funded through an interagency agreement between CMS and HHS based on GSA rate schedules and federal requirements. CMS must prepare both annual and quarterly financial statements in OMB Bulletin A-136.

[18] https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

HIGLAS has been instrumental in helping CMS and HHS achieve compliance with the Federal Financial Management Improvement Act and maintain a “clean” audit opinion as required by the Chief Financial Officer’s Act.

Budget Request: $97.4 Million

The budget request is consistent with the FY 2026 Enacted Level. Given CMS’ projected requirements and workload demand, this request is essential for maintaining operations and successfully addressing mission needs in FY 2027. Through assessing and identifying system enhancements by potential impact and value, CMS aims to decrease change management hours through task automation and the adaptation of new processes and technology. CMS remains committed to evaluating all financial operations to ensure accurate and reliable, financial accounting and reporting.

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 protecting patient information in the nation's health care system, it will improve the use of electronic data interchange which serves as one of CMS’ long-standing goals for the nation’s health care.

Budget Request: $27.4 Million

The budget request is a reduction of $18.7 million below the FY 2026 Enacted Level. In part, the reduction is due to critical system operational and technical enhancements cost in FY 2026, including system security and data screening for the National Plan and Provider Enumerations System (NPPES). This funding primarily supports two critical systems: the HIPAA Eligibility Transaction System (HETS), which provides real-time Medicare eligibility information to providers, and the National Plan and Provider Enumerations System (NPPES), which has already assigned over 6 million individual and 1.5 million organizational National Provider Identifiers (NPIs).

Additionally, this funding supports the advancement, through rulemaking, of electronic healthcare transaction standards, and implementation of such standards through required enforcement actions. More specifically, CMS is planning improvements to the existing industry standards adopted under HIPAA, including updating the entire suite of transactions to more technologically advanced versions. This will be the first time work of this significance has occurred in over 15 years.

These systems and regulatory and enforcement actions fulfill HIPAA Title II requirements for national standards in electronic health care transactions, provider identifiers, and data security, advancing CMS’ goal of improving electronic data interchange efficiency across the nation’s health care system.

IT Systems and Support

Information Technology Systems and Support activities provide infrastructure and support for applications and operations across CMS. Technology is a major driver for healthcare affordability. Through innovation, modernization, and AI enablement, CMS will enhance operational efficiency, reduce waste, and improve patient experiences while building a future-ready workforce capable of responsibly implementing emerging technologies.

As healthcare needs evolve, cyber threats intensify, and AI reshapes operations, CMS is strategically transforming its IT infrastructure to enhance agility, security, and mission effectiveness. The FY 2027 IT strategy represents fundamental shifts from siloed systems to integrated platforms, from reactive problem-solving to proactive innovation, and from outsourcing by default to developing in-house expertise.

CMS IT enhancements include:

- Data Sharing Improvements: Modernizing CMS' data sharing to automate processes and improve transparency, leading to better access to data and reduced costs.
- AI for Payment Monitoring: Identifying irregular Medicare payments, reducing wasteful spending, and ensuring effective use of taxpayer funds while maintaining care quality.
- Business Intelligence Upgrades: Updating outdated business intelligence technology to boost efficiency and align with government goals.
- Ensuring trust and security is in place for both providers and patients by providing modern identity solutions to verify and validate the identity of those interacting with CMS

These improvements, combined with the Healthcare IT Ecosystem Initiative and ClaimsCore program, will modernize CMS' infrastructure, provide a more scalable and flexible system architecture, enable efficient real-time claims processing, enhanced policy feedback through real-time data access, support for innovative payment models that incentivize value over volume, and result in fewer costly manual interventions across the IT enterprise.

Budget Request: $657.1 Million

The budget request is a reduction of $262.4 million below the FY 2026 Enacted Level. The request funds foundational and base operational support for Enterprise Enablement, Business Operations Support, and Core Mission activities detailed in the "Information Technology" chapter. The request level supports development costs for CMS priorities; however, CMS will continue evaluating resource gaps and ongoing fiscal needs. CMS will insource expertise, continue to streamline contracts, and utilize technologies to create a more agile workforce while maximizing fiscal resource allocation. Transforming CMS' outdated internal and external business operations is critical to achieve our health care experience and industry-wide modernization goals.

CMS is currently actualizing these priorities through policies, programs, and initiatives, some of which are described below. While these efforts began in FY 2025, work is planned to continue into 2027 as initial efforts are iterated and expanded upon. Notable strategic IT enhancements in progress are listed below:

- **Healthcare IT Ecosystem Initiative**: CMS is transforming its IT infrastructure to meet the operational demands of administering the nation's largest health care programs, improving agility, security, and mission effectiveness. This work requires moving from siloed, program-specific systems to shared, integrated platforms and from reactive problem-solving to proactive, scalable capabilities. By modernizing how CMS manages identity, provider information, and data exchange, this initiative supports CMS's ability to better operate Medicare.gov, administer benefits, and oversee providers more effectively. This initiative also enables improved interoperability, modernized patient data access, and streamlined provider operations across the health care ecosystem. These investments will directly reduce administrative burden, returning time to clinicians and improving care delivery.

  CMS has identified critical infrastructure gaps that hinder effective program administration and contribute to fragmentation across the health care system. These include insufficient identity verification for Medicare beneficiaries accessing Medicare.gov, largely manual and duplicative provider identity validation processes for National Provider Identifier issuance and Medicare enrollment, and limited interoperability and data-sharing infrastructure. CMS requests funding for targeted investments in core digital infrastructure to modernize Medicare.gov, strengthen CMS-managed provider identity and directory services as authoritative sources of truth, and improve internal data processing, security, and information-sharing capabilities. Because CMS must build these capabilities to fulfill its statutory responsibilities, designing them as shared infrastructure also enables the private sector to rely on common, trusted services, reducing duplication, improving data sharing, and lowering administrative costs system-wide.

- **ClaimsCore Program:** CMS must modernize its claims infrastructure to ensure long-term security, integrity, and operational resilience for Original Medicare. Today's legacy environment limits policy agility, constrains real-time insight, and makes it harder to deploy modern payment-integrity defenses at the speed of emerging fraud and cyber threats. ClaimsCore will replace the legacy Shared Systems, including the CWF, with a best-in-class commercial claims processing platform, enabling a secure and configurable foundation for faster policy execution, improved transparency for beneficiaries and providers, and near real-time adjudication. This is a mission-critical effort that protects the Medicare Trust Funds and strengthens stewardship of taxpayer dollars while positioning CMS to support the Administration's value-based care objectives.

  This request includes a strategic down payment that will help fund early-phase ClaimsCore activities that de-risk full implementation and produce tangible deliverables including:

  1. Initial implementation of a limited, non-production, proof of concept claims processing solution
  2. Development of critical path initial integrations and data migration necessary for claims adjudication, including interfaces with some external systems.
  3. Technical evaluation, project management, MAC and stakeholder readiness activities, and outcomes validation supporting the challenge-based procurement of an enterprise COTS solution
  4. Mapping and extraction of business rules, claims edits, and other existing processes supported by the Shared Systems and CWF that are not well documented or understood today.

- **Mission-Driven Digital Experiences (System Modernization and Reducing Technical Debt):** CMS is modernizing mission-critical digital infrastructure to reduce technical debt, strengthen security, and improve the agility of systems that support core program operations. Legacy systems continue to drive elevated operations and maintenance costs, rely on obsolete technologies, and limit interoperability across programs and partners. These constraints increase cybersecurity risk, slow policy implementation, and hinder CMS's ability to effectively support program integrity and improper payment reduction efforts.

  Through this initiative, CMS will accelerate retirement, refactoring, or replacement of legacy systems that present the greatest operational risk and cost burden. Modernization will transition critical capabilities to secure, interoperable, and supportable platforms that lower long-term maintenance costs, improve resilience, and enable faster, more reliable delivery of policy and operational changes. By executing disciplined modernization plans with clear system dispositions, CMS will reduce duplicative tooling, mitigate outage and cyber incident risk, and establish a more sustainable digital foundation that supports mission outcomes and responsible stewardship of taxpayer resources.

- **Enterprise Platforms and Shared Services (IT Optimization and Consolidation):** CMS is undertaking a strategic shift from a fragmented, program-centric IT operating model to a more efficient and secure enterprise approach that reduces duplication, strengthens governance, and improves outcomes for beneficiaries and providers. An Agency-wide review of IT investments identified significant opportunities to streamline contracts, eliminate redundant platforms, and better align technology spending with mission priorities. These findings underscore the need for a coordinated, enterprise-level approach to managing IT resources.

  CMS will consolidate duplicative IT contracts and systems and expand shared services. Through this initiative, CMS is building foundational enterprise capabilities that enable shared services, standardized platforms, and disciplined investment decision-making across the Agency. For example, CMS is working to migrate the Centralized Data Repository to the Integrated Data Repository, enabling future consolidation of CMS's data warehouse infrastructure. Transitioning to enterprise IT services will reduce long-term operating costs, enhance cybersecurity and operational resilience, accelerate the delivery of digital services, and improve transparency and accountability. CMS intends to complete this transition by institutionalizing an enterprise IT model that delivers sustained efficiencies, strengthens program integrity, and maximizes value for taxpayers while supporting the scale and criticality of CMS's mission.

- **AccessCMS:** CMS is advancing an enterprise approach to security and privacy that embeds protection into every digital capability from the outset, rather than treating it as an afterthought. This initiative establishes a preemptive, AI-enhanced Zero Trust cybersecurity strategy that continuously anticipates, prevents, and contains threats in real time. By modernizing how CMS safeguards systems and data, the Agency strengthens mission continuity, protects sensitive beneficiary and provider information, and reinforces public trust while enabling secure digital transformation at scale.

  A central component of this effort, known as AccessCMS, is designed to ensure that only authorized individuals and systems can access CMS resources, while providing enterprise-class identity services that support modern digital operations. AccessCMS

improves data-driven decision-making related to identity and security risks, standardizes identity services across the enterprise, and delivers a secure, user-friendly experience that enables users to connect seamlessly and with confidence across the CMS and Healthcare ecosystem.

- **Trusted Data, AI, and Interoperability:** CMS is advancing a trusted data and artificial intelligence framework in which information is shareable by default, protected by design, and used responsibly to improve health and program outcomes. This initiative establishes the foundation for a shared understanding of secure healthcare data so it can be consistently interpreted and exchanged across authorized people, systems, and organizations. By strengthening interoperability and data governance, CMS will improve clarity, timeliness, and confidence in how information is used to support mission-critical decisions.

  Through this effort, CMS will unlock the full value of its data by applying responsible, governed AI capabilities to drive measurable mission outcomes. These capabilities will support high-value care for vulnerable populations, enable CMS to lead across payers, incentivize providers to deliver data-driven care, strengthen fraud prevention and improper payment reduction, and empower beneficiaries with personalized information that supports informed decision-making and care navigation. Internally, this initiative will improve how CMS aligns spending with outcomes, ensuring that data and AI investments deliver greater value and accountability for the American public.

- **IT Workforce, Operating Model, and Governance Excellence**: CMS is strengthening mission delivery by modernizing its IT workforce, operating model, and governance to ensure faster decisions, clearer accountability, and consistent execution across the enterprise. This initiative focuses on building a skilled, merit-based technology workforce capable of delivering secure, digital-first services at scale, particularly in mission-critical areas such as cybersecurity, data, artificial intelligence, and cloud computing. Targeted investments in workforce development, including a CMS AI and Cyber Upskilling Academy, will expand internal expertise while leveraging existing federal hiring authorities and shared hiring approaches to improve agility and reduce long-term reliance on duplicative contractor support.

  In parallel, CMS is advancing operating model excellence by expanding shared services, standard platforms, and secure cloud adoption to reduce fragmentation and accelerate delivery. Emphasis on reuse over bespoke development, including reuse of FedRAMP-authorized cloud services and existing security authorizations, will lower risk, improve speed, and strengthen security by design. Governance enhancements will codify clear decision rights, enterprise-wide risk visibility, and shared accountability through streamlined technology governance, continuous authorization, and responsible AI guardrails. Together, these efforts ensure CMS modernizes technology in a disciplined, transparent manner that delivers results, strengthens accountability, and demonstrates sound stewardship of taxpayer resources.

Enterprise Operational Support

Administrative functions in this section create the operational foundation enabling CMS to effectively deliver health care services and programs to millions of Americans through Medicare, Medicaid, CHIP, and the Exchanges. CMS internal business needs, consistent with OMB Circular internal control requirements and the Federal Acquisition Regulation (FAR) are

essential for Agency operations. To achieve greater efficiency, CMS is assessing and undergoing the following organizational changes:

- Streamlining operations to remove administrative duplication
- Exploring business requirements that will be performed by federal FTEs rather than contractors
- Insourcing generation of public data products and data management
- Assessing licensing costs and business needs for administration functions

CMS is committed to improve productivity, streamline critical business functions, and modernize antiquated tools resulting in a more responsive, agile, workforce to deliver results while maximizing taxpayer value. All these efforts are critical to better serving beneficiaries in our programs across America.

Budget Request: $89.3 Million

The budget request is a decrease of $39.8 million below the FY 2026 Enacted. The request supports critical interoperability infrastructure that enables health data exchange across CMS programs and external health care systems. This investment directly advances CMS' strategic objectives for data modernization and represents a critical step toward CMS' vision of a fully interoperable health care ecosystem that empowers beneficiaries, reduces provider burden, reduces cost through integrated care coordination, and improves overall health care delivery efficiency.

The budget also supports activities critical for CMS' mission to improve service delivery, enhance operational efficiency, and general operating support for our beneficiaries and health care system. These include:

- Ongoing operational funding for the CMS Acquisition Lifecycle Modernization (CALM) system. CALM is used to procure items or services and execute contracting activities.
- Actuarial Services provides support for additional modeling and cost estimation for statutory requirements and programs.
- Data Analytics funding supports the collection and distribution of Medicare claims data, geographic variation information, and market basket studies, ensuring this critical information reaches CMS users and outside entities.
- Shared services to integrate administrative tasks and workflow
- Document processing support provides customer service to beneficiaries regarding enrollment, premium billing inquiries, and data validation.

Opioid and Substance Use Disorders (SUD) Support

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT Act) 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’ programs. CMS continues 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: $1.5 Million

The budget request is an increase of $0.6 million above the FY 2026 Enacted Level. CMS will continue ongoing outreach and education, monitoring of prescriber compliance, analysis of root causes for non-compliance, and development of appropriate non-compliance actions at this funding level.

Research, Demonstrations, and Evaluation (Research)

This funding supports most of CMS' research data collection and data storage activities. The data is critical for the development, implementation, and evaluation of many CMS programs, and used by industry stakeholders to conduct health care research. This body of work supports the efficiency of payment, service delivery, access to care, and quality of health outcomes for CMS beneficiaries.
CMS' activities supported in the Research budget include:

- The Medicare Current Beneficiary Survey (MCBS) is CMS' primary tool for understanding Medicare beneficiaries' health care experiences, providing unique data that cannot be obtained from any other federal data source. This data enables policymakers and researchers to understand the health care needs of over 65 million Medicare beneficiaries and informs evidence-based policy development aimed at strengthening the Medicare program. It also supports the Congressional Budget Office and CMS' Office of the Actuary in their program oversight responsibilities.

- The Chronic Conditions Data Warehouse (CCW) supports the health care industry and other federal agencies by providing a centralized, research-oriented database of Medicare and Medicaid data. This database helps researchers study chronic conditions, improve care quality, and potentially reduce health care costs.

Budget Request: $18.1 Million

The budget request is a decrease of $2.0 million below the FY 2026 Enacted level. CMS is requesting to shift this body of work into the Program Administration budget to reduce complexity and provide funding flexibility for these activities. CMS will continue critical data collection and dissemination efforts, including conducting the Medicare Current Beneficiary Survey (MCBS) and maintaining the Chronic Conditions Warehouse (CCW) database.

VIII. FEDERAL ADMINISTRATION

Federal Administration funds operating expenses in support of CMS' mission and programs, making these and future successes possible. This account provides funding for employee compensation, rent/utilities, enterprise level administration and services, as well as providing for business needs such as supplies, equipment, printing, training, and travel. CMS operations stretch nationwide and oversee health care coverage for about 1 in 2 Americans.

CMS employees achieve the Agency's mission through their active engagement in statutorily required activities as well as implementation of new health care policies and regulations; setting payment rates; overseeing contractors delivering education and outreach to beneficiaries, consumers, employers, and providers; crushing fraud, waste, and abuse; and assisting law enforcement agencies in prosecuting fraudulent activities. In addition, CMS collaborates with state surveyors in health care facilities to ensure compliance with CMS health and safety

standards as well as to assist states with Medicaid, Children's Health Insurance Program, and other health care programs. Through CMS' nationwide footprint, the Agency is positioned to effectively serve beneficiaries, determined to accomplish the Make America Healthy Again mission.

Budget Request: $734.1 Million

The budget request is $734.1 million, a decrease of $38.5 million below the FY 2026 Enacted Level. In FY 2025, CMS commenced several initiatives to better position the Agency financially for future fiscal years such as reducing contract spend, adjusting staffing, undertaking needed facility maintenance/repair, and completing obligations for two large mortgages for our San Francisco and Woodlawn Headquarter buildings. The strategic investments in FY 2025 reduced CMS's outyear budget needs.

This budget request assumes 3,576 FTEs, relatively consistent as compared to FY 2026 Enacted. Building upon the successes of FY 2025, CMS leadership will continue to analyze staffing levels to best support the Agency's mission.

- **Personnel Compensation and Benefits (Payroll):** This funds CMS' payroll and benefit costs, including Commissioned Corps staff, which are entitled to certain additional benefits. This request assumes a 0% COLA increase for civilian employees and 3.6% COLA increase for Commissioned Corps staff. The CMS workforce contains world-leading experts in key areas, which supports CMS' mission to provide the best health coverage to the most vulnerable.

  Additional CMS staffing levels are funded through other directly appropriated accounts, not included in this request, such as HCFAC, the Federal Exchange, and other mandatory or reimbursable sources. These accounts cover the FTE costs required to execute their specific workload required to meet the Agency's needs.
  To ensure administrative costs are appropriately applied to these other sources, CMS utilizes a cost allocation methodology to offset indirect costs.

- **Other Objects of Expense (Non-Payroll):** This includes non-payroll related expenses such as rent and maintenance, enterprise IT, travel, and organizational level Contracts/IAAs. These activities support the operational function of the Agency and efficient oversight of various processes. This request will enable CMS to continue providing services that are critical to the CMS and HHS mission.

IX. HHS REORGANIZATION

The planned HHS reorganization, driven by a desire for efficiency and cost savings, involves consolidating divisions, reducing regional offices, and centralizing functions like human resources, IT, and procurement. This proposed restructuring aims to streamline operations and create a more unified HHS. New organizational responsibilities are described below.

Health Resources and Services Administration (HRSA)/340B

The 340B Drug Pricing Program provides discounts on outpatient drugs to specific safety net health care providers, known as covered entities. These entities include Federally Qualified Health Centers, family planning grantees, Ryan White grantees, and a variety of other hospitals and clinics. The program supports health care access for high-need communities by allowing

covered entities to purchase medications at reduced prices. CMS will continue efforts to improve program oversight and integrity by providing technical assistance to grantees and covered entities, performing eligibility checks and annual recertifications, conducting audits, and maintaining the critical Office of Pharmacy Affairs Information System (OPAIS) that underpins 340B operations. These activities are crucial for maintaining the program's effectiveness and ensuring efficient use of federal resources.

Budget Request: $20.5 Million

The budget request is an increase of $8.3 million above HRSA's appropriated FY 2026 Enacted Level. The increase will enable CMS to manage growing program complexity and areas of heightened risk through enhanced policy development, guidance, and operational support. Funding will support staff capacity to analyze emerging program issues, provide technical assistance to stakeholders, effectively identify non-compliance and take corrective action, and implement policy decisions necessary to ensure consistent interpretation and application of 340B statutory and regulatory requirements

State Survey and Certification

(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Discretionary				
Survey and Certification	$397,334	$397,334	$487,000	$89,666
Medicare Operations general provision[1]	$40,000	$40,000	$0	($40,000)
Mandatory[2]				
IMPACT Act	$5,304	$6,400	$0	($6,400)
Consolidated Appropriation Act (CAA), 2021	$9,430	$9,430	$9,430	$0
Grants to States for Medicaid (S&C)	$344,631	$373,000	$373,000	$0
Subtotal, Mandatory	**$359,365**	**$388,830**	**$382,430**	**($6,400)**
Total	**$796,699**	**$826,164**	**$869,430**	**$43,266**

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 2026 Authorization – Public Law 119-75, Consolidated Appropriations Act, 2026

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 efficient, outcome-driven verification activities carried out by qualified surveyors. The S&C program serves Long-Term Care (LTC) residents and other individuals who receive care from the approximately 67,000 Medicare and Medicaid-certified providers.

CMS accomplishes its mission in collaboration with the States and their respective State Survey Agencies (SAs), private accrediting organizations (AOs), and contracted private-sector survey organizations, who conduct specialized surveys and investigations. Where CMS has been given statutory authority, the Agency takes progressively escalating enforcement action when quality standards are not met or maintained by participating providers. An enforcement action is a

[1] FY 2025 and FY 2026 includes $455 million from the Medicare Operations general provision from the FY 2025 continuing resolution, Public Law 119-4 and the FY 2026 annual appropriation, Public Law 119-75.Distribution of the Medicare Operations general provision in FY 2026 is tentative and should not be considered as final.

[2] The Improving Medicare Post-Acute Care Transformation (IMPACT) Act's and the 2021 Consolidated Appropriations Act's (CAA) funding is targeted to help keep hospice survey frequencies at every three years. The CAA and FY 2025 IMPACT Act funding levels displayed are post-sequester.

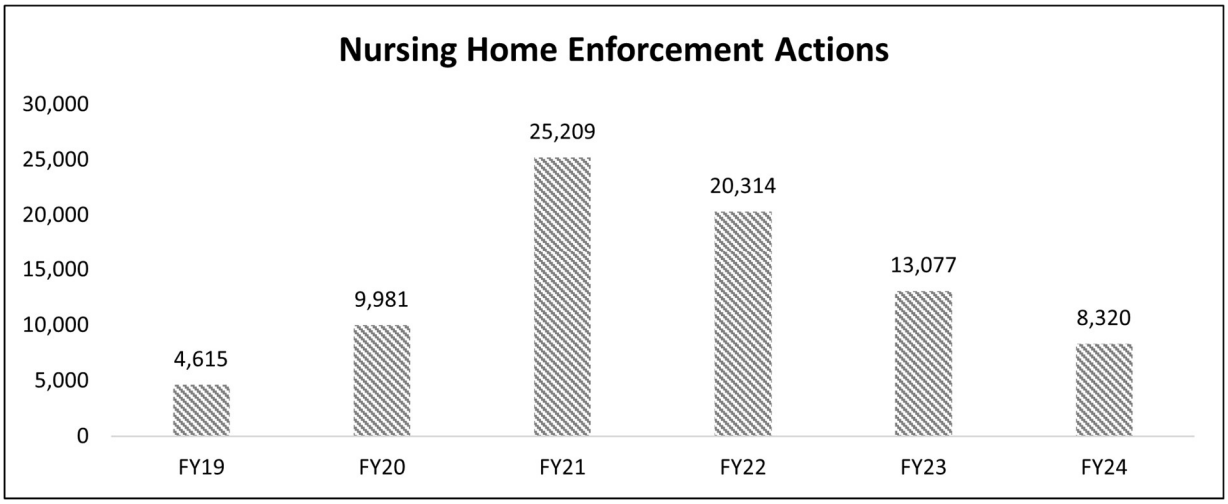
process of imposing “remedies”, based on the scope and severity of the non-compliance, and may range from increased State monitoring and directed in-service training to the imposition of civil monetary penalties (CMPs) and termination from the Medicare and Medicaid programs.

CMS optimizes oversight of SAs through a combination of federal surveys and contracts with national surveyors and establishment of national performance metrics. 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, targeting areas 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 strengthen state oversight.

To streamline CMS’ existing data systems used in the S&C program, including the Internet Quality Improvement and Evaluation System (iQIES), CMS has deployed various information technology efforts that make program information more efficient for program operations and emergency response as well as transparent and accessible to the public. Another example of data improvement efforts is CMS’ nursing home Five-Star Quality Rating System on the Care Compare website, which is regularly updated to increase quality and customer usability.

Nursing Home Enforcement

In FY 2021 and FY 2022, the Survey and Certification program saw the enforcement action workload increase to a staggering 20,000 cases over historical norms of about 5,000 annually. The increase in the number of enforcement actions was in direct correlation to COVID-19 and the increase in infection control surveys, with more complaints and serious findings. As demonstrated in the graph below, with the help of additional funding, FY 2023 and FY 2024 actions have retreated from this high-water mark. To address this workload and align with the CMS’ commitment to improve the safety and quality of nursing home care, CMS requests an increase in funding in FY 2027.



Complaint surveys are the primary oversight mechanism for most provider types, with each case representing vulnerable beneficiaries seeking help for negligence or poor care quality. Complaints are categorized by severity: Immediate Jeopardy (IJ), Non-IJ High (NIJH), Non-IJ Medium (NIJM), and Non-IJ Low (NIJL), with IJ and NIJH being top priority. IJ complaints require onsite assessment generally within three days, while NIJH complaints require

assessment within 15 to 45 days depending on the specific provider type. These incoming complaints cause abrupt workload shifts and increase financial burden. To fund the rising complaint surveys, CMS has reduced support for standard surveys, resulting in fewer recertification and validation surveys year-over-year.

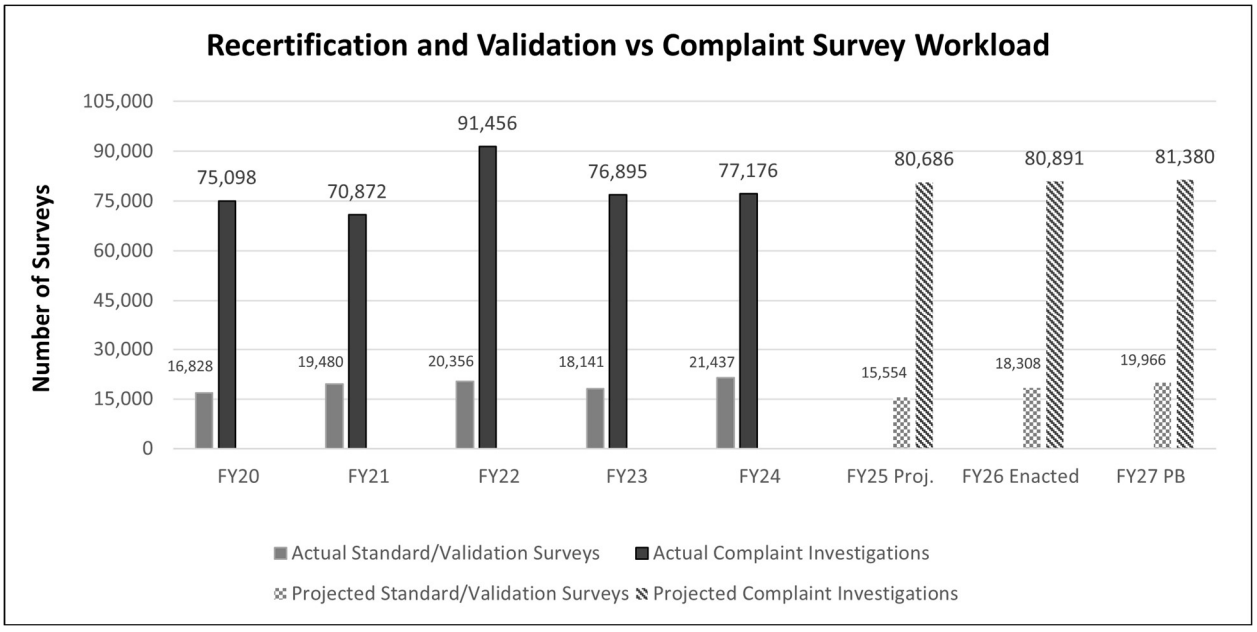
From FY 2015 to FY 2024, the number of IJ determinations increased by 75%.

The number of IJs identified on complaint investigations alone has increased 103% over the same period.

When providers have serious deficiencies, CMS uses progressive enforcement strategies to protect patients and ensure compliance, requiring immediate correction plans for life-threatening conditions. For certain providers, CMS can impose civil monetary penalties, deny payment for new admissions, or ultimately terminate providers from Medicare and Medicaid programs, if compliance cannot be achieved. For nursing homes with consistently poor performance, the Special Focus Facility Program provides enhanced oversight through more frequent inspections and intensive monitoring.

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 from FY 2025 through FY 2027 respectively based on available/requested funding. The projections going forward sustain a higher level of complaint investigations, representing a continued upward trend.

Survey, Recertification, and Complaint Investigation Historical and Projected (Table Displays All Medicare/Medicaid Participating Provider Types)



Innovative Initiatives

CMS is continuing to advance the Administration's priorities, finding ways to effectively and efficiently ensure that patients and residents are receiving health care services that meet the minimum quality standards. CMS is focused on opportunities to *Make America Healthy Again* such as prevention-focused activities; modernized survey and certification processes using advanced data-focused tools and analytics; reduced provider-burden of the survey process without compromising the quality of care; and ensuring that patient safety remains at the forefront.

Funding History

Fiscal Year	Amount [3]
FY 2023 Final	$397,334,000
FY 2024 Final	$407,334,000
FY 2025 Final	$437,334,000
FY 2026 Enacted	$437,334,000
FY 2027 President's Budget	$487,000,000

Budget Request: $487.0 Million

The FY 2027 Budget Request for the S&C program is $487.0 million, an increase of $50 million over the FY 2026 Enacted Level[3]. This funding level will increase the estimated completion rate from a current level of 67% to 78% for statutorily mandated surveys and maintain the estimated 10% level for non-statutory surveys. This budget also enables CMS to account for operational adjustments related to the nursing home staffing rule moratorium established under the Working Families Tax Cut Law (WFTCL).

The S&C program continues to experience increased costs due, in part, to growth in complaints, continued survey backlogs, and other cost drivers, including the increase in the number of beneficiaries, surveyor wage growth, overall economic inflation, and improvements in quality standards.

In FY 2022, an additional $10.0 million per fiscal year from the Consolidated Appropriations Act (CAA) of 2021 was allocated to maintain hospice survey frequencies at a three-year rate, establish a special focus program (SFP) for hospice agencies, and to maintain and update the hospice module in iQIES. CMS established a hospice SFP in the Calendar Year (CY) 2024 Home Health Prospective Payment System (HH PPS) final rule (88 FR 77676). Through increased regulatory oversight and enforcement of poor performing hospice programs, the SFP will address issues that could place hospice beneficiaries at risk of receiving poor quality of care through increased oversight. Effective February 14, 2025, implementation of the hospice SFP was temporarily paused so that CMS may further evaluate the program before resuming SFP surveys.

[3] Since FY 2015, the Program has been held at an Enacted level of $397.3 million. The funding levels in FY 2024, 2025, and 2026 include additional Medicare Operations general provision funding allocations.

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

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
State Direct Survey	$391,280	$393,596	$442,384	$48,788
Mandatory Surveys (non-add)	*$326,244*	*$326,234*	*$371,490*	*$45,256*
Non-Statutory Surveys (non-add)	*$65,036*	*$67,362*	*$70,894*	*$3,532*
Federal Direct Surveys	$12,434	$11,376	$11,918	$542
Support Contract and Information Technology	$33,620	$32,362	$32,698	$336
Total S&C PM Discretionary[4]	**$437,334**	**$437,334**	**$487,000**	**$49,666**
IMPACT Act, Hospice [5]	$5,304	$6,400	$0	($6,400)
Consolidated Appropriations Act of 2021, Hospice	$9,430	$9,430	$9,430	$0
Grants to States for Medicaid - S&C	$344,631	$373,000	$373,000	$0
Total S&C Mandatory	**$359,365**	**$388,830**	**$382,430**	**($6,400)**
Total Program Level	**$796,669**	**$826,164**	**$869,430**	**$43,266**

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 providers. It also includes funds to support SAs' cost for travel, training, and supplies.

Budget Request: $442.4 Million

The FY 2027 Budget request is $442.4 million. This level of funding provides the resources necessary to maintain the integrity of our national health and safety oversight, with $371.5 million to inspect, survey, and certify statutory provider types, and $70.9 million to inspect, survey, and certify non-statutory provider types.

With this level of funding, CMS projects that states will have the resources to complete approximately 78% of the recertification surveys for statutory provider types and projected complaints for all providers at an IJ and Non-IJ High levels. Additionally, this level provides a proportional recertification survey frequency rate of approximately 10% for non-statutory provider types with a focus on those provider types with higher beneficiary risks. These completion rates move the Program in a positive direction and increase quality and safety.

This FY 2027 Budget request lays the path towards enabling the states to maintain certainty to retain and potentially hire additional workforce to handle the increased workload, and to better anticipate/react to any future public health emergencies. The cost to achieve the survey frequency completion rate and workload for each provider type in the next table on the next page is funded by the sources listed above. The percentages are derived from a national average and may not reflect individual state results. The survey frequencies are based on current law and CMS' administrative policy, resulting in varying survey intervals depending on provider type.

[4] FY 2025 and FY 2026 levels include a $40 million allocation of the Medicare Operations general provision.
[5] Funding provided through the Consolidated Appropriations Act is net of sequester.

Provider Survey Frequency Rate Completion Projections[6]

Provider Status and Type	Target Survey Frequency Intervals	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Statutory				
Nursing Facilities (NF)	100% Surveyed 12.9-15.9 mo.	100%	100%	100%
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	100% Surveyed 12.9-15.9 mo.	69%	67%	78%
Special Focus Facility Nursing Homes (SFF)	100% Surveyed 6 mo.	100%	100%	100%
Skilled Nursing Facilities (SNF)	100% Surveyed 12.9-15.9 mo.	69%	67%	78%
ICF/IID	100% Surveyed 12.9-15.9 mo.	100%	100%	100%
Home Health Agencies (HHAs)	100% Surveyed 36.9 mo.	69%	67%	78%
Hospice Agencies	100% Surveyed 36.9 mo.	100%	100%	85%
Special Focus Program Hospice Agencies (SFP) [7]	100% Surveyed 6 mo.	-	-	-
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	10%	10%	10%
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%

[6] The FY 2025 and FY 2026 provider survey frequency rate is based on $437.334 million; of which $397.334 million is the discretionary appropriation and a projected $40 million from the Medicare Operations general provision allocation. FY 2025 values are estimated, as final frequencies are currently not available.

[7] Surveys of Special Focus Program has been paused for FY 2025 and FY 2026 to allow for further evaluation and exploration of options for program implementation and future rulemaking.

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.

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

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Statutory	**$326,244**	**$326,234**	**$371,490**
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	$300,361	$300,311	$334,095
Special Focus Facility Nursing Homes (SFF)	$1,828	$1,939	$1,983
Skilled Nursing Facilities (SNF)	$12,159	$12,265	$13,840
Home Health Agencies (HHAs)	$11,896	$11,719	$13,572
Hospice Agencies	$0	$0	$6,845
Special Focus Program Hospice Agencies (SFP)	$0	$0	$1,155
Non-Statutory	**$65,036**	**$67,362**	**$70,894**
Ambulatory Surgical Centers (ASCs)	$2,353	$2,295	$2,344
Community Mental Health Centers (CMHCs)	$30	$33	$44
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	$24	$24	$24
End Stage Renal Disease (ESRD)	$9,112	$9,120	$9,239
Hospitals - Non-Deemed	$5,106	$5,123	$5,333
Hospitals - Deemed	$47,004	$49,407	$52,516
Home Health Agencies (HHAs) - Deemed	$227	$232	$237
Outpatient Physical Therapy (OPT)	$217	$210	$220
Portable X-Ray Suppliers	$67	$64	$74
Rural Health Clinics (RHCs)	$608	$533	$549
Transplant Centers	$288	$321	$314
Total State Direct Survey Budget	**$391,280**	**$393,596**	**$442,384**
IMPACT Act, Hospice Surveys	$5,304	$6,400	$0
Consolidated Appropriations Act, Hospice Surveys	$9,430	$9,430	$9,430

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

Actual vs. Projected Survey Counts by Provider Type

	FY 2024 Actuals				FY 2027 President's Budget (Projected)			
	Comp Survey	Recert Survey	Initial Survey	Total Surveys	Comp Survey	Recert Survey	Initial Survey	Total Surveys
Total State Direct Survey Budget	**77,176**	**20,793**	**272**	**97,345**	**81,380**	**19,748**	**218**	**101,346**
Statutory	**71,071**	**17,942**	**96**	**89,109**	**75,670**	**19,303**	**79**	**95,052**
Nursing Facilities (NF)	897	204	10	1,111	996	250	4	1,250
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	63,015	10,453	31	73,499	67,640	10,833	18	78,491
Special Focus Facility Nursing Homes	0	120	0	0	0	120	0	120
Skilled Nursing Facilities (SNF)	1,164	421	6	1,591	1,174	425	3	1,602
ICF/IID	4,180	4,606	28	8,814	4,081	5,254	16	9,351
Home Health Agencies (HHAs)	1,018	1,554	12	2,584	1,012	1,732	13	2,757
Hospice Agencies	797	704	9	1,510	767	639	25	1,431
Special Focus Program Hospice Agencies (SFP)	0	0	0	0	0	50	0	0
Non-Statutory Non-Deemed	**1,509**	**2,851**	**176**	**3,640**	**1,550**	**445**	**139**	**2,134**
Ambulatory Surgical Centers (ASCs)	181	687	28	896	196	64	20	280
Community Mental Health Centers (CMHCs)	2	23	6	31	1	2	3	6
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	1	9	2	12	1	2	1	4
End Stage Renal Disease (ESRD)	897	1,288	23	2,208	918	235	38	1,191
Hospitals	384	0	38	422	385	41	18	444
Outpatient Physical Therapy (OPT)	8	161	9	178	9	27	7	43
Portable X-Ray Suppliers	2	63	25	90	1	9	13	23
Rural Health Clinics (RHCs)	22	342	45	409	28	60	39	127
Transplant Centers	12	38	0	50	11	5	0	16
Non-Statutory Deemed	**4,596**	**0**	**0**	**4,596**	**4,160**	**0**	**0**	**4,160**
Ambulatory Surgical Centers	0	0	0	0	0	0	0	0
End Stage Renal Disease	0	0	0	0	0	0	0	0
Home Health Agencies	0	0	0	0	0	0	0	0
Hospice Agencies	0	0	0	0	0	0	0	0
Hospitals	4,596	0	0	4,596	4,160	0	0	4,160
Outpatient Physical Therapy	0	0	0	0	0	0	0	0
Rural Health Clinics (RHCs)	0	0	0	0	0	0	0	0

Number of Facilities, Beginning of Year

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget (Projected)
Total Facilities within State Direct Survey Budget	**65,489**	**68,069**	**65,153**
Statutory	**29,129**	**28,693**	**28,860**
Nursing Facilities (NF)	261	256	250
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	13,988	13,912	13,888
Skilled Nursing Facilities (SNF)	565	549	545
ICF/IID	5,357	5,235	5,254
Home Health Agencies (HHAs)	6,669	6,208	6,669
Hospice Agencies	2,289	2,533	2,254
Non-Statutory Non-Deemed	**18,353**	**18,472**	**18,308**
Ambulatory Surgical Centers (ASCs)	3,849	4,018	3,849
Community Mental Health Centers (CMHCs)	116	128	122
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	141	138	136
End Stage Renal Disease (ESRD)	7,100	7,073	7,053
Hospitals	1,246	1,229	1,225
Outpatient Physical Therapy (OPT)	1,570	1,548	1,592
Portable X-Ray Suppliers	522	540	525
Rural Health Clinics (RHCs)	3,575	3,564	3,577
Transplant Centers	234	234	229
Non-Statutory Deemed	**18,007**	**20,904**	**17,985**
Ambulatory Surgical Centers (ASCs)	2,238	2,578	2,238
End Stage Renal Disease (ESRD)	531	547	560
Home Health Agencies (HHAs)	4,837	6,443	4,837
Hospice Agencies	3,304	4,241	3,025
Hospitals	4,790	4,785	4,821
Outpatient Physical Therapy (OPT)	340	212	295
Rural Health Clinics (RHCs)	1,967	2,098	2,209

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 providers by conducting statutorily required comparative LSC surveys including parts of the physical environment standards applicable to long term care provider types, as well as Emergency Preparedness (EP) requirements. CMS also contracts to conduct targeted and performance surveys covering emergency surveys, implementation of new survey requirements, and GAO and OIG recommendations to improve care.

For example, CMS has 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 will be some complaints that require onsite surveys. Further, CMS envisions 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: $11.9 Million

The FY 2027 Budget request for Federal Direct Surveys is $11.9 million. This level represents continued funding for the Federal oversight of State surveys and additional funding to assist states with validation survey work.

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 data for the development, education, and implementation of procedures. These efforts include replacing Survey and Certification related 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: $32.7 Million

The FY 2027 Budget request for Support Contracts and IT is $32.7 million. This amount includes $22.1 million for support contracts and $10.6 million for IT contracts.

Grants to States Mandatory Appropriation: $373.0 Million

The FY 2027 Mandatory appropriation for the Grants to States for Medicaid is $373.0 million. This funding will allow states to conduct surveys, certifications, investigations, and a portion of the survey backlog of Medicaid eligible provider types.

(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Medicaid Grants to States	**$344,631**	**$373,000**	**$373,000**
Statutory	**$342,455**	**$370,710**	**$370,789**
Nursing Facilities (NF)	*$9,116*	*$9,289*	*$8,781*
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	*$252,232*	*$275,628*	*$278,256*
Special Focus Facility Nursing Homes (SFF)	*$1,641*	*$1,727*	*$1,668*
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	*$56,766*	*$59,400*	*$57,063*
Home Health Agencies (HHAs)	*$22,700*	*$24,666*	*$25,021*
Non-Statutory Deemed	**$2,176**	**$2,290**	**$2,211**
Home Health Agencies (HHAs)	$2,176	$2,290	$2,211
Total Medicaid S&C Funding	**$344,631**	**$373,000**	**$373,000**

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

	FY 2025 Estimate	FY 2026 Estimate	FY 2027 Estimate
CLIA Lab Obligations	$82,900	$84,700	$86,000

The CLIA program is entirely funded by user fees that are charged to the laboratories regulated by the program. The FY 2027 Budget projection for CLIA is $86.0 million in obligations.

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 tests performed, as defined by the Food and Drug Administration. CMS also has inter-agency agreements with the Centers for Disease Control and Prevention 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. Complexity of the tests performed dictates the level of requirements that a laboratory must meet.

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. CMS saw a significant increase in laboratories during the SARS-CoV-2 Public Health Emergency (PHE) in response to the need for increased testing. With the end of the PHE in FY 2023, CMS expects to see laboratories cease testing over the next several years now that the demand has decreased and the overall number of laboratories has essentially plateaued.

Lab Type	**FY 2023 Actual**	**FY 2024 Actual**	**FY 2025 Actual**	**FY 2026 Projected**	**FY 2027 Projected**
Compliance Labs	17,723	17,158	16,956	16,956	16,956
Accredited Labs	16,020	17,021	17,000	17,000	17,000
Waived Labs	257,103	249,545	248,425	248,425	248,425
PPMP Labs	26,840	24,962	24,412	24,412	24,412
Total	**317,686**	**308,686**	**306,793**	**306,793**	**306,793**

The table below provides the projected CLIA Survey Workload from FY 2023 to FY 2027, and directly following is a table showing what the actual CLIA Survey workload was between FY 2022 to FY 2025.

Original projected workload

Type of Survey	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
Compliance: Initial and Recertification	9,542	9,172	8,326	7,933	7,933
Complaint/Follow-up	668	642	2,996	2,812	2,812
Validation Surveys	431	433	420	393	393
Total	**10,641**	**10,247**	**11,742**	**11,138**	**11,138**

Note: FY 2025-2027 estimates as of July 2025.

Actual workload

Type of Survey	FY 2022	FY 2023	FY 2024	FY 2025
Compliance: Initial and Recertification	8,266	7,749	7,839	TBD
Complaint/Follow-up	981	2,626	2,818	TBD
Validation Surveys	148	403	305	TBD
Total	**9,395**	**10,778**	**10,962**	**TBD**

This page intentionally left blank.

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

This page intentionally left blank.

Grants to States for Medicaid

Appropriated Budget Request [1]

(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Program Activity				
Medical Assistance Payments	$614,336,815	$731,155,776	$744,849,084	$13,693,308
State and Local Administration	$31,624,824	$31,984,549	$33,560,000	$1,575,451
Vaccines for Children	$6,575,625	$6,072,286	$6,783,662	$711,376
Subtotal, Medicaid Program Level	**$652,537,264**	**$769,212,611**	**$785,192,746**	**$15,980,135**
Less funds advanced in prior year	$245,580,414	$261,063,820	$316,514,725	$55,450,905
Total, Grants to States for Medicaid	**$406,956,850**	**$508,148,791**	**$468,678,021**	**($39,470,770)**
New advance 1st quarter of subsequent FY	$261,063,820	$316,514,725	$321,205,275	$4,690,550

Budget Authority Table

(Dollars in Thousands)

	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
CMS - Grants to States [2] Grants to States, Subsidies	$775,002,620	$779,946,084	$4,943,464
CDC - Vaccines For Children Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$6,072,286	$6,783,662	$711,376
Total Budget Authority	**$781,074,906**	**$786,729,746**	**$5,654,840**

Authorizing Legislation – Social Security Act, title XIX, Section 1901 and Public Law 111-5, Public Law 111-148, Public Law 111-152
FY 2025 Authorization – Public Laws 118-47, 118-158, 119-4
FY 2026 Authorization – Public Laws 119-4, 119-75
Allocation Method – Formula Grants

[1] Funding represented in the chart equals the FY 2027 President's Budget estimates. FY 2025 and FY 2026 does not include $19.8 billion and $10.4 billion in indefinite funding authority, respectively.
[2] Includes budget authority from offsetting collections.

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 as well as institutional long-term care services to seniors and individuals with disabilities. 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 2027.

Summary of Request
(Dollars in Thousands)

Program Activity	FY 2025	FY 2026	FY 2027	
	Final [3]	Enacted [4]	President's Budget	+/- FY 2026
Medical Assistance Payments	$634,110,416	$741,595,071	$744,849,084	$3,254,013
State and Local Administration	$31,624,824	$31,984,549	$33,560,000	$1,575,451
Vaccines for Children	$6,575,625	$6,072,286	$6,783,662	$711,376
Total Mandatory Appropriation Request [5]	**$672,310,865**	**$779,651,906**	**$785,192,746**	**$5,540,840**

FY 2027 Mandatory Appropriation Request

CMS' FY 2027 mandatory appropriation request for the Grants to States for Medicaid account is $785.2 billion, an increase of $16.0 billion relative to the FY 2026 request level of $769.2 billion[6]. This appropriation is composed of $316.5 billion in an authorized advance appropriation for FY 2026 and a remaining appropriation of $468.7 billion for FY 2027.

Resources will help fund $786.7 billion in anticipated FY 2027 Medicaid obligations. CMS also anticipates budget authority from offsetting collections from the Supplementary Medical Insurance trust fund and Medicare Part D account in the amount of $1.5 billion to fund the remaining anticipated obligations. These estimated obligations include:

- $746.4 billion in Medicaid medical assistance payments (MAP);
- $33.6 billion for Medicaid state and local administrative functions including funding for Medicaid state survey and certification and the state Medicaid fraud control units; and
- $6.8 billion for the Centers for Disease Control and Prevention's Vaccines for Children (VFC) program.

This submission is based on projections from state-submitted estimates and CMS using Medicaid expenditure data as recently as the third quarter of FY 2025. The projections

[3] FY 2025 includes indefinite funding of $19.8 billion.
[4] FY 2026 includes indefinite funding of $10.4 billion.
[6] Numbers may not add due to rounding. Vaccines for Children totals reflect estimates under current law.
[6] The FY2026 amount of $769.2 billion in the narrative does not include anticipated indefinite authority.

incorporate the economic and demographic assumptions provided by the Office of Management and Budget (OMB) for the FY 2027 President's Budget.

Under current law, the federal share of Medicaid net outlays is estimated to be $715.7 billion in FY 2027, an increase of $800.0 million from the FY2026 level of $714.9 billion.

The FY 2027 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.

Funding History

Fiscal Year	Amount
FY 2023 [7]	$611,245,154,000
FY 2024 [8]	$640,469,335,000
FY 2025 [9]	$672,310,865,000
FY 2026 [10]	$779,651,906,000
FY 2027	$785,192,746,000

[7] Includes $78.2 billion in indefinite funding authority obligated during FY 2023.
[8] Includes $35.9 billion in indefinite funding authority obligated during FY 2024.
[9] Includes $19.8 billion in indefinite funding authority obligated during FY 2025.
[10] Includes an estimate of $10.4 billion in indefinite funding authority obligated during FY 2026.

Medical Assistance Payments
(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Medical Assistance Payments	$634,110,416	$741,595,071	$744,849,084	$3,254,013

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 people. 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 from state to state. State legislatures may change Medicaid eligibility, benefits, and/or reimbursement, subject to federal standards, at any time.

States make Medicaid payments directly 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 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Aged	9.8	10.2	10.5	0.3
Disabled	8.2	8.1	8.0	(0.1)
Adults	12.4	12.5	12.5	0.0
Children	30.6	30.7	30.6	(0.1)
Expansion Adult	19.9	20.1	17.0	(3.1)
Territories	1.5	1.5	1.5	0.0
Total [11]	**82.4**	**83.0**	**80.1**	**(2.9)**

According to CMS projections of Medicaid enrollment, 80.1 million Americans will be enrolled in Medicaid for the equivalent of a full year during FY 2027. In FY 2027, 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 2.9 million in FY 2027.

FY 2027 Budget Estimate

CMS's Medical Assistance Payments budget estimate is $744.8 billion, a $3.2 billion increase above the FY 2026 request. To arrive at an accurate estimate of Medicaid expenditures, CMS adjusted 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

OACT has found that state-submitted estimates of the grant awards tend to be higher than actual expenditures. Because of this, OACT relies more on actual expenditure data than the state-submitted estimates. OACT developed the MAP estimate for FY 2027 using the three quarters of FY 2025 state-reported expenditures as a base. Expenditures for FY 2025, FY 2026, and FY 2027 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 provided by OMB and demographic trends in Medicaid enrollment. 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 2027 estimate of $69.5 billion represents the entire liability for Medicaid medical services incurred but not paid from October 1, 2026, to September 30, 2027. 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.

[11] Totals may not add due to rounding.

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 pay for the Medicare program's costs attributable to state coverage of Medicare cost-sharing for certain low-income enrollees. OACT estimates this amount at $1.5 billion for FY 2027. 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

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

This Act provides funding for the expansion of community mental health services demonstration programs. 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)

This Act includes provisions relating to prescription drug costs and health care costs. This Act included a Medicaid provision that requires coverage of vaccines recommended by the Advisory Committee on Immunization Practices for adults without cost-sharing.

Consolidated Appropriations Act of 2024 (P.L. 118-42)

This Act provides consolidated appropriations for the fiscal year ending September 30, 2024. This Act permanently extends the requirement to provide coverage for MAT (Medication-Assisted Treatment), certified community behavioral health clinic services under Medicaid, and prohibits beneficiary disenrollment due to incarceration.

The Working Families Tax Cut Act of 2025 (P.L. 119-21)

This Act generates savings and provides funding for several sections affecting Medicaid which have been categorized by the following:

> Improving Eligibility and Enrollment Processes – Sections include eligibility redeterminations, moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP, and the Basic Health Program, revising the home equity limit for determining eligibility for long-term care services under the Medicaid program, changes to eligibility and reimbursement for non-citizens, and restoring the traditional FMAP for emergency Medicaid.

Stopping Abusive Financing Practices and Improving 1115 Demonstration Fiscal Integrity – Achieved through reforms to state directed payments, provider taxes, and requirements regarding waiver of uniform tax requirement for the Medicaid provider tax, as well as strengthening determinations of Section 1115 demonstration budget neutrality.

Increasing Personal Accountability - Establishes Medicaid community engagement requirements for certain individuals and modifies cost sharing requirements for certain expansion individuals under the Medicaid program.

Expanding Access to Care - Making certain adjustments to coverage of home or community-based services under Medicaid.

The Consolidated Appropriations Act of 2026 (P.L. 119-75)

Sections 6102, 6103, 6105, and 6106 of the Consolidated Appropriations Act of 2026 primarily focus on extending critical health, community, and safety programs in the Medicaid program.

Sec. 6102 - Removing certain age restrictions on Medicaid eligibility for working adults with disabilities.

Sec. 6103 – Medicaid State plan requirement for determining residency and coverage for military families.

Sec. 6105 – Modifying certain disproportionate share hospital allotments.

Sec. 6106 – Modifying certain limitations on disproportionate share hospital payment adjustments under the Medicaid program.

Regulatory Actions

SMDL: Medicaid Managed Care Payments and Emergency Medical Condition Coverage for Aliens Ineligible for Full Medicaid Benefits

A September 30, 2025, State Medicaid Director Letter (SMDL) from CMS updates policy to restrict federal financial participation (FFP) to verified emergency medical services provided to individuals ineligible for full Medicaid due to immigration status. This prohibits FFP for risk-based capitation payments, State Directed Payments, and administrative costs for emergency services Medicaid and any administrative activities associated with “emergency Medicaid”. It also prohibits states from using managed care contracts and capitation payments for federally funded Medicaid to provide entirely state-funded health care coverage benefits to noncitizens ineligible for full Medicaid.

DHS NPRM Public Charge Ground of Inadmissibility (RIN 1615-AD06)

The DHS Notice of Proposed Rulemaking (NPRM) "Public Charge Ground of Inadmissibility" (RIN 1615-AD06), published on November 19, 2025, proposes to rescind the 2022 Biden administration rule and implement a stricter, more discretionary standard for assessing if immigrants are likely to become "primarily dependent" on government assistance.

NPRM: Prohibition on Federal Medicaid and CHIP Funding for Sex-Rejecting Procedures Furnished to Children

This proposed rule would require that a State Medicaid plan must provide that the Medicaid agency will not make payment under the plan for sex-rejecting procedures for children under 18 and prohibit the use of Federal Medicaid dollars to fund sex-rejecting procedures for individuals under the age of 18.

Vaccines for Children
(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Vaccines for Children	$6,575,625	$6,072,286	$6,783,662	$711,376

Program Activity Description and Accomplishments

The Vaccines for Children program is funded by the Medicaid appropriation and operated by the Centers for Disease Control and Prevention (CDC). This program provides eligible children access to vaccines recommended by the Advisory Committee on Immunization Practices. VFC serves children ages 0 through 18 years who are uninsured, underinsured, Medicaid-eligible, or American Indian/Alaska Native children. Children with commercial insurance that lack an immunization benefit can also 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 63 state and local public health immunization programs that include all 50 states, eight city/urban areas, and five U.S. territories.

FY 2027 Budget Estimate

CMS's Vaccines for Children budget estimate under current law is $6.8 billion, a $711.4 million increase above the FY 2026 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 to fight outbreaks of Vaccine Preventable Diseases (VPDs) and mitigate the impact of unanticipated shortages of routinely recommended vaccines. The remaining budget supports vaccine ordering and distribution, including costs of ordering vaccines on behalf of states, and program support and oversight.

State and Local Administration
(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
State and Local Administration	$31,624,824	$31,984,549	$33,560,000	$1,575,451

Program Activity Description and Accomplishments

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.

FY 2027 Budget Estimate

CMS's State Administration estimate is $33.6 billion, which is a $1.6 billion dollar increase compared to the FY 2026 estimated level.

This estimate is composed of $373.0 million for Medicaid state survey and certification, $427 million for state Medicaid Fraud Control Units, and $32.8 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: 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. The current FY 2027 estimate for Medicaid state survey and certification is $373.0 million, matching the FY 2026 estimated amount of $373.0 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 2027, Medicaid Fraud Control Units (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 $427.0 million, which represents an increase of $15.0 million over the FY 2026 estimate of $412.0 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 2024, MFCUs were responsible for 1,151 convictions, 493 civil

settlements and judgments, and expected monetary recoveries for both civil and criminal cases of $1.4 billion. MFCU cases in FY 2024 were also responsible for the exclusion of 1,042 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 2027 estimate for this transfer is $5.0 million, a flatline from the FY 2026 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 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 2027.

All Other Medicaid State and Local Administration: The CMS estimate for FY 2027 is $32.8 billion. CMS adjusted the FY 2026 state-submitted estimates of $31.2 billion upward to reflect a growth rate more consistent with recent expenditure history and current economic conditions, and anticipated increases in state systems changes due to the Working Families Tax Cut Act.

This page intentionally left blank.

Payments to the Health Care Trust Funds

Annual Budget Authority
(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Budget Authority	$588,782,000	$593,817,000	$686,855,000	$93,038,000

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 2027 estimated request of $480.4 billion is a net increase of $15.6 billion over the FY 2026 estimate of $464.8 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 2027 estimated request of $28.0 million for Hospital Insurance for Uninsured Federal Annuitants is a net decrease of $13.0 million from the FY 2026 amount of $41.0 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 2027 budget estimate to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare trust fund activities remains at $1.0 billion.

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

The Medicare Prescription Drug Plan program was created as a result of the enactment of 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 2027 budget estimate of $204.3 billion for General Revenue for Part D (Benefits) is a net increase of $19 billion over the FY 2026 amount of $185.3 billion.

The FY 2027 budget estimate of $645.0 million request for General Revenue for Part D Federal Administration is a net increase of $59.0 million over the FY 2026 amount of $586.0 million.

The FY 2027 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 FY 2027 budget estimate of $390.0 million for reimbursement of HCFAC is a net increase of $13.0 million over the FY 2026 amount of $377.0 million. This amount reflects an estimate of the portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds, but which are properly chargeable to the general fund. This includes non-Medicare program integrity activities for Medicaid, the Children's Health Insurance Program, and the Federal Exchanges. The FY 2027 request is an estimate based on the current allocation of HCFAC spending data for the above-mentioned non-Medicare program integrity activities.

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

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Supplementary Medical Insurance (SMI)	$373,973,000	$464,796,000	$480,445,000	**$15,649,000**
Indefinite Annual[1] Appropriation, SMI	$44,910,000	$0	$0	**$0**
Hospital Insurance for Uninsured Federal Annuitants	$44,000	$41,000	$28,000	**($13,000)**
Program Management Administrative Expenses	$1,000,000	$1,000,000	$1,000,000	**$0**
General Revenue for Part D Benefit	$100,805,000	$127,012,000	$204,342,000	**$77,330,000**
Indefinite Annual[1] Appropriation, Part D Benefits	$67,147,000	$58,289,000	$0	**($58,289,000)**
General Revenue for Part D Federal Administration	$523,000	$586,000	$645,000	**$59,000**
Part D: State Low Income Determination	$5,000	$5,000	$5,000	**$0**
Reimbursement for HCFAC	$375,000	$377,000	$390,000	**$13,000**
Total Budget Authority	**$588,782,000**	**$652,106,000**	**$686,855,000**	**$34,749,000**

Funding History

.

Fiscal Year	Amount
FY 2023	$557,729,683,000
FY 2024	$508,196,012,000
FY 2025 Final	$588,782,000,000
FY 2026 Enacted	$593,817,000,000
FY 2027 President's Budget	$686,855,000,000

[1] CMS' methodology for budgeting the Payments to the Health Care Trust Funds costs incorporate its lowest estimated budgetary needs and rely upon its indefinite authority if it is determined additional funding is needed. Additionally, due to the passage of Full-Year Continuing Appropriations and Extensions Act, 2025 (PL 119-4), the FY 2025 levels were flatlined at the FY 2024 levels, creating a larger need for indefinite authority.

Permanent Budget Authority
(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Tax on OASDI Benefits	$41,054,000	$47,990,000	$52,094,000	**$4,104,000**
HCFAC, FBI	$173,565	$178,252	$182,886	**$4,634**
HCFAC, Asset Forfeitures	$162,000	$163,000	$164,000	**$1,000**
HCFAC, Criminal Fines	$10,000	$20,000	$11,000	**($9,000)**
HCFAC, Civil Penalties and Damages: Administration	$23,000	$40,000	$34,000	**($6,000)**
Total Budget Authority	**$41,422,565**	**$48,391,252**	**$52,485,886**	**$4,094,634**

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.

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

This page intentionally left blank.

Health Care Fraud and Abuse Control [1]

(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Discretionary	**$941,000**	**$941,000**	**$976,000**	**$35,000**
CMS	$699,058	$699,058	$740,260	$41,202
HHS-OIG	$108,735	$108,735	$97,862	($10,873)
DOJ	$133,207	$133,207	$137,878	$4,671
Mandatory	**$1,648,828**	**$1,693,490**	**$1,737,659**	**$44,169**
CMS	$1,109,012	$1,139,098	$1,168,853	$29,755
HHS-OIG	$243,601	$250,178	$256,682	$6,505
HHS Wedge	$46,592	$47,850	$49,094	$1,244
DOJ Wedge	$76,059	$78,112	$80,143	$2,031
FBI	$173,565	$178,252	$182,886	$4,635
Program Level	**$2,589,828**	**$2,634,490**	**$2,713,659**	**$79,169**

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

FY 2026 Authorization – Public Law (P.L.) 104-191 and P.L. 119-75

Allocation Method – Other

Program Description and Accomplishments

The Health Care Fraud and Abuse Control (HCFAC) program greatly enhances federal efforts to combat health care fraud, waste, and abuse. The HCFAC account provides resources to CMS, the HHS Office of Inspector General (HHS-OIG), and the U.S. Department of Justice (DOJ) to coordinate oversight and law enforcement efforts to efficiently and effectively target bad actors, identify and reduce improper payments, and protect the sustainability of federal health care programs that provide health care to Americans.

Crushing Fraud, Waste, and Abuse

The Administration is committed to crushing fraud, waste, and abuse in federal health care programs. To achieve this goal, the FY 2026 President's Budget request prioritized program integrity through strategic investments in anti-fraud initiatives and efforts to reduce improper payments. Key activities included innovative fraud-fighting technologies, including artificial intelligence (AI) and enhanced pre-payment reviews, and modernizing provider enrollment systems. The FY 2027 President's Budget builds upon the foundation laid in the FY 2026 request, while prioritizing the integrity of Medicare Advantage (MA) and Medicaid as well as enhancing efforts to swiftly investigate fraud.

[1] All mandatory amounts are net of sequester. Discretionary and mandatory amounts do not include any carryover resources.

In May 2025, CMS announced a major expansion of its Risk Adjustment Data Validation (RADV) auditing efforts.[2] The RADV program is CMS' primary way to address the approximately $17 billion in overpayments made to MA organizations each year. After years of stagnation that led to audit delays, CMS is working to expedite RADV audits so that the Agency can catch up on outstanding audits and initiate new audits as close to the most recent payment year as possible.[3] CMS is also developing a strategy to strengthen oversight of the MA program by harnessing modern technology to more efficiently identify overpayments while reducing agency burden.

CMS also plans to implement a more robust and effective program integrity strategy to address the pervasiveness of fraud, waste, and abuse in state Medicaid programs. Following reports of fraud across numerous Medicaid-funded programs in Minnesota, CMS took action to provide on-site fraud oversight and direction to the state. The breadth of the issues in Minnesota requires CMS to review similar services in other states and significantly ramp up oversight activities, as appropriate. This will include additional audits and investigations, additional federal resources on the ground, data analysis and new processes to support law enforcement. In addition, CMS plans to increase oversight in Medicaid managed care and conduct new audits of beneficiary eligibility determinations related to changes made under the Working Families Tax Cut legislation, P.L. 119-21.

The budget will strengthen CMS's ability to prevent Medicaid fraud, waste, and abuse by enhancing advanced data analytics and emerging technologies, including AI, to proactively identify investigative leads and emerging risk patterns. These efforts will improve the identification of state-level vulnerabilities and support more timely, targeted oversight of Medicaid program integrity activities across states. CMS will be able to better assess the effectiveness of state Medicaid program integrity efforts and focus oversight where risk is greatest. CMS will also expand its capacity to provide technical assistance, guidance, and education to states, supporting continuous improvement in program integrity operations while promoting consistent, scalable best practices nationwide.

CMS is also increasing efforts to proactively detect and identify fraud in real time. In July 2025, CMS permanently established the Fraud Defense Operations Center (FDOC). The FDOC integrates cross-functional expertise through a specialized team of data analysts, investigators, health policy experts, legal advisors, and law enforcement personnel who leverage advanced AI and machine learning technologies to detect and respond to fraudulent activity swiftly. This mission-critical effort demands exceptional coordination to manage complex cases simultaneously while maintaining strict adherence to operational timeliness, performing daily case management across multiple systems, facilitating FDOC actions such as payment suspensions and medical reviews, and ensuring comprehensive quality assurance and regulatory compliance. In calendar year 2025, FDOC efforts resulted in $1.8 billion in payments suspended.[4]

CMS is aggressively modernizing the tools it uses to reduce fraud, waste, and abuse including AI, machine learning, and similar technologies. These investments align with the

[2] https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-and-accelerate-medicare-advantage-audits

[3] On September 25, 2025, the U.S. District Court for the Northern District of Texas vacated certain portions of CMS' 2023 RADV Final Rule, thus preventing CMS from extrapolating audit findings for payment recovery at this time. CMS continues to carefully evaluate the implications of this decision and will determine whether any potential changes to current and future audits are needed.

[4] Numbers are cumulative of the pilot dates (March 31 - May 1, 2025) and the FDOC (July 22 – December 31, 2025).

Administration's commitment to American leadership in artificial intelligence (Executive Order 14179). CMS continues to expand the use of these innovations in its everyday program integrity activities. CMS already integrates AI into its fraud detection and analysis processes and will expand on these efforts through new use cases that streamline investigative workflows, improve prepayment detection capabilities, and increase the scalability of fraud response operations. AI also has the potential to greatly expand the Agency's capacity to conduct medical review and prior authorization.

Collaboration Among Federal Partners

The Federal partners undertake coordinated efforts to combat fraud and recover taxpayer dollars. The recent 2025 National Health Care Fraud Takedown demonstrated the effectiveness and efficiency of the HCFAC partnership, with 324 defendants criminally charged for fraudulent billings of over $14.6 billion.[5] This takedown was more than double the size of the largest prior national health care takedown and included alleged fraud by domestic and foreign actors. Importantly, HHS-OIG and CMS used their respective investigative and administrative authorities—along with advanced data analytics—to swiftly stop payments to the defendants.

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 to develop many of these fraud leads. Through FY 2023, there have been over 5,000 cases reviewed at the MCC, and law enforcement partners have made over 3,100 requests for CMS to refer reviewed cases.

HCFAC investments in law enforcement collaboration continue to demonstrate positive results, yielding a $2.80 to $1.00 return on investment for these efforts over a three-year period (2021-2023).[6] The return on investment continues to be adversely impacted by unique factors associated with the COVID-19 pandemic, such as court closures as well as interrupted or slowed enforcement activities.

Medicare Integrity Program

With projected spending of more than $1 trillion in Calendar Year 2027, Medicare is one of the largest and most attractive targets for financial fraud in the world.[7] CMS processes over one billion Original Medicare claims annually, even as enrollment continues to shift towards managed care. The program has continually been on the Government Accountability Office's (GAO's) High Risk List, with an estimated $56.7 billion in improper payments across Original Medicare, Part C, and Part D in FY 2025.

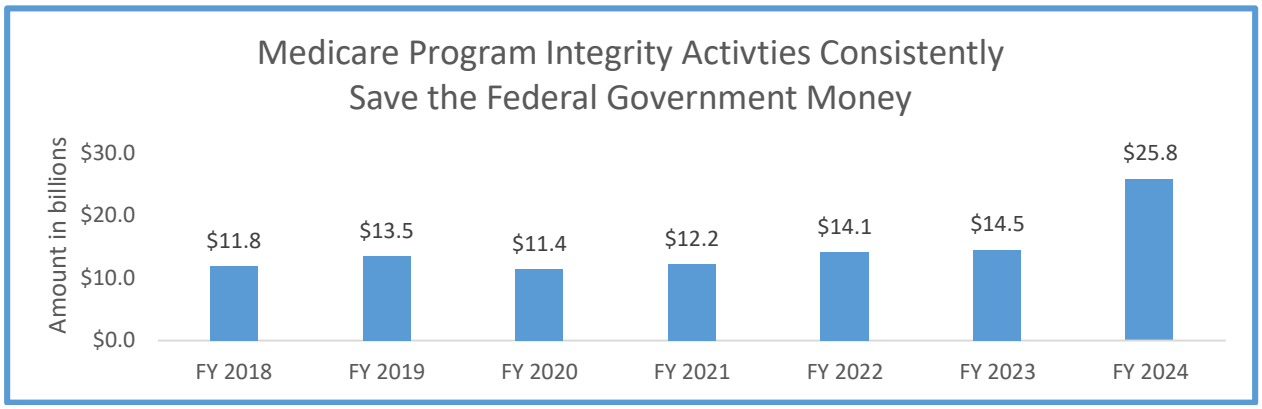
Using the resources and authorities provided by Congress, CMS employs a number of tools to safeguard the CMS health programs, including, but not limited to, provider enrollment and

[5] https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146

[6] Additional detail can be found in the FY 2023 Annual HCFAC Report (https://oig.hhs.gov/reports/all/2024/health-care-fraud-and-abuse-control-program-report-fiscal-year-2023/). It is important to note that the HCFAC law enforcement ROI does not include Medicare Part C and Part D recoveries. HHS and DOJ are working together to adjust the HCFAC law enforcement ROI methodology to ensure it captures Medicare Part C and Part D recoveries.

[7] National Health Expenditures Data, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data

screening processes, data analyses, investigations, and reviews of medical records. These efforts have proven to be successful, with CMS consistently generating savings of more than $11 billion annually. The chart below shows annual Medicare program integrity savings resulting from activities funded with mandatory and discretionary HCFAC resources, as well as provider enrollment user fees.[8]



In FY 2024, the Agency's Medicare program integrity activities produced a return on investment of $14.6 to $1. Notably, 35 percent ($9.3 billion) of CMS's total Medicare program integrity savings stemmed from actions on suppliers suspected of problematic urinary catheter billing.

Medicaid Program Integrity

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. As with Medicare, Medicaid has continually been on GAO's High-Risk List, with an estimated $37.4 billion in improper payments in FY 2025. CMS addresses Medicaid program integrity through oversight, systems and data analytics, and technical assistance to States.

Exchange Program Integrity

The Health Insurance Exchanges are important avenues for individuals and families to obtain private market health insurance coverage and receive financial assistance in the form of advance premium tax credits (APTCs) to help pay for insurance premiums. This program is threatened by various forms of misconduct, particularly unauthorized enrollment and plan changes by agents and brokers. Through the use of data analytics, CMS supports and prioritizes investigations that aim to safeguard the integrity of the Federally-Facilitated Exchange (FFE) and expenditures of federal dollars. CMS also annually measures and reports the estimated improper payments for the APTC program in the FFE.

[8] The savings in the chart excludes savings from the Recovery Audit Contractors. Additional detail can be found in the Medicare and Medicaid Integrity Programs Report to Congress (https://www.cms.gov/medicare/medicaid-coordination/center-program-integrity/reports-guidance).

Funding History

Fiscal Year	Amount [9]
FY 2023 Final	$2,415,894,000
FY 2024 Final	$2,514,895,000
FY 2025 Final	$2,589,828,000
FY 2026 Enacted	$2,634,490,000
FY 2027 President's Budget	$2,713,659,000

Since its inception in 1997, HCFAC has been financed from the Federal Hospital Insurance Trust Fund, which provides both mandatory and discretionary funding.[10]

Discretionary Budget Request: $976.0 Million

HCFAC resources have proven indispensable in the fight against health care fraud, delivering billions in recoveries and safeguarding program integrity. The FY 2027 request for discretionary funding is $976.0 million, an increase of $35.0 million above the FY 2026 Enacted Level. The total post-sequester FY 2027 mandatory funding level is $1,737.7 million, $44.2 million above the FY 2026 Enacted Level.

CMS' allocation of the discretionary HCFAC request is $740.3 million, an increase of $41.2 million above the FY 2026 Enacted Level and reflects activities that support the emerging needs across all health care programs under CMS' jurisdiction. In addition to ongoing operations for a wide array of program integrity activities, the request focuses the increased discretionary resources on increasing Medicaid oversight targeted at high-risk areas and modernizing the Medicare provider enrollment system.

This Budget reflects operational efficiencies started in FY 2025 to reduce costs, lower the Agency's contractor footprint, and ensure that resources are focused on the most effective activities. This includes eliminating duplication and lower-priority work, insourcing activities that can be performed by existing federal staff, and leveraging advanced technologies.

[9] Includes both mandatory and discretionary HCFAC resources; mandatory amounts are net of sequester. These amounts do not include any carryover resources from prior fiscal years.
[10] The Trust Fund is reimbursed for discretionary HCFAC activities properly chargeable to the general fund, such as Medicaid activities. Additional detail can be found in the Payments to the Health Care Trust Funds chapter.

HCFAC Budget Authority by Activity – CMS
(Dollars in Thousands)

Activity	FY 2025 Final [11]	FY 2026 Enacted [12]	FY 2027 President's Budget			FY 2027 +/- FY 2026
			Discretionary Request	Mandatory Resources	Total	
MAC Program Integrity Operations	$418,000	-	$0	$436,000	$436,000	$12,000
Provider Enrollment & Screening	$112,487	-	$56,415	$78,312	$134,728	$7,363
Technical Assistance, Outreach & Education	$74,435	-	$63,899	$8,615	$72,514	($10,104)
Medical Review	$89,741	-	$42,193	$34,612	$76,806	($7,485)
Medicare Secondary Payer	$82,720	-	$0	$86,344	$86,344	($1,131)
PI Investigation, Systems & Analytics	$361,179	-	$205,533	$205,559	$411,092	$38,537
Audits & Appeals	$115,079	-	$133,183	$39,451	$172,634	$8,097
Provider & Plan Oversight	$41,113	-	$33,613	$15,253	$48,866	$6,377
Error Rate Measurement	$80,703	-	$77,719	$30,000	$107,719	$3,756
Program Support & Administration	$320,741	-	$127,705	$234,707	$362,413	$13,547
Total [13]	**$1,808,070**	**$1,838,156**	**$740,260**	**$1,168,853**	**$1,909,113**	**$70,957**

MAC Program Integrity Operations

CMS conducts many of its cornerstone program integrity activities through the Medicare Administrative Contractors (MACs).[14] In addition to their administrative role, the MACs audit cost reports, perform medical review, engage in outreach and education with providers, and support the Medicare Secondary Payer (MSP) program. CMS works with each MAC to develop improper payment reduction strategies, based on vulnerabilities identified by MAC specific jurisdictional data analysis.

MAC Program Integrity Operations activities will be funded with $436.0 million in mandatory resources. Funding will support ongoing operations, which includes:

Provider Cost Report Audit – 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 2025, the MACs received and accepted 54,235 Medicare cost reports, which included initial as well as amended cost report filings; desk reviewed and tentatively settled 42,060 cost reports; and completed 473 audits.

[11] The FY 2025 total includes $111.9 million in discretionary funds that will be carried over into FY 2026. CMS plans to obligate these carryover funds in FY 2026 to support Administration priorities.
[12] Allocations for FY 2026 have not yet been determined.
[13] These amounts do not include any carryover resources. Activity amounts may not add due to rounding.
[14] As discussed in the Program Administration chapter, the MACs separately receive funding from the Program Management account to process Original Medicare claims and support participating providers for all parts of Medicare.

Medical Review – The MACs perform medical review to identify and address improper payments through the analysis of Original Medicare claims data and medical documentation. These activities include conducting targeted reviews of claims that pose the highest risk of improper payment and educating providers on Medicare coverage and documentation requirements to prevent future billing errors.

In FY 2025, the MACs completed 561,908 medical record reviews.[15] Of these reviews, 151,614 (27%) resulted in denial. The table below shows the amount of medical review conducted by the MACs, including Targeted Probe and Educate, since FY 2018.

Total Number of MAC Original Medicare Medical Review

Fiscal Year	Medical Review of Claims	Denials
2018	470,988	38%
2019	462,029	31%
2020	258,041	30%
2021	25,500[16]	41%
2022	429,393	33%
2023	530,218	37%
2024	538,167	30%
2025	561,908	27%

The typical cost associated with each review varies by contractor and is dependent on the service, volume, and program. The complexity of the topic and corresponding records are factors that affect the time and cost associated with each claim review conducted in the MAC jurisdiction. For example, a home health medical review is more costly and time consuming than a review of a Vitamin D laboratory claim.

Medicare Secondary Payer (MSP) – The MACs play a key role in the MSP program, which is discussed in greater detail later in this chapter.

Outreach and Education – The MACs 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.

Provider Enrollment & Screening

Provider enrollment is the gateway to the Medicare and Medicaid programs. Through a comprehensive system of enrollment requirements, screening protocols, and ongoing monitoring, CMS maintains strict oversight of all participating providers and suppliers, with the authority to deny enrollment or revoke participation when necessary to protect program integrity. In FY 2025, CMS denied 5,959 enrollments, deactivated 192,636 enrollments, and revoked 3,675 enrollments.

At the center of this process is the Provider Enrollment, Chain, and Ownership System

[15] This figure does not include prior authorizations, which the MACs also conduct. Prior authorization is discussed later in this chapter.
[16] FY 2021 totals are lower due to a pause in TPE review during this timeframe, due to the COVID-19 Public Health Emergency.

(PECOS), which functions as the system of record for all Medicare provider and supplier enrollment data across Part A, Part B, and durable medical equipment. In FY 2025, PECOS maintained more than 2.9 million approved enrollments. This centralized platform not only stores comprehensive provider information and tracks MAC processing activities but also supports claims payment systems. Through data-sharing initiatives, state Medicaid programs leverage this robust infrastructure to enhance their own provider screening efforts.

The Advanced Provider Screening (APS) system provides an additional layer of scrutiny to the enrollment process. 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 2025 alone, APS resulted in more than 12 million screenings which generated more than 118,000 potential licensure alerts and more than 2,500 criminal alerts for potentially fraudulent providers and suppliers for further review by CMS. Such review resulted in approximately 353 criminal revocations, 356 licensure revocations, and more than 42,000 licensure deactivations.

Discretionary Budget Request: $56.4 Million

In addition to the discretionary request, CMS will utilize $78.3 in mandatory resources. Funding will support ongoing operations for PECOS and APS. This funding will further support the Data Exchange (DEX) system, which facilitates the sharing of provider termination and revocation data among CMS and state programs.

This funding will allow CMS to continue modernization of PECOS, which is expected to resume in FY 2026. CMS is committed to improving the provider enrollment experience. PECOS is transitioning to a cloud-based platform and will continue to improve provider enrollment processing. This funding will also maintain the End User Services, the first line of contact for providers.

This funding will also maintain the National Provider Enrollment East and West contractors, which process all Medicare enrollment applications for Durable Medical Equipment, Prosthetic Devices, Prosthetics, Orthotics, & Supplies (DMEPOS).

Technical Assistance, Outreach & Education

Effective outreach and education initiatives help prevent fraud, waste, and abuse before they occur. As discussed above, the MACs conduct a robust outreach and education program targeted at Medicare providers. Beyond the MACs, CMS uses a multi-faceted approach to reach key audiences and stakeholders. These proactive efforts not only help safeguard federal health care programs but also promote a culture of compliance while reducing improper payments and strengthening program integrity across the health care system.

Outreach to beneficiaries empowers them to prevent, recognize, and report health care fraud. The Fraud Prevention Campaign is an annual national outreach initiative that educates beneficiaries to protect their personal information and Medicare card, stay alert to unsolicited requests for Medicare information through phone calls, emails, and texts, and report suspected fraud to 1-800-MEDICARE. The awareness campaign utilizes media tactics including TV, radio, and digital platforms to reach 85 percent of the Medicare audience, generating approximately 225 million impressions annually. The campaign also deploys quick-response outreach to warn specific geographic areas and vulnerable communities about emerging scams and fraud schemes in real-time.

The Senior Medicare Patrol (SMP) program provides more direct engagement with Medicare beneficiaries and their families through outreach, counseling and education.[17] In calendar year 2024, SMP activities reached an estimated 1,172,875 people through 22,752 group outreach and education events and held 283,724 individual counseling sessions with, or on behalf of, Medicare beneficiaries.

CMS also maintains key relationships with relevant federal and state agencies, and other stakeholders impacted by CMS' program integrity activities. For example, the Healthcare Fraud Prevention Partnership (HFPP) is a voluntary, public-private partnership between the Federal Government, state agencies, law enforcement, private health insurance plans, employer organizations, and health care anti-fraud associations to identify and reduce fraud, waste, and abuse across the health care sector. The HFPP allows for the exchange of data and information, leveraging various analytic tools using claims and other data provided by HFPP partners, and providing a forum for leaders and subject matter experts to share successful practices and effective methodologies.

Discretionary Budget Request: $63.9 Million

In addition to the discretionary request, CMS will utilize $8.6 million in mandatory resources. This funding covers ongoing activities for the HFPP, the Fraud Prevention Campaign, and the SMP program.

This funding also supports technical assistance for and oversight of states' Medicaid enterprise systems, ensuring compliance with federal requirements, improving data accuracy, and reducing costs and risks. CMS provides comprehensive technical assistance and oversight to state Medicaid Enterprise Systems across all 50 states, the District of Columbia, and territories, ensuring compliance with federal requirements, including the Medicaid Information Technology Architecture framework and Streamlined Modular Certification criteria. Through continuous monitoring and engagement with State Officers, CMS ensures timely claims payment, accurate eligibility determinations, and proper provider screening to reduce fraud, waste, and abuse. The outcomes-based Streamlined Modular Certification process, together with the Advanced Planning Document modernization initiative also supported by this funding, enhance accountability while providing states flexibility to maintain systems that deliver necessary care to beneficiaries at reasonable costs.

Medical Review

The review of medical records ensures that payment is made only for services that meet all Medicare coverage, coding, and medically necessary requirements. Medical review improves compliance and results in savings; however, it also requires significant resources. Many improper claims can be identified only by manually reviewing associated medical records, including a beneficiary's claim history, and exercising clinical judgment to determine whether a service is reasonable and necessary. Currently, CMS conducts medical review on less than one percent of all Original Medicare claims.

Prior authorization helps to ensure that applicable Medicare coverage, payment, and coding rules are met while allowing providers and suppliers to address claim issues early and avoid denials and appeals. CMS has limited statutory authority to use prior authorization in a limited

[17] Under the planned HHS reorganization, the SMP program will be administered by the Administration for Children and Families (ACF) in FY 2027. The budget requests $35.0 million for FY 2027.

number of contexts in the Original Medicare program, and it has proven to be an effective way to prevent fraud, waste, and abuse.

CMS continually assesses vulnerabilities for 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. Currently, CMS allows prior authorization for certain DMEPOS items and outpatient hospital department (OPD) services and intends to continue adding appropriate items and services where the authority exists.

CMS' prior authorization efforts have demonstrated remarkable success. The results highlighted in the table below showcase the program's effectiveness in generating substantial savings while maintaining appropriate access to care.

Spending Decreases After Prior Authorization Implementation

OPD Services	Spending Decrease through FY 2024
July 1, 2020: Blepharoplasty, Botulinum toxin injections, Panniculectomy, Rhinoplasty, and Vein ablation	25.0%
July 1, 2021: Implanted Spinal Neurostimulators and Cervical Fusion with Disc Removal	16.8%
July 1, 2023: Facet Joint Interventions	25.5%
DMEPOS Items	**Spending Decrease through FY 2024**
July 22, 2019: 5 Pressure Reducing Support Surfaces	45.0%
April 13, 2022: 5 Orthoses	26.7%

Discretionary Budget Request: $42.2 Million

In addition to the discretionary request, CMS will utilize $34.6 million in mandatory resources. This discretionary request includes ongoing operations for the Supplemental Medical Review Contractor (SMRC), prior authorization on Original Medicare claims,[18] activities to reduce the error rate, and information technology (IT) systems.

CMS will continue to test and implement AI initiatives that create efficiencies in Original Medicare medical review and prior authorization. These efficiencies include, for example, tabulation of the medical record to make it easier for clinicians to read, conversion of unstructured documentation to a structured format that allows it to be searchable and machine readable, and capabilities for AI to review medical records and make a recommendation regarding payment. If successful, these initiatives could reduce the time necessary to complete medical review and reduce the cost needed per review, possibly allowing for more reviews to be completed and more overpayments to be returned to the Trust Fund.

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

[18] Most prior authorization is funded out of the MAC Program Integrity Operations amount. Note that HCFAC funding does not fund any of CMS's prior authorization models or pre-claim review initiatives.

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 saves approximately $9 billion annually through cost avoidance and recoveries.

In FY 2027, this activity will be funded with $86.3 million in mandatory HCFAC resources. This funding will support the centralized MSP Coordination of Benefits & Recovery (COB&R) program and ancillary services such as postage and telecommunications services. System and database costs include cloud migration, operations and maintenance, software development, and creating efficiencies for the program. MSP operations in FY 2025 included over 12 million phone calls, 22 million letter prints, and 3.9 million letter pieces.

PI Investigation, Systems & Analytics

CMS combats fraud, waste, and abuse through specialized contractors and advanced analytics systems that work together to detect and investigate fraud, waste, and abuse in the federal health care programs. Through this approach, CMS identifies suspicious patterns, swiftly investigates violations, takes administrative actions against bad actors, and delivers referrals to law enforcement.

Unified Program Integrity Contractors (UPICs) identify and investigate potential fraud, waste, and abuse in Original Medicare and Medicaid. Working across five strategic jurisdictions throughout the United States, the UPICs conduct medical review, audits, and investigations to review claims and ensure compliance with coverage coding regulations and policies. Meanwhile, the Medicare Drug Integrity Contractors (MEDICs) deliver targeted enforcement in Medicare Part C and Part D. Investigations often result in revocations and the delivery of compelling case referrals to law enforcement; in FY 2025, the MEDICs generated 776 investigations and 175 law enforcement referrals. The MEDICs also analyze Part C and Part D data, implement rigorous audits of plan sponsors, and deliver education and outreach support.

Three systems primarily support fraud identification and investigation:

- The Fraud Prevention System (FPS), which uses advanced predictive analytics to identify irregular billing patterns, flag high-risk providers, and prioritize investigations.
- The Unified Case Management system, which allows CMS and its contractors to track leads, audits, and investigations across programs.
- The One PI system, which delivers centralized access to data from the Integrated Data Repository, enables CMS and law enforcement to conduct comprehensive Medicare and Medicaid data analysis.

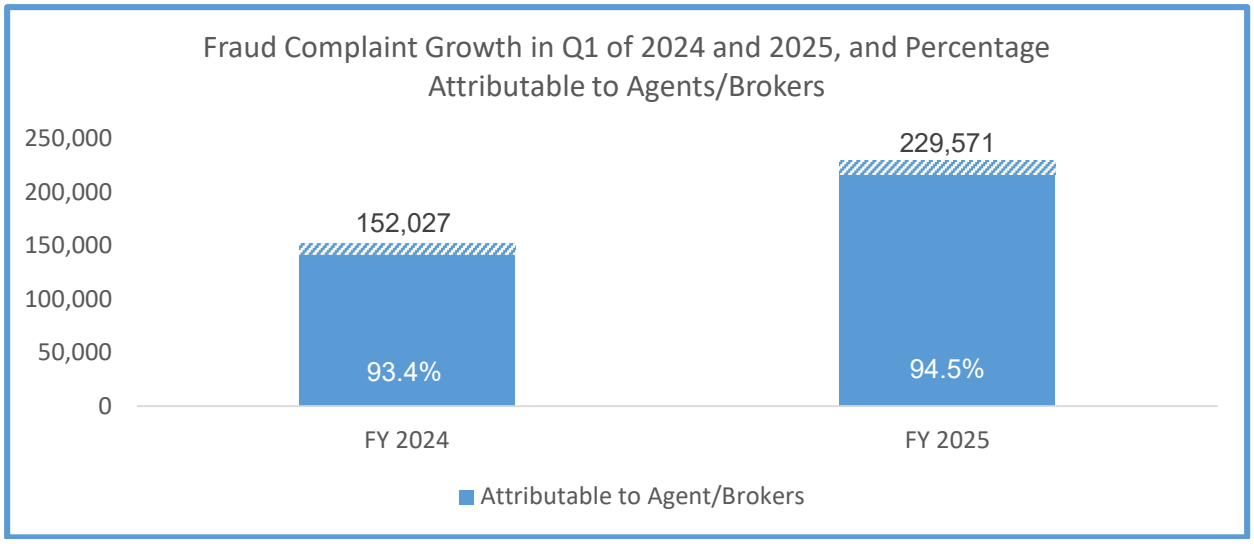
Together with the Application Programming Interface (API) Gateway, which consolidates disparate data across program integrity systems so it can be easily accessed and used, these systems create a technological infrastructure that enables CMS and its contractors to combat threats to the integrity of federal health care programs.

Effective monitoring and analytics requires access to complete and accurate data. The Encounter Data System Program collects and processes encounter data records submitted by MA organizations and Medicare-Medicaid Plans. This data supports CMS' oversight and integrity efforts, including analysis, outreach, and the development of benchmarks to evaluate the completeness and accuracy of the data for plan monitoring.
CMS strengthens Medicaid program integrity through the Medicaid and CHIP Business

Information Solution (MACBIS), an enterprise-wide initiative that modernizes data exchanges with states and partners.[19] MACBIS delivers critical operational, financial, pharmacy, quality, and business performance data, enabling comprehensive monitoring, oversight, and fraud prevention capabilities. MACBIS serves as the national system of record for Medicaid and CHIP data, providing beneficiary-level enrollment, claims, encounters, and provider information. All 50 states, DC, and participating territories submit data monthly, with CMS holding states accountable for correcting high-priority data quality issues. MACBIS provides a modern, web-based system for reviewing state plan amendments, waivers, and demonstrations to ensure proper oversight before implementation. The system improves accuracy and oversight of over $900 billion in total computable annual state-reported budget and expenditure data, enabling CMS to detect discrepancies and ensure proper federal payment calculations. MACBIS also modernizes oversight of the $38+ billion Medicaid drug rebate program, managing drug manufacturer agreements, pricing submissions, and state utilization data to ensure compliance and detect potential fraud in pharmaceutical billing. Through this integrated approach, CMS identifies patterns through advanced analytics, monitors compliance, and takes administrative actions when necessary. MACBIS provides the comprehensive data infrastructure necessary to detect and investigate fraud, waste, and abuse across Medicaid and CHIP.

CMS also aggressively safeguards the Health Insurance Exchanges through data analytics and targeted investigations that proactively prevent, identify, and address fraud allegations. Consumer complaints of fraud undergo rigorous review to determine whether administrative action can be taken. CMS recently introduced a new machine learning-based Exchange consumer complaint categorization process that has reduced complaint resolution timelines by more than 45 days and contractor workload by 85 percent. These efficiencies have enabled CMS to route consumer complaints to the appropriate entity more quickly to investigate and take action, as appropriate.

After the 2023 open enrollment period, CMS saw an increase in suspected Exchange fraud. The number of complaints in that period notably grew in 2025. Typically, CMS receives the greatest number of complaints in the first quarter of a given year. When the consumer becomes aware of these unauthorized enrollments, particularly after open enrollment and during tax season, they notify CMS.



[19] More information can be found in the Program Administration chapter.

Most of this fraud has taken the form of unauthorized enrollments and unauthorized plan switches performed by agents and brokers without the consumer's consent. CMS dedicates much of its resources here to reviewing and investigating these types of complaints so that appropriate action can be taken against the agents or brokers.

Discretionary Budget Request: $205.5 Million

In addition to the discretionary request, CMS will utilize $205.6 million in mandatory resources. This funding supports ongoing operations for CMS' primary anti-fraud contractors and systems.

In FY 2027, CMS plans to implement a more robust and effective program integrity strategy to address significantly growing risks in the Medicaid program. This initiative will involve tackling fraud schemes through additional investigations, data analysis, and law enforcement support; conducting audits related to Medicaid beneficiary eligibility and enrollment changes in the Working Families Tax Cut legislation; and expanding oversight of Medicaid managed care. AI and machine learning initiatives will continue to be a priority in FY 2027. CMS is developing machine learning models in FPS that automate the detection of fraud in both Medicare and Medicaid, reinforcing its broader strategy of using AI to reduce fraud, waste, and abuse. The AI Innovation Lab within One PI system further supports fraud investigations through the development of AI use cases that focus on process optimization, burden reduction, and detection of fraud, waste and abuse.

The request continues funding for program integrity modeling and analytics support (PIMAS) work. CMS utilizes contractors to gather, analyze, and apply data for fighting Medicare and Medicaid fraud, waste, and abuse. The PIMAS contractors develop and coordinate models and edits for FPS. They also develop demographic data and analysis for the UPICs, who then take investigative action, implement administrative actions, or coordinate possible fraud with our law enforcement partners, supporting CMS's Crushing Fraud priority. Essentially, the PIMAS contractors provide the analytical muscle, feeding data (like beneficiary demographics) for the UPICs and other integrity partners to identify and stop fraud, waste, and abuse.

The budget further supports the FDOC. The FDOC approach allows for quick, decisive action against suspected fraud and improper payments, which are expected to save taxpayers billions of dollars. CMS continues to develop the UPIC reform strategy with plans to start awarding new contracts in FY 2027. The next iteration of the UPICs will encompass the strategies that CMS has learned from the FDOC. This funding will allow for close coordination with contractors as well as the prompt engagement and analysis needed to swiftly deal with suspicious activity.

In FY 2027, HCFAC funding will continue to support MACBIS as well as the Encounter Data System Program. Within MACBIS, HCFAC funding will support the Medicaid and CHIP Program (MACPro) Portal, the Transformed Medicaid Statistical Information System (T-MSIS), and associated data analytics efforts that enable CMS to detect, investigate, and address fraud, waste, and abuse. T-MSIS collects and makes available standardized, high-quality Medicaid and CHIP claims, enrollment, and provider data that are critical for oversight and monitoring activities. MACPro provides a modern, web-based system for submitting, reviewing, and taking final action on all Medicaid and CHIP state plan amendments, waivers, and demonstrations, ensuring that program changes undergo proper oversight and compliance review to prevent potential fraud and abuse before implementation. Together, these investments strengthen CMS's ability to protect the integrity of Medicaid and CHIP.

Audits & Appeals

CMS conducts targeted, risk-based audit activities in Original Medicare and Medicare managed care to strengthen program integrity, protect federal funds, and ensure beneficiaries receive the services for which Medicare has paid. These audits promote payment accuracy, validate the reliability of data used to determine program expenditures, and provide insights that inform improvements to oversight, operations, and policy. By applying consistent audit principles while tailoring methods to each program's payment and delivery structure, CMS enhances accountability and supports the efficient use of public resources.

In particular, the Administration is committed to expanding RADV efforts.[20] Ensuring the accuracy and integrity of MA risk adjustment data is critical for the future solvency of the Medicare Trust Funds. Through RADV audits, CMS validates diagnosis codes submitted for risk adjustment payment purposes are properly supported by medical record documentation. This critical program employs a multi-stage process beginning with the selection of enrollee samples from MA organizations, followed by comprehensive medical record collection and expert review by certified medical coders. When discrepancies are identified between submitted diagnoses and supporting documentation, CMS recalculates risk scores and adjusts payments accordingly. The RADV program currently uses AI to initially screen medical records to ensure they meet CMS validity requirements before they are reviewed.

CMS conducts a wide range of audit activities, including financial and program audits of MA organizations, Part D sponsors, and Program of All-Inclusive Care for the Elderly (PACE) organizations, as well as targeted oversight of Original Medicare operations and payment requirements.[21] These activities validate the accuracy of reported costs and utilization, assess compliance with contractual and regulatory standards, and identify emerging risks affecting program expenditures and beneficiary access. Audit findings inform refinements to CMS' oversight processes and support ongoing improvements in payment accuracy, data quality, and beneficiary protections across Medicare programs. These audits also help drive the industry towards improvements in the delivery of health services.
While the majority of audit resources focus on Medicare, CMS also carries out certain audit activities in Medicaid. This includes medical loss ratio audits and targeted reviews of findings from single state agency audits and HHS-OIG audits of state Medicaid and CHIP programs. CMS also supports oversight and review of the annual Medicaid/CHIP compliance supplement, which serves as a tool for the required single state audits and analysis of single state audit findings. This includes outreach with the single state audit community.

Finally, CMS appeals initiatives support efficient processing and the fair, timely adjudication of appeals. This includes system work as well as support for the administrative adjudicative process established for MA organizations to appeal RADV determinations to a CMS Hearing Officer. Additionally, CMS will enable Qualified Independent Contractors (QICs) to participate as a party in approximately 2,450 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. In FY 2025, the

[20] On September 25, 2025, the U.S. District Court for the Northern District of Texas vacated certain portions of CMS' 2023 RADV Final Rule, thus preventing CMS from extrapolating audit findings for payment recovery at this time. CMS continues to carefully evaluate the implications of this decision and will determine whether any potential changes to current and future audits are needed.
[21] Original Medicare activities here complement the cost report reviews conducted by the MACs, which are discussed earlier in the chapter.

estimated amount in controversy of dollars upheld or dismissed following QIC participation as a party was approximately $46.6 million.

Discretionary Budget Request: $133.2 Million

In addition to the discretionary request, CMS will utilize $39.5 million in mandatory resources. CMS will continue its auditing functions and appeals initiatives in FY 2027, including IT operations for supporting systems.

As discussed earlier, CMS is undertaking a new strategy to significantly expand RADV auditing efforts going forward. In FY 2027, discretionary funding will continue to support the expanded RADV audit efforts that will include auditing all eligible MA contracts and conducting increased levels of medical review per audit.

In FY 2027, CMS expects to conduct:

- approximately 250 financial audits (also known as one-third financial audits[22]), including work to resolve audit issues noted in the audit reports;
- 30 Program audits of MA organizations and PDP sponsors,
- 45 audits of PACE plans; and
- audits of 8-11 Medicare managed care cost reports to ensure payment accuracy.

The request also includes fiscal oversight enhancements in Medicaid and CHIP through in-depth analysis of expenditure trends, variances between quarters/years, and spending anomalies to enhance the identification of state, regional, and national vulnerabilities.

This funding will also support a certified public accounting firm to assess the CMS internal controls over financial reporting, as required under OMB Circular A-123. The request further supports SSAE-18 audits for MACs, which assesses the quality of financial reporting focused on internal controls.

Provider & Plan Oversight

CMS carries out oversight responsibilities to ensure compliance with federal requirements, safeguard the integrity of Medicare and Medicaid funds, and promote accountability across federal health programs. These oversight activities protect beneficiaries, ensure taxpayer dollars are spent appropriately, and strengthen public trust in the federal health care programs.

CMS is committed to proper oversight in Medicare managed care. There has been tremendous growth in the MA program over the past ten years. Approximately 50 percent of all Medicare eligible enrollees are in MA plans today. Along with this enrollment growth, CMS has seen the number of MA plan offerings increase by more than 25 percent from FY 2020 to FY 2025 (see below).

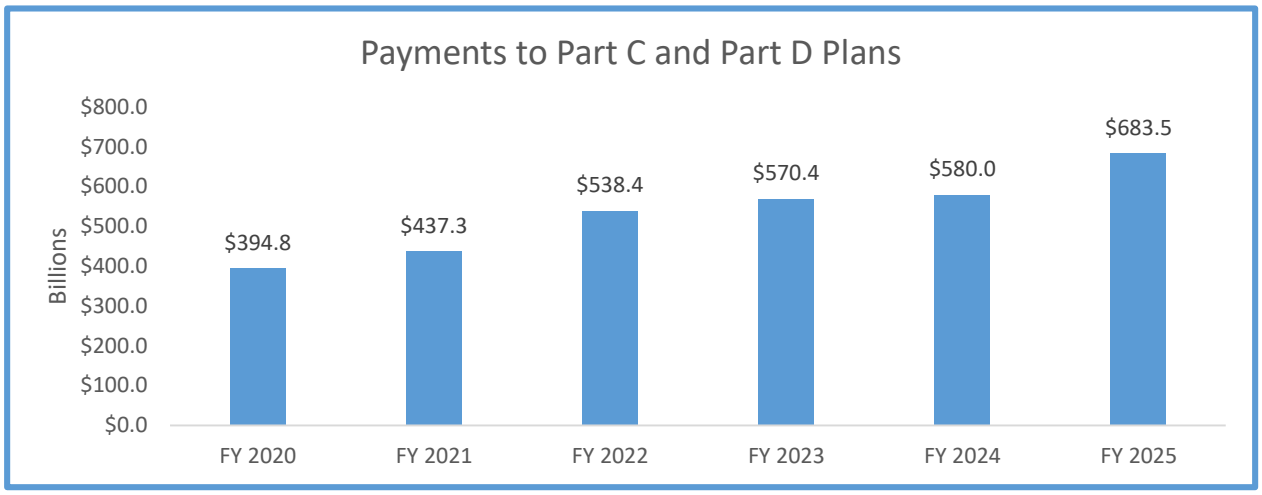
[22] Sections 1857(d)(1) and 1860D-12(b)(3)(c) of the Social Security Act require the Secretary to provide for the audits of financial records of at least one third of MA organizations and PDPs.

Growth in MA Plans, FY 2020-2025

Plans	5,674	6,308	6,899	7,350	7,276	7,135
Growth from Prior Year	16.2%	11.2%	9.4%	6.5%	-1.0%	-1.9%

While MA plan growth has leveled off somewhat in the past few years, the complexity of the plans being offered (and accompanying growth in the complexity of CMS' review) has also increased with the introduction of new benefit flexibilities such as Expanded Primarily Health Related Benefits, Uniformity Flexibility, and Special Supplemental Benefits for the Chronically Ill.

Meanwhile, payments to plans have consistently increased from FY 2020 to FY 2025 (see below), and CMS expects that payments will continue to grow in the future.



Oversight is more important than ever to ensure that Part C and Part D payments are correct and that plans are held accountable for compliance.

CMS also provides oversight of Medicaid to protect beneficiaries, ensure fiscal integrity, and support state innovation. Through this work, CMS promotes financial integrity and payment accuracy, state payment practices, evaluates demonstrations, and enforces financial safeguards to confirm that federal and state funds are and used appropriately. These activities promote accountability, strengthen program integrity, and help sustain Medicaid as a reliable source of health coverage for millions of low-income individuals and families.

This section also includes the Open Payments program. Established under Section 1128G of the Social Security Act, Open Payments promotes transparency and accountability regarding the financial relationships between the health care industry (reporting entities) and certain health care providers (covered recipients). In Program Year 2024, reporting entities collectively reported $13.2 billion in publishable payments and ownership and investment interests; these payments are comprised of 16.2 million records.

Discretionary Budget Request: $33.6 Million

In addition to the discretionary request, CMS will utilize $15.3 million in mandatory resources. Funding will maintain ongoing operations for these oversight activities, with additional funding for certain rate reviews.

In FY 2027, HCFAC funding will support a number of critical payment controls. CMS conducts a routine monthly Beneficiary Payment Validation 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. CMS also validates and processes retroactive requests for enrollment and related transactions.

CMS will continue to review MA plan benefits and ensure they meet all regulatory and statutory requirements. CMS also conducts activities that support the monitoring and oversight strategy for the Part C and Part D programs, including sponsors' compliance with CMS network adequacy standards, enrollment guidelines, appeals processes, and actuarial review of bids submitted by plans.

CMS will continue to develop and collect MA Healthcare Effectiveness Data and Information Set measures for MA organizations and Special Needs Plans (SNPs), and review and approve SNP models of care as required under 1859(f) of the Social Security Act. This work also includes evaluating the impact of agency guidance and regulations that could negatively impact the quality of care provided to beneficiaries.

CMS oversight of Medicaid ensures fiscal integrity, protects beneficiaries, and supports effective state innovation. In FY 2027, CMS will provide oversight of rate setting and financial reporting for Home and Community-Based Services (HCBS) and PACE as well as support accurate calculations for the annual Medicaid Disproportionate Share Hospital allotments provided to states.

Furthermore, this funding will support oversight for section 1115 demonstrations. States often use section 1115 demonstrations to innovate their programs, total state and federal outlays reaching $273.4 billion in 2024 (representing 45 percent of total Medicaid spending). CMS safeguards the integrity of section 1115 demonstrations by implementing a risk-based oversight strategy and ensuring compliance with federal budget neutrality requirements. This approach allows CMS to focus resources on the most significant program vulnerabilities, streamline state reporting, provide targeted technical assistance, and monitor state expenditures to ensure budget neutrality. Utilizing this funding, CMS developed and now maintains the operation of an information system that supports the administration of the demonstration program under Medicaid Section 1115 of the Social Security Act (also known as '1115 waivers'). The information system collects and produces data and descriptive information about Section 1115 applications submitted by states, and supports the workflow associated with CMS' complex review and disposition of these applications. This funding is also used to support the critical ongoing monitoring of substance use disorder and severe mental illness demonstrations. Additionally, HCFAC funding supports technical assistance to CMS for the monitoring and evaluation of section 1115 demonstrations. In 2025, CMS redesigned the approach to monitoring section 1115 demonstrations to enhance the ability to identify risks and vulnerabilities associated with on-going demonstration implementation. This includes, among other activities, developing implementation plan and monitoring plan templates, performance metric sets, and evaluation guidance for specific demonstration types. To support states'

implementation of the new monitoring plan, CMS will use this funding to provide technical assistance to states in the application of these tools to their specific 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. CMS currently measures improper payments in Medicare, Medicaid, CHIP, and the APTC program in the Federally-Facilitated Exchange (FFE). This work helps CMS better understand the extent of improper payments and the factors driving them.[23]

Medicare

- Through the Comprehensive Error Rate Testing program, CMS reviews a stratified sample of Original Medicare claims to determine if CMS properly paid claims under Medicare coverage, coding, and billing rules. In FY 2024, the improper payment rate was below 10 percent for the eighth consecutive year.
- CMS also measures improper payments in Part C and Part D programs. The Part C methodology estimates improper payments resulting from errors in beneficiary risk scores. The Part D methodology estimates payment error relating to prescription drug event data.

Medicaid and CHIP

- The Payment Error Rate Measurement (PERM) program estimates improper payment rates based on the fee-for-service, managed care, and eligibility components of Medicaid and CHIP. The PERM program uses a three-year rotation, meaning each state is reviewed once every three years.

Exchanges

- CMS reviews a statistically valid random sample of health insurance applications to determine if the FFE properly paid APTC benefits consistent with eligibility and payment requirements.
- For State-based Exchanges (SBEs), CMS is conducting pre-testing and assessment activities to prepare SBEs for a future APTC improper payment measurement program.

Discretionary Budget Request: $77.7 Million

In addition to the discretionary request, CMS will utilize $30.0 million in mandatory resources. This funding supports ongoing operations for CMS' improper payment measurement programs.

Program Support and Administration

CMS depends on a number of programmatic, IT, and administrative activities to ensure efficient, effective program integrity operations in Medicare, Medicaid, and the Exchanges. These activities achieve economies of scale and allow for CMS to reuse existing processes to reduce costs.

The activities in this section promote enterprise vulnerabilities management as well as efforts to ensure proper oversight in Medicaid. CMS also maintains a robust technological foundation to support its program integrity initiatives through investments in both infrastructure upgrades and

[23] Additional information on these programs can be found in the annual HHS Agency Financial Report.

ongoing operational support. This includes specialized software licenses, systems, and data analytics support.

Discretionary Budget Request: $127.7 Million

In addition to the discretionary request, CMS will utilize $234.7 million in mandatory resources. These activities provide program support and much of the technological infrastructure that underpin the Agency's program integrity efforts, including:

- Fraud risk assessments to support the Agency's vulnerabilities management process led by the Vulnerability Collaboration Council.
- Efforts to improve CMS' monitoring and oversight of Medicaid managed care.
- IT infrastructure including systems, data analytics support, and software licenses to provide functionality and ensure continuity of operations.
- Enterprise services that benefit the program, such as shared IT services, acquisition support, and litigation and enforcement support from the Office of General Counsel.

In FY 2027, CMS will expand the Managed Care Oversight Reviews (MCORs) to improve compliance monitoring and identify vulnerabilities in Medicaid managed care operations. A key focus of MCORs will be analyzing how states use sanctions against managed care plans and whether states properly report these sanctions to CMS as required—critical components in preventing and addressing fraud, waste, and abuse. These reviews will also enable CMS to assess policy improvements, share best practices, and provide targeted technical assistance to states. Following four MCOR reviews in FY 2026, CMS will increase the number of reviews in FY 2027. Additionally, CMS will improve Medicaid managed care workflows to be more efficient with improved, web-based contract review tools. CMS is also expanding the wireframes and dashboards for the managed care reporting data to make reporting easier for states, more transparent to review across the board, and increase the overall readability of managed care data.

The discretionary request also includes funding for regulatory and implementation support relating to program integrity-focused policy development. This may take the form of drafting policy papers regarding regulatory framework and approach, drafting regulation preamble language, or developing tool kits supporting state implementation.

Finally, mandatory funding will cover employee compensation and related administrative expenses that support HCFAC activities.

HHS OFFICE OF INSPECTOR GENERAL

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. In FY 2025, HHS-OIG's oversight efforts resulted in 701 criminal actions against individuals or entities that engaged in crimes related to healthcare, and 876 civil actions, which include false claims, unjust enrichment lawsuits filed in Federal district court, and civil monetary penalty settlements. In addition, HHS-OIG excluded a total of 2,837 individuals and entities from participation in Federal health care

programs. For FY 2025, HHS-OIG's potential monetary impacts were estimated to be $19.04 billion. HHS-OIG's expected recoveries from its involvement in health care audits and investigations totaled more than $6.2 billion.

Budget Request: $97.9 Million

The FY 2027 HHS-OIG discretionary request is $97.9 million, a decrease of $10.9 million below the FY 2026 Enacted Level. In addition, mandatory resources total $256.7 million for a total operating budget of $354.6 million.

DEPARTMENT OF JUSTICE

Program Description

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 enforcement and investigative efforts. These offices dedicate substantial resources to combating health care fraud and abuse nationwide. HCFAC funding builds on those resources by providing dedicated positions for attorneys, paralegals, auditors, investigators, and subject matter experts, as well as funds for electronic discovery, data analysis, and litigation of resource-intensive health care fraud cases.

Budget Request: $137.9 Million

The FY 2027 DOJ discretionary request is $137.9 million, an increase of $4.7 million above the FY 2026 Enacted Level. In addition, mandatory resources total $80.1 million for a total operating budget of $218.0 million.

FEDERAL BUREAU OF INVESTIGATION (FBI)

Program Description

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. The FBI's efforts in combatting health care fraud, in coordination with the efforts of our Federal, state, and local law enforcement, regulatory partners, as well as private sector partners, are crucial to the success and sustainability of the health care system that so many Americans depend upon.
The FY 2027 FBI budget includes mandatory resources in the amount of $182.9 million.

HHS WEDGE FUNDING

Program Description and Accomplishments

HHS uses resources from the Wedge funds to carry out fraud and abuse activities across the department. Decisions about Wedge funding levels for DOJ and the HHS agencies are made by agreement between the Attorney General and the Secretary of HHS.

HHS Wedge Budget: $49.1 Million

For FY 2027, negotiated amounts are expected to be $49.1 million for HHS and $78.0 million for DOJ, not including carryover from the prior year.

This page intentionally left blank.

Information Technology

(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Program Administration [1]	$1,566,717	$1,646,474	$1,346,403	($300,071)
Survey & Certification [1]	$10,389	$10,387	$10,655	$268
Subtotal: Program Management Discretionary Appropriation	**$1,577,106**	**$1,656,861**	**$1,357,058**	**($299,803)**
CLIA	$5,100	$5,055	$5,055	$0
COB User Fees	$32,830	$37,930	$37,930	$0
Exchange Risk Adjustment User Fees	$17,616	$21,158	$17,378	($3,780)
Exchange User Fees	$668,084	$778,965	$802,790	$23,825
Recovery Audit Contractors	$20,653	$20,798	$21,068	$270
Sale of Data	$21,114	$22,143	$22,143	$0
Independent Dispute Resolution	$41,929	$50,581	$50,581	$0
Other Reimbursable Appropriations	$3,467	$5,308	$5,142	($166)
Subtotal: Offsetting Collections and Reimbursables	**$810,793**	**$941,938**	**$962,087**	**$20,149**
Health Care Fraud & Abuse	$392,324	$429,150	$431,027	$1,877
Subtotal: HCFAC	**$392,324**	**$429,150**	**$431,027**	**$1,877**
No Surprises Act	$12,491	$1,440	$0	($1,440)
Consolidated Appropriations[2] Acts	$4,050	$4,875	$4,875	$0
Inflation Reduction Act	$49,821	$57,236	$57,236	$0
Other Mandatory Appropriations	$2,293	$2,076	$310	($1,766)
Quality Improvement Organizations	$314,247	$296,304	$310,665	$14,361
Innovation Center	$122,402	$124,373	$122,359	($2,014)
Medicaid Integrity Program	$12,116	$11,708	$10,366	($1,342)
Working Family Tax Cut Act	$0	$18,441	$18,441	$0
Subtotal: Mandatory Appropriation	**$517,420**	**$516,453**	**$524,252**	**$7,799**
Total Information Technology	**$3,297,643**	**$3,544,402**	**$3,274,424**	**($269,978)**

[1] Program Administration and Survey & Certification are within the Program Management appropriations for FY 2025 and FY 2026 but distinct proposed project, programs, and activities for the FY 2027 budget.
[2] Reflects section 4125 of the Consolidated Appropriations Act of 2023 (P.L. 117-328) and section 202 of the Consolidated Appropriations Act of 2024 (P.L. 118-42).

Program Description

The Centers for Medicare & Medicaid Services sits at the forefront of delivering high-value, accessible, and secure health care services for a projected 164 million Americans in FY 2027. At a time when health care needs are evolving, cyber threats are intensifying, and emerging technologies like artificial intelligence (AI) are reshaping operations, CMS is strategically transforming its operations to enhance agility, security, and mission effectiveness.

CMS' FY 2027 IT strategy goes beyond modernization to achieve transformation. This strategy represents a shift in mindset: from siloed systems to integrated platforms, from reactive problem-solving to proactive innovation, and from outsourcing by default to developing in-house expertise. The result will be a faster, smarter, and more secure CMS that delivers greater value to beneficiaries and taxpayers.

To accomplish these objectives, CMS developed a strategy-driven framework that focuses on eight high-impact IT priorities:

1. **Enhance Cyber Defense and Build Digital Resilience** - *Defending Data, Securing Healthcare Systems; Bolstering CMS' cyber posture to protect sensitive information and ensure operational continuity in an increasingly complex threat landscape*.
2. **Enhance Fraud Prevention with Secure Identity and Data Analytics** - *Stopping Fraud Before It Starts; Leveraging identity and access management tools, advanced analytics and intelligent systems to prevent improper payments and safeguard trust in federal health care programs.*
3. **Streamline and Modernize Medicare Claims for Faster Processing** - *Smarter, Faster Medicare Claims Processing; Reengineering aging systems to improve speed, accuracy, and adaptability in Medicare claims management.*
4. **Leverage AI to Drive Productivity and Data Insights** - *AI-Powered Insights for Smarter Decisions; Expanding responsible AI adoption to drive efficiencies, uncover insights, and enhance program oversight.*
5. **Unify Data and Drive Seamless Interoperability** - *Connected Data, Coordinated Care; Integrating data platforms and Application Programming Interfaces to enable seamless, secure information exchange across the health care ecosystem*.
6. **Build and Empower a Modern Federal Health IT Workforce** - *Building CMS' Next-Gen Tech Workforce; Developing internal expertise and attracting leading technology professionals to meet evolving mission needs.*
7. **Enable Scalable, Secure, and Future-Ready Infrastructure** - *Cloud-Ready, Scalable, and Secure Infrastructure; Transitioning to modular, cloud-based architectures to support agility, resilience, and future growth.*
8. **Expand Reusable Platforms to Drive Enterprise Efficiency** - *Shared Tools, Streamlined Services; Expanding scalable services and platforms to reduce duplication, improve user experience, and drive operational efficiency.*

Together, these eight priorities define CMS' IT strategy for FY 2027, providing a clear roadmap for strengthening security, improving program integrity, modernizing core systems, and delivering better experiences for beneficiaries, providers, and partners. Achieving these outcomes, however, requires more than isolated system upgrades. It requires a coordinated, enterprise-wide execution model that enables modernization efforts to scale across programs, portfolios, and stakeholders.

CMS' Healthcare IT Ecosystem initiative represents the agency's enterprise-wide execution model and is a foundational step toward a more secure, connected, and patient-centered digital health environment. These efforts address long-standing infrastructure gaps that fragment the health care experience, including inconsistent digital identity verification, outdated provider data, limited interoperability, and barriers to trusted third-party innovation. By strengthening shared digital capabilities and modernizing how systems connect and exchange information, CMS is improving how beneficiaries, providers, plans, and partners interact with CMS programs and services.

Advancements supporting the Healthcare IT Ecosystem are implemented across multiple IT portfolios and program areas, reflecting the breadth of CMS' mission and statutory responsibilities. These efforts include improving digital identity and access management, expanding secure data exchange through standards-based APIs, and enabling trusted use of health applications and real-time information at the point of care. Collectively, these investments enhance operational efficiency, protect sensitive information, reduce administrative burden, and support CMS' ability to deliver high-quality, value-based care to millions of Americans.

Funding History

Fiscal Year	Amount
FY 2023	$3,283,702,000
FY 2024	$3,234,970,000
FY 2025 Final	$3,297,643,000
FY 2026 Enacted	$3,544,402,000
FY 2027 President's Budget	$3,274,424,000

FY 2027 IT Funding Level: $3,274,424 million

The FY 2027 President's Budget Level for CMS-wide IT is $3,274,424 million, a decrease of $270.0 million below the FY 2026 Enacted Level.

This decrease is in response to the Trump Administration's priority to reduce government spending and find efficiencies. CMS plans to convert high-cost cloud engineering, cybersecurity, data analytics, and systems modernization recurring contractor functions into federal roles. This reduces exposure to escalating contractor labor rates while strengthening institutional expertise and improving operational control. CMS also plans to focus on upskilling current staff in priority areas such as AI, cloud architecture, and Development, Security, and Operations (DevSecOps) to further reduce the need for premium external resources.

In parallel, CMS will continue to streamline its contract portfolio by consolidating duplicative vehicles, narrowing advisory and assistance scopes, expanding shared enterprise platforms, and increasing automation to reduce reliance on labor-intensive support. Funding for CMS' IT budget is broken into the following five portfolios:

- **Business Operations Support:** Enable CMS corporate services that ensure compliance, staff readiness, and financial accountability.
- **Core Mission:** Directly enable CMS' statutory health care programs and services.
- **Cross-Cutting Program:** Drive transformation, quality improvement, and oversight across all CMS programs.
- **Customer and Stakeholder Engagement:** Deliver essential engagement, education, and support services to the public and stakeholders.
- **Enterprise Enablement:** Provide enterprise-wide capabilities that all program offices depend on to operate securely and effectively.

Information Technology Budget
By Portfolio Category
(Dollars in Thousands)

IT Funding by Portfolio	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Business Operations Support	$130,856	$131,462	$124,204	($7,258)
Core Mission	$1,329,406	$1,577,811	$1,491,516	($86,295)
Cross-Cutting Program	$627,154	$638,238	$629,001	($9,237)
Customer and Stakeholder Engagement	$238,426	$273,210	$268,791	($4,419)
Enterprise Enablement	$971,800	$923,681	$760,912	($162,769)
Total IT Portfolio	**$3,297,642**	**$3,544,402**	**$3,274,424**	**($269,978)**

Business Operations Support Portfolio

The Business Operations Support portfolio is responsible for providing the foundational corporate services that ensure CMS' staff are equipped, accountable, and mission-ready year after year. This portfolio supports CMS' financial management IT which includes rigorous financial controls, planning tools, cost reporting, and budgeting mechanisms that support compliance with OMB and Department standards and enable transparent stewardship of taxpayer funds. Business Operations Support portfolio funds are also used for necessary grants & acquisition systems that underpin the efficient administration of grants, contracts, and procurement—streamlining acquisition workflows, tracking obligations, and aligning with federal grant-making transparency requirements.

Additionally, the work in this portfolio allows CMS to implement and maintain human capital & workforce IT technologies that enable recruitment, training, staffing analytics, and workforce planning—ensuring CMS has the right people, properly onboarded and prepared to fulfill mission-critical functions while building the organizational capacity necessary to meet future health care challenges.

Funding Level: $124.2 million

FY 2027 funding for Business Operations Support Portfolio will progress priority 6, *Build and Empower a Modern Federal Health IT Workforce*, by developing internal expertise and attracting leading technology professionals to meet evolving mission needs. Funds will be used to train

existing and hire new staff to perform the roles and services that were previously accomplished through vending partners. Learning opportunities will focus on power skills (Human Centered-Design, Product Management, Leadership Development, etc.) and technologies (Artificial Intelligence, Cloud, Cybersecurity, etc.).

Core Mission Portfolio

The Core Mission Portfolio is responsible for investments that directly power Medicare, Medicaid & CHIP, and the Health Insurance Exchange programs and empower CMS to deliver on its core mission to administer health coverage programs reliably and efficiently.

Work in this portfolio allows CMS to implement and maintain Medicare IT that powers the systems managing benefits delivery, claims, enrollment, payment processing, and regulatory compliance across original Medicare and Medicare Parts C and D. Funding for Medicaid & CHIP IT delivers technology for state-CMS collaboration, eligibility tracking, claims processing, and program integrity across Medicaid and CHIP. Funding also supports Health Insurance Exchange IT operations, eligibility determination, enrollment, and data exchange systems, enabling consumers to shop and enroll in coverage.

Funding Level: $1,491.5 million

FY 2027 funding for Core Mission Portfolio will advance priority 3, *Streamline and Modernize Medicare Claims for Faster Processing*, by furthering progress towards ClaimsCore.

ClaimsCore's goal is to modernize CMS' claims infrastructure to ensure long-term security, integrity, and operational resilience for Original Medicare. Today's legacy environment limits policy agility, constrains real-time insight, and makes it harder to deploy modern payment-integrity defenses at the speed of emerging fraud and cyber threats. ClaimsCore will replace the legacy Shared Systems (including the CWF) with a best-in-class commercial claims processing platform, enabling a secure and configurable foundation for faster policy execution, improved transparency for beneficiaries and providers, and near real-time adjudication. This is a mission-critical effort that protects the Medicare Trust Fund and strengthens stewardship of taxpayer dollars while positioning CMS to support the Administration's value-based care objectives.

The portfolio also furthers priority 2 by exploring how to strengthen CMS' ability to proactively prevent Medicaid fraud by improving systems, and allowing access to real-time, high-quality data analytics. Medicaid operates through a complex and fragmented, state-based claims processing and beneficiary management environment that relies on aging and highly customized systems. These legacy platforms are costly to maintain, difficult to modernize, and often lack the flexibility needed to support evolving delivery models and program integrity efforts. Critically, they do not allow for real-time visibility into activity at the Federal level. Fragmented data and limited interoperability across each State and managed care organizations constrain oversight and slow claims adjudication. As part of CMS' ongoing efforts to combat fraud, waste, and abuse in Medicaid, the Budget provides CMS with $25 million to explore investing in a scalable and modernized Medicaid system and tools to support State systems with the goal of improving transparency in and access to Medicaid data; enhancing administrative efficiency; and serving as a critical capability in supporting States in managing fraud, waste, and abuse.

Cross-Cutting Program Portfolio

The Cross-Cutting Program portfolio is responsible for driving system-wide transformation, quality improvements, and oversight that elevates care standards and promotes innovation across all CMS programs. This portfolio supports CMS' clinical standards & quality IT which includes infrastructure for quality measurement, standards enforcement, and clinical data exchange to ensure consistency and comparability in health care quality across programs. Cross-Cutting Program portfolio funds are also used for the Innovation Center IT that supports models, pilots, and data-driven experimentation, enabling CMS to explore alternative payment models, delivery system reform, and improvements in value-based care. Additionally, the work in this portfolio allows CMS to implement and maintain program integrity IT that equips the agency with advanced fraud detection, data analytics, and investigative tools, protecting program integrity and reducing improper payments.

Funding Level: $629.0 million

FY 2027 funding for Cross-Cutting Program Portfolio will help further priority 2, *Enhance Fraud Prevention with Secure Identity and Data Analytics*, by funding activities and program integrity IT systems that detect, prevent, and investigate fraud, waste, and abuse. For example, the Provider Enrollment, Chain, and Ownership System (PECOS), the Advanced Provider Screening (APS) system, and the Fraud Prevention System (FPS) replace outdated paper processes with automated vetting that cross-references commercial and government data, continuously flagging changes in licensure or criminal history to block bad actors before they can enroll. Additionally, these systems leverage advanced analytics, predictive modeling, and case management tools to monitor ongoing claims for fraudulent activities.

Customer and Stakeholder Engagement Portfolio

The Customer and Stakeholder Engagement portfolio is responsible for supporting transparent, accessible, and responsive outreach to both beneficiaries and providers, ensuring CMS remains human-centered in service and communication. This portfolio supports CMS' appeals & grievance systems which power platforms that allow beneficiaries and providers to appeal decisions, lodge grievances, and track case statuses, promoting fairness and transparent processes. These funds are also used for necessary provider & beneficiary outreach tools that include education, support, and communications platforms. Additionally, the work in this portfolio allows CMS to engage stakeholders with guidance, resources, and feedback loops that enhance the overall customer experience and stakeholder relationships.

Funding Level: $268.8 million

FY 2027 funding for Customer and Stakeholder Engagement Portfolio will help further priority 4, *Leverage AI to Drive Productivity and Data Insights*, by promoting the use of AI to enhance how CMS communicates with beneficiaries and others (e.g., assisters and caregivers). CMS plans to leverage AI-powered productivity tools and data insights to provide accessible, accurate, and personalized content delivery throughout our digital communications platforms. Additionally, funds will support the modernization of the Customer Relationship Management (CRM) platform at the Medicare and Exchange call centers to ensure AI technologies are leveraged and available to provide enhanced and streamlined services for the call center representatives to support both beneficiaries and consumers.

Enterprise Enablement Portfolio

The Enterprise Enablement portfolio is responsible for building and maintaining the enterprise-wide infrastructure that underpins all CMS programs, ensuring the agency operates securely, agilely, and insightfully. This portfolio supports CMS' data & analytics which includes data warehouses, reporting platforms, and analytics tools to power operational insight, evidence-based decision-making, and performance metrics across CMS. Funding is necessary for IT Infrastructure that ensures reliable, scalable, and resilient CMS data centers, networks, cloud services, and shared common platforms. Additionally, the work in this portfolio allows CMS to implement and maintain security, privacy, and compliance safeguards for all its systems and data, ensures compliance with federal privacy laws, and manages cybersecurity risk.

Funding Level: $760.9 million

FY 2027 funding for Enterprise Enablement Portfolio will help further priority 1, *Enhance Cyber Defense and Build Digital Resilience*, by bolstering CMS' cyber posture to protect sensitive information and ensure operational continuity in an increasingly complex threat landscape. A focus of this portfolio is strengthening enterprise security, privacy, and resilience by embedding protection directly into CMS' digital architecture. CMS will continue advancing a modern, Zero Trust security model that is enhanced by AI to emphasize continuous verification, real-time risk awareness, and proactive threat containment across users, systems, and data. This approach enhances mission continuity, safeguards beneficiary and provider information, and enables secure digital transformation at scale.

Additionally, funding will advance priority 5, *Unify Data and Drive Seamless Interoperability*, by integrating data platforms and Application Programming Interfaces to enable seamless, secure information exchange across the health care ecosystem. This portfolio supports the consolidation of 15 separate data repositories into the Integrated Data Repository (IDR), creating a single, authoritative source for high-quality, timely program data. This effort will streamline access, reduce duplication, and improve CMS' ability to conduct enterprise analytics, program monitoring, and performance measurement across Medicare, Medicaid, CHIP, and Exchange programs

FY 2027 funding also supports priority 4, *Leverage AI to Drive Productivity and Data Insights*, by expanding responsible AI adoption to drive efficiencies, uncover insights, and enhance program oversight. The CMS Innovation, Modernization, and AI Enablement initiative is a strategic investment that equips the agency to deliver smarter, more efficient, and person-centered healthcare services. By modernizing legacy systems, automating data sharing, and advancing AI capabilities, CMS will enhance operational efficiency, reduce waste, and improve decision-making across the enterprise.

FY 2027 funding will aid priority 8, *Expand Reusable Platforms to Drive Enterprise Efficiency*, by continuing to invest in the Software Asset Management (SAM) program.

The SAM program enhances CMS' IT governance through complete software asset visibility across all CMS and contract partner environments, ensuring compliance with federal mandates including FITARA and the MEGABYTE Act while strengthening cybersecurity risk management and standardizing pricing across all business units to provide equitable access to critical collaboration and analytics platforms agency wide. SAM achieved a transformative reduction in collaboration tool licensing costs while enhancing operational efficiency through consolidated communication platforms, reduced tool redundancy, and streamlined workflows. This program

creates foundational infrastructure that powers data-driven decision-making, strengthens security and compliance safeguards, maximizes taxpayer value, and enables CMS to reinvest savings into mission-critical beneficiary services while ensuring the agency operates securely, agilely, and insightfully across all programs.

FY 2027 funding will strengthen priority 7, *Enable Scalable, Secure, and Future-Ready Infrastructure*, by allowing CMS to transition to modular, cloud-based architectures to support agility, resilience, and future growth. CMS will advance CMS' cloud modernization strategy, expanding scalable, resilient hosting environments that support rapid deployment, improved performance, and reduced reliance on legacy infrastructure. These cloud services integrate with enterprise network and data center operations to ensure reliable, secure access nationwide while supporting evolving mission needs.

Federal Exchange

(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Program Management	**$2,102,965**	**$2,138,928**	**$2,093,140**	**($45,788)**
Discretionary	$88,567	$84,147	$0	($84,147)
Mandatory	$1,952,317	$1,995,330	$2,043,440	$48,110
Federal Exchange User Fee (non-add)	*$1,894,160*	*$1,932,643*	*$1,982,675*	*$50,032*
Risk Adjustment User Fee (non-add)	*$58,157*	*$62,687*	*$60,765*	*($1,922)*
Other	$62,081	$59,451	$49,700	($9,751)
Penalty Mail	$62,081	$59,451	$49,700	($9,751)
Heath Care Fraud and Abuse Control	**$28,216**	**$41,176**	**$41,000**	**($176)**
Discretionary	*$28,216*	*$41,176*	*$41,000*	*($176)*
Program Level	**$2,131,182**	**$2,180,105**	**$2,134,140**	**($45,965)**

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)

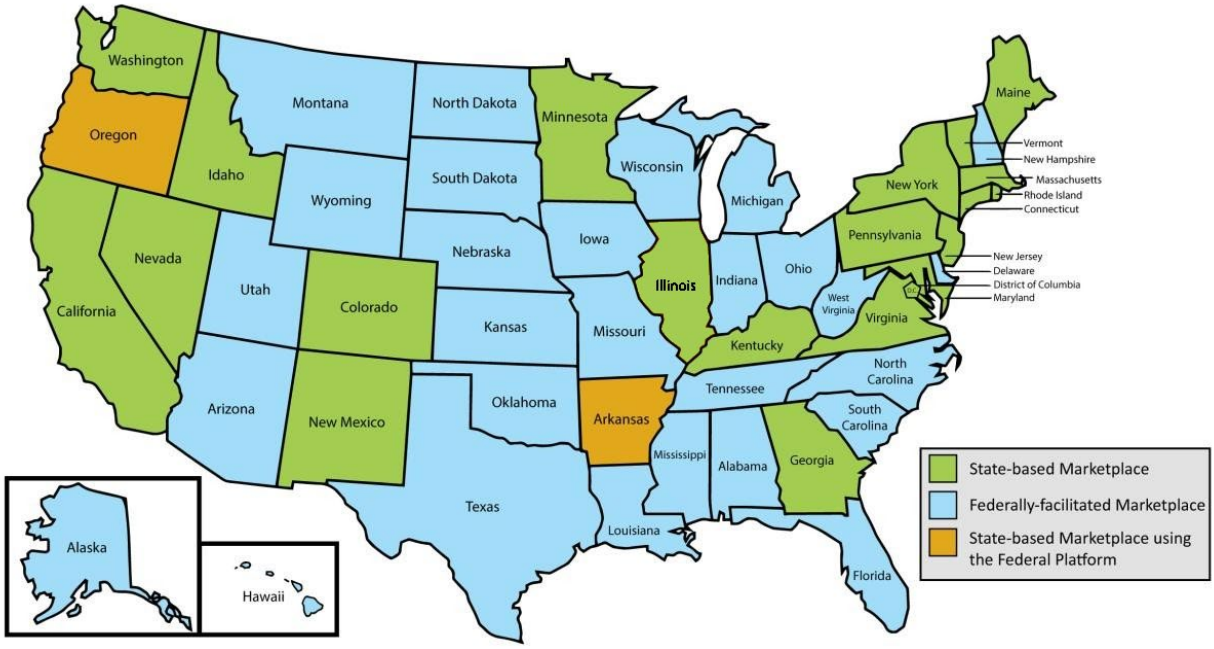
Allocation Method – Direct, Contracts, and Competitive Grants

Program Descriptions and Accomplishments

The Affordable Care Act (ACA) gives states the option of establishing a Health Insurance Exchange. The Exchange facilitates the purchase of qualified health plans (QHPs) and meets other requirements specified in section 1311(d) of the ACA. CMS operates a Federally-Facilitated Exchange (FFE) or State-Based Exchange–Federal Platform (SBE-FP) on HealthCare.gov in those states that elect not to pursue a State-based Exchange (SBE) on their own platform.

Since October 1, 2013, consumers and small employers have used the Exchanges to assess their insurance options and shop for, select, and enroll in private health insurance plans. The Exchanges facilitate the receipt of tax credits to offset premium costs for insurance, provide cost-sharing assistance to reduce consumer out-of-pocket costs, and help eligible consumers enroll in other federal or state insurance affordability programs.

The graphic below illustrates which states are using HealthCare.gov compared to those operating their own State-Based Exchange in Plan Year 2026.[1]



CMS conducts the following core responsibilities on behalf of all Exchanges:

- Verifying eligibility data for financial assistance through the Exchange or for 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 when an applicant is determined eligible;
- Operating a quality rating system for display on Exchange websites; and
- Conducting certification and oversight of SBEs.

In states electing to use the FFE, CMS oversees these additional functions:

- Certifying qualified health plans (QHPs) and stand-alone dental plans (SADPs) after reviewing health plan benefits and rates;
- Providing consumers with the ability to apply for and enroll in coverage, conducting enrollment reconciliation with issuers, conducting appeals, and assisting with APTC reconciliation; and
- Educating consumers about the Exchange, including the open enrollment period (OEP), coverage options, and providing assistance to applicants and enrollees.

As a High Impact Service Provider (HISP), the Exchange will continue to drive customer experience improvements by leveraging ongoing Exchange consumer research, gathering

[1] https://www.cms.gov/marketplace/in-person-assisters/training-webinars/training/marketplaces-map

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	Amount
FY 2023 Final	$2,440,747,000
FY 2024 Final	$2,635,413,000
FY 2025 Final	$2,131,182,000
FY 2026 Enacted	$2,180,105,000
FY 2027 President's Budget	$2,134,140,000

Budget Request: $2,134.1 Million

The FY 2027 Budget request for FFE activities is $2,134.1 million, of which $2,093.1 million is funded from several CMS Program Management sources and $41.0 million is from the discretionary Health Care Fraud and Abuse Control (HCFAC) appropriation. The Budget does not assume use of discretionary CMS Program Management Budget Authority to finance the Exchange – see General Provision included in the Budget, discussed below. In FY 2027, CMS plans to continue program updates and cost saving initiatives intended to reduce improper enrollments in Exchanges on the Federal platform and help prevent Exchange coverage from continuing for consumers who are unaware of their Exchange enrollments.

Health Plan Bid Review, Management, and Oversight: $87.1 million. CMS oversees the annual certification process for QHPs and SADPs offered on the individual and small group markets. CMS supports the process by developing operational guidance, creating tools, providing technical assistance to issuers on certification requirements, and certifying agents and brokers to participate in the FFE. CMS supports over 4,700 QHPs and over 1,000 SADPs each year.

Payment and Financial Management: $51.5 million. States and issuers supply a range of enrollment, premium, and claims data to calculate financial payments across multiple Exchange activities using the Health Insurance Oversight System (HIOS). Exchange-related payments leverage CMS' Healthcare Integrated General Ledger Accounting System and financial management processes such as reporting and debt management.

Eligibility and Enrollment: $476.2 million. This activity allows consumers to submit applications for health coverage throughout the year, including Open Enrollment, mid-year updates, and Special Enrollment Periods (SEPs). Electronic applications are processed through eligibility and enrollment systems. Data to support eligibility for enrollment and financial assistance is verified through the Data Services Hub.

Consumer Information and Outreach: $634.0 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 consumers to ask questions, get help with online tools, report life event changes and respond to Exchange notices.

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

Information Technology (IT): $663.3 million. The Exchange 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 scale during peak enrollment periods while delivering a reliable and consistent user experience. New technical architecture and application code are integrated into production through a comprehensive end-to-end testing process that improves performance. CMS maintains a robust IT security program that is designed to prevent, detect, and respond to cyber threats across the Exchange environments. The Exchanges also utilize CMS Enterprise Shared Services for identity management, infrastructure, and operational support. Major applications that support the Exchanges include:

- *Data Services Hub* – Provides a secure, single-point of entry, query-based verification service that connects with Federal entities and private data sources to validate information submitted by consumers during the application process for the federal exchange, state exchanges and state Medicaid agencies. Key verified data includes citizenship or immigration status, income, household size, and eligibility for Medicare, veteran's benefits, or Federal employee benefits. The Hub also provides secure data file exchanges for QHP plan information as well as financial information with our Hub partners.

- *Health Insurance Oversight System (HIOS)* – Serves as the primary data collection system for issuer oversight and plan information such as claims for risk adjustment, rate review justifications, and medical loss ratios.

- *Federal Health Care Exchanges (HIX)* – Provides the back-end functionality of the Federal Exchange including plan management, eligibility, and enrollment.

- *HealthCare.gov Web Portal* – Allows consumers to learn about the Exchange, 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 operates the Federally-facilitated SHOP (FF-SHOP) in states that have elected not to operate their own SHOP Exchange. CMS intends to continue to fund the operation of a toll-free telephone hotline and email mailbox to respond to requests for assistance related to the SHOP program and maintain SHOP and small business webpages.

Exchange Quality: $5.9 million. CMS provides quality rating information using a five-star rating scale based on clinical quality measures and an enrollee satisfaction survey to give consumers and families easy-to-compare quality metrics on QHPs.

Program Integrity: $41.0 million. CMS reviews a statistically valid random sample of health insurance applications to determine if the FFE properly paid APTC benefits under eligibility and payment requirements. For State-based Exchanges, CMS is conducting pre-testing and

assessment activities and expects the improper payment measurement program to begin as early as benefit year 2027.

Planning and Performance: $19.2 million. CMS supports general planning and oversight of Exchange activities to ensure integration and coordination across CMS with issuers and Federal partners.

Administration: $155.8 million. This funding supports staffing and administration expenses for work across the Federal Exchange, State-based Exchanges, and payment programs.

Proposed Legislation

General Provision:

SEC. XXX. Any assessment or user fee charged pursuant to section 1311(d)(5)(A) of the Patient Protection and Affordable Care Act credited to the "Centers for Medicare and Medicaid Services—Program Management" account shall be available for any other Federal administrative expenses the Secretary incurs for activities related to the Exchange program, in addition to any other purposes authorized by law and shall remain available until expended for the purposes described in this section.

This page intentionally left blank.

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

This page intentionally left blank.

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 2025 Estimates	FY 2026 Estimates	FY 2027 Estimates
Drug Resources by Decision Unit and Function/Program			
Medicaid Treatment	$9,970.0	$10,620.0	$10,970.0
Total Decision Unit #1 Medicaid	**$9,970.0**	**$10,620.0**	**$10,970.0**
Medicare Treatment	$3,110.0	$3,410.0	$3,670.0
Total Decision Unit #2 Medicare	**$3,110.0**	**$3,410.0**	**$3,670.0**
Total Funding	**$13,080.0**	**$14,030.0**	**$14,640.0**
Drug Resources Personnel Summary			
Total FTEs (direct only)	--	--	--
Drug Resources as a Percent of Budget			
Total Agency Budget (in billions)[1]	$1,827.8	$2,009.1	$2,140.2
Drug Resources Percentage	0.7%	0.7%	0.7%

Program Summary

Mission

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

Methodology

Medicaid

The projections provided in the above table were based on data from the Medicaid Analytic eXtract (MAX) for Fiscal Year (FY) 2007 through 2013, based on expenditures for claims with

[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.

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 2024 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, Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) data. 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 2027 President's Budget baseline. These projections reflect estimated Part A and Part B spending and are based on an analysis of historical fee-for-service claims through 2024, 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 2025 President's Budget and vary only slightly 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 2027 drug control outlay estimate for CMS is $14,640.0 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 2027 outlay estimate: $10,970.0 million
(Reflects $350.0 million increase from FY 2026)

The increase in Medicaid substance use spending from FY 2026 to FY 2027 is due to a projected increase in Medicaid utilization and price.

Medicaid is a means-based health care entitlement program financed by the States and the Federal Government. Medicaid covers all medically necessary services, including SUD detoxification and treatment services, in accordance with the early and periodic screening, and

[2] Based on the International Classification of Diseases (ICD) coding system. The applicable ICD-9 codes for substance abuse include a subset of the 291, 292, 303, 304, and 305 category of codes; ICD-9 codes 7903, E9352, and E9401; and *Other Chronic and Potentially Disabling Conditions for Alcohol and Drug Use Disorders*, excluding V65.42 and V79.1. The applicable ICD-10 codes for substance abuse include a subset of the F10, F11, F12, F13, F14, F15, F16, F17, F18, and F19, G62, I42, K29, K70, O35, O99, P04, P96, Q86, R78, T40, T50, and T51 ICD-10 category of codes.

diagnostic and treatment (EPSDT) requirements for EPSDT-eligible individuals under 21 years of age.[3] States generally have the option to cover SUD treatment services for adult beneficiaries. The Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT*) for Patients and Communities Act* (Public Law 115-271) as amended by the Consolidated Appropriations Act of 2024 (Public Law 118-42) also requires states to cover medication-assisted treatment.

Medicare
FY 2027 outlay estimate: $3,670.0 million
(Reflects $260.0 million increase from FY 2026)

The increase in Medicare SUD spending from FY 2026 to FY 2027 is due to normal program growth, reflecting the impact of changes in enrollment and utilization of health care services.

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 covered under 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.

[3] Section 1905(a)(4)(B) and (r) of the Social Security Act entitles eligible children under the age of 21 to Medicaid coverage of health care, diagnostic services, treatment, and other measures described in section 1905(a) that are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, whether or not such services are covered under the state plan.

This page intentionally left blank.

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

This page intentionally left blank.

CMS Program Management
Object Classification - Direct Budget Authority /1
(Dollars in Thousands)

Object Class	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Direct Budget Authority				
Personnel compensation:				
Full-time permanent (11.1)	$ 346,671	$ 350,351	$ 351,203	$ 852
Other than full-time permanent (11.3)	$ 19,215	$ 19,215	$ 19,071	$ (144)
Other personnel compensation (11.5)	$ 11,501	$ 11,496	$ 12,218	$ 722
Military personnel (11.7)	$ 14,870	$ 14,926	$ 15,211	$ 285
Special personnel services payments (11.8)	$ 83	$ 83	$ 74	$ (9)
Subtotal personnel compensation	**$ 392,340**	**$ 396,071**	**$ 397,777**	**$ 1,706**
Civilian benefits (12.1)	$ 205,825	$ 206,236	$ 207,346	$ 1,110
Military benefits (12.2)	$ 1,871	$ 1,873	$ 1,875	$ 2
Benefits to former personnel (13.0)	$ 4,823	$ 2,411	$ -	$ (2,411)
Subtotal Pay Costs	**$ 604,859**	**$ 606,591**	**$ 606,998**	**$ 407**
Travel and transportation of persons (21.0)	$ 2,113	$ 4,947	$ 4,947	$ -
Transportation of things (22.0)	$ 59	$ 53	$ 53	$ -
Rental payments to GSA (23.1)	$ 26,302	$ 25,890	$ 25,890	$ -
Communication, utilities, and misc. charges (23.3)				
Printing and reproduction (24.0)	$ 89,392	$ 89,392	$ 79,961	$ (9,431)
Other Contractual Services:				
Advisory and assistance services (25.1)				
Other services (25.2)	$ 2,754,541	$ 2,747,973	$ 2,390,280	$ (357,693)
Purchase of goods and services from				$ -
government accounts (25.3)	$ 241,926	$ 241,926	$ 216,401	$ (25,525)
Operation and maintenance of facilities (25.4)				$ -
Research and Development Contracts (25.5)	$ 17,654	$ 20,054	$ 18,054	$ (2,000)
Medical care (25.6)	$ 398,139	$ 398,139	$ 356,132	$ (42,007)
Operation and maintenance of equipment (25.7)	$ 26	$ 26	$ 24	$ (2)
Subsistence and support of persons (25.8)				
Subtotal Other Contractual Services	**$ 3,412,286**	**$ 3,408,118**	**$ 2,980,891**	**$ (427,227)**
Supplies and materials (26.0)	$ 195	$ 195	$ 175	$ (20)
Equipment (31.0)	$ 106	$ 106	$ 95	$ (11)
Land and Structures (32.0)				
Investments and Loans (33.0)				
Grants, subsidies, and contributions (41.0)	$ 1,669	$ 1,689	$ 1,483	$ (206)
Interest and dividends (43.0)				
Refunds (44.0)				
Subtotal Non-Pay Costs	**$ 3,532,122**	**$ 3,530,390**	**$ 3,093,495**	**$ (436,895)**
Total Direct Budget Authority	**$ 4,136,981**	**$ 4,136,981**	**$ 3,700,493**	**$ (436,488)**

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

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2025 Actual Civilan	2025 Actual Military	2025 Actual Total	2026 Est. Civilian	2026 Est. Military	2026 Est. Total	2027 Est. Civilian	2027 Est. Military	2027 Est. Total
Discretionary									
Direct FTEs	3,467	83	3,550	3,489	83	3,572	3,493	83	3,576
Reimbursable FTEs	0	0	0	0	0	0	0	0	0
Subtotal /1	3,467	83	3,550	3,489	83	3,572	3,493	83	3,576
Program Management, Direct									
Direct FTEs	208	5	213	390	5	395	390	5	395
Reimbursable FTEs	0	0	0	0	0	0	0	0	0
Subtotal	208	5	213	390	5	395	390	5	395
Program Management, Reimbursable									
Direct FTEs	0	0	0	0	0	0	0	0	0
Reimbursable FTEs	671	13	684	709	13	722	709	13	722
Subtotal	671	13	684	709	13	722	709	13	722
Total, CMS Program Management FTE /2	**4,346**	**101**	**4,447**	**4,588**	**101**	**4,689**	**4,592**	**101**	**4,693**

/1 The FY 2027 Budget assumes the planned HHS Reorganization, which includes HRSA's Office of Pharmacy Affairs program residing in CMS Program Management. This display comparably adjusts FY 2025 and FY 2026 columns to the FY 2027 Budget policy.
/2 Includes FTEs funded from Program Management only (discretionary, mandatory, and reimbursables).

CMS Program Management
Detail of Positions
(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Subtotal, EX	1	1	1
Total - Exec. Level Salary	$183	$208	$208
Subtotal, ES	66	66	66
Total - ES Salaries	$15,264	$15,416	$15,416
GS-15	511	514	515
GS-14	627	631	632
GS-13	1,753	1,765	1,767
GS-12	403	406	406
GS-11	57	57	57
GS-10	0	0	0
GS-9	40	40	40
GS-8	0	0	0
GS-7	5	5	5
GS-6	1	1	1
GS-5	0	0	0
GS-4	1	1	1
GS-3	2	2	2
GS-2	0	0	0
GS-1	0	0	0
Subtotal /1	3,400	3,422	3,426
Total - GS Salary /1 /2	$589,412	$590,967	$591,374
Commission Corps	83	83	83
Total - FTE Level /3	3,550	3,572	3,576
Average GS Grade /1	13	13	13
Average GS Salary /1 /2	$173	$173	$173

Note: This table excludes salaries for Commission Corps; however, their FTE level is displayed to provide comparability.

/1 Reflects direct discretionary staffing within the Program Management account and includes benefits.

/2 FY 2027 salary levels are subject to change.

/3 The FY 2027 Budget assumes the planned HHS Reorganization, which includes HRSA's Office of Pharmacy Affairs program residing in CMS Program Management. This display comparably adjusts FY 2025 and FY 2026 columns to the FY 2027 Budget policy.

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 2017			FY 2018			FY 2019			FY 2020		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated													
Affordable Choices of Health Benefit Plans	1311	$ 18,221	25		$ 11,698	24			0			0	
Adult Health Quality Measures	2701		8			6			10			10	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		551			540			600		$ 10,000,000	528	
Independence At Home Demonstration	3024		1			1			0			0	
Graduate Nurse Education	5509		2			2			0			0	
Sunshine Act	6002	$ 5,615	22			0			0			0	
LTC National Background Checks	6201		6			4			6			6	
Provider Screening & Other Enrollment Requirements	6401	$ 3,509	9			0			0			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 468	1			0			0			0	
Total ACA Direct Appropriated FTEs			**625**			**577**			**616**			**544**	

Program	Section	FY 2021			FY 2022			FY 2023			FY 2024		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated													
Adult Health Quality Measures	2701		10			9			9			9	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		523			506			545			579	
LTC National Background Checks	6201		10			5			6			5	
Total ACA Direct Appropriated FTEs			**543**			**520**			**560**			**593**	

Program	Section	FY 2025			FY 2026			FY 2027		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		507			577			615	
Total ACA Direct Appropriated FTEs			**507**			**577**			**615**	

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 Control (HCFAC) activities in addition to funds provided by ACA Section 6402.

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.)*
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. Many 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. Physicians tend to accept more private sector opportunities due to the restrictions of the Federal pay scale.

3-4) Please complete the table below with details of the PCA agreement for the following years:

	FY 2025 Actuals	FY 2026 Estimates	FY 2027 Estimates
3a) Number of Physicians Receiving PCAs	22	27	30
3b) Number of Physicians with One-Year PCA Agreements	2	5	6
3c) Number of Physicians with Multi-Year PCA Agreements	20	22	24
4a) Average Annual PCA Physician Pay (without PCA payment)	$191,680	$193,834	$195,530
4b) Average Annual PCA Payment	$23,659	$25,804	$27,465

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 has required CMS to implement new programs. Some of these mandates require establishing additional new physician positions or quickly filling vacated physician positions to fill very specific needs. Even though CMS has experienced many hurdles trying to recruit physicians, the PCA is still necessary because the candidates with quality experience make significantly more money in the private sector compared to what CMS would be able to offer them without PCA. PCA has made the salary offers more comparable, allowing 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 as a result of physicians being eligible for step increases. The average annual PCA amounts may increase slightly as a physician completes their 24 months as a government physician. There are currently 22 Physicians in CMS receiving PCA, seven at the maximum PCA amount of $30,000. In FY 2025, CMS observed a rapid decrease in the number of physicians. However, we anticipate a reversal to this trend by the end of FY 2026, as we reinforce key areas within CMS required to promote the mission of Making America Healthy Again. CMS is projecting the number of physicians needed to carry out new programs and other duties will carry into FY 2027.

Department of Health and Human Services

Centers for Medicare and Medicaid Services

FY 2027 MANDATORY STATE GRANTS [1]

CFDA Number 93.778

Grants to States for Medicaid
(dollars in thousands)

STATE/TERRITORY	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Alabama	$6,068,036	$6,709,447	$6,944,344	$234,898
Alaska	$2,486,344	$2,722,566	$2,780,975	$58,409
Arizona	$16,142,333	$19,108,569	$20,861,594	$1,753,025
Arkansas	$6,660,211	$6,888,494	$7,028,874	$140,380
California	$106,010,547	$126,732,346	$122,457,889	($4,274,457)
Colorado	$9,809,043	$10,981,714	$11,281,288	$299,575
Connecticut	$6,956,502	$7,236,800	$7,408,899	$172,099
Delaware	$2,245,788	$2,377,460	$2,405,510	$28,050
District of Columbia	$3,131,233	$3,830,169	$3,831,987	$1,818
Florida	$22,571,902	$22,170,781	$27,540,029	$5,369,248
Georgia	$13,085,369	$11,986,894	$11,383,534	($603,360)
Hawaii	$2,194,349	$2,161,156	$2,055,214	($105,942)
Idaho	$3,024,860	$3,427,253	$3,610,928	$183,675
Illinois	$22,118,115	$22,607,787	$22,855,347	$247,560
Indiana	$14,165,229	$15,361,406	$15,803,075	$441,670
Iowa	$6,037,878	$7,323,612	$7,227,021	($96,591)
Kansas	$4,058,700	$4,906,766	$5,315,905	$409,139
Kentucky	$15,867,841	$18,095,188	$17,616,789	($478,399)
Louisiana	$11,897,667	$17,219,290	$15,254,691	($1,964,598)
Maine	$3,470,324	$3,636,492	$3,645,448	$8,956
Maryland	$11,023,172	$11,396,423	$11,529,685	$133,261
Massachusetts	$15,873,704	$18,059,173	$17,910,971	($148,201)
Michigan	$19,379,709	$21,280,770	$22,277,531	$996,761
Minnesota	$12,135,015	$15,174,179	$16,094,587	$920,407
Mississippi	$5,917,035	$6,183,096	$6,972,095	$788,999
Missouri	$11,952,293	$16,245,164	$17,797,455	$1,552,291
Montana	$1,973,121	$2,090,249	$2,053,251	($36,999)
Nebraska	$2,765,884	$4,087,442	$4,002,829	($84,613)
Nevada	$5,316,514	$8,115,856	$7,406,091	($709,765)
New Hampshire	$1,793,527	$1,815,272	$1,851,034	$35,761

[1] Obligation estimates reflect the State and Territory estimates submitted to CMS in November of 2025.

STATE/TERRITORY	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
New Jersey	$15,651,242	$16,914,802	$18,202,159	$1,287,357
New Mexico	$8,191,191	$9,246,106	$7,922,783	($1,323,323)
New York	$59,773,581	$63,502,469	$61,889,994	($1,612,474)
North Carolina	$17,730,850	$22,679,987	$23,302,636	$622,648
North Dakota	$1,076,024	$1,157,532	$1,192,681	$35,149
Ohio	$26,790,513	$29,766,186	$28,148,036	($1,618,150)
Oklahoma	$8,088,011	$8,423,690	$8,372,701	($50,990)
Oregon	$13,161,132	$15,314,616	$16,196,590	$881,973
Pennsylvania	$29,954,538	$34,182,587	$36,657,038	$2,474,451
Rhode Island	$2,711,894	$3,053,318	$3,106,246	$52,928
South Carolina	$7,120,172	$7,855,014	$7,482,717	($372,297)
South Dakota	$1,254,003	$1,313,204	$1,305,093	($8,111)
Tennessee	$11,627,062	$12,086,360	$12,577,572	$491,212
Texas	$32,990,957	$40,063,734	$40,312,615	$248,882
Utah	$3,767,000	$3,783,587	$3,680,629	($102,958)
Vermont	$1,513,087	$1,627,661	$1,627,076	($585)
Virginia	$14,359,237	$18,870,095	$19,187,882	$317,787
Washington	$14,375,108	$20,653,469	$22,995,961	$2,342,492
West Virginia	$4,521,700	$5,888,312	$5,670,497	($217,815)
Wisconsin	$8,408,530	$9,373,271	$9,933,874	$560,603
Wyoming	$472,376	$543,484	$556,016	$12,532
Subtotal	**$649,670,453**	**$746,231,298**	**$755,525,666**	**$9,294,368**
American Samoa	$44,203	$97,617	$96,581	($1,036)
Guam	$170,868	$199,701	$182,867	($16,834)
Northern Mariana Islands	$76,873	$87,329	$80,664	($6,665)
Puerto Rico	$4,006,899	$4,302,832	$4,478,266	$175,434
Virgin Islands	$88,381	$167,697	$159,869	($7,828)
Subtotal	**$4,387,224**	**$4,855,176**	**$4,998,247**	**$143,071**
Other Adjustments (undistributed)	$70,309,076	$29,988,432	$26,205,833	($3,782,599)
Subtotal	**$70,309,076**	**$29,988,432**	**$26,205,833**	**($3,782,599)**
TOTAL RESOURCES	**$724,366,753**	**$781,074,906**	**$786,729,746**	**$5,654,840**

[1] Obligation estimates reflect the State and Territory estimates submitted to CMS in November of 2025.

Department of Health and Human Services

Centers for Medicare and Medicaid Services

FY 2027 MANDATORY STATE GRANTS

CFDA NUMBER 93.767

State Children's Health Insurance Program
(dollars in thousands)

STATE/TERRITORY	FY 2025 Final	FY 2026 Enacted[1]	FY 2027 President's Budget[2]	FY 2027 +/- FY 2026
Alabama	$441,275	$466,721	$659,614	$192,893
Alaska	$24,641	$26,062	$27,548	$1,486
Arizona	$313,160	$331,218	$406,464	$75,245
Arkansas	$198,271	$209,705	$216,824	$7,119
California	$4,159,356	$4,399,208	$6,153,149	$1,753,942
Colorado	$294,689	$311,682	$394,680	$82,997
Connecticut	$69,070	$73,053	$92,103	$19,050
Delaware	$36,321	$38,416	$41,544	$3,139
District of Columbia	$57,163	$60,459	$82,685	$22,226
Florida	$782,504	$827,628	$753,797	($73,831)
Georgia	$450,791	$476,786	$560,602	$83,816
Hawaii	$56,473	$59,729	$65,329	$5,600
Idaho	$69,701	$73,721	$75,484	$1,763
Illinois	$561,970	$594,377	$542,460	($51,916)
Indiana	$340,561	$360,200	$383,800	$23,600
Iowa	$197,592	$208,986	$263,711	$54,725
Kansas	$145,352	$153,733	$229,930	$76,196
Kentucky	$418,011	$442,116	$477,133	$35,017
Louisiana	$617,830	$653,458	$857,280	$203,822
Maine	$61,779	$65,341	$87,778	$22,437
Maryland	$469,027	$496,074	$583,622	$87,548
Massachusetts	$790,343	$835,918	$927,112	$91,194
Michigan	$499,915	$528,742	$589,639	$60,867
Minnesota	$106,496	$112,637	$163,857	$51,220
Mississippi	$210,202	$222,323	$199,503	($22,820)
Missouri	$474,442	$594,745	$549,131	($45,614)
Montana	$83,228	$88,027	$35,599	($52,428)

[1] FY2026 projected CHIP allotments do not include amount of increase, if any, for approved program expansions as allowed under Section 2104(m)(7) of the Act.

[2] FY2027 projected CHIP allotments do not include amount of increase, if any, for approved program expansions as allowed under Section 2104(m)(7) of the Act; they also use FY 2026 Allotment Increase Factor (AIF) as a proxy since the FY 2027 AIF was not available at time of publishing. Amounts are subject to change.

STATE/TERRITORY	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Nebraska	$96,849	$102,434	$176,750	$74,316
Nevada	$93,366	$98,750	$129,489	$30,739
New Hampshire	$48,194	$50,973	$56,104	$5,130
New Jersey	$703,186	$743,735	$355,909	($387,826)
New Mexico	$122,709	$129,785	$120,227	($9,558)
New York	$1,989,955	$2,104,707	$2,258,657	$153,950
North Carolina	$928,689	$982,243	$919,231	($63,012)
North Dakota	$25,230	$26,685	$29,226	$2,541
Ohio	$658,032	$695,977	$828,712	$132,735
Oklahoma	$246,992	$261,235	$335,980	$74,745
Oregon	$574,333	$607,452	$835,588	$228,136
Pennsylvania	$595,419	$629,754	$693,017	$63,263
Rhode Island	$114,730	$121,346	$139,923	$18,577
South Carolina	$184,624	$195,271	$230,928	$35,658
South Dakota	$36,920	$39,049	$36,428	($2,621)
Tennessee	$436,904	$462,099	$417,264	($44,835)
Texas	$990,849	$1,047,987	$1,022,687	($25,300)
Utah	$130,831	$138,375	$129,551	($8,824)
Vermont	$18,414	$19,476	$21,374	$1,898
Virginia	$485,206	$513,186	$658,623	$145,437
Washington	$135,544	$143,630	$155,883	$12,523
West Virginia	$98,530	$104,212	$102,736	($1,476)
Wisconsin	$258,561	$273,471	$378,339	$104,868
Wyoming	$7,868	$8,321	$10,728	$2,406
Subtotal	**20,912,096**	**22,210,950**	**25,463,744**	**3,252,794**
American Samoa	$8,664	$9,164	$9,164	$0
Guam	$33,720	$35,665	$37,018	$1,353
Northern Mariana Islands	$16,668	$17,629	$18,646	$1,017
Puerto Rico	$83,877	$88,714	$33,203	($55,511)
Virgin Islands	$16,189	$17,122	$9,055	($8,067)
Subtotal	**159,118**	**168,294**	**107,086**	**(61,208)**
TOTAL RESOURCES[3] [4]	**21,071,214**	**22,379,242**	**25,570,830**	**3,191,586**

[3] This table displays current anticipated state-by-state obligations per the allotment formula in Section 2104 of the Social Security Act, and reflects final state reporting for FY 2025.
[4] Totals may not sum due to rounding.

This page intentionally left blank.

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

This page intentionally left blank.

Health Insurance Exchange Transparency - The agreement continues bill language requiring CMS to provide cost information for the Health Insurance exchange, including all categories described under this heading in the explanatory statement accompanying the Consolidated Appropriations Act of 2026 (Public Law 119-75) (Administrative Costs; Marketplace related Information Technology [IT]; Non-IT Program Costs, including Health Plan Benefit and Rate Review, Marketplace Oversight, Payment and Financial Management, Eligibility and Enrollment; Consumer Information and Outreach, including the Call Center, Navigator Grants and Consumer Education and Outreach; Marketplace Quality Review; Small Business Health Options Program and Employer Activities; and Other Marketplace Activities), for each fiscal year since the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148), as well as estimated costs for fiscal year 2027.

Health Insurance Marketplaces Transparency Table

Dollars in Thousands

Activity	FY 2019 Actual	FY 2020 Actual	FY 2021 Actual	FY 2022 Actual	FY 2023 Actual	FY 2024 Actual	FY 2025 Actual	FY 2026 Enacted	FY 2027 President's Budget
Health Plan Bid Review, Management and Oversight	**$45,797**	**$45,480**	**$38,841**	**$54,255**	**$56,276**	**$97,614**	**$82,360**	**$89,291**	**$87,132**
Payment and Financial Management	**$50,220**	**$39,178**	**$49,821**	**$47,780**	**$51,757**	**$46,792**	**$55,472**	**$52,112**	**$51,452**
Eligibility and Enrollment[1]	**$348,488**	**$371,802**	**$350,482**	**$391,341**	**$346,946**	**$428,523**	**$389,078**	**$410,631**	**$476,229**
Consumer Information and Outreach	**$579,088**	**$503,271**	**$843,729**	**$903,220**	**$1,206,902**	**$1,177,935**	**$777,911**	**$663,022**	**$633,952**
Call Center (non-add)	*$499,053*	*$440,000*	*$477,247*	*$535,219*	*$557,926*	*$564,500*	*$620,906*	*$501,730*	*$501,730*
Navigators Grants & Enrollment Assisters (non-add)	*$19,499*	*$19,689*	*$91,233*	*$133,293*	*$138,821*	*$161,204*	*$40,919*	*$38,403*	*$19,744*
Consumer Education and Outreach (non-add)	*$11,231*	*$14,082*	*$245,749*	*$211,592*	*$443,753*	*$348,656*	*$33,492*	*$50,818*	*$40,568*
Information Technology	**$504,283**	**$549,369**	**$515,388**	**$511,706**	**$588,819**	**$686,814**	**$603,883**	**$729,483**	**$663,262**
Quality	**$7,334**	**$7,063**	**$6,391**	**$6,706**	**$6,142**	**$6,331**	**$6,360**	**$5,908**	**$5,914**
SHOP and Employer Activities	**$2,117**	**$200**	**$197**	**$195**	**$0**	**$195**	**$194**	**$194**	**$195**
Other Marketplace	**$40,290**	**$63,579**	**$38,827**	**$35,400**	**$59,192**	**$62,179**	**$66,173**	**$80,449**	**$60,172**
Administrative Costs[2]	**$77,750**	**$85,833**	**$120,071**	**$134,741**	**$124,713**	**$129,030**	**$149,750**	**$149,014**	**$155,832**
Total	**$1,655,367**	**$1,665,775**	**$1,963,746**	**$2,085,344**	**$2,440,747**	**$2,635,413**	**$2,131,182**	**$2,180,105**	**$2,134,140**

[1] Funding for Enrollment Assisters under Eligibility and Enrollment ended in FY 2017. Starting in FY 2022, this activity is funded under Navigator Grants and Enrollment Assisters.
[2] Beginning in FY 2023, the funding for Federal Administration FTEs was removed from the Federal Exchange budget display. These FTEs are still accounted for in the Federal Administration budget display in the CMS FY 2027 Congressional Justification.
Note: Fiscal years 2010 through 2025 include obligations as of September 30 of each year.
Note: Before the Marketplaces were transferred to CMS, $4.7 million and $66.3 million in obligations were incurred in FY 2010 and FY 2011, respectively.

Health Insurance Marketplaces Transparency Table

Dollars in Thousands

Activity	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Actual	FY 2017 Actual	FY 2018 Actual
Health Plan Bid Review, Management and Oversight	**$0**	**$300**	**$21,936**	**$40,595**	**$33,497**	**$43,960**	**$40,520**	**$39,846**	**$37,910**
Payment and Financial Management	**$0**	**$1,698**	**$24,998**	**$25,832**	**$49,615**	**$43,733**	**$51,325**	**$47,640**	**$45,141**
Eligibility and Enrollment[3]	**$0**	**$2,218**	**$3,433**	**$275,501**	**$339,754**	**$363,768**	**$445,249**	**$484,144**	**$392,660**
Consumer Information and Outreach	**$0**	**$2,427**	**$32,610**	**$701,075**	**$704,136**	**$753,238**	**$805,833**	**$640,232**	**$591,948**
Call Center (non-add)	*$0*	*$0*	*$22,000*	*$505,446*	*$545,600*	*$566,178*	*$563,638*	*$540,197*	*$525,326*
Navigators Grants & Enrollment Assisters (non-add)	*$0*	*$0*	*$0*	*$107,513*	*$97,152*	*$75,996*	*$99,677*	*$51,166*	*$12,720*
Consumer Education and Outreach (non-add)	*$0*	*$0*	*$7,043*	*$77,436*	*$49,334*	*$54,897*	*$101,048*	*$16,599*	*$10,744*
Information Technology	**$2,346**	**$92,672**	**$166,455**	**$402,553**	**$770,957**	**$798,648**	**$664,083**	**$710,867**	**$767,413**
Quality	**$0**	**$0**	**$0**	**$0**	**$17,189**	**$15,634**	**$11,736**	**$7,301**	**$7,240**
SHOP and Employer Activities	**$0**	**$366**	**$18,479**	**$25,076**	**$30,541**	**$42,717**	**$34,520**	**$16,500**	**$4,418**
Other Marketplace	**$1,879**	**$14,906**	**$13,738**	**$4,400**	**$6,728**	**$3,614**	**$12,032**	**$49,584**	**$31,196**
Administrative Costs[4]	**$429**	**$10,805**	**$43,493**	**$68,429**	**$80,000**	**$80,000**	**$85,000**	**$79,602**	**$70,892**
Total	**$4,654**	**$125,392**	**$325,142**	**$1,543,461**	**$2,032,418**	**$2,145,312**	**$2,150,297**	**$2,075,714**	**$1,948,818**

[3] Funding for Enrollment Assisters under Eligibility and Enrollment ended in FY 2017. Starting in FY 2022, this activity is funded under Navigator Grants and Enrollment Assisters.
[4] Beginning in FY 2023, the funding for Federal Administration FTEs was removed from the Federal Exchange budget display. These FTEs are still accounted for in the Federal Administration budget display in the CMS FY 2027 Congressional Justification.
Note: Fiscal years 2010 through 2025 include obligations as of September 30 of each year.
Note: Before the Marketplaces were transferred to CMS, $4.7 million and $66.3 million in obligations were incurred in FY 2010 and FY 2011, respectively.

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

This page intentionally left blank.

PROGRAM OPERATIONS

MCR9: Ensure Beneficiary Telephone Customer Service

Measure	FY	Target	Result
MCR9.3: Minimum of 90 percent pass rate for the Customer Satisfaction Survey (1-800 Medicare)	2027	90%	October 31, 2027
	2026	90%	October 31, 2026
	2025	90%	96% (Target Exceeded)
	2024	90%	96% (Target Exceeded)
	2023	90%	96% (Target Exceeded)
	2022	90%	94% (Target Exceeded)
	2021	90%	94% (Target Exceeded)
MCR9.5: Minimum of 90 percent pass rate for the Customer Satisfaction Survey (Federal Exchange)	2027	90%	October 31, 2027
	2026	90%	October 31, 2026
	2025	90%	94% (Target Exceeded)
	2024	90%	94% (Target Exceeded)
	2023	90%	93% (Target Exceeded)

The CMS Contact Center Operations (CCO) provides high-quality customer service to people with Medicare and Federal Exchange health insurance. Our contact centers consistently score above 90% on quality measures. Some areas score even higher — between 95% and 99% — and have maintained these scores for several years.

To uphold our quality standards, CMS continuously works to improve our service by analyzing audit results to find and fix problems, updating training materials regularly, and improving the tools and information our customer service representatives use. CMS will continue to track our performance metrics, maintain customer satisfaction at 90% or higher, and regularly review and improve our customer service tools and materials.

CMS is committed to providing world-class customer service to all Americans who get their health insurance through Medicare or the Federal Exchange.

MCR12: Maintain CMS's Improved Rating on Financial Statements

Measure	FY	Target	Result
MCR12: Maintain an unmodified opinion	2027	Maintain an unmodified opinion	November 15, 2027
	2026	Maintain an unmodified opinion	November 15, 2026
	2025	Maintain an unmodified opinion	Target Met
	2024	Maintain an unmodified opinion	Target Met
	2023	Maintain an unmodified opinion	Target Met
	2022	Maintain an unmodified opinion	Target Met
	2021	Maintain an unmodified opinion	Target Met

CMS has demonstrated exceptional financial management, maintaining an unmodified "clean" audit opinion for 26 consecutive years. This achievement aligns with the Chief Financial Officers (CFO) Act of 1990's requirement for federal agencies to provide consistent and reliable financial information to Congress. CMS's financial systems are fully integrated according to the Office of Management and Budget (OMB) requirements, with the Healthcare Integrated General Ledger Accounting System (HIGLAS), serving as the official financial system of record.

In FY 2025, CMS achieved significant milestones in its financial performance, obtaining an unmodified opinion on four out of six principal financial statements. The agency has maintained substantial compliance with Federal Manager's Financial Integrity Act of 1982 (FMFIA) since FY 2010 and provided FMFIA statements of reasonable assurance for internal controls. However, auditors were unable to express an opinion on two statements: the Statement of Social Insurance (SOSI) and the Statement of Changes in Social Insurance Amounts (SCSIA).

The agency's financial excellence is particularly noteworthy as no material weaknesses were reported in either the CFO audit or the OMB Circular A-123 review. This success demonstrates CMS's commitment to maintaining robust financial controls and transparency in its operations.

The measure met the FY 2025 target of maintaining an unmodified opinion, and will continue to meet requirements set forth by OMB Bulletin 21-04, the Federal Manager's Financial Integrity Act of 1982, and the OMB Circular A-127.

MCR37: Increase In New Patient Choice in Dialysis Treatment

Measure	CY	Target	Result
MCR37: Increase the percentage of new dialysis patients who choose home dialysis modalities	2027	23.50%	June 30, 2028
	2026	23.50%	June 30, 2027
	2025	23.00%	June 30, 2026
	2024	24.62%	22.80% (Target Not Met)
	2023	23.60%	23.13% (Target Not Met But Improved)
	2022	22.57%	22.90% (Target Exceeded)
	2021	19.92%	21.50% (Target Exceeded)
	2020	19.02%	20.52% (Target Exceeded)

This measure tracks the percentage of incident End-Stage Renal Disease (ESRD) patients who start and transition to home dialysis within 365 days of dialysis initiation. The program focuses on two main home dialysis options: Peritoneal Dialysis (PD), which uses the lining of the patient's abdomen and pelvis, and Home Hemodialysis (HHD), which utilizes compact equipment for home treatments and flexible scheduling.

The current performance metrics show a 22.8% utilization rate as of 2024, with a small target gap of -1.82% and a projected annual growth of 1.26% for FYs 2024-2026. The program encounters significant implementation challenges related to healthcare system barriers including workforce shortages and limited geographic access, as well as patient-related factors such as knowledge gaps and financial constraints that prevent optimal care utilization. Many patients with ESRD lack adequate education about their treatment options, including the choice to receive home dialysis as an alternative to in-center treatment or the possibility of a kidney transplant. To address these challenges, the program has developed strategic solutions focusing on educational initiatives, support programs, and healthcare system improvements, with an emphasis on enhanced patient education and peer mentoring networks.

This performance measure supports the Make America Healthy Again (MAHA) initiative, which addresses the rise of chronic diseases, including kidney disease. The CMS Kidney Care Choices (KCC) Innovation is designed to help empower patients to be more active in their care and encourage greater use of home dialysis for Medicare beneficiaries with ESRD, while reducing Medicare expenditures and maintaining or improving the quality of care provided to ESRD beneficiaries. CMS also established the ESRD Network Program, which is statutorily mandated under Section 1881 of the Social Security Act to support patients with ESRD. This program provides comprehensive educational support programs, collaboration with home dialysis program leaders across the U.S. and territories, patient listening sessions, enhanced patient and staff modality education, and peer mentoring

programs to help patients successfully transition to home-based dialysis care. This performance measure also compliments the technical specifications in the ESRD Dialysis Facility Care Compare (DFCC) and future initiatives of the End Stage Renal Disease Quality Incentive Program (ESRD QIP), established by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

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	2027	Contextual Measure	November 30, 2027
	2026	Contextual Measure	November 30, 2026
	2025	Contextual Measure	2,190,298
	2024	Contextual Measure	1,995,965
	2023	Contextual Measure	1,988,037
	2022	Contextual Measure	1,750,006
	2021	Contextual Measure	1,550,608

CMS continues to make significant progress in improving service integration for dual-eligible beneficiaries. During FY 2024, over 14 million Americans were enrolled in both Medicare and Medicaid programs, with 23% of full-benefit dually eligible individuals enrolled in integrated care programs. The enrollment in integrated care models has increased from 161,777 in 2011 to nearly 2 million in 2024.

Barriers to integration include state capacity limitations, misaligned enrollment across Medicare and Medicaid health plans, fragmented care delivery, and misaligned incentives for payers and providers. To address these challenges, CMS has implemented solutions through partnerships with states, focusing on Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), Programs of All-inclusive Care for the Elderly (PACE), and demonstrations such as the Medicare-Medicaid Financial Alignment Initiative which ended December 31, 2025. CMS has also advanced integrated care programs through rule-making and technical assistance to states.

The ultimate goal of this initiative is to improve care quality and cost-effectiveness for dually eligible individuals. Technical assistance is provided through the Integrated Care Resource Center to support these objectives.

PHI10: Nationwide Independent Dispute Resolution Throughput

Measure	FY	Target	Result
PHI10: Increase the IDR monthly dispute throughput rate	2027	230,000 disputes per month	April 1, 2027

The No Surprises Act protects patients from unexpected out-of-network medical bills while establishing a fair payment resolution system between healthcare providers and insurance companies. When providers disagree with payment denials or initial payments, they must first engage in a 30-business-day open negotiation period with the health plan. If no agreement is reached, either party can initiate the Federal Independent Dispute Resolution (IDR) process within 4 business days. This process involves selecting a certified independent third-party entity to evaluate both parties' payment offers and supporting information. The IDR entity must select one of the two offers presented (they cannot choose an alternate amount), and both parties must accept this binding decision, with payment required within 30 calendar days.

The Federal IDR portal launched in April 2022 with initial challenges, processing only 1,200 payment determinations from 46,000 initiated disputes by August 2022. By the end of 2023, dispute volume had increased dramatically to 679,318 new cases (879,501 total since launch), creating a backlog exceeding 500,000 cases by January 2024. Despite dispute initiations more than doubling to 1.4 million in 2024, IDR entities significantly improved their performance metrics: open dispute volume increased by only 17%, while eligibility determinations rose by 274%, case closures by 343%, and payment determinations by 401%. During the second half of 2024, IDR entities closed more disputes than were initiated in four out of six months. This positive trend has continued into 2025, with IDR entities regularly closing more disputes than assigned, steadily reducing the case backlog, and remaining on track to meet throughput goals. CMS has consistently exceeded this goal since April 2025. In Q1 of 2025, CMS closed 195,000 IDR disputes per month. In Q2, this number increased to 228,000 cases per month. In Q3, it further increased to 230,000 cases per month.

The IDR program operates under the joint oversight of three federal departments—Health and Human Services, Labor, and Treasury—with CMS, through the Center for Consumer Information and Insurance Oversight, handling day-to-day operations on their behalf.

PHI11: Fight Misleading Marketing

Measure	FY	Target	Result
PHI11: Monitor, identify, and link misleading ads to the original agent/broker so CMS can take appropriate enforcement action against the agents/brokers for engaging in misleading marketing practices.	2027	Identification of 70 misleading ads	April 1, 2027

CMS, through the Center for Consumer Information and Insurance Oversight, has identified a concerning trend of misleading marketing activities by agents and brokers on the Federal Exchange. These deceptive practices include promoting "$0 premiums" without clearly explaining the associated tax liability from Advance Premium Tax Credits (APTC), offering inappropriate incentives like gift cards and vacations, and misrepresenting enrollment deadlines for both the annual Open Enrollment Period and Special Enrollment Periods.

Federal regulations require all Federal Exchange-registered agents and brokers to provide consumers with accurate information about the Federally-facilitated Exchanges (FFEs), qualified health plans, and insurance affordability programs. Any marketing that misleads consumers—whether by providing incorrect information or omitting important facts—violates these regulations. This prohibition specifically includes generating leads or enrolling consumers through deceptive marketing tactics.

To address this issue, CMS has implemented a monitoring initiative to identify and trace misleading advertisements back to their originating agents or brokers. This evidence-gathering effort will enable CMS to take appropriate enforcement actions against those engaging in these prohibited marketing practices, helping to protect consumers and maintain the integrity of the Federal Exchange. As of November 2025, CMS is meeting this goal, and has received and reviewed 70 misleading ads.

MEDICARE SURVEY & CERTIFICATION PROGRAM

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	2027	85% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2028
	2026	92.5% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2027
	2025	95.5% of hospice facilities are surveyed within the required 36 month timeframe	88.3% (Target Not Met)
	2024	98% of hospice facilities are surveyed within the required 36 month timeframe	92.3% (Target Not Met)
	2023	98% of hospice facilities are surveyed within the required 36 month timeframe	96.4% (Target Not Met But Improved)
	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)

This measure aims to ensure that the statutory requirement for the hospice survey interval is met nationally. Although the CMS target is not in 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.

This program establishes a comprehensive monitoring system for monitoring and improving Medicare-certified hospice facilities through regular inspections and enhanced transparency measures. The program currently oversees 7,084 facilities that serve more than 1.5 million Medicare beneficiaries annually.

The oversight structure operates through two main channels: State Survey Agencies

(SAs), which handle primary inspection responsibilities, and through Accrediting Organizations. The program encompasses essential services related to a beneficiary's terminal diagnosis and includes specialized palliative care delivery and comprehensive patient support intended to allow patients to remain at home, or in home-like settings until death.

Strategic priorities focus on both immediate and long-term objectives. Immediate priorities include eliminating survey backlogs, improving compliance rates, maintaining quality standards, and enhancing transparency. Long-term objectives encompass strengthening oversight systems, enhancing quality metrics, improving public reporting, and increasing operational efficiency. The program continues to monitor progress through regular compliance assessments, service quality evaluations, and performance trend analysis.

Hospices are required to be surveyed for compliance with CMS's Conditions of Participation no more than 36 months after their last survey. We aim to maintain survey compliance targets of 98% within 36-month intervals, though performance has been below target during FY 2020-2024.

CMS did not meet the FY 2020 – FY 2024 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 staffing and other resources challenges making it difficult to meet previously established targets.

After considering these challenges, CMS has reduced the FY 2026 target to 92.5% to provide SAs an opportunity to be successful during this period of transition post PHE. As SAs reduce the backlog, we anticipate meeting the target goal of hospice facilities surveyed within the required 36 months in the upcoming years.

Additionally, CMS is adjusting its FY27 target percentage to reflect a budget percentage. From a funding perspective, given the available resources for hospice survey activities, it is only possible to estimate achieving 85% of the anticipated national hospice workload. This adjustment resulted from the conclusion of IMPACT Act funding, which specifically supported hospice surveys and ended in FY2025. Due to this constraint, coupled with no increases to the Survey & Certification (S&C) budget since FY2015, an additional one-time IMPACT award was allocated in FY2026 to ensure the program could continue to operate at full capacity. Should IMPACT funds be received again in FY2027, or if another funds source can be utilized outside of S&C funding, it is likely that estimates would increase, positioning states to meet the established performance target.

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)*	2027	98.0%	December 31, 2027
	2026	98.0%	December 31, 2026
	2025	97.9%	98.5% (Target Exceeded)
	2024	98.0%	98.2% (Target Exceeded)
	2023	98.0%	97.5% (Target Not Met But Improved)
	2022	97.5%	96.7% (Target Not Met)
	2021	96.9%	97.0% (Target Exceeded)

*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 is designed to enhance nursing home care quality through mandatory staffing data reporting, enabling informed decision-making for consumers and stakeholders. The program has demonstrated strong performance, with compliance rates exceeding the FY 2025 target (97.9%).

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 program. The staffing measures focus on key reporting elements including staff-to-resident ratios, employee turnover statistics, and weekend staffing levels.

The operational framework is built on mandatory requirements for long-term care providers to submit verifiable staffing documentation through the Payroll-Based Journal (PBJ) system. The program maintains robust quality control measures through regular data validation, compliance monitoring, and performance audits. Implementation is supported by a comprehensive technology infrastructure that includes secure electronic submission platforms, automated verification systems, and real-time compliance tracking.

The program's success is measured through reporting compliance rates, data accuracy scores, system reliability statistics, and user satisfaction levels, all of which contribute to the overall goal of improving nursing home care quality through transparency and accountability.

MSC8: Decrease the Percentage of Long-stay Nursing Home Residents Receiving an Antipsychotic Medication

Measure	FY	Target	Result
MSC8: Decrease the population of long-stay nursing home residents receiving antipsychotic medication **FY 2024 result achieved before the 2025 methodology change was 14.7%.*	2027	16.98%	July 31, 2028
	2026	16.98%	July 31, 2027

*The previous version of this measure (MSC5) was discontinued due to the June 18, 2025 memo (see the Discontinued Measures section of this report). This new measure is aligned with the increased national percentage of residents receiving antipsychotic medications.

This initiative focuses on improving dementia care quality while reducing unnecessary medication use among residents who have stayed in nursing homes for 101 days or more. The initiative excludes residents with specific medical conditions such as Schizophrenia, Tourette's syndrome, or Huntington's disease, where antipsychotic medications may be medically necessary.

CMS uses three key approaches to achieve this goal. First, the program promotes non-drug treatments through proven methods and person-centered dementia care, including the Hand in Hand training program for nursing home staff. Second, it maintains strong oversight by posting quality measures on the Nursing Home Care Compare website and including results in the Five-Star Quality Rating System. Third, it targets facilities that need the most help, focusing on nursing homes with lower staffing levels or compliance issues.

Due to the change in reporting methodology announced in the June 18, 2025 memo, CMS will improve measurement accuracy by combining nursing home reports with Medicare and Medicaid claims data and Medicare Advantage encounter data. This change addresses concerns raised by the Office of Inspector General in 2021 about potential underreporting of antipsychotic medication use. This new measure will increase the target for the national reported percentage of residents receiving antipsychotics from 14.64% to 16.98%, reflecting more accurate data capture. The updated measure will be implemented on Nursing Home Care Compare in January 2026, and will replace the current measure in the Five-Star Quality Rating System calculations.

This comprehensive approach balances the need to reduce inappropriate antipsychotic use while ensuring residents receive proper care for legitimate medical conditions. By combining better training, stronger monitoring, and more accurate data collection, the initiative aims to improve both the quality of dementia care and the safety of nursing home residents nationwide.

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	2027	Work with States to ensure that 96% of States report on at least twenty-two quality measures in the CHIPRA children's core set of quality measures	June 1, 2028
	2026	Work with States to ensure that 96% of States report on at least twenty-one quality measures in the CHIPRA children's core set of quality measures	June 1, 2027
	2025	Work with States to ensure that 96% 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	96% (Target Exceeded)
	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	96% (Target Exceeded)
	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% (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% (Target Exceeded)

Measure	FY	Target	Result
	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% (Target Exceeded)

The Child Core Set of Quality Measures, or Child Core Set, measures the quality of health care services provided to children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Congress created this program under Section 1139A of the Social Security Act to assess service delivery and help states improve health outcomes for children in these programs. As of January 1, 2024, all states, DC, Puerto Rico, Guam, and the U.S. Virgin Islands must report on all Child Core Set measures. This requirement comes from the Bipartisan Budget Act of 2018 and was detailed in the August 2023 Mandatory Medicaid and CHIP Core Set Reporting Final Rule. States can request exemptions if they cannot get the needed data, so not all states will report all measures each year.

CMS has successfully increased reporting on the Child Core Set, with 96% of states reporting at least 14 measures in fiscal year 2023 and 17 measures in fiscal year 2024. The program has met or exceeded its targets since 2019 by providing consistent technical assistance to states. Looking ahead, CMS has set ambitious goals, aiming for 96% of jurisdictions to report 20 or more quality measures in 2025, with the quality measure numbers increasing each year for 2026 and 2027. CMS will continue providing significant technical assistance to help states increase reporting and use quality measurement data to improve care.

The Child Core Set aims to standardize quality measurements, better assess service delivery, and improve health outcomes for children with Medicaid and CHIP. The program emphasizes data transparency, with annual results published on Medicaid.gov and interactive data available on data.medicaid.gov. Program operations are funded using no-year statutory funds appropriated for the Child Health Quality Measures Programs.

MCD8: Improve Adult Health Care Quality across Medicaid

Measure	FY	Target	Result
MCD8: Improve Adult Health Care Quality Across Medicaid	2027	Work with States to ensure that 89% of States report on at least fifteen quality measures in the Adult Medicaid core set of quality measures	June 1, 2028
	2026	Work with States to ensure that 89% of States report on at least fifteen quality measures in the Adult Medicaid core set of quality measures	June 1, 2027
	2025	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, 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	87% (Target Not Met)
	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	92% (Target Exceeded)
	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)

*When reporting on the behavioral health measures within the Adult Core Set became mandatory in FY 2024, the denominator increased from 51 (states and DC) to 54 (states, DC, Guam, Puerto Rico, and U.S. 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 number of total states reporting on the Adult Core Set.

The Adult Health Quality Measures program, or Adult Core Set, measures the quality of health care services provided to adults enrolled in Medicaid. Congress created this program under Section 1139B of the Social Security Act to help states improve health outcomes for Medicaid patients. Most of the Adult Core Set measures are optional for state reporting, except for the behavioral health measures in this Set that became required for state reporting as of 2024. This requirement comes from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (P.L. 115-271) and was outlined in the August 2023 Mandatory Medicaid and CHIP Core Set Reporting Final Rule. States can request exemptions if they cannot get the needed data, so not all states will report all measures each year.

The program has shown positive progress over the years, with mixed results recently. In fiscal year 2023, the Program exceeded reporting targets. In 2024, states focused their resources on meeting new mandatory reporting requirements on the Child and Behavioral Health Core Sets, resulting in fewer reported voluntary measures on the Adult Core Set and the program did not meet its 2024 target.

The program faces several challenges, including the voluntary nature of most reporting measures, limited territory participation, and the original funding, appropriated in the Affordable Care Act, being exhausted in fiscal year 2025. Starting in FY 2026, the program is operating out of the CMS Program Operations budget at a lower funding level with a focus on key technical assistance and data reporting to meet minimum statutory requirements.

The Adult Core Set aims to standardize quality measurements, better assess quality of service delivery, and improve health outcomes for adults enrolled in Medicaid. The program emphasizes data transparency, with annual results published on Medicaid.gov and interactive data available on data.medicaid.gov.

MCD9: Reduce Emergency Department Use under Substance Use Disorder Section 1115 Demonstrations

Measure	FY	Target	Result
MCD9.3: Reduce Emergency Department Use Under Substance Use Disorder (SUD) 1115 Demonstration	2027	Eighty-two 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, 2027
	2026	Eighty-one 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, 2026
	2025	Eighty percent of states that either demonstrate a decrease or remain consistent in their ED utilization for SUD will be similar to the 2023 baseline	89% (Target Exceeded)
	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	88% (Target Exceeded)
	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 demonstration authority enables states to implement innovative Medicaid reforms. One such innovation opportunity focuses on substance use disorder (SUD) treatment. As of December 2, 2025, 38 states have an approved SUD demonstration.

Performance monitoring is maintained through standardized metrics reporting, and state-specific data collection methods, with key indicators focusing on Emergency Department (ED) utilization tracking, SUD treatment access, and various outcome measurements. CMS is currently revising the CMS Behavioral Health strategy and remains committed to

optimizing the health outcomes and well-being of those who are living with, or at risk of developing, behavioral health conditions.

MCD11: Increase the Proportion of Medicaid Long-Term Services and Supports (LTSS) Beneficiaries Who Receive Home and Community-Based Services (HCBS)

Measure	CY	Target	Result
MCD11: Increase the proportion of Medicaid LTSS beneficiaries receiving HCBS	2027	87.4%	July 1, 2029
	2026	87.2%*	July 1, 2028
	2025	87.0%*	July 1, 2027
	2024	86.8%*	July 1, 2026
	2023	86.6%*	87.1% (Target Exceeded)
	2022	86.4%*	86.6% (Target Exceeded)
	2021	Historical Actual	86.2%*
	2020	Historical Actual	84.5%
	2019	Baseline	84.3%

*A 2024 quality audit identified substantial calendar year (CY) 2021 data quality issues for one reporting state. The CMS target-setting methodology relies on prior year results calculations, so the CY 2021 data has been corrected along with the targets for CYs 2022-2026.

Medicaid is the predominant payer for long-term services and supports (LTSS) in the United States, accounting for 46% of national LTSS spending as of 2023.[1] The program encompasses both medical and non-medical services for older adults and people with disabilities, with service delivery varying across states in terms of type, population coverage, and implementation models. The primary purpose of the LTSS Performance Measure is to track the proportion of Medicaid LTSS users receiving home and community-based services (HCBS).

Performance metrics show steady improvement in HCBS utilization, with the percentage of LTSS users receiving HCBS increasing from 84.3% in 2019 (baseline) to 87.1% in 2023. This progress is measured using the Transformed Medicaid and CHIP Statistical Information System (T-MSIS) Analytic Files (TAF), which is used to track unduplicated Medicaid beneficiaries receiving HCBS compared to total LTSS users. TAF data quality reviews of state-submitted data have led to some adjustments of the data, including the suppression of one state's 2021 data due to quality concerns, resulting in an adjustment of the 2021 figures from 87.2% to 86.2%. Moving forward, CMS will continue monitoring HCBS utilization trends, conducting regular data quality reviews, and tracking the impact of

[1] https://www.congress.gov/crs-product/IF10343#:~:text=Using%20this%20definition,%20total%20U.S.,spent%20on%20personal%20health%20care

American Rescue Plan Act of 2021 (ARP) section 9817 funding (discussed in more detail below) on HCBS use.

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.[2] More recently, ARP section 9817 has significantly impacted Medicaid HCBS programs by providing a temporary 10 percentage point increase (from April 1, 2021, until March 31, 2022) in the federal medical assistance percentage (FMAP) for certain Medicaid HCBS expenditures. States were expected to use an amount of state funds equivalent to the amount of federal funds attributable to the increased FMAP by March 31, 2025, to enhance, expand, or strengthen Medicaid HCBS. However, as of March 2026, 22 states have approved extensions and are continuing to expend the funds. ARP section 9817 has resulted in a substantial investment in states' HCBS programs since 2021, with total additional state and federal spending when the funds are fully expended estimated at $37 billion.

For more detailed information about the LTSS Performance Measure, interested parties can refer to https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations.

[2] 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/

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

Measure	FY	Target	Result
MCD12: Improving Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD)	2027	Work with States to ensure at least 44 states report on the Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD) measure in the Adult Medicaid Core Set of quality measures	June 1, 2028
	2026	Work with States to ensure at least 44 states report on the Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD) measure in the Adult Medicaid Core Set of quality measures	June 1, 2027
	2025	Work with States to ensure at least 43 states report on the Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD) measure in the Adult Medicaid Core Set of quality measures	June 1, 2026
	2024	Work with States to ensure at least 46 states report on the Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD) measure in the Adult Medicaid Core Set of quality measures	42 States (Target Not Met)
	2023	Work with States to ensure at least 45 states report on the Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD) measure in the Adult Medicaid Core Set of quality measures	46 States (Target Exceeded)

CMS launched the Medicaid and CHIP Maternal and Infant Health Initiative (MIHI) in July 2014 to help pregnant women, new mothers, and their babies get better healthcare. This program was created with input from medical experts and other stakeholders to build a strong foundation for improving maternal and infant health across the country. Based on expert input, the MIHI has focused on a range of key drivers of maternal and infant health including improving quality of postpartum care and reducing low risk Cesarean delivery.

The initiative is currently focusing on two health areas that significantly impact maternal deaths and complications: maternal mental health and substance use and maternal cardiovascular health, including hypertension. MIHI has been successful in engaging states nationwide, with all 50 states, the District of Columbia, and U.S. territories now participating.

The Program did not meet its FY 2024 reporting targets. CMS uses quality measures from the Medicaid Adult Core Set to determine progress on this Performance Measure. The Adult Core Set measures the quality of health care services provided to adults enrolled in Medicaid, and is voluntary for state reporting. In 2024, states focused their resources on meeting new mandatory requirements on the Child Core Set and behavioral health measures on the Adult Core Set, resulting in fewer reported voluntary measures on the Adult Core Set, including measures used for this Performance Measure. Additionally, the original funding for the Adult Core Set was exhausted in fiscal year 2025 and this Program is operating on a much smaller funding level beginning in FY 2026 (See MCD8: Improve Adult Health Care Quality Across Medicaid for additional information). CMS has adjusted future goals based on what states can realistically achieve.

CMS continues to provide technical support and guidance to help states collect and report this information, and evaluate how to maintain its work beyond 2025 while staying focused on improving health outcomes for mothers and babies. Additionally, CMS launched the Transforming Maternal Health (TMaH) Model through the CMS Innovation Center in 2025 to support participating state Medicaid agencies (SMAs) in the development of a whole-person approach to pregnancy, childbirth, and postpartum care. By addressing the physical, mental health, and social needs experienced during pregnancy, the model aims to improve outcomes and experiences for mothers and babies, while also reducing overall program expenditures.

For more information, visit Adult Health Care Quality Measures and Maternal and Infant Health Care Quality on 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	2027	TBD	November 15, 2027
	2026	6.45% (Target in FY 2025 AFR)	November 15, 2026
	2025	7.46% (Target in FY 2024 AFR)	6.55%* (Target Exceeded)
	2024	7.28% (Target in FY 2023 AFR)	7.66%* (Target Met Within Range)
	2023	7.36% (Target in FY 2022 AFR)	7.38%* (Target Met Within Range)
	2022	6.16% (Target in FY 2021 AFR)	7.46%* (Target Not Met)
	2021	6.17% (Target in FY 2020 AFR)	6.26%* (Target Met Within Range)

*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.

This measure monitors improper payments in Medicare Fee-for-Service through the Comprehensive Error Rate Testing (CERT) program, ensuring fiscal responsibility and promoting program integrity. CMS has made significant strides in combating fraud, waste, and abuse through innovative tools and collaborative efforts with state and law enforcement partners.

The Medicare FFS improper payment estimate for Fiscal Year (FY) 2025 is 6.55 percent, or $28.83 billion. The primary root causes of improper payments were insufficient documentation, particularly in skilled nursing facility (SNF) and hospital outpatient claims, and medically unnecessary services in hospice and inpatient rehabilitation facility claims. Information on the Medicare FFS improper payment measurement can be found in the 2025 Department of Health and Human Services (HHS) Agency Financial Report (AFR).

Designated as one of its five strategic pillars, CMS has prioritized crushing fraud, including in the Traditional Medicare program, underscoring its relentless pursuit of program integrity and commitment to safeguarding the health and welfare of all beneficiaries. For example, CMS has increased efforts to proactively detect and identify fraud in real time by establishing the Fraud Defense Operations Center (FDOC) in March 2025. This innovative approach integrates cross-functional expertise through a specialized team of data analysts, investigators, health policy experts, legal advisors, and law enforcement to identify potential fraud through rigorous data analysis. From March to December 2025, FDOC efforts

resulted in over $1.8 billion in payments suspended to suspect providers. This initiative is designed to save taxpayers billions while simultaneously protecting beneficiary care across federal healthcare programs.

Targets for improper payments are set annually in the Agency Financial Report. For more information, please see the FY 2025 Agency Financial Report.

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	2027	TBD	November 15, 2027
	2026	6.43% (Target in FY 2025 AFR)	November 15, 2026
	2025	5.95% (Target in FY 2024 AFR)	6.09%* (Target Met Within Range)
	2024	6.38% (Target in FY 2023 AFR)	5.61%* (Target Exceeded)
	2023	5.77% (Target in FY 2022 AFR)	6.01%* (Target Met Within Range)
	2022	9.69% (Target in FY 2021 AFR)	5.42%* (Target Exceeded)
	2021	Historical Actual	10.28%

*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.

This measure monitors improper payments in Medicare Part C, ensuring fiscal responsibility and promoting program integrity. In Fiscal Year (FY) 2025, CMS achieved its target by reporting a Medicare Part C improper payment rate of 6.09%, representing $23.67 billion in estimated improper payments. The primary cause of improper payments continues to be medical record discrepancies, which occur when medical record documentation submitted by the Medicare Advantage Organization (MAO) does not substantiate a CMS Hierarchical Condition Category (HCC) for which the MAO received payment.

To address these challenges, CMS has announced an aggressive expansion of its Medicare Advantage audit strategy to address significant overpayment issues. The agency is dramatically scaling up its Risk Adjustment Data Validation (RADV) audit capabilities by deploying advanced technology systems and expanding audits from approximately 60 contracts annually to all RADV-eligible contracts for each payment year. Although the U.S. District Court for the Northern District of Texas vacated certain portions of CMS' 2023 RADV Final Rule on September 25, 2025, the Department of Health and Human Services (HHS) appealed this decision on November 21, 2025. HHS will fully comply with the district court's order, while continuing to pursue RADV payment year audits at an accelerated rate in accordance with its authority under 42 CFR 422.310.

This expansion initiative represents a fundamental shift in CMS's oversight approach, moving from limited sampling to comprehensive auditing of the Medicare Advantage program to ensure accurate billing and compliance with federal requirements, addressing a

significant backlog where the last major recovery occurred following the 2007 payment year audit.[3]

Targets for improper payments are set annually in the Agency Financial Report. For more information, please see the FY 2025 Agency Financial Report.

[3] On September 25, 2025, the U.S. District Court for the Northern District of Texas vacated certain portions of CMS' 2023 RADV Final Rule. CMS continues to carefully evaluate the implications of this decision and will determine whether any potential changes to current and future audits are needed.

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	2027	TBD	November 15, 2027
	2026	4.23% (Target in FY 2025 AFR)	November 15, 2026
	2025	3.91% (Target in FY 2024 AFR)	4.00%* (Target Met Within Range)
	2024	N/A**	3.70%**
	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 Within Range)
	2021	1.14% (Target in FY 2020 AFR)	1.33%* (Target Met Within Range)

*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.
**Medicare Part D is not reporting a 2024 improper payment reduction target for FY 2024 due to numerous methodology changes implemented in the FY 2023 reporting period and a baseline had not yet been established.

This measure monitors improper payments in Medicare Part D, ensuring fiscal responsibility and promoting program integrity.

The Medicare Part D improper payment estimate for Fiscal Year (FY) 2025 is 4.00 percent, or $4.23 billion. The primary root causes of improper payments continues to be missing documentation to support payment.

To address these challenges, CMS has implemented a comprehensive quality assurance system that includes prescription drug event (PDE) data review, claims processing verification, and risk management components. The implementation strategy focuses on provider support through education programs and technical assistance, including regular training sessions, documentation guidelines, and help desk support. In addition, designated as one of its five strategic pillars, CMS has prioritized crushing fraud, including in the Part D program, underscoring its relentless pursuit of program integrity and commitment to safeguarding the health and welfare of all beneficiaries.

Targets for improper payments are set annually in the Agency Financial Report. For more information, please see the FY 2025 Agency Financial Report.

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	2027	TBD	November 15, 2027
	2026	8.99% (Target in FY 2025 AFR)	November 15, 2026
	2025	5.29% (Target in FY 2024 AFR)	6.12%* (Target Not Met)
	2024	7.34% Target in FY 2023 AFR)	5.09%* (Target Exceeded)
	2023	12.68% (Target in FY 2022 AFR)	8.58%* (Target Exceeded)
	2022	18.94%** Target in FY 2021 AFR)	15.62%* (Target Exceeded)
	2021	Historical Actual	21.69%
MIP9.2: Reduce the Improper Payment Rate in the Children's Health Insurance Program (CHIP)	2027	TBD	November 15, 2027
	2026	9.52% (Target in FY 2025 AFR)	November 15, 2026
	2025	6.49% (Target in FY 2024 AFR)	7.05%* (Target Met Within Range)
	2024	10.28% (Target in FY 2023 AFR)	6.11%* (Target Exceeded)
	2023	21.04% (Target in FY 2022 AFR)	12.81%* (Target Exceeded)
	2022	27.88%** (Target in FY 2021 AFR)	26.75%* (Target Exceeded)
	2021	Historical Actual	31.84%

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

This measure is designed to evaluate improper payments in Medicaid and CHIP, ensuring fiscal responsibility and promoting program integrity. The Centers for Medicare & Medicaid Services (CMS) are actively addressing Medicaid fraud, waste, and abuse through several key initiatives. One major effort is the Comprehensive Medicaid Integrity Plan (CMIP) for Fiscal Years 2024-2028, which focuses on areas such as Medicaid managed care oversight, accurate eligibility determinations, and risk-based approaches to target high-risk vulnerabilities. Additionally, as applauded by the Senate Finance Committee, CMS has identified 2.8 million Americans enrolled in multiple Medicaid or Affordable Care Act Exchange plans. As one of its five strategic pillars, CMS has prioritized crushing fraud, underscoring their relentless pursuit of program integrity and commitment to safeguarding the health and welfare of all beneficiaries.

In FY 2025, CMS did not achieve its target by reporting a Medicaid improper payment rate of 6.12%, representing $37.39 billion in estimated improper payments. For CHIP, CMS achieved its target by reporting a CHIP improper payment rate of 7.05% (with a lower confidence limit of 6.27%), representing $1.37 billion in estimated improper payments.

Medicaid improper payments consist of two primary error types: missing or insufficient documentation to support payment and state non-compliance with federal payment requirements. CHIP improper payments consist of three primary error types: missing or insufficient documentation to support payment, state non-compliance with federal payment requirements, and improper eligibility determinations.

Targets for improper payments are set annually in the Agency Financial Report. For more information, please see the FY 2025 Agency Financial Report.

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	2027	$280 million	April 30, 2028
	2026	$225 million	April 30, 2027
	2025	$142.2 million	April 30, 2026
	2024	$65.0 million	$207 million (Target Exceeded)
	2023	$62.0 million	$116.5 million (Target Exceeded)
	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)

*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".

The Fraud Prevention System (FPS) safeguards Medicare funds by screening Fee-for-Service (FFS) claims before payment. This proactive approach aligns with CMS's commitment to fiscal responsibility and program integrity. Through its Strategic Direction, CMS has made significant strides in combating fraud, waste, and abuse through innovative tools and collaborative efforts with state and law enforcement partners. By leveraging predictive modeling technology and rigorous provider screening, CMS has saved billions of dollars, ensuring that resources are used effectively to benefit patients. As one of its five strategic pillars, CMS has prioritized crushing fraud, underscoring their relentless pursuit of program integrity and commitment to safeguarding the health and welfare of all beneficiaries.

The FPS has demonstrated exceptional performance in FY 2024, achieving total savings of $207 million, significantly exceeding its target of $65 million. FPS Edits focus on automatically identifying and stopping various types of problematic claims, including non-covered services, incorrectly coded claims, up coded claims, claims that exceed frequency limitations, or inappropriate billing patterns.

Recent program improvements have focused on an agile approach to revising edit logic in response to evolving coverage decisions or new or revised codes. The initiative maintains a robust operational framework supported by Medicare FFS integrity funding, with a strong emphasis on operational efficiency and cost-effective implementation strategies.

The FPS edits team continually researches and works with partners across the agency to discover new vulnerability areas and determines whether an edit can be utilized to help

stop or curb the issue. The team also continually evaluates the performance of existing edits.

The program has established new performance measurement methodologies for FY 2025, incorporating rolling 3-year average calculations to help determine annual target adjustments. As new edits are developed and the number of edits in operation increases year over year, the savings are expected to show continued growth.

MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS (QIO)

QIO14: Demonstrate the Impact of the Quality Innovation Network – Quality Improvement Organization (QIN-QIO) Program by Improving Quality of Care in Nursing Homes (NH)

Measure	FY	Target	Result
QIO14: Demonstrate NH Quality of Care by Reductions in Survey Deficiency Tags for F660, F661, F697, F698, F710, F741, F743, F759, F867, F880, F883. The tags encompass these deficiency categories: • Resident Assessment and Care Planning (F660, F661). • Quality of Life and Care (F697, F698, F741, F743). • Nursing and Physician Services (F710). • Pharmacy Service (F759). • Administration (F867), and • Infection Control (F880, 883). Baseline: 56% (projected for FY25)	2027	47.6% (15% reduction from baseline)	January 17, 2028
	2026	50.4% (10% reduction from baseline)	January 17, 2027
	2025	Projected Developmental Baseline	56%

CMS is improving nursing home quality through a new strategic approach in the 13th Scope of Work (SoW). Over 1.4 million people live in more than 15,000 Medicare and Medicaid certified nursing homes across the U.S. CMS is working to improve their care in four key areas:

- Prevention and Chronic Disease Management
- Quality and Patient Safety
- Resilient and High Performing Health Care Systems
- Transparency, Interoperability, and Care Coordination

Currently, about 56% of nursing homes have serious deficiencies (rated severity level D or higher) in these areas, meaning they could cause more than minimal harm to residents.

Starting in fiscal year 2025, CMS deployed Quality Improvement Organizations (QIN-QIOs) to provide education and hands-on support to approximately 8,500 nursing homes that need the most help. This approach focuses on serious survey deficiencies that indicate

widespread, continuing quality issues that put residents at risk for harm, rather than single incidents that are quickly corrected by the nursing home before harm occurs.

CMS aims to target the most critical deficiencies to make meaningful improvements in nursing home care quality and resident safety. This streamlined approach helps CMS focus resources where they're needed most — on facilities with serious quality concerns that put their residents at risk.

QIO15: Increase the Percentage of Medicare Fee-for-Service Beneficiaries Who Have an Annual Wellness Visit

Measure	FY	Target	Result
QIO15: Increase the Percentage of Medicare Fee-for-Service Beneficiaries Who Have an Annual Wellness Visit	2027	49.5% (10% increase from baseline)	June 30, 2027
Baseline: 45% (projected for FY26)	2026	Projected Developmental Baseline	June 30, 2026

CMS has launched the 13th Scope of Work (SoW) to support healthcare quality improvement and the HHS Secretary's Make America Healthy Again (MAHA) initiative. As one of the largest federally funded quality improvement programs in the country, CMS directs Quality Improvement Organizations (QIOs) to collaborate with healthcare providers nationwide to improve outcomes for more than 68 million Medicare beneficiaries. CMS is focusing on improving care through four key areas (aims):

- Prevention and Chronic Disease Management
- Quality and Patient Safety
- Resilient and High Performing Health Care Systems
- Transparency, Interoperability, and Care Coordination

The Annual Wellness Visit (AWV) represents a fundamental shift in Medicare from a treatment-focused to a prevention-focused approach, supporting healthier aging and sustainable costs. This Medicare Part B benefit aligns with the MAHA initiative by enabling early health risk detection, personalized care planning with shared decision-making, and cost reduction by addressing health issues proactively and preventing costly emergency interventions.

There is a noted variance in AWV utilization by state and region, with rural areas generally showing lower rates of AWV. Targeted outreach and provider and beneficiary education programs are shown to increase uptake of the AWV in the community. QIN-QIOs impact utilization rates through targeted outreach and education, including provider training on AWV benefits and coding, beneficiary education on AWV importance, and practice workflow integration and optimization.

This measure represents an evolution in quality improvement strategy by implementing a more targeted approach by focusing on deficiencies that have the potential to cause more than minimal harm and creating a more meaningful measurement framework that aligns with the goals of the 13th SoW.

MEDICARE BENEFITS

CMS is developing new performance measures to be included in subsequent reporting, that will support elements of the Make America Healthy Again (MAHA) Initiative.

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	2027	45,000,000 children (Medicaid – 36,070,000/ CHIP – 8,930,000)	July 31, 2028
	2026	44,000,000 children (Medicaid - 35,275,000/ CHIP - 8,725,000)	July 31, 2027
	2025	48,000,000 children (Medicaid - 39,072,000/ CHIP - 8,928,000)	July 31, 2026
	2024	37,000,000 children (Medicaid - 29,500,000/ CHIP - 7,500,000)	47,175,830 children (Medicaid - 37,960,297/ CHIP - 9,215,533) (Target Exceeded)
	2023	41,900,000 children (Medicaid - 34,700,000/ CHIP - 7,200,000)	48,062,154 children (Medicaid - 39,144,018/ CHIP - 8,918,136) (Target Exceeded)
	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)

The Children's Health Insurance Program (CHIP) and Medicaid provide healthcare coverage for low-income children across the United States. In Federal Fiscal Year (FY) 2024, these programs served over 47 million children, 37.9 million under Medicaid and 9.2 million in CHIP. Total child enrollment decreased 1.8% in FY 2024 compared to FY 2023 but still exceeded the FY 2024 target.

To meet targets for FY 2024-2027, CMS will continue building on its successful outreach and enrollment strategies. CMS will also provide technical assistance to states as they implement policies that affect child enrollment and retention in Medicaid and CHIP. This includes 12 months of continuous eligibility for children required by the Consolidated Appropriations Act, 2023 (P.L. 117-73).

CMS runs several programs that support this goal, including the Connecting Kids to Coverage program which helps find, enroll, and retain coverage for children who qualify for Medicaid and CHIP. In August 2025, CMS allocated $66 million in grant funding to 25 organizations for the Connecting Kids to Coverage outreach and enrollment program. Congress provided funding for these outreach and enrollment activities for FY 2024 through 2027 in the Advancing Chronic Care, Extenders, and Social Services Act.

CMS is also working with states, individuals, and state-based exchanges to prevent people from being enrolled in multiple coverage programs. For example, under section 71103 of the "Working Families Tax Cut" Legislation (P.L. 119-21), HHS must create a system to stop individuals from being enrolled in Medicaid or CHIP in multiple states. States will send Social Security numbers and other required information to this system and regularly verify addresses. If a state finds that someone is enrolled in more than one state, it must take action to fix it. CMS is committed to safeguarding taxpayer funds and enhancing the public's confidence in these vital programs.

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 Fee-for-Service beneficiaries aligned/attributed to Innovation Center Section 3021 models	2027	Contextual Indicator	November 30, 2027
	2026	Contextual Indicator	November 30, 2026
	2025	Contextual Indicator	28%
	2024	Contextual Indicator	27%
	2023	Contextual Indicator	26%
	2022	Contextual Indicator	16%
	2021	Contextual Indicator	17%
CMMI3.3: Number of providers* participating in Innovation Center Section 3021 models Baseline: < 60,000	2027	Contextual Indicator	November 30, 2027
	2026	Contextual Indicator	November 30, 2026
	2025	Contextual Indicator	139,085
	2024	Contextual Indicator	121,351
	2023	Contextual Indicator	100,681
	2022	Contextual Indicator	91,950
	2021	Contextual Indicator	139,788

*Note: The term providers includes conventional medical providers, ACOs or other accountable entities, and participants in the ACCESS model, but not MAHA ELEVATE grantees, states, or health plans.

On May 13, 2025, the CMS Innovation Center's Strategy to Make America Healthy Again was launched. The CMS Innovation Center's strategic direction focuses on empowering Americans to achieve their health goals and live healthier lives. Building on 15 years of Innovation Center experience and lessons learned, the updated 2025 Innovation Center strategy takes a comprehensive approach to preventive care anchored in our statutory mandate to protect taxpayers.

The Innovation Center's vision will be achieved through three interrelated pillars: promote evidence-based prevention, empower people to achieve their health goals, and drive

choice and competition. Together, they will support the varying needs of the populations served by the Innovation Center.

As of FY 2025, CMMI achieved significant reach, serving 28% of Medicare beneficiaries through various programs, including the ACO REACH model, the Expanded Home Health Value-Based Purchasing model, and the addition of the ACO Primary Care Flex model.

The Models demonstrate strong healthcare provider engagement with 139,085 active providers participating across different models. Several high-impact programs have shown successful participation levels, including the ACO REACH model, the Expanded Home Health Value-Based Purchasing model, the Guiding an Improved Dementia Experience model, and the Kidney Care Choices model. FY 2025 reflected an increase from FY 2024 with the addition of the ACO Primary Care Flex model.

CMS DISCONTINUED PERFORMANCE MEASURES

Program Operations Discontinued Measure

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

This measure evaluates hospital readmission rates among dual-eligible beneficiaries who are enrolled in both Medicare and Medicaid programs. As of 2024, this population encompasses over 14 million individuals. This measure has shown significant improvement in recent years, with notable decreases in readmission rates: 16.4% (2020), 8.6% (2021), 5.6% (2022) and 19% (2023).

Readmission rates for dually eligible individuals may be impacted by a number of CMS initiatives, including the Hospital Readmissions Reduction Program, Skill Nursing Facility (SNF) Value-Based Purchasing, Medicare Shared Savings Program, and various Innovation Center Models. The higher readmission rates for dually eligible individuals may reflect unique challenges faced by dual-eligible beneficiaries, such as higher rates of chronic conditions, increased institutionalization rates, and complex benefit coordination needs.

CMS discontinued this measure in FY 2025 because it does not reflect the current Administration's priorities. The new focus has moved toward integrated care, including state payment of Medicare Parts A and B costs, which enables enrollment into these benefits and conveys eligibility for integrated care plans.

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	Discontinue	-
	2024	83.97 per 1000 (0.75% Reduction from 2019 Actual)	April 30, 2026
	2023	84.18 per 1000 (0.50% Reduction from 2019 Actual)*	66 per 1000 (Target Exceeded) (19.0% below 2019 Actual)
	2022	64.44 per 1000 (0.25% Reduction from 2021 Actual)	61 per 1000 (Target Exceeded) (5.6% Below 2021 Actual)
	2021	70.52 per 1000 (0.25% Reduction from 2020 Actual)	64.6 per 1000 (Target Exceeded) (8.6% Below 2020 Actual)
	2020	84.18 per 1000 (0.5% Reduction from 2019 Actual)	70.7 per 1000 (Target Exceeded) (16.4% Below 2019 Actual)
	2019	82.86 per 1000 (1% Reduction from 2018 Actual)	84.6 per 1000 (Target Not Met) (1.1% Above 2018 Actual)

*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.

Medicare Survey & Certification Program Discontinued Measure

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

This initiative focuses on reducing antipsychotic medication use in nursing homes while improving dementia care quality, and maintains robust monitoring and transparency through Quality measures posted on the Nursing Home Care Compare website and integration with the Five-Star Quality Rating System. The program has shown significant progress since its inception, with the percentage of long-stay residents receiving antipsychotic medications decreasing from 23.9% in 2011 (Q4) to 14.7% in 2024 (Q4), representing a substantial 38.4% overall reduction.

Due to the change in reporting methodology announced in the June 18, 2025 memo, CMS is discontinuing this measure in FY 2025. The new performance measure, MSC8: Decrease the population of long-stay nursing home residents receiving antipsychotic medication, is aligned with the increased national percentage of residents receiving antipsychotic medications. This updated methodology addresses concerns raised by the Office of Inspector General in 2021 about potential underreporting of antipsychotic medication use in nursing homes.

Measure	FY	Target	Result
MSC5: Decrease the population of long-stay nursing home residents receiving antipsychotic medication	2026	Discontinue	-
	2025	15.20%	July 31, 2026
	2024	14.30%	14.7% (Target Not Met But Improved)
	2023	14.70%	14.8% (Target Not Met)
	2022	15.00%	14.6% (Target Exceeded)
	2021	15.30%	14.5% (Target Exceeded)
	2020	15.40%	14.5% (Target Exceeded)

Medicaid Discontinued Measure

MCD7: Improve Access to and Utilization of Oral Health Care Services for Children Covered by Medicaid and Medicaid Expansion CHIP Programs

CMS launched an Oral Health Initiative in 2010 to improve dental care access for children enrolled in Medicaid and CHIP programs. Dental quality measurement is an important part of the Child Core Set, which includes three oral health measures that are mandatory for states to report in 2025. CMS engages with states to improve dental access through multiple channels, including Section 1115 demonstrations, 1915(b) managed care waivers, state plan amendments and technical assistance offerings such as a 2021-2023 quality improvement affinity group with 14 participating states. CMS also hosts Oral Health Technical Advisory Group calls with state Medicaid and CHIP programs to share information on quality measurement and improvement.

CMS will sunset this measure based on the CMS-416 (Early and Periodic Screening, Diagnostic and Treatment (EPSDT) annual report), and replace it with the Oral Evaluation, Dental Services (OEV-CH) measure to better align GPRA reporting with other reporting pathways. The OEV measure is used in multiple other CMS systems (Child Core Set, Universal Foundation) and is similar to the measure used in the HEDIS managed care reporting system. CMS will establish targets for this new measure in FY 2027.

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%	2026	Discontinue	-
	2025	50% (+4 percentage points over 2016 baseline)	October 15, 2026
	2024	53%* (+7 percentage points over 2016 baseline)	49% (Target Not Met But Improved)
	2023	53%* (+7 percentage points over 2016 baseline)	47% (Target Not Met)
	2022	52% (+6 percentage points over 2016 baseline)	47% (Target Not Met But Improved)
	2021	51% (+5 percentage points over 2016 baseline)	46% (Target Not Met But Improved)
	2020	50% (+4 percentage points over 2016 baseline)	43% (Target Not Met)

*The COVID-19 public health emergency (PHE) has lingering impacts on Medicaid and CHIP child use of preventive dental services. CMS set targets for FY 2023 and FY 2024 targets based on data available during this PHE, with high levels of uncertainty, during this time. As such, it is likely the results achieved for these fiscal years will fall short of the designated goals.

Health Care Fraud And Abuse Control (HCFAC) Discontinued Measure

MIP11: Improve Efficiency in the Medicare Enrollment Process by Increasing the Proportion of Providers Initially Enrolling in the Medicare Program Online

The Provider Enrollment, Chain and Ownership System (PECOS) serves as CMS's centralized online platform for Medicare provider enrollment management. This system streamlines the enrollment process by enabling healthcare providers and suppliers to digitally submit and manage their Medicare enrollment information. PECOS is a critical digital system that provides four core functionalities: digital submission of Medicare enrollment applications by providers, processing of digital as well as paper Medicare enrollment applications by the Medicare Administrative Contractor (MAC), real-time enrollment information management, and application status monitoring. In CY 2024, the system has significantly exceeded its performance target of 60%, demonstrating strong provider acceptance and system effectiveness.

The initiative's strategic objectives focused on maximizing digital enrollment adoption while minimizing paper-based processes, with particular emphasis on enhancing operational efficiency, reducing processing time and costs, accelerating provider certification, and improving overall healthcare access. Additional information and resources are available through the official PECOS website at https://pecos.cms.hhs.gov/, providing users with detailed guidance and support for system utilization.

CMS is discontinuing this measure in CY 2026 because achieving higher results is not attainable without significant drivers to overcome challenges on increased adoption, including budget constraints for system maintenance, limited enhancement potential within the current architecture, and some provider resistance to digital transition in the near term.

Measure	CY	Target	Result
MIP11: Increase the proportion of providers performing initial enrollment in the Medicare Program online Baseline: 30.1%	2026	Discontinue	-
	2025	84%	April 30, 2026
	2024	60%	81.78% (Target Exceeded)
	2023	56%	78.82% (Target Exceeded)
	2022	52%	74.65% (Target Exceeded)
	2021	50%	62.57% (Target Exceeded)
	2020	46%	59.08% (Target Exceeded)

Medicare Quality Improvement Organizations (QIO) Discontinued Measure

QIO13: Reduce Healthcare Associated Infections [HAIs] in Critical Access Hospitals (CAH)

The Quality Improvement Network-Quality Improvement Organization (QIN-QIO) program achieved significant success in reducing healthcare-associated infections (HAIs) in Critical Access Hospitals (CAHs) during FY 2024. The program exceeded its infection reduction targets, with catheter-associated urinary tract infections (CAUTI) decreasing by 16.3% and C. difficile infections (CDI) dropping by 17.6% compared to the FY 2022 baseline. These results demonstrate that rural hospitals working with Quality Improvement Organizations are making substantial progress in patient safety.

The FY 2024 data shows a CAUTI Standardized Infection Ratio (SIR) of 0.568 and a CDI SIR of 0.686. While CAUTI rates remained stable from FY 2023 to FY 2024 (maintaining previous gains), CDI infections showed continued improvement with an 11.1% reduction in just one year. Both infection types are now on track to meet the 2028 national HAI targets outlined in the National HAI Action Plan, indicating sustained progress in infection prevention efforts.

When viewed over a longer timeframe, the results are even more impressive. CAUTI rates have successfully returned to pre-pandemic 2015 levels after experiencing increases during COVID-19, while CDI rates have dropped by over 25% since 2015. This sustained improvement over nearly a decade reflects the effectiveness of embedding infection prevention and control strategies and maintaining close monitoring of HAI data in rural healthcare settings.

The QIN-QIO program transitioned from its 12th Statement of Work (which concluded in 2024) to its 13th Statement of Work that began in May 2025. This new scope continues work on patient safety and HAI reduction and also includes a strong focus on prevention and chronic disease management, behavioral health, opioid stewardship and chronic pain management, emergency preparedness and building resilient healthcare systems.

CMS is discontinuing this measure in FY 2025 and is developing a new measure in FY 2026 that will align with the QIN-QIO 13th SoW.

Measure	FY	Target	Result
QIO13.1: Reduce CAUTI Standardized Infection Ratio (SIR) in critical access hospitals	2026	Discontinue	-
	2025	0.645 4.95% reduction from baseline)	June 30, 2026
	2024	0.647 (4.5% reduction from baseline)	0.568 (Target Exceeded) (16.3% reduction from baseline)
	2023	0.656 (3.3% reduction from baseline)	0.563 (Target Exceeded) (17.1% reduction from baseline)
	2022	Baseline*	0.679
	2021	0.584 (1.1% reduction from baseline)	0.585 (Target Not Met But Improved) (0.5% reduction from baseline)
	2020	Historical Actual	0.641
QIO13.2: Reduce CDI SIR in critical access hospitals	2026	Discontinue	-
	2025	0.776 (6.45% reduction from baseline)	June 30, 2026
	2024	0.796 (4.5% reduction from baseline)	0.686 (Target Exceeded) (17.6% reduction from baseline)
	2023	0.806 (3.3% reduction from baseline)	0.774 (Target Exceeded) (11.14% reduction from baseline)
	2022	Baseline*	0.833
	2021	0.801 (1.1% reduction from baseline)	0.766 (Target Exceeded) (4.4% reduction from baseline)
	2020	Historical Actual	0.709

*In 2022, the CDC re-baselined all HAIs due to significant increases seen across all hospital settings, related to the pandemic. The new baseline reflects alignment with CDC NHSN and mirrors the increases seen with CMS data.

Medicare Benefits Discontinued Measure

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

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) amended Title XVIII (Medicare) of the Social Security Act by adding a Voluntary Prescription Drug Benefit Program (Medicare Part D). Since its inception in 2006, 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) made significant changes to the Part D benefit design. Beginning in 2025, the IRA eliminated the coverage gap benefit phase, introduced manufacturer discounts in the initial and catastrophic coverage phases, changed enrollee and plan liability in the initial coverage phase, and changed plan and government reinsurance liability in the catastrophic phase.

This measure was discontinued in FY 2025 because it is no longer consistent with current law.

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	Discontinue	-
	2024	25%	April 30, 2026
	2023	25%	25% (Target Met)
	2022	25%	25% (Target Met)
	2021	25%	25% (Target Met)
	2020	25%	25% (Target Met)
	2019	28%	27% (Target Exceeded)

Center for Medicare and Medicaid Innovation Discontinued Measures

CMMI3.5: Percentage of Model Awardees Participating in Learning Activities

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.

CMS discontinued this measure in FY 2025. The Learning Systems metric was created nearly 10 years ago, and during this time Learning Systems have evolved significantly to advance CMS priorities. Tracking the percentage of model awardees attending events is no longer the best measure of Learning System participation. Learning System event attendance indicates presence, but does not specify the level of involvement in the Learning System, which can range from minimal to active, without necessarily implying a deeper commitment. Additionally, measuring Learning System attendance does not provide CMS with the understanding needed to design Learning Systems to ensure they not only attract model participants, but also foster deep engagement to drive meaningful outcomes and improvements.

Measure	FY	Target	Result
CMMI3.5: Percentage of model awardees participating in learning activities	2025	Discontinue	-
	2024	54%	51.4% (Target Not Met)
	2023	54%	52% (Target Not Met But Improved)
	2022	52%	50% (Target Not Met)
	2021	50%	51.7% (Target Exceeded)
	2020	50%	54% (Target Exceeded)

CMMI6: Percentage of Original Medicare Beneficiaries in a Care Relationship with Accountability for Quality and Cost of Care

The Center for Medicare and Medicaid Innovation (CMMI) is leading healthcare transformation through value-based care models and innovative payment systems, focusing on improved outcomes and cost efficiency. As of 2024, the program has achieved significant reach, covering 13.9 million beneficiaries and reaching 50% of traditional Medicare beneficiaries. The program demonstrates strong engagement with 480 operating Accountable Care Organizations (ACOs) and 634,657 participating providers, serving 10.8 million direct beneficiaries.

With strategic implementation of new programs, CMMI is positioned to further advance value-based care initiatives across the healthcare system.

CMS is discontinuing this measure because it no longer aligns with current administration priorities. To ensure cost efficiencies and savings, resources to track and calculate performance data have been descoped in accordance with Executive Order 14222, *Implementing the President's "Department of Government Efficiency" Cost Efficiency Initiative.*

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	Discontinue*	-
	2024	60%	50.2% (Target Not Met But Improved)
	2023	50%	50% (Target Met)
	2022	45%	47% (Target Exceeded)
	2021	Baseline	44%