DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2026

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

The Centers for Medicare & Medicaid Services (CMS) serves the public as a trusted partner and steward, dedicated to improving health outcomes for Americans. Our work is rooted in the basic premise that great societies protect their most vulnerable. However, different from previous Administrations, CMS is now going to be a driving force to empower beneficiaries with better tools and increased transparency into their healthcare; a driving force to incentivize physicians and other clinicians, in real-time, to optimize their care within their workflow; and a driving force in crushing fraud, waste, and abuse head-on. With these three interrelated goals, CMS will be a leader in making America Healthy Again.

In Fiscal Year (FY) 2026, over 170 million, or roughly 1 in 2 Americans, will rely on the programs CMS administers or oversees, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federal Exchanges. Under this Administration, these Americans – and all Americans - will see positive changes in our programs and their health care!

In concert with our Federal partners under the Department of Health and Human Services' umbrella, this Budget Request demonstrates the pivotal role CMS will have in the healthcare of Americans. We will be part of the solution that gets to the root causes of chronic conditions, unmask surprise and unfair billing practices, and will work to fix our health care system and get people healthy. To be clear, CMS is going to partner with the physicians and other clinicians on the frontlines, who are directly caring for our beneficiaries, to turn the tide. We know that there are many healthcare providers in America who do great work; they are powerful allies in reaching our goals. For CMS' part, we will find efficiencies and reduce red tape, while making it easier and more affordable for Americans to adopt healthy lifestyles.

CMS' FY 2026 Budget Request demonstrates an investment that will keep CMS on the leading edge of providing the high-quality health benefits that all Americans deserve. This Budget Request also reflects CMS' dogged pursuit of innovative program integrity efforts to stamp out fraud, waste, and abuse. There is simply too much at stake not to use every lever we have to ensure every dollar spent goes to increasing health in America. Under this Administration, CMS will do everything in its power to restore the public's confidence in the work we do, the value we bring, and the mission of CMS.

With this, I am pleased to present the CMS FY 2026 performance budget. On behalf of our beneficiaries and consumers, I thank you for your continued support of CMS and its FY 2026 President's Budget Request. America is too great for small dreams, and I'm ready to get to work on the President's agenda.

Dr. Mehmet Oz

DR OZ

Administrator

Ensuring our most vulnerable receive high-value care by leading all payors and supporting providers.

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 an Operating Division within the Department of Health and Human Services (HHS) responsible for administering the largest Federal healthcare programs, Medicare, and Medicaid, as well as providing oversight for the Children's Health Insurance Program (CHIP) and runs the Federal Exchange. As a driving force in the healthcare industry, CMS recognizes the direct impact its programs have on over 170 million beneficiaries and consumers that it will serve in FY 2026.

The budget request reflects our vision to serve the public as a trusted partner and a steward of taxpayer dollars, dedicated to the success of the Make America Healthy Again agenda. CMS delivers for our customers and stakeholders by demanding accountability and collaboration. By centering around those we serve, CMS is fully aligned with HHS' aspiration to drive our country towards the best health outcomes in the world, ensuring services are high quality and provided with respect. We strive to transform healthcare by promoting innovation, tackling our collective healthcare system challenges, and strengthening program integrity by eliminating fraud, waste, and abuse. CMS will continue to apply oversight responsibilities to ensure the best value for Americans and the sustainability of our programs for future generations.

Further, we aim to Make America Healthy Again with curiosity, courage, competence, and compassion. Within this budget, CMS will work to modernize Medicare, Medicaid, CHIP, and the Exchanges so Americans get the care that they want, need, and deserve.

This includes:

- Empowering 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 prices of drugs, hospital care, and health insurance.
- Equipping health care providers with better information about the patients they serve and holding them accountable for health outcomes rather than unnecessary paperwork that distracts them from their mission. CMS will work to streamline access to life saving treatments.
- Identifying and eliminating fraud, waste, and abuse to stop unscrupulous individuals who are stealing from vulnerable patients and taxpayers.
- Shifting 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.

Overview of FY 2026 Budget Request

CMS' resource needs are principally driven by statute with accompanying workloads that grow annually as the number of Americans served by CMS programs increases year-to-year. As our workloads increase with an aging population, CMS must continue to contain costs. Through an initiative known as the Spending Optimization Subcommittee (SOS), CMS uses data-driven approaches to capture saving opportunities to further improve our financial efficiency to ensure the long-term sustainability of our programs. Highly successful, the SOS is continuing in FY 2025 and 2026, with even more ambitious goals. Further, CMS has undertaken another cost-

cutting initiative, which involves an extensive recalibration of our contracting strategy. By stepping through a wholistic contract review, CMS has changed the way we think about federal contracts and contractor support. In addition to reducing overall contract expenditure, this positive change opens opportunities for new innovations, insourcing, and knowledge retention.

The FY 2026 President's Budget request reflects a level of funding that will not only allow CMS to maintain core operations but also improve its traditional activities to better serve the millions of Americans that rely on CMS' programs. We understand this budget request is an investment in CMS; an investment that will fund core operations resulting in high quality care for beneficiaries and make America the healthiest nation in the world. Our aim is to target key areas for improvement such as improving our use of modern technologies and to use innovative solutions that will eliminate fraud, waste, and abuse across all CMS programs.

CMS requests funding for its annually appropriated discretionary accounts, including Program Management (PM) and discretionary Health Care Fraud and Abuse Control (HCFAC). The next table displays CMS' funding for Fiscal Year (FY) 2024, our FY 2025 Enacted, and FY 2026 President's Budget request.

CMS Annually Appropriated Accounts

(Dollars in Millions)

Account	FY 2024 Final	FY 2025 Enacted[1]	FY 2026 President's Budget	FY 2026 +/- FY 2025
Program Management	-	$3,669.744	-	($3,669.744)
Program Operations	*$2,913.823*	-	-	-
Federal Administration	*$778.533*	-	-	-
Survey & Certification	*$412.334*	*$397.334*	$442.000	$44.666
Research [2]	*$20.054*	-	-	-
Medicare Operations General Provision [3]	-	$455.000	-	($455.000)
Planned HHS Reorganization (HRSA) [4]	$12.238	-	-	-
Program Administration [5]	-	-	$3,022.391	$3,022.391
Program Operations (non-add)	-	-	*$2,276.092*	$2,276.092
Federal Administration (non-add)	-	-	*$734.061*	$734.061
HRSA (non-add)	-	-	*$12.238*	$12.238
Program Management [6]	**$4,136.982**	**$4,136.982**	**$3,464.391**	**($672.591)**
HCFAC	**$915.000**	**$941.000**	**$941.000**	**-**
Grants to States (Medicaid)	**$640,469.335**	**$711,733.765**	**$769,212.611**	**$57,478.846**
Payments to Health Care Trust Funds	**$508,196.012**	**$561,015.000**	**$593,817.000**	**$32,802.000**
Total	**$1,153,717.329**	**$1,277,826.747**	**$1,367,435.002**	**$89,608.255**

[1] Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025 and is rolled up within the Program Management account.
[2] In FY 2026, CMS requests Research funding in the new Program Administration category.
[3] The allocation of the additional Medicare Operations funding for FY 2025 is not yet available.
[4] The FY 2026 Budget assumes the planned HHS Reorganization, which includes certain HRSA programs residing in CMS Program Management. This display comparably adjusts FY 2024 and FY 2025 columns to the FY 2026 Budget policy
[5] In FY 2026, CMS requests to consolidate Program Operations/Research and Federal Administration funding into a new Program Administration category.
[6] FY 2024 assumes $455 million in additional Medicare Operations funding from the FY 2024 annual appropriation, Public Law 118-47, General Provision Section 227.

Program Administration

In recent years CMS began to reduce costs while driving efficiencies as an innovative solution to contain operational costs. As the next step in this process, CMS proposes merging our Program Operations/Research and Federal Administration accounts into a single Program Administration account. 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 will allow CMS to adjust the ratio of contractor and federal staffing levels, which is currently heavily weighted with contractor staff at 6:1. As seen in the table below, our FY 2026 President's Budget request for Program Administration is $3,022.4 million.

Program Operations

CMS' FY 2026 President's Budget request is $2,288.3 million. 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 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.

Planned HHS Reorganization

Within the Make America Healthy Again edifice, certain work elements that are currently completed by the Health Resources and Services Administration (HRSA) are planned to be strategically shifted to CMS. Particularly, the 340B Drug Pricing Program, which plays a crucial role in enhancing healthcare outcomes and ensuring affordability, is planned to reside within CMS. The 340B Drug Pricing Program FY 2026 budget request is $12.2 million, a level comparable to FY 2024, which will fulfill statutory obligations and ensure program oversight. The program mandates drug manufacturers to provide discounts on outpatient drugs to covered entities.

Federal Administration

CMS' FY 2026 Budget request of $734.1 million supports our dedicated workforce of 3,390 FTEs who serve over 170 million Americans daily, the people that deliver exceptional service, advance innovative solutions, and build a more responsive healthcare system that benefits all Americans.

Survey and Certification

CMS' $442.0 million Budget request for Survey and Certification, an increase of $45 million above FY 2025, provides the resources to achieve 65% completion of mandatory surveys and 10% 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 healthcare facilities while advancing comprehensive federal oversight that protects millions of Americans.

Research

CMS' $18.1 million Budget request for Research supports the continued operation of the Medicare Current Beneficiary Survey while powering data-driven solutions through the Virtual Research Data Center and Chronic Condition Warehouse.[7] This funding enables us to deliver evidence-based improvements that enhance healthcare outcomes for all Americans.

Health Care Fraud and Abuse Control

CMS' $941.0 million discretionary HCFAC funding request strengthens our partnerships with DOJ and 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. This investment empowers CMS to identify and eliminate fraud, waste, and abuse, protecting vulnerable patients and taxpayer dollars through targeted initiatives and advanced modeling techniques.

Grants to States for Medicaid

The FY 2026 Medicaid appropriations request is $769.2 billion, an increase of $57.5 billion above the FY 2025 level, consisting of $508.1 billion for FY 2026 and $261.1 billion in advance appropriation from FY 2025.

Appropriations coupled with offsetting collections from the Supplementary Medical Insurance (SMI) Trust Fund and Medicare Part D account will support $770.9 billion in estimated gross obligations in FY 2026. These obligations primarily consist of Medicaid medical assistance benefits but also includes Medicaid administrative functions including Medicaid survey and certification and state fraud control units, and Centers for Disease Control and Prevention's Vaccines for Children program.

Payments to the Health Care Trust Funds

The FY 2026 President's Budget request for Payments to the Health Care Trust Funds account totals $593,817.0 million, an increase of $32,802.0 million above the FY 2025 estimate level. This account transfers payments from the General Fund to the Trust Funds to make the SMI Trust Fund and the Hospital Insurance (HI) Trust Fund whole for certain costs, initially borne by the trust funds, which are properly chargeable to the General Fund. The largest transfer provides the General Fund contribution to the SMI Trust Fund for the General Fund's share of the SMI program. Other transfers include payments from the General Fund to the HI and SMI Trust Funds including the Medicare Prescription Drug Account, for costs such as general revenue for prescription drug benefits, HCFAC, and other administrative costs that are

[7] Research is requested under Program Administration in the FY 2026 President's Budget.

properly chargeable to the General Fund.

Overview of Performance

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

Our performance measures highlight the core purposes of our programs and focus on the Agency’s role as an efficient and effective steward of taxpayer dollars as well as a provider and funder of high-quality care to beneficiaries. Established performance measures are actively aligned with CMS and HHS priorities and continuously improved to advance our mission effectively. Thus, our performance goals may change periodically as we refine our focus and respond to new priorities.

Conclusion

CMS' $3,464.4 million President's Budget request for Program Management represents our unwavering commitment to excellence in serving over 170 million Americans through Medicare, Medicaid, CHIP, and the Exchanges. This strategic investment, combined with $941.0 million in discretionary HCFAC funds, positions us to not only maintain but enhance our oversight capabilities, strengthening early detection and prevention while protecting our beneficiaries.

Through pioneering initiatives like our Spending Optimization Subcommittee (SOS) and our dedication to modernization, we are building a more efficient, responsive, person-focused, and sustainable healthcare system for future generations. Our commitment to data-driven decision making and program integrity ensures that every dollar invested delivers maximum value for the American people.

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

Together, we are not just maintaining programs – we are actively shaping the future of healthcare 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 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget Level	+/- FY 2025 Enacted
Program Management	$ -	$ 3,669.744	$ -	$ (3,669.744)
Program Operations	$ 2,913.823	$ -	$ -	$ -
Federal Administration	$ 778.533	$ -	$ -	$ -
State Survey & Certification	$ 412.334	$ *397.334*	$ 442.000	$ 44.666
Research /1	$ 20.054	$ -	$ -	$ -
Medicare Operations General Provision /2	$ -	$ 455.000	$ -	$ (455.000)
Planned HHS Reorganization (HRSA) /3	$ 12.238	$ -	-	$ -
Program Administration /4	$ -	$ -	$ 3,022.391	$ 3,022.391
Program Operations (non-add)	*$ -*	*$ -*	*$ 2,276.092*	*$ 2,276.092*
Federal Administration (non-add)	*$ -*	*$ -*	*$ 734.061*	*$ 734.061*
HRSA (non-add)	*$ -*	*$ -*	*$ 12.238*	*$ 12.238*
Subtotal, Appropriation/BA Current Law (Discretionary; 0511) /5	**$ 4,136.982**	**$ 4,136.982**	**$ 3,464.391**	**$ (672.591)**
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	$ 5.304	$ -	$ (5.304)
BBA (P.L. 115-123)	$ 4.715	$ 4.715	$ 4.715	$ -
Consolidated Appropriations Act, 2021 (P.L. 116-260)	$ 16.031	$ 16.031	$ 11.316	$ (4.715)
Bipartisan Safer Communities Act (P.L. 117-159)	$ 4.715	$ 0.943	$ 0.943	$ -
Inflation Reduction Act (P.L. 117-169)	$ 44.321	$ 44.321	$ 44.321	$ -
Consolidated Appropriations Act, 2024 (P.L. 118-42)	$ 42.750	$ -	$ -	$ -
American Relief Act (P.L. 118-158)	$ -	$ 5.780		$ (5.780)
Full-Year Continuing Appropriations and Extensions Act (P.L. 119-4)	$ -	$ 10.500		$ (10.500)
Total, Mandatory Appropriation/BA C.L. (Mandatory; 0511)	**$ 122.551**	**$ 92.309**	**$ 66.010**	**$ (26.299)**
Total, Appropriation/BA Current Law (0511)	**$ 4,259.533**	**$ 4,229.291**	**$ 3,530.401**	**$ (698.890)**
	$ -	$ -	$ -	$ -
Total, Appropriation/BA Proposed Law (0511)	**$ 4,259.533**	**$ 4,229.291**	**$ 3,530.401**	**$ (698.890)**
-				
User Fees and Reimbursements	$ 484.035	$ 634.818	$ 617.711	$ (17.107)
Marketplace User Fees (FFM)	$ 2,406.059	$ 2,298.598	$ 1,788.543	$ (510.055)
Risk Adjustment User Fees (RA)	$ 72.935	$ 70.158	$ 70.000	$ (0.158)
Recovery Audit Contracts (RACs) /7	$ 133.941	$ 251.684	$ 291.100	$ 39.416
Total, Offsetting Collections	**$ 3,096.970**	**$ 3,255.258**	**$ 2,767.354**	**$ (487.904)**
Subtotal, New BA, Current Law (0511)	**$ 7,356.503**	**$ 7,484.549**	**$ 6,297.755**	**$ (1,186.794)**
	$ -	$ -	$ -	$ -
Program Level, Proposed Law (0511)	**$ 7,356.503**	**$ 7,484.549**	**$ 6,297.755**	**$ (1,186.794)**
HCFAC Discretionary (8393)	**$ 915.000**	**$ 941.000**	**$ 941.000**	**$ -**
Non-CMS Administration /8	**$ 3,379.000**	**$ 3,629.000**	**$ 3,980.000**	**$ 351.000**
NEF	**$ 20.000**	**$ -**	**$ -**	**$ -**
Discretionary (Federal Administration) /9	4,023	3,502	0	(3,502)
Discretionary (Program Administration) /10	0	0	3,390	3,390
Reimbursable (CLIA, CoB, RAC, Marketplace)	640	674	658	(16)
Mandatory (Direct Appropriations)	243	216	211	(5)
Program Management, Proposed Law (non-add)	*0*	*0*	*0*	*0*
Subtotal, Current Law Program Management FTEs	**4,906**	**4,392**	**4,259**	**(133)**
HCFAC (Mandatory)	597	605	594	(11)
Medicaid Integrity (State Grants; Mandatory)	264	274	270	(4)
Affordable Care Act Section 3021 (Mandatory)	579	492	483	(9)
Quality Improvement Organizations	277	250	243	(7)
Demonstrations	5	5	5	0
No Surprises Act	53	28	0	(28)
Other Sources, Proposed Law (non-add)	*0*	*0*	*0*	*0*
Subtotal, Current Law Other Sources FTEs	**1,775**	**1,654**	**1,595**	**(59)**
Total, Current Law CMS FTEs /11	**6,681**	**6,046**	**5,854**	**(192)**

/1 In FY 2026, CMS requests Research funding in the new Program Administration category.

/2 The allocation of the additional Medicare Operations funding for FY 2025 is not yet available.

/3 The FY 2026 Budget assumes the planned HHS Reorganization, which includes certain HRSA programs residing in CMS Program Management. This display comparably adjusts FY 2024 and FY 2025 columns to the FY 2026 Budget policy

/4 In FY 2026, CMS requests to consolidate Program Operations and Federal Administration funding into a new Program Administration category.

/5 FY 2024 assumes $455 million in additional Medicare Operations funding from the FY 2024 annual appropriation, Public Law 118-47, General Provision Section 227.

/6 Displayed amounts reflect current law, net of sequester and pop-up authority as applicable

/7 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

/8 Includes discretionary funds only for the SSA, DHHS/OS, MedPac, and the SHIPs.

/9 FYs 2024 and 2025 include 20 FTEs and 22 FTEs, respectively, from HRSA to CMS for comparability per the planned HHS Reorganization.

/10 FY 2026 includes 22 FTEs transferring from HRSA to CMS, per the planned HHS Reorganization.

/11 FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change, per the planned HHS Reorganization.

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 2025 Enacted		
Total estimated budget authority /1	$4,137	3,502
FY 2026 President's Budget		
Total estimated budget authority /1 /2	$3,464	3,390
Net Change	**($673)**	**(112)**

	FY 2025 Enacted		FY 2026 President's Budget		FY 2026 +/- FY 2025	
	BA	FTE	BA	FTE	BA	FTE
Increases:						
A. Program:						
1. State Survey & Certification	*$397*	0	$442	0	$442	-
2. Program Administration /3	$0	0	$3,022	3,390	$3,022	3,390
3. Medicare Operations	$455	0	$0	0	($455)	-
4. HHS Reorganization (HRSA)	$0	22	$0	0	$0	(22)
Subtotal, Program Increases /1					**$3,009**	**3,368**
Total Increases /1					**$3,009**	**3,368**
Decreases:						
A. Program:						
1. Program Management	$3,670	3,480	$0	0	($3,670)	(3,480)
2. Program Operations /3	$0	0	$0	0	$0	-
3. Federal Administration /3	$0	0	$0	0	$0	-
4. Research /4	$0	0	$0	0	$0	-
Subtotal, Program Decreases /1					**($3,670)**	**(3,480)**
Total Decreases /1					**($3,670)**	**(3,480)**
Net Change /1	$4,137	3,502	$3,464	3,390	**($673)**	**(112)**

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

/2 FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

/3 In FY 2026, CMS requests to consolidate Program Operations and Federal Administration funding into a new Program Administration category.

/4 In FY 2026, CMS requests to consolidate Research funding in the new Program Administration category.

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2017				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($207,000)
Subtotal				$2,793,000
Trust Fund Appropriation:				
Base **/1 /2**	$4,109,549,000	$0	$0	$3,966,314,000
IMPACT Act (PL 113-185)	$0	$0	$0	$21,333,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$211,000,000
21st Century Cures (PL 114-255)	$0	$0	$0	$18,000,000
Sequestration	$0	$0	$0	($16,444,977)
Subtotal	$4,109,549,000	$0	$0	$4,206,202,023
2018				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($198,000)
Subtotal				$2,802,000
Trust Fund Appropriation:				
Base **/1 /2**	$3,587,996,000	$3,451,141,000	$3,974,744,000	$3,964,880,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$163,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$18,625,000
21st Century Cures Act (PL 114-255)	$0	$0	$0	$12,000,000
Bipartisan Budget Act '18 (PL 115-123)	$0	$0	$0	$35,500,000
Sequestration	$0	$0	$0	($13,175,250)
Subtotal	$3,587,996,000	$3,451,141,000	$3,974,744,000	$4,186,829,750
2019				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($186,000)
Subtotal				$2,814,000
Trust Fund Appropriation:				
Base **/1 /2**	$3,543,879,000	$3,502,024,000	$3,974,744,000	$3,965,796,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
MACRA (PL 114-10)	$0	$0	$0	$115,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$18,625,000
Bipartisan Budget Act '18 (PL 115-123)	$0	$0	$0	$25,500,000
SUPPORT Act (PL 115-271)	$0	$0	$0	$83,000,000
Sequestration	$0	$0	$0	($8,904,750)
Subtotal	$3,543,879,000	$3,502,024,000	$3,974,744,000	$4,209,016,250
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

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2021				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
American Rescue Plan (PL 117-2) **/3**	$0	$0	$0	$500,000,000
Consolidated Appropriations Act, '21 (PL 116-260)	$0	$0	$0	$37,000,000
Sequestration	$0	$0	$0	$0
Subtotal				$540,000,000
Trust Fund Appropriation:				
Base **/1 /2**	$3,693,548,000	$3,984,744,000	$3,974,744,000	$3,962,811,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
Bipartisan Budget Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Consolidated Appropriations Act, '21 (PL 116-260)	$0	$0	$0	$61,000,000
Sequestration	$0	$0	$0	$0
Subtotal	$3,693,548,000	$3,984,744,000	$3,974,744,000	$4,044,436,000
2022				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Postal Services Reform Act (PL117-108)	$0	$0	$0	$7,500,000
Bipartisan Safer Communities Act (PL 117-159)	$0	$0	$0	$8,000,000
Inflation Reduction Act (PL 117-169)	$0	$0	$0	$3,046,500,000
Sequestration	$0	$0	$0	($85,734)
Subtotal				$3,064,914,266
Trust Fund Appropriation:				
Base **/1**	$4,315,843,000	$4,315,843,000	$4,250,843,000	$4,024,744,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$5,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
Bipartisan Budget Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Consolidated Appropriations Act, '21 (PL 116-260)	$0	$0	$0	$47,000,000
Sequestration	$0	$0	$0	($1,789,702)
Subtotal	$4,315,843,000	$4,315,843,000	$4,250,843,000	$4,085,579,298
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

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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**	$4,550,070,000	$3,326,690,000	$4,124,744,000	$4,136,982,000
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	$4,192,668,375
2025				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Bipartisan Safer Communities Act (PL 117-159)	$0	$0	$0	$1,000,000
Inflation Reduction Act (PL 117-169)	$0	$0	$0	$47,000,000
Sequestration	$0	$0	$0	($2,907,000)
Subtotal				$48,093,000
Trust Fund Appropriation:				
Base **/1 /4**	$4,329,000,000	$3,909,690,000	$4,174,690,000	$4,136,982,000
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	$4,174,690,000	$4,181,198,375
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
Sequestration	$0	$0	$0	($2,907,000)
Subtotal				$48,093,000
Trust Fund Appropriation:				
Base **/4**	$3,464,391,000	$0	$0	$0
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
Sequestration	$0	$0	$0	($1,083,000)
Subtotal	$3,464,391,000	$0	$0	$17,917,000

/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 Reduced to reflect HHS Secretary's Transfer in a given Fiscal Year.
/3 The FY 2021 Enacted level for Sections 9402 and 9818 of the American Rescue Plan Act reflects the funding to be transferred from CMS to the Centers for Disease Control and Prevention (CDC).
/4 The FY 2026 Budget assumes the planned HHS Reorganization, which includes the 340B program residing in CMS Program Management from HRSA. This display comparability adjusts FY 2024 and FY 2025 sections to the FY 2026 Budget policy.

This page intentionally left blank.

Program Operations

(Dollars in Thousands)

	FY 2024 Final [1]	FY 2025 Enacted [2]	FY 2026 President's Budget
Budget Authority	$2,926,061	-	$2,288,330

Allocation Method – Contracts, Competitive Grants, Cooperative Agreements

Overview

The Make America Healthy Again initiative, spearheaded by HHS under Secretary Robert F. Kennedy Jr., involves restructuring CMS to streamline operations, maximize taxpayer value, and improve healthcare outcomes for all Americans. This will be done through the implementation of more person-focused, efficient and responsive evidence-based health policies. In alignment with Executive Order 14192, "Unleashing Prosperity Through Deregulation," the Agency is prioritizing administrative simplification across the healthcare continuum to promote and enhance patient care. The national healthcare system is a complex web of actors and regulations. Other entities, such as state governments, private insurers, and various healthcare providers, will also play critical roles in reaching the goal of delivering high-quality, value-based care outcomes.

The Agency has a broad set of responsibilities, all heavily reliant on the Program Operations 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[3] within the healthcare system. Some of CMS' main responsibilities include:

- Administering the nation's major healthcare 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 healthcare system.
- Ensuring the most vulnerable populations receive the highest-value, appropriate care by leading payors and supporting providers.

Program Descriptions

In FY 2024, CMS began to reduce costs while driving efficiencies as an innovative solution to contain operational costs. As the next step in this process, CMS proposes merging our Program Operations and Federal Administration accounts into a single Program Administration account, thereby providing CMS with the necessary flexibility to reduce its reliance on external contractors. By integrating funding of federal staff within program costs, CMS can reduce costs by strategically utilizing the workforce

[1] Public Law 118-47 General Provision, Section 227, provided $455 million to support CMS Medicare Operations in addition to the FY 2024 annual appropriation. CMS allocated $434 million to Program Operations, $6 million to Federal Administration, and $15 million to Survey & Certification.
[2] Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for 2025 and is rolled up within the Program Management account.
[3] Please refer to the Health Care Fraud and Abuse Control narrative.

and resources to accomplish tasks and projects rather than outsourcing them to external vendors or contractors. The merging of these accounts will allow CMS to reduce the ratio of contractors to federal staffing levels, which is currently six contractors to every one CMS staff.

As an example, with IT talent in high demand, 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. CMS plans to establish a robust, in-house IT domain workforce of federal leaders, complemented by targeted contractor support. CMS has identified several potential areas for insourcing, a few of which are mentioned below:

- Artificial Intelligence and Automation: Includes deployment of AI technologies and enabling robotic process automation (RPA) to include clinical AI, data science, and digital health experts.
- Administrative Efficiency: Includes streamlining legacy processes such as claims review, appeals, and enrollment, and electronic case management to efficiently manage and speed up handling of beneficiary and provider cases leveraging AI.
- Digital Infrastructure and Cloud Enablement: Includes an enterprise scalable digital environment that supports AI, analytics, and Application Programming Interface (API) delivery.

In addition to leveraging IT talent, CMS is also exploring the need for insourcing expertise in other areas such as:

- Developing and coordinating policy implementation requirements.
- Support for grants and contract close-out activities.
- Generating user-friendly, public data products; and
- Graphic design activities to improve the beneficiary, patient, and consumer experience.

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 ESRD. It expanded in 2006 with Part D, a prescription drug benefit. Enrollment grew from 21 million in 1966 to a projected 71 million in FY 2026. 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 92.5 million Americans to be enrolled in these programs by FY 2026. They provide coverage for vulnerable populations like low-income children, pregnant women, certain elderly individuals, and disabled individuals. This chapter's funding includes 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 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 QHPs, the implementation of Exchange eligibility and enrollment rules, including eligibility for financial assistance, and tracks and evaluates private health insurance market stability.

Funding History

Fiscal Year	Amount
FY 2022	$2,834,823,000
FY 2023	$2,914,823,000
FY 2024 Final	$2,926,061,000
FY 2025 Enacted [4]	-
FY 2026 President's Budget	$2,288,330,000

Budget Request: $2,288.3 Million

This Budget reflects operational efficiencies achieved through eliminating procedural duplication, procurement consolidation, accelerating technology modernization, a focus on providing the highest quality care for beneficiaries, and prioritizing administrative effort on statutory mandates. CMS continues to assess its federal contract footprint with the goal of insourcing expertise for many critical business functions.

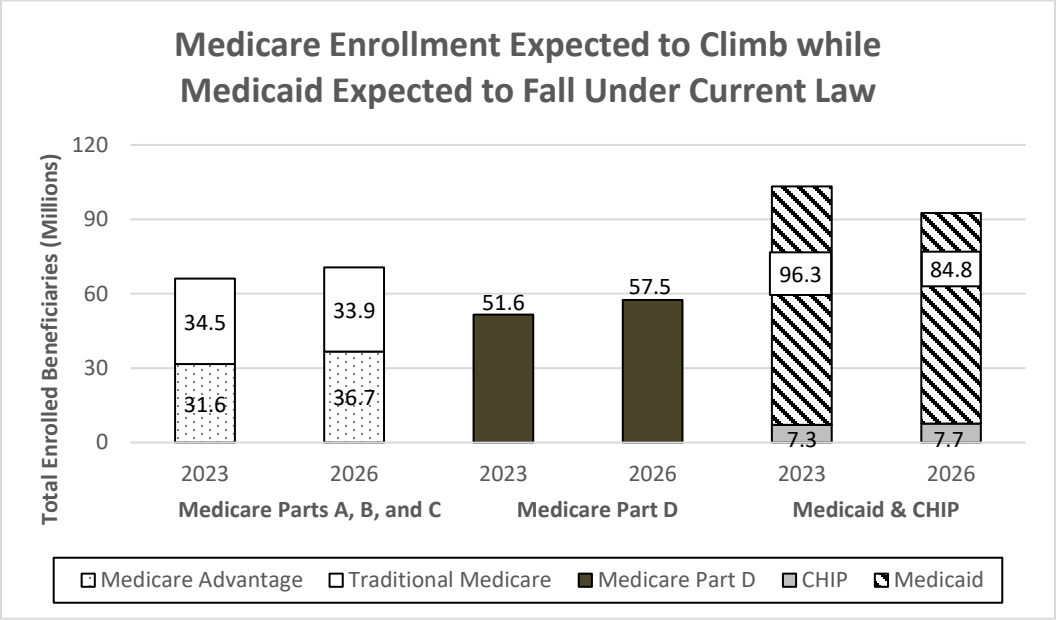
CMS administrative obligations totaled $11.62 billion in FY 2024, which represents 0.67% of the total expenditures of $1.75 trillion that the agency oversees. The Program Operations discretionary appropriation accounts for one-fourth of the total Agency operational budget. Funding is critical to execute CMS' 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.

As the 65+ population grows, healthcare administration responsibilities are increasing in. Medicare and Medicaid. Medicare enrollment is projected to rise by 7 percent from FY 2023 to FY 2026, with more beneficiaries opting for Part C plans. During the pandemic, CMS saw growth in Medicaid/CHIP enrollment mostly due to the continuous enrollment condition, reaching over 100 million individuals in FY 2023. CMS actuaries project FY 2026 Medicaid enrollment will decrease by 12 percent in FY 2026 as compared to FY 2023, while CHIP enrollment is projected to increase by 5 percent.

Medicare, Medicaid, and CHIP enrollment is affected by healthcare policy changes, economic conditions, and enrollment provisions.

[4] Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for 2025 and is rolled up within the Program Management account.

In summary, CMS is expected to serve 170 million, or 1 in 2, Americans.



Funding detail by Program Operations category is included below (FY 2024 – FY 2026):

Program Operations
(Dollars in Thousands)

Activity	FY 2024 Final	FY 2025 Enacted [5]	FY 2026 President's Budget
I. Medicare Parts A&B			
MAC Operations	$850,097	-	$588,754
Parts A/B Operational Support	$47,468	-	$52,965
Parts A/B Claims Processing	$87,011	-	$79,899
DME/B Competitive Bidding	$1,513	-	$21,234
Parts A/B Appeals	$58,748	-	$51,500
II. Medicare Parts C&D			
Parts C/D Oversight & Management	$76,891	-	$69,730
Parts C/D Appeals	$36,921	-	$36,126
III. Medicaid & CHIP			
Medicaid & CHIP Operations	$188,522	-	$129,611
IV. Private Health Insurance			
Market Oversight and Support	$10,892	-	$11,551
Exchanges	$129,722	-	$0

[5] Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for 2025 and is rolled up within the Program Management account.

Activity	FY 2024 Final	FY 2025 Enacted [6]	FY 2026 President's Budget
V. Outreach & Education			
National Medicare Education Program	$356,109	-	$284,000
Tribal Outreach & Enrollment	$3,000	-	$3,000
VI. Health Care Quality			
Value-Based Care Initiatives	$120,131	-	$95,000
VII. Enterprise Operations			
Accounting and Audits	$102,001	-	$97,403
HIPAA Administrative Simplification	$28,888	-	$27,426
Information Technology (IT) Systems and Support	$639,776	-	$624,053
Enterprise Operational Support	$118,388	-	$84,315
Opioid Support Services	$1,894	-	$1,471
Research, Demonstrations, and Evaluation [7]	$0	-	$18,054
Discontinued Programs [8]	$23,004	-	$0
VIII. Planned HHS Reorganization			
Office of Pharmacy Affairs/340B (HRSA)	$12,238	-	$12,238
Total [9, 10]	**$2,926,061**	**-**	**$2,288,330**

I. MEDICARE - PARTS A AND B

FFS, also known as "Original Medicare", is a health insurance program that pays doctors, hospitals, and other healthcare providers a fee for each service they provide to Medicare beneficiaries. It includes Part A (hospital insurance) and Part B (medical insurance). The FFS 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 FFS 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. FFS 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.

[6] Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for 2025 and is rolled up within the Program Management account.
[7] CMS is requesting funding for Research under the Program Operations request in the FY 2026 President's Budget.
[8] The Budget eliminates discretionary funding for health equity, certain community outreach activities (excluding Tribal), and certain unnecessary administrative costs to implement the Inflation Reduction Act.
[9] Totals may not add due to rounding.
[10] $32.8 million is included in the FY 2024 total for prior year contract adjustments.

MAC Operations

A MAC is a private healthcare insurer split by geographical jurisdictions to process Medicare FFS 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).

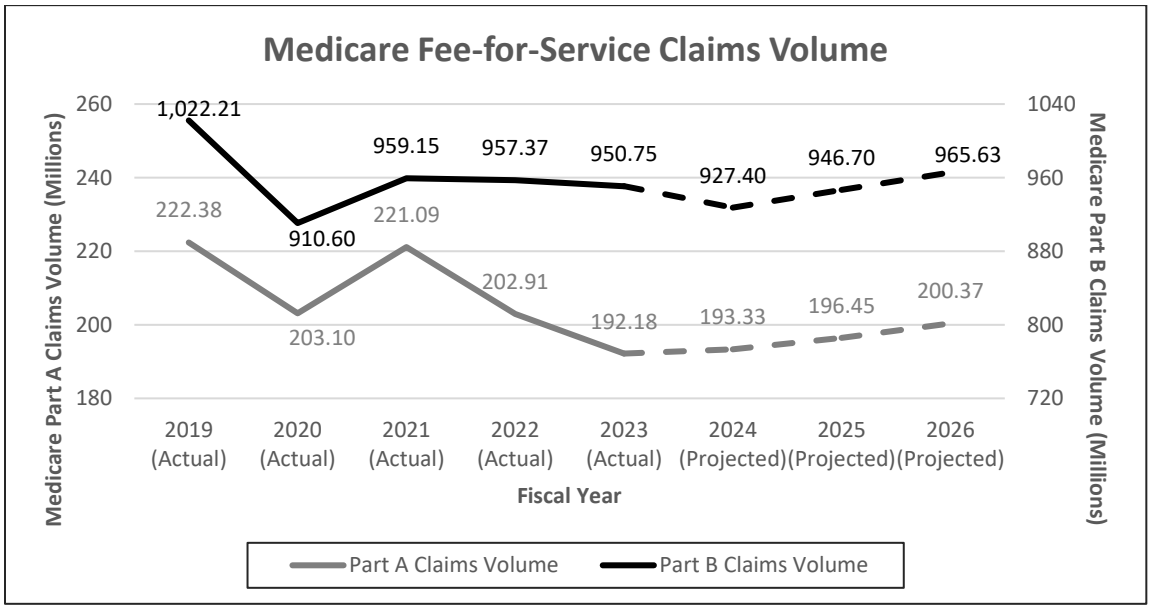
The MACs play a crucial role in ensuring the coordination of benefits within each jurisdiction and continuity of claims payment for providers. In disruption events, such as the Change Healthcare cyberattack, the CHOPD Accelerated and Advance Payment Program allowed eligible providers and suppliers interim 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: $588.8 Million

Approximately 25 percent of the Program Operations request supports FFS claims management and administering business operations for the Medicare provider community. This request reflects efficiencies 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 FFS 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 2026. Historical and projected claim workloads are illustrated below:



- Appeals**:** The MACs perform the first level of appeal 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 2.5 million redeterminations.

- Provider/Supplier Services**:** The MACs offer a range of services to healthcare 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 healthcare 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, and Non-Physician Practitioners and 35.2 thousand suppliers participating in Medicare.

- Provider Contact Centers (PCC): The MACs answer 12 million provider toll-free telephone inquiries historically. Costs for the PCC are primarily driven by the number of minutes of telephone service. Approximately 46% of calls are handled through interactive voice response (IVR) systems. This increased use of automation frees up customer service representatives to handle the more complex questions. PCC workloads are illustrated below.

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

	FY 2022 Actual	FY 2023 Actual	FY 2024 Actual	FY 2025 Estimate	FY 2026 Estimate
Completed Calls	12.1	12.2	11.9	11.2	11.2
Written Inquiries	0.3	0.3	0.3	0.3	0.3
IVR (% Completed)	43%	45%	46%	46%	46%

- Outreach and Education: Medicare Learning Network (MLN) Matters® serves as the official source of information for FFS. CMS and the MACs are required to use MLN products to promote consistent outreach messaging. The production budget 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. The MLN aids providers in their billing, coding, and documentation practices, assisting them in preventing errors and ensuring prompt payments.

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

Parts A and B Operational Support

As the government agency responsible for delivering the FFS 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 FFS 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 Medicare FFS 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 healthcare administrative burden leaving more time for patient care and improved outcomes.

Budget Request: $53.0 Million

CMS manages a comprehensive healthcare financing framework through the Medicare Physician Fee Schedule and Prospective Payment Systems, requiring annual updates in regulation. 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 Communications Management Information System (CMIS), 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 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 healthcare needs of the aging population continue to evolve, it is critical to meet the needs of seniors while also protecting them from harm.

Furthermore, the budget supports the adaptation and modernization of the Medicare FFS payment systems. Examples include expanding telehealth and home infusion therapy for Medicare and Hospice beneficiaries, analytics to identify and test alternative data sources to support the development of Medicare payment rates, and support for competitive bidding of durable medical equipment prosthetics, orthotics, and supplies.

Parts A and B Claims Processing

CMS operates several sophisticated claim adjudication systems to process Medicare claims. These systems are designed to validate claims, determine coverage, apply payment rules, and issue payments to healthcare providers. CMS-owned shared systems adjudicate approximately 1.2 billion Part A, Part B, and DME claims annually. All claims are sent to the

Common Working File (CWF) for eligibility, duplication, and utilization checks before final adjudication. Payment processing and claim support systems are essential for ensuring accuracy, efficiency, and proper use of taxpayer funds.

The primary FFS claims processing systems 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 non-durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Part B services (e.g., ambulance)
- *ViPS Medicare System (VMS)*: VMS is used to process claims for DMEPOS.

Budget Request: $79.9 Million

The request supports sustainability modernization necessary to maintain ongoing operations and systems maintenance as well as analysis and design modernization efforts to ensure the long-term sustainability of CMS' aging claims processing systems. Change management, such as annual coding updates, is required to ensure proper payment of claims following each payment policy change.

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 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 information technology (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

- 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: $21.2 Million

Upon completion of a formal public notice and comment rulemaking process, CMS must update all the DMEPOS CBP IT systems and bidding materials to reflect the changes from the final rule and educate stakeholders on the bidding program in preparation for the next round.

CMS must also perform critical operational tasks such as:

- Bidder Registration – CMS must assist potential bidders in obtaining user identification and passwords to gain access to the bidding system
- Solicitation of Bids – Managing call center operations to respond to bidding questions, and
- Begin the Bid Evaluation Process – Preliminary bid evaluation and screening include tasks such as:
    - licensure and accreditation validation,
    - reviewing bid surety bond submissions, and
    - identifying those bidders that met the covered document review date, then determining if those bidders have missing documentation.

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 assumes efficiencies gained from descoping non-statutory case file data collection requirements to decrease administrative burden. Funding supports QIC appeal processing costs and operations for the Medicare Appeals System (MAS), CMS' system of record for Medicare appeals. CMS projects the need to process 197,060 appeals (non-Recovery Audit Contractor (RAC) related) within the statutorily mandated 60-day timeframe.[12]

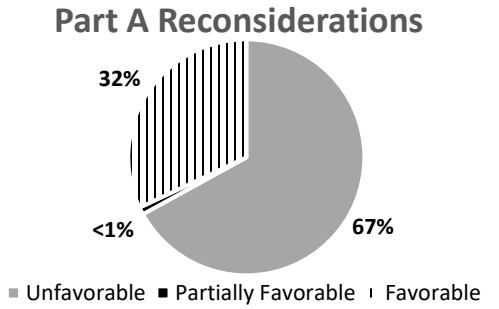
[12] Section 1869(c) of the Social Security Act

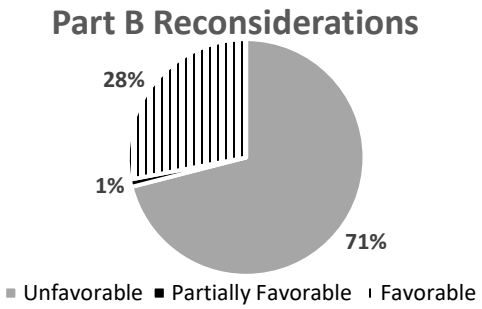
QIC A/B appeals reconsideration workload history and projections[13] are presented below:

QIC Appeals Workload
(Volume in Appeals)

	FY 2022 Actual	FY 2023 Actual	FY 2024 Actual	FY 2025 Estimate	FY 2026 Estimate
Non-RAC QIC Appeals	177,909	199,978	203,587	183,302	184,900
% Increase from Previous Year	-0.03%	12.40%	1.80%	-9.96%	0.87%

The chart below illustrates claim dispositions (i.e., outcomes) for appeals processed by the QIC contractors in CY 2023.[14] "Favorable" disposition means the reconsideration decision sided with the appellant (health provider or beneficiary).





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 healthcare 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 protections.

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

[13] The FY 2024 through FY 2026 appeals (cases) projections were formulated based upon FFS 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 2023 FFS Appeals Fact Sheet and include claims originating from both non-RAC reviews and RAC reviews.

include MA plans, prescription drug plans, Medicare-Medicaid 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 people with Medicare currently enrolled in LIS are receiving expanded benefits, such as no deductible, no premium, and fixed or lower copayments for certain medications.

Activities described in this section support the MA (Part C) and Prescription Drug (Part D) Annual Proposed Final Rule and Advance Notice, including technical assistance, sub-regulatory support, and the triage of public comments received in response to the calendar year and future proposed rules and advanced notices.

Budget Request: $69.7 Million

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 need/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 2026, CMS expects:

    - An estimated 25% cost increase to produce and mail LIS annual notices, including 1.5 million changes in copay; 95,000 for plan assignment; 2.0 million plan reassignments due to plan termination or premium increase; and as many as 2.5 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 Operations: 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: $36.1 Million

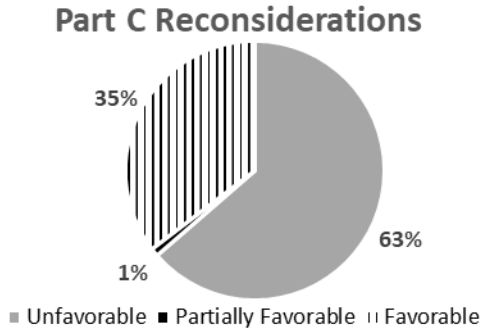
CMS requests funding to support a 34 percent increase in Part C appeals volume as compared to FY 2024 actual workloads. CMS expects the number of new beneficiaries choosing Part C plans over Original Medicare to continue to increase, which directly correlates with Parts C and D claims growth. As Parts C and D claims increase, second level appeals increase. Moreover, Part C second level appeals growth rate has more than doubled Part C enrollment growth annually since 2021, which CMS expects to continue driving higher IRE workloads. Funding also supports non-contract provider payment disputes.

Parts C and D appeals workload history and projection are presented below:

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

	FY 2022 Actual	FY 2023 Actual	FY 2024 Actual	FY 2025 Estimate	FY 2026 Estimate
Part C Appeals	160,428	195,706	218,323	262,000	293,000
Part D Benefit Appeals	38,047	39,000	47,265	57,000	62,000
Part D LEP Appeals	46,629	48,000	43,495	46,000	47,000

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



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

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 across the country. 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-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; serves as agency lead for addressing emerging and precedent setting policies that require section 1115 demonstration authority.

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.

Budget Request: $129.6 Million

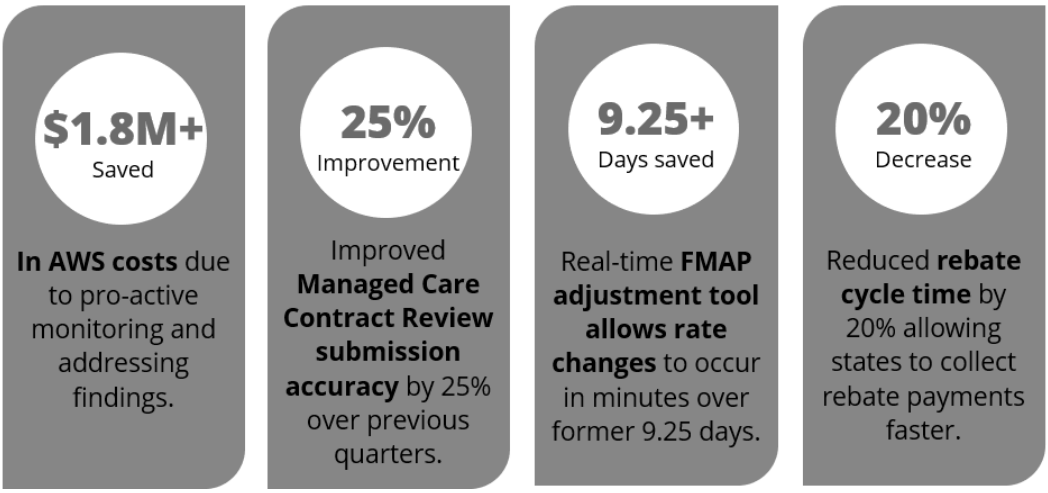
The largest portion of the Medicaid and CHIP budget request supports investments in the systems and tools that CMS uses to administer, oversee, and analyze the Medicaid and CHIP programs. In addition to ongoing operations and maintenance needs, CMS plans to:

- 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, creating budget and staffing inefficiencies, as well as financial, programmatic, and reputational risk.
- 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 begin a multi-year push to consolidate the number of SPA processing systems, introduce streamlined workflows, and templates with structured data elements to improve 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. Also, invest in strategies to identify, track, and resolve incidences of individuals enrolled in Medicaid in two or more states at the same time.
- 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. Below are the Medicaid and CHIP Business Information Solution (MACBIS) modernization successes and investment value returned over the past 2 years.[16]



The largest programmatic investments are aimed at ensuring the right care, at the right time, in the right place; removing unnecessary burden, friction, and complexity from Medicaid and CHIP; and Making America Healthy Again.

In FY 2026, CMS anticipates:

- Refocusing and strengthening Medicaid Section 1115 Demonstration innovation by maximizing efforts to support financial integrity. CMS anticipates prioritizing investments in 1115 budget neutrality policy and oversight, and 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, some learning collaboratives and technical assistance activities focused on the highest priority topics including chronic disease prevention, ensuring 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

Funding supports information standardization, conducting rate reviews, ensuring compliance with public reporting mandates, and responding to inquiries, addressing complaints, and enforcing market conduct rules. CMS must perform market conduct examinations and analyses, data collection, and enforcement to achieve these goals.

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 2026 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. For additional information, please refer to the Federal Exchanges section of this FY 2026 Congressional Justification.

Budget Request: $0.0 Million

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 take Part B as more and more people delay their SSA 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 people 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 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.

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

CMS strives to empower beneficiary healthcare 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 un-biased decision making for better health outcomes.

Budget Request: $284.0 Million

The request supports operating needs to perform statutorily mandated workloads and meet service level expectations. CMS expects to mail over 53 million Medicare & You handbooks as required by statute and maintain an approximate 5-minute Average Speed to Answer (ASA) for 1-800-MEDICARE. All outreach efforts require annual content review and revision to reflect programmatic changes.

In addition to the request, the Budget assumes $119.8 million in user fees from MA and Part D plans to share the cost of Medicare outreach, and $60.7 million in penalty mail funding to cover handbook postage. 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 currently have the option to opt out of receiving a hard copy by signing up at Medicare.gov/go-digital/ for an electronic copy. Approximately 6% of beneficiaries are estimated to opt-out of the mailed copy in FY 2026.

  The annual handbook mailing history and projection is presented below.

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

	FY 2022 Actual	FY 2023 Actual	FY 2024 Actual	FY 2025 Estimate	FY 2026 Estimate
Number of Handbooks Mailed	49.5	50.3	51.1	52.0	52.9
Number of eHandbooks Sent	2.5	2.8	3.0	3.2	3.4

- 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.

  All calls are initially answered by the IVR system. Thirty percent of all calls are handled completely by IVR.

  The annual call volume history and future estimates are presented below.

1-800-MEDICARE Call Volume
(in Millions)

	FY 2022 Actual	FY 2023 Actual	FY 2024 Actual	FY 2025 Estimate	FY 2026 Estimate
Number of Calls	23.9	23.0	23.9	24.7	24.8

- Website Operations and Maintenance: The official and most comprehensive website for Medicare is Medicare.gov. This website provides a wealth of 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). That's up 5% from the prior 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 2022 Actual	FY 2023 Actual	FY 2024 Actual	FY 2025 Estimate	FY 2026 Estimate
Number of Page Views for http://www.Medicare.gov	613.8	650.0	675.0	700.0	720.0

- 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, which have impacted budgetary needs.

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

CMS requests funding to continue ongoing AI/AN outreach effort.

VI. HEALTH CARE QUALITY

Value-based healthcare 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). MSSP), 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 healthcare transformation toward better patient outcomes at lower costs while improving the overall patient experience.

CAHPS surveys are integral to value-based healthcare programs by providing standardized patient experience data that directly informs quality measurement, payment adjustments, and performance improvement. These surveys capture critical patient perspectives on healthcare 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 MSSP, results impact performance assessments, potential shared savings payments, and shared losses owed.

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

Budget Request: $95.0 Million

In accordance with HHS priorities, CMS has adjusted its focus by descoping work in accordance with recent Executive Orders, discontinuing non-essential workloads, and prioritizing resources to enhance health outcomes and support value-based care programs. The details of the programs supported by this request are outlined below.

- Medicare Shared Savings Program: In 2025, 476 MSSP ACOs serve more than 11.2 million FFS beneficiaries, and we expect continued growth in participation in the program for FY 2026. The funding request supports application and change cycles, benchmarking and 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 $14.8 billion over 12 years. (Reg cite 87 FR 70193) https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

- 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 healthcare 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 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 needs 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 healthcare 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.

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 FY 2026 request supports the cost of audits, as well as software licenses and operations and maintenance costs for HIGLAS. Through assessing and identifying system enhancements by potential impact and value, CMS will 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, 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 healthcare.

Budget Request: $27.4 Million

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). These systems fulfill HIPAA Title II requirements for national standards in electronic healthcare transactions, provider identifiers, and data security, advancing CMS' goal of improving electronic data interchange efficiency across the nation's healthcare system. NPPES completed its cloud migration in FY 2023, and HETS continues to mature in the cloud environment to achieve cost efficiencies.

IT Systems and Support

Information Technology Systems and Support activities provide infrastructure and support for applications and operations that are used across the agency. Through innovation, modernization, and AI enablement, CMS will better equip all stakeholders to deliver smarter, more efficient, and person-centered healthcare services. The goal is to enhance operational efficiency, reduce waste, and improve patient experiences across the enterprise. CMS is building a future-ready workforce capable of responsibly implementing emerging technologies transforming CMS into a more agile, accountable, and data-driven organization.

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.
- Evaluating Changes in Laws: Analyzing how new legislation and guidelines affect CMS, allowing for quick compliance and integration of new regulations.
- Business Intelligence Upgrades: Updating outdated business intelligence technology to boost efficiency and align with government goals.

Consistent with the Administration's Workforce Optimization Initiative, CMS will insource expertise and utilize modern technologies to create a more agile workforce while maximizing fiscal resource allocation. This budget request allows CMS to operationalize this vision.

Budget Request: $624.1 Million

CMS must continue ongoing IT operations in a safe and secure environment, including making necessary investments to existing systems that support improvements in the effectiveness and efficiency of CMS operations. Improvements in systems allow for better services to our customers including states, stakeholders, and beneficiaries. These activities provide operational support to manage CMS' data environment for mission-critical and enterprise-wide CMS IT strategies for the IT ecosystem. CMS priorities in this request are below.

- Enhancing Cybersecurity: The increasing frequency and sophistication of cyber threats, traditional reactive security monitoring, and siloed threat detection capabilities present significant challenges. Our strategic investments will implement a real-time threat detection and response platform, apply AI and behavioral analytics for security monitoring, and consolidate security alert management. These enhancements will protect Medicare, Medicaid, Federal Exchange, and clinical quality programs, enable faster investigations with reduced false positives, enhance Zero Trust security implementation, provide continuous visibility across hybrid environments, and establish proactive defense against advanced persistent threats.

- Identity, Credential, and Access Management (ICAM) Platform: Modernization of the ICAM platform is vital for strengthening security and enhancing operational Efficiency within Medicare and Medicaid. CMS strategic investments will implement an enterprise-wide ICAM platform with unified login and identity verification across all CMS systems and automated access management capabilities. This will offer seamless and secure access for over 5,500 employees and tens of thousands of partners and providers. It will

enable faster onboarding and offboarding to our systems and data, providing a more streamlined and secure identity management solution for our beneficiaries. This upgrade offers many other benefits, including Enhanced Security by adhering to Zero Trust Architecture principles and federal standards, ensuring improved protection of sensitive healthcare data.

- Digital Infrastructure Modernization: Current challenges include dependency on mainframe products with restrictive licensing, siloed Customer Relationship Management (CRM) instances fragmenting engagement, and rising costs. Our strategic investments will migrate from mainframe products to flexible alternatives, unify CRM environments, and modernize core digital infrastructure. These improvements will generate approximately $120M in savings over five years through migration, reduced annual CRM licensing costs, decreased vendor lock-in, centralized access control and Zero Trust security enforcement, and enabled a build-once, reuse-across-programs development approach.

- Medicare Fee-for-Service Claims Processing Modernization: The Medicare Claims Processing System currently runs on decades-old technology, creating inconsistent processes across MACs and relying on legacy payment systems that are expensive to maintain and complex to scale. Our strategic investments will focus on cloud migration of payment systems to standardize workflows and reduce variation, modernization of Medicare Part B appeals processing, and implementation of real-time claims data analysis capabilities. By leveraging automation and artificial intelligence, these improvements will lead to efficient claims processing with enhanced payment integrity, scalable and adaptive system architecture, reduced costly manual interventions, better policy feedback loops through real-time data access, and support for innovative payment models that reward value over volume.

Enterprise Operational Support

Administrative functions in this section create the operational foundation enabling CMS to effectively deliver healthcare 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
- Providing support for grants and contract close-out activities, including audits
- 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: $84.3 Million

These activities collectively support CMS' mission to improve service delivery, enhance operational efficiency, and general operating support for our beneficiaries and healthcare system. These include:

- Acquisition Support funding enhances the CMS Acquisition Lifecycle Modernization (CALM) system while supporting contract closeout efforts and conducting background investigations on CMS contractors to comply with Homeland Security Presidential Directive 12 (HSPD-12) requirements.
- Actuarial Services provides additional modeling and cost estimates for statutory requirements.
- 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 request supports outreach and education, monitoring prescriber compliance, analyzing root causes for non-compliance, and developing appropriate non-compliance actions.

Research, Demonstrations, and Evaluation (Research)

Most of CMS' data collection and data storage efforts are housed in this category. The data is not only critical for the development, implementation, and evaluation of many CMS programs, but also used by industry stakeholders to conduct healthcare 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) benefits the healthcare industry by providing valuable data on Medicare beneficiaries' health status, healthcare use, expenditures, and access to care. This data helps policymakers understand the health care needs of Medicare beneficiaries and informs the development of policies and programs to improve the Medicare program.

- The Chronic Conditions Data Warehouse (CCW) supports the healthcare industry 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 healthcare costs.

CMS is taking steps to streamline its data architecture to meet business needs while minimizing data redundancy. This improves data discoverability and streamlines cross-program analytics, enhancing the Agency's ability to deliver timely analysis to support critical program decision-making. This optimized data architecture creates efficiencies from centralizing data storage, computing needs and eliminating redundant licensing fees.

Budget Request: $18.1 Million

In addition to operating efficiencies gained for streamlining data architecture, CMS will realize savings of certain data analysis tasks, through strategic insourcing, previously contracted to external vendors. CMS data scientists are currently leveraging AI to increase their productivity, reducing the need for contractor support.

In FY 2026, CMS will continue data collection and dissemination efforts including but not limited to conducting the MCBS and maintaining the CCW database. Continued fiscal support is necessary to deliver better health outcomes for our beneficiaries.

VIII. PLANNED 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)

The 340B Drug Pricing Program provides discounts on outpatient drugs to specific safety net healthcare 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 will continue providing healthcare access for high-need communities by allowing these 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: $12.2 Million

This budget request will fund the 340B program and includes resources for program integrity and compliance activities, such as audits of manufacturers and covered entities, to ensure adherence to program requirements and prevent noncompliance. Within this funding request is support for 22 FTEs, in accordance with the manner HRSA formulated and executed its budget.

Federal Administration

(Dollars in Thousands)

	FY 2024 Final	FY 2025 Enacted [1]	FY 2026 President's Budget	FY 2026 +/- FY 2025
Budget Authority [2]	$778,533	-	$734,061	-
Indirect Costs	$229,322	-	$200,000	-
Program Level	**$1,007,855**	**-**	**$934,061**	**-**
Total CMS FTE [3]	**4,003**	**3,480**	**3,368**	**(112)**
Total HRSA FTE [4]	**20**	**22**	**22**	**(0)**
Total CMS FTE	**4,023**	**3,502**	**3,390**	**(112)**

Allocation Method – Direct Federal/Intramural, Contracts, Other

Program Description and Accomplishments

New for FY 2026, CMS is proposing an innovative approach that will allow us to deliver more, through flexibility. The proposal is a new funding account, Program Administration, which will merge Program Operations and Federal Administration. By integrating funding of FTEs within program costs, CMS envisions better alignment with mission priorities and an increased flexibility in workforce planning. This alignment of accounts will allow CMS to better adjust staffing levels based on evolving program needs and hire more subject matter experts, leveling the federal staff and contractor support levels. This strategic consolidation represents the next evolution in CMS' ongoing commitment to fiscal responsibility and operational excellence.

Federal Administration funds routine operating expenses in support of CMS' mission and programs. This account provides funding for employee compensation, rent and utilities, administrative information technology and contractual services, as well as providing for business needs such as supplies, equipment, printing, training, and travel. Costs are impacted by annual inflationary factors, such as increases in benefits paid on behalf of the employee and annual cost of living adjustments (COLA).

CMS operates nationwide and oversees health care coverage for about 1 in 2 Americans, or 170 million people. The Agency's organizational structure is designed to facilitate efficient cohesion and integration in fulfilling its mission. Employees achieve the CMS mission by developing and implementing health care policies and regulations; setting payment rates; overseeing contractors in support of the mission, delivering education and outreach to beneficiaries, consumers, employers, and providers; identifying and eliminating fraud, waste, and abuse; and assisting law enforcement agencies in prosecuting fraudulent activities.

[1] Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025 and is rolled up within the Program Management account.
[2] FY 2024 Final included $455 million of additional Medicare Operations Funding. CMS has allocated $425 million to Program Operations, $15 million to Federal Administration, and $15 million to State Survey and Certification, all of which supported Medicare programs.
[3] FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.
[4] Due to the planned HHS reorganization, HRSA FTEs are displayed under CMS Program Management.

CMS is also pursuing activities to enhance customer engagement and improve the use of digital technologies and methodologies. To help do that, this budget request will support $3 million for the U.S DOGE Service team, which applies the best-in-class private sector practices, talent, and technology to transform the way IT products are developed and delivered within CMS and HHS.

CMS employees also work 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 (CHIP), 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.

Funding History

Fiscal Year	Amount [5]
FY 2022	$772,533,000
FY 2023	$782,533,000
FY 2024 Final	$778,533,000
FY 2025 Enacted [6]	-
FY 2026 President's Budget	$734,061,000

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

Budget Request: $734.1 Million

The FY 2026 Budget Request for Federal Administration is $734.1 million. CMS projects $200 million will be available from the administrative indirect cost allocation, bringing the total program level to $934.1 million.

[5] The funding levels seen in FY 2022, 2023, and 2024 include additional Medicare Operations funding.
[6] Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for 2025 and is rolled up within the Program Management account.

Federal Administration Program Level Summary Table [7]
(Dollars in Thousands)

Objects of Expense	FY 2024 Actual	FY 2025 Enacted [8]	FY 2026 President's Budget
Personnel Compensation and Benefits	$798,043	-	$718,219
Rent, Maintenance, and Building Loans	$35,457	-	$33,069
Service and Supply Fund	$41,415	-	$45,374
Administrative Services	$4,172	-	$11,450
Administrative IT	$52,339	-	$53,590
Supplies and Equipment	$338	-	$671
Administrative Contracts and Inter/Intra-Agency Agreements	$59,075	-	$58,545
Training	$3,036	-	$3,435
Travel	$4,582	-	$7,301
Printing	$4,897	-	$2,407
Postage	$4,501	-	-
Total, Federal Administration	**$1,007,855**	**-**	**$934,061**

Personnel Compensation and Benefits

Personnel compensation and benefits provides funding for CMS' staff payroll and benefit costs. Beyond payroll, this category provides funding for within-grade increases, awards, and overtime, as well as fringe benefits. Commissioned Corps staff are entitled to additional benefits including housing and other allowances. The CMS workforce contains world leading experts in key areas, which supports CMS' mission to provide the best health coverage to the most vulnerable.

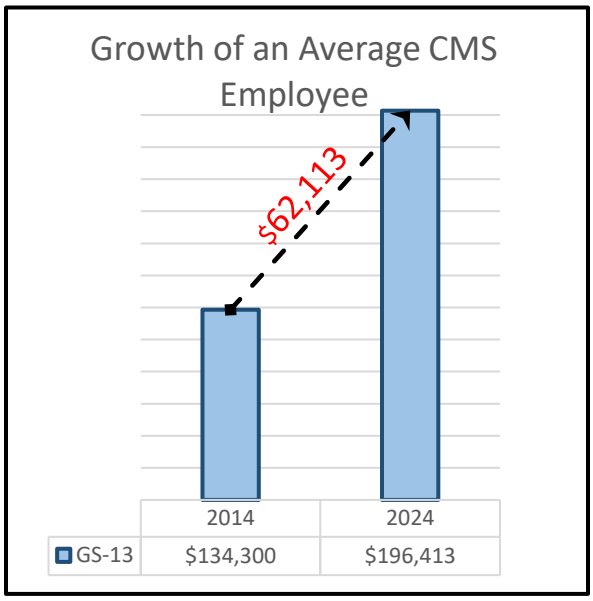
CMS administers or oversees programs that provide health care coverage for over 170 million people through Medicare, Medicaid, CHIP, and the Federal Exchanges across the country. In addition to its core work, CMS continues to improve its customer experience and drive innovation, contributing to continuous improvements within the health care system and addressing healthcare inefficiencies. With the requested level of funding, CMS will be equipped to fulfill its current mission while also preparing for future challenges. The Agency is committed to building a responsive healthcare system and enhancing program integrity to effectively eliminate fraud, waste, and abuse.

[7] This table and corresponding narrative reflect program level funding, which includes appropriated resources in addition to funds from CMS indirect cost allocations.
[8] Allocations for FY 2025 have not yet been determined.

Budget Request: $718.2 Million

Payroll and benefits are impacted by annual cost increases associated with cost-of-living adjustments (COLA) and increased benefit costs. In FY 2025, CMS, along with other divisions of HHS, performed cost saving measures, which included calculated workforce right-sizing initiatives to lower costs in payroll and associated benefits. These cost reduction efforts established a new, cost-effective baseline for FTEs supporting the mission. For FY 2026, CMS requests funding to support 3,410 direct FTEs.

The FY 2026 request does not assume a COLA increase for civilian employees and assumes a 3.8% increase for Commissioned Corps, with a 1.0% increase in benefits costs for both. To illustrate, the graph shows the growth of CMS' average employee, a GS-13 Step 7. From 2014 to 2024, the cost to CMS per GS-13 Step 7 increased from $134,300 to $196,413, a $62,113 increase per average employee. In FY 2024, CMS exercised a prudent hiring freeze to remain within budget due to the rising costs as described here. This initiative has allowed CMS to maintain a sustainable payroll consumption entering FY 2025.



Additional CMS staffing levels are funded through other directly appropriated accounts, such as HCFAC, the Federal Exchange, and other mandatory sources. These accounts cover the FTE costs required to execute their specific workload required to meet the Agency's needs.

Rent, Maintenance, & Building Loans

CMS utilizes rented and leased building space to conduct its operations. These facilities provide work and meeting areas, housing for infrastructure, and places where engagement with stakeholders can occur. In FY 2024, CMS went through a multi-phase process that returned the workforce to physical locations using a flexible hybrid work approach, moving away from the pandemic-induced posture of remote work. In FY 2025, CMS began its move of employees back into the office full-time, in accordance with the President's memorandum on January 20, 2025.

Budget Request: $33.1 Million

CMS has undertaken measures to enhance its operational efficiency, particularly in terms of optimizing its physical office space. The Agency has successfully aligned its real estate footprint with its evolving operational needs, which is a notable reduction compared to pre-COVID levels, reflecting a more efficient use of resources. This object class provides funding for CMS' offices, including rent and operational costs, as calculated by the General Services Administration. CMS' leased locations include CMS Central Office Headquarters in Woodlawn, MD, offices in Washington, D.C. and Bethesda, MD, and Regional Offices. Other items in this category include certain contract labor costs, such as grounds maintenance, cleaning, and trash and snow removal.

Service and Supply Fund

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

Budget Request: $45.4 Million

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

Administrative Services

CMS has a sizable operation that requires several internal services to maintain day-to-day continuity. This makes it necessary for administrative services such as facility improvement projects, employee badging, and even heating and air conditioning (HVAC). Current cost projections are due to consolidation and completion of delayed maintenance.

Budget Request: $11.5 Million

In addition to the costs, there are various projects in place to ensure compliance and maintenance of CMS facilities.

Administrative Information Technology (IT)

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

Budget Request: $53.6 Million

This request will enable CMS to continue providing a user-friendly and streamlined IT environment for employees with integrated data, voice, and video services that provide seamless connections between meeting rooms, workstations, and remote locations. These services are critical to CMS' efficient operation as the workplace continues to evolve.

Supplies and Equipment

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

Budget Request: $0.7 Million

CMS' workforce, being fully in the office, will make it necessary to restock office supplies on a more frequent basis.

Contracts and Intra/Inter-Agency Agreements (IAAs)

CMS holds several enterprise contracts and IAAs which provide services throughout various operations. These contracts include services for background investigations, translation services, mailroom operations and physical security. These and other contracted services allow CMS employees to work in a safe, professional environment. IAAs are productive ways to partner with colleagues from other agencies across government. These partnerships allow CMS access to subject matter experts for specific engagement. CMS also supports Tribal Resources which enhance relationships with Native Americans and Alaska Natives (AI/AN).

Budget Request: $58.5 Million

These enterprise contracts allow CMS to gain efficiency in utilizing bulk buying power.

Training

The Training costs support continuous learning of technical, professional, and financial skills. Technical and professional continuing education provided under this object class include areas such as contract and project management, advanced program and policy administration, and information technology. These qualifications help build a more efficient workforce. The category also includes a special emphasis on leadership and management development, and includes certifications for staff, such as actuaries, contract specialists, financial managers, nurses, and other health care professionals. Funding also supports Agency wide training, such as Reasonable Accommodation, Alternative Dispute Resolution, and Ethics.

Budget Request: $3.4 Million

As a robust, professional workforce, CMS has the need to keep its teams at the cutting edge of technology, clinical knowledge and know-how, and remain up to date on changes in the health care industry.

Travel

Travel enables CMS to continue the Agency's mission by conducting site visits at contractor operations, healthcare facilities, and places us with health providers in every State and U.S. Territory. As CMS administers its programs primarily through contractors, site visits are a critical method of oversight and contract management, ensuring efficient use of resources and eliminating waste. These site visits allow CMS to effectively manage and evaluate programs and to ensure compliance with the terms and conditions of contracts and cooperative agreements.

Budget Request: $7.3 Million

This budget request enables CMS to position people effectively to support the Administration's mission. As such, CMS will continue to review and adjust the need for travel.

Printing

CMS, as the nation's largest health insurer, has the administrative need to print and mail a large volume of correspondence. Specifically, the largest expense in this category is for printing notices in the Federal Register and Congressional Record. CMS is required

to publish regulations that adhere to notice and comment rulemaking procedures. Historically, one major piece of new authorizing legislation involving CMS' programs is enacted annually.

Budget Request: $2.4 Million

The Agency anticipates mail volumes will remain similar to current operations.

This page intentionally left blank.

State Survey and Certification

(Dollars in Thousands)

	FY 2024 Final [1]	FY 2025 Enacted [2]	FY 2026 President's Budget	FY 2026 +/- FY 2025
Discretionary				
Survey and Certification	$412,334	$397,334	$442,000	$44,666
Mandatory				
IMPACT Act [3]	$5,304	$5,304	$0	($5,304)
Consolidated Appropriation Act (CAA), 2021 [3]	$9,430	$9,430	$9,430	$0
Grants to States for Medicaid (S&C)	$351,000	$362,000	$373,000	$11,000
Subtotal, Mandatory	**$365,734**	**$376,734**	**$382,430**	**$5,696**
Total	**$778,068**	**$774,068**	**$824,430**	**$50,362**

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 facilities.

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 the Agency has been given statutory authority, CMS takes progressively escalating enforcement action when quality standards are not met or maintained by participating providers. Remedies, based on the scope and severity of the non-compliance, 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,

[1] FY 2024 Final included $455 million of additional Medicare Operations funding. CMS has allocated $425 million to Program Operations, $15 million to Federal Administration, and $15 million to State Survey and Certification, all of which supported Medicare programs.

[2] The allocation of the additional Medicare Operations funding for FY 2025 has not yet been determined.

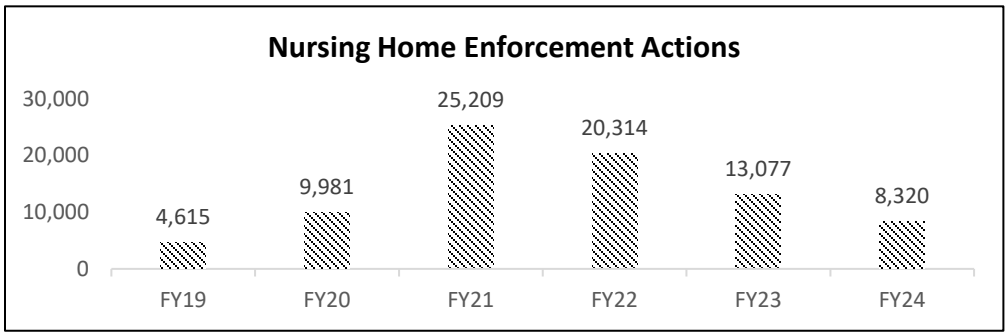
[3] IMPACT and the CAA, 2021 funding is targeted to help keep hospice survey frequencies at every three years. The funding levels displayed are net sequester.

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 a direct correlation to COVID-19 and the increase in infection control surveys, with more complaints and serious findings. As demonstrated in the table below, with the help of the CARES Act funds, FY 2022 and FY 2023 actions have retreated from this high-water mark and the expectation is a continued level of necessary nursing home enforcement actions. To address the increasing workloads and align with the CMS' commitment to improve the safety and quality of nursing home care, the Budget requests an increase in funding.



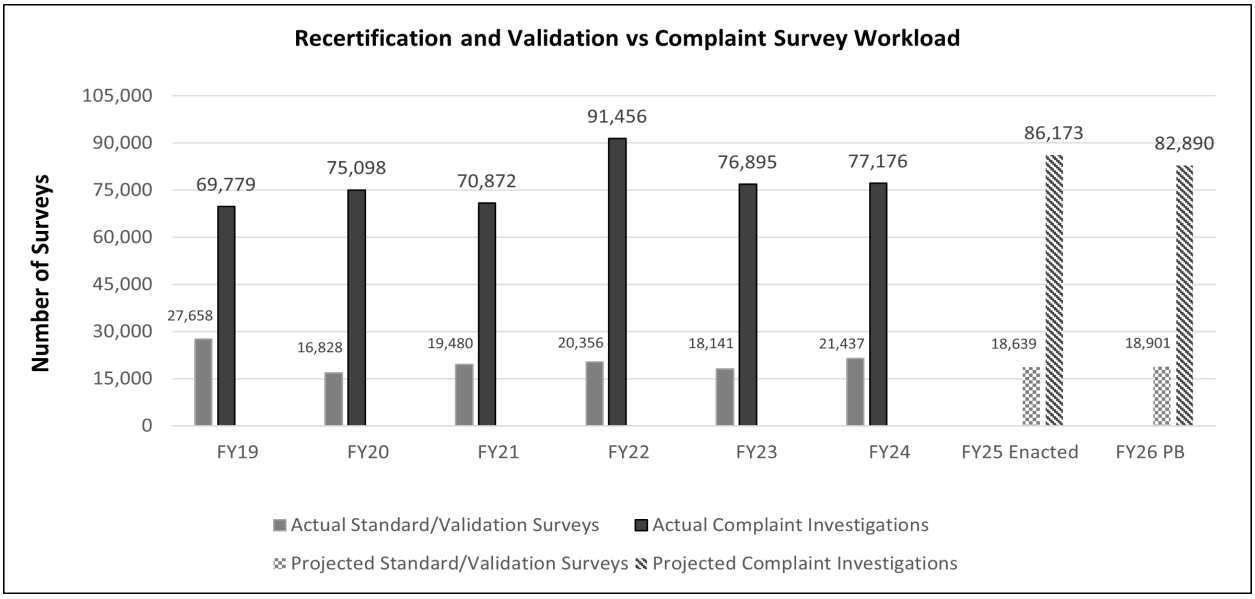
Complaint surveys have become the primary oversight mechanism for most provider types. Each complaint case represents a beneficiary or family member calling CMS or their SA directly for help when they are at their most vulnerable, such as a beneficiary facing negligence and/or poor quality of care. Complaints are categorized into four levels of severity: Immediate Jeopardy (IJ), Non-IJ High (NIJH), Non-IJ Medium (NIJM), and Non-IJ Low (NIJL). IJ and NIJH complaints are considered the top priority to ensure the safety and well-being of the beneficiary community. The standard timeline for IJ complaints requires SAs to complete an onsite assessment within two days of such a complaint. The next level of complaint, NIJH, although not as severe, requires the SAs to complete an assessment within 10 days of the complaint. Both higher severity level complaints cause abrupt shifts in planned and scheduled workload completion, resulting in a greater financial burden on the Program. CMS has maintained prioritization of funds to pay for the rise in complaint surveys by reducing support to standard surveys, resulting in a year-over-year decrease in the number of recertification and validation surveys.

*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 this period.*

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 2024 through FY 2026 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 Facilities)



Innovative Initiatives

Ensuring patients have access to high quality healthcare in their communities is a top priority. An adjustment to the initial survey prioritization has been implemented starting in FY 2024 to help ensure beneficiary access to services. CMS adjusted the Tier assignments regarding initial surveys to provide flexibility for SAs in surveying prospective providers and suppliers approved to enter the program. CMS will update the State Operations Manual (e.g. Section 2003B), a change in which states have already been notified, to reflect that initial surveys remain at Tier 3 and will move to the highest Tiers, a Tier 1 or Tier 2, based on available deeming options or if certain timelines have elapsed.

Funding History

Fiscal Year	Amount [4]
FY 2022	$397,334,000
FY 2023	$407,334,000
FY 2024 Final	$412,334,000
FY 2025 Enacted	$397,334,000
FY 2026 President's Budget	$442,000,000

Budget Request: $442.0 Million

The FY 2026 Budget Request for the S&C program is $442.0 million. This funding level will allow for an estimated completion rate of 65% for statutorily mandated surveys and the completion rate of non-statutory surveys at 10%. This increased funding level allows CMS to address the most serious and concerning situations, placing surveyors where they are needed the most.

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. Based on recent trends, overall starting in FY 2022, the total participating facilities are projected to decline by approximately 1.3 percent, or approximately 900 facilities. However, the deemed facilities (those accredited by a CMS-approved accrediting organization) are still projected to rise, with an increase of nearly 6.5 percent, whereas the total number of non-deemed facilities is expected to decrease by 4.0 percent. Complaints from deemed facilities are a driver in SAs complaint workload for acute and continuing care providers, and an increase in the number of deemed facilities has grown the workload.

In FY 2026, the S&C program will no longer receive additional $5.3 million of mandatory funding provided since FY 2015 from the IMPACT Act. However, starting 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. The CAA of 2021 required CMS to establish a special focus program for hospice agencies.

[4] Since FY 2015, the Program has been held at $397.3 million. The funding levels seen in FY 2023 and 2024 include additional Medicare Operations funding allocations.

Medicare Program Management Discretionary Survey and Complaint Visit Cost Projections

(Dollars in Thousands)

	FY 2024 Final [5]	FY 2025 Enacted [6]	FY 2026 President's Budget	FY 2026 +/- FY 2025
State Direct Survey	$363,369	-	$397,384	-
Mandatory Surveys (Nursing Homes/Home Health/Hospice) (non-add)	*$315,670*	-	$330,002	-
Non-Statutory Surveys Non-Deemed and Deemed (non-add)	*$47,699*	-	$67,382	-
Federal Direct Surveys	$17,198	-	$11,918	-
Support Contract and Information Technology	$31,767	-	$32,698	-
Total S&C PM Discretionary	**$412,334**	**$397,334**	**$442,000**	**$44,666**
IMPACT Act, Hospice [7]	$5,304	$5,304	$0	($5,304)
Consolidated Appropriations Act of 2021, Hospice	$9,430	$9,430	$9,430	$0
Grants to States for Medicaid - S&C	$351,000	$362,000	$373,000	$11,000
Total S&C Mandatory	**$365,734**	**$376,734**	**$382,430**	**$5,696**
Total Program Level	**$778,068**	**$774,068**	**$824,430**	**$50,362**

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: $397.384 Million

The FY 2026 Budget request is $397.4 million. This level of funding provides the resources necessary to maintain the integrity of our national health and safety oversight, with $330.0 million to inspect, survey, and certify statutory facilities, and $67.4 million to inspect, survey, and certify non-statutory facilities.

With this level of funding, CMS projects that states will have the resources to complete approximately 65% of the recertification surveys for statutory facilities and projected complaints in all facility types at an Actual Harm, IJ, and Non-IJ High levels. Additionally, this level provides a proportional recertification survey frequency rate of approximately 10% for non-statutory facilities with a focus on those facility types with higher beneficiary risks. These completion rates move the program in a positive direction and increase quality and safety across the country.

This FY 2026 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 that may arise.

[5] FY 2024 Final included $455 million of additional Medicare Operations funding. CMS has allocated $15 million for Survey and Certification.
[6] Allocations for FY 2025 have not yet been determined.
[7] Funding provided through the Improving Medicare Post-Acute Care Transformation (IMPACT) and Consolidated Appropriations Acts are net of sequester. The IMPACT Act funding ends in FY 2025.

The cost to achieve the survey frequency completion rate and workload for each provider type in the table below is funded by the sources listed above. Note that 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 (facility).

Please note that the percentages represented below are based on modeling from a national average perspective and may not represent the actual workload results from individual states. The survey frequencies are based on current law and CMS' administrative policy, resulting in varying survey intervals depending on provider type (facility).

Provider Survey Frequency Rate Completion Projections

Provider Status and Type	Target Survey Frequency Intervals	FY 2024 Final [8]	FY 2025 Enacted	FY 2026 President's Budget
Statutory				
Nursing Facilities (NF)	100% Surveyed 12.9-15.9 mo.	75%	-	100%
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	100% Surveyed 12.9-15.9 mo.	74%	-	65%
Special Focus Facility Nursing Homes (SFF)	100% Surveyed 6 mo.	100%	-	100%
Skilled Nursing Facilities (SNF)	100% Surveyed 12.9-15.9 mo.	72%	-	65%
ICF/IID	100% Surveyed 12.9-15.9 mo.	84%	-	100%
Home Health Agencies (HHAs)	100% Surveyed 36.9 mo.	70%	-	65%
Hospice Agencies	100% Surveyed 36.9 mo.	91%	-	100%
Special Focus Program Hospice Agencies (SFP) [9]	100% Surveyed 6 mo.	100%	-	-
Non-Statutory Non-Deemed				
Ambulatory Surgical Centers (ASCs)	100% Surveyed 72 mo.	100%	-	10%
Community Mental Health Centers (CMHCs)	100% Surveyed 60 mo.	100%	-	10%
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	100% Surveyed 72 mo.	37%	-	10%
End Stage Renal Disease (ESRD)	100% Surveyed 36 mo.	54%	-	10%
Hospitals	100% Surveyed 36 mo.	57%	-	10%
Outpatient Physical Therapy (OPT)	100% Surveyed 72 mo.	62%	-	10%
Portable X-Ray Suppliers	100% Surveyed 72 mo.	73%	-	10%
Rural Health Clinics (RHCs)	100% Surveyed 72 mo.	57%	-	10%
Transplant Centers	100% Surveyed 60 mo.	80%	-	10%
Non-Statutory Deemed				
Ambulatory Surgical Centers (ASCs)	5% of Validation Surveys	10%	-	10%
End Stage Renal Disease (ESRD)	5% of Validation Surveys	10%	-	10%
Home Health Agencies (HHAs)	5% of Validation Surveys	10%	-	10%
Hospice Agencies	5% of Validation Surveys	10%	-	10%
Hospitals	5% of Validation Surveys	10%	-	10%
Outpatient Physical Therapy (OPT)	5% of Validation Surveys	10%	-	10%
Rural Health Clinics (RHCs)	5% of Validation Surveys	10%	-	10%

The next table displays the projected costs to respond to reported complaints and the costs to conduct the projected survey frequency rates provided in the Survey Frequency Rates table by provider type. Hospice survey work is supported by supplemental funding provided through the FY 2026 Budget request and the CAA of 2021.

[8] The FY 2024 Actual survey frequency rates were higher than expected because of State Agencies self-funding additional surveys.

[9] Surveys of Special Focus Program for Hospice Agencies started in FY 2024. Program paused for FY 2025 and FY 2026 to allow for further evaluation and exploration of options for program implementation and future rulemaking.

Medicare Program Management Discretionary Survey and Complaint Visit Cost Projections

(Dollars in Thousands)

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Statutory	**$315,670**	**-**	**$330,002**
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	$293,091	-	$303,384
Special Focus Facility Nursing Homes (SFF)	$1,462	-	$1,869
Skilled Nursing Facilities (SNF)	$12,062	-	$12,388
Home Health Agencies (HHAs)	$9,055	-	$12,361
Hospice Agencies	$0	-	$0
Special Focus Program Hospice Agencies (SFP)	$0	-	$0
Non-Statutory	**$47,699**	**-**	**$67,382**
Ambulatory Surgical Centers (ASCs)	$1,636	-	$2,289
Community Mental Health Centers (CMHCs)	$56	-	$43
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	$17	-	$23
End Stage Renal Disease (ESRD)	$8,414	-	$9,117
Hospitals - Non-Deemed	$4,291	-	$5,146
Hospitals - Deemed	$32,408	-	$49,410
Home Health Agencies (HHAs) - Deemed	$159	-	$232
Outpatient Physical Therapy (OPT)	$153	-	$209
Portable X-Ray Suppliers	$29	-	$69
Rural Health Clinics (RHCs)	$380	-	$536
Transplant Centers	$156	-	$308
Total State Direct Survey Budget	**$363,369**	-	**$397,384**
IMPACT Act, Hospice Surveys	$5,304	$5,304	$0
Consolidated Appropriations Act, Hospice Surveys	$9,430	$9,430	$9,430

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

Actual vs. Projected Survey Counts by Provider Type

	FY 2024 Actuals				FY 2026 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**	**82,590**	**18,826**	**229**	**101,645**
Statutory	**71,071**	**17,942**	**96**	**89,109**	**77,039**	**18,381**	**90**	**95,510**
Nursing Facilities (NF)	897	204	10	1,111	1,018	256	4	1,278
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	63,015	10,453	31	73,499	69,065	9,957	17	79,039
Special Focus Facility Nursing Homes	0	120	0	0	0	120	0	120
Skilled Nursing Facilities (SNF)	1,164	421	6	1,591	1,155	397	3	1,555
ICF/IID	4,180	4,606	28	8,814	4,045	5,306	15	9,366
Home Health Agencies (HHAs)	1,018	1,554	12	2,584	991	1,588	16	2,595
Hospice Agencies	797	704	9	1,510	765	757	35	1,557
Special Focus Program Hospice Agencies (SFP)	0	0	0	0	0	0	0	0
Non-Statutory Non-Deemed	**1,509**	**2,851**	**176**	**3,640**	**1,547**	**445**	**139**	**2,131**
Ambulatory Surgical Centers (ASCs)	181	687	28	896	190	64	22	276
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	926	236	40	1,202
Hospitals	384	0	38	422	378	41	18	437
Outpatient Physical Therapy (OPT)	8	161	9	178	0	26	7	42
Portable X-Ray Suppliers	2	63	25	90	1	9	12	22
Rural Health Clinics (RHCs)	22	342	45	409	31	60	36	127
Transplant Centers	12	38	0	50	11	5	0	16
Non-Statutory Deemed	**4,596**	**0**	**0**	**4,596**	**4,004**	**0**	**0**	**4,004**
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	4,004	0	0	4,004
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 2024 Actuals	FY 2025 Actuals	FY 2026 Projected
Total Facilities within State Direct Survey Budget	**65,825**	**65,489**	**67,733**
Statutory	**29,398**	**29,129**	**28,996**
Nursing Facilities (NF)	272	261	256
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	14,088	13,988	13,938
Special Focus Facility Nursing Homes (SFF)	N/A	0	N/A
Skilled Nursing Facilities (SNF)	585	565	555
ICF/IID	5,460	5,357	5,306
Home Health Agencies (HHAs)	6,669	6,669	6,669
Hospice Agencies	2,324	2,289	2,272
Special Focus Program Hospice Agencies (SFP)	N/A	0	N/A
Non-Statutory Non-Deemed	**18,398**	**18,353**	**20,739**
Ambulatory Surgical Centers (ASCs)	3,849	3,849	3,849
Community Mental Health Centers (CMHCs)	110	116	119
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	146	141	139
End Stage Renal Disease (ESRD)	7,147	7,100	7,077
Hospitals	1,267	1,246	1,236
Outpatient Physical Therapy (OPT)	1,548	1,570	1,899
Portable X-Ray Suppliers	519	522	524
Rural Health Clinics (RHCs)	3,573	3,575	5,664
Transplant Centers	239	234	232
Non-Statutory Deemed	**18,029**	**18,007**	**17,998**
Ambulatory Surgical Centers (ASCs)	2,238	2,238	2,238
End Stage Renal Disease (ESRD)	502	531	546
Home Health Agencies (HHAs)	4,837	4,837	4,837
Hospice Agencies	3,583	3,304	3,165
Hospitals	4,759	4,790	4,806
Outpatient Physical Therapy (OPT)	385	340	318
Rural Health Clinics (RHCs)	1,725	1,967	2,088

Federal Direct Surveys

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

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

Budget Request: $11.9 Million

The FY 2026 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 Budget request for Support Contracts and IT is $32.7 million. This amount includes $22.6 million for support contracts and $10.1 million for IT contracts. This level reflects a shift of one contract from Supports Contracts to Federal Direct.

Grants to States Mandatory Appropriation: $373.0 Million

The FY 2026 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 facilities.

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Medicaid Grants to States	**$351,000**	**-**	**$373,000**
Statutory	**$349,921**	**-**	**$367,766**
Nursing Facilities (NF)	*$7,887*	*-*	*$7,576*
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	*$279,188*	*-*	*$289,622*
Special Focus Facility Nursing Homes (SFF)	*$1,575*	*-*	*$1,418*
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	*$49,733*	*-*	*$50,585*
Home Health Agencies (HHAs)	*$11,538*	*-*	*$18,565*
Non-Statutory Deemed	**$1,079**	**-**	**$5,234**
Home Health Agencies (HHAs)	*$1,079*	*-*	*$5,234*
Total Medicaid S&C Funding	**$351,000**	**$362,000**	**$373,000**

Clinical Laboratory Improvement Amendments Program (CLIA)

(Dollars in thousands)

	FY 2024 Final	FY 2025 Estimate	FY 2026 Estimate
CLIA Lab Obligations	$82,200	-	$86,000

The CLIA program is entirely funded by user fees that are charged to the laboratories regulated by the program. The FY 2026 President's 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 (FDA). CMS also has inter-agency agreements with the Centers for Disease Control and Prevention (CDC) to define quality and safety standards. Laboratories performing similar tests must meet similar standards, whether located in a hospital, doctor's office, or other sites. The more complex the tests performed, the more stringent the requirements.

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

The table below provides the number of labs that are subject to CLIA oversight. From FY 2021 to FY 2024, the number of labs grew by approximately 20 percent. CMS is not expecting growth in the number of labs in FY 2026. 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 to grow minimally.

Lab Type	**FY 2021 Actual**	**FY 2022 Actual**	**FY 2023 Actual**	**FY 2024 Actual**	**FY 2025 Projected**	**FY 2026 Projected**
Compliance Labs	17,411	17,934	17,723	17,158	-	17,158
Accredited Labs	15,656	15,907	16,020	17,021	-	17,021
Waived Labs	193,146	233,909	257,103	249,545	-	249,545
PPMP Labs	30,248	29,826	26,840	24,962	-	24,962
Total	**256,461**	**297,576**	**317,686**	**308,686**	**-**	**308,686**

The table below provides the projected CLIA Survey Workload from FY 2021 to FY 2026, and directly following is a table showing what the actual CLIA Survey workload was between FY 2021 to FY 2024.

Original projected workload

Type of Survey	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
Compliance: Initial and Recertification	8,620	9,508	9,542	9,172	-	7,933
Complaint/Follow-up	155	132	668	642	-	2,812
Validation Surveys	418	430	431	433	-	393
Total	**9,193**	**10,070**	**10,641**	**10,247**	**-**	**11,138**

Note: FY 2023-2026 estimates as of April 2025.

Actual workload

Type of Survey	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Compliance: Initial and Recertification	8,127	8,266	7,749	7,839
Complaint/Follow-up	1,212	981	2,626	2,818
Validation Surveys	69	148	403	305
Total	**9,408**	**9,395**	**10,778**	**10,962**

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 2024 Final	FY 2025 Estimate	FY 2026 President's Budget	FY 2026 +/- FY 2025
Program Activity				
Medical Assistance Payments	$569,115,889	$615,050,387	$732,739,733	$117,689,346
State and Local Administration	$28,182,592	$29,729,772	$28,542,606	($1,187,166)
Vaccines for Children	$7,238,843	$7,757,105	$7,930,272	$173,167
Subtotal, Medicaid Program Level	**$604,537,324**	**$652,537,264**	**$769,212,611**	**$116,675,347**
Less funds advanced in prior year	$197,580,474	$245,580,414	$261,063,820	$15,483,406
Total, Grants to States for Medicaid	**$406,956,850**	**$406,956,850**	**$508,148,791**	**$101,191,941**
New advance 1st quarter of subsequent FY	$245,580,414	$261,063,820	$316,514,726	$55,450,906

Budget Authority Table

(Dollars in Thousands)

	FY 2025 Estimate	FY 2026 President's Budget	FY 2026 +/- FY 2025
CMS - Grants to States [2] Grants to States, Subsidies	$705,842,811	$762,939,339	$57,096,528
CDC - Vaccines For Children Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance [3]	$7,757,105	$7,930,272	$173,167
Total Budget Authority	**$713,599,916**	**$770,869,611**	**$57,269,695**

[1] Funding represented in the chart equals the respective FY 2026 President's Budget estimates. FY 2024 and FY 2025 does not include $35.9 billion and $59.2 in indefinite funding authority, respectively.
[2] Includes budget authority from offsetting collections.
[3] Reflects Vaccines for Children estimates under current law.

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 2026.

Summary of Request
(Dollars in Thousands)

Program Activity	FY 2024	FY 2025	FY 2026	
	Final [4]	Estimate [5]	President's Budget	+/- FY 2025
Medical Assistance Payments	$605,047,900	$674,246,888	$732,739,733	$58,492,845
State and Local Administration	$28,182,592	$29,729,772	$28,542,606	($1,187,166)
Vaccines for Children	$7,238,843	$7,757,105	$7,930,272	$173,167
Total Mandatory Appropriation Request [6]	**$640,469,335**	**$711,733,765**	**$769,212,611**	**$57,478,846**

FY 2026 Mandatory Appropriation Request

CMS' FY 2026 mandatory appropriation request for the Grants to States for Medicaid account is $769.2 billion, an increase of $57.5 billion relative to the FY 2025 request level of $711.7 billion. This appropriation is composed of $261.1 billion in an authorized advance appropriation for FY 2025 and a remaining appropriation of $508.1 billion for FY 2026.

Resources will help fund $770.9 billion in anticipated FY 2026 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 $1.7 billion to fund the remaining anticipated obligations. These estimated obligations include:

- $734.4 billion in Medicaid medical assistance payments (MAP);
- $28.6 billion for Medicaid state and local administrative functions including funding for Medicaid state survey and certification and the state Medicaid fraud control units; and
- $7.9 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 recent as the third quarter of FY 2024. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget (OMB) for the FY 2026 President's Budget.

[4] FY 2024 includes indefinite funding of $35.9 billion.
[5] FY 2025 includes indefinite funding of $59.2 billion.
[6] Numbers may not add due to rounding. Vaccines for Children totals reflect estimates under current law.

Under current law, the federal share of Medicaid net outlays is estimated to be $707.6 billion in FY 2026, an increase of $47.3 billion from the FY2025 level of $660.3 billion.

The FY 2026 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 2022 [7]	$608,620,011,000
FY 2023 [8]	$611,245,154,000
FY 2024 [9]	$640,469,335,000
FY 2025 [10]	$711,733,765,000
FY 2026	$769,212,611,000

[7] Includes $91.2 billion in indefinite funding authority obligated during FY 2022.
[8] Includes $78.2 billion in indefinite funding authority obligated during FY 2023.
[9] Includes $35.9 billion in indefinite funding authority obligated during FY 2024.
[10] Includes $59.2 billion in indefinite funding authority obligated during FY 2025.

Medical Assistance Payments
(Dollars in Thousands)

	FY 2024 Final	FY 2025 Estimate	FY 2026 President's Budget	FY 2026 +/- FY 2025
Medical Assistance Payments	$605,047,900	$674,246,888	$732,739,733	$58,492,845

Program Activity Description and Accomplishments

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

Within broad national guidelines established by Federal statutes, regulations, and policies, each State establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably 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 2024 Final	FY 2025 Estimate	FY 2026 President's Budget	FY 2026 +/- FY 2025
Aged	7.5	7.7	7.9	0.2
Disabled	10.1	9.8	9.9	0.1
Adults	18.8	17.5	17.6	0.1
Children	31.1	30.7	31.0	0.3
Expansion Adult	17.4	16.8	17.0	0.2
Territories	1.6	1.5	1.5	0.0
Total [11]	**86.5**	**84.0**	**84.8**	**0.8**

According to CMS projections of Medicaid enrollment, 84.8 million Americans will be enrolled in Medicaid for the equivalent of a full year during FY 2026. In FY 2026, 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 increase by 800,000 in FY 2026.

FY 2026 Budget Estimate

CMS' Medical Assistance Payments (MAP) budget estimate is $732.7 billion, a $58.5 billion increase above the FY 2025 request. To arrive at an accurate estimate of Medicaid expenditures, CMS made adjustments to reflect actuarial estimates developed by CMS' Office of the Actuary (OACT), legislative and regulatory impacts, entitlement benefits due and payable, CMS financial management reviews and estimates of expenditure transfer authority from the Medicare trust funds.

Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

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 2026 using the three quarters of FY 2024 state-reported expenditures as a base. Expenditures for FY 2024, FY 2025, and FY 2026 were projected by applying factors to account for assumed growth rates in Medicaid caseloads, utilization of services, and payment rates. These growth rates were derived mainly from economic assumptions promulgated by OMB and demographic trends in Medicaid enrollment. 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 2026 estimate of $61.6 billion represents the entire liability for Medicaid medical services incurred but not paid from October 1, 2025, to September 30, 2026. 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

[11] Totals may not add due to rounding.

to the states for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases.

Transfer from the Supplementary Medical Insurance Trust Fund for Qualified Individuals

Social Security Act Title XIX Section 1933(f) authorizes a transfer from the Supplementary Medical Insurance Trust Fund to the Grants to States for Medicaid account to account for the Medicare programs costs attributable to state coverage of Medicare cost-sharing for certain low-income sets its estimate at $1.7 billion for FY 2026. This transfer of funding is used to offset MAP obligations, thereby reducing the overall mandatory appropriation request.

Legislative and Regulatory Impacts to the Medicaid Baseline

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

Legislative Actions

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 2023 (P.L. 117-328)

This Act provides consolidated appropriations for the fiscal year ending September 30, 2023. This Act made modifications to postpartum coverage under Medicaid and CHIP and the Medicaid Improvement Fund, which supports improvement to managing the Medicaid Program.

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) and certified community behavioral health clinic services under Medicaid, prohibits beneficiary disenrollment due to incarceration, and promotes value in Medicaid Managed Care.

Regulatory Actions

Preserving Medicaid Funding for Vulnerable Populations – Closing a Health Care-Related Tax Loophole Proposed Rule

This proposed rule is intended to address an algorithmic loophole in State proposals for Medicaid tax waivers. The inadvertent loophole currently allows states to impose health care-related taxes, especially taxes on managed care organizations, with higher rates on Medicaid entities than non-Medicaid entities, contrary to legal and regulatory intent for health care-related taxes to be generally redistributive. This rule improves the legal requirements by adding additional safeguards to ensure that proposals exploiting the loophole are not approvable.

Vaccines for Children
(Dollars in Thousands)

	FY 2024 Final	FY 2025 Estimate	FY 2026 President's Budget	FY 2026 +/- FY 2025
Vaccines for Children	$7,238,843	$7,757,105	$7,930,272	$173,167

Program Activity Description and Accomplishments

The Vaccines for Children (VFC) program is funded by the Medicaid appropriation and operated by the Centers for Disease Control and Prevention (CDC). This program provides eligible children access to vaccines recommended by the Advisory Committee on Immunization Practices. VFC serves children through 18 years of age who are uninsured, underinsured, Medicaid-eligible, and 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.

Millions of children have benefited from vaccination since the VFC Program began in 1994. CDC estimates that routine vaccination of children born during 1994–2023 will have prevented approximately 508 million lifetime cases of illness, 32 million hospitalizations, and 1,129,000 deaths, at a net savings of $540 billion in direct costs and $2.7 trillion in societal costs.[12]

FY 2026 Budget Estimate

CMS' Vaccine for Children (VFC) budget estimate under current law is $7.9 billion, a $173.2 million increase above the FY 2025 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.

[12] https://www.cdc.gov/mmwr/volumes/73/wr/mm7331a2.htm

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, immunization coverage surveys, and program support and oversight.

State and Local Administration
(Dollars in Thousands)

	FY 2024 Final	FY 2025 Estimate	FY 2026 President's Budget	FY 2026 +/- FY 2025
State and Local Administration	$28,182,592	$29,729,772	$28,542,606	($1,187,166)

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 2026 Budget Estimate

CMS' State Administration estimate is $28.5 billion, a $1.2 million dollar decrease compared to the FY 2025 estimated level.

This estimate is composed of $373.0 million for Medicaid state survey and certification, $432 million for state Medicaid Fraud Control Units, and $27.7 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 2026 estimate for Medicaid state survey and certification is $373.0 million, which represents an increase of $11.0 million above the FY 2025 estimated amount of $362.0 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 2026, 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 $432.0 million, which represents an increase of $32.0 million over the FY 2025 estimate of $400.0 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 2026 estimate for this transfer is $5.0 million, a flatline from the FY 2025 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 2026.

All Other Medicaid State and Local Administration: The CMS estimate for FY 2026 is $27.7 billion. CMS adjusted the FY 2025 state-submitted estimates of $29.0 billion downward to reflect a growth rate more consistent with recent expenditure history and current economic conditions.

This page intentionally left blank.

Payments to the Health Care Trust Funds

Annual Budget Authority
(Dollars in Thousands)

	FY 2024 Final	FY 2025 Estimate	FY 2026 President's Budget	FY 2026 +/- FY 2025
Budget Authority	$508,196,012	$561,015,000	$593,817,000	$32,802,000

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

The annual appropriation for the Payments to the Health Care Trust Funds account makes payments from the general fund to the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) Trust Funds to reimburse the trust funds for amounts to which they are entitled under law. These payments make the Medicare Trust Funds whole for certain costs, described below, initially borne by the trust funds which are properly charged to the General Fund under current law, including amounts due to the SMI Trust Fund for the General Fund contribution for the cost of the Part B and Part D programs. Due to the passage of Full-Year Continuing Appropriations and Extensions Act, 2025 (PL 119-4), the FY 2025 levels listed below are flatlined at the FY 2024 levels plus indefinite authority when needed.

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

Federal Contribution for SMI:

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

The FY 2026 estimated request of $464.8 billion is a net increase of $50.1 billion over the FY 2025 estimate of $414.7 billion, which included $40.7 billion of indefinite authority.

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 2026 estimated request of $41.0 million for Hospital Insurance for Uninsured Federal Annuitants is a net decrease of $3.0 million from the FY 2025 amount of $44.0 million. The Medicare-eligible retirees are no longer growing, therefore less funding is needed.

Program Management Administrative Expenses:

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

The FY 2026 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 2026 budget estimate of $127.012 billion for General Revenue for Part D (Benefits) is a net decrease of $17.4 billion over the FY 2025 amount of $144.4 billion, which included $43.6 billion of indefinite authority. This decrease is due to the manufacturing discount program (MDP) which replaced the coverage gap discount (CGD) starting in 2025. The MDP cost savings operates on a delay and will not take effect until FY 2026.

The FY 2026 budget estimate of $586.0 million request for General Revenue for Part D Federal Administration is a net increase of $63.0 million over the FY 2025 amount of $523.0 million. This is due to an increase of the Social Security Administration's calculation for Part D share of the Limitation on Administrative Expenses (LAE).

The FY 2026 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 2026 budget estimate of $377.0 million for reimbursement of HCFAC is a net increase of $2.0 million over the FY 2025 amount of $375.0 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 2026 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
Budget Authority by Activity
(Dollars in Thousands)

	FY 2024 Final	FY 2025 Estimate	FY 2026 President's Budget	FY 2026 +/- FY 2025
Supplementary Medical Insurance (SMI)	$373,973,000	$373,973,000	$464,796,000	**$90,823,000**
Indefinite Annual Appropriation, SMI	$8,842,583	$40,727,000	$0	**($40,727,000)**
Hospital Insurance for Uninsured Federal Annuitants	$44,000	$44,000	$41,000	**($3,000)**
Program Management Administrative Expenses	$1,000,000	$1,000,000	$1,000,000	**$0**
General Revenue for Part D Benefit	$100,805,000	$100,805,000	$127,012,000	**$26,207,000**
Indefinite Annual Appropriation, Part D Benefits	$22,628,429	$43,563,000	$0	**($43,563,000)**
General Revenue for Part D Federal Administration	$523,000	$523,000	$586,000	**$63,000**
Part D: State Low Income Determination	$5,000	$5,000	$5,000	**$0**
Reimbursement for HCFAC	$375,000	$375,000	$377,000	**$2,000**
Total Budget Authority	**$508,196,012**	**$561,015,000**	**$593,817,000**	**$32,802,000**

Funding History

Fiscal Year	Amount
FY 2022	$497,862,000,000
FY 2023	$557,729,683,000
FY 2024 Final	$508,196,012,000
FY 2025 Estimate	$561,105,000,000
FY 2026 President's Budget	$593,817,000,000

Permanent Budget Authority
(Dollars in Thousands)

	FY 2024 Final	FY 2025 Estimate	FY 2026 President's Budget	FY 2026 +/- FY 2025
Tax on OASDI Benefits	$39,794,000	$41,335,000	$51,273,000	**$9,938,000**
HCFAC, FBI	$168,347	$173,565	$177,905	**$4,340**
HCFAC, Asset Forfeitures	$193,473	$35,000	$36,000	**$1,000**
HCFAC, Criminal Fines	$1,932	$18,431	$21,809	**$3,378**
HCFAC, Civil Penalties and Damages: Administration	$18,584	$39,475	$41,833	**$2,358**
Total Budget Authority	**$40,176,336**	**$41,601,471**	**$51,550,547**	**$9,949,076**

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

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

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 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
Discretionary	**$915,000**	**$941,000**	**$941,000**	**$0**
CMS	$675,058	$699,058	$699,058	$0
HHS-OIG	$107,735	$108,735	$108,735	$0
DOJ	$132,207	$133,207	$133,207	$0
Mandatory	**$1,599,895**	**$1,648,828**	**$1,690,182**	**$41,354**
CMS	$1,076,310	$1,109,012	$1,136,870	$27,858
HHS-OIG	$236,276	$243,601	$249,691	$6,090
HHS Wedge	$45,191	$46,592	$47,756	$1,164
DOJ Wedge	$73,772	$76,059	$77,960	$1,901
FBI	$168,347	$173,565	$177,905	$4,340
Program Level	**$2,514,895**	**$2,589,828**	**$2,631,182**	**$41,354**

Allocation Method – Other

Program Description and Accomplishments

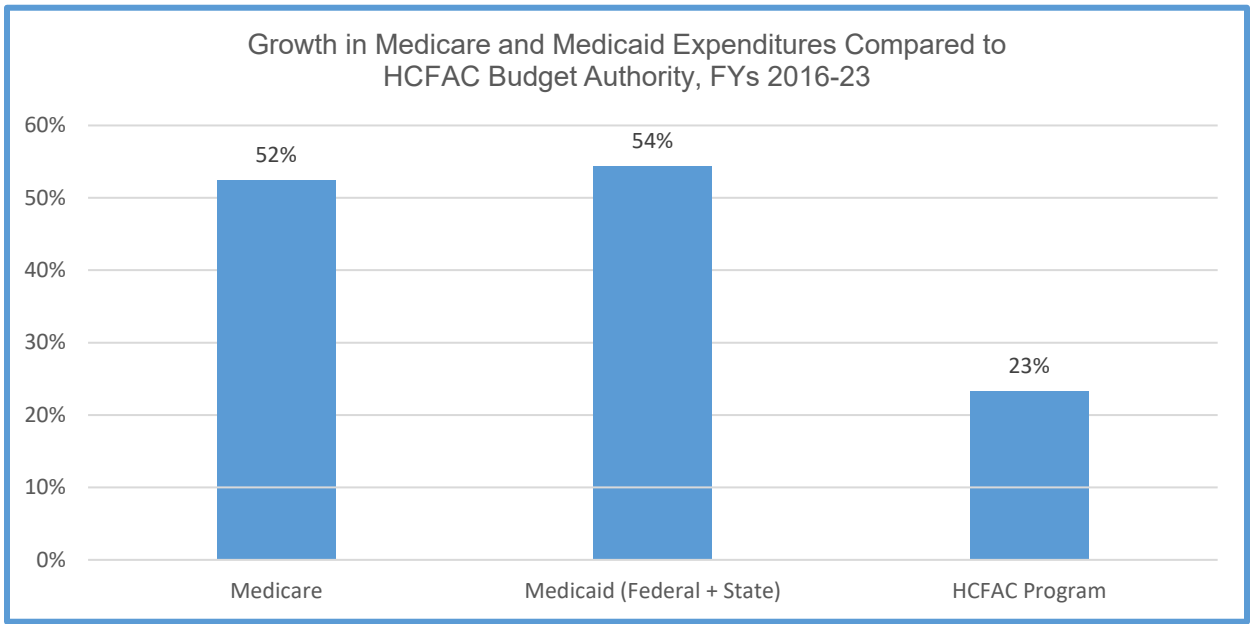
The Health Care Fraud and Abuse Control (HCFAC) program supports Federal efforts to detect, prevent, and combat health care fraud, waste, and abuse. The HCFAC account provides resources to the HHS Office of Inspector General (HHS-OIG), the U.S. Department of Justice (DOJ), and CMS to coordinate oversight 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 healthcare to Americans.

Discretionary HCFAC resources have proven indispensable in the fight against health care fraud, delivering billions in recoveries and safeguarding program integrity. The FY 2026 discretionary investments will intensify enforcement actions, strengthen fraud prevention technologies, and fortify the Medicare, Medicaid, and Exchange programs. These enforcements protect both taxpayer dollars and vulnerable beneficiaries from exploitation.

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

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

Growth in Medicare and Medicaid expenditures has outpaced growth in HCFAC funding over the last eight years, creating a widening gap in our ability to safeguard public funds and promote the sustainability of federal health care programs. Continued investment in the HCFAC program is critical to preventing improper payments and addressing the challenges posed by bad actors.



Source: National Health Expenditure Data taken from CMS website. Note that the HCFAC Program figure is based on the fiscal year while the expenditures data is based on the calendar year.

Crushing Fraud, Waste, and Abuse

Health care fraud encompasses a variety of sophisticated and evolving schemes that jeopardize program integrity and patient safety. Common schemes include:

- Medical identify theft
- Upcoding (billing for more expensive services than those actually provided)
- Phantom billing for services that were never rendered
- Kickbacks for referrals

Fraud, waste, and abuse present risk throughout the entire health care system. Recently, fraud has been identified in hospices, genetic testing, and medical supplies. These schemes drain resources from health care programs annually but also compromise patient safety and impact the sustainability of health care resources for those who truly need them.

CMS is taking action to respond to these threats. In April 2025, CMS established the Fraud Defense Operations Center (FDOC) pilot, also known as the “fraud war room,” to integrate cross-functional expertise through the creation of a specialized team of data analysts, investigators, health policy experts, legal advisors, and law enforcement. The FDOC employs data-driven analytics to proactively detect, address, and prevent fraud, waste, and abuse in real time. This pilot tested a data-driven approach to safeguard beneficiaries and protect taxpayer resources by analyzing investigative leads through rigorous data analysis and facilitate real-time engagement with subject matter experts and key federal stakeholders. Using this approach over a six-week period, the team assessed 106 providers and coordinated timely intervention on 76 providers, ensuring $90 million of potentially improper payments were prevented from going

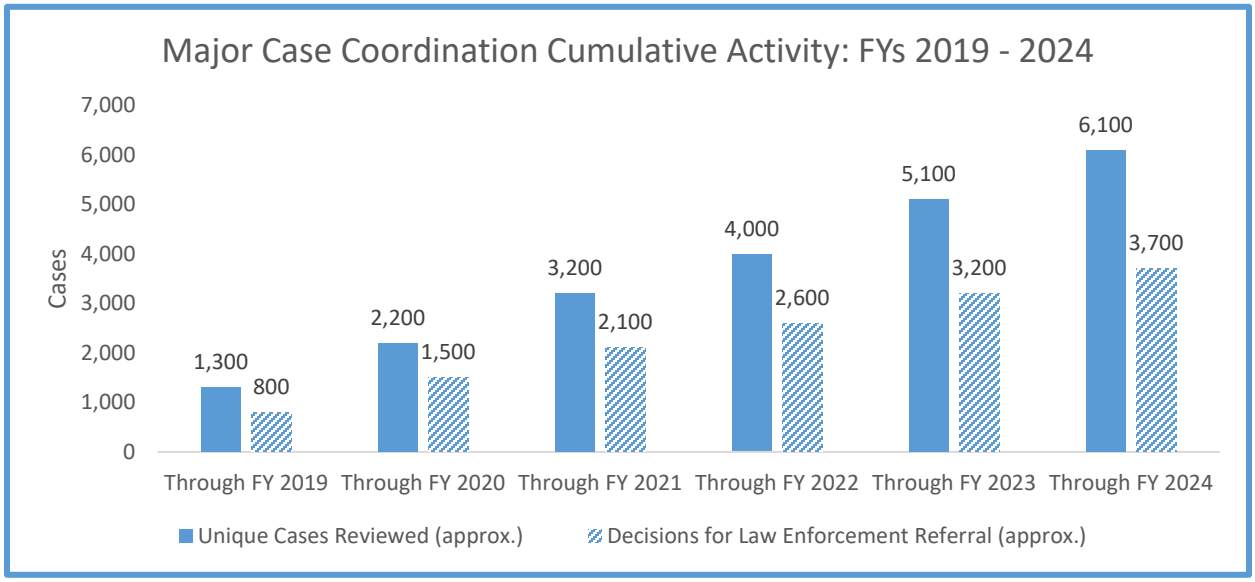
out the door and that other appropriate actions were taken before additional financial losses were incurred.

In addition, CMS is aggressively modernizing the tools it uses to reduce fraud, waste, and abuse. Artificial intelligence (AI), machine learning, and similar technologies continue to improve, and CMS likewise 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

CMS works with its law enforcement partners who take a lead role in investigating and prosecuting alleged fraud. CMS has pursued this through participating in the Health Care Fraud Strike Force teams, which investigate and track down individuals and entities that are defrauding Medicare and other government health care programs. From FY 2020 to FY 2023, Strike Force prosecutors have charged more than 1,600 defendants who have collectively billed federal health care programs and private insurers approximately $12.5 billion.

CMS also coordinates with its law enforcement partners through the Major Case Coordination (MCC) initiative, which provides a forum for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and CMS fraud investigators to collaborate before, during, and after the development of fraud leads. CMS leverages its program integrity contractors and systems to develop many of these fraud leads.



The Federal partners target areas with high incidence of fraud to carry out synchronized efforts to reduce fraud and recover taxpayer dollars. Together, activities like CMS' enhanced provider screening and fraud prevention activities; HHS-OIG's investigative, audit, evaluation, and data analytic work; and DOJ's investigative and prosecutorial actions and tougher sentencing guidelines, root out existing fraud and abuse while acting as a deterrent for potential future bad actors. HCFAC investments in law enforcement collaboration continue to demonstrate positive results, yielding a $2.80 to $1.00 return on investment for these efforts over a three-year period

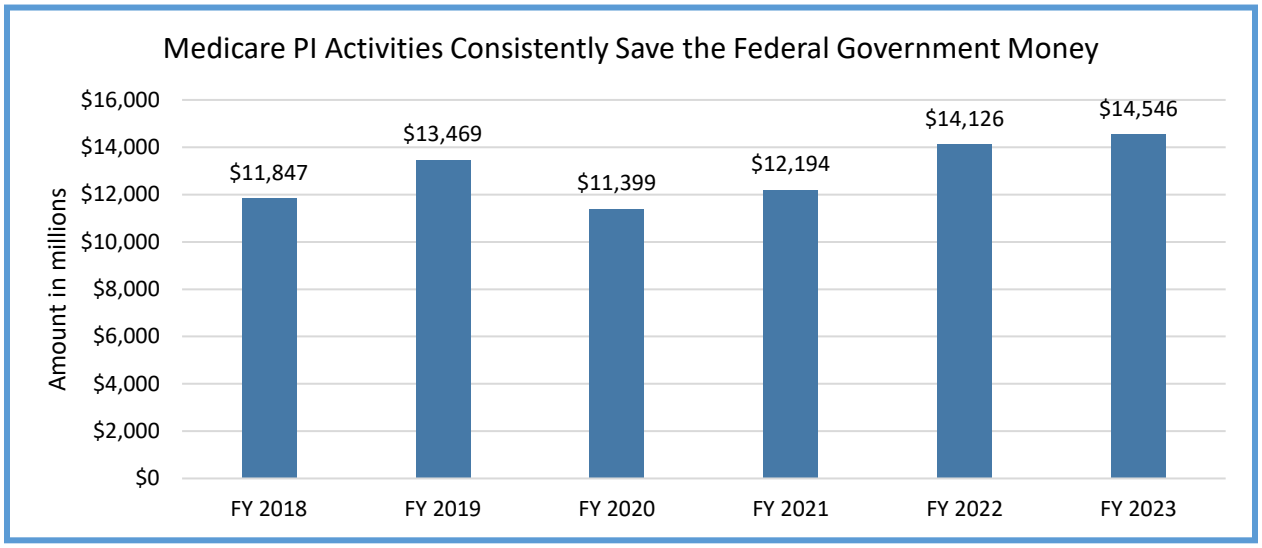
(2021-2023).[2] The return on investment continues to be adversely impacted by unique factors associated with the COVID-19 pandemic, such as court closures as well as interrupted or slowed enforcement activities.

Medicare Integrity Program

Medicare is one of the nation's largest, most complex health programs. Medicare processes over one billion fee-for-service claims annually, even as enrollment continues to shift towards managed care. Total Medicare spending reached $1.0 trillion in Calendar Year 2023. The program has continually been on the Government Accountability Office's (GAO's) High Risk List, with an estimated $54.3 billion in improper payments across Medicare Fee-for-Service, Part C, and Part D in FY 2024.

Using the resources and authorities provided by Congress, CMS has developed a comprehensive program integrity framework that addresses Medicare fraud, waste, abuse, and improper payments. CMS employs a number of tools to safeguard the CMS health programs, including, but not limited to, provider enrollment 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 Medicare Integrity Program, Medi-Medi, and discretionary HCFAC resources as well as provider enrollment user fees.[3]



CMS' Medicare savings greatly exceed its annual program integrity spending. In FY 2023, CMS' Medicare program integrity activities produced a return on investment of $8.3 to $1.

[2] Developed in 1997, the HCFAC return-on-investment does not include some recoveries related to pertinent Medicare Part C and Part D enforcement actions. These recoveries may be incorporated into the ROI in future years.

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

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

Medicaid Program Integrity

Medicaid is one of, if not the, largest budget items for nearly every state. Fraud, waste, and abuse contribute to the high costs of health care, stealing money from beneficiaries as well as taxpayers and leading to higher costs. CMS and its federal partners are dedicated to safeguarding our Nation's most vulnerable individuals from those who seek to exploit the health care system.

Medicaid is a federal-state partnership, and this partnership is central to the program's success. 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. In FY 2024, 86.5 million beneficiaries were enrolled in Medicaid for the equivalent of a full year. As with Medicare, Medicaid has continually been on GAO's High-Risk List, with an estimated $31.1 billion in improper payments in FY 2024.

HCFAC funding allows CMS to address Medicaid program integrity through oversight, data analytics, and education/technical assistance. CMS continues to collect and analyze state data through the Transformed Medicaid Statistical Information System (T-MSIS), which is being used for new efforts to detect fraud, waste, and abuse. CMS exercises appropriate oversight over Medicaid expenditures as well as states' enterprise systems. HCFAC funding also supports efforts to measure improper payments through the Payment Error Rate Measurement (PERM) program. In addition to HCFAC funding, CMS conducts its Medicaid program integrity efforts using Medicaid Integrity Program resources.[4]

Exchange Program Integrity

The Health Insurance Exchanges are important avenues for individuals and families to obtain private market health insurance coverage and get financial assistance in the form of advance premium tax credits (APTCs) to help pay for insurance premiums. This program is threatened by various forms of misconduct, particularly unauthorized enrollment and plan changes by agents and brokers.

CMS investigates complaints and leads from health insurance issuers and other partners to protect consumers. Through the use of data analytics, CMS supports and prioritizes investigations that aim to safeguard the integrity of the Federally-Facilitated Exchange (FFE) and expenditures of federal dollars. And CMS annually measures and reports the estimated improper payments for the APTC program in the FFE.

[4] Deficit Reduction Act of 2005, Public Law 109-171.

Funding History

Fiscal Year	Amount[5]
FY 2022 Final	$2,311,989,000
FY 2023 Final	$2,415,894,000
FY 2024 Final	$2,514,895,000
FY 2025 Enacted	$2,589,828,000
FY 2026 President's Budget	$2,631,182,000

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

Budget Request: $941.0 Million

The FY 2026 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2026 request for discretionary funding is $941.0 million, the same as the FY 2025 Enacted level. The total post-sequester FY 2026 mandatory funding level is $1,690.2 million, $41.4 million above the FY 2025 Enacted level.

The FY 2026 budget assumes discretionary HCFAC spending will continue over the 10-year budget window through dedicated program integrity discretionary investments, pursuant to the Congressional Budget Act in the Congressional Budget Resolution. Of the $941.0 million in discretionary HCFAC funding for FY 2026, $630.0 million is additional new budget authority. The table below shows the projected total and net savings from these dedicated discretionary investments over the 10-year budget window.

HCFAC Discretionary Investments and Savings
(Dollars in Millions)

	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
HCFAC Discretionary Investments (BA) [Non-add]	*$630*	*$656*	*$683*	*$711*	*$740*	*$770*	*$802*	*$835*	*$869*	*$905*
HCFAC Discretionary Investments (Outlays)	$484	$662	$691	$718	$749	$779	$812	$844	$879	$914
Federal Health Care Savings from HCFAC Discretionary Investments	-$1,194	-$1,281	-$1,374	-$1,472	-$1,532	-$1,594	-$1,661	-$1,730	-$1,800	-$1,874
Net Federal Health Care Savings from HCFAC Discretionary Investments	-$710	-$619	-$683	-$754	-$783	-$815	-$849	-$886	-$921	-$960

[5] Includes both mandatory and discretionary HCFAC resources; mandatory amounts are net of sequester and reflect current law. These amounts do not include any carryover resources from prior fiscal years.
[6] 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.

The FY 2026 CMS allocation of the discretionary HCFAC request is $699.1 million, the same as the FY 2025 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 discretionary resources on activities such as prior authorization, artificial intelligence initiatives, provider enrollment modernization, program integrity efforts in the Exchanges, and Medicaid oversight.

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

Activity	FY 2024 Final	FY 2025 Enacted[7]	FY 2026 President's Budget
MAC Program Integrity Operations	$398,122	-	$436,000
Provider Enrollment & Screening	$90,056	-	$129,430
Technical Assistance, Outreach & Education	$85,259	-	$72,614
Medical Review	$104,527	-	$106,270
Medicare Secondary Payer	$94,068	-	$90,544
PI Investigation, Systems & Analytics	$344,112	-	$372,665
Audits & Appeals	$118,169	-	$143,168
Provider & Plan Oversight	$66,232	-	$48,551
Error Rate Measurement	$112,325	-	$90,315
Program Support & Administration	$338,495	-	$346,126
Total[8]	**$1,751,368**	**-**	**$1,835,928**

MAC Program Integrity Operations

CMS conducts many of its cornerstone program integrity activities through the Medicare Administrative Contractors (MACs).[9] The MACs are private health care insurers that have been awarded a geographical jurisdiction to process Medicare Part A and B medical claims or durable medical equipment claims for Medicare. In addition to their administrative role discussed in the Program Operations chapter, 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. The MACs play a key role in safeguarding Medicare from fraud, waste, and abuse as well as improper payments.

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

[7] Allocations for FY 2025 have not yet been determined.
[8] Totals reflect mandatory and discretionary resources; these amounts do not include any carryover resources. Activity amounts may not add due to rounding.
[9] As discussed in the Program Operations chapter, the MACs separately receive funding from the Program Management account to process FFS claims and support participating providers for all parts of Medicare.

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 2024, the MACs received and accepted 54,648 Medicare cost reports, which included initial as well as amended cost report filings; desk reviewed and tentatively settled 41,670 cost reports; and completed 448 audits.

Medical Review – The MACs perform medical review to identify and address improper payments through the analysis of Medicare Fee-for-Service (FFS) 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 2024, the MACs completed 538,167 medical record reviews.[10] Of these reviews, 162,688 (30%) 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 Medicare FFS Medical Review

Fiscal Year	Medical Review of Claims
2018	470,988
2019	462,029
2020	258,041
2021	25,500[11]
2022	429,393
2023	530,218
2024	538,167

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.

Medical review improves compliance and results in savings; however, medical review also requires significant resources to conduct and there is a high volume of Medicare FFS claims each year. Many improper claims can be identified only by manually reviewing associated medical records and a beneficiary's claim history and exercising clinical judgment to determine whether a service is reasonable and necessary. Significantly less than one percent of Medicare claims undergo manual reviews.

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

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

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 serves as the critical first line of defense in protecting Medicare and Medicaid program integrity, establishing a robust screening process that prevents ineligible providers and suppliers from accessing these federal healthcare 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.

At the heart of this process is the Provider Enrollment, Chain, and Ownership System (PECOS), which functions as the system of record for all Medicare provider and supplier enrollment data across Part A, Part B, and DME. This centralized platform not only stores comprehensive provider information and tracks MAC processing activities but also supports mission-critical claims payment systems. Through data-sharing initiatives, state Medicaid programs leverage this robust infrastructure to enhance their own provider screening efforts. In FY 2024, PECOS maintained more than 2.9 million approved enrollments.

In addition to PECOS, the Advanced Provider Screening (APS) system provides a more sophisticated layer of protection. 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 2024 alone, APS resulted in more than 22 million screenings which generated more than 49,000 potential licensure alerts and more than 3,800 criminal alerts for potentially fraudulent providers and suppliers for further review by CMS. Such review resulted in approximately 250 criminal revocations, 212 licensure revocations, and more than 41,000 licensure deactivations.

For Medicaid specifically, the Data Exchange (DEX) system facilitates the sharing of provider termination and revocation data among CMS and state programs, maintaining a centralized repository accessed by all 50 states, the District of Columbia, and Puerto Rico. In FY 2024, states submitted 1,850 termination records through DEX.

Budget Request: $55.7 Million

The discretionary request for Provider Enrollment & Screening activities is $55.7 million. In addition, CMS will utilize $73.7 in mandatory resources. Funding will support ongoing operations for multiple systems, including PECOS, APS, and the DEX system. 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).

In FY 2026, CMS plans to resume modernization of PECOS, which has been paused to give CMS time to evaluate and implement the best technical approach moving forward. CMS is committed to improving the provider enrollment experience.

Technical Assistance, Outreach & Education

Effective outreach and education initiatives serve as critical components of CMS' comprehensive program integrity strategy, helping 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 further strengthens to reduce improper payments and prevent fraud, waste, and abuse through a multi-faceted approach to reach beneficiaries, state Medicaid agencies, and other 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.

Healthcare Fraud Prevention Partnership

CMS maintains key relationships with relevant federal and state agencies, and other stakeholders impacted by CMS' program integrity activities. 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. To achieve its objectives, the HFPP uses a Trusted Third Party (TTP), a CMS contractor, to act as a "common data aggregator" under the HIPAA Privacy Rules and as well as to support HFPP initiatives that fall under the Consolidated Appropriations Act of 2021. The HFPP allows for the exchange of data and information, leveraging various analytic tools using claims and other data provided by HFPP partners, and providing a forum for leaders and subject matter experts to share successful practices and effective methodologies. As of April 2025, the HFPP has a broad membership comprised of 310 Partners.

Medicare Beneficiary Outreach

In addition to the provider outreach as part of the MACs' core operations, CMS supports initiatives designed to educate beneficiaries and protect them against health care fraud, waste, and abuse. The Fraud Prevention Campaign is a national outreach effort to increase the awareness of fraud in the Medicare program and provide beneficiaries with tools to protect themselves. In FY 2026, CMS plans to reach the Medicare audience across a media mix of broadcast and digital advertising.

Additionally, the Senior Medicare Patrol (SMP) program provides more direct engagement with Medicare beneficiaries.[12] The mission of the SMP program to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. In calendar year 2023, SMP activities reached an estimated 1,244,697 people through 22,356 group outreach and education events and held 270,348 individual counseling sessions with, or on behalf of, Medicare beneficiaries.

Medicaid Systems Technical Assistance

CMS provides over $10 billion annually in federal financial participation for state Medicaid systems that determine Medicaid beneficiary eligibility, screen and enroll providers, and pay enrolled providers' claims, which are critical to reducing fraud, waste, and abuse. CMS

[12] The SMP program will be administered by the Administration for Children and Families (ACF) in FY 2026, reflecting the planned HHS reorganization. The budget requests $35.0 million in FY 2026.

supports an outcomes-based oversight model for states' Medicaid enterprise systems and provides technical assistance to states during development and implementation in accordance with regulatory and sub-regulatory guidance. This methodology allows CMS to ensure funding for information technology systems is closely aligned with, and in support of, the state Medicaid and Children's Health Insurance Program (CHIP) programs to ensure federal dollars are spent appropriately. This funding will also support the operation and further enhancement of the oversight model, including design and prototyping of business processes, reports, statistics, and data analytics. This activity reduces costs and risks, improves data accuracy, shortens development timelines, and more effectively manages these expenditures.

Budget Request: $63.9 Million

The discretionary request for Technical Assistance, Outreach & Education activities is $63.9 million. In addition, CMS will utilize $8.7 million in mandatory resources. This funding covers ongoing activities and reflects contract efficiencies resulting from certain work being de-scoped and others being in-sourced.

Medical Review

Medical review (MR) serves as a frontline defense against fraud, waste, and abuse as well as improper payments. MR ensures that payment is made only for services that meet all Medicare coverage, coding, and medically necessary requirements.

This detailed examination helps identify potential billing errors, whether intentional or unintentional, before they result in improper payments. MR activities can be conducted pre-payment or post-payment and concentrate on areas identified through a variety of means, including targeted data analysis, Comprehensive Error Rate Testing (CERT) results, and oversight agency findings that indicate questionable billing patterns.

These activities improve compliance and result in savings; however, they also require 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, complex MR is conducted on less than one percent of all Medicare FFS claims.

CMS will continue to test and implement AI initiatives that create efficiencies in Medicare FFS medical review and prior authorization. These efficiencies include, for example, tabulation of the medical record to make it easier for clinicians to read, and conversion of unstructured documentation to a structured format that allows it to be searchable and machine readable. This also includes the capabilities for AI to review medical records and make a recommendation regarding payment. If successful, these initiatives could reduce the time necessary to complete MR 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.

In addition to the MR work performed by the MACs, the Supplemental Medical Review Contractor (SMRC) conducts nationwide MR of Medicare claims as directed by CMS. The SMRC supports Specialty Reviews for issues identified by Federal agencies such as HHS-OIG, GAO, and other CMS groups, as well as Program Integrity Reviews that focus on ensuring claims and encounter data are paid correctly.

Prior authorization is a key corrective action towards lowering improper payments. For items and services subject to prior authorization, a request for provisional affirmation of coverage is submitted to the MACs for review before those items and services are furnished to the Medicare patient. 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' prior authorization efforts have grown substantially over the years, as 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. CMS has steadily increased the number of DMEPOS items subject to nationwide prior authorization over the years, from just two items in FY 2017 to 69 items in FY 2024. There are also 53 power mobility device accessories available for voluntary prior authorization. In FY 2020, CMS began requiring prior authorization for certain outpatient hospital department (OPD) services. As of FY 2024, there are 51 services included.

CMS' prior authorization efforts have demonstrated remarkable success, consistently delivering significant cost reductions for covered items and services. The impressive 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 2023
July 1, 2020: Blepharoplasty, Botulinum toxin injections, Panniculectomy, Rhinoplasty, and Vein ablation	27.1%
July 1, 2021: Implanted Spinal Neurostimulators and Cervical Fusion with Disc Removal	25.7%
DMEPOS Items	**Spending Decrease through FY 2023**
July 22, 2019: 5 Pressure Reducing Support Surfaces	37%
Sept. 1, 2020: 6 Lower Limb Prosthetics	14.6%
April 13, 2022: 5 Orthoses	52.2%

Budget Request: $68.3 Million

The discretionary request for medical review activities is $68.3 million. In addition, CMS will utilize $38.0 million in mandatory resources. This discretionary request includes ongoing operations for the SMRC, additional prior authorization on Medicare FFS claims,[13] AI efforts, and activities to reduce the error rate.

This funding will also support the Medical Review Accuracy Contractor, which conducts MR of review determinations made by the MACs and the SMRC. The results allow CMS to develop an accuracy score for each contractor and determine where inconsistencies may exist. In FY 2024, the MRAC completed 9,471 standard workload claim reviews with a standard accuracy review percentage of 98.9 percent.

[13] Most prior authorization is funded out of the MAC Program Integrity Operations amount. Note that HCFAC funding does not cover the Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model or the Review Choice Demonstration for Home Health Services (HH RCD).

This funding will also support operations for the National Correct Coding Initiative for Medicare and Medicaid as well as systems operations the Services Tracking Analysis and Reporting System (STARS), and the Electronic Submission of Medical Documentation System (esMD) system.

Medicare Secondary Payer

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

In FY 2026, this activity will be funded with $90.5 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 annual operations include approximately 11 million phone calls, 21 million letter prints, and 3.6 million letter pieces.

PI Investigation, Systems & Analytics

CMS aggressively combats fraud, waste, and abuse through a formidable network of specialized contractors and cutting-edge technical systems. This sophisticated, multi-layered defense system identifies suspicious patterns, swiftly investigates violations, takes immediate administrative actions against offenders, and delivers solid cases to law enforcement. By strategically combining expertise with advanced analytics and state-of-the-art technology, CMS has established a protective shield that safeguards federal health care programs while reducing provider burden, enforcing contractor accountability, revolutionizing data capabilities, and ensuring program oversight across Medicare, Medicaid, and the Exchanges.

Fraud, Waste, and Abuse Detection and Investigation

Unified Program Integrity Contractors (UPICs) stand as the vanguard of Medicare and Medicaid program integrity across five strategic jurisdictions throughout the United States. The UPICs execute reviews of claims payments, ensuring compliance with coverage coding regulations and policies. UPICs conduct audits and investigations that form the foundation of CMS' program integrity arsenal. Their efforts identify, and correct fraud, waste, and abuse across both Medicare and Medicaid programs.

The Medicare Drug Integrity Contractors (MEDICs) deliver targeted enforcement in Medicare Part C and Part D through two entities. The Investigations MEDIC (I-MEDIC) aggressively pursues investigations, often resulting in revocations and the delivery of compelling case referrals to law enforcement, generating 989 investigations and 132 law enforcement referrals in FY 2024 alone. The Plan Program Integrity MEDIC (PPI MEDIC) conducts penetrating analysis of Part C and D data, implements rigorous audits of plan sponsors, and delivers authoritative education and outreach support, executing numerous Self-Audits, National Audits, and Program Integrity Audits that ensure compliance across Medicare's managed care programs.

CMS operates multiple integrated systems that support fraud detection and investigation, with the Fraud Prevention System (FPS) serving as the center of these efforts. FPS uses advanced predictive analytics to assess Medicare FFS claims both pre- and post-payment, identifying irregular billing patterns, flagging high-risk providers, and prioritizing investigations. CMS has developed 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.

Beyond FPS, CMS maintains a strategic network of systems that enhance CMS' abilities to combat fraud, waste, and abuse. The Unified Case Management (UCM) system allows CMS and its contractors to track leads, audits, and investigations across programs. The One PI system delivers centralized access to data from the Integrated Data Repository, enabling users to conduct comprehensive Medicare and Medicaid data analysis through a unified platform. The AI Innovation Lab, within the OnePI system, will also build on these successes through the development of AI use cases that focus on process optimization, burden reduction, and detection of fraud, waste and abuse.

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 aggressive action to combat threats to the integrity of federal health care programs.

Encounter Data System Program

MA organizations and Medicare-Medicaid Plans submit encounter data records (EDRs) to CMS via the Encounter Data Front-End System and the Encounter Data Processing System. In Calendar Year 2024, CMS collected and processed over 1.69 billion EDRs. 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.

Medicaid and CHIP Business Information Solution

The Medicaid and CHIP Business Information Solution (MACBIS) is an enterprise initiative providing tools and analytics to improve Medicaid and CHIP operations. It enables CMS, states, and researchers to analyze data for program integrity, monitoring, and evaluation. Funding supports the Medicaid and CHIP Program (MACPro) Portal, Transformed Medicaid Statistical Information System (T-MSIS), and data analytics efforts.

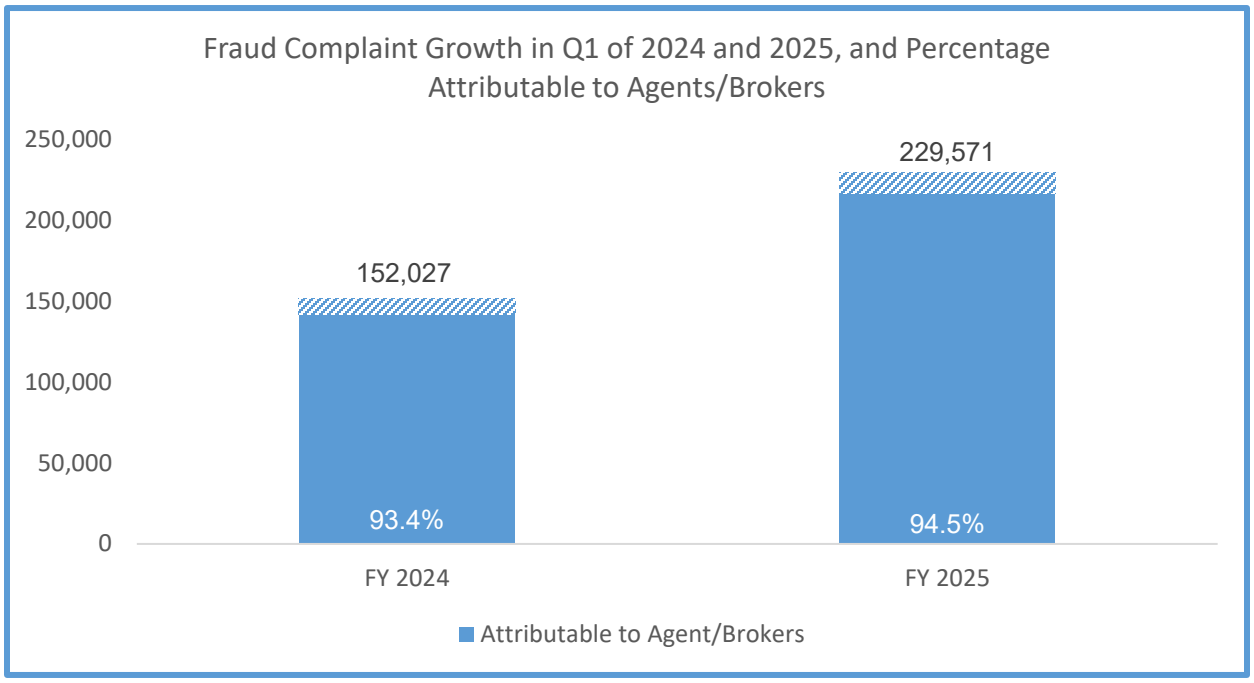
T-MSIS collects state beneficiary data, claims, and provider information from Medicaid and CHIP programs, supporting policy making, monitoring, reporting, and oversight. MACPro facilitates data collection and workflow for state plan amendments, waivers, and managed care contracts, allowing CMS to verify service delivery and cost data against T-MSIS or the Medicaid and CHIP Budget & Expenditure System. MACBIS efforts ensure that CMS has access to the most complete and accurate Medicaid data to support its oversight role.

Health Insurance Exchanges

CMS aggressively safeguards the Health Insurance Exchanges, or 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.



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.

Budget Request: $190.7 Million

The discretionary request for PI Investigation, Systems & Analytics activities is $190.7 million. In addition, CMS will utilize $182.0 million in mandatory resources. This funding supports ongoing operations for the activities discussed above, including the AI Lab initiative as well as AI enhancements to OnePI and FPS.

Audits & Appeals

Effective program integrity requires robust auditing mechanisms. CMS employs a multi-faceted auditing approach across the Medicare FFS, Medicare managed care, and Medicaid programs to ensure payment accuracy and appropriate service delivery to beneficiaries. These audit activities not only recover improper payments but also drive systemic improvements in health care delivery, ultimately protecting both beneficiary access to care and the financial

sustainability of these vital programs. Through specialized audits tailored to each program's unique structure, CMS maintains accountability while continuously refining oversight methods to address emerging risks in the evolving healthcare landscape.

Medicare FFS

While MACs conduct comprehensive reviews of all Medicare FFS cost reports as described earlier in this chapter, this section addresses complementary auditing activities, including appeals support, risk assessments, and change request processing. Additionally, CMS maintains responsibility for evaluating the performance of Medicare, Medicaid, and private plan sponsors in healthcare and prescription drug service delivery, ensuring beneficiaries receive the appropriate services these entities have been compensated to provide.

Medicare Managed Care

Ensuring the accuracy and integrity of MA risk adjustment data is critical for the future solvency of the Medicare Trust Funds. The MA Risk Adjustment Data Validation (RADV) program is CMS' primary way to address approximately $17 billion in overpayments made to MA organizations each year. After years of delays, CMS is working to expedite RADV audits so the agency will be current with its audits of prior payment years and new audits will be started as close to the most recent payment year as possible. CMS is also developing a strategy to make it more efficient at identifying overpayments while reducing agency burden by providing more effective oversight of the MA program.

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.

Recently, CMS has been focused on implementing the 2023 final rule,[14] which, among other provisions, established a methodology for extrapolating audit findings. In Fall 2024, CMS began collecting overpayments resulting from past CMS and HHS-OIG RADV audits and initiating RADV audits of additional MA payment years. Based on the data published in the RADV rule, CMS anticipates recovering approximately $425 million per year once extrapolated audits begin with the PY 2018 RADV Audits.

CMS further holds MA organizations fiscally accountable through cost report audits and financial audits (also known as one-third financial audits[15]). CMS audits managed care cost reports to ensure costs are allowable and in accordance with contract requirements and CMS regulations; this includes cost report examinations performed by independent audit contractors as well as medical review performed by medical coders. In addition, one-third financial audits scrutinize the financial records of MA organizations and PDP sponsors, including data relating to Medicare

[14] Medicare Advantage Risk Adjustment Data Validation Final Rule (CMS-4185-F2), published on Jan. 30, 2023.

[15] 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.

utilization, costs, and development of the bid. Prompt audits of the financial data permit CMS to evaluate and refine its plan oversight, which assures accurate bidding and enhances payment accuracy.

Finally, CMS conducts program audits to test whether MA organizations, PDPs, and Program for All-Inclusive Care for the Elderly (PACE) plans provided beneficiaries with the appropriate health services and medications as required under their contract with CMS. These audits help drive the industry towards improvements in the delivery of health services in the MA, Part D, and PACE programs. Recently, CMS began conducting utilization management criteria audits for MA organizations. These targeted audits will enable CMS to collect, review, and evaluate data regarding MA organizations' compliance with new utilization management requirements that were effective Calendar Year 2024.

Medicaid

CMS conducts targeted audits of Medicaid Managed Care Organizations' (MCOs') compliance with Medical Loss Ratio (MLR) requirements in high-risk states. This work includes conducting analyses to identify the states most at risk as well as reviewing the source data and documentation from the Medicaid MCOs and the state-reported data.

CMS reviews and analyzes findings from single state agency audits and HHS-OIG audits of state Medicaid and CHIP programs. Through improvements to its internal audit resolution process, CMS can obtain a global picture of audit results in Medicaid and improve its financial oversight through guidance on how to address audit findings and better target audit resources towards high-risk areas.

Appeals Initiatives

CMS appeals initiatives support efficient processing of appeals, which includes efforts to reduce reversal rates. 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 2,400 Administrative Law Judge (ALJ) cases, which affords the QICs additional rights to successfully defend a claim denial. Historically, the ALJ cases in which the QIC has participated as a party generally have lower ALJ overturn rates. In FY 2024, the estimated amount in controversy of dollars upheld or dismissed following QIC participation as a party was approximately $30.3 million.

Budget Request: $104.1 Million

The discretionary request for Audit & Appeals activities is $104.1 million. In addition, CMS will utilize $39.1 million in mandatory resources. CMS will continue its auditing functions and appeals initiatives in FY 2026, including IT operations for several supporting systems.

In FY 2026, RADV will focus on continuing the RADV audit acceleration strategy that is being implemented in FY 2025, which will include quicker processing of RADV appeals and collecting maximizing overpayments collected for completed audits.

CMS will perform approximately 250 financial audits, as well as work to resolve audit issues noted in the audit reports. To contain costs while ensuring appropriate oversight, CMS expects to conduct 23 program audits on MA organizations and PDP sponsors as well as meet statutory

requirements for PACE audits.

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

Provider & Plan Oversight

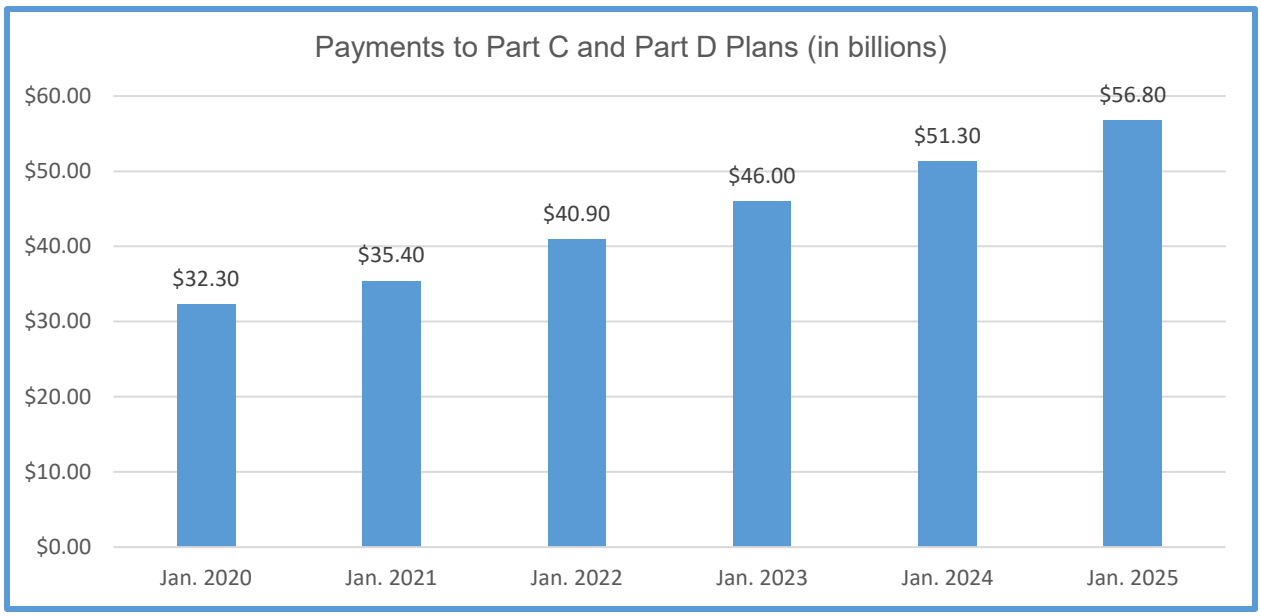
CMS promotes transparency by linking financial, programmatic, and performance data to push accountability and uphold program efficiency and effectiveness. These activities are also intended to help beneficiaries and consumers make informed decisions about their treatment based on knowledge gained through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

Open Payments

The Open Payments program is a statutorily required national disclosure program that promotes transparency and accountability by providing the public with information regarding the financial relationships between the health care industry (pharmaceutical and medical device manufacturers and their distributors) and health care providers (physicians, physician assistants, certain advanced practice nurses, and teaching hospitals). In Program Year 2023, reporting entities collectively reported $12.8 billion in publishable payments and ownership and investment interests. These payments are comprised of 15.6 million payment records attributable to 630,384 physicians, 309,438 non-physician practitioners, and 1,225 teaching hospitals.

Medicare Managed Care

CMS maintains a number of controls to ensure that Part C and Part D payments are correct. With Medicare enrollment shifting towards managed care in recent years, payments to plans have consistently increased (see table below). Oversight is more important than ever to ensure that these payments are accurate.



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. This work also includes validating and processing retroactive requests for enrollment and related transactions. CMS also maintains a tool that facilitates the reporting and returning of plan-identified overpayments.

In addition to payment controls, 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, marketing, formulary, and enrollment guidelines, and appeals processes. Analysis of annual plan benefit package submissions and performance and subsequent consequences of possible compliance actions drive improvements in the industry. These increase sponsors' compliance with core program functions in the Part C and Part D programs.

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 2020 to 2025 (see below).

Growth in MA Plans, FY 2016-2025

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Plans	3,568	3,656	4,063	4,885	5,674	6,308	6,899	7,350	7,276	7,135
Growth from Prior Year	N/A	2.5%	11.1%	20.2%	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 like Expanded Primarily Health Related Benefits, Uniformity Flexibility, and Special Supplemental Benefits for the Chronically Ill.

There is no indication that the growth of the MA program will stop, therefore, the need for accuracy in CMS' bid reviews will become even more critical. CMS will continue to review MA plan benefits and ensure they meet all regulatory and statutory requirements.

CMS also develops and collects MA Healthcare Effectiveness Data and Information Set measures for MA organizations and Special Needs Plans, and reviews and approves SNP models of care as required under 1859(f) of the Social Security Act. CMS evaluates the impact of agency guidance and regulations that could negatively impact the quality of care provided to beneficiaries. CMS also conducts actuarial review of bids submitted by plans and monitors the reasons beneficiaries leave their plans.

Medicaid

States are increasingly using Medicaid section 1115 demonstrations to innovate their programs, with applications rising 37 percent from 2020 to 2023 (162 to 222). Total state and federal outlays reached $270.7 billion in 2023, representing 31.7 percent of total Medicaid spending. As demonstrations become more complex, post-approval deliverables increased 47 percent (487 to 715). To address the corresponding program integrity risks, CMS is implementing a risk-based oversight strategy by better targeting resources at key program vulnerabilities; developing standardized performance assessment, reporting tools, and other strategies to examine those vulnerabilities; and applying them in an efficient and effective manner. CMS has also updated its approach to budget neutrality formulation and is providing technical assistance to states as well as conducting reviews of states' reported demonstration expenditures. CMS' oversight also ensures proper billing and rate reimbursement in Home and Community-Based Services (HCBS) waiver and state plan programs and improves oversight of rate setting and financial reporting for PACE. This includes, but is not limited to, ensuring that rates are financially sound, ensuring that states are in compliance with the HCBS assurances as defined in section 1915(c) of the Social Security Act, providing technical assistance, and the detection and prevention of fraud and abuse in the delivery of personal care and other HCBS services.

Budget Request: $35.1 Million

The discretionary request for Provider & Plan Oversight activities is $35.1 million. In addition, CMS will utilize $13.5 million in mandatory resources. Funding will maintain ongoing operations for these oversight activities. CMS expects to complete the Open Payments System's transition to Amazon Web Services in FY 2026, which would significantly reduce hosting and software costs.

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). Through this work, CMS better understands not only the amount of improper payments in its health care programs but also the drivers of those improper payments. [16]

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

Medicare

CMS annually estimates the Medicare FFS improper payment rate through the Comprehensive Error Rate Testing (CERT) program. The CERT program reviews a stratified random sample of Medicare FFS claims to determine if CMS properly paid claims under Medicare coverage, coding, and billing rules. In FY 2024, the improper payment rate was below 10 percent for the eighth consecutive year.

The CERT program provides valuable insight into the drivers of improper payments in Medicare FFS. While the factors contributing to improper payments are complex and vary by year, the primary causes continue to be insufficient documentation and medically unnecessary errors.

CMS also annually estimates the improper payment rates for the Part C and Part D programs. The Part C methodology estimates improper payments resulting from errors in beneficiary risk scores while the Part D methodology measures payment error relating to prescription drug event data. CMS has implemented policy and methodology refinements to improve the accuracy of these payment error estimates, resulting in better data to assist the agency in focusing efforts to reduce future improper payments.

Medicaid and CHIP

CMS annually measures the improper payment rates for Medicaid and CHIP through the Payment Error Rate Measurement (PERM) program. The PERM program uses a three-year, 17-state rotation, meaning each state is reviewed once every three years, and each cycle measurement includes one-third of all states. The improper payment rates are based on reviews of the FFS, managed care, and eligibility components of Medicaid and CHIP. The Medicaid and CHIP improper payment rate has consecutively decreased the past four years due to improved improper payment data and focused agency corrective actions on improper payment drivers.

The majority of Medicaid and CHIP improper payments are due to missing or insufficient documentation, such as states failing to provide documentation that required verifications of eligibility (e.g., income verification) were completed; or medical records were not submitted to support the medical necessity of the claim. Beyond insufficient documentation, the other area driving the Medicaid improper payment estimate is state non-compliance. This means that states did not comply with federal eligibility redetermination requirements; did not appropriately screen enrolled providers; paid providers that were not enrolled; or paid claims that lacked the required National Provider Identifier.

Exchanges

CMS annually measures the improper payment rate for the APTC program in the FFE. CMS reviews a statistically valid random sample of health insurance applications to determine if the FFE properly paid APTC benefits under the statutory and regulatory requirements relating to eligibility and payment determinations. This includes a statistical valid sample of 2,000 health insurance applications.

The causes of overpayments include manual administrative errors (88.84 percent of overpayments) and automated process errors (11.16 percent of overpayments) associated with determining consumer eligibility for APTC payments.

CMS continues to develop the improper payment measurement program for the State-Based Exchanges (SBEs). This includes working with the SBEs on improper payment pre-testing and assessment (IPPTA) activities. IPPTA is designed to prepare SBEs for the planned measurement of improper payments, create and test processes for procedures that support CMS' review of determinations of APTC made by SBEs, and to provide a mechanism for CMS and SBEs to share information that will aid in developing an efficient measurement process. SBEs were divided into two cohorts of states with requirements for each SBE to complete an IPPTA:

- Cohort A: 8 states (Jan. 2024 – Dec. 2025), and
- Cohort B: 11 states (Jan. 2025 – Dec. 2026).

Budget Request: $64.3 Million

The discretionary request for Error Rate Measurement activities is $64.3 million. In addition, CMS will utilize $26.0 million in mandatory resources. This funding supports ongoing operations for CMS' error rate measurement programs.

In FY 2025, the PERM program consolidated two contractors into one contract to reduce redundancies, which will increase efficiencies and cost savings going forward. The PERM program also descoped a variety of generally low risk tasks and will bring some work in-house.

In FY 2026, CMS will continue implementing and wrapping up IPPTA activities for both cohorts of states and development of the SBE improper payment measurement program.

Program Support and Administration

CMS depends on several programmatic and operational support activities that are critical to achieving the Agency's program integrity goals. These activities achieve economies of scale and allow for business owners to reuse existing processes to reduce cost.

Program Support

CMS utilizes a centralized vulnerability management process to identify, prioritize, track, and mitigate vulnerabilities that affect the integrity of federal health programs. The centralized component of this process, known as the Vulnerability Collaboration Council (VCC), is comprised of CMS leadership and subject matter experts that work collaboratively to identify and mitigate vulnerabilities in payment and coverage policies. The VCC uses a risk-based approach aligned with GAO's Fraud Risk Management Framework. In FY 2025, CMS is conducting program integrity risk assessments on Part C Capitated Payments, Part D Biologics, Biosimilars and Specialty Tier Drugs, and FFS Critical Access Hospitals.

CMS supports a number of efforts to support state Medicaid programs in reducing improper payments and promoting regulatory compliance. Funding will support the Agency's oversight of state Medicaid managed care programs and program monitoring. These funds will also support an analysis of managed care plans' subcontracting relationships, the creation and refinement of final reporting tools to identify remittances owed to the Federal Government, and program reporting tools to monitor critical program areas, including network and payment adequacy, sanctions, grievances and appeals, quality, and beneficiary support systems. Sustained funding will support the implementation of Medicaid managed care oversight reviews that will allow CMS to examine high-risk areas of regulatory compliance that directly impact the Medicaid managed

care enrollee experience and critical areas of program integrity. CMS will continue its efforts to reduce state errors relating to eligibility and enrollment policies.

CMS will also support drug pricing compliance efforts, primarily to implement the Misclassification of Drugs, Program Administration and Program Integrity Updates Under the Medicaid Drug Rebate Program (CMS-2434) Final Rule, released on September 20, 2024.

Technological Support

CMS maintains a robust technological foundation to support its program integrity initiatives through strategic investments in both infrastructure upgrades and ongoing operational support. This encompasses a comprehensive ecosystem of enterprise-level technology solutions, including specialized software licenses, systems, and data analytics support. By maintaining this technological infrastructure, CMS ensures the continuity of operations for its program integrity functions while providing the analytical capabilities needed to identify vulnerabilities, detect improper payments, and safeguard federal health care programs against fraud, waste, and abuse. CMS also utilizes specialized technical expertise to assist in developing a conceptual and technical vision for its program integrity data infrastructures and systems as well as to provide acquisition support.

Budget Request: $117.0 Million

The discretionary request for Program Integrity Support and Administration activities is $117.0 million. In addition, CMS will utilize $229.4 million in mandatory resources. This funding will support ongoing operations for program support and much of the technological infrastructure that underpins the Agency's program integrity efforts.

HCFAC funding will be allocated to support certain enterprise services that benefit the program, including shared IT services, HSPD-12, contract closeout support, and litigation and enforcement support from the Office of General Counsel.

Finally, mandatory funding will cover employee compensation and other 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. As described in the FY 2023 HCFAC Report to Congress, HHS-OIG's Medicare and Medicaid oversight efforts in resulted in 651 criminal actions against individuals or entities that engaged in crimes related to Medicare and Medicaid, and 733 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 2,112 individuals and entities from participation in Federal health care programs. For FY 2023, potential savings from legislative and administrative actions that were supported by HHS-OIG recommendations were estimated by third parties, such as the Congressional Budget Office or actuaries within HHS, to be $1.362 billion. HHS-OIG's expected recoveries from its involvement in health care audits and investigations totaled more than $3.35 billion.

Budget Request: $108.7 Million

The FY 2026 HHS-OIG discretionary request is $108.7 million, the same as the FY 2025 Enacted Level. In addition, mandatory resources total $249.7 million for a total operating budget of $358.4 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. DOJ also provides additional funding to the DOJ Office of the Inspector General for audits and investigations, and may provide additional funding to the FBI for Strike Force and other health care fraud investigations.

Budget Request: $133.2 Million

The FY 2026 DOJ discretionary request is $133.2 million, the same as the FY 2025 Enacted Level. In addition, mandatory resources total $78.0 million for a total operating budget of $211.2 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 55 field offices have personnel assigned to investigate health care fraud matters. FBI special agents, intelligence analysts, and professional staff members at headquarters and in the field, work proactively to identify and target health care fraud in all its forms. 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 2026 FBI budget includes mandatory resources in the amount of $177.9 million.

HHS WEDGE FUNDING

Program Description and Accomplishments

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

HHS Wedge Budget: $47.8 Million

For FY 2026, negotiated amounts are expected to be $47.8 million, not including carryover from the prior year, for HHS and $78.0 million for DOJ.

This page intentionally left blank.

Information Technology Strategic Transformation

Overview

The Centers for Medicare & Medicaid Services sits at the forefront of delivering high-value, accessible, and secure healthcare services for 170 million Americans. At a time when healthcare 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.

Strategic Alignment

This transformation supports important healthcare priorities that align with broader Health and Human Services objectives. At its core, CMS aims to ensure our most vulnerable Americans receive high-value care by leading all payors and supporting providers. Several key focus areas guide this mission:

1. Establishing excellence in payment systems and processes
2. Addressing fraud and reducing inappropriate spending
3. Providing beneficiaries with personalized, actionable health tools to support informed decision-making
4. Creating incentives for providers to deliver their best, data-driven care
5. Working collaboratively with stakeholders to better align spending and value

To support these important areas, we have prioritized resources to continue investments in People, Processes, and Technology. CMS is navigating transformation amid rising cybersecurity threats and an increasing need for, and demand of, artificial intelligence. The secure and uninterrupted delivery of Medicare, Medicaid, CHIP, Federal Exchange, and clinical quality programs relied upon by millions of Americans necessitates a strong CMS cybersecurity program. Additionally, providers and partners often encounter long wait times or inconsistent responses from help desks and support centers; AI tools can assist in delivering prompt, accurate answers. Critical networking and infrastructure software upgrades are essential to ensure the reliable operation of Medicare, Medicaid, and Program Integrity systems, especially as AI-driven demand for network and server capacity escalates. Having the top technical talent is critical to be able to deliver these initiatives. These upgrades enable CMS to meet increasing performance, security, and scalability requirements without interruption.

This is a crucial moment, and we cannot afford to wait. CMS must innovate and invest in emerging technologies, test and develop in areas like AI, and address challenges in high-risk areas such as cybersecurity where we face active threats. To achieve this, we need to reshape and transform the agency to be more agile and adaptable.

While we continue to perform our missions and serve the most vulnerable, we remain committed to providing high-value care to American citizens. We must lean into the challenges we face and embrace the opportunities for improvement.

CMS' FY 2026 IT strategy is not just about modernization, it's about 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 nine 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 healthcare 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 healthcare 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. **Create a Unified National Provider Directory for Healthcare Access** - *One Trusted Source for Provider Data*
   Creating a unified, authoritative directory to improve data quality and reduce provider burden nationwide.

8. **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.

9. **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.

The sections below discuss these nine focus areas.

I. Enhance Cyber Defense and Build Digital Resilience

The security of Medicare, Medicaid, CHIP, Federal Exchange, and clinical quality programs is paramount, as millions of Americans depend on these services. However, traditional security monitoring methods are reactive and siloed, which means they often fail to detect and respond to threats in a timely manner. This is particularly concerning given the increasing frequency and sophistication of cyber threats targeting healthcare systems.

To address these challenges, CMS is investing in a real-time threat detection and response platform. This platform will consolidate alerts, apply AI and behavioral analytics, and enable our cyber teams to act within seconds, not days. This approach is a core pillar of Zero Trust, providing continuous visibility across our hybrid environment, including cloud, data centers, and partner networks. It ensures we can detect anomalous behavior, lateral movement, and advanced persistent threats before they cause damage.

The investment in real-time threat detection is about mission assurance. It's how we protect the nation's health infrastructure in real time, ensuring that our programs remain secure and uninterrupted. This strategic investment will also enhance our ability to manage security alerts, reduce false positives, and allow our cybersecurity workforce to focus on more critical tasks.

Outcome: Proactive defense posture reduced false positives, lower incident response and recovery costs, stronger security across Medicare, Medicaid, CHIP, and Federal Exchange operations.

II. Enhance Fraud Prevention with Secure Identity and Data Analytics

The identity and access management approach at CMS currently operates through multiple systems with opportunities for greater integration. This structure results in extended processing times, duplicative efforts, and areas where security could be enhanced. Employees, partners, and beneficiaries may experience different access procedures across various systems, which can affect both operational efficiency and security measures.

CMS will implement a unified, enterprise-wide Identity, Credential, and Access Management (ICAM) platform to transform access and security. This critical upgrade will enable seamless, secure login for CMS employees, thousands of partners, and millions of beneficiaries. By providing consistent identity verification across all CMS systems, users will experience faster, more secure access, driving greater satisfaction and collaboration. Beyond a technology update, this is a vital mission infrastructure improvement that will streamline workflows, enhance security, and directly support CMS' core objectives. The new ICAM platform will automate access management, significantly reducing help desk tickets and streamlining onboarding and offboarding. This will enable CMS program administrators to focus on driving healthcare outcomes, innovation, and enhanced beneficiary services, rather than spending time on IT account management and security issues. Additionally, ICAM is a cornerstone of CMS' Zero Trust strategy, ensuring that only authorized individuals access critical resources, preventing unauthorized access, and ensuring full compliance with security mandates.

Investing in the ICAM platform is vital for building trust, reducing friction, and enabling secure scalability. It is not just an IT upgrade; it's critical to the enhancement to CMS' mission infrastructure. It will streamline processes, bolster security, and deliver a more efficient, consistent user experience, empowering CMS to operate more effectively and securely at scale.

To combat fraud and improve operational efficiency, CMS will leverage advanced analytics and intelligence systems to monitor payments in real time, prevent improper payments, and safeguard trust in federal healthcare programs. By using AI to detect anomalies in Medicare payments, we aim to improve data accuracy and ensure taxpayer dollars are used effectively, all while maintaining high-quality care. Simultaneously, CMS will continue to modernize its Medicare claims processing systems to support these advanced fraud prevention capabilities and build a more secure, efficient, and trusted healthcare infrastructure.

Outcome: Reduced fraud, faster access to systems, and unified, secure user experience for staff, providers, and partners.

III. Streamline and Modernize Medicare Claims for Faster Processing

The Medicare Payment Systems Modernization (MPSM) initiative is transforming Medicare's fee-for-service claims processing systems to support CMS' strategic priorities: addressing systemic challenges, accelerating the shift to value-based care, and ensuring long-term sustainability through responsible stewardship of public funds.

Building on recent successes such as launching a cloud-based dental claims processing system and developing streamlined reporting tools for Medicare Administrative Contractors (MACs) that significantly reduced data access times, CMS is expanding its modernization efforts to further improve efficiency, scalability, and service delivery. Current priorities include migrating core payment systems to the cloud, standardizing workflows across contractors, modernizing Medicare Part B appeals processing, and implementing real-time claims data analysis capabilities. These enhancements are essential to delivering faster, more accurate claims processing, improving payment integrity, and supporting advanced analytics for informed policy and operational decision-making.

Building on recent modernization efforts, CMS will leverage automation and AI to transform claims processing. These technologies will drive greater efficiency, enhance payment integrity, and enable a more scalable and resilient system architecture. By reducing manual interventions and accelerating access to actionable data, CMS is strengthening policy feedback loops and supporting the shift to innovative payment models that reward value over volume. These advancements are not isolated improvements; they are laying the groundwork for enterprise-wide AI adoption and a smarter, more agile CMS.

Outcome: Lower operational costs, improved payment accuracy, and scalable architecture to support future growth.

IV. Leverage AI to Drive Productivity and Data Insights

CMS is building on its modernization progress to address persistent operational challenges such as long help desk wait times, inconsistent support, manual workflows, and maturing our AI infrastructure. To overcome these barriers, we are making strategic investments to develop a secure, enterprise-wide AI infrastructure and launch an AI Lab staffed with expert talent. This will support the deployment of AI-powered virtual assistants and chatbots across support centers and deliver workforce training in prompt engineering and applied AI.

We are also upgrading our business intelligence capabilities to replace outdated technologies, increase efficiency, and align with government-wide modernization goals. These efforts will enable CMS to deliver fast, accurate, 24/7 responses to provider inquiries, reduce call volumes and resolution times, ensure centralized governance for responsible AI use, and build agency-wide fluency in AI applications. To fully realize these benefits, CMS is prioritizing data consolidation and interoperability which are essential foundations for scaling AI innovation in alignment with federal guidelines. To fully leverage AI capabilities, we must mature our fragmented data landscape through consolidation and improved interoperability.

Outcome: Streamlined operations, better customer service, and accelerated innovation aligned with federal AI strategy.

V. Unify Data and Drive Seamless Interoperability

CMS currently maintains over 15 different data repositories, creating siloed data that impedes innovation, increases costs, and creates inconsistent views of healthcare information. Our strategic investments will consolidate multiple databases into the Integrated Data Repository (IDR), enhance data integration capabilities, and create a single source of truth for operations and decision-making. This consolidation enables seamless data sharing across the healthcare ecosystem, provides a foundation for advanced analytics and AI applications, improves data quality and consistency, and enhances program integrity through comprehensive data visibility.

CMS aims to modernize the nation's digital health ecosystem, with a strong focus on empowering Medicare beneficiaries through improved access to innovative, patient-centered technologies. In collaboration with the Assistant Secretary for Technology Policy, CMS is actively engaging the public to inform a seamless, secure, and interoperable digital health infrastructure**.** This initiative aims to unlock the full potential of modern technology, helping seniors and their families take control of their health, better manage chronic conditions, and access care more efficiently. This is enabled by investments in cloud migration, AI, data consolidation, and interoperability**.** To successfully deliver on these goals, CMS must attract and retain top-tier technical talent capable of driving secure, scalable digital infrastructure across a complex healthcare environment. Continued investment in this workforce is essential to realizing a future-ready, accessible digital health system that benefits beneficiaries and ensures the long-term sustainability of federal healthcare programs.

Outcome: A single source of truth enabling faster decisions, deeper insights, and stronger cross-program coordination.

VI. Build and Empower a Modern Federal Health IT Workforce

CMS is aligning its technical talent strategy with the agency's broader modernization priorities to ensure we have the internal capabilities to meet our software engineering, programming, and cybersecurity needs. By shifting focus from costly external contracts to building a robust in-house workforce, CMS will not only enhance technical expertise but also generate long-term savings for taxpayers.

To support this transformation, CMS is prioritizing the recruitment, development, and retention of top-tier technical talent. Building strong, self-sustaining internal capabilities will reduce reliance on contractors, preserve institutional knowledge, and ensure the consistent and efficient execution of strategic initiatives. This investment in insourced expertise enables CMS to implement cutting-edge technologies, maintain continuity across mission-critical projects, and increase agility in responding to evolving needs. This shift supports a broader strategy to invest in people over contracts, by reskilling and upskilling existing staff and recruiting top-tier talent in areas essential to CMS' evolving mission. By building internal capacity, CMS not only enhances program efficiency and stewardship of taxpayer dollars, but also strengthens its ability to deliver on complex, high-impact initiatives such as the National Provider Directory. This investment in a modern, capable federal workforce lays the foundation for sustainable innovation and mission excellence in the years ahead.

Outcome: Sustainable in-house talent base aligned with CMS priorities, saving costs and preserving institutional knowledge.

VII. Create a Unified National Provider Directory for Healthcare Access

CMS is advancing plans to establish a unified National Provider Directory that will serve as a single, authoritative source of up-to-date provider data across the healthcare system. Built on CMS' robust existing datasets, this effort will improve data accuracy and interoperability, reducing duplication and inconsistency across payers, systems, and platforms. Today, clinicians often spend time updating their information with as many as 20 different payers each month, which is a fragmented process that consumes valuable resources and creates data integrity issues across the system. By streamlining provider data management, CMS will significantly reduce administrative burden on healthcare providers, improve care coordination, and enhance the reliability of provider information available to beneficiaries, plans, and partners. This initiative aligns with CMS' broader goals of modernizing digital infrastructure, promoting interoperability, and improving the efficiency of healthcare operations, all of which support better outcomes for patients and providers alike.

Outcome: Reduces clinician burden, increases data transparency, and strengthens network adequacy across health plans.

VIII. Enable Scalable, Secure, and Future-Ready Infrastructure

CMS has made significant strides in cloud adoption, moving from just 13% in 2015 to 78% in 2023, with over 90 systems now operating in the cloud. This transition has already led to lower operating costs, improved performance, enhanced security, greater elasticity, and flexible pay-per-use models. These benefits are foundational to CMS' broader IT modernization strategy, which includes continuing the migration of applications and services to the cloud as long as funding supports this critical effort. As part of our insourcing strategy, CMS is also building

internal expertise in Digital Infrastructure and Cloud Enablement, creating an enterprise-level, scalable digital environment that supports AI, advanced analytics, and Application Programming Interface delivery. This shift will reduce our reliance on external vendors, ensure greater control over our infrastructure, and help maximize the value of cloud technologies.

Our current challenges, such as dependency on mainframe products, siloed Customer Relationship Management (CRM) systems, and rising costs, are being addressed through strategic investments in modernization and migration to flexible, cost-effective alternatives. By unifying CRM environments, migrating off mainframes, and modernizing core infrastructure, CMS will reduce costs, improve data security through Zero Trust models, and implement a build-once, reuse-across-programs approach.

In addition to infrastructure modernization, CMS is transitioning to a shared services model, ensuring that efficiencies are maximized across the organization as we continue to innovate and expand our cloud capabilities.

Outcome: Lower infrastructure costs, enhanced resilience, and elastic capacity for mission-critical systems.

IX. Expand Reusable Platforms to Drive Enterprise Efficiency

CMS is undergoing a strategic transformation in its IT management by consolidating and utilizing shared services. This fundamental transformation in how CMS purchases, manages, and delivers technology positions the agency to create a more agile digital foundation for healthcare delivery while achieving significant cost savings and process simplification.

The insourcing strategy complements these efforts by focusing on administrative efficiency, including streamlining legacy processes such as claims review, appeals, and enrollment, and implementing electronic case management to efficiently manage beneficiary and provider cases leveraging AI. By bringing these capabilities in-house, CMS can ensure consistent quality and continuous improvement while reducing costs.

The organization has already made meaningful progress in reducing its technological footprint through a cloud-first approach and continues to drive efficiency in technology operations. By optimizing our resources through shared services, we can eliminate redundancies and focus investments on innovation.

Building on this foundation of operational excellence and infrastructure optimization, CMS continues to prioritize IT modernization efforts to enhance service delivery, strengthen security posture, and improve operational efficiency. Through strategic investments in cloud migration, cybersecurity, payment systems modernization, and emerging technologies like AI, CMS is positioning itself to better serve beneficiaries while maintaining its responsibility as a steward of public funds.

These technological advancements support CMS' broader mission of ensuring access to quality healthcare services while promoting innovation and value-based care across the healthcare ecosystem. By developing enterprise platforms that can be leveraged across multiple programs, we maximize the return on our technology investments and create a more cohesive user experience. CMS will advance toward a unified enterprise service model by consolidating core capabilities to drive greater efficiency, scalability, and consistency across CMS.

Outcome: Simplified operations, reduced duplication, and reallocation of resources toward innovation.

Conclusion

CMS is committed to safeguarding the integrity and security of our healthcare systems, from enhancing cybersecurity measures to combating fraud. By modernizing Medicare claims processing systems and leveraging AI, CMS is not only increasing productivity but also refining analytics to deliver prompt and accurate services to beneficiaries. Our efforts to consolidate data and prioritize interoperability are key to creating a seamless, efficient healthcare experience while ensuring that every interaction is faster, more responsive, and more reliable.

In tandem with these efforts, investing in top-tier technology talent and upgrading digital infrastructure lays the foundation for sustained innovation and service excellence. The shift towards a shared services model is especially critical, as it eliminates redundancies, maximizes resource efficiency, and drives cost-effective solutions across CMS. These initiatives are not only focused on immediate improvements, but they are strategic investments that will enhance the long-term resilience and efficiency of CMS, empowering the agency to provide fast, scalable, and secure services. As we modernize, strengthening identity and credential systems becomes fundamental to building trust, reducing friction, and enabling secure scaling of our services. These investments are central to our mission assurance, ensuring that CMS can continue to protect the nation's health infrastructure in real-time and lead proactive healthcare programs.

Ultimately, these changes fortify CMS' resilience, save taxpayer dollars, and enhance our ability to deliver superior service for years to come. By accelerating AI innovation and optimizing healthcare delivery, CMS is positioning itself to fulfill its mission more efficiently, ensuring that we remain an innovative, future-ready agency serving millions of beneficiaries.

Federal Exchange

(Dollars in Thousands)

	FY 2024 Final	FY 2025 Enacted [1]	FY 2026 President's Budget
Program Management	**$2,610,918**	**-**	**$2,075,000**
Discretionary	$124,727	-	$0
Mandatory	$2,450,833	-	$2,026,000
Federal Exchange User Fee (non-add)	*$2,397,850*	-	*$1,965,235*
Risk Adjustment User Fee (non-add)	*$52,983*	-	*$60,765*
Other	$35,359	-	$49,000
Penalty Mail	$35,359	-	$49,000
Heath Care Fraud and Abuse Control	**$24,495**	**-**	**$38,000**
Discretionary	*$24,495*	-	*$38,000*
Program Level	**$2,635,413**	**-**	**$2,113,000**

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 must facilitate the purchase of qualified health plans (QHPs) and meet other requirements specified in section 1311(d) of the ACA. CMS operates a Federally-Facilitated 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).

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

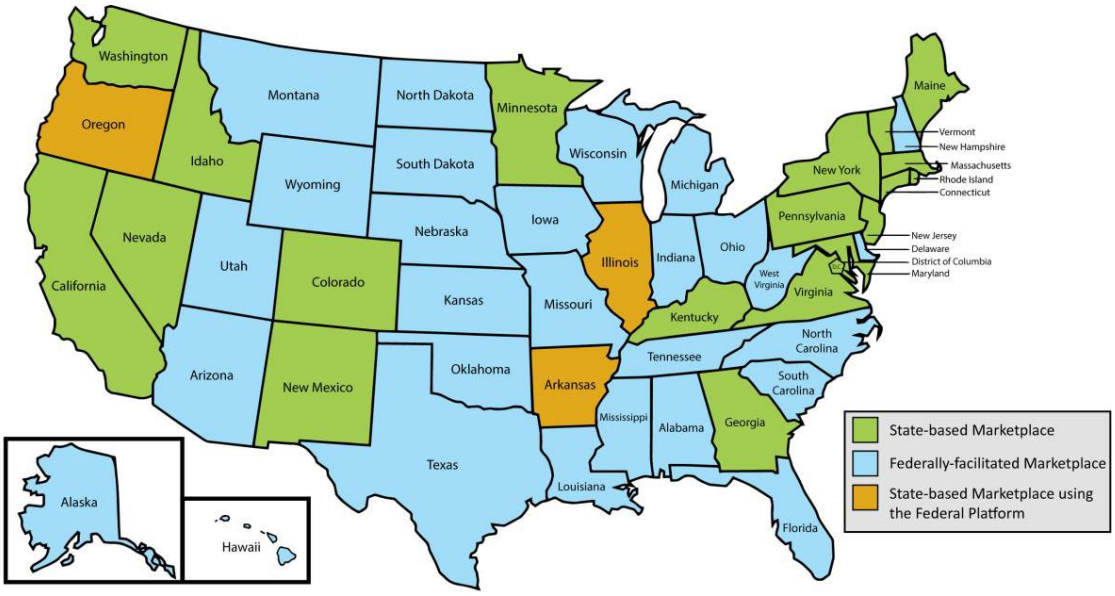
Section 1401 of the ACA established a premium tax credit designed to lower the monthly health insurance premium for eligible consumers with low or moderate income (generally between 100 and 400 percent of the federal poverty level who purchase coverage through the Exchange. The American Rescue Plan Act of 2021 made temporary changes to the premium tax credit by expanding eligibility and increasing the credit amount for tax years 2021 and 2022. The Inflation Reduction Act of 2022 (IRA) extended these enhanced premium tax credits for three additional years through 2025. The enhanced premium tax credit provides full premium subsidies (toward benchmark Exchange plans) to eligible consumers with annual incomes between 100 and 150 percent of the federal poverty level, reduces the premium tax credit applicable percentage for all eligible consumers, and expands access to the premium tax credit to individuals and families with incomes above 400 percent of the federal poverty

[1] Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for 2025 and is rolled up within the Program Management account.

level. The FY 2026 Budget assumes the enhanced premium tax credits are not extended beyond 2025.

In FY 2025, CMS announced a reduction in funding for the Navigator program to $10 million per year and estimates that $360 million will be saved over the next four years. The savings from this reduction will allow the FFE to focus on more effective strategies that improve Exchange outcomes.[2]

The graphic below illustrates which states utilized HealthCare.gov compared to those operating their own State-Based Exchange in Plan Year 2025.[3]



In FY 2026, CMS proposes to implement cost saving initiatives included in the Marketplace Integrity and Affordability Notice of Proposed Rulemaking (NPRM)[4]. This rule would revise standards relating to past-due premium payments; exclude Deferred Action for Childhood Arrivals recipients from the definition of "lawfully present", define the evidentiary standard HHS uses to assess an agent's, broker's, or web-broker's potential noncompliance; reinstate the one-year requirement for failure to file and reconcile; strengthen income eligibility verifications for premium tax credits and cost-sharing reductions; amend annual eligibility redeterminations for consumers in $0 premium plans; eliminate the special enrollment period for consumers with annual household incomes below 150 percent of the federal poverty level; amend the automatic reenrollment hierarchy; shorten the annual open enrollment period; tighten special enrollment periods; widen the de minimis thresholds for the actuarial value for plans subject to essential health benefits (EHB) requirements and for income-based cost sharing reduction plan variations; amend the premium adjustment percentage methodology; and prohibit inclusion of sex trait modification as an essential health benefit.[5]

[2] https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding
[3] https://www.cms.gov/marketplace/in-person-assisters/training-webinars/training/marketplaces-map
[4] https://www.federalregister.gov/public-inspection/2025-04083/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability
[5] https://www.cms.gov/newsroom/fact-sheets/2025-marketplace-integrity-and-affordability-proposed-rule

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

- Verifying eligibility data for financial assistance through the Exchange or other health insurance programs, including Medicaid and the Children's Health Insurance Program (CHIP);
- Ensuring proper payment of financial assistance in the form of advanced payment of the premium tax credit (APTC) to issuers where an applicant is determined eligible;
- Operating a quality rating system for display on Exchange websites; and
- Conducting certification and oversight of SBEs.

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

- Certifying qualified health plans (QHPs) and stand-alone dental plans (SADPs) after reviewing health plan benefits and rates;
- Providing 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 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 2022	$2,085,344,000
FY 2023	$2,440,747,000
FY 2024	$2,635,413,000
FY 2025 [6]	-
FY 2026 President's Budget	$2,113,000,000

Budget Request: $2,113.0 Million

The FY 2026 Budget request for FFE activities is $2,113.0 million, of which $2,075.0 million is funded from several Program Management sources and $38.0 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.

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

[6] Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for 2025 and is rolled up within the Program Management account.

technical assistance to issuers on certification requirements, and certifying agents and brokers to participate in the FFE. CMS supports over 4,370 QHPs and over 970 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: $452.3 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 HealthCare.gov where eligibility for financial assistance is verified through the Data Services Hub.

Consumer Information and Outreach: $645.2 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 Printing Office, CMS prints and mails pertinent consumer notices and provides educational publications on a wide variety of topics.

Information Technology (IT): $684.6 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 support peak volumes, while ensuring a smooth user experience. New technical architecture and software code is integrated into existing production environments using a comprehensive end-to-end testing methodology that ensures existing performance levels are maintained or improved. CMS administers a comprehensive IT security program that is designed to prevent and detect intrusions into the environments. The Exchanges also leverage existing CMS Enterprise Shared Services. Major applications that support the Exchanges include:

- *Data Services Hub* – Provides a query-based verification service with Federal entities and private data sources for information supplied by consumers during the application process. Verified data includes citizenship or immigration status, income, household size, and eligibility for Medicare, veteran's benefits, or Federal employee benefits.

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

- *Federal Health Care 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: $38.0 million. In coordination with efforts funded by the Health Care Fraud and Abuse Control account, this section includes work necessary to ensure program integrity in the Exchanges. CMS annually measures the improper payment rate for the APTC program in the FFE. In FY 2026, CMS will continue measurement in the FFE as well as continue pre-testing and assessment activities for the SBEs to prepare them for implementation of the improper payment measurement program. CMS will also continue to operate a consumer complaint call center, investigate complaints, and conduct investigations and data analytics using the FFE and other data sources. CMS operates focused fraud prevention efforts in areas that have high risk factors for enrollment fraud and provides oversight for agents and brokers to ensure they are in good standing with the state. Additional funding in FY 2026 compared to FY 2024 will allow for increased capacity to review consumer complaints and conduct investigations to meet the expected workload.

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: $129.0 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.

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

Object Class	FY 2024 Final	FY 2025 Enacted /2	FY 2026 President's Budget
Direct Budget Authority			
Personnel compensation:			
Full-time permanent (11.1)	$ 398,083	-	$ 351,134
Other than full-time permanent (11.3)	$ 12,467	-	$ 10,997
Other personnel compensation (11.5)	$ 9,181	-	$ 8,098
Military personnel (11.7)	$ 15,845	-	$ 13,976
Special personnel services payments (11.8)	$ 34	-	$ 30
Subtotal Personnel Compensation	**$ 435,611**	**$ -**	**$ 384,235**
Civilian benefits (12.1)	$ 204,522	-	$ 180,401
Military benefits (12.2)	$ 1,989	-	$ 1,754
Benefits to former personnel (13.0)		-	
Subtotal Pay Costs	**$ 642,121**	**$ -**	**$ 566,390**
Travel and transportation of persons (21.0)	$ 4,582	-	$ 7,301
Transportation of things (22.0)	$ -	-	$ -
Rental payments to GSA (23.1)	$ -	-	$ -
Communication, utilities, and misc. charges (23.3)	$ -	-	$ -
Printing and reproduction (24.0)	$ 4,897	-	$ 2,407
Other Contractual Services:		-	
Advisory and assistance services (25.1)		-	
Other services (25.2)	$ 2,190,321	-	$ 1,892,863
Purchase of goods and services from government accounts (25.3)		-	
Operation and maintenance of facilities (25.4)		-	
Research and Development Contracts (25.5)	$ 20,054	-	$ 18,054
Medical care (25.6)	$ 1,262,431	-	$ 1,030,754
Operation and maintenance of equipment (25.7)		-	
Subsistence and support of persons (25.8)	$ -	-	$ -
Subtotal Other Contractual Services	**$ 3,485,044**	**$ -**	**$ 2,887,622**
Supplies and materials (26.0)	$ 338	-	$ 671
Equipment (31.0)		-	
Land and Structures (32.0)	$ -	-	$ -
Investments and Loans (33.0)	$ -	-	$ -
Grants, subsidies, and contributions (41.0)	$ -	-	$ -
Interest and dividends (43.0)	$ -	-	$ -
Refunds (44.0)	$ -	-	$ -
Subtotal Non-Pay Costs	**$ 3,494,861**	**$ -**	**$ 2,898,001**
Total Direct Budget Authority /3	**$ 4,136,982**	**$ -**	**$ 3,464,391**

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

/2 Allocations for FY 2025 have not yet been determined.

/3 FY 2024 includes $455 million in additional Medicare Operations funding from the FY 2024 annual appropriation, Public Law 118-47, General Provision Section 227. CMS has allocated $434 million to Program Operations, $6 million to Federal Administration, and $15 million to State Survey and Certification, all of which will support Medicare programs.

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2024 Actual Civilan	2024 Actual Military	2025 Est. Civilian	2025 Est. Military	2026 Est. Civilian	2026 Est. Military
Discretionary						
Direct FTEs	3,932	91	3,415	87	3,303	87
Reimbursable FTEs	0	0	0	0	0	0
Subtotal	3,932	91	3,415	87	3,303	87
Program Management, Direct						
Direct FTEs	240	3	211	5	206	5
Reimbursable FTEs	0	0	0	0	0	0
Subtotal	240	3	211	5	206	5
Program Management, Reimbursable						
Direct FTEs	0	0	0	0	0	0
Reimbursable FTEs	625	15	660	14	644	14
Subtotal	625	15	660	14	644	14
Total, CMS Program Management FTE /1 /2	**4,797**	**109**	**4,286**	**106**	**4,153**	**106**

/1 Includes FTEs funded from Program Management only (discretionary, mandatory, and reimbursables).
/2 FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

CMS Program Management
Detail of Positions
(Dollars in Thousands)

	FY 2024 Final	FY 2025 Enacted /1	FY 2026 President's Budget
Subtotal, EX	1	1	1
Total - Exec. Level Salary	$174	-	$170
Subtotal, ES	64	63	63
Total - ES Salaries	$14,703	-	$14,414
GS-15	578	493	477
GS-14	714	633	611
GS-13	1,939	1,700	1,643
GS-12	440	364	351
GS-11	91	70	67
GS-10	0	0	0
GS-9	67	64	62
GS-8	0	0	0
GS-7	18	13	12
GS-6	1	1	1
GS-5	0	0	0
GS-4	4	3	3
GS-3	3	2	2
GS-2	0	0	0
GS-1	0	0	0
Subtotal /2 /3	3,855	3,342	3,230
Total - GS Salary /2 /4	$606,931	-	$596,235
Average GS Grade /2	13	-	13
Average GS Salary /2 /4	$157	-	$183

/1 FY 2025 data is subject to change due to ongoing workforce changes.

/2 Reflects direct discretionary staffing within the Program Management account.

Note: This table does not include salaries for military/CoC personnel.

/3 FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

/4 FY 2026 salary levels are subject to change.

CMS Program Management
Programs Proposed for Elimination

The Budget eliminates discretionary funding for health equity, certain community outreach activities (excluding Tribal), and certain unnecessary administrative costs to implement the Inflation Reduction Act.

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

Program	Section	FY 2016			FY 2017			FY 2018			FY 2019		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated													
Health Insurance Consumer Information	1002		0			0			0			0	
Rate Review Grants	1003		0			0			0			0	
Pre-existing Condition Insurance Plan Program	1101		0			0			0			0	
Reinsurance for Early Retirees	1102		0			0			0			0	
Affordable Choices of Health Benefit Plans	1311	$ 20,163	34		$ 18,221	25		$ 11,698	24			0	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322		0			0			0			0	
Adult Health Quality Measures	2701		11			8			6			10	
Medicaid Emergency Psychiatric Demonstration	2707		0			0			0			0	
Quality Measurement	3014		0			0			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		521			551			540			600	
Independence At Home Demonstration	3024		1			1			1			0	
Community Based Care Transitions	3026		1			0			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		0			0			0			0	
Community Prevention and Wellness	4202		0			0			0			0	
Graduate Nurse Education	5509		1			2			2			0	
Sunshine Act	6002	$ 4,211	17		$ 5,615	22			0			0	
LTC National Background Checks	6201		6			6			4			6	
Provider Screening & Other Enrollment Requirements 1/	6401	$ 3,509	14		$ 3,509	9			0			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 468	2		$ 468	1			0			0	
Expansion of the Recovery Audit Contractor Program 1/	6411	$ 468	2			0			0			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323	$329	1			0			0			0	
Total ACA Direct Appropriated FTEs			**611**			**625**			**577**			**616**	

1/ Section 1303 of The Health Care and Education Reconciliation Act of 2010 (HCERA) provides funding that may also be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ Net sequester reduction in FY 2016 (-6.8%).

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

Program	Section	FY 2020			FY 2021			FY 2022			FY 2023		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated													
Health Insurance Consumer Information	1002		0			0			0			0	
Rate Review Grants	1003		0			0			0			0	
Pre-existing Condition Insurance Plan Program	1101		0			0			0			0	
Reinsurance for Early Retirees	1102		0			0			0			0	
Affordable Choices of Health Benefit Plans	1311		0			0			0			0	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322		0			0			0			0	
Adult Health Quality Measures	2701		10			10			9			9	
Medicaid Emergency Psychiatric Demonstration	2707		0			0			0			0	
Quality Measurement	3014		0			0			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021	$ 10,000,000	528			523			506			545	
Independence At Home Demonstration	3024		0			0			0			0	
Community Based Care Transitions	3026		0			0			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		0			0			0			0	
Community Prevention and Wellness	4202		0			0			0			0	
Graduate Nurse Education	5509		0			0			0			0	
Sunshine Act	6002		0			0			0			0	
LTC National Background Checks	6201		6			10			5			6	
Provider Screening & Other Enrollment Requirements 1/	6401		0			0			0			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402		0			0			0			0	
Expansion of the Recovery Audit Contractor Program 1/	6411		0			0			0			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards	10323		0			0			0			0	
Total ACA Direct Appropriated FTEs			**544**			**543**			**520**			**560**	

1/ Section 1303 of The Health Care and Education Reconciliation Act of 2010 (HCERA) provides funding that may also be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

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

Program	Section	FY 2024			FY 2025			FY 2026		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Health Insurance Consumer Information	1002		0			0			0	
Rate Review Grants	1003		0			0			0	
Pre-existing Condition Insurance Plan Program	1101		0			0			0	
Reinsurance for Early Retirees	1102		0			0			0	
Affordable Choices of Health Benefit Plans	1311		0			0			0	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322		0			0			0	
Adult Health Quality Measures	2701		9			0			0	
Medicaid Emergency Psychiatric Demonstration	2707		0			0			0	
Quality Measurement	3014		0			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		579			492			483	
Independence At Home Demonstration	3024		0			0			0	
Community Based Care Transitions	3026		0			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		0			0			0	
Community Prevention and Wellness	4202		0			0			0	
Graduate Nurse Education	5509		0			0			0	
Sunshine Act	6002		0			0			0	
LTC National Background Checks	6201		5			0			0	
Provider Screening & Other Enrollment Requirements 1/	6401		0			0			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402		0			0			0	
Expansion of the Recovery Audit Contractor Program 1/	6411		0			0			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards	10323		0			0			0	
Total ACA Direct Appropriated FTEs 2/			**593**			**492**			**483**	

1/ Section 1303 of The Health Care and Education Reconciliation Act of 2010 (HCERA) provides funding that may also be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Physicians' Comparability Allowance (PCA) Worksheet

1) Department and component:

DHHS: Centers for Medicare and Medicaid Services (CMS)

2) Explain the recruitment and retention problem(s) justifying the need for the PCA pay authority.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*
In order to attract and retain highly skilled and qualified physicians, CMS uses two special pay systems: Physician's Comparability Allowance (PCA) and the Physician, Dentist, and Podiatrist Pay (PDP). Details of the PDP are not included in this report. The majority of CMS physicians receive PCA and are recruited nationwide for the Central Office and Regional Offices to support the work of Medicare and Medicaid Programs. CMS has a continual need to access highly skilled physicians to carry out the unique mission of the agency. The biggest challenge is that even with the PCA, CMS is unable to match physician salary in the private sector. Physicians tend to accept more private sector opportunities due to the restrictions of the GS pay scale.

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

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget /1
3a) Number of Physicians Receiving PCAs	35	23	27
3b) Number of Physicians with One-Year PCA Agreements	5	3	4
3c) Number of Physicians with Multi-Year PCA Agreements	30	20	23
4a) Average Annual PCA Physician Pay (without PCA payment)	$181,866	$191,834	$186,850
4b) Average Annual PCA Payment	$22,729	$23,804	$23,266

/1 FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

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.)*
Whether CMS is trying to backfill a critical position and/or is faced with new legislation, the ability to enhance employment packages via the PCA remains an important component of our acquisition of physicians. Filling vacant physician positions to fill very specific needs is a challenge, given the reduced compensation CMS can offer. And even though CMS has experience in recruiting physicians, the PCA is still necessary because the candidates with quality experience make significantly more money in the private sector compared to what CMS would be able to offer them without PCA. PCA has made the salary offers more comparable, 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 fluctuate as a result of physicians being eligible for step increases. The average annual PCA amounts may fluctuate slightly as a physician completes their 24 months as a government physician. There are currently 23 Physicians in CMS receiving PCA, including seven at the maximum PCA amount of $30,000. CMS may see an increase in the number of physicians needed in FY 2026 to carry out new programs aligned with the Administration's Make America Healthy Again agenda.

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 Reporting – The information below details the uses of all funds by CMS for the Health Insurance Exchanges, including: Administrative Costs; Marketplace related Information Technology [IT]; Non-IT Program Costs, including Health Plan Benefit and Rate Review, Plan 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 Exchange 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 2026.

Health Insurance Exchange 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 Enacted [1]	FY 2026 President's Budget
Health Plan Bid Review, Management and Oversight	**$45,797**	**$45,480**	**$38,841**	**$54,255**	**$56,276**	**$97,614**	**-**	**$87,132**
Payment and Financial Management	**$50,220**	**$39,178**	**$49,821**	**$47,780**	**$51,757**	**$46,792**	**-**	**$51,452**
Eligibility and Enrollment [2]	**$348,488**	**$371,802**	**$350,482**	**$391,341**	**$346,946**	**$428,523**	**-**	**$452,321**
Consumer Information and Outreach	**$579,088**	**$503,271**	**$843,729**	**$903,220**	**$1,206,902**	**$1,177,935**	**-**	**$645,244**
Call Center (non-add)	*$499,053*	*$440,000*	*$477,247*	*$535,219*	*$557,926*	*$564,500*	-	$501,730
Navigators Grants & Enrollment Assisters (non-add)	*$19,499*	*$19,689*	*$91,233*	*$133,293*	*$138,821*	*$161,204*	-	$19,744
Consumer Education and Outreach (non-add)	*$11,231*	*$14,082*	*$245,749*	*$211,592*	*$443,753*	*$348,656*	-	$52,560
Information Technology	**$504,283**	**$549,369**	**$515,388**	**$511,706**	**$588,819**	**$686,814**	**-**	**$684,570**
Quality	**$7,334**	**$7,063**	**$6,391**	**$6,706**	**$6,142**	**$6,331**	**-**	**$5,914**
SHOP and Employer Activities	**$2,117**	**$200**	**$197**	**$195**	**$0**	**$195**	**-**	**$195**
Other Exchange	**$40,290**	**$63,579**	**$38,827**	**$35,400**	**$59,192**	**$62,179**	**-**	**$57,172**
Administrative Costs [3]	**$77,750**	**$85,833**	**$120,071**	**$134,741**	**$124,713**	**$129,030**	**-**	**$129,000**
Total	**$1,655,367**	**$1,665,775**	**$1,963,746**	**$2,085,344**	**$2,440,747**	**$2,635,413**	**-**	**$2,113,000**

[1] Funding Allocations for FY 2025 have not yet been determined.

[2] 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.

[3] 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 2026 Congressional Justification.

Note: Fiscal years 2010 through 2021 include obligations as of September 30 of each year.

Note: Before the Exchanges were transferred to CMS, $4.7 million and $66.3 million in obligations were incurred in FY 2010 and FY 2011, respectively.

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 [4]	**$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 Exchanges	**$1,879**	**$14,906**	**$13,738**	**$4,400**	**$6,728**	**$3,614**	**$12,032**	**$49,584**	**$31,196**
Administrative Costs [5]	**$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**

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

[5] 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 2026 Congressional Justification.

Note: Fiscal years 2010 through 2021 include obligations as of September 30 of each year.

Note: Before the Exchanges 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)	2026	90%	October 31, 2026
	2025	TBD*	October 31, 2025
	2024	90%	96% (Target Exceeded)
	2023	90%	96% (Target Exceeded)
	2022	90%	94% (Target Exceeded)
	2021	90%	94% (Target Exceeded)
	2019	90%	94% (Target Exceeded)
MCR9.5: Minimum of 90 percent pass rate for the Customer Satisfaction Survey (Federal Exchange)	2026	90%	October 31, 2026
	2025	TBD*	October 31, 2025
	2024	90%	94% (Target Exceeded)
	2023	90%	93% (Target Exceeded)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.
*Program target under development to align with future Administration priorities.

The Centers for Medicare & Medicaid Services (CMS) Contact Center Operations (CCO) demonstrates exceptional performance in delivering customer service for Medicare and Health Insurance Marketplace beneficiaries. The program consistently maintains quality metrics above 90% across all measured service dimensions, with some measures achieving impressive 95-99% success rates over multiple fiscal years.

The quality improvement process remains robust, featuring systematic root cause analysis of Independent Quality Assessment (IQA) audit results, continuous enhancement of training materials, and regular updates to customer service representative tools and content. Moving forward, CMS will continue monitoring core performance metrics, maintain the 90% customer satisfaction results, while regularly assessing and improving customer service tools and materials.

CMS has demonstrated a continued level of sustained success and will maintain our standards to provide world class customer service for the Americans who receive 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	2026	Maintain an unmodified opinion	November 15, 2026
	2025	TBD*	November 15, 2025
	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
	2020	Maintain an unmodified opinion	Target Met

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.
*Program target under development to align with future Administration priorities.

The Centers for Medicare & Medicaid Services (CMS) has demonstrated exceptional financial management, maintaining an unmodified "clean" audit opinion for 25 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 2023, 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 (FFMIA) 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.

Looking forward, the measure is on track to achieve the FY 2024 target of maintaining an unmodified opinion, and continue to meet requirements set forth by OMB Bulletin 21-04, the Federal Manager's Financial Integrity Act of 1982, and 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	2026	23.50%	June 30, 2027
	2025	TBD**	June 30, 2026
	2024	24.62%	July 15, 2025*
	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)
	2019	Baseline	18.11%

*To ensure cost efficiencies and savings, the ESRD network program's national coordinating contract was terminated before the final FY 2024 results were computed. FY 2024 result reporting will be delayed until July 15. CMS is developing a workaround to designate a data scientist to support this measure going forward.
**Program target under development to align with future Administration priorities.

This measure tracks the percentage of new End-Stage Renal Disease (ESRD) patients who transition to home dialysis within their first 180 days of treatment. The program focuses on two main home dialysis options: Peritoneal Dialysis (PD), which uses the patient's abdominal lining, and Home Hemodialysis (HHD), which utilizes compact equipment for flexible treatment scheduling.

The current performance metrics show a 23.13% utilization rate as of 2023, with a small target gap of -0.47% and a projected annual growth of 1.26% for FYs 2024-2026. This initiative is achieving an 80% home dialysis/transplant rate while promoting health inclusion and patient-centered care delivery.

The program faces several implementation challenges, including healthcare delivery barriers such as workforce shortages and geographic access limitations, as well as patient-related factors like knowledge gaps and financial constraints. To address these challenges, the program has developed strategic solutions focusing on educational initiatives, support programs, and healthcare system improvements, including enhanced patient education, and peer mentoring networks.

The outcome measurements demonstrate positive progress, with 21,253 transplant procedures in 2022 and 28,253 waitlist additions, showing year-over-year growth of 6% for transplants and 5% for waitlist additions.

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	2026	Contextual Measure	November 30, 2026
	2025	Contextual Measure	November 30, 2025
	2024	Contextual Measure	1,995,965
	2023	Contextual Measure	1,988,037
	2022	Contextual Measure	1,750,006
	2021	Contextual Measure	1,550,608
	2020	Contextual Measure	1,107,518

The Centers for Medicare & Medicaid Services (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. 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.

MEDICARE SURVEY & CERTIFICATION PROGRAM

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

Measure	FY	Target	Result
MSC5: Decrease the population of long-stay nursing home residents receiving antipsychotic medication	2026	15.4%	July 31, 2027
	2025	TBD*	July 31, 2026
	2024	14.3%	July 31, 2025
	2023	14.7%	14.8% (Target Not Met)
	2022	15.0%	14.6% (Target Exceeded)
	2021	15.3%	14.5% (Target Exceeded)
	2020	15.4%	14.5% (Target Exceeded)
	2019	15.5%	14.0% (Target Exceeded)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budget.
*Program target under development to align with future Administration priorities.

This initiative focuses on reducing antipsychotic medication use in nursing homes while improving dementia care quality. 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 14.8% in 2023 (Q4), representing a substantial 37.9% overall reduction.

The initiative implements three main strategic approaches. First, it promotes non-pharmacologic interventions through evidence-based practices and person-centered dementia care, including the Hand in Hand training program. Second, it maintains robust monitoring and transparency through Quality measures posted on the Care Compare website and integration with the Five-Star Quality Rating System. Third, it emphasizes quality by targeting facilities with lower staffing levels or compliance issues.

Despite the overall success, the program faces several challenges, including variable success rates across different states and CMS locations. While some locations have achieved more than 50% reduction, FY 2024 targets may not be met in all areas, and there remains a need for improved practice standards in nursing homes.

The measurement methodology focuses on long-stay nursing home residents (101+ days or more), excluding those with specific conditions like Schizophrenia, Tourette's syndrome, or Huntington's disease, and reports are based on the last quarter of each calendar year.

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	2026	95% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2027
	2025	TBD**	May 31, 2026
	2024	98% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2025
	2023	98% of hospice facilities are surveyed within the required 36 month timeframe	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)
	2019	98% of hospice facilities are surveyed within the required 36 month timeframe	98.3% (Target Exceeded)

*CMS did not meet the targets for FYs 2020 – 2023 due to the COVID-19 Public Health Emergency (PHE) and reprioritization of survey activities based on guidance published throughout the PHE.
**Program target under development to align with future Administration priorities.

This measure aims to ensure that the statutory requirement for the hospice survey interval is met nationally. Although the CMS target is 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 2020-2023.

CMS did not meet the FY 2020 – FY 2023 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 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.

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)	2026	98.0%	December 31, 2026
	2025	TBD*	December 31, 2025
	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)
	2020	95.8%	95.8% (Target Met)

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.
*Program target under development to align with future Administration priorities.

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 2024 target (98%).

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.

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	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)
	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 is a data and reporting initiative used to quantify the quality of services children receive through Medicaid and the Children's Health Insurance Program (CHIP) programs. Established under Section 1139A of the Social Security Act, the Child Core Set supports broader work within Child Health Care Quality to assess delivery of services and work with states to improve health outcomes for children enrolled in these programs. As of January 1, 2024, all states, DC, Puerto Rico, Guam, and the U.S. Virgin Islands must report on all measures in the Child Core Set, as required by the Bipartisan Budget Act of 2018 (P.L. 115-123) and outlined in the August 2023 Mandatory Medicaid and CHIP Core Set Reporting Final Rule. The final rule codified requirements for mandatory reporting on the Core Sets and annual updates to the Core Sets of measures, and allows states the option to request exemptions from reporting specific populations if they are unable to obtain the necessary data. For this reason, not all states will report all measures each year.

CMS continues to increase reporting on the Child Core Set, reaching 96% of states reporting at least fourteen measures in FY 2023 and seventeen measures in FY 2024. CMS has met or exceeded reporting targets since 2019 by providing consistent and significant technical assistance to states. Looking ahead, the program has set ambitious targets, aiming for 96% of jurisdictions to report 20 or more measures, increasing the target number of measures each year.

CMS will continue to provide significant technical assistance to states to increase reporting on the Child Core Set and awareness of strategies to use quality measurement data to drive quality improvement at the state and programmatic levels. 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.

The ultimate goals of the program include enhanced quality measurement standardization, improved service delivery assessment, and better health outcomes for enrolled children. This comprehensive approach to quality measurement and reporting helps ensure consistent monitoring and improvement of healthcare services for children enrolled in Medicaid and CHIP programs. For more detailed information, visit Medicaid.gov or access the interactive data portal at data.medicaid.gov.

MCD8: Improve Adult Health Care Quality across Medicaid

Measure	FY	Target	Result
MCD8: Improve Adult Health Care Quality Across Medicaid	2026	Work with States to ensure that 90% of States report on at least fifteen quality measures in the Adult Medicaid core set of quality measures	June 1, 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)

Prior years targets and results (including baseline) for this goal can be found in previous CMS Budgets.
*When reporting on the behavioral health measures within the Adult Core Set 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 reporting due to the increase in the denominator.

The Adult Health Quality Measures program, or Adult Core Set, is a health care quality reporting initiative, established under Section 1139B of the Social Security Act to assess delivery of services and work with states to improve health outcomes for adults enrolled in Medicaid. State reporting on most of the Adult Core Set is optional, except for the behavioral health measures. In 2024, all states, DC, Puerto Rico, Guam, and the U.S. Virgin Islands must report on the behavioral health measures on the Adult Core Set as required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (P.L. 115-271) and outlined in the August 2023 Mandatory Medicaid and CHIP Core Set Reporting Final Rule. The final rule codified requirements for mandatory reporting on the Core Sets and annual updates to the Core Sets of measures, and allows states the option to request exemptions from reporting specific populations if they are unable to obtain the necessary data. For this reason, not all states will report all measures each year.

The program has demonstrated positive progress, with FY 2023 exceeding its targets. With the transition to mandatory state reporting in 2024 on the Child Core Set and behavioral health measures on the Adult Core Set, states focused resources on meeting these new mandatory requirements. As such, some states reported on fewer voluntary measures on the Adult Core Set and the target for FY 2024 was not met. The program faces several challenges, including the voluntary nature of most reporting requirements and gaps in territory participation. These challenges may impact the program's ability to meet targets on this performance measure in the future.

In FY 2026, CMS plans to focus program resources on a subset of key technical assistance and data reporting activities to meet core statutory requirements. The program continues to emphasizes data transparency, with annual results published on Medicaid.gov and interactive data available on data.medicaid.gov.

The ultimate goals of the program include enhanced quality measurement standardization, improved service delivery assessment, and better health outcomes for enrolled adults. This comprehensive approach to quality measurement and reporting helps ensure consistent monitoring and improvement of healthcare services for adults enrolled in Medicaid programs.

For more detailed information, users can visit Medicaid.gov or access the interactive data portal at data.medicaid.gov.

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

Measure	FY	Target	Result
MCD9.3: Reduce Emergency Department Use Under Substance Use Disorder (SUD) 1115 Demonstration	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.	September 30, 2025
	2024	Fifty percent of states that either demonstrate a decrease or remain consistent in their ED utilization for SUD will be similar to the 2023 baseline.	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 May 6, 2025, 37 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.

Also, CMS's behavioral health priorities advance the HHS Roadmap for Behavioral Health Integration, the HHS Overdose Prevention Strategy, and the HHS Pain Management Task Force Report.

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

Measure	FY	Target	Result
MCD11: Increase the proportion of Medicaid LTSS beneficiaries receiving HCBS	2026	87.2%*	July 1, 2028
	2025	87.0%*	July 1, 2027
	2024	86.8%*	July 1, 2026
	2023	86.6%*	July 1, 2025
	2022	86.4%*	86.6% (Target Exceeded)
	2021	86.2%* Historical Actual	April 30, 2023
	2020	84.5% Historical Actual	October 1, 2022
	2019	84.3% Baseline	April 30, 2022

*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 44% of national LTSS spending as of 2021. 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 users increasing from 84.3% in 2019 (baseline) to 86.6% in 2022. This progress is measured using the Transformed Medicaid Statistical Information System (T-MSIS) Analytic File (TAF), which tracks 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 ARP funding 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.[1] More recently, the American Rescue Plan Act of 2021 (ARP) Section 9817 has significantly impacted Medicaid HCBS programs by providing a temporary (from April 1, 2021, until March 31, 2022) 10 percentage point increase in the federal medical assistance percentage (FMAP) for certain Medicaid HCBS expenditures. States are 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 May 2025, 26 states have approved extensions to expend the funds after March 31, 2025. 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.

[1] 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)	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)

The CMS Medicaid and CHIP Maternal and Infant Health Initiative (MIHI), launched in July 2014, is designed to improve access and quality of care for pregnant and postpartum women and their infants. The initiative was developed through extensive collaboration with an Expert Panel and other stakeholder input, establishing a strong foundation for maternal and infant health improvements.

The initiative identified three key focus areas in 2020: 1) increase the use and quality of postpartum care visits; 2) increase the use and quality of well-child visits; and 3) decrease the rates of cesarean section births in low-risk pregnancies. In 2024, CMS added a cross-cutting focus on addressing the primary drivers of maternal morbidity and mortality: maternal mental health and substance use and maternal cardiovascular health, including hypertension. Current achievements show progress engaging states in maternal health quality improvement, with 50 states, plus DC, and U.S. territories participating in the initiative.

The postpartum-related quality measures are part of a subset of maternal health measures on the Medicaid Adult Core Set and are voluntary for state reporting. With the transition to mandatory state reporting in 2024 on the Child Core Set and behavioral health measures

on the Adult Core Set, states focused resources on meeting these new mandatory requirements. As such, some states reported on fewer voluntary measures on the Adult Core Set, including this prenatal and postpartum care measure, and the target for FY 2024 was not met. We have re-evaluated the state ability to meet this goal in future years and adjusted targets accordingly.

This work is supported through the Medicaid Adult Health Care Quality Measures program and Adult Core Set. See MCD8 for additional information on the Adult Core Set.

CMS continues to encourage states to report on the all measures in the Adult Core Set, and provides significant technical assistance and guidance to support states in using this data to drive quality improvement at the state and programmatic levels. Data reporting and access are maintained through Medicaid.gov and data.medicaid.gov.

For more detailed information, interested parties can visit the Adult Health Care Quality Measures webpage 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	2026	TBD	November 15, 2026
	2025	7.46% (Target in FY 2024 AFR)	November 15, 2025
	2024	7.28% (Target in FY 2023 AFR)	7.66%* (Target Met)
	2023	7.36% (Target in FY 2022 AFR)	7.38%* (Target Met)
	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)
	2020	7.15% (Target in FY 2019 AFR)	6.27%* (Target Exceeded)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets and HHS AFRs.
*CMS uses Payment Integrity Information Act (PIIA) standards, rather than GPRAMA standards, for performance reporting on improper payments. Programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

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. In FY 2024, CMS has achieved its target with an overall improper payment rate of 7.66%, falling within the acceptable 7.28% confidence interval, representing $31.70 billion in estimated improper payments.

The primary causes of improper payments continue to be insufficient documentation and medical necessity errors. Below are the four driver service areas for 2024:

1) Skilled Nursing Facilities (SNF): The improper payment estimate for SNF claims increased from 13.76% in Reporting Year (RY) 2023 to 17.22% in RY 2024.
2) Hospital Outpatient: The improper payment estimate for hospital outpatient claims decreased from 5.20% in RY 2023 to 3.15% in RY 2024.
3) Inpatient Rehabilitation Facilities (IRF): The improper payment estimate for IRF claims decreased from 27.33% in FY 2023 to 26.51% in RY 2024.
4) Hospice: The improper payment estimate for hospice claims increased from 5.36% in RY 2023 to 7.10% in RY 2024

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	2026	TBD	November 15, 2026
	2025	5.95% (Target in FY 2024 AFR)	November 15, 2025
	2024	6.38% (Target in FY 2023 AFR)	5.61% (Target Exceeded)
	2023	5.77% (Target in FY 2022 AFR)	6.01%* (Target Met)
	2022	9.69% (Target in FY 2021 AFR)	5.42%* (Target Exceeded)
	2021	Historical Actual	10.28% (Historical Actual)
	2020	7.77%** (Target in FY 2019 AFR)	6.78%* (Target Exceeded)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets and HHS AFRs.
*CMS uses Payment Integrity Information Act (PIIA) standards, rather than GPRAMA standards, for performance reporting on improper payments. Programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.
**Due to a temporary medical record submission policy change enacted during the COVID-19 Public Health Emergency, significant changes were made to the sampling and estimation plan for FY 2020 Medicare Part C improper payment reporting. This impacted HHS's ability to set an aggressive, yet realistic, out-year target.

This measure monitors improper payments in Medicare Part C, ensuring fiscal responsibility and promoting program integrity. In FY 2024, CMS achieved its target by reporting a Medicare Part C improper payment rate of 5.61%, representing $19.07 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 model (CMS-HCC) which the MAO received payment.

To address these challenges, CMS has implemented immediate actions centered around Risk Adjustment Data Validation (RADV) Program Enhancement, including the launch of PY 2018 audits and strengthened MAO oversight. Quality control measures have been established through expanded audit protocols, provider education programs, and real-time monitoring systems. CMS also focuses on systemic improvements through standardized documentation templates, electronic verification, and automated validation processes.

CMS sets aggressive yet realistic performance targets, aiming for a 5.95% Medicare Part C improper payment rate in FY 2025.

Targets for improper payments are set annually in the Agency Financial Report. For more information, please see the FY 2024 Agency Financial Report.

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	2026	TBD	November 15, 2026
	2025	3.91%	November 15, 2025
	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)
	2021	1.14% (Target in FY 2020 AFR)	1.33%* (Target Met)
	2020	0.74% (Target in FY 2019 AFR)	1.15%* (Target Met)

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets and HHS AFRs.
*CMS uses Payment Integrity Information Act (PIIA) standards, rather than GPRAMA standards, for performance reporting on improper payments. Programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.
**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 has not yet been established.

This measure monitors improper payments in Medicare Part D, ensuring fiscal responsibility and promoting program integrity. In FY 2024, CMS achieved its target by reporting a Medicare Part D improper payment rate of 3.70%, representing $3.58 billion in estimate improper payments.

The primary cause 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.

CMS maintains a rigorous monitoring framework with continuous improvement cycles through monthly progress reviews, quarterly strategy updates, and annual performance assessments. Looking forward, the initiative has established a clear action timeline for 2025, including strategy refinement, system upgrades, and full deployment, all while maintaining fiscal responsibility and program sustainability.

CMS sets aggressive yet realistic performance targets, aiming for a 3.91% Medicare Part D improper payment rate in FY 2025.
Targets for improper payments are set annually in the Agency Financial Report. For more information, please see the FY 2024 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	2026	TBD	November 15, 2026
	2025	5.29% (Target in FY 2024 AFR)	November 15, 2025
	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%
	2020	Historical Actual	21.36%
MIP9.2: Reduce the Improper Payment Rate in the Children's Health Insurance Program (CHIP)	2026	TBD	November 15, 2026
	2025	6.49% (Target in FY 2024 AFR)	November 15, 2025
	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%
	2020	Historical Actual	27.00%

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets and HHS AFRs.
*Targets are 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. In FY 2024, CMS achieved its target by reporting a Medicaid improper payment rate of 5.09%, representing $31.10 billion in estimated improper payments. For CHIP, CMS achieved its target by reporting a CHIP improper payment rate of 6.11%, representing $1.05 billion in estimated improper payments.

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

To address these challenges, the programs have established a comprehensive state support framework that includes technical assistance, customized guidance, and extensive training programs through the Medicaid Integrity Institute. This framework emphasizes provider education, staff development, and compliance training to ensure consistent program execution across all states.

CMS sets aggressive yet realistic performance targets, aiming for a 5.29% Medicaid and a 6.49% CHIP improper payment rate in FY 2025.

Targets for improper payments are set annually in the Agency Financial Report. For more information, please see the FY 2024 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	2026	$155.1 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)

*Note: this measure was previously titled, "Maintain or increase dollar savings through the prevention of improper payments in Medicare Fee-For-Service (FFS) claims through innovative edit techniques employed by Fraud Prevention System (FPS) Edits."
**Will be revised based on the availability of actual data from the most recent fiscal year.

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. 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: Make Nursing Home (NH) Care Safer by Reducing Quality-of-Care Survey Deficiencies for NHs that Have Received Technical Assistance (TA) for Quality Improvement Initiatives

Measure	FY	Target	Result
QIO14: Reduce Quality-of-Care Deficiencies for NHs that have received TA. 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)	2026	50.4% (10% reduction from baseline)	January 17, 2027
	2025	Projected Developmental Baseline	56% (Projected baseline to be confirmed January 17, 2026)

CMS is enhancing Nursing Home quality through strategic improvement initiatives by launching an innovative approach to elevate nursing home care quality through the 13th Scope of Work (SoW), building on successful strategies while introducing transformative new methodologies. Over 1.4 million residents live in 15,000+ Medicare and Medicaid certified nursing homes in the US. 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

For the 13th Scope of Work (SoW), CMS plans to expand the GPRAMA goal beyond just Infection Control Deficiencies (F880) to include deficiencies related to all four aims. Current data indicates approximately 56% of nursing home surveys have deficiencies with severity

level D or higher (potential to cause more than minimal harm) in these four areas, which indicates substandard care.

To address these issues, CMS deploys Quality Improvement Network Quality Improvement Organizations (QIN-QIOs) to provide education and technical assistance to about 8,500 targeted facilities needing quality and patient safety improvements. This new focus will begin in FY 2025 and will target more serious quality issues while excluding minor deficiencies.

This goal 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 Baseline: 37,311,641 children	2026	49,000,000 children (Medicaid - 40,180,000/ CHIP - 8,820,000)	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)	July 31, 2025
	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)
	2019	46,556,502 children (Medicaid - 37,245,202/ CHIP - 9,311,300)	44,745,129 children (Medicaid - 35,090,387/ CHIP - 9,654,742) (Target Not Met)

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

The Children's Health Insurance Program (CHIP) and Medicaid serve as vital healthcare coverage programs for low-income children across the United States. As of FY 2023, these programs collectively serve over 48 million children, with Medicaid covering approximately 39.1 million and CHIP serving nearly 8.9 million children. The overall enrollment showed a 3.5% increase from the previous fiscal year, exceeding performance targets for both programs.

CMS administers several strategic initiatives that support this performance metric, including the Connecting Kids to Coverage program which activities aimed at identifying, enrolling, and improving retention for children who are eligible for Medicaid and CHIP.

Congress appropriated funding for these outreach and enrollment activities for FY's 2024 – 2027 in the Advancing Chronic Care, Extenders, and Social Services Act.

Through these strategic initiatives, CMS exceeded child enrollment targets on this metric in FY 2023 and increased eligible child enrollment from the previous year

CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMMI)

CMMI3: Accelerate the Spread of Successful Practices and Models

Measure	FY	Target	Result
CMMI3.1: Percentage of Medicare beneficiaries impacted by Innovation Center models	2026	Contextual Indicator	November 30, 2026
	2025	Contextual Indicator	November 30, 2025
	2024	Contextual Indicator	27%
	2023	Contextual Indicator	26%
	2022	Contextual Indicator	16%
	2021	Contextual Indicator	17%
	2020	Contextual Indicator	13%
CMMI3.3: Number of providers participating in Innovation Center models Baseline: < 60,000	2026	Contextual Indicator	November 30, 2026
	2025	Contextual Indicator	November 30, 2025
	2024	Contextual Indicator	121,351
	2023	Contextual Indicator	100,681
	2022	Contextual Indicator	91,950
	2021	Contextual Indicator	139,788
	2020	Contextual Indicator	136,682

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

The Center for Medicare and Medicaid Innovation (CMMI) is focused on developing and testing innovative healthcare delivery and payment models to reduce costs while improving care quality for Medicare, Medicaid, and CHIP beneficiaries. As of FY 2024, CMMI has achieved significant reach, serving 27% of Medicare beneficiaries through various programs, with notable growth driven by the addition of the Enhancing Oncology Model, the Guiding an Improved Dementia Experience Model, and the Making Care Primary Model.

The Models demonstrate strong healthcare provider engagement with 121,351 active providers participating across different models. Several high-impact programs have shown success, including Accountable Care Organization Realizing Equity, Access, and

Community Health Model, the Expanded Home Health Value-Based Purchasing Model, the Kidney Care Choices Model, Maryland Total Cost of Care Model, the Medicare Diabetes Prevention Program Expanded Model, and the Primary Care First Model.

The CMMI3.5 measure will be discontinued in FY 2025. See the Discontinued Measures section of this report. The Learning Systems metric was created nearly 10 years ago, and during this time Learning Systems have evolved significantly to advance CMS priorities. In the future, CMS will be exploring new learning system technologies.

CMS DISCONTINUED PERFORMANCE MEASURES

Program Operations Discontinued Measures

MCR9: Ensure Beneficiary Telephone Customer Service

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

The CCO handles both beneficiary (Medicare) and consumer (Federal Exchange) inquiries. A CMS Quality Call Monitoring process is used by the CCO to evaluate each Customer Service Representative's (CSR's) performance in responding to telephone inquiries. The CCO is responsible for evaluating and scoring each CSR's performance each month in handling telephone inquiries using the quality standards of privacy act, knowledge skills, and customer skills.

For FY 2025, CMS is discontinuing the sub-measures that have achieved survey results of 95% to 99% for several fiscal years because only small increases can be achieved in future years. CMS has demonstrated a continued level of sustained success and will maintain our standards to provide world class customer service for the Americans who receive their health insurance through Medicare or the Federal Exchange.

Measure	FY	Target	Result
MCR9.1a: Quality Standards: Minimum of 90 percent pass rate for Adherence to Privacy Act	2025	Discontinue	-
	2024	90%	99% (Target Exceeded)
	2023	90%	99% (Target Exceeded)
	2022	90%	99% (Target Exceeded)
	2021	90%	99% (Target Exceeded)
	2020	90%	99% (Target Exceeded)
MCR9.1b: Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment	2025	Discontinue	-
	2024	90%	99% (Target Exceeded)
	2023	90%	99% (Target Exceeded)
	2022	90%	99% (Target Exceeded)
	2021	90%	99% (Target Exceeded)
	2020	90%	99% (Target Exceeded)
MCR9.1c: Quality Standards Minimum of 90 percent meets expectations for Knowledge Skills Assessment	2025	Discontinue	-
	2024	90%	96% (Target Exceeded)
	2023	90%	96% (Target Exceeded)
	2022	90%	96% (Target Exceeded)
	2021	90%	95% (Target Exceeded)
	2020	90%	93% (Target Exceeded)
MCR9.4a: Quality Standards: Minimum of 90 percent pass rate for Adherence to Privacy Act (Federal Exchange)	2025	Discontinue	-
	2024	90%	97% (Target Exceeded)
	2023	90%	97% (Target Exceeded)

Measure	FY	Target	Result
MCR9.4b: Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment (Federal Exchange)	2025	Discontinue	-
	2024	90%	99% (Target Exceeded)
	2023	90%	99% (Target Exceeded)
MCR9.4c: Quality Standards: Minimum of 90 percent meets expectations for Knowledge Skills Assessment (Federal Exchange)	2025	Discontinue	-
	2024	90%	96% (Target Exceeded)
	2023	90%	96% (Target Exceeded)

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

CMS has expanded healthcare coverage to over 24 million enrollees in 2025, representing a 198% increase from the 2014 baseline.

CMS has taken significant steps in consumer protection through the enforcement of the No Surprises Act (NSA), enhanced network requirements, and the standardization of marketplace options. Affordability initiatives have been strengthened through extended premium support through 2025 and increased access to $10/month coverage options.

CMS has decided to discontinue this performance measure in FY 2026. A replacement performance measure will be launched to showcase the new body of work implementing the NSA. PHI10, *Independent Resolution Throughput*, will begin reporting in FY 2027.

Measure	FY	Target	Result
PHI8: Improve access to Health Insurance Coverage by increasing Marketplace enrollment nationwide	2026	Discontinue	-
	2025	22 million	24.3 million (Target Exceeded)
	2024	17 million	21.4 million (Target Exceeded)
	2023	15 million	16.4 million (Target Exceeded)
	2022	13 million	14.5 million (Target Exceeded)

PHI9: Increase Federally-Facilitated Marketplace Enrollment Among Underrepresented Populations

CMS has expanded healthcare coverage to over 24 million enrollees in 2025, representing a 198% increase from the 2014 baseline.

CMS has strengthened network adequacy requirements, enhanced coverage transition processes, and simplified plan comparison tools.

CMS has decided to discontinue this performance measure in FY 2026. To align with new Administration priorities to crush fraud, waste and abuse, a replacement performance measure will launch focusing on combating fraud through agent/broker oversight on the Marketplace. PHI11, *Misleading Marketing*, will begin reporting in FY 2027.

Measure	FY	Target	Result
PHI9: Increase Federally-facilitated Marketplace enrollment among underrepresented populations	2026	Discontinue	-
	2025	3.5 million	3.9 million (Target Exceeded)
	2024	3.0 million	3.4 million (Target Exceeded)
	2023	2.1 million	2.9 million (Target Exceeded)
	2022	1.9 million	2.7 million (Target Exceeded)

Medicaid

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.

The technical assistance and quality improvement activities are supported through the Division of Quality and Health Outcome's Technical Assistance/Administrative Support contract using no-year statutory Child Health Quality Measures funds. Future activities will be shaped by the recommendations of a 2023 expert workgroup, which emphasize three key areas: preventive and minimally invasive care, enhanced managed care accountability, and improved quality measurement capabilities.

CMS has set a performance target of four percentage points of improvement above the 2016 baseline by FY 2025, and will maintain that performance in FY 2026.

CMS will sunset this measure that is 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 beginning in FY 2027 reporting.

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)	October 15, 2025
	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)
	2019	49% (+3 percentage points over 2016 baseline)	52% (Target Exceeded)

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

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. As of CY 2023, the system has significantly exceeded its performance target of 56% with a current adoption rate of 78.82%, 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 updated the measure' target to 84% for CY 2025 and proposed discontinuing this measure from 2026 onwards in accordance with Executive Order 14222, *Implementing the President's "Department of Government Efficiency" Cost Efficiency Initiative*. Achieving higher level measures 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)
	2019	44%	53.23% (Target Exceeded)

Medicare Quality Improvement Organizations (QIO) Discontinued Measures

QIO12: Make Nursing Home Care Safer by Reducing the Infection Control Survey Deficiencies (of F880) for Nursing Homes that Have Received a Targeted Response Quality Improvement Initiative (TR-QII)

This federal program is designed to enhance nursing home safety through targeted technical assistance, specifically focusing on facilities with documented infection control deficiencies. This program impacts more than 1.4 million residents across over 15,000 Medicare and Medicaid certified nursing homes throughout the United States. All participating facilities must meet federal standards for quality improvement and infection control as outlined in 42 CFR § 483.80.

When a facility is out of compliance with quality-of-care standards, they receive deficiency citations during surveys. CMS identifies cited NHs that have received assistance from Quality Improvement Network Quality Improvement Organizations (QIN-QIOs) and analyzes if there were further deficiencies after the QIN-QIO assistance.

CMS recommends discontinuing this measure to expand on the 12th Scope of Work (SoW) measure focused on Infection Control Deficiencies (F880) to cover deficiencies associated with any of the 4 outcomes of interest for the 13th SoW. These outcomes of interest are:

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

The new focus on deficiencies that have a potential to cause more than minimal harm represents a more focused look at poor quality-of-care delivered in NHs. QIN-QIO performance measures in the 13th SoW weight inspections by severity. CMS proposes the identification of any deficiency in the categories with a D or higher severity, to better align with the CMS definition of actions with a "potential for more than minimal harm" in the reporting of this measure beginning in FY 2025.

The QIN-QIO 13th SoW also represents a dramatic change in how quality improvement (QI) work is addressed. It is vital that the QIN-QIOs first assess the landscape of the regions to identify already-existing QI work. The QIN-QIOs will then determine which of three actions they will undertake with providers: Complement, Coordinate, or Create.

Where there are existing QI initiatives, QIN-QIOs will complement the work where gaps have been identified. Where there are existing QI initiatives with no evident gaps, the QIN-QIOs will serve as a force multiplier in coordinating QI work, delivering synergies, communication support and unification of efforts. If quality improvement initiatives do not exist, and there are no effective opportunities to complement or coordinate efforts, the QIN-QIO shall create quality improvement work.

As a result of this new approach, the QIN-QIOs will spend the first eight months of the 13th SoW assessing existing QI initiatives in their regions. During the first year, they will be focused on performing in-depth assessments at the state and provider levels; and will perform minimal TA work, hence, they will have reduced impact on quality-of-care

deficiencies in FY 2025. The assessment work will be used to set the baseline for the new performance measure. Measurement of the effectiveness of QIN-QIO TA in reducing quality-of-care deficiencies will begin in FY 2026. See QIO14, *Make Nursing Home (NH) Care Safer by Reducing Quality-of-Care Survey Deficiencies for NHs that Have Received Technical Assistance (TA) for Quality Improvement Initiatives*.

Measure	FY	Target	Result
QIO12: Reduce Infection Control Deficiencies of F880 of TR-QII Baseline: 30.7%	2025	Discontinue	-
	2024	24.6% (20% reduction from baseline)	11.55% (Target Exceeded) (29.2% reduction from baseline)
	2023	26.1% (15% reduction from baseline)	29.60% (Target Not Met) (1.1% reduction from baseline)
	2022	27.6% (10% reduction from baseline)	13.49% (Target Exceeded) (17.21% reduction from baseline)
	2021	29.2% (5% reduction from baseline)	20.97% (Target Exceeded) (9.73% reduction from baseline)
	2020	Developmental (Baseline)	30.70%

*Beginning in FY 2025, at the start of the 13th SoW, we propose to expand the GPRA goal to include reduction of all quality-of-care survey deficiencies, which includes F660, F661, F697, F698, F710, F741, F743, F759, F867, F880, and F883. The **new** performance measure will be: **(QIO14) Make Nursing Home (NH) Care Safer by Reducing Quality-of-Care Survey Deficiencies for NHs that Have Received Technical Assistance (TA) for Quality Improvement Initiatives**

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

The Healthcare-Associated Infections (HAIs) initiative for Critical Access Hospitals (CAHs) has exceeded its FY 2023 performance targets, with 63% participation in Catheter-Associated Urinary Tract Infection (CAUTI) reporting and 60% in Clostridium Difficile Infection (CDI) reporting. This program improves healthcare quality and patient safety in small, rural hospitals and hospitals serving underserved populations through data collection, implementation support, and addressing social determinants of health.

The program faces several challenges including COVID-19 impacts, limited resources in rural settings, voluntary reporting structures, and complex data collection. To address these issues, program administrators have implemented enhanced support systems, flexible reporting options, targeted resource allocation, and streamlined data collection processes.

The QIO 13th Scope of Work (SoW) begins in 2025 with a new assessment-first approach for the QIN-QIOs. During the assessment phase, QIN-QIOs will spend the first eight months evaluating existing quality improvement initiatives before acting. A three-action framework: complement existing initiatives by addressing identified gaps; coordinate efforts where initiatives exist but need unification; and create new quality improvement work where none exists. QIN-QIOs will begin technical assistance after this phase which represents a significant shift in methodology from previous approaches.

The approach to the next FY2026 GPRA will reflect this strategic shift using knowledge from the existing landscape of quality improvement (QI). This method prioritizes healthcare topics in most need of improved outcomes and localizes where those needs exist to create an effective, value-based quality improvement program.

Measure	FY	Target	Result
QIO13.1: Reduce CAUTI 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)	June 30, 2025
	2023	0.656 (3.3% reduction from baseline)	0.563 (Target Exceeded) (11.5% reduction from baseline)
	2022	Baseline*	0.6786
	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
	2019	Baseline	0.590
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)	June 30, 2025
	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)

Measure	FY	Target	Result
	2020	Historical Actual	0.709
	2019	Baseline	0.810

*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 Measures

MCR1: Ensure Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive

CMS has monitored Medicare Fee-for-Service (FFS) and MA access to care through measures of patient experiences of care since the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. CMS is continuing to monitor FFS and MA access to care in order to maintain the same level of access to care for its beneficiaries. This indicator monitors, from the beneficiary perspective, if they are getting needed care as quickly as they need it.

To measure access, CMS uses the percent of persons with FFS (or Medicare Advantage (MA) Plans) that report they usually or always get needed care right away, as soon as they needed it. CMS has met or exceeded its targets for this performance goal since the inception of the goal. Since FY 2016, CMS has reported the data trends annually for these contextual measures to track beneficiary access to care. High performance has continued for this measure. For the survey conducted in 2023, the scores went down slightly, which is attributable to the continuing shortage of healthcare workers.

For FY 2025, CMS is discontinuing this measure because it is very difficult to improve performance further, given the very high rates for these measures. Budget limitations to fund the FFS Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey is also a major driver to discontinue reporting at this time.

Measure	FY	Target	Result
MCR1.1a: Maintain or exceed percent of beneficiaries in Medicare Fee-for-Service (FFS) who report access to care	2025	Discontinue	-
	2024	Contextual Indicator	89%
	2023	Contextual Indicator	89%
	2022	Contextual Indicator	90%
	2021	Contextual Indicator	91%
	2020	Contextual Indicator	Not Available*
MCR1.1b: Maintain or exceed percent of beneficiaries in Medicare Advantage (MA) who report access to care	2025	Discontinue	-
	2024	Contextual Indicator	89%
	2023	Contextual Indicator	89%
	2022	Contextual Indicator	90%
	2021	Contextual Indicator	91%
	2020	Contextual Indicator	Not Available*

Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.
*Survey data was not available due to survey administration being curtailed as a result of the Coronavirus (COVID-19) pandemic.

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. The current GPRA goal is no longer consistent with current law in 2025. 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. Because the coverage gap phase is eliminated and the Coverage Gap Discount Program (CGDP) is sunset as of January 1, 2025, this measure which is based on out-of-pocket spending in the coverage gap will be retired.

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)

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

Center for Medicare and Medicaid Innovation

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. Additionally, Learning Systems advance CMS priorities by supporting model participants.

CMS fell slightly short of meeting the 52 percent target for FY 2022 with a 50 percent learning system participation rate for 7 models. Learning system participation was high for InCK (93 percent), Maternal Opioid Misuse (MOM) Model (89 percent), and Oncology Care Model (OCM) (60 percent), but decreased for Bundled Payments for Care Improvement Advanced (BPCI-A) Model (21 percent), ET3 (24 percent), ACO REACH Model (25 percent), and KCC (34 percent), thus bringing down the overall participation rate to 50 percent, which is 2 percent shy of the target 52 percent for FY 2022.

CMS will discontinue 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 not a meaningful 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%	November 30, 2025
	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)
	2019	50%	54.2% (Target Exceeded)

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

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 immediately 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	2026	Discontinue*	-
	2025	Discontinue*	-
	2024	60%	November 30, 2025
	2023	50%	50% (Target Met)
	2022	45%	47% (Target Exceeded)
	2021	Baseline	44%

*CMS is discontinuing this measure immediately 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*.