DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2022

Centers for Medicare & Medicaid Services

Justification of Estimates for Appropriations Committees

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

Message from the Acting Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) Fiscal Year (FY) 2022 performance budget. In FY 2022, nearly 149 million Americans will rely on the programs CMS administers including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplaces.

For most of these Americans, the recent past has been an ever-changing environment, from the impacts of the COVID-19 pandemic to advances in, and the way we all access, health care. Through it all, CMS has worked tirelessly to ensure that our beneficiaries and consumers have stable, dependable, and trustworthy programs for their health care. As CMS looks forward to FY 2022 and beyond, we diligently strive to do more than accomplish a mission; we challenge ourselves to improve access to health care for all, remove barriers to health care, and to ensure equity across the health care industry.

CMS has always focused on our beneficiaries and consumers first, giving them meaningful information about quality and costs to be active health care consumers. This also includes supporting innovative approaches to improving quality, accessibility, and affordability, while finding the best ways to use advanced technology to support patient-centered care. This focus will be a guiding principle as we navigate forward.

While CMS has always worked to improve its programs, COVID-19 reinforced the need to ensure our programs are accessible, reward high quality healthcare, and encourage lower health care costs. The budget supports tools that permit patient control and provider sharing of secure health care data, allowing for better coordination of care and less duplication. Additionally, CMS is proposing to further modernize our programs to address the increasing role of technology in seniors' lives while safeguarding their data.

The investments proposed in FY 2022 will keep CMS on the leading edge of providing high quality health care that all Americans deserve, while also pursuing program integrity methods to better prevent fraudulent or improper payments.

On behalf of our beneficiaries and consumers, I thank you for your continued support of CMS and its FY 2022 performance budget.

Elizabeth Richter

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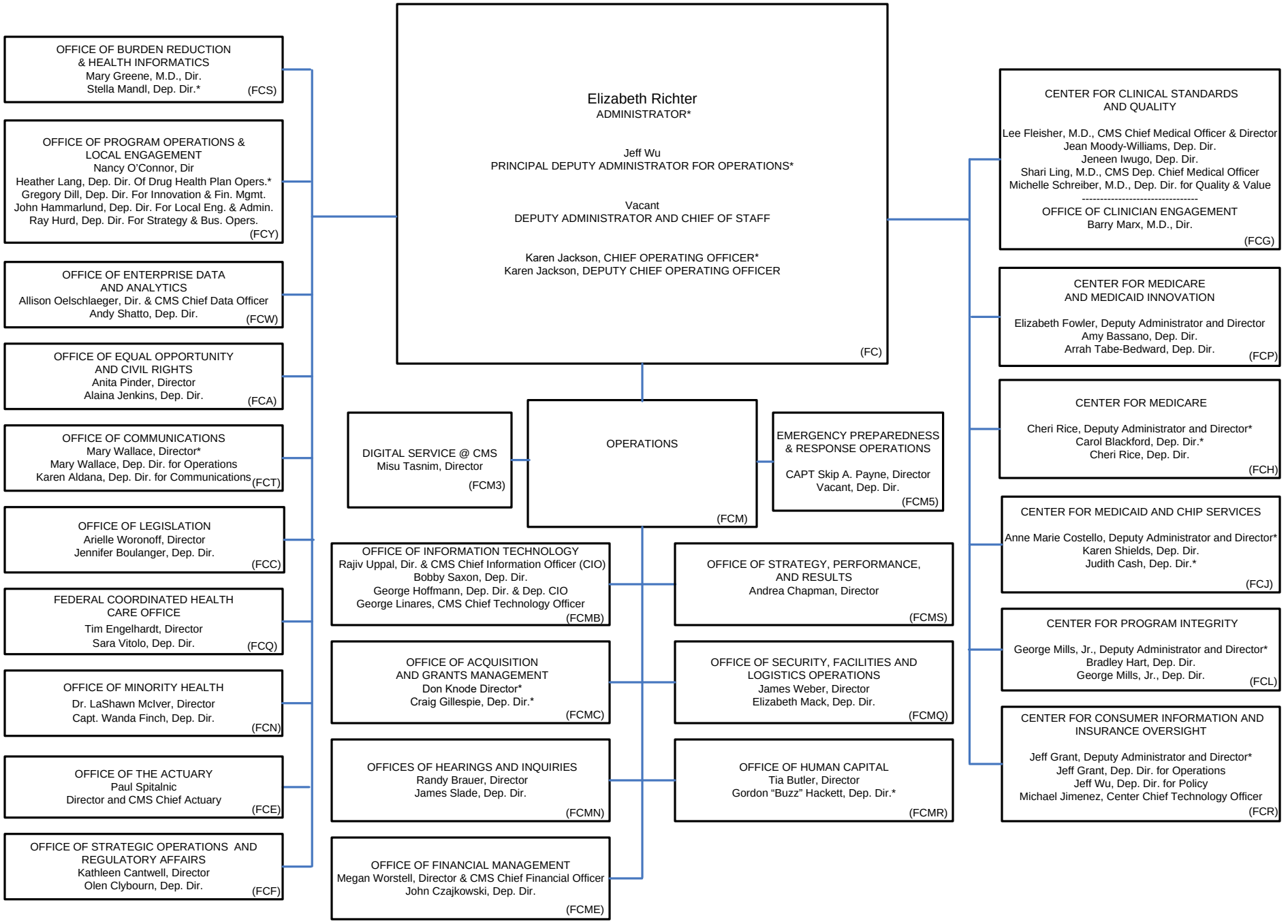
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED as of May 3, 2021
* Acting



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EXECUTIVE SUMMARY

Agency Overview

The Centers for Medicare & Medicaid Services (CMS) is an Operating Division within the Department of Health and Human Services (HHS). CMS administers the two largest Federal healthcare programs - Medicare and Medicaid - as well as the Children's Health Insurance Program (CHIP) and the Federal Marketplaces. CMS is a driving force in the healthcare industry, managing programs that will touch the lives of over 148 million beneficiaries and consumers in FY 2022. CMS understands the trust that has been placed with us, as our oversight responsibilities impact millions of citizens and continue to grow dramatically.

This budget request reflects CMS' continued approach of improving the health and healthcare system for all our beneficiaries and consumers. Ensuring all our populations have equitable access to healthcare, our continued work on reducing Opioid and Substance Use Disorders (SUD), and reducing the costs of healthcare are just a few ways in which CMS will continue to add value and work on behalf of all Americans. CMS strives for meaningful outcomes while ensuring maximum benefit from the use of our resources. As a result, CMS' focus is for a better healthcare system for the populations we serve.

CMS knows the toll the COVID-19 pandemic has taken and now, more than ever, we need to do everything we can to ensure customers' access to quality, affordable health care, including helping to ensure there are no surprises in billing. The pandemic has also made emergency preparedness a key focus and CMS will learn from our successes to continually evolve our response to events that impact our Nation.

CMS works closely with its customers and other stakeholders to maintain our programs and foster innovation and collaboration to further enhance our ability to serve the American public. Through such collaboration, CMS is able to promote our work in areas such as child welfare and maternal health. Many programs serve a CMS population that often needs strong advocacy and all customers are best served through the robust collaboration of Federal, State, and local entities.

We are transforming healthcare by reducing disparities in health equity, strengthening program integrity by reducing fraud, waste, and abuse, and promoting innovation. CMS supports innovative approaches to improve quality, accessibility and affordability and understands that we must proactively evolve to deliver high quality healthcare programs with cutting edge technologies and polices.

Overview of Budget Request

CMS requests funding for its annually-appropriated accounts including Program Management (PM), discretionary Healthcare Fraud and Abuse Control (HCFAC), Grants to States for Medicaid, and Payments to the Health Care Trust Funds. The table on the next page displays CMS' FY 2020 Final, FY 2021 Enacted, and FY 2022 Request for these accounts.

CMS' resource needs are principally driven by workloads that grow annually and by its role in leading national efforts to improve efficiency, healthcare quality, and access to care. The FY 2022 budget request reflects a level of funding that will not only allow CMS to focus on base operations, but also improve its traditional activities throughout its various programs.

CMS Annually-Appropriated Accounts
(Dollars in Millions)

Account	FY 2020 Final	FY 2021 Enacted	FY 2022 Request
Program Management	$3,974.7	$3,974.7	$4,315.8
HCFAC Discretionary	$786.0	$807.0	$872.8
Grants to States for Medicaid	$411,120.2	$453,807.2	$517,398.4
Payments to Health Care Trust Funds	$410,796.1	$439,514.0	$487,862.0
Total Discretionary Request	**$826,677.0**	**$898,102.9**	**$1,010,449.0**

FY 2022 Request

Program Management

In FY 2022, CMS requests $4,315.8 million in Budget Authority appropriated funding. The budget invests in mission-critical operations to ensure CMS can better serve its increasing beneficiary population and carry out its growing legislative responsibilities. CMS' budget request supports the Agency's priorities of improving quality and lowering cost, providing flexibility to state and local communities, and expanding access. CMS will find ways to make equity integral in our programs. With this level of requested funding, CMS can appropriately execute core Agency functions, maintain public-facing services, and accomplish the priorities of this administration.

- Program Operations:

  CMS' FY 2022 budget request for Program Operations totals $2,979.7 million. Most funding within the Program Operations line supports CMS' traditional Medicare operations. This funding level will allow CMS to process more than 1.2 billion fee-for-service claims and related workloads; support information technology systems and IT-related initiatives such as Medicare Payment Systems Modernization and cybersecurity; maintain our 1-800-MEDICARE call centers; support oversight of Part C and D plans; and provide outreach and education to millions of beneficiaries and consumers. Further, the FY 2022 request includes funding for Medicaid and CHIP operations, including state use of the Federal Data Services Hub to determine Medicaid eligibility,

funding for CMS' COVID-19 response, and funding to address recent Executive Orders that help reduce health disparities in vulnerable populations and minorities.

- Federal Administration:

  CMS' FY 2022 budget request for Federal Administration totals $864.0 million. Of this request, $793.1 million supports 4,384 direct FTEs, an increase of 145 FTEs when compared to the FY 2021 Enacted level. At this level CMS will be able to maintain current operations and increase its FTE strength to cover hiring of essential positions for specific administrative priorities. The FY 2022 FTE estimate includes a 2.7 percent pay inflation assumption for both civilian employees and Commissioned Corps staff and a 1.0 percent inflation estimate to cover increases in benefits costs. This budget also accounts for the absorption of additional FTEs from expiring and exhausting mandatory funding sources, ensuring continued operations of required activities.

- Survey and Certification:

  CMS' FY 2022 budget request for Survey and Certification totals $472.2 million. With this level of funding, CMS projects that the States will be able to maintain survey frequency rates of statutory facilities at 100 percent and improve the rates of non-statutory facilities, enhancing the ability of the program to provide oversight. The request sustains efforts initiated during the COVID-19 pandemic to ensure long-term care and other facilities have proper infection controls in place, not only as a response to COVID-19, but also preparing these facilities for future public health emergencies. This funding also provides opportunities through increased routine surveys to assess and correct quality issues before they manifest as substantiated complaints and increased survey workload. Overall, this request allows CMS to strengthen the effectiveness of its quality improvement efforts by improving national survey consistency and strengthening program oversight. Additionally, the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136; CARES Act) provides CMS with $200 million in multi-year Program Management funding available through FY 2023 to "prevent, prepare for, and respond to the Coronavirus (COVID-19) domestically and internationally." Within this amount, the CARES Act includes no less than $100 million to support the necessary expenses of CMS' survey and certification program. In FY 2022, the CARES Act funds dedicated to Survey and Certification will allow the State Agencies to perform additional surveys of nursing homes in localities with community transmission of COVID-19.

Health Care Fraud and Abuse Control

In FY 2022, CMS requests $872.8 million in discretionary HCFAC funding, which would be allocated among CMS, DOJ, and HHS/OIG. Increased funding over FY 2021 Budget levels will provide resources for CMS to address emerging fraud and abuse schemes that have evolved during the OVID-19 pandemic, respond to work paused because of the pandemic, and conduct additional Medicare FFS medical review. With these additional resources, CMS and its law enforcement partners will invest in new and expanded activities that will reduce fraud in Medicare, Medicaid and CHIP, and the Marketplaces. CMS plans to place emphasis in the following areas: pre-pay claim review with the aid of predictive analytic support; streamlining provider enrollment initiatives and simplifying documentation requirements to reduce provider burden; enhanced use of artificial intelligence tools,

including as part of Medicare medical review, to make program integrity efforts more efficient; individual provider education; increasing communication and data sharing with internal and external stakeholders; and enhancing States' abilities to detect and deter fraud and abuse.

Grants to States for Medicaid

The FY 2022 Medicaid request is $517,398.4 million, adecrease of $2,519.1 million below the FY 2021 estimate. COVID-19 related legislation has had an impact on this account, which contributed to the funding increase from FY 2021 when compared to FY 2022. For example, States received an additional 6.2 percent Federal match on certain Medicaid medical assistance benefits (MAP). This appropriation consists of $368.6 billion for FY 2022 and $148.7 billion in an advance appropriation from FY 2021. These funds will help finance $563.7 billion in estimated gross obligations in FY 2022. These obligations consist of:

- $536.3 billion in Medicaid medical assistance benefits;
- $22.3 billion for Medicaid administrative functions including Medicaid survey and certification and State fraud control units; and
- $5.1 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

Payments to the Health Care Trust Funds

The FY 2022 request for Payments to the Health Care Trust Funds account totals $487,862.0 million, an increase of $48,348.0 million above the FY 2021 enacted level. This account transfers payments from the General Fund to the trust funds in order to make the Supplementary Medical Insurance (SMI) Trust Fund and the Hospital Insurance (HI) Trust Fund whole for certain costs, initially borne by the trust funds, which are properly chargeable to the General Fund. The largest transfer provides the General Fund contribution to the SMI Trust Fund for the General Fund's share of the SMI program. Other transfers include payments from the General Fund to the HI and SMI Trust Funds including the Medicare Prescription Drug Account, for costs such as general revenue for prescription drug benefits, HCFAC, and other administrative costs that are properly chargeable to the General Fund. The change in CMS' FY 2022 request, when compared to the FY 2021 Enacted level, is largely driven by increases for the General Fund contributions for the SMI Trust Fund.

Budget Highlights

Cybersecurity ($123.1 million): CMS faces daily cybersecurity threats to the data we safeguard because of the increased technical capacity of "malicious actors" across the globe. Threats continue to intensify and CMS must enhance our IT security program to meet these vulnerabilities. Combating security threats, which are constantly finding new and innovative ways to breach infrastructure, is one of CMS' IT top priorities.

Funding is needed to establish and maintain ongoing authorization, automate Indicators of Compromise (IOCs) sharing with data centers, increase the viability of cloud security, and maintain improvements made to our IT security programs. As a result of the accelerated implementation timeline for all Continuous Diagnostics and Mitigation (CDM) phases, CMS must plan and execute multiple CDM phases simultaneously. CDM delivers cybersecurity

tools, integration services, and dashboards that improve security posturing and improve response capabilities.

Medicare Payment Systems Modernization (MPSM) ($37.3 million): CMS has been incrementally developing a framework to modernize all the Fee-For-Service systems through introducing new tools, technologies, and processes into the ecosystem. This methodical process is aimed at vastly improving our 40-year-old claims processing systems, containing millions of lines of outdated and complex code. Implementing a more agile framework will result in improved flexibility, adaptability, and speed of the suite of systems. CMS continues to build on the incremental foundation of this initiative and maximize operational efficiencies through a comprehensive strategic plan.

Opioid Support Services ($16.3 million): The opioid crisis continues to be a pressing public health challenge, impacting many Americans, and CMS will be contributing to a significant, government-wide investment to end the opioid epidemic. As the largest healthcare payer in the United States, CMS uses coverage and payment levers to advance evidence-based responses to the epidemic. CMS will continue to advance its strategy to promote safe and effective treatment options for pain that rely less on opioids, expand access to Substance Use-Disorder (SUD) support and treatment, and better use data to improve operations.

Health Equity ($25.0 million): As the largest payer of healthcare in the U.S, CMS is uniquely positioned to drive equity in the healthcare system. CMS, in accordance with Executive Orders "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government" and "Ensuring Equitable Pandemic Response and Recovery", will address current and emerging public health issues and related health disparities impacting CMS's priority, underserved populations.

COVID-19 Response ($50.0 million): CMS expects to exhaust all CARES Act funding for general operations (the non-survey and certification funding) by the end of FY 2021. Therefore, in FY 2022, CMS would continue funding relevant activities through the duration of the public health emergency such as end-user IT support, beneficiary education and outreach associated with COVID-19, Technical Assistance to States for the Medicaid program, and other COVID-19 related support efforts.

Overview of Performance

CMS supports the Administration's goals to make government more effective, efficient, and customer-focused in managing and delivering HHS programs by implementing the Government Performance and Results Act of 1993 (GPRA) and GPRA Modernization Act of 2010 (GPRA-MA). CMS performance measures highlight fundamental program purposes and focus on the agency's role as an efficient and effective steward of taxpayer dollars. We continue to work on aligning our performance commitments to the CMS and HHS priorities. CMS tracks many of its established performance measures and will work to introduce improvements that reflect the Administration's priorities.

CMS uses performance information to identify opportunities for improvement and to shape and improve its programs. The use of performance measures also provides a method of clear communication of CMS programmatic objectives to partners, such as states and

national professional organizations. Performance data are extremely useful in shaping policy and management choices in both the short and long term.

The CMS FY 2022 Performance section is designed to create a more complete presentation of performance commitments, accomplishments, and trends. Due to the PHE (COVID-19), some CMS performance reporting is delayed or revised. We continue to assess the impact of this on our program performance reporting.

Conclusion

CMS' FY 2022 program level request for Program Management totals $4,315.8 million. This funding will allow CMS to continue its traditional activities in the Medicare, Medicaid, and CHIP programs. Funding will also be used to fund key budget initiatives such as cybersecurity and ensuring healthcare equity for our beneficiaries.

This request includes $872.8 million in discretionary HCFAC funds for CMS, DOJ, and HHS/OIG. This funding will be devoted to maintaining and improving oversight programs related to early detection and prevention, and reducing improper payments.

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

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

	FY 2020		FY 2021		FY 2022	
	Final /1	Supplemental Funding	Enacted	Supplemental Funding	President's Budget	FY 2022 +/- FY 2021
Program Operations	$ 2,774.823	$ -	$ 2,784.823	$ -	$ 2,979.680	$ 194.857
Federal Administration	$ 782.533	$ -	$ 772.533	$ -	$ 864.000	$ 91.467
State Survey & Certification	$ 397.334	$ -	$ 397.334	$ -	$ 472.163	$ 74.829
Research /2	$ 20.054	$ -	$ 20.054	$ -	$ -	$ (20.054)
CARES Act Supplemental (P.L. 116-136)	$ -	$ 200.000	$ -	$ -	$ -	$ -
Subtotal, Appropriation/BA Current Law (Discretionary; 0511)	**$ 3,974.744**	**$ 200.000**	**$ 3,974.744**	**$ -**	**$ 4,315.843**	**$ 341.099**
MIPPA (Mandatory; P.L. 110-275)	$ 2.897	$ -	$ 3.000	$ -	$ 2.872	$ (0.128)
PAMA (P.L. 113-93)	$ 9.657	$ -	$ 10.000	$ -	$ 4.787	$ (5.213)
IMPACT (P.L. 113-185)	$ 5.432	$ -	$ 5.625	$ -	$ 5.385	$ (0.240)
MACRA (P.L. 114-10)	$ 19.313	$ -	$ -	$ -	$ -	$ -
BBA (P.L. 115-123)	$ 4.828	$ -	$ 5.000	$ -	$ 4.787	$ (0.213)
Health Extenders Sec. 1402 (P.L. 116-59)	$ 1.852	$ -	$ -	$ -	$ -	$ -
Further Health Extenders Sec. 1402 (P.L. 116-69)	$ 1.033	$ -	$ -	$ -	$ -	$ -
Further Consolidated Appropriations Act (P.L. 116-94)	$ 10.315	$ -	$ -	$ -	$ -	$ -
CARES Act (P.L. 116-136)	$ 19.800	$ -	$ -	$ -	$ -	$ -
Consolidated Appropriations Act (P.L. 116-260)	$ -	$ -	$ 98.000	$ -	$ 44.996	$ (53.004)
American Rescue Plan Act (P.L. 117-2) /3	$ -	$ -	$ -	$ 500.000	$ -	$ -
Total, Mandatory Appropriation/BA C.L. (Mandatory; 0511) /4	**$ 75.127**	**$ -**	**$ 121.625**	**$ 500.000**	**$ 62.827**	**$ (58.798)**
Total, Appropriation/BA Current Law (0511)	**$ 4,049.871**	**$ 200.000**	**$ 4,096.369**	**$ 500.000**	**$ 4,378.670**	**$ 282.301**
Proposed Law Appropriation (Mandatory)	$ -	$ -	$ -	$ -	$ -	$ -
Total, Appropriation/BA Proposed Law (0511)	**$ 4,049.871**	**$ 200.000**	**$ 4,096.369**	**$ 500.000**	**$ 4,378.670**	**$ 282.301**
Est. Offsetting Collections from Non-Federal Sources: /4						
User Fees and Reimbursements	$ 256.364	$ -	$ 260.946	$ -	$ 266.203	$ 5.257
Marketplace User Fees (FFM)	$ 1,578.362	$ -	$ 1,494.259	$ -	$ 1,407.977	$ (86.282)
Risk Adjustment User Fees (RA)	$ 40.615	$ -	$ 49.547	$ -	$ 59.430	$ 9.883
Recovery Audit Contracts	$ 458.656	$ -	$ 580.000	$ -	$ 688.456	$ 108.456
Total, Offsetting Collections	**$ 2,333.997**	**$ -**	**$ 2,384.752**	**$ -**	**$ 2,422.066**	**$ 37.314**
Subtotal, New BA, Current Law	**$ 6,383.868**	**$ 200.000**	**$ 6,481.121**	**$ 500.000**	**$ 6,800.736**	**$ 319.615**
Proposed Law Discretionary	$ -		$ -		$ -	$ -
Program Level, Proposed Law (0511)	**$ 6,383.868**	**$ 200.000**	**$ 6,481.121**	**$ 500.000**	**$ 6,800.736**	**$ 319.615**
HCFAC Discretionary	**$ 786.000**	**$ -**	**$ 807.000**	**$ -**	**$ 872.793**	**$ 65.793**
Non-CMS Administration /5	**$ 2,854.050**	**$ -**	**$ 3,123.974**	**$ -**	**$ 3,438.765**	**$ 314.791**
CMS FTEs:						
Discretionary (Federal Administration)	4,329		4,239		4,384	145
Reimbursable (CLIA, CoB, RAC, Marketplace)	304		459		459	0
Mandatory (Direct Appropriations)	118		66		61	(5)
Subtotal, Program Management FTEs	**4,751**	**0**	**4,764**	**0**	**4,904**	**140**
Program Management, Proposed Law	0		0		0	0
Total, Program Management FTEs	**4,751**	**0**	**4,764**	**0**	**4,904**	**140**
HCFAC Mandatory	437		478		478	0
Medicaid Integrity (State Grants; Mandatory)	199		214		214	0
Affordable Care Act Section 3021 (Mandatory)	528		552		552	0
Quality Improvement Organizations	282		270		270	0
Demonstrations	9		11		7	(4)
Consolidated Appropriations Act (No Surprises)	0		25		57	32
Subtotal, Other Sources FTEs	**1,455**	**0**	**1,550**	**0**	**1,578**	**28**
Total, CMS FTEs	**6,206**	**0**	**6,314**	**0**	**6,482**	**168**

/1 Reflects amounts appropriated and any reprogrammings or reallocations notified to Congress.
/2 In FY 2022, CMS proposes to request Research funding within the Program Operations account.
/3 The FY 2021 Enacted level for Sections 9402 and 9818 of the American Rescue Plan Act reflects the funding to be transferred from CMS to the Centers for Disease Control (CDC).
/4 Amounts are net of sequester and pop-up authority, as applicable.
/5 Includes funds for the SSA, DHHS/OS, MedPac, and the SHIPs.

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Program Management

Appropriations Language

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare *&* Medicaid Services, not to exceed **[**$3,974,744,000**]** *$4,315,843,000*, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act*;* together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 1893(h) of the Social Security Act, and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended: *Provided,* That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: *Provided further*, That the Secretary is directed to collect fees in fiscal year **[**2021**]** *2022* from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act: *Provided further,* That of the amount made available under this heading, **[**$397,334,000**]** *$472,163,000* shall remain available until September 30, **[**2022**]** 2023, and shall be available for the Survey and Certification Program. **[**Provided further, That amounts available under this heading to support quality improvement organizations (as defined in section 1152 of the Social Security Act) shall not exceed the amount specifically provided for such purpose under this heading in division H of the Consolidated Appropriations Act, 2018 (Public Law 115-141)**.]** *(Department of Health and Human Services Appropriations Act, 2021.)*

Program Management

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare & Medicaid Services, not to exceed **[**$3,974,744,000**]** *$4,315,843,000*, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act*;*	Provides a one-year appropriation from the HI and SMI Trust Funds for the administration of the Medicare, Medicaid, Children's Health Insurance, and consumer information and insurance oversight and protection programs. The HI Trust Fund will be reimbursed for the General Fund share of these costs through an appropriation in the Payments to the Health Care Trust Funds account.
together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 1893(h) of the Social Security Act, and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended:	Provides funding for the Clinical Laboratory Improvement Amendments program, which is funded solely from user fee collections. Authorizes the collection of fees for the sale of data, and other authorized user fees and offsetting collections to cover administrative costs, including those associated with providing data to the public, and other purposes. All of these collections are available to be carried over from year to year, until expended.
Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation:	Authorizes the crediting of HMO user fee collections to the Program Management account.
Provided further, That the Secretary is directed to collect fees in fiscal year **[**2021**]** *2022* from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act	Authorizes the collection of user fees from Medicare Advantage organization for costs related to enrollment, dissemination of information and certain counseling and assistance programs.

Language Provision	Explanation
Provided further, That of the amount made available under this heading, $472,163,000, to remain available until September 30, 2023 and shall be available for the Survey and Certification Program.	Extends the period of availability of Survey and Certification funding to two-year.

CMS Program Management
Amounts Available for Obligation

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS)	$3,974,744,000	$3,974,744,000	$4,315,843,000
CARES Act Supplemental (PL 116-136)	$200,000,000	$0	$0
Trust Fund Mandatory Appropriation:			
PAMA/SGR (PL 113-93)	$9,656,639	$10,000,000	$4,786,836
IMPACT Act (PL 113-185)	$5,431,860	$5,625,000	$5,385,190
MACRA (PL 114-10)	$19,313,279	$0	$0
BBA (PL 115-123)	$4,828,320	$5,000,000	$4,786,836
Health Extenders (116-59)	$1,852,000	$0	$0
Further Health Extenders (116-69)	$1,033,000	$0	$0
Further Consolidated Appropriations (116-94)	$10,315,000	$0	$0
CARES (PL 116-136)	$19,800,000	$0	$0
Consolidated Appropriations (PL 116-260)	$0	$98,000,000	$44,996,255
American Rescue Plan (PL 117-2) /1	$0	$500,000,000	$0
Subtotal, trust fund mand. Appropriation /2	$72,230,098	$618,625,000	$59,955,117
Mandatory Appropriation			
MIPPA (PL 110-275)	$2,896,992	$3,000,000	$2,872,101
Subtotal, trust fund mand. Appropriation /2	$2,896,992	$3,000,000	$2,872,101
Offsetting Collections from Non-Federal Sources:			
Sale of data user fees	$29,151,718	$25,000,000	$27,000,000
Marketplace user fees (FFM)	$1,578,362,488	$1,494,258,891	$1,407,976,600
Risk Adjustment user fees (RA)	$40,615,368	$49,546,583	$59,430,000
Recovery audit contracts	$458,655,589	$580,000,000	$688,455,623
CLIA user fees	$60,195,497	$61,295,000	$56,580,000
Part D COB user fees	$47,825,381	$35,000,000	$33,507,849
MA/PDP user fees	$95,347,154	$99,196,696	$105,597,594
Provider enrollment user fees	$14,972,182	$18,765,834	$23,715,000
Civil Monetary Penalties	$8,872,258	$21,689,000	$19,803,000
Subtotal, offsetting collections /3	$2,333,997,635	$2,384,752,004	$2,422,065,666
Total Budget Authority /4	**$6,583,868,725**	**$6,981,121,004**	**$6,800,735,884**

/1 The FY 2021 Enacted level for Sections 9402 and 9818 of the American Rescue Plan Act reflects the funding to be transferred from CMS to the Centers for Disease Control (CDC).
/2 Current law display. Net of sequester.
/3 Amounts are net of sequester and pop-up authority, as applicable.
/4 Totals may not add due to rounding.

Program Management
Summary of Changes

2021 Enacted	
Total estimated budget authority 1/	$3,974,744,000
(Obligations) 1/	($3,974,744,000)
2022 President's Budget	
Total estimated budget authority 1/	$4,315,843,000
(Obligations) 1/	($4,315,843,000)
Net Change	**$341,099,000**

	FTE	2021 Estimate Budget Authority	FTE	Change from Base Budget Authority
Increases:				
A. Program:				
1. Program Operations		$2,784,823,000		$311,504,000
2. Federal Administration		$772,533,000		$91,467,000
3. State Survey & Certification		$397,334,000		$75,655,659
4. Research		$20,054,000		$0
Subtotal, Program Increases 1/				**$478,626,659**
Total Increases 1/				**$478,626,659**
Decreases:				
A. Program:				
1. Program Operations		$2,824,823,000		($116,647,000)
2. Federal Administration	4,239	$732,533,000	145	$0
3. State Survey & Certification		$397,334,000		($826,659)
4. Research		$20,054,000		($20,054,000)
Subtotal, Program Decreases 1/				**($137,527,659)**
Total Decreases 1/				**($137,527,659)**
Net Change 1/				**$341,099,000**

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

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

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
1. Program Operations /1	$2,469,823	$2,784,823	$2,979,680
Additional Medicare Operations Funding	$305,000	$0	$0
CARES Act Supplemental (116-136)	$100,000		
MIPPA (PL 110-275)	$3,000	$3,000	$3,000
PAMA/SGR (PL 113-93)	$10,000	$10,000	$5,000
MACRA (PL 114-10)	$20,000	$0	$0
BBA (115-123)	$5,000	$5,000	$5,000
Health Extenders (116-59)	$1,852	$0	$0
Further Health Extenders (116-69)	$1,033	$0	$0
Further Consolidated Appropriation (116-94)	$10,315	$0	$0
CARES Act (116-136)	$19,800	$0	$0
Consolidated Appropriations Act (116-260)	$0	$98,000	$47,000
Sequester	($1,305)	$0	($2,558)
Subtotal, Program Operations	**$2,944,518**	**$2,900,823**	**$3,037,122**
(Obligations) /2	($3,033,879)	($3,499,823)	($3,094,118)
2. Federal Administration /1	$782,533	$772,533	$864,000
Sequester	$0	$0	$0
Subtotal, Federal Administration	**$782,533**	**$772,533**	**$864,000**
(Obligations) /3	($799,780)	($772,533)	($864,000)
3. State Survey & Certification	$397,334	$397,334	$472,163
IMPACT Act (PL 113-185)	$5,625	$5,625	$5,625
CARES Act Supplemental (116-136)	$100,000	$0	$0
American Rescue Plan Act (117-2) /4	$0	$500,000	$0
Sequester	($193)	$0	($240)
Subtotal, State Survey & Certification	**$502,766**	**$902,959**	**$477,548**
(Obligations)	($419,433)	($973,959)	($477,548)
4. Research, Demonstration & Evaluation /5	$20,054	$20,054	$0
Sequester	$0	$0	$0
Subtotal, Research, Demonstration & Evaluation	**$20,054**	**$20,054**	**$0**
(Obligations)	($19,654)	($20,054)	$0
5. Reimbursables	$2,337,231	$2,380,000	$2,459,614
Sequester	($123,258)	($93,708)	($126,240)
Sequester Pop-Up	$120,025	$98,460	$88,692
Subtotal, User Fees	**$2,333,998**	**$2,384,752**	**$2,422,066**
(Obligations)	($1,742,580)	($2,044,647)	($2,130,892)
Total, Budget Authority /6	**$6,583,869**	**$6,981,121**	**$6,800,736**
(Obligations)	**($6,015,326)**	**($7,311,016)**	**($6,566,558)**
FTE /7	**4,751**	**4,764**	**4,904**

/1 FY 2020 includes $50 million reprogramming from Program Operations to Federal Administration.

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

/3 FY 2020 obligations include administrative cost reimbursements from external agencies.

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

/5 Research is appropriated its own PPA in FYs 2020 and 2021. In FY 2022, CMS proposes to request this funding within the Program Operations account.

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

/7 Includes direct and reimbursable FTEs only.

CMS Program Management
Authorizing Legislation

	FY 2021 Amount Authorized	FY 2021 Enacted	FY 2022 Amount Authorized	FY 2022 President's Budget
Program Management:				
1. Research:				
a) Social Security Act, Title XI				
- Section 1110	Indefinite	Indefinite		
- Section 1115 1/	$ 2,000,000	$ 2,000,000		
b) P.L. 92-603, Section 222	Indefinite	Indefinite		
c) P.L. 90-248, Section 402	Indefinite	Indefinite		
d) Social Security Act, Title XVIII	Indefinite	Indefinite		
2. Program Operations:				
Social Security Act, Titles XI, XVIII, XIX and XXI	Indefinite	Indefinite	Indefinite	Indefinite
a) Social Security Act, Title XI				
- Section 1110			Indefinite	Indefinite
- Section 1115 1/			$ 2,000,000	$ 2,000,000
b) P.L. 92-603, Section 222			Indefinite	Indefinite
c) P.L. 90-248, Section 402			Indefinite	Indefinite
d) Social Security Act, Title XVIII			Indefinite	Indefinite
3. State Certification:				
Social Security Act, Title XVIII, Section 1864	Indefinite	Indefinite	Indefinite	Indefinite
4. Administrative Costs:				
Reorganization Act of 1953	Indefinite	Indefinite	Indefinite	Indefinite
5. CLIA 1988:				
Section 353, Public Health Service Act	Indefinite	Indefinite	Indefinite	Indefinite
6. MA/PDP:				
Social Security Act, Section 1857(e)(2) Balanced Budget Refinement Act of 1999 Medicare Prescription Drug, Improvement and Modernization Act of 2003	2/	2/	2/	2/
7. Coordination of Benefits:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA)	Indefinite	Indefinite	Indefinite	Indefinite
8. Provider Enrollment:				
Patient Protection and Affordable Care Act P.L. 111-148/152 Section 6401, amended	2/	2/	2/	2/
9. Marketplaces:				
Patient Protection and Affordable Care Act P.L. 111-148/152 Sections 1311 and 1321; 31 USC 9701.	Indefinite	Indefinite	Indefinite	Indefinite
10. Recovery Audit Contractors:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA) Tax Relief and Health Care Act of 2006 (PL 109-432 TRHCA)	Indefinite	Indefinite	Indefinite	Indefinite
Unfunded authorizations:				
Total request level	$ -	$ -	$ -	$ -
Total request level against definite authorizations	$ -	$ -	$ -	$ -

1/ The total authorization for section 1115 is $4.0 million. CMS' share of this funding is estimated at $2.0 million in FY 2022.
2/ Limits authorized user fees to an amount computed by formula.

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2013				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Transfers	$0	$0	$0	$453,803,000
Sequestration	$0	$0	$0	($5,763,000)
Subtotal				$561,040,000
Trust Fund Appropriation:				
Base	$4,820,808,000	$0	$4,370,112,000	$3,872,227,000
Transfers (P.L. 113-6)	$0	$0	$0	$113,588,000
Rescissions (P.L. 113-6)	$0	$0	$0	($7,656,000)
Sequestration	$0	$0	$0	($194,827,000)
ATRA (PL 112-240)	$0	$0	$0	$17,500,000
ACA (PL 111-148/152)	$0	$0	$0	$25,440,000
Sequestration	$0	$0	$0	($2,190,000)
Subtotal	$4,820,808,000	$0	$4,370,112,000	$3,824,082,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($7,140,000)
2014				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Sequestration	$0	$0	$0	($8,136,000)
Subtotal				$104,864,000
Trust Fund Appropriation:				
Base **1/**	$5,217,357,000	$0	$5,217,357,000	$3,974,744,000
Transfers (P.L. 113-76)	$0	$0	$0	$118,582,000
Sequestration	$0	$0	$0	($1,584,000)
ACA (PL 111-148/152)	$0	$0	$0	$25,341,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$48,500,000
Sequestration	$0	$0	$0	($1,825,000)
Subtotal	$5,217,357,000	$0	$5,217,357,000	$4,163,758,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($10,080,000)
2015				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$50,000,000
Sequestration	$0	$0	$0	($3,869,000)
Subtotal				$49,131,000
Trust Fund Appropriation:				
Base **1/**	$4,199,744,000	$0	$0	$3,974,744,000
ACA (PL 111-148/152)	$0	$0	$0	$5,559,200
Sequestration	$0	$0	$0	($408,000)
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$204,500,000
IMPACT Act (PL 113-185)	$0	$0	$0	$107,333,000
Subtotal	$4,199,744,000	$0	$0	$4,297,728,200
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($10,220,000)

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2016				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($204,000)
Subtotal				$2,796,000
Trust Fund Appropriation:				
Base **1/ 2/**	$4,245,186,000	$0	$0	$3,970,785,000
ACA (PL 111-148/152)	$0	$0	$0	$353,000
Sequestration	$0	$0	$0	($1,883,000)
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$216,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$21,333,000
Subtotal	$4,245,186,000	$0	$0	$4,212,588,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$65,000,000
Sequestration	$0	$0	$0	($4,420,000)
2017				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($207,000)
Subtotal				$2,793,000
Trust Fund Appropriation:				
Base **1/ 2/**	$4,109,549,000	$0	$0	$3,966,314,000
IMPACT Act (PL 113-185)	$0	$0	$0	$21,333,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$211,000,000
21st Century Cures (PL 114-255)	$0	$0	$0	$18,000,000
Sequestration	$0	$0	$0	($16,444,977)
Subtotal	$4,109,549,000	$0	$0	$4,206,202,023
2018				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($198,000)
Subtotal				$2,802,000
Trust Fund Appropriation:				
Base **1/ 2/**	$3,587,996,000	$3,451,141,000	$3,974,744,000	$3,964,880,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$163,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$18,625,000
21st Century Cures Act (PL 114-255)	$0	$0	$0	$12,000,000
BB Act '18 (PL 115-123)	$0	$0	$0	$35,500,000
Sequestration	$0	$0	$0	($13,175,250)
Subtotal	$3,587,996,000	$3,451,141,000	$3,974,744,000	$4,186,829,750
2019				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($186,000)
Subtotal				$2,814,000
Trust Fund Appropriation:				
Base **1/ 2/**	$3,543,879,000	$3,502,024,000	$3,974,744,000	$3,965,796,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
MACRA (PL 114-10)	$0	$0	$0	$115,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$18,625,000
BB Act '18 (PL 115-123)	$0	$0	$0	$25,500,000
SUPPORT Act (PL 115-271)	$0	$0	$0	$83,000,000
Sequestration	$0	$0	$0	($8,904,750)
Subtotal	$3,543,879,000	$3,502,024,000	$3,974,744,000	$4,209,016,250

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2020				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($103,008)
Subtotal				$2,896,992
Trust Fund Appropriation:				
Base **1/**	$3,579,427,000	$3,984,744,000	$3,974,744,000	$3,974,744,000
CARES Act Supplemental (PL 116-136)	$0	$0	$0	$200,000,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
MACRA (PL 114-10)	$0	$0	$0	$20,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
BB Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Health Extenders (PL 116-59)	$0	$0	$0	$1,852,000
Further Health Extenders (PL 116-69)	$0	$0	$0	$1,033,000
Further Consolidated Appropriation (PL 116-94)	$0	$0	$0	$10,315,000
CARES Act (PL 116-136)	$0	$0	$0	$19,800,000
Sequestration	$0	$0	$0	($1,394,903)
Subtotal	$3,579,427,000	$3,984,744,000	$3,974,744,000	$4,246,974,097
2021				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	$0
Subtotal				$3,000,000
Trust Fund Appropriation:				
Base **1/**	$3,693,548,000	$3,984,744,000	$3,974,744,000	$3,974,744,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
BB Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Consolidated Appropriation (PL 116-260)	$0	$0	$0	$98,000,000
American Rescue Plan (PL 117-2) **3/**	$0	$0	$0	$500,000,000
Sequestration	$0	$0	$0	$0
Subtotal	$3,693,548,000	$3,984,744,000	$3,974,744,000	$4,593,369,000
2022				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($127,899)
Subtotal				$2,872,101
Trust Fund Appropriation:				
Base **4/**	$4,315,843,000	$0	$0	$0
PAMA/SGR (PL 113-93)	$0	$0	$0	$5,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
BB Act '18 (PL 115-123)	$0	$0	$0	$5,000,000
Consolidated Appropriation (PL 116-260)	$0	$0	$0	$47,000,000
Sequestration	$0	$0	$0	($2,669,884)
Subtotal	$4,315,843,000	$0	$0	$59,955,116

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

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

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

4/ Based on Current Law Request

CMS Program Management
Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2021

CMS Program Management has no appropriations not authorized by law.

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Program Operations
(Dollars in Thousands)

FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
$2,774,823	$2,784,823	$2,979,680	$194,857

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

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

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

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

FY 2021 Authorization – One Year/Multi-Year P.L. 116-260

Allocation Method – Contracts, Competitive Grants, Cooperative Agreements

OVERVIEW

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

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

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

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

Program Description and Accomplishments

Medicare

Authorized in 1965 under title XVIII of the Social Security Act, the Medicare program provides hospital and supplemental medical insurance to Americans age 65 and older and to disabled persons, including those with ESRD. The program was expanded in 2006 with the introduction of a voluntary prescription drug benefit, Part D. Medicare enrollment has increased from 21 million in 1966 to a projected 65 million beneficiaries in FY 2022. Medicare benefits, that is, the payments made to providers, health plans, and drug plans for their services, are permanently authorized. The Medicare administrative expenses discussed in this chapter are funded annually through the CMS Program Management appropriation.

Medicaid and CHIP

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

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

Private Health Insurance Protections and Programs

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

Funding History

Fiscal Year (FY)	Budget Authority
FY 2018 [1]	$2,814,959,000
FY 2019 [2]	$2,815,875,000
FY 2020 [3]	$2,774,823,000
FY 2021 Enacted	$2,784,823,000
FY 2022 President's Budget	$2,979,680,000

Budget Request: $2,979.7 Million

CMS' FY 2022 President's Budget request for Program Operations is $2,979.7 million, an increase of $194.9 million above the FY 2021 Enacted Level. This request provides the funding needed for CMS to administer, oversee, and support Medicare, Medicaid, CHIP, and private insurance. The funding increase supports state use of the Federal Marketplace Data Services Hub to determine Medicaid eligibility, funding for the Federal Marketplaces, and a larger portion of the cost to operate MACBIS including new data analytic work in FY 2022. In addition, this budget invests in several critical initiatives including, but not limited to, the opioid crisis, health equity, and the COVID-19 response. Claim volumes and subsequent workloads were impacted in FY 2020 due to COVID-19. CMS will continue to invest in high priority activities with a focus on high quality service for beneficiaries and participating providers and will continue evaluating areas for contract efficiencies to maximize resources.

[1] FY 2018 includes $9.864 million in HHS Secretary's Transfer Authority.
[2] FY 2019 includes $8.948 million in HHS Secretary's Transfer Authority.
[3] FY 2020 Enacted Base includes $50 million reprogrammed to Federal Administration.

Program Operations
(Dollars in Thousands)

Activity	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
I. Medicare Parts A&B				
Ongoing Operations	$801,849	$789,922	$800,459	$10,537
FFS Operations Support	$43,521	$48,682	$52,995	$4,313
Claims Processing Investments	$75,026	$79,026	$88,592	$9,566
DME Competitive Bidding	$3,776	$77,296	$9,800	($67,496)
QIC Appeals	$57,447	$70,361	$79,597	$9,236
II. Medicare Parts C&D				
Oversight and Management of Health Plans	$43,820	$47,987	$46,898	($1,089)
Medicare Parts C and D Appeals	$20,616	$23,895	$25,167	$1,272
Medicare Parts C and D IT Systems Investments	$28,736	$32,866	$31,502	($1,364)
III. Medicaid & CHIP				
MACBIS	$70,622	$80,671	$98,129	$17,458
MAC Scorecard	$16,840	$17,997	$18,447	$450
Section 1115 Waivers	$12,754	$13,300	$14,761	$1,461
Medicaid Oversight and Support	$68,105	$63,429	$69,213	$5,784
IV. Private Health Insurance				
Market Oversight and Support	$8,747	$11,262	$11,085	($177)
Federal Marketplaces	$226,035	$135,140	$152,512	$17,372
V. Outreach & Education				
NMEP	$263,610	$288,616	$301,448	$12,832
Targeted Outreach and Enrollment	$7,089	$12,946	$15,423	$2,477
VI. Improving Health Care Quality				
Health Care Quality Initiatives	$54,118	$77,557	$31,037	($46,520)
Medicare Quality Improvement - Value Based Transformation	$68,251	$26,300	$35,000	$8,700
Quality Payment Program	$18,099	$36,243	$40,000	$3,757
VII. Enterprise Operations				
Accounting and Audits	$99,011	$100,108	$100,702	$594
HIPAA Administrative Simplification	$37,191	$31,318	$36,616	$5,298
IT Systems and Support	$673,960	$605,634	$685,637	$80,003
Operational Support	$68,635	$110,880	$118,000	$7,120
Opioid Support Services	$6,965	$3,387	$16,282	$12,895

Activity	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Research, Demonstrations, and Evaluation [4]	$0	$0	$25,378	$25,378
Health Equity	$0	$0	$25,000	$25,000
COVID-19 Response	$0	$0	$50,000	$50,000
TOTAL	**$2,774,823**	**$2,784,823**	**$2,979,680**	**$194,857**

I. MEDICARE - PARTS A AND B

Program Description and Accomplishments

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

Ongoing Operations

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

The following table displays claims volumes for the period FY 2019 - 2020 (actuals) and FY 2021 – 2022 (estimated).

FFS Claims Volume
(Claim Count in Thousands)

Activity	FY 2019 Actual	FY 2020 Actual	FY 2021 Estimate	FY 2022 Estimate
Part A (in thousands)	222,375	203,097	225,711	227,968
Part B (in thousands)	1,022,209	910,600	1,029,726	1,040,023
Total	**1,244,584**	**1,113,697**	**1,255,437**	**1,267,991**

[4] Research is appropriated its own PPA in FYs 2020 and 2021. In FY 2022, CMS proposes to request this funding within the Program Operations account.

Budget Request: $800.5 Million

The FY 2022 President's Budget request for Ongoing Operations is $800.5 million, an increase of $10.5 million above the FY 2021 Enacted level. This request allows the MACs to continue processing Medicare claims accurately, in a timely manner, and in accordance with CMS' program requirements. The funding request supports a one percent increase in MAC workload and other provider service and claim management operations.

In FY 2022, MACs are expected to:

- Process over 1.2 billion claims;
- Handle 2.4 million Medicare first-level appeal redeterminations; and
- Answer 12.3 million provider toll-free inquiries.

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

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

Medicare Appeals – The Medicare appeals process affords beneficiaries, providers, and suppliers the opportunity to dispute an adverse determination, including coverage and payment decisions. The first level of appeal begins at the MAC with a redetermination of the initial decision. MAC personnel not involved in the original determination review the original claim and any new information to determine if the original determination should be changed and handle any reprocessing activities as required. The statute stipulates that MACs issue a decision within 60 calendar days of receipt of an appeal request. In FY 2022, the MACs are expected to process 2.4 million redeterminations.

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

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

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

In FY 2022, contractors are expected to respond to 12.8 million telephone inquiries and 278,445 written inquiries (which include rare walk-in inquiries) from 2 million FFS providers. In an effort to drive efficiency, Interactive Voice Response (IVR) systems are used to automate approximately 50 percent of their telephone inquiries. Increased utilization of the IVR frees up customer service representatives to handle the more complex questions.

The following table displays provider toll-free line call volumes for FY 2019 - 2020 (actuals) and FY 2021 – 2022 (estimated):

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

	FY 2019 Actual	FY 2020 Actual	FY 2021 Estimate	FY 2022 Estimate
Completed Calls	19.1	15.5	12.8	12.8

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

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

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

MAC Transition Cost – CMS must support the transition, termination, and implementation costs associated with transitioning from incumbent MACs to their successor MACs. In FY 2022, CMS has scheduled the re-procurements of three A/B MAC Jurisdiction contracts. There are currently no DME MAC Jurisdiction contracts scheduled for re-compete in FY 2022.

Virtual Data Center Operations (VDC) – The VDC provides the infrastructure to all CMS Medicare Fee for Service Part A, B, and DME production operations. This includes hosting the Common Working File (CWF), web hosting services for Medicare.gov, CMS.HHS.gov, CMSNet and the Health Plan Management System (HPMS), and Application Hosting services for the 1-800 Medicare Next Generation Desktop Data Warehouse, and the Provider Environment.

Fee-for-Service Operations Support

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

Budget Request: $53.0 Million

The FY 2022 President's Budget request for FFS operations support is $53.0 million, an increase of $4.3 million above the FY 2021 Enacted level. CMS is requesting additional funding to support CMS systems security program requirements for the Common Electronic Data Interchange (CEDI). Additional funding is also requested for the Hospital Inpatient and Outpatient contracts to support an uptick in applications for add-on payments. CMS is developing new models and enhancements to IT systems to automate and simplify this process.

At this funding level, CMS will continue funding ongoing operations for critical services supporting the Medicare FFS program. Without these activities CMS would be unable to administer Medicare Parts A and B and pay claims according to law. These are described in more detail below:

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

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

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

- *Large Appeals Settlement Initiative*: This request pays for effectuation activities performed by the MACs to support CMS' Large Appeals Support Settlement Contractor, which is responsible for ensuring that all appeals settlements are executed correctly. Appeals settlements result in the removal of settled appeals from the backlog pending at the Office of Medicare Hearings and Appeals. CMS estimated costs based on historical rates for this same function in past years.

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

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

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

- *Printing and Postage*: This contract covers the printing and mailing of the Medicare Premium Bill (CMS-500) that is utilized to collect premiums from direct billed beneficiaries (42 CFR Section 408.60), including periodic mandatory and informational bill stuffers. CMS anticipates the number of bills mailed to direct bill beneficiaries to continue to increase by approximately 10% over FY 2021 levels.

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

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

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

- *Medicare Premium Billing:* This interagency agreement provides reimbursement to Treasury for remittance services related to premiums collected by the Medicare Premium Collection Center (MPCC) lockbox for directly billed beneficiaries. The directly billed population has historically increased 10% each year. It is expected by FY 2022 the direct billed population will have increased to over 2.6 million beneficiaries. CMS anticipates the direct bill population will continue to grow as the Medicare population increases and the Social Security eligibility age rises, creating a greater proportion of beneficiaries who must be directly billed for their Medicare premiums.

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

Claims Processing Investments

CMS' claims processing systems process over 1.2 billion Part A and Part B claims each year. The claims processing systems receive, verify, and log claims and adjustments, perform internal claim edits and claim validation edits, complete claims development and adjudications, maintain pricing and user files, and generate reports. The requested funding provides ongoing systems maintenance and operations.

The main systems include:

- *Medicare Fee-For-Service Shared Systems:* Medicare Administrative Contractors (MACs) use standard systems to adjudicate Part A, Part B, and DME claims. All claims are sent to the Common Working File (CWF) for eligibility, duplication, and utilization checks before final adjudication.

- *Fiscal Intermediary Shared System (FISS): FISS* is used to process more than 225 million Medicare Part A claims, including outpatient claims submitted under Part B.

- *Multi Carrier System (MCS):* MCS is used to process over 1 billion Medicare Part B claims for physician and non-physician practitioner care and other non-DMEPOS Part B services (e.g., ambulance)

- *ViPS Medicare System (VMS):* VMS is used to process claims for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS).

- *Common Working File (CWF):* The CWF system works with Medicare claims processing systems to ensure that:

- The beneficiary is entitled to either Part A or Part B benefits, depending on the type of claim submitted;

- The co-pay and/or deductible applied, if any, is accurate; and,

- Medicare benefits are available for the services submitted on the claim for that beneficiary.

The CWF system also ensures that the services on the claim have not been paid on another claim - either the same type or another type of claim to prevent duplicate payments.

- *Single Testing Contractor:* provides integration and regression testing for Medicare fee-for-service claims processing systems.

Budget Request: $88.6 Million

The FY 2022 President's Budget Level for claims processing systems is $88.6 million, an increase of $9.6 million above the FY 2021 Enacted level. In FY 2022, CMS will continue to implement recurring and non-recurring software changes and upgrades to the claims processing systems. The funding increase supports cloud hosting costs for the full system migration to the cloud environment of the Medicare Enrollment and Premium Billing Systems (MEPBS). Funding increases will also be used to support the current Beta testing effort and the new integrated testing effort concurrently for the Medicare Integrated Systems Testing (MIST) and revitalization efforts for the maintenance of grouper system that supports software and editing programs throughout CMS.

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

- *Enrollment Database and Direct Billing Support:* This funding supports system development, maintenance and also FISMA compliance of the Medicare Enrollment and Premium Billing Systems (MEPBS).

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

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

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

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

DME Competitive Bidding

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

Budget Request: $9.8 Million

The FY 2022 President's Budget request for DME competitive bidding is $9.8 million, a decrease of $67.5 million below the FY 2021 Enacted level. The DME competitive bidding process occurs on a three year cycle. CMS' FY 2022 budget request takes into account that the 2021 consolidated round has been awarded and is fully operational.

- *Competitive Bidding Implementation Contractor (CBIC)*: The request supports conducting surveys to key stakeholders (e.g., beneficiaries, suppliers, and referral agents), analyze survey results, and memorialize survey findings to determine the impact the Competitive Bidding Program is having on beneficiaries requiring DMEPOS. CMS is dedicated to ensure that Medicare beneficiaries receive quality items and services in a timely manner.

- *DME Bidding Systems (DBidS)*: DBids allows for entities to submit an online application to participate Medicare's DMECB Program. The FY 2022 request supports ongoing operations and maintenance.

Qualified Independent Contractor (QIC) Appeals

Section 521 of the Benefits Improvement and Protection Act of 2000 (BIPA) requires CMS to contract with Qualified Independent Contractors (QICs) to adjudicate second level appeals resulting from an adverse redetermination of a claim by a MAC during the first level of appeal. BIPA requires that QICs process Medicare Parts A and B claim appeals within 60 calendar days of receipt. If a QIC is unable to complete the appeal within the 60 day timeframe, then it must notify the appellant that it cannot timely complete the appeal

and offer the appellant an opportunity to escalate the appeal to an Administrative Law Judge at the Office of Medicare Hearings and Appeals (OMHA). This program ensures that Medicare beneficiaries' providers have the opportunity to continue seeking payment for services in the event of an initial adverse claim determination and is essential to maintain provider participation in Medicare.

Budget Request: $79.6 Million

The FY 2022 President's Budget request for QIC appeals (BIPA section 521) is $79.6 million, an increase of $9.2 million above the FY 2021 Enacted level. The request funds the estimated contractual needs for FY 2022 to continue QIC ongoing operations and related workloads. Factored in this request is the projections for continued increases in the Part A workload, which typically cost more to adjudicate.

- *QIC Operations*: This request includes annual operational costs and activities to advance the Departmental priority of continuing to timely adjudicate Medicare appeals at the second level in the appeals process.

The table below includes a breakout of the reconsiderations workload from FY 2019 – 2020 (actuals) and FY 2021 – 2022 (estimated). The FY 2021 through FY 2022 projections were formulated based upon FFS enrollment growth projections from CMS Office of Actuary. As in previous years, CMS will continue to review and analyze workload trends and adjust as necessary.

QIC Appeals Workload
(Volume in Appeals)

	FY 2019 Actual	FY 2020 Actuals	FY 2021 Estimate	FY 2022 Estimate
Non-RAC QIC Claims	253,480	219,848	224,867	229,477
% Increase from Previous Year	-21.86%	-13.27%	2.28%	2.05%

The following chart details the percentage of appeals completed timely by type from FY 2016 through FY 2020:

Fiscal Year	Reconsiderations (2nd Level of Appeal)	
	Part A	Part B
2016	96.73%	99.72%
2017	92.74%	99.68%
2018	99.71%	99.61%
2019	99.90%	99.50%
2020	100.0%	99.90%

- *Medicare Appeals System (MAS)*: MAS is a system that tracks and records Medicare appeals through multiple levels of the appeal process. The system leverages processes and consolidates data to allow users across appeal levels to realize benefits

of reusable, centralized data. The system supports standard processing of appeals and availability of data to other appeal levels while allowing stakeholders and user groups to shape procedures at their desired level. CMS maintains the system and implements all necessary system changes.

II. MEDICARE – PARTS C AND D

Program Description and Accomplishments

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

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

Oversight and Management of Health Plans

CMS oversees health insurance companies that offer health care coverage through private plans. Oversight and management activities needed to run the Part C, Part D, and private insurance programs include obtaining actuarial estimates, reviewing bids from the prescription drug and Medicare Advantage plans, approving new plan applicants for the new contract year, reviewing formularies and benefits, monitoring current plan performance, reconciling prior year plan payments, and expanding and supporting Part D enrollment of low-income beneficiaries. CMS funds activities to improve coordination between the federal government and states to enhance access to quality services for individuals dually eligible for both Medicare and Medicaid benefits, and helps states innovate using data-driven insights to better serve these individuals. These activities are vital to ensuring that beneficiaries are receiving the health care services that they expect from our programs.

Budget Request: $46.9 Million

The FY 2022 President's Budget request for Oversight and Management of Health Plans is $46.9 million, a decrease of $1.1 million below the FY 2021 Enacted level. Other notable CMS programs supporting the oversight and management of Parts C and D health plans are described below:

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

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

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

Medicare Parts C and D Appeals

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

Budget Request: $25.2 Million

The FY 2022 President's Budget request for Medicare Parts C and D Appeals is $25.2 million, an increase of $1.3 million above the FY 2021 Enacted level. CMS is expecting a 13 percent increase in appeals volume for Part C due to the new non-contract payment dispute appeals. The non-contract payment dispute resulting in the increased appeals volume refers to an MAO's refusal to provide or pay for services that the enrollee believes should be furnished or arranged for by the MA organization or a disagreement with a medical provider's diagnosis or medical necessity determination.

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

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

	FY 2019 Actual	FY 2020 Actual	FY 2021 Estimate	FY 2022 Estimate
Part C Appeals	98,637	104,801	117,700	133,250
Part D Benefit Appeals	37,417	30,317	32,000	33,000
Part D LEP appeals	44,836	39,443	42,000	43,000

Parts C and D Information Technology (IT) Systems Investments

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

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

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

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

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

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

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

Budget Request: $31.5 Million

The FY 2022 President's Budget Level for Parts C and D IT Systems Investments is $31.5 million, a decrease of $1.4 million below the FY 2021 Enacted level. This request validates Parts C and D IT systems services contracts, which supports the daily business activities, business deliveries, and ongoing operational enhancements for a variety of systems. These activities include data center hosting, hardware/software maintenance, system technical support, database administration, and system security testing. Funding is also needed for new system contract testing for the MARx and the Risk Adjustment Suite of Systems (RASS).

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

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

- *Retiree Drug Subsidy Program*: This funding supports data center hosting, hardware/software maintenance and software licenses related to the RDS program.
- *Other C & D IT*: This funding supports the Part D Coverage Gap Discount Program, Risk Adjustment Suite of Systems, and Testing for Certification, Accreditation, Corrective Action and collaborative systems for sharing Part C & D data.

III. MEDICAID AND CHIP

Program Description and Accomplishments

CMS serves as the operational and policy center for the formulation, coordination and evaluation of all national program policies and operations relating to Medicaid and the Children's Health Insurance Program (CHIP). Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the states. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally enacted to provide medical assistance to recipients of cash assistance. At the time, cash assistance was provided to low-income families and children through the Aid to Families with Dependent Children program, while the Supplemental Security Income program provided cash assistance to low-income aged, blind and disabled individuals. Over the years, Congress incrementally expanded Medicaid well beyond these original traditional populations. Today, Medicaid is the primary source of health care for a large population of low-income adults and families, pregnant women, people of all ages with disabilities, and people who require long-term care services. CHIP is a federal-state matching, capped grant program providing health insurance to targeted low-income children in families with incomes above Medicaid eligibility levels. Approximately 84.3 million, or 1 in 4, Americans are expected to be enrolled in Medicaid and CHIP in FY 2022.

Medicaid and CHIP Business Information Solution (MACBIS)

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

Budget Request: $98.1 Million

The FY 2022 President's Budget request for MACBIS is $98.1 million, an increase of $17.5 million above the FY 2021 Enacted level. This funding supports the MACBIS operational need in FY 2022 and is directly aligned to meet agency critical objectives. CMS is rapidly increasing our use of MACBIS data to drive quality improvement and accountability for program results. We are implementing capabilities that reduce state burden, ensure every

federal dollar is spent with integrity, and deploying systems to improve business processes between CMS and states. The increase in FY 2022 is attributed to responding to rapidly increasing demands for data and data products to the Medicaid and CHIP program teams and other CMS users, supporting new administration directives and executive orders imputing race/ethnicity to strengthen analytic capabilities to study health equity and health disparity issues, COVID-19, informing program monitoring and oversight, and strengthening program integrity capabilities. In addition, MACBIS product teams are re-competing multiple contracts resulting in transition costs required to minimize any disruption in continuity of operations.

Medicaid and CHIP (MAC) Scorecard

In June 2018, CMS released its first Medicaid and CHIP (MAC) Scorecard to increase public transparency and accountability about the programs' administration and outcomes. In 2019, using the most recently available data, the Scorecard expanded data in the National Context pages and added measures to the State Health System Performance and the State and Federal Administrative Accountability pillars. The 2020 Scorecard continues to improve upon its functionality and includes additional measures across all pillars. In addition, starting with the FY 2022 Scorecard, users will also be able to access state specific data highlighted in the Scorecard through the greatly improved State Profiles (Quality of Care section) on Medicaid.gov. The design, content, and functionality updates made to this section of the State Profiles allows users to view Scorecard and Child/Adult Core Set measures reported by each state. The Scorecard includes measures voluntarily reported by states, as well as federally reported measures in three areas:

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

Funding is required to maintain operations of the Scorecard and to improve on existing versions.

Budget Request: $18.4 Million

The FY 2022 President's Budget request for the MAC Scorecard is $18.4 million, an increase of $0.5 million above the FY 2021 Enacted level. This funding will support the annual production of the Scorecard which includes: stakeholder engagement process used to assist in selecting measures; design of national context and measure pages; content development; measurement development and maintenance; and access to additional Medicaid-relevant data not currently available at CMS. The Scorecard's future work includes additional enhancements to the State Profile Quality of Care Section, improvements to user experience, and working with interested states on quality improvement and technical assistance activities designed to support performance and understanding of the how the Scorecard can be used.

Section 1115 Waivers

Section 1115 of the Social Security Act provides broad authority to CMS and states under Medicaid and CHIP to design, implement and test new approaches to coverage, payment and service delivery, with the intention of improving whether and how low-income people receive health care, the quality and outcomes of that care, and its cost to the federal

government and to states. This activity provides policy and operational technical assistance to CMS for states' Section 1115 demonstration implementation and reporting.

Budget Request: $14.8 Million

The FY 2022 President's Budget request for Section 1115 Waivers is $14.8 million, an increase of $1.5 million above the FY 2021 Enacted level. This activity provides technical assistance in the monitoring and evaluation of 1115 demonstrations. This includes, among other duties, developing implementation plan and monitoring plan templates, performance metric sets, and evaluation guidance. The funding increase will enhance the development work and one-on-one technical assistance that states need to successfully implement our more robust monitoring and evaluation expectations – expectations that we have communicated to Government Accountability Office (GAO) and Medicaid and CHIP Payment and Access Commission (MACPAC).

Medicaid Oversight and Support

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

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

Budget Request: $69.2 Million

The FY 2022 President's Budget request for Medicaid Oversight and Support is $69.2 million, an increase of $5.8 million above the FY 2021 Enacted level. The majority of the increase supports Medicaid eligibility determinations made via the Federal Data Services Hub by States. CMS projects State Medicaid/CHIP agencies will continue to request increased transaction volumes due to changes in state and federal policy which encourage more verification attempts, especially related to redeterminations and renewals.

Other activities funded in this section are included below:

- *The National Home and Community-Based Services (HCBS) Quality Enterprise*: The Home and Community-Based (HCB) settings activity assists CMS in reviewing and monitoring Statewide Transition Plans (Plans) designed to bring states into compliance with the HCB settings requirements, to ensure HCB settings are integrated, and individuals receiving Medicaid HCBS have equal access to community support. The Administration has given states additional time to come into compliance with the 2014 HCBS final rule; states must now be in compliance by March, 2022. Funding supports the HCBS Technical Assistance activity which provides individual goal assessment, technical assistance, and tools and information to help states determine the best options to meet the states' needs specifically individualized state interests.

- *Sources of Income for Medicaid Eligibility*: State's use the Federal Data Services Hub to make Medicaid eligibility determinations and this request supports the contractor providing this service. In FY 2022, CMS projects this contractor will provide 20 million income data transactions for State and Federal Patient Protection and Affordable Care Act (PPACA)-related eligibility determinations (including initial determinations and redetermination/renewals), and provide monthly project management and conduct ongoing service maintenance. These funds will purchase the income data transactions that are requested across 21 State Medicaid/CHIP agencies.

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

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

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

IV. PRIVATE HEALTH INSURANCE

Program Description and Accomplishments

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

Market Oversight and Support

CMS works in conjunction with states to ensure compliance with market reforms that protect consumers through policies like prohibiting health insurance issuers from denying

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

Budget Request: $11.1 Million

The FY 2022 President's Budget request for Market Oversight and Support is $11.1 million, a decrease of $0.2 million below the FY 2021 Enacted level. This slight reduction is the result of consolidating two contracts, which reduced the overall cost for support. The remaining funding need covers ongoing operations for the following activities:

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

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

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

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

Federal Marketplaces

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

Budget Request: $152.5 Million

The FY 2022 President's Budget request for the Marketplaces is $152.5 million, an increase of $17.4 million above the FY 2021 Enacted level. Program Operations funding supports Payment and Financial Management, Eligibility and Enrollment, Marketplace Information Technology, Consumer Information and Outreach, Marketplace Quality, Planning, Performance, and other Support activities. For additional information, please see the Marketplace Chapter.

V. OUTREACH AND EDUCATION

Program Description and Accomplishments

As the nation's largest healthcare payer, CMS serves more than 140 million people and is focused on providing quality care. As such, outreach and education is an integral part of this mission. CMS is responsible for conducting a range of outreach efforts including educational mailings, national communication campaigns to promote CMS programs, and other outreach initiatives to consumers, providers, and other key audiences. Informing and educating Americans about their health care benefits is required through the Balanced Budget Act, the Medicare Modernization Act, and the Affordable Care Act. CMS has an obligation and responsibility to educate our beneficiaries on the programs and services available to them. The activities in this section support CMS' communication and outreach strategy.

National Medicare Education Program (NMEP)

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

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

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

Budget Request: $301.4 Million

The FY 2022 President's Budget request for NMEP is $301.4 million, an increase of $12.8 million above the FY 2021 Enacted level. The funding supports CMS' need to maintain a 5 minute ASA for the 1-800-Medicare call center, operations for the eMedicare activities, and meeting statutory handbook requirements.

National Medicare Education Program Budget Summary
(Dollars in Millions)

NMEP Category/Description of Activity in FY 2022	Funding Source	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Beneficiary Materials - National Handbook with comparative information in English and/or Spanish (national & monthly mailing); targeted materials only to the extent that funding is available after funding the Handbook.	PM	$53.12	$43.30	$45.00
	Postage	$22.49	$30.00	$30.00
	Total	**$75.61**	**$73.30**	**$75.00**
1-800-MEDICARE - Call center and print fulfillment services available with 24 hours a day, 7 days a week access to customer service representatives.	PM	$130.42	$164.04	$153.70
	User Fees	$144.28	$96.00	$106.76
	Total	**$274.70**	**$260.04**	**$260.46**
Internet - Maintenance and updates to existing interactive websites to support the CMS initiatives for health and quality of care information; software licenses; enhancements to the on-line capabilities of MyMedicare.gov.	PM	$49.74	$50.50	$50.50
	Total	**$49.74**	**$50.50**	**$50.50**
Community-Based Outreach - Collaborative grassroots coalitions; training on Medicare for partner and local community based organizations, providers, and Federal/State/local agencies; and partnership building efforts that provide assistance to Medicare beneficiaries in their communities.	PM	$5.56	$5.88	$5.86
	Total	**$5.56**	**$5.88**	**$5.86**
Program Support Services - A multi-media Medicare education campaign, support services to include Handbook support contracts such as Braille, audio and translation support; minimal level of consumer research and assessment for planning, testing, and evaluating communication efforts to include efforts for targeted populations such as Low Income Subsidy.	PM	$24.77	$24.90	$46.39
	Total	**$24.77**	**$24.90**	**$46.39**
Funding Source Breakout Total	**PM**	**$263.61**	**$288.62**	**$301.45**
	User Fees[5]	**$144.28**	**$96.00**	**$106.76**
	Postage	**$22.49**	**$30.00**	**$30.00**
	Total	**$430.38**	**$414.62**	**$438.21**

[5] Reflects total planned obligations in FYs 2020 and 2021. FY 2022 reflects total collections net of sequester and pop up authority.

- *Beneficiary Materials:* The total FY 2022 request is $75.0 million, of which $45.0 million is discretionary budget authority. The Medicare & You handbook satisfies numerous statutory requirements including BBA Section 1851 (d) and MMA Section 1860(d) to provide print information to current and newly eligible beneficiaries about Medicare coverage options and available services. The handbook is updated annually and mailed to all current beneficiary households every October. Beneficiaries currently have the option to opt out of receiving a hard copy of the handbook by signing up at Medicare.gov/gopaperless for an electronic copy that gets emailed to them each fall. Updates to rates and plan information occur as needed for monthly mailings to newly-eligible beneficiaries.

  The chart below displays the actual number of Medicare & You handbooks distributed for FY 2019 through FY 2020 and the estimated distribution for FY 2021 through FY 2022. The yearly distribution includes the number of handbooks mailed to beneficiary households in October, handbooks pre-ordered for partners and warehouse stock to fulfill incoming requests, and handbooks mailed monthly throughout the year to newly eligible beneficiaries.

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

	FY 2019 Actual	FY 2020 Actual	FY 2021 Estimate	FY 2022 Estimate
Number of Handbooks Distributed	47.9	49.2	50.1	52.0

- *1-800-MEDICARE:* The total FY 2022 request is $260.5 million, of which $153.7 million is discretionary budget authority. The 1-800-MEDICARE national toll-free line provides beneficiaries with access to Customer Service Representatives (CSRs) who are trained to answer questions regarding the Medicare program. The toll-free line is available 24 hours a day, 7 days a week. CSRs respond to inquiries including, but not limited to: authorizations, benefit periods, claims (including denials, filing or status), election periods, deductibles, coverage, eligibility and enrollment, complaints, plan comparisons, prescription drug benefit enrollment and disenrollment, appeal status, etc. Beneficiaries can also use 1-800-MEDICARE to report fraud allegations.

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

The following table displays call volume experienced in FY 2019 through FY 2020 and the number of calls CMS expects to receive in FY 2021 through FY 2022. All calls are initially answered by the Interactive Voice Response (IVR) system and approximately 30 percent of the calls are handled completely by IVR. At the FY 2022 request level, CMS anticipates an average speed to answer of 5 minutes.

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

	FY 2019 Actual	FY 2020 Actual	FY 2021 Estimate	FY 2022 Estimate
Number of Calls	25.4	24.2	23.9	24.2

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

- *Internet:* $50.5 million. The Internet budget funds operations and maintenance for three websites. This funding in FY 2022 will provide additional software and hardware upgrades, while providing improvements to the web services offered online and improving beneficiary customer service.

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

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

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

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

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

	FY 2019 Actual	FY 2020 Actual	FY 2021 Estimate	FY 2022 Estimate
Number of Page Views for http://www.Medicare.gov	464.0	390.2	398.0	401.0

- *Community-Based Outreach:* $5.9 million. CMS relies heavily on community-level organizations, state and federal agencies, providers, and other partners to serve as trusted sources of CMS administered program information for consumers, particularly for hard-to-reach populations, and must provide these partners with accurate and up-to-date information and tools that equip them to effectively counsel and assist their constituencies.

  FY 2022 funding is requested for continued support and maintenance of the new Learning Management System and all related tasks. This funding will also provide the resources needed to support face-to-face sessions, web-based training, and regularly scheduled live- and pre-recorded webinars required to educate stakeholders to ensure eligible individuals enroll in CMS programs and make optimum use of their benefits. The request also supports the full availability of the Beneficiary Experience Data Analytics Platform (BEDAP) system which includes segmented outreach to Medicare beneficiaries, caregivers, and coming-of-agers with a wider array of personalized use cases and higher levels of testing and analysis.

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

  The Multi-Media Medicare Education Campaign raises beneficiary awareness about the coverage options, benefits, and services available through Medicare. It is designed to help people with Medicare and those who help them (caregivers including family and friends, information intermediaries, and others) maximize the use of their Medicare benefits to maintain their health, resulting in healthier beneficiaries and lower costs for Medicare. The campaign also promotes Medicare's official information sources including 1-800-MEDICARE, Medicare.gov, Medicare & You Handbook, and other localized partners and resource. As part of a Department-wide priority to invest in health equity, CMS' funding request includes a larger media buy for the General Market and Hispanic open enrollment campaign resulting in the extended reach to vulnerable populations.

In addition to the Program Management budget authority request, the NMEP budget request assumes $106.8 million in user fees and $30.0 million is postage funding bringing

the total FY 2022 budget request for NMEP to $438.2 million, an increase of $23.6 million above the total FY 2021 Enacted level.

Targeted Outreach and Enrollment

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

Budget Request: $15.4 Million

The FY 2022 President's Budget request for Targeted Outreach and Enrollment is $15.4 million, an increase of $2.5 million above the FY 2021 Enacted level. This budget request includes additional funding to enroll a growing beneficiary population, perform specialized outreach efforts to reach underserved populations, and supports a health literacy initiative, "Coverage to Care (C2C)", which is expanding resources to reflect changes in telehealth, digital tools, COVID-19, and stressing the importance of primary care and using health coverage.

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

- *Consumer Outreach*: Funding supports the printing of resources that allow vulnerable patients and consumers to understand and access health coverage and support our C2C contract. In addition to funding the C2C contract, this budget provides ongoing operations and maintenance to support informational updates to Healthcare.gov, outreach and education for rural communities, and outreach and education contracts to reach special needs groups such as AI/AN's.

VI. IMPROVING HEALTH CARE QUALITY

Program Description and Accomplishments

Health Care Quality Initiatives

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through health care quality initiatives, such as the Medicare Shared Savings Program (MSSP). Value-based programs such as this not only help our beneficiaries receive high quality of care, but also create a more efficient and better

healthcare service experience. The following describes the activities that aid CMS in providing higher quality care at a lower cost.

Budget Request: $31.0 Million

The FY 2022 President's Budget request for health care quality improvements is $31.0 million, a decrease of $46.5 million below the FY 2021 Enacted level. In FY 2021, CMS re-competed the ACO Program Analysis contract and must implement recent policy and program enhancements finalized in the Pathways to Success November and December 2018 final rules. This work will be finished in FY 2022 hence the decreased need in funding. The following activities will also be supported in FY 2022:

- *Medicare Shared Savings Program (MSSP)*: Funding will continue to support ongoing operations for approximately 477 Medicare Shared Savings Program ACOs in FY 2022. As part of Pathways to Success, the Shared Savings Program has developed a new direction for resetting the program design based on performance results and lessons learned to date. The funding request supports operations for multiple contracts that conduct beneficiary assignment, claims data analysis for purposes of calculating financial benchmarks/performance, calculating shared savings payments, generating and disseminating quarterly and annual data/reports, calculation of claims-based quality outcome measures and quarterly/annual reports, and technical assistance (e.g., user guides, templates) to implement the Medicare Shared Savings Program, established by Section 3022 of the Affordable Care Act.

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

Medicare Quality Improvement – Value-Based Transformation

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

Budget Request: $35.0 Million

The FY 2022 President's Budget request for Medicare Quality Improvement and Value-Based Transformation is $35.0 million, an increase of $8.7 million above the FY 2021 Enacted level. This request targets Medicare quality improvement and will support various value-based care and other supporting activities. The increase funds new health equity efforts to reduce health disparities for vulnerable populations.

- *Consumer Assessment of Healthcare Providers and Systems (CAHPS)*: *CAHPS* surveys are an integral part of CMS' efforts to improve healthcare in the U.S. Some CAHPS surveys are used in Value-Based Purchasing (pay for performance) initiatives.

The quality of services is measured clinically, administratively, and through the use of patient experience of care surveys. CAHPS surveys are developed with broad stakeholder input, including a public solicitation of measures and a technical expert panel, and the opportunity for anyone to comment on the survey through multiple public comments period through the Federal Register. The surveys are designed to reliably assess the experiences of a large sample of patients. The budget request will fund ongoing operations and data collection. The CAHPS surveys were formerly funded in the QIO budget but is integrated into quality improvement now that CMS is funding this activity in Program Operations.

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

- *Other Value-Based Transformational Costs*: CMS must fund contract closeout efforts, education and outreach, TA for the National Coverage Decision (NCD) process, among other ongoing operational needs that are required to support Value-Based Transformation activities.

Quality Payment Program (QPP)

Prior to the Quality Payment Program (QPP), payment increases for Medicare services were set by the Sustainable Growth Rate (SGR) law. This capped spending increases according to the growth in the Medicare population, and a modest allowance for inflation. However, as clinicians increased their utilization of services, the reimbursement for each unit of service had to be adjusted downward to hold costs constant. In practice, the SGR would have resulted in large decreases in the Physician Fee Schedule, which was not sustainable. To avoid these decreases in reimbursement, Congress had to pass a new law (every year) authorizing the current fee schedule and a small increase for inflation. With the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS did away with the SGR. The QPP is now one of CMS' programs to incentivize quality of care over volume.

Budget Request: $40.0 Million

The FY 2022 President's Budget request for the Quality Payment Program (QPP) is $40.0 million, an increase of $3.8 million above the FY 2021 Enacted level. Formerly funded from a mandatory source, the contracts are foundational to continue this important work and moved to Program Operations in FY 2020. The funding request supports ongoing operations.

VII. ENTERPRISE OPERATIONS

Program Description and Accomplishments

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

Accounting and Audits

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

Budget Request: $100.7 Million

The FY 2022 President's Budget Level for HIGLAS and the CFO audit is $100.7 million, an increase of $0.6 million above the FY 2021 Enacted level.

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

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

  The HIGLAS effort has significantly improved the ability of CMS/HHS to perform Medicare accounting transactions. These improvements and benefits attributable to HIGLAS include reduced costs due to elimination of redundant individual Medicare

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

In addition, HIGLAS supports the Federal Payment Levy Program (FPLP) operated by Treasury by offsetting payments. Through April 6, 2021, CMS has recouped $1.187 billion in Federal Tax debts and Non-Tax debts from Medicare Provider Payments under the FPLP.

- *CFO/Financial Statement Audits*: This funding is necessary for the statutorily required CFO audit which ensures CMS financial statements are reasonable, internal controls are adequate, and CMS complies with laws and regulations. The cost of the audit is funded through an interagency agreement between CMS and HHS and is based upon the General Services Administration rate schedules and federal audit requirements. CMS is required under OMB Bulletin A-136 to prepare annual and quarterly financial statements. The yearly CMS financial statements must be audited annually in accordance with the Government Management Reform Act of 1994 and OMB Bulletin No. 07-04. CMS' goal is to maintain an unmodified audit opinion, which indicates that our financial statements present fairly in all material respects, the financial position, net costs, social insurance, changes in net position, budgetary resources, and financing of CMS.

HIPAA Administrative Simplification

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

Budget Request: $36.6 Million

The FY 2022 President's Budget request for HIPAA Administrative Simplification is $36.6 million, an increase of $5.2 million above the FY 2021 Enacted level. At this funding level, CMS will maintain base operations and maintenance. The increase in funding will provide National Plan and Provider Enumeration System (NPPES) enumerator support due to the increased number of anticipated new provider applications and updates for existing providers. It will also support cloud migration, identity and authorization applications for HIPAA administrative systems. Funding will also be utilized for enhancements to the HIPAA Health Eligibility Transaction System (HETS) Claims-Based Transactions system which will

include additional story points to address HETS backlog items and disaster recovery requirements. Funding is requested for the following activities:

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

- *NPI and NPPES*: HIPAA requires the assignment of a unique National Provider Identifier (NPI) to all covered health care providers and non-covered health care providers who apply and are eligible for NPIs. This project covers the operational support for issuing NPIs, a national customer service call center to assist providers in obtaining their NPI, and operational costs for the NPPES system. CMS built NPPES to assign NPIs and process NPI applications. Currently, over 5 million NPIs have been assigned and over 4.9 million changes have been applied to the NPPES records of enumerated providers. In FY 2021, functionality is being expanded to send new NPIs to the Automated Provider Screening (APS) system in order to screen providers for identity, licensure, and criminal checks before they apply for Medicare Enrollment in the Provider Enrollment Chain Ownership System (PECOS), as well as sending provider identifications to the Data Exchange System (DEX) for Medicaid. In FY 2022, CMS expects an increase in support by Enumerators due to increased applications for NPIs and will continue efforts to transition to the cloud.

IT Systems and Support

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

In FY 2022, CMS will continue to align systems to cloud hosting and migration to the Virtual Data Center, which supports Medicare Part C and D operations. CMS will continue to invest in enterprise shared services, supporting the master data management environment, which is the only centralized data repository providing a unified view of data across Medicare, Medicaid, and Alternative Payment Models. Shared services also performs identity resolution services that link beneficiaries, providers, and organizations

across CMS programs. In FY 2022, CMS will invest in critical modernization efforts to the Health Plan Management System (HPMS) by upgrading software, complaint tracking module and moving to Amazon web services. HPMS ensures that nearly 800 MA organizations and Part D plans are fulfilling the various statutory, regulatory, and administrative requirements of those programs. CMS will continue to invest in securing identity and authorization for all systems within the IT portfolio.

Budget Request: $685.6 Million

The FY 2022 President Budgets level for Information Technology Systems and Support activities is $685.6 million, an increase of $80.0 million above the FY 2021 Enacted level. The request for FY 2022 is necessary to continue ongoing IT operations, including making necessary investments in existing systems that support improvements in the effectiveness and efficiency of CMS operations. These activities provide the operational support to manage CMS's data environment for mission-critical and enterprise-wide CMS IT strategies for systems. The increase in funding within this category supports the Baltimore Data Center, Enterprise Licensing, and the Integrated Data Repository system development efforts. Funding increases will also support security operations services such as network monitoring, penetration testing, forensics, and real time IT asset information. Security funding will also effectively manage risk by maintaining visibility across IT investments and verifying incident response readiness for all systems. Resources will also be dedicated to adding a design service around the provider data information and other priority needs for the Medicare payment systems modernization.

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

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

- *Continuity of Operations Disaster Recovery (COOP/DR)*: CMS continues to revitalize the agency-wide COOP and DR programs following audit findings in 2019 that determined the programs and systems that support CMS mission-essential functions require increased capabilities to meet federal requirements. CMS made major investments in DR in FY 2020 and FY 2021, which we expect to continue our significant progress leading into FY 2022 with closing recovery gaps and technology improvements. The CMS COOP program continues to make progress on preparedness

and will implement a tool to automate the Business Process and Business Impact Analysis cycle in FY 2022. This effort will reduce the time needed to validate the CMS mission essential functions and update federally mandated plans. CMS will also implement an Emergency Operations Center platform to provide centralized enterprise information to collect, analyze, and share critical information as dictated by emergency situations.

- *Medicare Payment Systems Modernization (MPSM) Initiative:* CMS processes over 1.2 billion Medicare Fee for Service (FFS) claims a year for care provided to over 38.5 million beneficiaries. Medicare's claims processing systems have enabled Medicare to become the fastest, most reliable health insurance payer in the country. Medicare is an industry leader, with commercial payers often modeling their own payment methods and policies after Medicare. However, with 40+ year old systems written in old computer languages, it's time to modernize to meet the changing world of healthcare. Medicare has evolved into a nationally managed program with more centralized policy; healthcare practices are shifting to focus on a holistic view of each patient's healthcare services and needs; and, health insurance payments are now accounting for the quality of services being provided.

  CMS is modernizing to move to a system designed for change and iteration, and reducing time and costs for making policy changes. Our systems need the ability to pay for value-based care, the flexibility and nimbleness to keep up with the pace of innovation and legislative changes, and the transparency to give access to information when needed in order to serve policymakers, beneficiaries, and providers. The benefits of this work are already being realized. Moving Medicare pricing software to a modern language on modern infrastructure has resulted in the ability to make changes at least twice as fast, demonstrating that modern technology, systems architecture, and software management processes will result in reduced costs in the long-run.

  Modernization efforts focus on migrating software to the cloud, converting older computer languages such as COBOL into modern ones such as Java, and implementing Application Programming Interfaces (APIs) that allow easy, flexible access to data and system functionality. In addition, CMS is modernizing contracting and change management processes in order to fully realize the benefits that modern technology offers.

  Through research and strategic design, CMS is laying out a vision of reusable and constantly available services that provide critical information for processing original Medicare claims and payments, such as provider data, beneficiary data, and quality measures while supporting new ways of paying for care that the Innovation Center develops. CMS will modernize strategic pieces of the Fee for Service (FFS) systems, fully integrating them with other modernized and legacy systems to ensure continued delivery of speed and reliability as the nation's top health insurance payer. Relying on informed research, CMS will also prototype solutions where appropriate to ensure viability and intended outcomes before significant financial investments are made. Along the way, CMS will implement additional APIs that will continue to help increase efficiency of our Medicare Administrative Contractors that not only process claims, but serve as Medicare's operational contact for providers enrolled in the program. While modernizing, CMS will look towards transparency and data availability that will give providers, beneficiaries, and health policy experts the information they need when they need it.

This funding will allow CMS to continue meeting existing contractual obligations such as our AWS infrastructure and other necessary environments, Strategic Design (Human Centered Design (HCD)) contract which enable us to make informed decisions on modernization opportunities, Application Development Organizations (ADOs) in place to perform development, site reliability and security, and introduce and maintain new software/technical tools. In addition, funding will allow CMS to accelerate the transformation of older and rigid change management/development processes by introducing agile principles and methods. These foundational changes will allow CMS to take full advantage of modernized infrastructure and software.

- *The Integrated Data Repository (IDR):* The IDR is a cornerstone to CMS's data environment. The IDR is a multi-platform, high-volume data warehouse comprising integrated views of data across Medicare Parts A, B, C, and D. Data maintained in the IDR includes claims data, plan payment data, beneficiary data, provider data, drug reference data, contract/plan data, and other reference data. The data in the IDR is also leveraged throughout CMS, the FBI, OIG and DOJ to combat fraud, waste and abuse.

  In FY 2022 funding will be utilized to run the IDR in unison in the Baltimore Data Center and the Amazon Web Services (AWS) Cloud, until the IDR is stabilized and secured in the cloud environment.

- *Hosting Operations and End User support*: The CMS IT infrastructure at the Baltimore Data Center (BDC) and Virtual Data Centers (VDCs) supports all facets of CMS business operations. The IT infrastructure which comprises the BDC and VDCs is one of the primary tools used to meet CMS's business needs and is integral to CMS operations and hosting critical CMS systems. The FY 2022 President's Budget will utilize an increase in funding for priced options and projected costs for contract recompetes.

Operational Support

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

Budget Request: $118.0 Million

The FY 2022 President's Budget request for Operational Support is $118.0 million, an increase of $7.1 million above the FY 2021 Enacted level. This increase supports necessary initiatives to modernize and innovate CMS' business operations and improve the functionality for awarding and managing contracts through the CMS Acquisition Lifecycle Modernization (CALM) effort. The request will be used for data and information technology needs, provider monitoring and auditing, performance measurement, and claims analysis.

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

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

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

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

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

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

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

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

- *Workplace Innovation and Modernization*: This activity funds contracts supporting enterprise operational improvements related to performance and data analytics,

enterprise risk management, change management, and continuous process improvements to modernize and invest in CMS' strategic initiatives.

Opioid and Substance Use Disorders (SUD) Support

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, is aimed at addressing the nation's opioid overdose epidemic. Substance Use Disorders (SUD) impact the lives of millions of Americans in the general population, including individuals that are enrolled in CMS' health care programs. CMS requests funding for our efforts to enact various provisions of the SUPPORT Act to strengthen behavioral health, improve access to SUD prevention, treatment and recovery services, ensure effective pain treatment and management, and use data for effective actions and impact.

Budget Request: $16.3 Million

As part of a government-wide investment to end the opioid epidemic, CMS' FY 2022 President's Budget request for Opioid Support Services is $16.3 million, an increase of $12.9 million above the FY 2021 Enacted level. In FY 2022, CMS anticipates nearly all of the SUPPORT Act provisions will have been implemented; several require continued funding. The funding requested will be used for data and information technology needs, provider education, monitoring and auditing, performance measurement, and claims analysis. CMS will continue to provide technical assistance to states on behavioral health, develop an updated Opioid and SUD Action Plan, work with the Office of National Drug Control Policy (ONDCP) on the National Drug Control Strategy, and collaborate with other HHS operating divisions on opioid and SUD actions, behavioral health, and pain initiatives.

Research, Demonstration, and Evaluation (RDE)

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

Budget Request: $25.4 Million

The FY 2022 President's Budget request for RDE is $25.4 million, an increase of $5.3 million above the FY 2021 Enacted level. This account is appropriated as a separate PPA and has been held flat for many years. CMS' request includes the Research, Demonstrations and Evaluation (RDE) budget in Program Operations to provide funding flexibility for the activities and programs funded in this account. This request provides an increase for ongoing research data analytic activities and the Medicare Current Beneficiary Survey (MCBS).

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

In FY 2022, CMS plans to continue an equal split of the MCBS' total operational cost between RDE and the Innovation Center.

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

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

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

Health Equity

As the largest payer of healthcare in the U.S, CMS is uniquely positioned to drive equity in the healthcare system. CMS, in accordance with Administration's new Executive Orders "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government" and "Ensuring Equitable Pandemic Response and Recovery" will address current and emerging public health issues and related health disparities impacting CMS's priority, underserved populations.

Budget Request: $25.0 Million

The FY 2022 President's Budget request for Health Equity is $25.0 million, an increase of $25.0 million above the FY 2021 Enacted level. Although CMS addresses health disparities throughout its various programs and activities, this funding will specifically focus on the impacts and implementation of the recently signed Executive Orders.

- *Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities through the Federal Government:* This reflects a whole government approach to advance equity for all. The funding provides resources to ensure that CMS is equitable in serving underrepresented and disadvantaged communities and that we

are allocating increased resources to address the need to invest sufficiently, and equitably in underserved communities. Funds also allow CMS to foster innovative approaches in planning, development, implementation, and evaluation of CMS' programs and policies focused on racial equity.

- *Executive Order 13995 on Ensuring Equitable Pandemic Response and Recovery:* This funding will help address issues related to the severe and disproportionate impacts of public health emergencies (e.g., COVID-19) on communities of color and other underserved populations. Examples of such activities would include: Analyzing and identifying relevant data, standardizing the data for use, and evaluating the impact of COVID-19 on vulnerable populations, development of reports and briefs that outline findings and support the work of emergency response and preparedness, and translation of disability resources for beneficiaries.

COVID-19 Response

The CARES Act provided *"$200,000,000, to remain available through September 30, 2023, to prevent, prepare for, and respond to coronavirus, domestically and internationally: Provided, That of the amount appropriated under this heading in this Act, not less than $100,000,000 shall be available for necessary expenses of the survey and certification program."* CMS anticipates that the funding for general operations (the non-survey and certification funding) will be fully obligated by the end of FY 2021.

Budget Request: $50.0 Million

The FY 2022 President's Budget request for COVID-19 Response is $50.0 million, an increase of $50.0 million above the FY 2021 Enacted level. CMS expects to exhaust all of the CARES Act general operations funding in FY 2021. Therefore, in FY 2022, CMS would continue funding these mission-critical and CARES Act activities such as end-user IT support, beneficiary education and outreach associated with COVID-19, Technical Assistance to States for the Medicaid program, and other COVID-19 related support activities through Program Operations. This is especially important due to the increasing responsibilities of CMS to ensure for high quality health coverage for over 145 million Americans that rely on the programs administered by the Agency during the ongoing Public Health Emergency.

Federal Administration

(Dollars in Thousands)

	FY 2020 Final[1]	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$782,533	$772,533	$864,000	$91,467
Indirect Costs	$141,528	$142,652	$141,932	($720)
Total Program Level	$924,061	$915,185	$1,005,932	$90,747
FTE[2]	4,329	4,239	4,384	145

Authorizing Legislation – Reorganization Act of 1953

FY 2021 Authorization – Public Law 116-94

Authorization Status – Permanent

Allocation Method – Direct, Contracts, Other

Program Description and Accomplishments

The Federal Administration account funds the majority of the routine operating expenses in support of CMS' activities for a variety of health care financing programs. This funding provides for employee compensation, rent and utilities, some IT and contractual services, supplies, equipment, printing, training, and travel. Many of these costs are impacted, on an annual basis, by escalation factors akin to inflation, such as increased costs for benefits paid on behalf of the employee and annual cost of living adjustments.

CMS has always been deployed throughout the country; however, to focus on facilitating greater cohesion and integration within our locations, CMS is now organized to provide a singular customer experience, a singular CMS, One CMS. This integration enables CMS to better serve our stakeholders and improves the development and execution of our policies. This alignment ensures our nationwide workforce works closely together to ensure the consistency of our operations. These employees accomplish the CMS mission by writing health care policies and regulations; setting payment rates; developing national health care operating systems; contractor monitoring and oversight; developing and implementing customer service improvements; providing education and outreach to beneficiaries, consumers, employers, and providers; implementing guidelines to fight fraud, waste, and abuse; and assisting law enforcement agencies in the prosecution of fraudulent activities. CMS employees also accompany State surveyors to health care facilities to ensure compliance with CMS health and safety standards; and assist States with Medicaid, Children's Health Insurance Program (CHIP), and other health care programs.

[1] The FY 2020 Final level includes $50 million in reprogrammed funds from Program Operations.

[2] Excludes staffing funded from directly appropriated funding sources and reimbursables.

CMS also has staff in the fraud “hot spot” offices in areas known to have high incidences of fraud and abuse. Being deployed throughout the country to known high fraud areas, they can quickly detect and respond to emerging schemes and tactics designed to defraud the Medicare and other CMS administered programs. Through CMS’ nationwide footprint, we are positioned where our beneficiaries need us, allowing us to accomplish our mission as One CMS.

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

Funding History

Fiscal Year	Budget Authority
FY 2018	$732,533,000
FY 2019	$732,533,000
FY 2020[3]	$782,533,000
FY 2021 Enacted	$772,533,000
FY 2022 President's Budget	$864,000,000

Budget Request: $864.0 million

The FY 2022 Request for Federal Administration is $864.0 million in Budget Authority. In addition, CMS projects $141.1 million will be available from the administrative cost allocation; bringing the total program level to $1,005.1 million.

[3] The FY 2020 Final level includes $50 million in reprogrammed funds from Program Operations.

Federal Administration Program Level Summary Table[4]

(Dollars in Thousands)

Objects of Expense	**FY 2020 Final**	**FY 2021 Enacted**	**FY 2022 President's Budget**	**FY 2022 +/- FY 2021**
Personnel Compensation and Benefits	$721,263	$724,561	$793,053	$68,492
Travel	$2,280	$5,282	$5,282	$0
Rent, Communications and Utilities	$32,993	$35,630	$36,760	$1,130
Printing	$3,513	$2,430	$2,430	$0
Contractual Services	$161,061	$143,278	$163,603	$20,325
Service and Supply Fund (non-add)	*$34,840*	*$42,640*	*$42,640*	*$0*
Administrative Services (non-add)	*$24,283*	*$6,329*	*$20,329*	*$14,000*
Administrative IT (non-add)	*$45,845*	*$40,727*	*$44,455*	*$3,728*
Inter-Agency Agreements (non-add)	*$2,876*	*$2,492*	*$2,492*	*$0*
Administrative Contracts and Intra-Agency Agreements (non-add)	*$53,217*	*$51,090*	*$53,687*	*$2,597*
Supplies	$442	$766	$766	$0
Training	$2,509	$3,238	$3,238	$0
Total, Federal Administration	**$924,061**	**$915,185**	**$1,005,132**	**$89,947**

- *Personnel Compensation and Benefits:* $793.0 million

  The FY 2022 President's Budget request includes $793.0 million in discretionary funding, an increase of $68.5 million above the FY 2021 Enacted level. The requested funding will support 4,384 direct Full-Time Equivalents (FTEs), an increase of 145 FTEs as compared to the FY 2021 Enacted level and an increase of only 55 FTEs above the FY 2020 Actuals.

  The President's Budget request for Federal Administration shores up neglected core operations, strengthening investment in these important administrative resources, which are necessary to ensure CMS's proper stewardship of its health entitlement programs. At the request level, CMS will be able to maintain current operations and increase its level by 136 new FTEs to cover hiring of essential positions for specific administrative priorities.

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

In FY 2020, CMS reprogrammed funding within Program Management to meet the demands of payroll, while taking steps to reduce outyear demands such as self-imposed hiring restrictions. In FY 2021, CMS' FTE levels, as compared to FY 2020, dipped slightly by 90 FTEs. As a result, CMS is seeking to increase its FTE level in FY 2022 to align its workforce with growing workloads that is slightly above the FTE level of FY 2020. The FY 2022 Budget's investment in CMS' workforce ensures adequate funding for increasing salaries and benefits, and right-sizes staffing levels to carry out consistently growing, mission-essential responsibilities across the agency's health care financing programs.

Beyond the absorption of shifting FTEs from exhausted mandatory sources, the FY 2021 Operating level does not allow for consideration of any additional workload increases.. The nature of CMS' work is not static; it is dynamic and fluid, requiring flexibility and the need to keep pace with variables largely outside of the Agency's control such as the impacts of COVID-19, unfunded legislative mandates, and/or annual payroll increases.

Personnel Compensation and Benefits encompass the full range of civilian and Commissioned Corps pay, within grade increases, awards and overtime, as well as fringe benefits. Our Commissioned Corps staff are entitled to additional benefits including housing and other allowances. Also included in the FY 2022 FTE estimate is a 2.7 percent pay inflation assumption for civilian employees and Commissioned Corps staff and a 1.0 percent inflation estimate to cover increases in benefits costs. The impact of these conservative assumptions for payroll inflation are projected to result in a $27.6 million increase, which is assumed in the President's Budget.

CMS' staffing levels, tied with related compensation and benefits expenses, are largely workload-driven. Staffing levels, at the FY 2022 President's Budget level, will enable CMS to execute the Administration's priorities, while maintaining and improving the performance of our traditional programs, including Medicare, Medicaid, CHIP, and other federal health programs, to ensure they are successfully delivered with the highest quality. Additional CMS staffing costs are funded through other directly appropriated accounts.

- *Travel:* $5.3 million

The FY 2022 request includes $5.3 million in program level funding, the same as the FY 2021 Enacted level. CMS' travel is dictated by our mission, comprising on-site visits to contractors, states, healthcare facilities, and other providers. Since CMS administers its programs primarily through contractors or third parties, site visits are critical to managing and evaluating these programs and ensuring compliance with the terms and conditions of contracts and cooperative agreements. Site visits also allow CMS to ensure our beneficiaries and consumers are receiving quality care and providers are not engaged in fraudulent practices.

- *Rent, Communications, & Utilities*: $36.8 million

The FY 2022 request includes $36.8 million in program level funding, a slight increase above the FY 2021 Enacted. This object class provides funding for CMS' offices, including rent and operational costs, which are calculated by the General Services Administration for of CMS. Other items in this category include certain contract labor costs, such as grounds maintenance, cleaning, and trash and snow removal.

- *Printing:* $2.4 million

The FY 2022 request includes $2.4 million in program level funding, the same as the FY 2021 Enacted level. The largest expense in this category is for printing notices in the Federal Register and Congressional Record. CMS is required to publish regulations that adhere to notice and comment rulemaking procedures. Historically, one major piece of new authorizing legislation involving CMS' programs is enacted annually. Each piece of legislation requires CMS to publish regulations that implement the numerous provisions in these bills.

- *Contractual Services:* $163.6 million

The FY 2022 request includes $163.6 million in program level funding, an increase of $20.3 million above the FY 2021 Enacted level, of which $14.0 million is attributed to funding the next phase of the Real Estate Consolidation (REC) project. This REC project is intended to reduce CMS' physical footprint as well as to reduce our overall rent/lease cost. This innovative REC project will meet GSA requirements to reduce the overall net footprint to about 135 square feet per employee as well as result in estimated long-term savings of $88.0 million.

Contractual Services also include costs for our day-to-day operations via contracts and interagency agreements (IAAs). This funding supports critical information technology infrastructure and services, which provide CMS employees with a secure and technologically-efficient workplace. CMS has also made a concerted effort to promote a more user-friendly IT environment for employees with integrated data, voice, and video services that provide seamless connections between meeting rooms, work stations, and remote locations. In addition, this request includes $3.0 million to support United States Digital Service (USDS) administrative staffing costs at CMS for up to 16 FTEs.

Essential IAAs, such as legal services with the HHS's Office of General Counsel and security services with the Department of Homeland Security, are also included within this category and are crucial in supporting CMS operations. In addition, the CMS share of the Department of Health and Human Services Program Support Center and other shared expenses, including payroll, financial management, and e-mail systems, are funded within this object code. The HSPD-12 initiative is partially funded within this category and provides support for continuous credentialing of employees and contractors to meet the requirements of Federal policies. In FY 2022, CMS will continue to credential new employees and rebadge existing staff. CMS also projects to credential approximately 5,000 contractors, an existing effort that was slowed due to COVID-19.

- *Supplies:* $0.8 million

The FY 2022 request includes $0.8 million in program level funding, the same as the FY 2021 Enacted level. This category funds general everyday office supplies and materials for CMS employees, including office equipment, paper, and small desktop-related supplies.

- *Training:* $3.2 million

The FY 2022 request includes $3.2 million in program level funding, the same as the FY 2021 Enacted level. This category supports continuous learning of technical, professional, and general business skills. The category also includes a special emphasis on leadership and management development, which includes certifications for staff, such as actuaries, contract specialists, financial managers, nurses, and other health professional specialists. Funding also supports mandatory agency wide trainings, such as Reasonable Accommodation, Alternative Dispute Resolution, and Ethics.

State Survey and Certification
(Dollars in Thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2021 +/- FY 2022
Discretionary:				
State Survey and Certification	$397,334	$397,334	$472,163	**$74,829**
Medicare Quality Improvement – Value Based Transformation (non-add)	*$0*	*$7,000*	*$7,000*	**$0**
Mandatory:				
IMPACT Act[1]	$5,432	$5,625	$5,385	**$(240)**
Consolidated Appropriation Act 2021[2]	$0	$0	$9,574	**$9,574**
CARES Act[3]	$100,000	$0	$0	**$0**
Medicaid Grants (S&C)	$286,750	$296,000	$306,000	**$10,000**
American Rescue Plan (ARP)[4]	$0	$500,000	$0	($500,000)
CLIA Lab Fees[5]	$64,936	$66,429	$75,320	**$8,891**
Total	**$854,452**	**$1,272,388**	**$875,442**	**($396,946)**

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

FY 2021 Authorization - Public Law 116-260

Allocation Method – Contract and Grants

Program Description and Accomplishments

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

CMS accomplishes its quality assurance functions through collaboration with States and their respective State Survey Agencies (SAs), private accrediting organizations (AOs), and through contractor-supplied private sector survey organizations to conduct specialized surveys and

[1] Funding provided through the IMPACT P.L. 113-185 Section 3 for hospice surveys are net of sequester authority.

[2] Funding provided through the Consolidated Appropriation Act is net sequester authority.

3 Coronavirus Aid, Relief, and Economic Security Act (or CARES Act) funding was provided in FY 2020 and is available through 2023.

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

[5] Funding provided through offsetting collections.

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

The S&C program is funded by multiple sources. The Program Management annual discretionary appropriation supports the S&C program's oversight efforts for most types of providers serving both Medicare and Medicaid eligible patients. To help keep hospice survey frequencies at a 3-year rate, funding is provided through the Improving Medicare Post-Acute Care Transformation (IMPACT) Act and the Consolidated Appropriation (CA) Act of 2021, which will provide $10 million for each fiscal year starting in FY 2022. Additionally, Congress passed the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136; CARES Act), which included no less than $100 million for the necessary expenses of CMS' survey and certification program response to the COVID-19 pandemic. S&C activity for the Medicaid program is funded from the Grants to States for Medicaid account; these costs are shared with States.

More recently, the American Rescue Plan (ARP) Act of 2021, authorized the deployment of Federal Strike teams to skilled nursing and nursing faciliites in states (including District of Columbia and each territory) with diagnosed or suspected cases of COVID-19 among residents or staff. The Strike teams are composed of clinicians and public health service officials who will provide onsite technical assistance and education to nursing homes to reduce transmission and spread of COVID-19 by providing clinical care, implementing continued infection control standards, or staffing. The funding from the ARP for Sections 9402 and 9818 will be transferred to the Centers for Disease Control and Prevention to implement and manage the Federal Strike teams.

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

1. Investigation of reported complaints;
2. Conducting Focused Infection Control (FIC) surveys
3. Survey and recertification of statutory facilities such as nursing homes, home health agencies (HHAs), and hospices as required by current law; and
4. Survey and recertification of non-statutory facilities as required by CMS policy developed in part through GAO and OIG recommendations, and best practices.

CMS exercises oversight of SAs through a combination of Federal surveys and contracts with national surveyors. CMS contractors perform mandatory comparative surveys of SAs to ensure States are effectively investigating and enforcing compliance with the Medicare health and safety standards. CMS also contracts for other programmatic activities, such as surveyor

training, AO oversight, improving key processes such as the survey process for nursing homes, and identifying new methods for collecting and reporting data used to evaluate survey variation and performance and strengthen state oversight.

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

Recent S&C program accomplishments include the implementation of focused infection control surveys in response to the COVID-19 pandemic and two initiatives, which are highlighted below, that seek to ensure continued quality and safety for the Nation's health care services.

Implementation of Focused Infection Control (FIC) Nursing Home Surveys

Supplemental funding provided through the CARES Act is being used in coordination with SAs to conduct FIC surveys. By the end of FY 2020, SAs performed FIC surveys, with collaboration with the Centers for Disease Control and Prevention (CDC), in over 15,000 nursing home facilities to ensure minimum standards of nursing home infection control practices and education. To maintain these best practices, a minimum of 20 percent of nursing homes will be surveyed for infection control annually based on COVID-19 infection rates or other factors. In FY 2022, States will need to conduct FIC surveys at approximately 3,100 nursing homes.

Projected Focused Infection Control (FIC) Surveys and Cost
(Dollars in Millions)

	FY 2020		FY 2021		FY 2022	
Provider Type	**FIC Surveys**	**Cost**	**FIC Surveys**	**Cost**	**FIC Surveys**	**Cost**
Nursing Facilities (NF)	316	$0.253	72	$0.059	67	$0.054
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	14,370	$11.49	2,904	$2.390	2,893	$2.342
Skilled Nursing Facilities (SNF)	665	$0.532	148	$0.122	140	$0.113
Total	**15,351**	**$12.274**	**3,124**	**$2.570**	**3,099**	**$2.509**

CMS projects that the increase in workload will continue after the CARES Act funding is exhausted and States will need to maintain their trained workforce and state of the art reporting system for tracking, tracing and testing for infectious diseases.

Initiative 1: Improve Care in Long-Term Care Facilities

In FY 2022, CMS projects that Long-Term Care (LTC) facilities will account for 32.7 percent of all Medicare and Medicaid participating facilities, the largest single facility type. Additionally, 84.1 percent of all complaint surveys in 2019 (the last non-COVID-19 impacted full survey year) were in LTC facilities. Given the number of LTC facilities and the vulnerability of its beneficiaries, CMS places high programmatic priority on maintaining and improving the quality of care and transparency in these facilities. The goal of the LTC initiative is to protect resident health and safety by improving the identification of noncompliance and remediation. This effort directly addresses key questions including: How will the quality of life and care improve for nursing home residents? How will survey effectiveness and efficiency improve?

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

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

Initiative 2: Improve Oversight of Accrediting Organizations (AOs)

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

In response to ongoing concerns, such as the widening survey disparity rate between non-deemed and deemed facilities, CMS has developed this strategic initiative to improve its oversight of AOs. CMS aims to improve the transparency and effectiveness of the AO program, thus strengthening our commitment to quality and patient safety. This initiative is designed to answer questions surrounding the following: How has compliance with Medicare quality and safety standards improved care in acute care settings? Has increased oversight improved disparity findings? And, how has CMS improved partnerships and communications with AOs? CMS has proposed crucial milestones to implement this initiative:

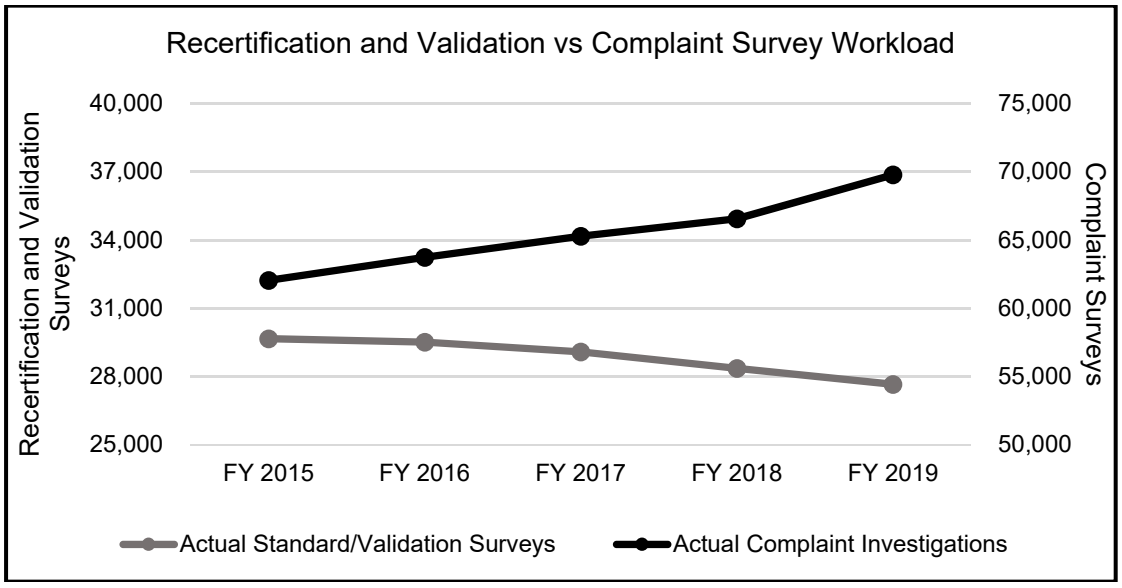
- Public posting of information about AO performance and ownership;
- Improved guidance pertaining to AO conflict of interest;
- Establishment of an AO Liaison Program; and,
- AO validation survey redesign

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

Improved Program Efficiency

The S&C program annual discretionary appropriation has remained flat since FY 2014, which, over time, has limited the program's capacity to perform routine recertification and validation surveys. Further, the ongoing growth in complaints and associated survey workload inhibit the SAs' ability to address issues proactively through standard surveys. As a result, complaint surveys have become the primary oversight mechanism for many provider types. In some cases, issues that could be easily identified during standard health surveys go unaddressed and become more difficult and expensive to correct. At times, these issues escalate to possible life threating circumstances, as substantiated through reported complaints.

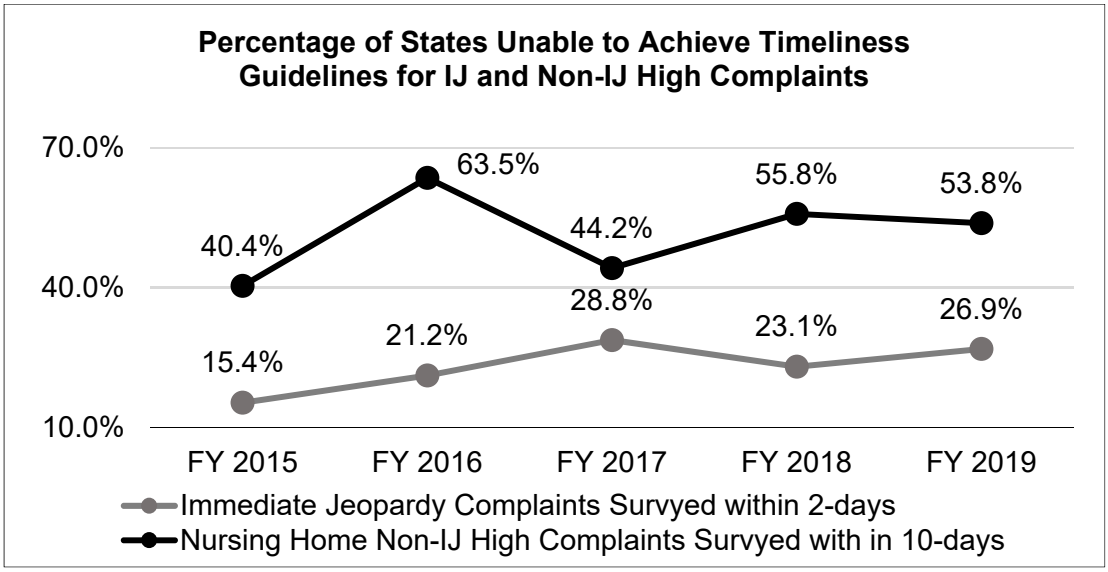
The below graph shows the correlation between the two workloads – standard surveys/recertification and complaint surveys, which includes both Medicare and Medicaid providers. As the number of complaint surveys climbs, the funding levels for the more routine surveys is reduced. However, with the additional funding in this FY 2022 request, CMS will continue to address complaints, while also increasing the SAs ability to complete standard surveys, recertification, and validations, improving the overall effectiveness of the program. Due to the COVID-19 pandemic, the FY 2020 workload data is still being processed, with early indications showing that a comparison to recent historical data will be skewed.



Complaints categorized as Immediate Jeopardy (IJ) and Non-IJ High are considered top priority to ensure the safety and well-being of the beneficiary community. CMS provides performance standards to SAs detailing acceptable timelines to address varying levels of complaints. 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, Non-IJ High, although not as severe, requires the SAs to complete an assessment within 10 days of the complaint.

As indicated in the table below, since 2017, over 25 percent of States were unable to maintain performance standards for both IJ and Non-IJ High complaints (95 percent compliance rate is considered passing). In FY 2019, States' inability to assess non-IJ complaints remained high with over half of the SAs (53.8 percent) unable to meet the 10-day timeline. In 2019, complaints accounted for 69.5 percent of all surveys performed. While CMS does project forward based on

historical trending, the complaint workload is unplanned and uncontrolled. While non-statutory recertification surveys can be performed with decreased frequency in response to funding shortfalls, complaints have to be addressed timely and therefore take priority. The data in the chart includes Medicare and Medicaid nursing homes and ends with FY 2019 due to the COVID-19 pandemic. FY 2020 data is still being processed; however, preliminary data shows that the impacts of the pandemic could result in anomalies in the data for these workloads.



CMS' Response to COVID-19

The Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136; CARES Act) which provided CMS with $200 million in multi-year Program Management funding through FY 2023 to "prevent, prepare for, and respond to the Coronavirus (COVID-19) domestically and internationally." Within this amount, the CARES Act includes no less than $100 million to cover the necessary expenses of CMS' survey and certification program. CMS leveraged its oversight role to increase focus on infection control at the facility level. By the end of FY 2020, all nursing homes in the nation received FIC surveys to standardize best practices to control the spread of infectious diseases. To maintain these best practices, a minimum of 20 percent of nursing homes will be surveyed for infection control annually.

CMS will prioritize funding for survey activities of nursing home facilities in localities with community transmission of COVID-19. Survey activities at the SAs will continue to maintain a risk-based posture and will prioritize their use of funds as follows:

- All IJ complaints (cases that represent a situation in which the entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death or harm) and allegations of abuse and neglect;
- Complaints alleging infection control concerns, including facilities with potential COVID-19 or other respiratory illnesses;
- Statutorily required recertification surveys (Nursing Home, Home Health, Hospice, and ICF/IID facilities);
- Any re-visits necessary to resolve current enforcement actions;
- Initial certifications;

- Surveys of facilities/hospitals that have a history of infection control deficiencies at the immediate jeopardy level in the last three years;
- Surveys of facilities/hospitals/dialysis centers that have a history of infection control deficiencies at lower levels than immediate jeopardy.
- Completion of the backlog of pending recertification surveys created during this public health emergency.

Furthermore, in June of 2020, CMS published guidance on Focused Infection Control Nursing Home Surveys and CARES Act Supplemental Funding for Directors of State Survey Agencies. CMS stated that there had been wide variation in the number of FIC surveys of nursing homes performed by States, ranging between 11 percent and 100 percent (with a national average of 54.1 percent). Based on the COVID-19 trend data reported by nursing homes to the Centers for Disease Control and Prevention (CDC), CMS believed further action was needed to prioritize completion of focused infection control surveys in nursing homes. To that end, CMS provided that States, which had not completed 100 percent of their FIC surveys by July 31, 2020, were required to submit a corrective action plan outlining the strategy for completion of these surveys within 30 days. By the end of August, States had achieved a nationwide completion level of nearly 100 percent for all FIC surveys.

The $100 million provided for S&C, enables States to conduct FIC surveys and respond to the potential increases in complaint surveys, based on COVID-19 trend data reported by nursing homes to the CDC. States will also be able to perform “re-opening” surveys of facilities with previous COVID-19 outbreaks using unique survey protocols to ensure the facilities have Infection Control systems to respond to another phase of the outbreak. States will also be able to purchase additional Personal Protective Equipment (PPE) (e.g. N-95 face masks, surgical gowns, goggles, gloves, and thermometers) for surveyors to ensure worker safety.

States will also be able to increase the use of enforcement remedies for lower level infection control deficiencies. These enforcement remedies include expanded use of Directed Plans of Correction and compressed timeframes for infection control enforcement actions, such as 45-day termination instead of six months for nursing homes or 90-days for all others. The funds will also allow implementation of state-specific interventions, such as Strike Teams, enhanced surveillance, and monitoring, that would not be possible without the CARES Act funding.

CARES Act funding will also be used to purchase PPE and provide hazard pay for Federal surveyors. Other uses for CARES Act funding currently being considered include enhancements for the Internet Quality Improvement and Evaluation System (iQIES) system to include a focus on improving surveillance and tracking capabilities, to improve data management support for CMS’ survey and enforcement program.

CMS is working to ensure that activities funded through the CARES Act are effectively managed. CMS is closely coordinating with federal, state, local, and private sector stakeholders to make sure these efforts are complementary across programs, reflect evolving factors associated with the COVID-19, and provide the highest priority response activities, without overly burdening facilities treating patients with COVID-19.

While additional funding will allow for some expansion and the ability to better target poor performing providers, it will primarily allow CMS to begin closing a growing quality gap of increasing complaints and providers against flat-lined resources. As mentioned above, the $100 million CARES Act is planned to be exhausted in FY 2023 and the required FIC and related enforcement actions workload will continue after it expires. Dedicated funding in the

Program Management's Survey and Certification annual discretionary appropriation to match the increasing workload is a necessity.

Funding History

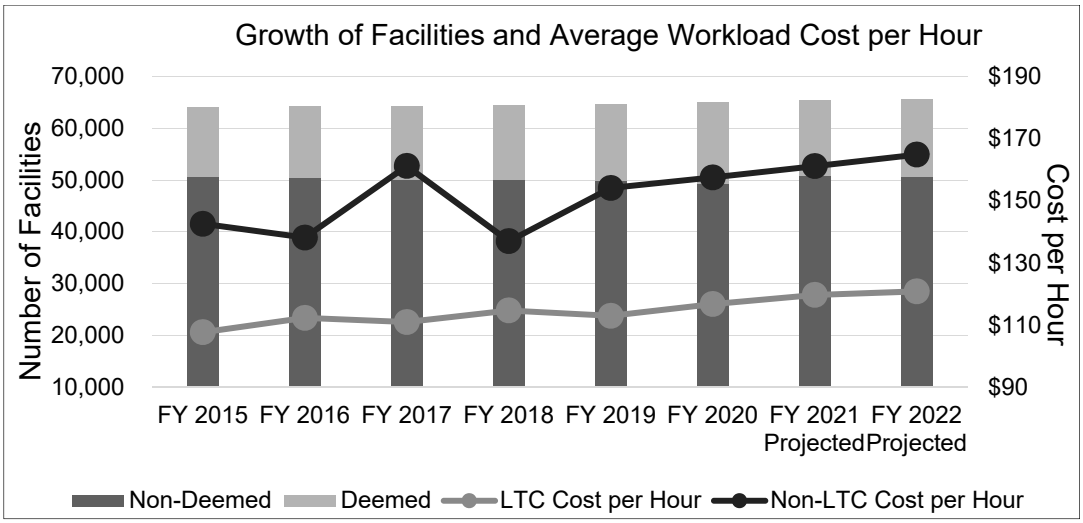
Fiscal Year	Discretionary Appropriation
FY 2018	$397,334,000
FY 2019	$397,334,000
FY 2020	$397,334,000
FY 2021 Enacted	$397,334,000
FY 2022 President's Budget	$472,163,000

Budget Request Discretionary Appropriation: $472.2 million

The Program Management discretionary FY 2022 Request is $472.2 million, which is an increase of $74.8 million above the FY 2021 Enacted level. Above the historical workloads for this account, this increase in funding will allow States to investigate facilities prone to outbreaks of infectious diseases like COVID-19. CMS also projects that this funding increase will help States maintain the increased workload in response to COVID-19. Increased funding will allow States to maintain a trained and appropriately equipped workforce and a state of the art reporting system for tracking, tracing, and testing for infectious diseases. This budget request will also aid in ensuring that Medicare and Medicaid certified facilities are better prepared for any future public health emergency. This budget request includes funding for SA surveys, along with ongoing contract support to strengthen quality improvement efforts, improve national survey consistency, improve AO oversight, and adhere to GAO and OIG recommendations to promote gains in efficiency and effectiveness. Above all, at this funding level, CMS projects that SAs will be in a better position to identify deficiencies in facilities, that if left unaddressed, can reach to Actual Harm, IJ, or Non-IJ High levels.

The FY 2022 Budget request also accounts for the rise in the cost to operate the S&C program. As indicated in the table below, the S&C program has faced increased costs due, in part, from growth in the number of beneficiaries (which has created a demand for more facilities), surveyor wage growth, and improvements in quality standards. From FY 2015 to FY 2022, participating facilities are expected to grow by nearly 6 percent, or 1,575 facilities. During this time, deemed facilities will account for a majority of this growth, with an increase of nearly 12 percent, whereas the total number of non-deemed facilities will increase by 0.02 percent. This growth in the number of deemed facilities reinforces the significance of the aforementioned initiative, to Improve Oversight of Accrediting Organizations.

The overall average cost per hour to conduct the S&C workload will increase by about 14 percent between the end of FY 2015 through the end of FY 2022. This is due in part to cost growth at the State level; as States have increased wages to attract and retain surveyors, who are medical professionals in high demand. On average, the LTC cost per hour is projected to increase by 12.2 percent and the non-LTC cost per will grow by 15.6 percent. Finally, contributing further to the cost growth to conduct surveys, certifications, and investigations is the implementation of revised COPs, which will result in average survey length increases of nearly 12 percent by the end of FY 2022. The graph below demonstrates the overall growth in number of facilities, the incremental increase of more facilities entering the Medicare and Medicaid programs through accreditation (i.e. the "deeming" process), and the increase in costs to conduct surveys for LTC and non-LTC facilities.



CMS' S&C program will also receive $5.6 million through FY 2025 from the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, and starting in FY 2022, an additional $10.0 million from the Consolidated Appropriation Act of 2021 to maintain hospice survey frequencies at a 3-year rate. The Consolidated Appropriation Act of 2021 also establishes a special focus program for hospice agencies, which will require low performing hospices to be surveyed every 6 months. In addition, the CARES Act funding will be used for FIC surveys and supplement the payment of standard surveys for FY 2020, FY 2021, and FY 2022. The following table provides each funding source and its respective breakout per FY.

FY 2020 to FY 2022 Funding Sources Breakout by Activity
(Dollars in Millions)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Total State Direct Survey Budget	**$368.039**	**$359.296**	**$429.420**
Mandatory Surveys (Nursing Homes/Home Health/Hospice) (non-add)	*$293.341*	*$325.149*	*$341.825*
Non-Statutory Surveys non-Deemed and Deemed (non-add)	*$74.698*	*$34.147*	*$87.595*
All Other Surveys (State Direct)	$.156	$2.248	$5.670
Federal Direct Surveys	$6.71	$6.040	$5.213
Support Contract and Information Technology	$22.429	$29.750	$31.86
Total: S&C PM Discretionary Appropriation	**$397.334**	**$397.334**	**$472.163**
IMPACT P.L. 113-185. Hospice Surveys	$5.432	$5.625	$5.385
Consolidated Appropriation P.L. 116-260 Hospice Surveys	N/A	N/A	$9.574
CARES Act[6]	$100.000	N/A	N/A
Grants to States for Medicaid (S&C)	$286.750	$296.000	$306.00
American Rescue Plan P.L. 117-2[7]	$0	$500.000	$0
Clinical Laboratory Fees[8]	$64.936	$66.429	$75.320

[6] Funding provided through the CARES Act pays for FIC surveys and supplements standard surveys for each FY.

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

[8] CLIA user fees pay for surveys and certification of labs.

Discretionary State Direct Survey Budget: $429.4 million

The Total Discretionary State Direct Survey Budget request is $429.4 million, an increase of $70.12 million above the FY 2021 Enacted level to support SA's efforts to conduct surveys and certifications of health care facilities. As reported for previous FYs, CMS projects that States will spend 99 percent of the Total State Direct Survey Budget request to conduct surveys. This includes $341.8 million to inspect, survey, and certify statutory facilities and $87.6 million to inspect, survey, and certify non-statutory facilities. From this budget request, CMS also funds a portion of SA's cost for travel, training, and supplies for $5.7 million, which is $3.4 million above the FY 2021 Enacted level.

The cost to reach the projected survey frequency completion rate for each provider type displayed in the following table is funded by all sources shown in the above table excluding Clinical Laboratory Fees. In particular, funding from the CARES Act is prioritized to pay for FIC surveys, dedicated to combat the spreadof COVID-19, and support direct surveys operations such as initial and recertification surveys. With this additional funding, CMS projects an improved survey frequency rate for all providers per fiscal year. The survey frequencies are based on current law and CMS' administrative policy, resulting in varying survey intervals dependent on provider type (facility). For example, ESRD facilities have a policy-set, three-year survey frequency interval for the entire population. This means that at the end of a three year cycle, if policy-set levels are met, 100 percent of ESRD facilities will have been surveyed. To accomplish this, one-third of the ESRD facilities should be surveyed each year. The percentages seen in the table below are the completion rates of the one-third (or 33 percent) of all ESRD facility surveys. Following this methodology, CMS projects that about 96 percent of one-third of all ESRD facilities will be surveyed in FY 2022, falling short of the policy-set levels but still a significant increase over FY 2021 levels.

FY 2020 to FY 2022 Provider Survey Frequency Rate Completion Projections[9]

Provider Status and Type	Survey Frequency Intervals	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Statutory				
Nursing Facilities (NF)	100% Surveyed 12.9-15.9 months	100.0%	100.0%	100.0%
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	100% Surveyed 12.9-15.9 months	100.0%	100.0%	100.0%
Special Focus Facility Nursing Homes (SFF)	100% Surveyed 6 months	100.0%	100.0%	100.0%
Skilled Nursing Facilities (SNF)	100% Surveyed 12.9-15.9 months	100.0%	100.0%	100.0%
ICF/IID	100% Surveyed 12.9-15.9 months	100.0%	100.0%	100.0%
Home Health Agencies (HHAs)	100% Surveyed 36.9 months	100.0%	100.0%	100.0%
Hospice Agencies	100% Surveyed 36.9 months	100.0%	100.0%	100.0%
Special Focus Facility Hospice Agencies (SFF)[10]	100% Surveyed 6 months	N/A	N/A	100.0%
Non-Statutory Non-Deemed				
Ambulatory Surgical Centers (ASCs)	100% Surveyed within 36 months	73.7%	65.2%	89.9%
Community Mental Health Centers (CMHCs)	100% Surveyed within 72 months	75.0%	67.9%	96.3%
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	100% Surveyed 72 months	90.0%	83.9%	100.0%
End Stage Renal Disease (ESRD)	100% Surveyed 36 months	77.9%	69.3%	95.5%
Hospitals	100% Surveyed 36 months	71.0%	63.0%	86.9%
Outpatient Physical Therapy (OPT)	100% Surveyed 72 months	85.3%	76.0%	100.0%
Portable X-Ray Suppliers	100% Surveyed 72 months	67.7%	61.1%	83.7%
Psychiatric Hospitals[11]	100% Surveyed 72 months	12	12	12
Rural Health Clinics (RHCs)	100% Surveyed 72 months	79.6%	70.7%	97.5%
Transplant Centers	100% Surveyed 60 months	42.6%	38.0%	52.9%
Non-Statutory Deemed				
Ambulatory Surgical Centers (ASCs)	5% of Validation Surveys	25.5%	23.9%	32.6%
End Stage Renal Disease (ESRD)	5% of Validation Surveys	12	12	12
Home Health Agencies (HHAs)	5% of Validation Surveys	58.3%	8.4%	11.3%
Hospice Agencies	5% of Validation Surveys	7.1%	5.8%	8.6%
Hospitals	5% of Validation Surveys	44.4%	39.1%	54.7%
Outpatient Physical Therapy (OPT)	5% of Validation Surveys	12	12	12
Psychiatric Hospitals	5% of Validation Surveys	12	12	12
Rural Health Clinics (RHCs)	5% of Validation Surveys	12	12	12

[9] Supplemental funding from the CARES Act is included to pay for the projected survey frequency completion rates.

[10] Surveys of Special Focus Facility for Hospice Agencies will start in FY 2022.

[11] Starting in FY 2021, surveys, certifications, and complaint investigation in psychiatric hospitals will be transitioned from being conducted by federal contractors to State Agencies.

[12] States will continue to respond to complaints, and based on availability of resources, conduct recertification surveys, and certify new facilities.

The next table displays the projected costs to respond to reported complaints and the costs to conduct the projected survey frequency rates provided in the Survey Frequency Rates table per provider type from FY 2020 to FY 2022. This table also includes supplemental funding provided through the IMPACT, Consolidated Appropriations Act for hospice surveys, and the CARES Act.

Medicare PM Discretionary Survey and Complaint Visit Cost Projections[13] (Dollars in Millions)			
	FY 2020 Final	**FY 2021 Enacted**	**FY 2022 President's Budget[14]**
Statutory	**$294.879**	**$325.149**	**$341.825**
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	$258.400	$284.531	$299.532
Special Focus Facility Nursing Homes (SFF)	$2.186	$2.424	$2.472
Skilled Nursing Facilities (SNF)	$13.706	$16.074	$24.941
Home Health Agencies (HHAs)	$14.527	$15.345	$14.881
Hospice Agencies	$6.060	$6.775	$0
Special Focus Facility Hospice Agencies (SFF)[15]	N/A	N/A	$0
Non-Statutory Non-Deemed	**$43.066**	**$12.932**	**$50.061**
Ambulatory Surgical Centers (ASCs)	$9.544	$2.43	$11.578
Community Mental Health Centers (CMHCs)	$0.116	$0.024	$0.335
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	$0.105	$0.024	$0.098
End Stage Renal Disease (ESRD)	$20.825	$6.376	$25.008
Hospitals	$9.492	$3.32	$9.247
Outpatient Physical Therapy (OPT)	$0.951	$0.227	$0.946
Portable X-Ray Suppliers	$0.145	$0.034	$0.192
Psychiatric Hospitals	[16]	[16]	[16]
Rural Health Clinics (RHCs)	$1.518	$0.405	$2.174
Transplant Centers	$0.370	$0.092	$0.482
Non-Statutory Deemed	**$30.095**	**$21.215**	**$37.534**
Ambulatory Surgical Centers (ASCs)	$0.330	$.074	$.332
End Stage Renal Disease (ESRD)	[16]	[16]	[16]
Home Health Agencies (HHAs)	$0.321	$0.064	$0.229
Hospice Agencies	$0.162	$0.033	$0.112
Hospitals	$29.282	$21.043	$36.861
Outpatient Physical Therapy (OPT)	[16]	[16]	[16]
Psychiatric Hospitals	[16]	[16]	[16]
Rural Health Clinics (RHCs)	[16]	[16]	[16]
Total State Direct Survey Budget	**$368.039**	**$359.296**	**$429.420**
IMPACT Act Hospice Survey	$5.432	$5.625	$5.385
Consolidated Appropriation P.L. 116-260 Hospice Surveys	N/A	N/A	$9.574
CARES Act[17]	$100.000	N/A	N/A

[13] Amounts include cost to conduct complaint investigations, initial, recertification, and validation surveys.

[14] In FY 2022, cost of survey and complaint workload for hospice agencies will be funded from the IMACT Act and Consolidated Appropriation Act.

[15] Surveys of Special Focus Facility for Hospice Agencies will start in FY 2022.

[16] Based on historical trends, CMS projects that States will allocate survey and certification funding from non-statutory facilities to fulfill requirements.

[17] The $100 million from the CARES Act will supportthe volume of standard surveys for each FY.

In FY 2022, CMS expects SAs to complete approximately 30,416 initial and recertification surveys, 78,212 visits in response to complaints. The S&C Visit Tables below show that the majority of surveys and complaint visits in FY 2022 are projected to be in nursing homes, illustrating the challenges discussed in the Accomplishment Section's Initiative 1.

FY 2022 Survey and Complaint Visit Table – Projected[18]					
Survey & Certification Metrics	**Facilities Beginning of Year**	**Recertification Surveys**	**Initial Surveys**	**Complaint Surveys**	**Total Surveys**
Total State Direct Survey Budget	**64,008**	**29,663**	**753**	**78,212**	**108,628**
Statutory	**30,659**	**24,629**	**234**	**72,962**	**97,825**
Nursing Facilities (NF)	312	312	23	1,002	1,337
SNF/NF	14,379	14,379	85	61,532	75,996
SFF Nursing Homes	88	176	N/A	N/A	176
Skilled Nursing Facilities (SNF)	674	674	24	4,879	5,577
ICF/IID	5,808	5,808	52	4,306	10,166
HHAs	7,004	2,335	25	869	3,229
Hospice Agencies	2,306	769	25	374	1,168
SFF Hospice Agencies[19]	88	176	N/A	N/A	176
Non-Statutory Non-Deemed	**19,173**	**4,841**	**519**	**1,448**	**6,808**
ASCs	3,748	1,119	42	87	1,248
CMHCs	118	19	7	1	27
CORFs	165	31	3	1	35
ESRD	7,303	2,310	320	1,112	3,742
Hospitals	1,349	390	8	208	606
OPT	1,718	301	32	7	340
Portable X-Ray Suppliers	470	62	20	1	83
Psychiatric Hospitals	450	0	0	0	0
RHCs	3,614	585	84	24	693
Transplant Centers	238	24	3	7	34
Non-Statutory Deemed	**14,176**	**193**	**0**	**3,802**	**3,995**
ASCs	1,893	31	0	0	31
ESRD	1	0	0	0	0
HHAs	4,232	24	0	0	24
Hospice Agencies	2,320	10	0	0	10
Hospitals	4,684	128	0	3,802	3,930
OPT	253	0	0	0	0
Psychiatric Hospitals	150	0	0	0	0
RHCs	643	0	0	0	0

[18] Supplemental funding from the CARES Act is included to pay for the recertification surveys.

[19] Surveys of Special Focus Facility for Hospice Agencies will start in FY 2022.

FY 2021 Survey and Complaint Visit Table – Projected[20]					
	Facilities Beginning of Year	**Recertification Surveys**	**Initial Surveys**	**Complaint Surveys**	**Total Surveys**
Total Survey & Certification Metrics	**63,828**	**28,225**	**758**	**66,869**	**95,852**
Statutory	**31,046**	**24,760**	**272**	**63,470**	**88,502**
Nursing Facilities (NF)	336	336	24	1,143	1,503
SNF/NF	14,424	14,424	95	55,841	70,360
SFF Nursing Homes	88	176	N/A	N/A	176
Skilled Nursing Facilities (SNF)	710	710	29	1,081	1,820
ICF/IID	5,927	5,927	75	3,898	9,900
HHAs	7,127	2,376	28	852	3,256
Hospice Agencies	2,434	811	21	655	1,487
SFF Hospice Agencies[21]	N/A	N/A	N/A	N/A	N/A
Non-Statutory Non-Deemed	**18,992**	**3,327**	**486**	**1,053**	**4,866**
ASCs	3,714	799	24	86	909
CMHCs	134	13	6	0	19
CORFs	176	24	2	0	26
ESRD	7,030	1,523	325	709	2,557
Hospitals	1,382	287	9	222	518
OPT	1,760	216	28	3	247
Portable X-Ray Suppliers	474	42	16	1	59
Psychiatric Hospitals	450	0	0	8	8
RHCs	3,630	406	74	24	504
Transplant Centers	242	17	2	1	20
Non-Statutory Deemed	**13,790**	**138**	**0**	**2,346**	**2,484**
ASCs	1,846	22	0	0	22
ESRD	1	0	0	0	0
HHAs	4,279	18	0	0	18
Hospice Agencies	2,056	6	0	0	6
Hospitals	4,706	92	0	2,346	2,438
OPT	230	0	0	0	0
Psychiatric Hospitals	150	0	0	0	0
RHCs	522	0	0	0	0

[20] Supplemental funding from the CARES Act is included to pay for the recertification surveys.

[21] Surveys of Special Focus Facility for Hospice Agencies will start in FY 2022.

FY 2020 Survey and Complaint Visit Table – Projected[22]					
	Facilities Beginning of Year	**Recertification Surveys**	**Initial Surveys**	**Complaint Surveys**	**Total Surveys**
Total Survey & Certification Metrics	**63,440**	**28,087**	**756**	**66,679**	**95,522**
Statutory	**29,907**	**23,975**	**315**	**62,200**	**86,490**
Nursing Facilities (NF)	285	285	29	1,399	1,713
SNF/NF	14,185	14,186	102	54,295	68,583
SFF Nursing Homes	88	176	N/A	N/A	176
Skilled Nursing Facilities (SNF)	630	630	31	1,033	1,694
ICF/IID	5,687	5,687	86	3,557	9,330
HHAs	6,712	2,238	40	1,321	3,599
Hospice Agencies	2,320	773	27	595	1,395
SFF Hospice Agencies[23]	N/A	N/A	N/A	N/A	N/A
Non-Statutory Non-Deemed	**18,605**	**3,848**	**441**	**1,423**	**5,712**
ASCs	3,749	910	22	139	1,071
CMHCs	121	14	4	12	30
CORFs	159	24	3	1	28
ESRD	7,233	1,817	278	916	3,011
Hospitals	1,366	320	11	315	646
OPT	1,694	235	38	6	279
Portable X-Ray Suppliers	487	50	15	1	66
Psychiatric Hospitals	0	0	0	0	0
RHCs	3,560	458	70	33	561
Transplant Centers	236	20	0	0	20
Non-Statutory Deemed	**14,928**	**264**	**0**	**3,056**	**3,320**
ASCs	1,966	25	0	0	25
ESRD	216	0	0	0	0
HHAs	4,368	127	0	0	127
Hospice Agencies	2,533	9	0	0	9
Hospitals	4,642	103	0	3,056	3,159
OPT	287	0	0	0	0
Psychiatric Hospitals	0	0	0	0	0
RHCs	916	0	0	0	0

[22] Supplemental funding from the CARES Act is included to pay for the recertification surveys.

[23] Surveys of Special Focus Facility for Hospice Agencies will start in FY 2022.

Discretionary Federal Direct Surveys: $5.2 million

The FY 2022 Budget request for Federal Direct Surveys is $5.2 million, $0.827 million below the FY 2021 Enacted level. The reduction reflects the transition of S&C activities for Psychiatric hospitals to State Agencies from federal contractors.

Discretionary Support Contracts and IT: $31.9 million

The FY 2022 Budget request for Support Contracts and IT is $31.9, an increase of $2.1 million above the FY 2021 Enacted level, which includes: $23.6 million for support contracts and $8.2 million for IT contracts. The majority of the increase for Support Contracts and IT request in FY 2022 will support Medicare Quality Improvement IT projects. IT systems enhancements will allow CMS to improve its ability to provide real-time data and improved transparency and expanded enforcement and better integration with COVID-19 and other data sources. The need for these enhancments was highlighted through CMS' response to the COVID-19 PHE.

Offsetting Collections Clinical Laboratory Improvement Amendments of 1988 (CLIA): $75.3 million

The CLIA program is entirely funded by user fees that are charged to the laboratories regulated by the program. The FY 2022 Budget projection for CLIA is $75.3 million in user fee collections, which is $8.9 million above the FY 2021 President's Budget.

The Clinical Laboratory Improvement Amendments of 1988 (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 on-site inspections of CLIA-identified laboratories. CMS works with SAs and AOs who perform inspections to ensure CLIA policies and procedures are followed.

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

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

Inspection of these laboratories by CMS or by an approved agent applies to all certificate types. Laboratories must allow access in order to assess compliance with requirements and must provide all information required to determine compliance. Failure to permit a survey will result in adverse action by CMS. The CMS survey process is outcome-oriented and utilizes an educational approach to assess compliance.

Number of Laboratories Subject to CLIA Oversight[24]

Lab Type	FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Actual	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Compliance Labs	18,344	18,064	17,883	17,717	17,404	17,404	TBD
Accredited Labs	16,430	16,394	16,311	16,035	15,746	15,746	TBD
Waived Labs	173,121	176,019	178,616	184,458	189,410	189,410	TBD
PPMP	35,329	34,684	33,411	32,578	31,254	31,254	TBD
Total No. of Labs	**243,224**	**245,161**	**246,221**	**250,788**	**253,814**	**253,814**	**TBD**

Projected Workloads	FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Actual	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Recertification/Initial of Compliance Labs	9,172	9,032	8,942	8,859	8,702	8,702	TBD
Complaint/Follow-ups of Compliance Labs	642	632	626	620	394	394	TBD
Validation Surveys of Accredited labs	411	410	408	401	609	609	TBD
Complaint/Follow-ups of Accredited Labs	29	29	28	28	27	27	TBD
Total Number of Projected Workloads	**10,254**	**10,103**	**10,004**	**9,908**	**9,732**	**9,732**	**0**
Actual Workloads							
Initial Surveys	1,188	1,143	1,272	1,088	N/A	N/A	N/A
Recertification	6,956	8,038	7,585	7,538	N/A	N/A	N/A
Validation	328	361	329	334	N/A	N/A	N/A
Complaints	191	330	307	220	N/A	N/A	N/A
Follow-Ups	904	1,258	626	589	N/A	N/A	N/A
Total Workload Completed	**9,567**	**11,130**	**10,119**	**9,769**	**N/A**	**N/A**	**N/A**

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

Mandatory Appropriation Grants to States Mandatory Appropriation: $306.0 million

The FY 2022 mandatory appropriation for the Grants to States for Medicaid is $306.0 million, $10.0 million above FY 2021 level. This funding will allow States to conduct surveys, certifications, and investigations of Medicaid eligible facilities. With this funding, CMS projects to meet all statutory requirements of the S&C program, including responding to IJ complaints and adherence to statutorily required survey frequencies.

FY 2020 to FY 2022 Mandatory Facilities' Survey Cost Projections[25]
(Dollars in Millions)

Provider Type	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Statutory	**$284.836**	**$296.000**	**$306.000**
Nursing Facilities (NF)	$7.742	$8.408	$9.571
Skilled Nursing Facilities/Nursing Facilities (SNF/NF)	$216.131	$224.716	$233.667
Special Focus Facility Nursing Homes (SFF)	$1.828	$1.862	$1.902
ICF/IID	$44.339	$46.535	$46.788
Home Health Agencies (HHAs)	$14.796	$14.479	$14.073
Non-Statutory Deemed	**$1.914**	**$0**	**$0**
Home Health Agencies (HHAs)	$1.914	[26]	[26]
Total Medicaid S&C Funding	**$286.750**	**$296.000**	**$306.000**

[25] Amounts include cost to conduct complaint investigations, initial, and recertification surveys.

[26] Based on historical trends, CMS projects that States will allocate survey and certification funding from non-statutory facilities to fulfill requirements.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Grants to States for Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, [$313,904,098,000] *$368,666,106,000,* to remain available until expended.

[For making,] *In addition, for carrying out such titles* after May 31, [2021, payments to States under title XIX or in the case of section 1928 on behalf of States under title XIX of the Social Security Act] *2022,* for the last quarter of fiscal year [2021] *2022* for unanticipated costs incurred for the current fiscal year, such sums as may be necessary, *to remain available until expended.*

[For making payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act]. *In addition, for carrying out such titles* for the first quarter of fiscal year [2022] *2023*, [$148,732,315,000] *$165,722,018,000,* to remain available until expended.

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

Grants to States for Medicaid

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, *[$313,904,098,000] $368,666,106,000,* to remain available until expended.	This section provides a no-year appropriation for Medicaid for FY 2022. This appropriation is in addition to the advance appropriation of $148.7 billion for the first quarter of FY 2022. Funds will be used under title XIX for medical assistance payments and administrative costs and under title XI for demonstrations and waivers.
[For making,] *In addition, for carrying out such titles after May 31, [2022, payments to States under title XIX or in the case of section 1928 on behalf of States under title XIX of the Social Security Act] 2023,* for the last quarter of fiscal year *[2022] 2023*, for unanticipated costs incurred for the current fiscal year, such sums as may be necessary, *to remain available until expended.*	This section provides indefinite authority for payments to states in the last quarter of FY 2022 to meet unanticipated costs for carrying out titles XI and XIX, including the costs of the Vaccines for Children program. “For carrying out” is substituted for consistency throughout the appropriations language. “To remain available until expended” is included for alignment with other Medicaid appropriations provided in this language.

Grants to States for Medicaid

Language Analysis

Language Provision	Explanation
[For making payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act] *In addition, for carrying out such titles* for the first quarter of fiscal year [2022] *2023, [$148,732,315,000] $165,722,018,000,* to remain available until expended.	This section provides an advance appropriation for the first quarter of FY 2023 to ensure continuity of funding for activities authorized under titles XI and XIX. This allows the Medicaid program, including the Vaccines for Children program, to continue operating in the event a regular appropriation for FY 2023 is not enacted by October 1, 2022. "For carrying out" is substituted for consistency throughout the appropriations language.
Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.	This section makes clear that funds are available with respect to state plans or plan amendments only for expenditures on or after the beginning of the quarter in which a plan or amendment is submitted to the Department of Health and Human Services for approval.

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

	FY 2020 Actual	FY 2021 Est.	FY 2022 Est.	FY 2022 +/- FY 2021
Mandatory Appropriation:				
Advanced Appropriation.....	$137,931,797	$139,903,075	$148,732,315	$8,829,240
Annual Appropriation.....	$273,188,478	$313,904,098	$368,666,106	$54,762,008
Indefinite Annual Appropriation..	$56,448,819	$66,110,403	$0	($66,110,403)
Subtotal, Mandatory Appropriation	$467,569,094	$519,917,576	$517,398,421	($2,519,155)
Offsetting Collections from Federal Sources:				
Collection Authority: Medicare Part D……..	$0	$5,000	$5,000	$0
Collection Authority: Medicare Part B……..	$1,292,102	$1,162,000	$1,309,000	$147,000
Subtotal, Collections Authority	$1,292,102	$1,167,000	$1,314,000	$147,000
Total New Budget Authority	**$468,861,196**	**$521,084,576**	**$518,712,421**	**($2,967,069)**
Unobligated Balances:				
Unobligated balance, Start of year.....	$14,678,963	$311,287	$0	($311,287)
Unobligated balance, Recoveries of Prior Year Obligations (Unpaid)……	$21,623,009	$45,850,000	$44,955,118	($894,882)
Recoveries of Prior Year Obligations (Paid)……	$14,154,929			
Subtotal, Unobligated Balances.....	$50,456,901	$46,161,287	$44,955,118	($1,206,169)
Total Budgetary Resources (Amounts Available for Obligation)	**$519,318,097**	**$567,245,863**	**$563,667,540**	**($3,578,323)**
Unobligated balance, end of year……..	$311,287	$0	$0	$0
Total, Gross Obligations.....	**$519,006,811**	**$567,245,863**	**$563,667,540**	**($3,578,323)**
Net Obligations:				
Gross Obligations.....	$519,006,811	$567,245,863	$563,667,540	($3,578,323)
Actual Collections: Medicare Part D……..	$0	($5,000)	($5,000)	$0
Actual Collections: Medicare Part B……..	($1,292,102)	($1,162,000)	($1,309,000)	($147,000)
Unobligated balance, Start of year.....	($14,678,963)	($311,287)	$0	$311,287
Unobligated balance, Recoveries of Unpaid and paid Obligations.....	($35,777,938)	($45,850,000)	($44,955,118)	$894,882
Total Net Obligations	**$467,257,808**	**$519,917,576**	**$517,398,421**	**(2,519,155)**

Grants to States for Medicaid
Appropriations History Table

Fiscal Year	Budget Estimate to Congress	Appropriation
2013 [1]	$269,405,279,000	$269,405,279,000
2014 [2]	$284,208,616,000	$305,843,467,000
2015 [3]	$338,081,239,000	$368,405,940,000
2016 [4]	$356,817,550,000	$366,672,257,000
2017 [5]	$377,586,469,000	$389,349,760,000
2018	$410,017,836,000	$410,017,836,000
2019	$411,083,971,000	$411,083,971,000
2020 [6]	$411,120,275,000	$467,569,094,000
2021 [7]	$453,807,173,000	$453,807,173,000
2022	$517,398,421,000	--

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

	FY 2021 Estimate	FY 2022 Estimate	FY 2022 +/- FY 2021
CMS - Grants to States			
Grants to States, Subsidies	$515,616,471	$513,572,423	($2,044,048)
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$5,468,105	$5,139,998	($328,107)
Total Budget Authority	**$521,084,576**	**$518,712,421**	**($2,372,155)**

[1] Full year continuing resolution appropriation provided indefinite funding authority of $158.8 billion for FY 2013.
[2] Includes $21.6 billion in indefinite funding authority obligated during FY 2014.
[3] Includes $16.8 billion in indefinite funding authority obligated during FY 2015.
[4] Includes $9.9 billion in indefinite funding authority obligated during FY 2016.
[5] Includes $11.8 billion in indefinite funding authority obligated during FY 2017.
[6] Includes $56.5 billion in indefinite funding authority obligated during FY 2020.
[7] Does not include an estimate of $66.1 billion in indefinite authority to be obligated during FY 2021.

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

	FY 2020 Actual	FY 2021 Estimate	FY 2022 Estimate	FY 2022 +/- FY 2021
1. Medical Assistance Payments				
Medical Assistance Payments.....	$439,464,073	$446,609,404	$445,345,956	($1,263,448)
Benefits Due and Payable (IBNR)	$0	$44,955,118	$44,643,409	($311,709)
Subtotal, Benefits	**$439,464,073**	**$491,564,522**	**$489,989,365**	**($1,575,157)**
2. Vaccine for Children				
Vaccines for Children.....	$4,577,669	$5,468,105	$5,139,998	($328,107)
Subtotal, Vaccine for Children	**$4,577,669**	**$5,468,105**	**$5,139,998**	**($328,107)**
3. State Administration				
State and Local Administration.....	$21,792,757	$20,985,313	$21,636,000	$650,687
HIT- Incentives.....	$0	$0	$0	$0
HIT- Provider.....	$479,712	$80,000	$17,000	($63,000)
HIT- Administration.....	$714,798	$1,233,636	$23,059	($1,210,577)
State Survey and Certification.....	$250,085	$297,000	$306,000	$9,000
State Fraud Control Units.....	$290,000	$299,000	$308,000	$9,000
Subtotal, State Administration	**$23,527,352**	**$22,894,949**	**$22,290,059**	**($604,890)**
Total Mandatory Appropriation……..	$467,569,094	$519,917,576	$517,398,421	($2,519,155)
Total Offsetting Collection Authority [8,9]……..	$1,292,102	$1,167,000	$1,314,000	$147,000
Total, Budget Authority	**$468,861,196**	**$521,084,576**	**$518,712,421**	**($2,372,155)**

Authorizing Legislation - Social Security Act, title XIX, Section 1901 and Public Law 111-5, Public Law 111-148, Public Law 111-152
FY 2020 Authorization – Public Law 116-94
FY 2021 Authorization – Public Laws 116-62, 116-59, 116-260

Allocation Method - Formula Grants

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

Grants to States for Medicaid
Appropriated Budget Request [10]

(Dollars in Thousands)

	FY 2020 Actual	FY 2021 Estimate	FY 2022 President's Budget	FY 2022 +/- FY 2021
Program Activity				
Medical Assistance Payments.....	$382,944,425	$425,444,119	$489,968,364	$64,524,245
State and Local Administration.....	$23,598,181	$22,894,949	$22,290,059	($604,890)
Vaccine for Children.....	$4,577,669	$5,468,105	$5,139,998	($328,107)
Subtotal, Medicaid Program Level	**$411,120,275**	**$453,807,173**	**$517,398,421**	**$63,591,248**
Less funds advanced in prior year.	$137,931,797	$139,903,075	$148,732,315	$8,829,240
Total, Grants to States for Medicaid	**$273,188,478**	**$313,904,098**	**$368,666,106**	**$54,762,008**
New advance 1st quarter of subsequent FY.....	$139,903,075	$148,732,315	$165,722,018	$16,989,703

[10] Funding represented in the chart equals the respective President's Budget requests. FY 2020 does not include $56.5 billion in indefinite funding authority obligated during FY 2020. FY 2021 does not include projected indefinite funding need of $66.1 billion.

Grants to States for Medicaid

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

The table below, and the following language, provides additional detail on each of the Grants to States for Medicaid program activities for FY 2022.

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

Program Activity	FY 2020 Actual	FY 2021 Estimate	FY 2022 Estimate	FY 2022 +/- FY 2021
Medical Assistance Payments	$382,944	$425,444	$489,968	$64,524
State and Local Administration	$23,598	$22,895	$22,290	($605)
Vaccine for Children	$4,578	$5,468	$5,140	($328)
Total Mandatory Appropriation Request [11]	**$411,120**	**$453,807**	**$517,398**	**$63,591**

FY 2022 Mandatory Appropriation Request: $517.4 billion

CMS' FY 2022 mandatory appropriation request for the Grants to States for Medicaid account is $517.4 billion, an increase of $63.6 billion relative to the FY 2021 request level of $453.8 billion. This appropriation is composed of $148.7 billion in an authorized advance appropriation for FY 2022 and a remaining appropriation of $368.7 billion for FY 2022.

Resources will help fund $563.7 billion in anticipated FY 2022 Medicaid obligations. CMS also anticipates carryover balances and recoveries in the amount of $45.0 billion as well as budget authority from offsetting collections from the Supplementary Medical Insurance trust fund and Medicare Part D account in the amount of $1.3 billion to fund the remaining anticipated obligations. These estimated obligations include:

- $536.2 billion in Medicaid medical assistance payments (MAP);
- $22.3 billion for Medicaid state and local administrative functions including funding for Medicaid state survey and certification and the state Medicaid fraud control units; and
- $5.1 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 2020. The projections

[11] Numbers may not add due to rounding.

incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget (OMB) for the FY 2022 President's Budget.

Under current law, the federal share of Medicaid net outlays is estimated to be $517.7 billion in FY 2022, a decrease of $3.4 billion from the FY2021 level of $521.1 billion.

The FY 2022 estimate will be discussed in further detail by the major program activities of the Grants to States for Medicaid account; Medical Assistance Payments, Vaccines for Children, and State and Local Administration.

Grants to States for Medicaid

Medical Assistance Payments

(Dollars in Thousands)

	FY 2020 Actual	FY 2021 Estimate	FY 2022 Estimate	FY 2022 +/- FY 2021
Medical Assistance Payments	$382,944,425	$425,444,119	$489,968,364	$64,524,245

Program Activity Description and Accomplishments

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

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

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

Medicaid Eligibility and Enrollment

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

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

Medicaid Enrollment (Person-Years in Millions)

	FY 2020 Actual	FY 2021 Estimate	FY 2022 Estimate	FY 2021 +/- FY 2020
Aged	6.3	6.4	6.7	0.2
Disabled	10.2	10.3	10.4	0.1
Adults	15.5	15.5	15.3	(0.2)
Children	29.7	30.0	29.9	(0.1)
Expansion Adult	12.9	13.3	13.6	0.3
Territories	1.4	1.4	1.4	0.0
Total [12]	**76.0**	**76.9**	**77.2**	**0.3**

According to CMS projections of Medicaid enrollment, 77.2 million Americans will be enrolled in Medicaid for the equivalent of a full year during FY 2022. In FY 2022, Medicaid is projected to provide coverage to more than one out of every five people in the nation. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to remain the same in FY 2022.

Scope of Medicaid Services

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

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

[12] Totals do not add due to rounding.

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

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

FY 2022 Estimate

Budget Estimate: $490.0 Billion

CMS' Medical Assistance Payments (MAP) budget estimate is $490.0 billion, a $64.5 billion increase above the FY 2021 estimated level. The following language provides additional detail on CMS' FY 2022 estimate: In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to reflect actuarial estimates developed by CMS' Office of the Actuary (OACT), legislative and regulatory impacts, entitlement benefits due and payable, CMS financial management reviews and estimates of expenditure transfer authority from the Medicare trust funds.

Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

CMS' OACT has found that state-submitted estimates of the grant awards tend to be higher than actual expenditures and, because of this, CMS' OACT relies more on actual expenditure data than the state-submitted estimates. CMS' OACT developed the MAP estimate for FY 2022 using the three quarters of FY 2020 state-reported expenditures as a base. Expenditures for FY 2020, FY 2021, and FY 2022 were projected by applying factors to account for assumed growth rates in Medicaid caseloads, utilization of services, and payment rates. These growth rates were derived mainly from economic assumptions promulgated by OMB and demographic trends in Medicaid enrollment. CMS' OACT also incorporated adjustments to the Medicaid benefit estimates based on their analysis of the state-submitted estimates.

For an in-depth analysis of the actuarial Medicaid cost estimates and financial outlook on the Medicaid program, see the Actuarial Report on the Financial Outlook for Medicaid.

Entitlement Benefits Due and Payable (Incurred but not Reported)

The FY 2022 estimate of $44.6 billion represents the entire liability for Medicaid medical services incurred but not paid from October 1, 2021 to September 30, 2022. This Medicaid liability is developed from estimates received from the states. The incurred but not reported estimate represents the net of unreported expenses incurred by the states less amounts owed to the states for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases.

Transfer from the Supplementary Medical Insurance Trust Fund for Qualified Individuals

Social Security Act Title XIX Section 1933(f) authorizes a transfer from the Supplementary Medical Insurance Trust Fund to the Grants to States for Medicaid account to account for the Medicare programs costs attributable to state coverage of Medicare cost-sharing for certain low-income Medicare beneficiaries. This estimate is developed by CMS' OACT, which for FY 2022 is estimated to be $1.3 billion. This transfer of funding is used to offset MAP obligations, thereby reducing the overall mandatory appropriation request.

Legislative and Regulatory Impacts to the Medicaid Baseline

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

Legislative Actions

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

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

Medicaid Extenders Act of 2019 (P.L. 116-3)

This law includes extensions of Money Follows the Person program and spousal impoverishment rules, and reduces the federal match for states that have not implemented asset verification programs.

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

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

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

National Defense Authorization Act for Fiscal Year 2020 (P.L. 116-92)

This law extends the Afghan special immigrant visa (SIV) program and provides an adjustment for Liberian nationals. Both groups are eligible for Medicaid benefits.

Further Consolidated Appropriations Act of 2020 (P.L. 116-94)

This Act extends Sec. 223 grants, provides additional funding for territories for FYs 2020 and 2021, and repealed the health insurance provider tax.

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

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

Consolidated Appropriations Act of 2021 (P.L. 116-260)

This Act eliminates DSH reductions for fiscal years 2021 through 2023, promotes access to life-saving therapies for Medicaid enrollees, and extends the Money Follows the Person program, the community mental health services demonstration program, and spousal impoverishment protections.

Families First Coronavirus Response Act (P.L. 116-127)

This law temporarily increases the federal Medicaid matching by 6.2 percentage points for all states and territories, increases allotments to territories for FYs 2020 and 2021, requires states to cover COVID-19 testing in Medicaid without cost sharing, and allows states to extend Medicaid coverage for testing to the uninsured.

Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136)

This law clarifies some of the Medicaid changes in the Families First Act, delays the DSH allotment reductions, and extends the Money Follows the Person program, the community mental health services demonstration program, and spousal impoverishment protections.

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

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

Further, the bill extends 100% FMAP to Urban Indian Health Organizations and Native Hawaiian Health Care Systems, sunsets the limit of maximum rebate amount for single source drugs and innovator multiple source drugs, increases Medicaid home and community-based services FMAP during the COVID-19 emergency, and funds state strike teams for resident and employee safety in nursing facilities.

Regulatory Actions

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

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

CMS Interoperability and Patient Access final rule, (CMS–9115–F)

This final rule implements certain provisions of the 21st Century Cures Act (Cures Act), including conditions and maintenance of certification requirements for health information technology (IT) developers, the voluntary certification of health IT for use by pediatric health providers, health information network voluntary attestation to the adoption of a trusted exchange framework and common agreement in support of network-to-network exchange, and reasonable and necessary activities that do not constitute information blocking. The rule also addresses technical standards related to interoperability provisions, provisions of patient data access through application programming interfaces (APIs), requirements that Medicare Advantage (MA) and Medicaid plans make standardized information about their provider networks/directories available via APIs, establishing a coordination of care transaction to communicate between plans to improve health information exchange and care coordination, increasing the frequency of federal-state data exchanges to improve care for individuals dually eligible for Medicare and Medicaid, and information blocking and public reporting.

Grants to States for Medicaid

Vaccines for Children

(Dollars in Thousands)

	FY 2020 Actual	FY 2021 Estimate	FY 2022 Estimate	FY 2022 +/- FY2021
Vaccines for Children	$4,577,669	$5,468,105	$5,139,998	($328,107)

Program Activity Description and Accomplishments

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

The nation's childhood immunization coverage rates are at high levels for most vaccines and vaccination series measures. As childhood immunization coverage rates increase, cases of vaccine-preventable diseases (VPDs) decline significantly. Vaccination against diphtheria, *haemophilus influenza* type b, hepatitis A, hepatitis B, measles, mumps, pneumococcal, pertussis, polio, rotavirus, rubella, tetanus, and varicella is recommended. In addition to the health benefits of immunization, vaccines also provide significant economic value. Millions of children have benefited from vaccination since the Vaccines for Children Program began in 1994. Among children born during 1994-2018, vaccination will prevent an estimated 419 million illnesses, 26.8 million hospitalizations, and 936,000 early deaths over the course of their lifetimes, at a net savings of $406 billion in direct costs and $1.9 trillion in total societal costs. [13]

FY 2022 Budget Estimate: $5.1 Billion

CMS' Vaccine for Children (VFC) estimate is $5.1 billion, a $328.1 million decrease below the FY 2021 estimated level.

This estimate includes funds for vaccine-purchase contract costs and quality assurance and quality improvement site visits to VFC-enrolled providers. This budget will ensure sufficient quantities of pediatric vaccines are available to immunize VFC eligible children; approximately 96 percent of the VFC budget are used to purchase vaccines, including vaccine purchases for the VFC stockpile. The VFC stockpile is a strategic asset for the

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

nation's immunization system that is used to fight outbreaks of VPDs and mitigate the impact of unanticipated shortages of routinely recommended vaccines. The remaining budget supports vaccine ordering and distribution, including costs of ordering vaccines on behalf of states, immunization coverage surveys, and program support and oversight.

Grants to States for Medicaid

State and Local Administration

(Dollars in Thousands)

	FY 2020 Actual	FY 2021 Estimate	FY 2022 Estimate	FY 2022 +/- FY 2021
State and Local Administration	$23,598,181	$22,894,949	$22,290,059	($604,890)

Program Activity Description and Accomplishments

State and Local Administration

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

Medicaid Survey and Certification

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

Medicaid Fraud Control Units

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

Health Information Technology Meaningful Use Incentive Program

The American Recovery and Reinvestment Act of 2009 (ARRA) authorizes Medicaid to provide incentive payments to doctors, hospitals, and other providers for the implementation and meaningful use of certified EHRs. The provision allows for enhanced federal financial participation (FFP) of 100 percent for incentive payments to providers for

the purchase, maintenance, and meaningful use of certified EHRs, and 90 percent FFP for state and local administrative expenses associated with administering the incentive payments.

FY 2022 Budget Estimate: $22.3 Billion

CMS' State Administration estimate is $22.3 billion; a $605.0 million dollar decrease compared to the FY 2021 estimated level.

This estimate is composed of $306.0 million for Medicaid state survey and certification, $308 million for state Medicaid Fraud Control Units, $17.0 million for the Health Information Technology Provider Incentives, and $23.1 million for other Medicaid state and local administration. The estimate is also reduced by the estimated expenditure transfer authority from the Medicare Part D account for state low income determinations.

Medicaid State Survey and Certification

The purpose of survey and certification inspections for nursing facilities home health agencies and intermediate care facilities for individuals with intellectual disabilities in FY 2022 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2022 estimate for Medicaid state survey and certification is $306.0 million. This represents an increase of over $9.0 million above the FY 2021 estimated amount of $297.0 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 2022, 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 $308.0 million. This represents an increase of $9.0 million over the FY 2021 estimate of $299.0 million. Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud as well as neglect or abuse of patients in health care facilities and board and care facilities and of Medicaid beneficiaries in non-institutional or other settings. The MFCUs are typically a part of the state Attorney General's office or have arrangements with the Attorney General or another office with statewide prosecutorial authority. In FY 2020, MFCUs were responsible for 1,017 convictions, 786 civil settlements and judgments, and expected monetary recoveries for both civil and criminal cases of $1.028 billion. MFCU cases in FY 2020 were also responsible for the exclusion of 928 individuals and entities from participation in Medicaid and other federally funded health care programs.

Health Information Technology Meaningful Use Incentive Program

The current FY 2022 estimate for the provider incentives payments and state administrative costs is $40.1 million. These incentives continue to encourage adoption and meaningful use of electronic health records (EHRs). As providers have utilized the incentive payments to enhance their EHRs, states are seeing an increase in the need for ways to securely

share these records among health care providers. States are committed to supporting this and other initiatives like the Electronic health information exchange (HIE), which allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care.

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

The current FY 2022 estimate for this transfer is $5.0 million, a flatline from the FY 2021 estimate. Social Security Act Title XVIII Section 1860D-16(b)(2) authorizes a transfer from the Medicare Part D account to the Grants to States for Medicaid account to account for state administrative costs relating to Medicare prescription drug low-income subsidies, Medicare transitional prescription drug assistance, and Medicare cost-sharing. This amount is determined by CMS using actual state-submitted expenditure data projected into FY 2022.

All Other Medicaid State and Local Administration

The CMS estimate for FY 2022 is $21.7 billion. CMS adjusted the FY 2021 state-submitted estimates of $21.0 billion upward to reflect a growth rate more consistent with recent expenditure history and current economic conditions relative to the conditions when states submitted estimates.

FY 2022 MANDATORY STATE/FORMULA GRANTS [14]

(Dollars in Thousands)

CFDA No/Program Name: 93.778 Medical Assistance Program

State/Territory	FY 2020 Obligations	FY 2021 Estimate	FY 2022 Estimate	Difference +/- 2022
Alabama	$4,809,660	$5,296,995	$5,585,779	$288,784
Alaska	$1,633,529	$1,750,911	$1,816,723	$65,812
Arizona	$11,631,515	$13,991,456	$13,777,053	-$214,403
Arkansas	$5,632,255	$6,172,784	$5,979,369	-$193,415
California	$65,532,557	$77,408,160	$75,536,260	-$1,871,900
Colorado	$6,171,402	$6,746,401	$6,635,428	-$110,973
Connecticut	$5,511,940	$5,911,162	$5,676,856	-$234,306
Delaware	$1,692,893	$1,795,251	$1,831,154	$35,903
Dist. Of Col.	$2,574,185	$2,942,412	$2,219,389	-$723,023
Florida	$17,206,639	$19,447,215	$18,309,258	-$1,137,957
Georgia	$8,479,989	$8,761,970	$8,841,822	$79,852
Hawaii	$1,642,550	$1,841,904	$1,764,938	-$76,966
Idaho	$1,998,270	$2,485,083	$2,586,015	$100,932
Illinois	$14,669,396	$14,935,572	$12,330,693	-$2,604,879
Indiana	$11,024,610	$11,925,727	$11,009,276	-$916,451
Iowa	$4,191,167	$4,343,796	$3,979,884	-$363,912
Kansas	$2,612,240	$3,003,559	$2,973,292	-$30,267
Kentucky	$9,807,104	$12,928,414	$12,983,506	$55,092
Louisiana	$9,838,417	$12,675,277	$11,783,290	-$891,987
Maine	$2,374,365	$2,566,643	$2,425,355	-$141,288
Maryland	$7,843,979	$8,298,140	$7,900,113	-$398,027
Massachusetts	$11,262,027	$13,035,341	$11,984,663	-$1,050,678
Michigan	$14,491,171	$16,537,326	$16,324,956	-$212,370
Minnesota	$8,739,719	$9,845,147	$10,049,731	$204,584
Mississippi	$4,688,404	$5,187,251	$4,975,213	-$212,038
Missouri	$7,993,678	$9,351,407	$10,046,549	$695,142
Montana	$1,654,031	$1,727,492	$1,727,147	-$345
Nebraska	$1,486,393	$2,038,781	$1,983,796	-$54,985
Nevada	$3,320,533	$3,821,962	$4,136,800	$314,838
New Hampshire	$1,443,009	$1,586,714	$1,513,934	-$72,780
New Jersey	$10,857,275	$11,643,824	$12,422,149	$778,325
New Mexico	$5,384,803	$5,927,146	$5,634,098	-$293,048
New York	$46,511,583	$51,458,717	$49,987,393	-$1,471,324
North Carolina	$11,170,861	$12,040,481	$12,153,597	$113,116
North Dakota	$890,865	$981,606	$884,182	-$97,424

[14] Obligation estimates for FY 2021 and 2022 reflect the State-reported estimates of Medicaid needs available to CMS in November 2020 and do not account for recently enacted legislation, regulations, or guidance.

FY 2022 estimates for the territories have been adjusted to account for the limitation on total Medicaid payments to each territory as defined by 42 U.S.C. 1308.

State/Territory	FY 2020 Obligations	FY 2021 Estimate	FY 2022 Estimate	Difference +/- 2022
Ohio	$18,816,226	$21,602,268	$22,379,172	$776,904
Oklahoma	$3,721,917	$4,647,755	$4,195,532	-$452,223
Oregon	$8,310,688	$9,551,990	$9,596,184	$44,194
Pennsylvania	$22,585,634	$26,024,907	$24,235,711	-$1,789,196
Rhode Island	$1,892,133	$2,107,649	$1,909,118	-$198,531
South Carolina	$5,261,700	$5,748,601	$5,463,083	-$285,518
South Dakota	$650,543	$720,977	$680,672	-$40,305
Tennessee	$8,560,016	$9,288,009	$9,228,202	-$59,807
Texas	$28,444,359	$32,867,898	$29,126,544	-$3,741,354
Utah	$2,430,057	$2,704,044	$2,607,832	-$96,212
Vermont	$1,144,899	$1,212,789	$1,117,613	-$95,176
Virginia	$8,875,948	$11,970,382	$11,777,714	-$192,668
Washington	$9,366,486	$11,896,480	$15,860,360	$3,963,880
West Virginia	$3,500,800	$3,843,715	$3,954,746	$111,031
Wisconsin	$6,430,029	$7,176,304	$6,732,192	-$444,112
Wyoming	$405,846	$429,557	$416,644	-$12,913
Subtotal	**$457,170,294**	**$522,205,352**	**$509,050,980**	**-$13,154,372**
Amer. Samoa	$46,141	$85,550	$13,000	-$72,550
Guam	$122,816	$129,712	$19,200	-$110,512
N. Mariana Islands	$39,141	$65,725	$7,200	-$58,525
Puerto Rico	$2,516,888	$2,952,606	$392,500	-$2,560,106
Virgin Islands	$77,805	$103,706	$19,600	-$84,106
Subtotal	**$2,802,792**	**$3,337,299**	**$451,500**	**-$2,885,799**
Total States and Territories	**$459,973,086**	**$525,542,651**	**$509,502,480**	**-$16,040,171**
Survey & Certification	$250,085	$297,000	$306,000	$9,000
Fraud Control Units	$290,000	$299,000	$308,000	$9,000
Vaccines For Children	$4,577,756	$5,468,105	$5,139,998	-$328,107
Undistributed	$53,915,884	$35,639,107	$101,388,062	$65,748,955
Total Obligations	**$519,006,811**	**$567,245,863**	**$616,644,540**	**$49,398,677**

Obligation estimates for FY 2021 and 2022 reflect the State-reported estimates of Medicaid needs available to CMS in November 2020 and do not account for recently enacted legislation, regulations, or guidance.

FY 2022 estimates for the territories have been adjusted to account for the limitation on total Medicaid payments to each territory as defined by 42 U.S.C. 1308.

Payments to the Health Care Trust Funds

Appropriations Language

For payment to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as provided under sections 217(g),1844, and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d)(3) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, [$*439,514,000,000*] *$487,862,000,000.*

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

Payments to the Health Care Trust Fund

Language Analysis

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

Payments to the Health Care Trust Funds
Summary of Changes

FY 2021 Enacted

Total Budget Authority - $439,514,000,000

FY 2022 President's Budget

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

Net Change, Total Appropriation – $48,348,000,000

Changes	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Federal Payment for Supplementary Medical Insurance (SMI)	$304,044,600,000	$325,500,000,000	$384,646,000,000	$59,146,000,000
Indefinite Annual Appropriation, SMI	$0	$0	$0	$0
Hospital Insurance for Uninsured Federal Annuitants	$109,000,000	$95,000,000	$82,000,000	($13,000,000)
Program Management Administrative Expenses	$913,000,000	$904,000,000	$929,000,000	$25,000,000
General Revenue for Part D (Drug) Benefit	$104,539,500,000	$111,800,000,000	$100,968,883,000	($10,831,117,000)
Indefinite Annual Appropriation, Part D Benefits	$0	$0	$0	$0
General Revenue for Part D Federal Administration	$861,000,000	$882,000,000	$882,000,000	$0
Part D: State Low-Income Determination	$5,000,000	$5,000,000	$5,000,000	$0
Reimbursement for HCFAC	$324,000,000	$328,000,000	$349,117,000	$21,117,000
Net Change*	$410,796,100,000	$439,514,000,000	$487,862,000,000	$48,348,000,000

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

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Supplementary Medical Insurance	$304,044,600	$325,500,000	$384,646,000	$59,146,000
Indefinite Annual Appropriation, SMI	$0	$0	$0	$0
Hospital Insurance for Uninsured Federal Annuitants	$109,000	$95,000	$82,000	($13,000)
Program Management Administrative Expenses	$913,000	$904,000	$929,000	$25,000
General Revenue for Part D Benefit	$104,539,500	$111,800,000	$100,968,883	($10,831,117)
Indefinite Annual Appropriation, Part D Benefits	$0	$0	$0	$0
General Revenue for Part D Federal Administration	$861,000	$882,000	$882,000	$0
Part D: State Low-Income Determination	$5,000	$5,000	$5,000	$0
Reimbursement for HCFAC	$324,000	$328,000	$349,117	$21,117
Total Budget Authority *	$410,796,100	$439,514,000	$487,862,000	$48,348,000

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

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Payments to the Health Care Trust Funds (sections 217(g), 201(g), 1844, and 1860D-16 of the Social Security Act, section 103(c) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248)	$410,796,100	$439,514,000	$487,862,000	$48,348,000)
Total Budget Authority *	$410,796,100	$439,514,000	$487,862,000	$48,348,000

Annual Budget Authority by Activity

(Dollars in Thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Budget Authority*	$410,796,100	$439,514,000	$487,862,000	$48,348,000

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

Program Description and Accomplishments

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

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

Federal Contribution for SMI:

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

The FY 2022 President's Budget request of $384.6 billion is a net increase of $59.1 billion over the FY 2021 enacted amount of $325.5 billion. The cost of the federal match continues to rise from year to year because of beneficiary population and program cost growth.

Hospital Insurance for the Uninsured Federal Annuitants:

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

The FY 2022 estimated request of $82.0 million for Hospital Insurance for Uninsured Federal Annuitants is a net decrease of $13.0 million from the FY 2021 estimated amount of $95.0 million. The Medicare-eligible retirees are no longer growing, therefore less

funding is needed.

Program Management Administrative Expenses:

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

The FY 2022 budget estimate of $929.0 million to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare trust fund activities is a net increase of $25 million over the FY 2021 estimate of $904.0 million.

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

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

The FY 2022 President's Budget request of $101.0 billion for General Revenue for Part D (Benefits) is a net decrease of $10.8 billion over the FY 2021 Enacted amount of $111.8 billion. The benefit contribution decreases due to change in methodology for estimating General Revenue for Part D (Benefits) to be more in line with actual experience.

The FY 2022 President's Budget request for General Revenue for Part D Federal Administration remains $882.0 million.

The FY 2022 President's request for General Revenue for Part D State Eligibility Determinations remains at $5.0 million

Reimbursement for HCFAC:

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

The FY 2022 budget estimate of $349.1 million for reimbursement of HCFAC is a net increase of $21.1 million above the FY 2021 estimate of $328.0 million. This amount reflects an estimate of that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the HI and SMI Trust Funds, but which are properly chargeable to the general fund. The FY 2022 request reflects the estimated Medicare non-trust fund burdens only. This is based on the current allocation of HCFAC spending data for the above mentioned non-trust fund program integrity activities.

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

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

Funding History

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

Fiscal Year	Budget Authority
FY 2018	$352,597,300,000
FY 2019	$391,343,800,000
FY 2020	$410,796,100,000
FY 2021	$439,514,000,000
FY 2022*	$487,862,000,000

Permanent Budget Authority
(Dollars in Thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Tax on OASDI Benefits	$26,941,000	$29,437,000	$29,946,000	$509,000
SECA Tax Credits	$0	$0	$0	$0
HCFAC, FBI	$141,000	$148,000	$157,592	$9,592
HCFAC, Asset Forfeitures	$701,000	$32,000	$33,000	$1,000
HCFAC, Criminal Fines*	$2,000	$36,464	$34,447	($2,017)
HCFAC, Civil Penalties and Damages: Administration	$26,000	$52,000	$52,500	$500
Total Budget Authority	$27,811,000	$29,705,464	$30,223,539	$518,075

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

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

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

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

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Grants, subsidies and contributions: Non-Drug	$304,044,600	$325,500,000	$384,646,000	$59,146,000
Indefinite Annual Appropriation	$0	$0	$0	$0
Grants, subsidies and contributions: Drug	$104,539,500	$111,800,000	$100,968,883	($10,831,117)
Indefinite Annual Appropriation, Part D Benefits	$0	$0	$0	$0
Insurance claims and indemnities	$109,000	$95,000	$82,000	($13,000)
Administrative costs-General Fund Share	$2,098,000	$2,114,000	$2,160,117	$46,117
General Revenue Part D: State Eligibility Determinations	$5,000	$5,000	$5,000	$0
Total Budget Authority	$410,796,100	$439,514,000	$487,862,000	$48,348,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Appropriations Language

Centers for Medicare & Medicaid Services

Health Care Fraud and Abuse Control

In addition to amounts otherwise available for program integrity and program management, **[**$807,000,000**]** *$872,793,000*, to remain available through September 30, **[**2022**]** *2023*, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act, of which **[**$616,000,000**]** *$675,726,000* shall be for the Centers for Medicare & Medicaid Services program integrity activities, of which **[**$99,000,000**]** *$102,145,000* shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act, and of which **[**$92,000,000**]** *$94,922,000* shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act: *Provided*, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year **[**2021**]** *2022* shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation: *Provided further*, That of the amount provided under this heading, **[**$311,000,000**]** *$317,000,000* is provided to meet the terms of **[**section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended**]** *a concurrent resolution on the budget for health care fraud and abuse control activities*, and **[**$496,000,000**]** *$555,793,000* is additional new budget authority specified for purposes of **[**section 251(b)(2)(C) of such Act**]** *a concurrent resolution on the budget for additional health care fraud and abuse control activities*: *Provided further*, That the Secretary shall provide not less than $20,000,000 from amounts made available under this heading and amounts made available for fiscal year **[**2021**]** *2022* under section 1817(k)(3)(A) of the

Social Security Act for the Senior Medicare Patrol program to combat health care fraud and abuse.

Language Analysis

Language Provision	Explanation
In addition to amounts otherwise available for program integrity and program management, **[**$807,000,000**]** *$872,793,000*, to remain available through September 30, **[**2022**]** *2023*, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act,	Authorizes appropriation to be available for obligation over two fiscal years.
of which **[**$616,000,000**]** *$675,726,000* shall be for the Centers for Medicare & Medicaid Services program integrity activities,	Provides funding for Centers for Medicare & Medicaid Services for program integrity activities.
of which **[**$99,000,000**]** *$102,145,000* shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act,	Provides funding for the Office of Inspector General, and limits activities to those authorized under the original HIPAA statute.
and of which **[**$92,000,000**]** *$94,922,000* shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act:	Provides funding for the Department of Justice, and limits activities to those authorized under the original HIPAA statute.
Provided, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year **[**2021**]** *2022* shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation:	Specifies reporting requirement.
Provided further, That of the amount provided under this heading, **[**$311,000,000**]** *$317,000,000* is provided to meet the terms of **[**section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended**]** *a concurrent resolution on the budget for health care fraud and abuse control activities*, and **[**$496,000,000**]** *$555,793,000* is additional new budget authority specified for purposes of **[**section 251(b)(2)(C) of such Act**]** *a concurrent resolution on the budget for additional health care fraud and abuse control activities*:	Specifies $317,000,000 for ongoing base health care fraud and abuse control activities, and $555,793,000 is available as additional budget authority to meet the terms of a concurrent resolution on the budget to pay for additional health care fraud and abuse control activities in FY 2022.
Provided further, That the Secretary shall provide not less than $20,000,000 from amounts	Provides funding for the Administration for Community Living to conduct the Senior

made available under this heading and amounts made available for fiscal year **[**2021**]** *2022* under section 1817(k)(3)(A) of the Social Security Act for the Senior Medicare Patrol program to combat health care fraud and abuse.

Medicare Patrol program to combat health care fraud and abuse and flexibility to fund through either discretionary or mandatory HCFAC funds.

Health Care Fraud and Abuse Control

(Dollars in Thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Discretionary				
CMS Program Integrity	$610,000	$616,000	$675,726	$59,726
OIG	$93,000	$99,000	$102,145	$3,145
DOJ	$83,000	$92,000	$94,922	$2,922
Subtotal, Discretionary	$786,000	$807,000	$872,793	$65,793
Mandatory [1]				
CMS Program Integrity	$923,527	$941,463	$943,746	$2,283
FBI	$145,130	$152,394	$148,815	($3,579)
OIG	$205,326	$213,887	$208,863	($5,024)
DOJ Wedge	$64,108	$66,781	$65,213	($1,568)
HHS Wedge	$39,271	$40,908	$39,948	($960)
Subtotal, Mandatory	$1,377,362	$1,415,433	$1,406,585	($8,848)
Total	$2,163,362	$2,222,433	$2,279,378	$56,945

Authorizing Legislation – Social Security Act, Title XVIII, Section 1817(k)
FY 2021 Authorization – Public Law 104-191 and Public Law 116-260
Allocation Method – Other

Program Description and Accomplishments

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

CMS works with law enforcement partners who take a lead role in investigating and prosecuting alleged fraud. CMS has pursued this through participating in the Medicare Fraud Strike Force teams, which investigate and track down individuals and entities that are defrauding Medicare and other government health care programs. Since their inception in March 2007, Strike Force operations have charged more than 4,600 defendants who have collectively billed the Medicare program nearly $23.0 billion.

CMS also coordinates with its law enforcement partners through the Major Case Coordination (MCC) effort, which provides a forum for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and CMS fraud investigators to collaborate

[1] All mandatory amounts are post-sequester and include the impacts of the Medicare sequestration suspension enacted in section 3709(a) of the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), as amended by Public Law 116-260 and further amended by Public Law 117-7.

before, during, and after the development of fraud leads. CMS leverages its program integrity contractors and systems, discussed in detail in this chapter, to develop many of these fraud leads. Since implementation, there have been nearly 2,200 MCC reviews and 1,750 law enforcement referrals.

All three partners target areas with high incidence of fraud in order to carry out the synchronized efforts to reduce fraud and recover taxpayer dollars. Together, activities like the MCC; CMS' enhanced provider screening and fraud prevention activities; HHS OIG's investigative, audit, evaluation, and data analytic work; and DOJ's investigative and prosecutorial actions and tougher sentencing guidelines, root out existing fraud and abuse while acting as a deterrent for potential future bad actors. HCFAC investments in law enforcement collaboration continue to demonstrate positive results, yielding a $4.20 to $1.00 return on investment for law enforcement and detection efforts over a three-year period (2017-2019).

Medicare Integrity Program (MIP)

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

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

Medicaid Program Integrity

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

HCFAC funding allows CMS to address Medicaid program integrity through oversight, data analytics, and technical assistance. CMS continues to collect and analyze state data through the Transformed Medicaid Statistical Information System (T-MSIS), which is being used for new efforts to detect fraud, waste, and abuse; exercises appropriate oversight over Medicaid expenditures as well as states' enterprise systems; and uses the Payment Error Rate Measurement (PERM) program to produce error rates for each Medicaid program, supporting efforts to reduce improper payments. Investments in the MACPro system

support the collection of data regarding states' program operations and ensures that CMS can efficiently and consistently review and adjudicate submissions for approval.

Marketplace Program Integrity

The Health Insurance Marketplaces are important avenues for individuals and families to obtain private market health insurance coverage and get financial assistance, in the form of advanced premium tax credits, to help pay for insurance premiums. CMS investigates complaints and leads, from health insurance issuers and other partners, to protect consumers. Through the use of data analytics, CMS supports and prioritizes investigations that aim to safeguard the integrity of the Federally-facilitated Marketplace (FFM) and expenditures of federal dollars. Since FY 2018, CMS and its program integrity contractors have reviewed 10,000 consumer complaints per year on average, and that number has been increasing. In FY 2020, nearly 12,000 complaints were reviewed and approximately 9,500 complaints have been reviewed in the first half of FY 2021. CMS cancelled more than 11,000 insurance policies that met CMS' criteria for unauthorized enrollments without consumers' consent; over 5,000 of those were in FY 2020 alone. In addition, CMS initiated over 400 investigations of insurance agent misconduct and referred the most egregious cases to states' Departments of Insurance and HHS OIG for prosecution or other administrative actions.

HCFAC Funding History [2]

Fiscal Year	Budget Authority
FY 2018	$2,043,017,000
FY 2019	$2,095,374,000
FY 2020	$2,163,363,000
FY 2021 Enacted	$2,222,434,000
FY 2022 President's Budget	$2,279,378,000

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

Budget Request: $872.8 Million

The FY 2022 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2022 request for discretionary funding is $872.8 million, $65.8 million above the FY 2021 Enacted level. The total FY 2022 post-sequester mandatory funding level is $1,406.6 million, $8.8 million below the FY 2021 Enacted level. The FY 2021 mandatory funding level had no sequestration withheld due to the legislation suspending Medicare sequestration.

The Budget assumes the discretionary HCFAC account will include an allocation adjustment to be used pursuant to the Congressional Budget Act in the Congressional Budget Resolution, over the ten-year budget window. For FY 2022, of the $872.8 million in discretionary HCFAC funding, $555.8 million is additional new budget authority for the allocation adjustment. Over ten years, the Budget invests $6.3 billion in additional new

[2] Includes both mandatory and discretionary resources; mandatory amounts are post-sequester and includes the impact of the Medicare sequester suspension.

discretionary HCFAC budget authority, yielding $13.1 billion in mandatory health care savings to Medicare and Medicaid, for an over $2:1 return-on-investment. The FY 2022 allocation adjustment request includes funding priorities to invest in Medicare medical review; support data analytics and other program integrity activities in Medicaid; and heighten oversight of the Marketplaces, commensurate with ongoing efforts to increase enrollment.

HCFAC Allocation Adjustment (estimated outlays in millions)

	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031
HCFAC discretionary spending, allocation adjustment	$556	$571	$587	$604	$621	$638	$656	$674	$693	$712
Savings to Medicare and Medicaid	-$1,086	-$1,144	-$1,204	-$1,268	-$1,304	-$1,339	-$1,378	-$1,415	-$1,455	-$1,495

The FY 2022 CMS allocation of the discretionary HCFAC request is $675.7 million, which reflects activities that support the emerging needs across all health care programs under CMS' jurisdiction. This level of funding dedicates additional resources to long-term priorities such as increasing the level of medical review, enhancing data analytics and error rate measurement in Medicaid, and increasing Marketplace program integrity oversight in response to renewed efforts to boost enrollment through Special Enrollment Periods (SEPs).

CMS Program Integrity – HCFAC Funding by Authority
(Dollars in Thousands)

Activity	FY 2022 Discretionary Request	FY 2022 Mandatory Funding [3]	FY 2022 Total
Provider Enrollment & Screening	$60,970	$38,400	$99,370
Technical Assistance, Outreach & Education	$58,551	$36,183	$94,734
Medical Review	$96,720	$188,551	$285,271
Medicare Secondary Payer	$0	$116,726	$116,726
PI Investigation, Systems & Analytics	$160,913	$163,360	$324,273
Audits & Appeals	$107,804	$176,153	$283,957
Provider & Plan Oversight	$36,103	$19,004	$55,107
Error Rate Measurement	$71,961	$27,000	$98,961
Program Support & Administration	$82,704	$178,367	$261,071
Total CMS HCFAC [4]	$675,726	$943,746	$1,619,472

Provider Enrollment and Screening

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

Budget Request: $61.0 million

The discretionary request for Provider Enrollment and Screening activities is $61.0 million, a decrease of $5.4 million below the FY 2021 Enacted level. Funding will support ongoing operations, with reduced operations and maintenance costs for Provider Enrollment, Chain, and Ownership System (PECOS) as CMS implements PECOS 2.0.

- *Provider Enrollment, Chain, and Ownership System (PECOS):* $17.5 million. PECOS is the system of record for all Medicare provider/supplier enrollment data, which includes Part A, Part B, and DME. PECOS stores all information furnished by

[3] Includes HCFAC funding provided by Section 1817(k)(4) of the Social Security Act for the Medicare Integrity Program, including the Medicare-Medicaid Data Match Program, and reflects sequester.

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

providers/suppliers; tracks all enrollment processing by MACs; and provides feeds to FFS claims payment systems that are mission critical to processing all claims. State Medicaid programs also rely on data-sharing efforts to support requirements for screening providers. Costs for PECOS will decrease in FY 2022; the system will not require the same level of operations and maintenance costs because CMS expects PECOS 2.0 to begin operations in FY 2022.

PECOS 2.0 is a ground-up redesign of the current system, and CMS is focused on modernizing the system to create an enterprise resource that is a platform for all enrollments across Medicare, Medicaid, and emerging provider programs. PECOS 2.0 will be a centralized system that can support the collection, screening, and processing of multiple types of enrollments (i.e., Medicare and Medicaid), as well as the operational oversight and program management functions associated with enrollment. The underlying system changes will simplify access to data, create operational efficiency, increase alignment between Medicare and Medicaid, and strengthen overall program integrity. [This activity will be supplemented with $27.0 million in mandatory HCFAC funds.]

- *Advanced Provider Screening (APS):* $41.4 million. APS is an interactive screening, monitoring, and alerting system that identifies ineligible providers and houses a centralized provider repository of criminal activity, licensure status, and identity information. In FY 2020, APS resulted in more than 6.5 million screenings which generated more than 37,000 potential licensure alerts and more than 210 criminal alerts for potentially fraudulent providers for further review by CMS. Such review resulted in approximately 94 criminal revocations and over 200 licensure revocations. The increased request in FY 2022 is due to contracting; CMS will award a new 12-month contract in FY 2022 as well as a transition period for the incumbent contractor. [This activity will be supplemented with $3.4 million in mandatory HCFAC funds.]

- *National Supplier Clearinghouse (NSC):* This funding supports the contractual arrangement for the NSC's receipt, review, and processing of applications from organizations and individuals seeking to become suppliers of DMEPOS in Medicare. In FY 2022, the cost of this activity will decrease as certain functions, such as site visits and investigations, will be funded from provider enrollment user fees. [This activity will be funded with $8.0 million in mandatory HCFAC funds.]

- *Medicaid Provider Enrollment:* $2.1 million. This funding supports ongoing development, maintenance, and support for the Medicaid Data Exchange (DEX) system. The primary function of DEX is to share provider termination and revocation data among CMS and the separate Medicaid programs. CMS verifies and maintains a centralized repository of these providers in which all 50 states, the District of Columbia, and Puerto Rico have access. In FY 2020, CMS received 2,747 termination submissions through the DEX system from states.

Technical Assistance, Outreach & Education

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

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

Budget Request: $58.6 million

The discretionary request for Technical Assistance, Outreach & Education activities is $58.6 million, a decrease of $0.9 million below the FY 2021 Enacted level.

- *Outreach and Education - Ongoing Operations (MACs):* This funding is necessary for the MACs to maintain and execute an outreach and education program that will expand and enhance efforts to reduce improper payments. This includes disseminating information, education, training, and technical assistance. [This activity will be funded with $29.5 million in mandatory HCFAC funds.]

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

- *Healthcare Fraud Prevention Partnership (HFPP):* $19.0 million. The HFPP is a voluntary, public-private partnership between the Federal Government, state and local agencies, law enforcement, private health insurance plans, employer organizations, and health care anti-fraud associations to identify and reduce fraud, waste, and abuse across the health care sector. The HFPP allows for the exchange of data and information, leveraging various analytic tools using claims and other data provided by HFPP partners, and providing a forum for leaders and subject matter experts to share successful practices and effective methodologies. As of February 2021, the HFPP reached a total membership level of 204 partner organizations, comprised of federal agencies, associations, private payers, and state and local partners. The FY 2022 request will support ongoing operations for the Trusted Third Party (TTP), medical review conducted by the Supplemental Medical Review Contractor (SMRC), data analytics, and activities required under the Consolidated Appropriations Act of 2021.

- *Senior Medicare Patrol:* $20.0 million. CMS requests $20.0 million for the Administration for Community Living (ACL) Senior Medicare Patrol (SMP) program. The mission of the SMP program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. In 2019, SMP activities reached 1.6 million people through 28,146 group outreach and education events and held 320,590 individual counseling sessions with, or on behalf of, Medicare beneficiaries.

- *Medicaid Enterprise System:* $10.1 million. CMS provides over $7 billion annually in federal financial participation for state Medicaid systems that determine Medicaid eligibility, screen and enroll providers, and pay enrolled providers' claims, which are critical to reducing fraud, waste, and abuse. This funding supports an outcomes-based oversight model for states' Medicaid enterprise systems and provides technical assistance to states during development and implementation in accordance with regulatory and sub-regulatory guidance. This outcome-based methodology allows CMS

to ensure funding for IT systems is closely aligned with and in support of the state Medicaid and CHIP programs to ensure federal dollars are spent appropriately. Funding will also support the design and prototyping of reports, statistics, and data analytics. This activity reduces costs and risks, shortens development timelines, and more effectively manages these expenditures.

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

Medical Review

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

Budget Request: $96.7 million

The discretionary request for MR activities is $96.7 million, an increase of $50.5 million above the FY 2021 Enacted level. CMS proposes to use the additional funding to conduct greater levels of medical review in FY 2022.

- *Medical Review - Ongoing Operations (MACs):* $51.9 million. CMS contracts with the MACs to perform analysis of FFS claims data to identify atypical billing patterns and perform claims review. Medical reviews are an example of such FFS claims data analysis. The FY 2022 request supports ongoing MR operations, including Targeted Probe and Educate (TPE). In FY 2020, the MACs conducted more than 210,000 TPE reviews. TPE was impacted by the Public Health Emergency and was paused for a portion of FY 2020.

  Medical review improves compliance and results in savings; however, medical review also requires significant resources to conduct and there is a high volume of Medicare FFS claims each year. Many improper claims can be identified only by manually reviewing associated medical records and a beneficiary's claim history, and exercising clinical judgment to determine whether a service is reasonable and necessary. Significantly less than one percent of Medicare claims undergo manual reviews; this is substantially lower than private health insurers. CMS proposes to significantly increase funding to allow the MACs to conduct additional reviews in FY 2022. [This activity will also be funded with $154.7 million in mandatory HCFAC funds.]

- *Supplemental Medical Review Contractor (SMRC):* $19.0 million. The SMRC performs and provides support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of Medicare. The SMRC supports three initiatives: 1) Specialty Reviews for issues identified by Federal agencies such as HHS-OIG, the Government Accountability Office, and other CMS groups; 2) HFPP Reviews on providers or service types that have been identified as

being aberrant in HFPP studies; 3) and Program Integrity Reviews that will focus on ensuring claims, encounter data, and Prescription Drug Event (PDE) records are paid correctly. In FY 2020, the SMRC reviewed approximately 80,197 claims. SMRC reviews were paused for a portion of FY 2020 because of the Public Health Emergency. In FY 2022, CMS expects the SMRC to review 792,800 claims. [This activity will be supplemented with $20.0 million in mandatory HCFAC funds.]

- *Prior Authorization:* $7.5 million. Prior authorization is a key corrective action towards lowering improper payments. This funding will allow the MACs to conduct reviews of prior authorization requests and work related to appeals, conduct customer service operations, provide outreach and education, and create reports for CMS.

  CMS has continued to increase the number of Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) items subject to prior authorization in recent years. Additionally, in FY 2020, CMS established a nationwide prior authorization process and requirements for certain hospital outpatient department services as well as certain DMEPOS items. CMS continually performs data analysis to determine if there are services or items that are exhibiting unnecessary increases in volume or utilization due to fraud, waste, or abuse, for which prior authorization would be appropriate. As a result, CMS plans to continue increasing the number of items and services subject to required prior authorization.

- *Accuracy Reviews:* $2.5 million. The Medical Review Accuracy Contractor (MRAC) conducts MR of review determinations made by CMS contractors (e.g., MACs and SMRC). The results allow CMS to develop an accuracy score for each contractor and determine where inconsistencies may exist. As of the end of August 2020, the MRAC completed 5,747 standard claim reviews. The FY 2020 standard average accuracy review percentage is 99.37 percent. CMS expects approximately 8,231 accuracy reviews to be completed in FY 2021 and 11,000 to be completed in FY 2022. [This activity will be supplemented with $1.0 million in mandatory HCFAC funds.]

- *MR Systems:* $13.8 million. This funding supports IT operations for multiple MR activities including the National Correct Coding Initiative (NCCI) for Medicare and Medicaid, the Services Tracking Analysis and Reporting System (STARS), and the Electronic Submission of Medical Documentation (esMD). These systems ensure proper coding of claims, control overpayments, and assist in detecting, analyzing, investigating, coordinating, and documenting cases of fraud, waste, and abuse. [This activity will be supplemented with $7.4 million in mandatory HCFAC funds.]

- *Other MR Activities:* $2.0 million. This funding provides operational support for MR activities and error rate reduction. CMS provides hospital-specific Medicare data statistics in areas identified as at risk for improper payments (unnecessary admissions, readmissions, improper billing, or coding errors). Additionally, CMS will provide Comparative Billing Reports, giving providers the opportunity to compare their billing patterns to those of their peers. [This activity will be supplemented with $5.5 million in mandatory HCFAC funds.]

Medicare Secondary Payer

Medicare Secondary Payer (MSP) protects the Medicare Trust Funds by ensuring that Medicare does not pay for items and services that certain health insurance or coverage is primarily responsible for paying. Medicare statute and regulations require all entities that

bill Medicare must determine whether Medicare is the primary payer for those items or services.

In FY 2022, this activity will be funded with $116.7 million in mandatory HCFAC funds. This funding will support MAC operations related to MSP, the centralized MSP Coordination of Benefits & Recovery (COB&R) program, and the development and maintenance of systems and databases. CMS is modernizing its MSP systems to remove dependencies on COBOL code and to move processing to the cloud.

PI Investigation, Systems & Analytics

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

Budget Request: $160.9 million

The discretionary request for PI Investigation, Systems & Analytics activities is $160.9 million, an increase of $10.6 million above the FY 2021 Enacted level. This request includes funding to support ongoing operations, increased funding for modeling and analytics activities, and additional funding for program integrity oversight relating to special enrollment period (SEP) enrollment in the Marketplace.

- *PI Investigative Activities - Ongoing Operations (MACs):* CMS works with each MAC to develop improper payment reduction strategies, based on vulnerabilities identified by the Comprehensive Error Rate Testing (CERT) program, the Government Accountability Office (GAO), HHS/OIG, the Medicare FFS RACs, and other sources. These funds will be used to support the MIP operational activities of the MACs in identifying and reducing payment errors. [This activity will be funded with $22.1 million in mandatory HCFAC funds.]

- *Unified Program Integrity Contractors (UPICs):* The UPICs consolidate Medicare and Medicaid program integrity audit and investigation work across five jurisdictions throughout the United States. Benefits resulting from this consolidation include reduced state and provider burden, increased contractor accountability, enhanced data and reporting capabilities, and improved program oversight. The UPICs will continue to perform data analysis projects, support requests for information, and perform Medicare and Medicaid investigations. [This activity will be funded with $84.4 million in mandatory HCFAC funds.]

- *PI Modeling & Analytics Support:* $23.4 million. Aligning modeling and analytics with financial transparency helps CMS evaluate its program integrity efforts and make crucial decisions regarding future direction and program funding. CMS conducts analytics to identify Medicare fraud, waste, and abuse; utilizes rigorous statistical methodologies to assess whether program integrity vulnerabilities can be captured as models or edits in the Fraud Prevention System (FPS); and measures outcomes from its efforts. This work also supports other program integrity activities such as provider revalidation, the Medicare Exclusion Database, the Part C and Part D preclusion list, and changes of ownership tracking. On the Medicaid side, this work provides data to support states'

efforts to prevent risky providers from enrolling in Medicaid and revoke problematic providers. Increased funding in FY 2022 will dedicate additional resources towards validating and using Medicare and Medicaid data to identify suspicious patterns and trends. FY 2022 funding will also support operations for the Plan and Provider Enumeration System (NPPES) application, which assigns National Provider Identifiers (NPIs) and aids in CMS' ability to prevent improper payments and fight fraud. [This activity will be supplemented with $14.6 million in mandatory HCFAC funds.]

- *Fraud Prevention System (FPS):* FPS applies proven and effective predictive modeling tools into the Medicare claims processing system to stop payment on high-risk claims and perform analysis on paid claims to generate alerts of potentially fraudulent providers for further investigation. CMS plans to continue leveraging ML and AI technologies for advanced vulnerabilities in FY 2022. During FY 2020, the FPS generated alerts that resulted in 1,032 new leads for program integrity contractors (PICs) and augmented information for 413 existing PIC leads or investigations. [This activity will be funded with $29.4 million in mandatory HCFAC funds.]

- *One PI:* $29.4 million. The One PI program provides program integrity contractors, law enforcement, and HHS-OIG with centralized access to multiple analytical tools and data sources. The program provides access to current and historical Medicare and Medicaid data that is used to develop and refine predictive analytic models prior to integration into FPS. The increased request in FY 2022 is due to contracting; CMS will award a new 12-month contract in FY 2022 as well as a transition period for the incumbent contractor. [This activity will be supplemented with $1.0 million in mandatory HCFAC funds.]

- *Case Management:* $19.6 million. The Unified Case Management (UCM) System provides a central repository to support the UPICs, MEDICs, and other stakeholders across the Medicare and Medicaid programs. This includes the capability to track leads, audits, and investigations; capturing and managing workflow activities; reporting workload metrics; reporting status of administrative actions and referrals to law enforcement; and recording outcomes or disposition of program integrity audit and investigative actions across Medicare. The FY 2022 request supports ongoing operations as well as a redesign to modernize the system and replace aging hardware/software. [This activity will be supplemented with $11.8 million in mandatory HCFAC funds.]

- *Application Programming Interface (API) Gateway:* $10.0 million. CMS requests funding for development of the Application Programming Interface (API) Gateway, which will define CMS' approach and implementation to manage and use data and information to support business and technology goals. CMS will implement a full lifecycle API management platform that will be used to develop, deploy, and manage APIs for various program integrity systems.

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

- *Medicare Drug Integrity Contractors (MEDICs):* $21.5 million. CMS supports ongoing

program integrity efforts in Medicare Part C and Part D through its use of the MEDICs. The two MEDICs are known as the Investigations Medicare Drug Integrity Contractor (I-MEDIC) and the Plan Program Integrity Medicare Drug Integrity Contractor (PPI MEDIC). The I-MEDIC conducts investigations, makes administrative action recommendations, and submits case referrals to law enforcement. The PPI MEDIC analyzes Part C and Part D data, conducts audits of plans, provides outreach and education, and ensures compliance with regulatory requirements.

I-MEDIC Investigations

Calendar Year	Provider investigations	Pharmacy Investigations	Pharmacy / Provider Investigations	Other Investigations	Total Investigations
2019	380	317	37	88	822
2020	408	288	23	76	795

I-MEDIC Law Enforcement Referrals

Calendar Year	Referrals Accepted	Referrals Declined	Referrals Pending	Total Referrals
2019	241	55	126	422
2020	262	75	136	473

The PPI MEDIC is scheduled to implement 5 self-audits, 5 national audits, and 3 PI audits in FY 2021, as well as to support additional education and outreach initiatives for plan sponsors.

- *Encounter Data Collection System:* $19.9 million. MA organizations and Medicare-Medicaid Plans submit up to 5.5 million encounter data records per day via the Encounter Data Processing System. Funding supports all development, maintenance, enhancements, requirements gathering, and analytic activities related to the collection and processing of this data. This request also supports CMS' oversight and integrity efforts regarding encounter data, including outreach, analysis, development of benchmarks to evaluate the completeness and accuracy of the data for plan monitoring.

- *Medicaid and CHIP Program System (MACPro):* $8.7 million. MACPro is a portfolio of product tools that supports the data collection and workflow around the adjudication of state plan amendments (SPAs), waivers, and managed care contracts, and includes a data collection platform that collects quantitative data on Medicaid and CHIP programs including: Core Set Measures, annual and quarterly CHIP reporting on goals and enrollment, and managed care oversight data. This suite of products enables online collaboration between CMS and States ensuring the consistent adjudication of SPAs, waivers, managed care contracts, and advance planning documents (APDs) across all states and regional offices, and provides CMS with insight into how Medicaid and CHIP programs operate across the country. The efficient collection of State-submitted data also allows CMS to verify delivery of services and verify cost data, such as premiums and cost sharing, against T-MSIS or the Medicaid and CHIP Budget & Expenditure System (MBES). In FY 2022, increased funding will support core set measure reporting and costs related to contract recompetes.

- *Transformed Medicaid Statistical Information System (T-MSIS):* $2.9 million. T-MSIS is a state data ingestion application and reporting tool that encompasses a collection of beneficiary eligibility and enrollment data, managed care and FFS claims encounter data, and provider data produced in the daily operation of the Medicaid and CHIP

programs. This national dataset is integral for program monitoring and oversight, and is necessary for auditing and investigations. Now that all states are submitting data consistently on a monthly basis, focus has shifted to monitoring the quality of state submissions, including data critical for program integrity purposes. Funding supports user-friendly tools, guidance and oversight of the state submission process, improvements to overall operations for sustainability, efforts to continue data quality improvement, and increased cloud computing resources to handle the growing dataset and data user base. Less HCFAC funding is requested for FY 2022 due to implementing cloud improvements that resulted in cost savings for cloud services.

- *Marketplace Program Integrity:* $25.5 million. This funding will support general investigation activities, data analytics leveraging data from FFM systems and other sources, and project management resources to help with large operational projects related to oversight and audit activities. This includes targeting high-risk regions for audits and analytics as well as conducting license verification for agents and brokers to ensure those individuals meet established state standards. CMS will also review and evaluate consumer complaints of fraud to determine whether administrative action can be taken. FY 2022 funding would also support increased oversight for SEP enrollment.

Audits & Appeals

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

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

Budget Request: $107.8 million

The discretionary request for Audit & Appeals activities is $107.8 million, an increase of $6.9 million above the FY 2021 Enacted level. This funding will continue CMS' auditing functions and appeals initiatives in FY 2022. Increased funding will support Risk Adjustment Data Validation audits.

- *Provider Cost Report Audit - Ongoing Operations (MACs):* Part A providers are required to submit an annual Medicare cost report, which, after the settlement process, forms the basis for reconciliation and final payment to the provider. During FY 2019, the MACs received and accepted approximately 57,985 Medicare cost reports, which included initial as well as amended cost report filings; approximately 20,637 cost reports were desk reviewed and tentatively settled; and approximately 744 audits were completed. [This activity will be funded with $140.0 million in mandatory HCFAC funds.]

- *Targeted Provider Cost Report Audits:* This activity addresses a wide range of other cost report auditing activities, such as appeals support and risk assessments. CMS is responsible for evaluating Medicare, Medicaid, and other private plan sponsors' performance in the delivery of health and drug services and ensure that beneficiaries

receive appropriate services for which these sponsors have already been paid to provide. [This activity will be funded with $28.0 million in mandatory HCFAC funds.]

- *Risk Adjustment Data Validation (RADV):* $41.0 million. CMS uses diagnostic information submitted by MA organizations to risk adjust payments to plans. The more diagnostic information a plan submits, typically the higher their payments from Medicare. Each year, CMS conducts RADV audits to measure the accuracy of the plan-submitted diagnostic information and uses the results of these audits to estimate and recover overpayments for individual MA plans. CMS expects to initiate recovery of overpayments associated with audit findings for RADV payment years (PYs) 2011 through 2013 in FY 2022. CMS estimates recoveries of $87 million for the PY 2011 audit, $307 million for the PY 2012 audit, and $288 million for the PY 2013 audit. Audits for PYs 2014 and 2015 are in process. CMS will continue to implement process improvements to more effectively focus audits on higher risk areas, conduct audits more efficiently, and reduce the burden and the costs of the audits when practicable.

  The FY 2022 request will support the expected completion of the RADV audit for PY 2015 and the initiation of future RADV audits. At this funding level, CMS will continue to audit approximately 200 plans per payment year using advanced analytics to focus audits on higher risk areas. The request will also support the receipt and processing of appeals of overpayment determinations related to PYs 2011, 2012, and 2013.

- *Cost Plan Audits:* $3.5 million. CMS provides fiscal oversight over Managed Care Organizations (MCOs). This funding supports audits of Cost Report statements submitted by MCOs to ensure costs are allowable and in accordance with contract requirements and CMS regulations.

- *Part C & D Audits:* $7.5 million. This funding supports the audits of financial records of MA Organizations and PDPs, as required in Section 1857(d)(1) and 1860D-12(b)(3)(c) of the Social Security Act. CMS performs approximately 215 audits annually, as well as resolution of the audit issues noted in the audit reports. Prompt audits of the financial data will permit CMS to evaluate and refine CMS' plan oversight, thereby assuring accurate bidding and enhancing CMS' payment accuracy.

- *Targeted Programmatic Compliance Audits:* $19.6 million. This funding supports audits and other oversight initiatives to test whether MA Organizations, PDPs, Program for All-Inclusive Care for the Elderly (PACE) plans, and other private plan sponsors provided beneficiaries with the appropriate health services and medications as required under their contract with CMS. These audits help drive the industry towards improvements in the delivery of health services in the MA, Part D, and PACE programs.

- *Medical Loss Ratio (MLR) Audits:* $3.7 million. CMS conducts audits of Medicaid Managed Care Organizations' (MCOs') financial reporting. Specifically, CMS is evaluating compliance with Medicaid MLR requirements. This work includes conducting analyses to identify the States most at risk and reviewing the source data and documentation from the Medicaid MCOs and the State-reported data. This request also supports activities to ensure MA plans and Part D sponsors meet MLR requirements.

- *State Audit Compliance Support:* $2.3 million. This funding will support CMS' efforts to review and analyze audit findings from single state agency audits and OIG audits of state Medicaid programs. Through improvements to its internal audit resolution

process, CMS can obtain a global picture of audit results in Medicaid and improve its financial oversight through guidance on how to address audit findings and better target audit resources towards high risk areas.

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

- *Audit Systems:* $21.3 million. This request includes IT operations for multiple systems that perform oversight and audit activities required by CMS in regulations and statute. These systems include the Health Plan Management System (HPMS), Healthcare Cost Report Information System (HCRIS), PS&R-Provider Statistical & Reimbursement Report, and CMS administrative audit tracking for documentation clearances. [This activity will be supplemented with $7.2 million in mandatory HCFAC funds.]

- *Appeals Initiatives:* $6.2 million. This funding will support appeals initiatives designed to reduce reversal rates. Funding will allow Qualified Independent Contractors (QICs) to participate as a party in approximately 2,150 Administrative Law Judge (ALJ) cases, which affords the QICs additional rights to successfully defend a claim denial. Based on experience, CMS anticipates that by invoking party status in hearings, the QICs may reduce the ALJ reversal rate and lower Medicare Trust Fund expenditures. Funding will also support the Office of Hearings Case and Document Management System, which is expected to be fully operational in FY 2022.

Provider & Plan Oversight

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

Budget Request: $36.1 million

The discretionary request for Provider & Plan Oversight activities is $36.1 million, a decrease of $2.9 million below the FY 2021 Enacted level. The decrease is largely due to the Special Reviews Team activity being carried out by CMS staff and no longer needing dedicated funding.

- *Open Payments:* The Open Payments program provides the public with information regarding the financial relationships between the health care industry (pharmaceutical

and medical device manufacturers and their distributors) and health care providers (physicians and teaching hospitals). In FY 2022, recent changes to the program regarding additional covered recipients will go live in the system. In addition, the Open Payments system contract will be recompeted and a new award will be made. [This activity will be funded with $19.0 million in mandatory HCFAC funds.]

- *Part C & D Payment Analysis, Validation and Reconciliation:* $7.6 million. This funding supports the payment controls that validate and analyze monthly Medicare Part C and Part D payments to ensure that the proposed payment amounts are accurate prior to payment authorization.

- *Part C & D Review of Plans and Performance:* $20.0 million. This funding supports several activities that provide critical infrastructure to support the monitoring and oversight strategy for the Part C and Part D programs. Review of plans and performance and subsequent consequences of possible enforcement actions drive improvements in the industry and are increasing sponsors' compliance with core program functions in the Part C and Part D programs. CMS also evaluates the impact of agency guidance and regulations that could negatively impact the quality of care provided to beneficiaries. Less funding is required in FY 2022 as a result of the two-year contract being awarded in FY 2021.

- *Rate Reviews:* $6.4 million. This funding supports CMS' efforts to improve oversight of rate setting and financial reporting for PACE and ensure proper billing and rate reimbursement in Home and Community-Based Services (HCBS) waiver and state plan programs. This includes, but is not limited to, ensuring that states are in compliance with the HCBS assurances as defined in section 1915(c) of the Social Security Act, ensuring that states are in compliance with sections 12006(a) of the 21st Century Cures Act, and the detection and prevention of fraud and abuse in the delivery of personal care and other HCBS services.

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

Error Rate Measurement

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

Budget Request: $72.0 million

The discretionary request for Error Rate Measurement activities is $72.0 million, an increase of $3.4 million above the FY 2021 Enacted level. This funding supports ongoing activities, with increased resources for PERM.

- *Comprehensive Error Rate Testing (CERT):* This funding supports the CERT program, which calculates the Medicare FFS improper payment rate. The CERT program calculates national, contractor-specific, and service-specific improper payment rates. In FY 2022, additional funding is needed for expected increases to the review contract. [This activity will be funded with $27.0 million in mandatory HCFAC funds.]

- *Part C & D Error Rate Measurement:* $13.0 million. This funding supports the National-level Risk Adjustment Data Validation (National RADV) and the Payment Error Related to Prescription Drug Validation (PEPV) contracts. These contracts measure and report annual payment error estimates for Medicare Part C and Part D, respectively.

- *Payment Error Rate Measurement (PERM):* $45.7 million. This funding supports the PERM program, which calculates the improper payment rates for Medicaid and the Children's Health Insurance Program (CHIP). The error rates are based on reviews of the FFS, managed care, and eligibility components of Medicaid and CHIP. CMS requests increased funding for additional work that will be performed by the review contractor after a new contract award in FY 2021.

- *Marketplace Improper Payment Assessment:* $13.1 million. This funding supports the measurement and reporting of estimated improper payments in the Advance Premium Tax Credit (APTC) program. The request for FY 2022 will support contractor operations to estimate and report improper payments, as well as develop a risk management program, that is compliant and in accordance with statutory requirements. This funding will also support the development and piloting of the state-based Marketplace improper payment measurement program.

Program Support and Administration

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

Budget Request: $82.7 million

The discretionary request for Program Integrity Support and Administration activities is $82.7 million, a decrease of $2.4 million below the FY 2021 Enacted level.

- *Administrative Costs:* This funding will cover employee compensation, rent, utilities, information technology, contracts, supplies, equipment, training, and travel. In FY 2022, HCFAC funding will support 478 FTEs. [This activity will be funded with $124.7 million in mandatory HCFAC funds.]

- *Medicaid PI Improvements:* $3.5 million. This funding will support continued efforts to

improve program integrity in the Medicaid program. With this funding, CMS seeks to enable increased data sharing and more robust analytic tools, and provide further education, technical assistance, and collaboration with states.

- *Risk Management Support:* $4.0 million. This funding supports contractor operations to identify fraud risks and vulnerabilities in CMS programs and initiatives, as well as provide recommendations on how to mitigate those risks. CMS requests additional funding for this activity in FY 2022 to focus on risk assessments relating to waivers and flexibilities that CMS promulgated as a result of the COVID-19 public health pandemic as well as to continue developing a comprehensive program integrity risk assessment for Medicare.

- *PI Process Improvements:* $8.5 million. This funding supports specialized technical expertise to assist CMS in developing a conceptual and technical vision for its program integrity data infrastructures and systems. This activity involves reviewing the current vulnerability management structure for the purpose of implementing new processes to ensure operational efficiency. This activity also includes acquisition support to assist CMS with its IT and non-IT contracting needs.

- *System Infrastructure Upgrades and Software Support:* This funding supports enterprise software licenses, the Payment Recovery Information System (PRIS), and One PI Infrastructure Support & Expansion. This funding will be used to support Law Enforcement Investigation, which includes but is not limited to: data needs, data mining tools, database support, hardware needs and licenses. Funding will also be used for enterprise agreements with IBM, Microstrategy, Oracle, and others. [This activity will be funded with $28.4 million in mandatory HCFAC funds.]

- *Ongoing Systematic Support for all PI Programs:* $29.6 million. This funding supports operations and maintenance for the Common Working File (CWF), the Single Testing Contract (STC), the CMS Analysis Reporting and Tracking System (ART), Virtual Data Centers, and other CMS enterprise data, database management, records management, and claims systems. CMS hosts many systems to aid in supporting the Agency and contractors in managing our program integrity efforts, tracking detailed financial activity, deliverables and the performance of contracts, and other electronic data interchanges. This funding also supports operations and maintenance for the Command Center. [This activity will be supplemented with $22.1 million in mandatory HCFAC funds.]

- *Enterprise Services:* $37.2 million. This funding supports investments that span multiple program areas or provide CMS-wide services, such as shared IT services and litigation and enforcement support from the Office of General Counsel. [This activity will be supplemented with $3.2 million in mandatory HCFAC funds.]

FEDERAL BUREAU OF INVESTIGATION (FBI)

Program Description and Accomplishments

The FBI is responsible for detecting and investigating health care fraud in the United States and has jurisdiction over crimes targeting Federal health insurance programs and private health insurance plans. Rooting out health care fraud is central to the well-being of both our citizens and the overall economy. Consequently, health care fraud investigations are considered a top priority within the FBI's Criminal Investigative Division, Financial Crimes

Section, Complex Financial Crimes Program. Each of the FBI's 56 field offices has personnel assigned specifically 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. Coordinated national initiatives, including the Task Force and Working Group; COVID-19 Anti-Fraud; Prescription Drug; Major Provider Fraud; Large Scale Conspiracies; and the Outreach, Education, and Liaison Initiatives, assist the FBI in establishing priorities and aligning resources to address the health care fraud threat. The FBI seeks to identify and pursue investigations against the most egregious offenders involved in health care fraud through investigative partnerships with other Federal agencies, such as the Department of Justice (DOJ), Department of Health and Human Services - Office of Inspector General (HHS-OIG), Centers for Medicare & Medicaid Services (CMS), Food and Drug Administration (FDA), Drug Enforcement Administration (DEA), Defense Criminal Investigative Service (DCIS), Office of Personnel Management - Office of Inspector General (OPM-OIG), Department of Veterans Affairs - Office of the Inspector General (VA-OIG), and Internal Revenue Service - Criminal Investigation (IRS-CI). The FBI also routinely partners with our state and local partners, including state Medicaid Fraud Control Units (MFCU) and other state and local investigative and regulatory agencies to address health care fraud. In addition, the FBI maintains significant liaison with private insurance national groups, such as the National Health Care Anti-Fraud Association, the National Insurance Crime Bureau, private insurance special investigation units, and other professional associations to discuss and share threat information, successful anti-fraud practices, and effective methodologies and strategies for detecting and preventing health care fraud. The FBI's efforts in combatting health care fraud, in coordination with the efforts of our Federal, state, and local law enforcement and regulatory partners, as well as our partners in the private sector in combatting health care fraud, are crucial to the success and sustainability of the health care system that so many Americans depend upon.

The FY 2022 FBI budget includes mandatory resources in the amount of $148.8 million.

HHS OFFICE OF INSPECTOR GENERAL (OIG)

Program Description and Accomplishments

HHS-OIG uses HCFAC funding to conduct oversight of the Medicare and Medicaid programs. This includes holding individuals and corporations that engage in healthcare-related offenses accountable through criminal and civil actions, while providing recommendations for improving the health care system to HHS policymakers, program officials, and Congress. As described in the FY 2019 HCFAC Report to Congress, in FY 2019, HHS-OIG's Medicare and Medicaid oversight efforts in resulted in 747 criminal actions and 684 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties settlements and administrative recoveries related to provider self-disclosure matters. In addition, HHS-OIG excluded a total of 2,640 individuals and entities from participation in Federal health care programs. For FY 2019, 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 $27.5 billion.

Budget Request: $102.1 Million

The FY 2022 HHS-OIG discretionary request is $102.1 million, which represents an

increase of $3.1 million above the FY 2021 Enacted level. In addition, mandatory resources total $208.9 million for a total operating budget of $311.0 million.

DEPARTMENT OF JUSTICE (DOJ)

Program Description and Accomplishments

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

Budget Request: $94.9 Million

The FY 2022 DOJ discretionary request is $94.9 million, an increase of $2.9 million above the FY 2021 Enacted level. In addition, mandatory resources total $65.2 million for a total operating budget of $160.1 million.

HHS WEDGE FUNDING

Program Description and Accomplishments

HHS uses resources from the wedge funds to carry out fraud and abuse activities. Decisions about wedge funding levels for DOJ and the HHS agencies are made by agreement between the Attorney General and the Secretary of HHS. For FY 2020, negotiated amounts were $38.3 million for distribution among HHS components and $64.1 million for DOJ. The HHS portion of the wedge awards funded the following activities during FY 2020:

Office of the General Counsel (OGC): OGC primarily uses HCFAC funds on activities focused on litigation aimed at the recovery of program funds and review of CMS programs to strengthen them against potential fraud, waste, and abuse. As a result of its program integrity activities, OGC estimates that its HCFAC program has contributed to anticipated government recoveries of over $880.5 million to date in FY 2020.

Food and Drug Administration (FDA) Pharmaceutical Fraud Program (PFP): The PFP is designed to detect, prosecute, and prevent pharmaceutical, biologic, and medical device fraud. The PFP has identified multiple alleged medical product fraud schemes through various avenues. Since the inception of the PFP, OCI has opened a total of 297 criminal HCFAC investigations. In FY 2020 FDA's eleventh fiscal year of HCFAC Program activity, OCI, through its PFP, opened 20 criminal investigations, including investigations involving drug compounders, clinical trials, and foreign and domestic medical-product manufacturers.

HHS Office of Inspector General (OIG): Wedge funds have allowed HHS/OIG to fund new pilot programs and information technology investments that improve HHS/OIG's ability to conduct oversight of the Medicare and Medicaid programs. These new projects include: developing artificial intelligence (AI) solutions by automating some analytic operations to better target investigative efforts; modernizing the exclusion program online database, or the List of Excluded Individuals and Entities; deploying healthcare training programs for investigators geared toward emerging fraud trends; and modernizing communications equipment to allow investigators to safely conduct low and high risk health care fraud and abuse casework.

HHS Wedge Budget: $39.9 Million

The FY 2022 HHS Wedge request includes post-sequester mandatory funding of $39.9 million, which is a decrease of $1.0 million below the FY 2021 Enacted level. The HHS Wedge is subject to agreement between the Secretary of HHS and the Attorney General. Funding allocations are determined after HHS and DOJ complete negotiations.

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Children's Health Insurance Program

Current Law
(Dollars in Thousands)

	FY 2020 Enacted	FY 2021 Estimate	FY 2022 Estimate	FY 2022 +/- FY2021
State Allotments (Healthy Kids Act P.L. 115-120)	$23,700,000	$24,800,000	$25,900,000	$1,100,000
CHIP Performance Bonus Payments (P.L. 111-3, P.L. 113-235)	$0	$0	$0	$0
Child Health Quality Improvement (P.L. 111-3,114-10, 115-120)	$0	$0	$0	$0
Redistribution Payments	$0	$0	$0	$0
Performance Bonus Payments Preclusion (P.L. 116-133)	$0	($4,000,000)	$0	$4,000,000
Rescission of Unobligated Balance (P.L. 116-133)/1	($3,185,423)	($1,000,000)	$0	$1,000,000
Total Budgetary Resources /2	**$20,514,577**	**$19,800,999**	**$25,900,000**	**$6,100,000**
CHIP State Allotment Outlays	$16,865,169	$17,197,000	$17,114,000	($83,000)
Performance Bonus Payments Outlays/3	($118)	$0	$0	$0
Child Health Quality Improvement Outlays	$9,896	$23,000	$28,000	$5,000
Redistribution Payments	$4,518	$0	$0	$0
Total Outlays	**$16,879,465**	**$17,220,000**	**$17,142,000**	**($78,000)**

1/ The Department of Labor, Health and Human Services, and Education, and related Agencies Appropriations Act, 2020 (P.L. 116-94) rescinded $3.2 billion in unobligated FY 2020 allotments and the Consolidated Appropriations Act, 2018 (P.L. 115-141) rescinded the remaining $15.6 million from the Performance Bonus Fund.
2/ Funding levels reflect new appropriations and carry-forward balances from prior years net of enacted rescissions. These funding levels are subject to change due to adjustments throughout the year.
3/ Reflects recoveries related to OIG determinations regarding improper CHIPRA bonus payments (see https://oig.hhs.gov/oas/reports/region4/41708061.pdf).

Child Enrollment
Contingency Fund
Current Law
(Dollars in Thousands)

	FY 2020 Enacted	FY 2021 Estimate	FY 2022 Estimate	FY 2022 +/- FY 2021
Child Enrollment Contingency Fund, Budget Authority /1	**$14,870,408**	**$15,966,184**	**$21,159,225**	**$5,193,041**
Temporarily Unavailable/2	($6,093,181)	($14,000,000)	($19,001,520)	**($5,001,520)**
Transfer to Performance Bonus Fund	($4,037,227)	($523)	$0	**$523**
Payments to Shortfall States	($700)	$0	$0	**$0**
Interest Estimate	$173,703	$14,000	$6,000	**($8,000)**
Total Budgetary Resources, end of year/3	**$4,913,003**	**$1,979,661**	**$2,163,705**	**$184,044**
Total Outlays	**$1,706**	**$294,000**	**$0**	**($294,000)**

1/ Reflects both carryover resources and deposits into the Fund.
2/ The Department of Labor, Health and Human Services, and Education, and related Agencies Appropriations Act, 2020 (P.L. 116-94) made $6.1 billion temporarily unavailable for obligation in FY 2020 and the Consolidated Appropriations Act, 2021 (P.L.116-260) made $14.0 billion not available for obligation in this fiscal year.
3/ Funding levels reflect new appropriations and carry-forward balances from prior years net of enacted rescissions.

Authorizing Legislation –
The Balanced Budget Act of 1997 (BBA) (P.L. 105-33),
The Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-113),
The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173),
The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3),
The Patient Protection and Affordable Care Act (P.L. 111-148),
The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10),
The Continuing Appropriations Act, 2018 (P.L. 115-96),
The Extension of Continuing Appropriations Act, 2018 or The HEALTHY KIDS Act (P.L. 115-120),
Advancing Chronic Care, Extenders, and Social Security (ACCESS) Act (P.L. 115-123),
The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 (P.L. 115-245).
The Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2020 (P.L. 116-94).

The Departments of Labor, Health and Human Services, and Educations and Related Agencies Appropriations Act, 2021 (P.L. 116-133).

Allocation Method – Formula grants

Program Description and Accomplishments

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

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

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

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

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

Child Enrollment Contingency Fund – This fund is used to provide supplemental funding to states that exceed their allotment due to higher-than-expected child enrollment in CHIP. A state may qualify for a contingency fund payment if it projects a funding shortfall for the fiscal year and if its average monthly child enrollment exceeds the targeted average

number of enrollees for the fiscal year. MACRA (P.L. 114-10) extended the Child Enrollment Contingency Fund authorization through FY 2017. The HEALTHY KIDS Act (P.L. 115-120) extended the Contingency Fund through FY 2023 and the BBA authorized the Contingency Fund through FY 2027.

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

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

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

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

Medicaid and CHIP quality funding supports the Pediatric Quality Measures Program (PQMP), the CHIPRA Electronic Health Record Program, and CHIPRA Quality Demonstration Grants. The status of Child Health Quality Improvement activities in Medicaid and CHIP are discussed below:

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

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

These funds supported the Medicaid and CHIP child quality measurement and improvement program in FY 2021, including quality measure collection, reporting, analysis, quality improvement work with state agencies, accountability through the Medicaid and CHIP Scorecard, and managed care quality. CMS plans to continue to support this full range of child quality measurement and improvement in FY 2022.

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

In FY 2019, CMS began implementation of the next phase of the model EHR format, with support from the Office of the Chief Technology Officer, by initiating activities that will connect immunization data from state immunization information systems (IIS) with existing consumer based portals. This will enable these portals to provide consumers with access to the most complete immunization data, identify state recommended vaccination schedules, and provide immunization certificates. This phase of the EHR work was expected to be

completed in FY 2021, however, due to COVID-19, it is now expected to be completed in FY 2022. The implementation of the state pilots were delayed due to the need for state public health staff to shift priorities and the disruption to schools, as the pilot is testing the ability of parents to provide immunization data to schools using consumer based portals.

CHIPRA Quality Demonstration Grants:

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

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

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

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

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

History of Funding for State Allotments

Fiscal Year	Budget Authority
FY 2017/1	$19,098,000,000
FY 2018/2	$17,928,000,000
FY 2019/3	$20,539,000,000
FY 2020/4	$20,530,000,000
FY 2021/5	$23,800,000,000
FY 2022	$25,900,000,000

1/ Reflects rescission of $1.3 billion in funding from Section 301 of MACRA (P.L. 114-254, P.L. 115- 31).

2/ Reflects rescission of $3.6 billion in funding from Section 2104(a)(21) of the Social Security Act from the FY 2018 omnibus (P.L. 115-141).

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

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

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

Mandatory State/Formula Grants[1]
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program
(Dollars in Thousands)

STATE/TERRITORY	FY 2020 Actual	FY 2021[2] Estimate	FY 2022[3] Estimate	Difference +/-
Alabama	$426,629	$367,149	$386,824	19,676
Alaska	$32,126	$25,677	$27,053	1,376
Arizona	$266,358	$248,889	$262,860	13,971
Arkansas	$177,209	$208,780	$219,969	11,189
California	$3,208,988	$3,337,555	$3,516,417	178,861
Colorado	$315,358	$279,612	$294,596	14,985
Connecticut	$107,097	$73,475	$77,412	3,938
Delaware	$40,021	$37,363	$39,365	2,002
District of Columbia	$52,802	$61,115	$65,170	4,055
Florida	$842,520	$780,821	$827,136	46,315
Georgia	$469,255	$418,621	$441,073	22,451
Hawaii	$66,694	$55,278	$58,240	2,962
Idaho	$83,343	$85,666	$90,908	5,243
Illinois	$414,755	$535,993	$564,717	28,724
Indiana	$276,216	$272,103	$286,685	14,582
Iowa	$145,524	$166,523	$175,448	8,924

STATE/TERRITORY	FY 2020 Actual	FY 2021[2] Estimate	FY 2022[3] Estimate	Difference +/-
Kansas	$125,833	$146,403	$154,249	7,846
Kentucky	$230,237	$253,411	$266,991	13,580
Louisiana	$394,207	$393,708	$414,807	21,099
Maine	$39,129	$35,718	$37,632	1,914
Maryland	$334,413	$285,362	$300,655	15,293
Massachusetts	$765,244	$679,926	$716,364	36,438
Michigan	$289,108	$268,184	$282,556	14,372
Minnesota	$137,017	$114,762	$121,066	6,304
Mississippi	$271,641	$270,793	$285,305	14,512
Missouri	$294,625	$326,663	$344,169	17,506
Montana	$96,605	$86,630	$91,289	4,658
Nebraska	$92,167	$81,650	$86,025	4,376
Nevada	$83,404	$82,635	$87,643	5,008
New Hampshire	$47,372	$47,781	$50,342	2,561
New Jersey	$548,839	$613,931	$646,832	32,901
New Mexico	$107,040	$115,403	$121,587	6,185
New York	$1,555,817	$1,607,869	$1,694,036	86,167
North Carolina	$528,799	$555,820	$586,254	30,434
North Dakota	$28,532	$18,436	$19,653	1,217
Ohio	$550,058	$521,158	$549,087	27,929
Oklahoma	$246,739	$262,520	$276,588	14,069
Oregon	$511,609	$429,652	$452,678	23,025
Pennsylvania	$705,698	$695,236	$732,494	37,258
Rhode Island	$98,195	$75,618	$79,671	4,052
South Carolina	$195,598	$207,863	$219,952	12,090
South Dakota	$33,213	$29,485	$31,163	1,678
Tennessee	$247,943	$303,670	$320,618	16,948
Texas	$1,601,525	$1,355,609	$1,433,693	78,084
Utah	$143,321	$127,322	$134,251	6,929
Vermont	$29,836	$20,754	$21,866	1,112
Virginia	$399,647	$378,057	$398,317	20,260
Washington	$251,250	$247,639	$261,935	14,296
West Virginia	$81,736	$78,809	$83,032	4,223
Wisconsin	$288,112	$250,093	$263,496	13,403
Wyoming	$14,133	$12,190	$12,843	653
Subtotal	18,293,535	17,935,378	18,913,012	977,634
Commonwealths and Territories				
American Samoa	$5,103	$6,085	$6,411	326
Guam	$34,036	$30,678	$32,322	1,644

STATE/TERRITORY	FY 2020 Actual	FY 2021[2] Estimate	FY 2022[3] Estimate	Difference +/-
Northern Mariana Islands	**$11,825**	**$17,224**	**$18,147**	**923**
Puerto Rico	**$192,824**	**$87,294**	**$91,972**	**4,678**
Virgin Islands	**$11,562**	**$9,675**	**$10,194**	**519**
Subtotal	**255,349**	**150,957**	**159,047**	**8,090**
TOTAL RESOURCES	**18,548,884**	**18,086,335**	**19,072,058**	**985,724**

/1 Represents proposed law baseline projections of obligations.

/2 FY2021 projected allotments are calculate based on 2104(m) of the Social Security Act and do not include any updates for the American Rescue Plan Act (ARPA). Amounts are subject to change.

/3 FY 2022 projected allotments do not include projections for additional amounts that each state may potentially receive under section 2104(m)(7) of the Social Security Act. Therefore such amounts are subject to change.

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

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State Grants and Demonstrations

Budget Authority[1]
(Dollars in Thousands)
Budget Authority[2]

Program	FY 2020 Enacted	FY 2021 Enacted	FY 2022 Estimate	FY 2022 +/- FY 2021
Medicaid Integrity Program	$84,008	$85,325	$87,073	**$1,748**
Money Follows the Person (MFP) Demonstration	$337,500	$425,451	$424,350	**($1,101)**
Community-based Mobile Crisis Intervention Services	$0	$15,000	$0	**($15,000)**
Total Appropriation	**$421,508**	**$525,776**	**$511,423**	**($14,353)**

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

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

Gross Outlays[3]
(Dollars in Thousands)
Gross Outlays

Program	FY 2020 Actual	FY 2021 Estimate	FY 2022 Estimate	FY 2022 +/- FY 2021
Money Follows the Person (MFP) Demonstration-Grants	$212,927	$210,408	$264,899	**$54,491**
MFP Research & Evaluation	$347	$1,223	$225	**($998)**
MFP Best Practices	$0	$24	$93	**$69**
MFP QA/Tech Asst/Oversight	$0	$64	$248	**$184**
Medicaid Integrity Program	$95,453	$72,193	$58,873	**($13,320)**
Grants to Improve Outreach and Enrollment	$16,167	$15,469	$23,758	**$8,289**
Demonstration Programs to Improve Community Mental Health Services	$11	$1,476	$1,103	**($373)**
Demonstration Project to Increase Substance Use Provider Capacity	$7,862	$8,469	$9,527	**$1,058**
Community-based Mobile Crisis Intervention Services	$0	$0	$5,000	**$5,000**
Total Outlays for State Grants and Demonstrations	**$332,767**	**$309,326**	**$363,726**	**$54,400**

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

Program Description and Accomplishments

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

Funding History[4]

Fiscal Year	Budget Authority
FY 2018	$199,910,665
FY 2019	$391,678,963
FY 2020	$421,508,189
FY 2021	$525,775,745
FY 2022	$511,422,660

Budget Overview

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

MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION

Program Description and Accomplishments

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

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

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

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

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

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

Budget Overview

Section 6071 of the DRA authorized and appropriated a total of $1.8 billion for the MFP Rebalancing Demonstration over the period January 1, 2007 through FY 2011. Section 2403 of Patient Protection and Affordable Care Act amended the Deficit Reduction Act providing $450.0 million in each fiscal year from 2012-2016, totaling an additional $2.3 billion. In addition, Section 6071 of the DRA allows funding from each fiscal year's award to be used that fiscal year and for four additional fiscal years. The Medicaid Extenders Act of 2019 (P.L. 116-3) amended the DRA to make $112.0 million available for states with approved MFP demonstrations for FY 2019 and extended state MFP demonstrations through FY 2021. Of the $112.0 million, $500,000 was made available to carry out funding for quality assurance and improvement, technical assistance, and oversight. The Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16) included an additional $20.0 million and the Sustaining Excellence in Medicaid Act added 122.5 million in funding for the program. The Further Consolidated Appropriations Act, 2020 (P.L. 116-94) provided an additional $176 million and the Coronavirus Aid, Relief, and Economic Security Act, 2020 (P.L. 116-136) added $161.5 million in funding for the program in FY 2020. In FY 2021, the Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. 116-159) added $66.4 million and the Further Continuing Appropriations Act, 2021, and Other Extensions Act (P.L. 116-215) added $6.5 million. The Consolidated Appropriations Act, 2021 (P.L. 116-260/H.R. 133) added $1.253 billion ($1.201 billion after sequestration) and included statutory changes to enhance and extend the program through September 30, 2023.

States participating in the MFP demonstration are provided reimbursement for approved home and community-based services at an MFP-enhanced FMAP rate. The enhanced FMAP increases the regular FMAP rate for HCBS by the number of percentage points equal to 50 percent of the state share, capped at 90 percent. The American Reinvestment

and Recovery Act of 2009 authorized an increased FMAP rate to preserve a significant differential between the MFP enhanced FMAP and the increased MFP-enhanced FMAP that states were receiving for most other Medicaid funded services under the Recovery Act in order for states to continue to have a financial incentive to meet the goals of the MFP program. To address the national public health emergency, the Families First Coronavirus Response Act (FFCRA), 2020 (P.L. 116-127) included an indirect temporary 6.2 percentage point FMAP increase. These increases are reflected in the chart below.

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

As of December 1, 2020, CMS obligated approximately $3.7 billion in grants to 45 grantee states and the District of Columbia (DC). Grantees have transitioned approximately 101,540 individuals as of December 31, 2019, based on individual state reporting.

State	***Cumulative Award Total***	***Initial Award Date***
Alabama	$16,779,068	September 27, 2012
Arkansas	$60,257,522	January 1, 2007
California	$184,243,594	January 1, 2007
Colorado	$28,367,999	April 1, 2011
Connecticut	$248,227,600	January 1, 2007
Delaware	$14,264,778	May 1, 2007
District of Columbia	$36,191,272	May 1, 2007
Georgia	$147,415,141	May 1, 2007
Hawaii	$7,840,650	May 1, 2007
Idaho	$20,366,091	April 1, 2011
Illinois	$36,203,422	May 1, 2007
Indiana	$67,703,061	January 1, 2007
Iowa	$77,828,707	January 1, 2007
Kansas	$63,894,877	May 1, 2007
Kentucky	$52,817,744	May 1, 2007
Louisiana	$92,120,791	May 1, 2007
Maine	$7,824,580	April 1, 2011

State	*Cumulative Award Total*	*Initial Award Date*
Maryland	$153,590,465	January 1, 2007
Massachusetts	$95,060,502	April 1, 2011
Michigan	$79,802,401	January 1, 2007
Minnesota	$63,952,197	April 1, 2011
Mississippi	$28,972,180	April 1, 2011
Missouri	$80,588,987	January 1, 2007
Montana	$7,725,022	September 27, 2012
Nebraska	$17,419,791	January 1, 2007
Nevada	$11,854,022	April 1, 2011
New Hampshire	$13,972,772	January 1, 2007
New Jersey	$136,647,722	May 1, 2007
New Mexico	$49,205	April,1 2011
New York	$198,969,076	January 1, 2007
North Carolina	$50,151,654	May 1, 2007
North Dakota	$29,173,659	May 1, 2007
Ohio	$431,006,196	January 1, 2007
Oklahoma	$46,728,586	January 1, 2007
Oregon	$22,655,153	May 1, 2007
Pennsylvania	$163,879,169	May 1, 2007
Rhode Island	$14,125,572	April 1, 2011
South Carolina	$4,624,914	April 1, 2011
South Dakota	$8,577,350	September 27, 2012
Tennessee	$67,363,025	April 1, 2011
Texas	$361,371,146	January 1, 2007
Vermont	$20,429,133	April 1, 2011
Virginia	$70,866,895	May 1, 2007
Washington	$217,055,517	January 1, 2007
West Virginia	$19,382,431	April 1, 2011
Wisconsin	$65,613,596	January 1, 2007

NOTE: The table represents funding awarded to states. Funding for planning grants, quality initiatives, and reductions associated with sequestration are not reflected.

New Mexico and Florida had no transitions through the MFP program, rescinding grant awards in January 2012 and August 2013 respectively. Oregon deactivated their program in 2011 and officially closed out the grant in September 2016. The following MFP programs ended transitions and closed their grant awards: Illinois (February 2021), Kansas (August 2020), Michigan (February 2020), Nebraska (December 2020), New Hampshire (February

2021), and Virginia (February 2021).

MEDICAID INTEGRITY PROGRAM

Program Description and Accomplishments

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

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

Medicaid Program Integrity

The Deficit Reduction Act directed CMS to establish a Comprehensive Medicaid Integrity Plan (CMIP) every five years outlining its strategy for combating fraud, waste, and abuse in Medicaid. The first CMIP was published in July 2006, and covered FYs 2006 through 2010. CMS released the most recent CMIP in July 2020 for FYs 2019 through 2023, available at: https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf. Building upon CMS' existing program integrity efforts, the CMIP for FYs 2019 through 2023 includes the new and enhanced Medicaid program integrity initiatives that CMS announced in the June 2018 Medicaid Program Integrity Strategy. Continuing levels of funds will be required through FY 2022 to enable CMS to meet the program goals outlined in the CMIP. CMS' Medicaid program integrity efforts include the following:

Medicaid Improper Payments

- The Payment Error Rate Measurement (PERM) program measures improper payment rates in the Medicaid program and the Children's Health Insurance Program (CHIP), where each state is reviewed on a rolling three year basis and annually produces national and state-specific improper payment rates for each state. The improper payment rates are based on federal reviews of the fee-for-service, managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review. In FY 2020, CMS implemented a new enhanced state-specific PERM Corrective Action Plan (CAP) oversight process, which includes regular monitoring of states' progress in implementing PERM CAPs to address the root causes of improper payments in Medicaid and CHIP.
- The Medicaid Eligibility Quality Control (MEQC) program uses state-directed reviews in the two off-cycle PERM years to address Medicaid beneficiary eligibility errors and deficiencies. MEQC includes reviews of areas not addressed through

PERM reviews as well as areas identified as error-prone through the PERM program.

Medicaid Claiming and Financial Reporting

- A key component of CMS' managed care program integrity work is to conduct targeted examinations of selected states' Medicaid Managed Care Plans' (MCPs) financial reporting. As part of this effort, CMS conducted an examination of the Medical Loss Ratio (MLR) reported by California's 22 Medicaid MCPs to determine if the state's previous review correctly identified findings and overpayments, and the documentation accepted by the state was reasonable to support the amounts included in the MLR calculation. The report for this examination was released in June 2020,[5] and a second review is underway in Oregon.
- Section 6008 of the Families First Coronavirus Response Act (FFCRA) provided additional funding and opportunities for states. CMS is working to conduct additional COVID-19-related oversight activities in FY 2021 in areas identified as high-risk.

Medicaid and CHIP Oversight and Collaboration

- CMS is conducting oversight of states' program integrity efforts and is working to build a collaborative working relationship to share best practices and strengthen program integrity efforts. CMS is working to strengthen efforts to provide effective Medicaid provider education to reduce aberrant billing including targeted probe and educate efforts and comparative billing reports. Reviews are also conducted to determine if state policies and practices comply with federal regulations, identify program vulnerabilities that may not rise to the level of regulatory compliance issues, identify states program integrity promising practices, and monitor state CAPs.
- CMS conducts Technical Assistance Group (TAG) calls during which states share resources and promising practices, have the opportunity to ask questions to CMS and other states, and discuss trending issues in program integrity.
- CMS' Medicaid Integrity Institute (MII) provides training and education to more than one thousand state Medicaid program integrity staff annually. Previous course topics included provider screening and enrollment, managed care, personal care services, opioids, beneficiary fraud, data analytics, and investigatory techniques. In FY 2021, CMS will continue redesigning the MII to allow for greater state engagement and offer more robust virtual training opportunities. One virtual course was held in March 2021, which focused on potential fraud and abuse related to the COVID-19 public health emergency (PHE). Additional FY2021 virtual courses are being developed on various fraud, waste and abuse topics, including the COVIDE-19 PHE.
- Because CMS announced certain Medicaid and CHIP waivers and flexibilities to allow states to best respond to the PHE, CMS is now working to provide technical assistance and guidance to states regarding the potential program integrity risks that may arise as a result, including potential mitigation strategies to reduce these risks.

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

- In July of 2020, the Healthcare Fraud Prevention Partnership (HFPP) held a Virtual State Information Sharing Session for state health care and Medicaid Fraud Control Unit (MFCU) organizations. Attendees acquired the latest information on law enforcement activities, investigative strategies, and trending schemes to assist with fraud-fighting efforts. The HFPP will continue to engage state with hopes of additional states choosing to partners with the other HFPP members as an additional approach to combat fraud, waste and abuse. The HFPP will continue to engage state partners through a variety of means including producing study results, creating white papers and hosting virtual events which help state partners combat fraud, waste and abuse.

Medicaid Data Analysis

- Working closely with states to ensure that federal partners, stakeholders, and oversight bodies have access to the best, most complete and accurate Medicaid data. All 50 states, D.C., Virgin Islands, and Puerto Rico continue to submit data on their programs to the Transformed Medicaid Statistical Information System (T-MSIS) and have partnered with CMS to improve the quality of data submitted. As of January 2021, CMS has released T-MSIS Analytic Files with data for calendar years 2014-2020 to federal partners and stakeholders, and publically released research files for calendar years 2014-2019. This marks the timeliest availability of Medicaid and CHIP data ever. The DQ Atlas, an interactive web-based companion tool which allows users to explore the quality and usability of the data, is currently available for calendar years 2016-2019.
- T-MSIS data quality improvements have resulted in publically available data releases including an annual substance use disorder databook, annual state-level Medicaid per capita expenditures for the Medicaid and CHIP Scorecard, and a sickle cell disease infographic and report. CMS has also released data snapshots regarding Medicaid and CHIP beneficiaries and their service utilization during the COVID-19 Public Health Emergency (PHE). Data include, COVID testing, treatment and outcomes, service use among beneficiaries of Medicaid and the Children's Health Insurance Program (CHIP) who are 18 years of age and under, services delivered via telehealth during the COVID-19 PHE, and services for mental health and substance use disorders during the COVID-19 PHE.
- Sharing CMS' extensive knowledge gained from processing and analyzing large, complex Medicare data sets to help states apply algorithms and insights to analyze Medicaid state claim data and identify potential areas to target for investigation.

Medicaid Provider Enrollment

- Continuing to screen Medicaid providers on behalf of states. Centralizing the process will improve efficiency and coordination across Medicare and Medicaid and decrease state burden.
- Working with states to enhance data sharing and collaboration to tackle program integrity efforts in both the Medicare and Medicaid programs. For example, CMS has made the Social Security Administration's Death Master File available for states to support provider enrollment activities. CMS has also created and released the CMS Data Exchange (DEX) system, a platform to more effectively and efficiently share providers' adverse actions with State Medicaid Agencies.
- In FY 2022, CMS will continue to offer assistance to states regarding provider screening and enrollment requirements in an effort to reduce improper payments. Activities under this initiative include: providing one-on-one technical assistance, feedback, and collect and disseminate best practices; continue to offer the CMS data compare service, which identifies providers states may need to take action against and allows states to compare their provider population to the Medicare provider population in bulk to more easily rely on Medicare's screening and reduce the state's overall workload; updates to the Medicaid Provider Enrollment Compendium (MPEC); a dedicated CMS contact to work directly with the state in addressing concerns, questions, and issues that may arise regarding provider screening and enrollment..

<u>Unified Program Integrity Contractors (UPICs)</u>

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

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

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

In FY 2020, the UPICs initiated Medicaid provider investigations and audits in 37 states. The most common collaborative investigations and audits have been conducted in the areas of hospice, credit balance, hospice and general hospital services. Each of these investigative areas includes both fee for service and managed care providers. In FY 2021, CMS is continuing to collaborate with states to conduct investigations and audits in high priority areas, including addressing COVID-19 vulnerabilities.

Medicaid/CHIP Financial Management Project

Financial Management (FM) staff, including accountants and financial analysts work to improve CMS' financial oversight of the Medicaid and CHIP programs. In FY 2020 through the continued efforts of these specialists, CMS removed an estimated $1.1 billion (with approximately $866.0 million recovered and $269.0 million resolved) of approximately $10.25 billion identified in questionable Medicaid costs.

Furthermore, an estimated $174.0 million in questionable reimbursement was actually averted due to the FM staff preventative work with states to promote proper state Medicaid financing. The FM staff activities included reviews of proposed Medicaid state plan amendments that related to reimbursement; development of financial management reviews; research regarding state Medicaid financing policy and practices; collaboration with states to resolve the Medicaid and CHIP portions of the A-133 state single audits; and reviews of sources of the non-federal share.

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

State Program Integrity Reviews

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

CMS has completed 76 focused program integrity reviews on specific target areas since FY 2014 through FY 2020. These reviews have focused on a number of issues including the enhanced provider screening and enrollment provisions resulting from the Patient Protection and Affordable Care Act, the extent of states' program integrity oversight of the managed care program, the extent of selected managed care organizations' oversight of their own programs, and issues in personal care services.
CMS also conducts additional reviews that encompass a broader assessment of program

vulnerabilities and risk of Medicaid improper payments. Known as desk reviews, these reviews allow CMS to increase the number of states that received customized program integrity oversight.

Since their inception in FY 2016, CMS has completed 268 desk reviews in at least 45 states and the District of Columbia, with 57 desk reviews scheduled for FY 2020. The desk reviews allow CMS to increase the number of states that receive program integrity oversight.

Budget Overview

The DRA appropriated funds yearly beginning in FY 2006, and beginning in FY 2011, Section 1303(b) (3) of Public Law 111-152 adjusted this funding by the percentage increase in the CPI-U annually. The final FY 2020 budget authority was $84.0 million. The FY 2021 budget authority is $89.3 million with a CPI-U adjustment of 1.4 percent, bringing the adjusted budget authority to $90.5 million. The FY 2021 budget authority is reduced by 5.7 percent due to sequestration, bringing the final FY 2021 budget authority to $85.3 million. The FY 2022 budget authority is $90.5 million with an estimated CPI-U adjustment of 2.0 percent, bringing the adjusted budget authority to $92.3 million. The FY 2022 budget authority is reduced by 5.7 percent due to sequestration, bringing the estimated FY 2022 budget authority to $87.0 million. The CPI-U adjustments are based on the current FY 2022 President's Budget economic assumptions. Funds appropriated remain available until expended.

GRANTS TO IMPROVE OUTREACH AND ENROLLMENT

Program Description and Accomplishments

Program Overview

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

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

Legislative and Funding History

Congress has provided funding to improve outreach, education, and application assistance to enroll eligible, uninsured children in Medicaid and CHIP through several pieces of legislation. Section 201 of the CHIPRA (P.L. 111-3) provided $100.0 million for Outreach and Enrollment Grants, a National Enrollment Campaign, and Outreach to American Indian/Alaska Native (AI/AN) Children. Section 10203 of the Patient Protection and Affordable Care Act (ACA) provided an additional $40.0 million. Section 303 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provided an additional $40.0 million in FY 2016 through FY 2017. Section 3004 of the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2018 (referred to as the HEALTHY KIDS Act and included in P.L. 115-120) and Section 50103 of the Advancing Chronic Care, Extenders and Social Services Act (referred to as the ACCESS Act and included in P.L. 115-123) provided a combined total of $168.0 million for outreach and enrollment activities for FY 2018 through FY 2027. These programs will continue to conduct outreach and enrollment efforts designed to increase the enrollment of children who are eligible for Medicaid or CHIP.

Key Provisions of Authorizing Legislation and Grant Awards

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

CHIPRA

Of the $100.0 million provided by section 201 of CHIPRA, $80.0 million was appropriated for the Outreach and Enrollment Grants with an additional $10.0 million specifically dedicated to outreach and enrollment of AI/AN children and $10.0 million for a national outreach campaign for both the general population, and specifically for AI/AN families. The first $40.0 million in grant funds was awarded on September 30, 2009. CMS awarded 69 grants distributing $40.0 million in federal funds across 41 states and the District of Columbia. On April 16 2010, CMS awarded $10.0 million in grant funds to 41 health programs operated by the Indian Health Service, tribes and tribal organizations, and urban Indian organizations across 19 states for outreach and enrollment of uninsured AI/AN children into Medicaid and CHIP. On August 18, 2011, CMS awarded an additional $40.0 million in grant funds to 39 grantees across 23 states. These grants, entitled CHIPRA Outreach and Enrollment Grants (Cycle II), encouraged applicants to take a more systematic approach to outreach, enrollment, and retention. Grantees focused on five specific areas that had been identified as those most representing the opportunities and challenges for the enrollment and retention of children in health insurance coverage.

ACA and MACRA

As part of the $40.0 million provided by section 10203 of the ACA, CMS awarded the Connecting Kids to Coverage Outreach and Enrollment Grants (Cycle III) on July 2, 2013. CMS awarded $32.0 million in 41 grants to state agencies, community health centers, school-based organizations and non-profit groups in 22 states. On November 12, 2014, CMS awarded $3.9 million in grant funds to 10 grantees in seven states for outreach and enrollment of AI/AN children into Medicaid and CHIP.

MACRA extended the Outreach and Enrollment Program through FY 2017. It provided an additional $40.0 million, of which $32.0 million was dedicated to a fourth cycle of general outreach and enrollment grants. On June 13, 2016, CMS awarded 38 cooperative agreements in 27 states totaling just under the $32.0 million. Awards under these cooperative agreements funded activities aimed at educating families about the availability of free or low-cost health coverage under Medicaid and CHIP, identifying children likely to be eligible for these programs, and assisting families with the application and renewal process. The two-year performance period for these awards ended June 30, 2018. MACRA also provided $4.0 million for outreach and enrollment of AI/AN children and $4.0 million for a national outreach campaign. On June 14, 2017, CMS awarded eight cooperative agreements, dedicated to AI/AN children, in six states totaling just under $4.0 million. The two year performance period for these awards ended June 30, 2019.

HEALTHY KIDS and ACCESS Act

The HEALTHY KIDS Act provided $120.0 million for activities aimed at increasing the participation of eligible children in Medicaid and CHIP. Of the total $120.0 million in funding, 10 percent was set aside for outreach to AI/AN children ($12.0 million), 10 percent was set aside for the National Campaign ($12.0 million), and the remainder ($96.0 million) is dedicated to grants for the outreach and enrollment of uninsured children and their parents. On June 19, 2019, CMS awarded $48.0 million in cooperative agreements to 39 organizations in 25 states. The performance period for these awards is three years.

CMS is planning a second phase of $48.0 million for outreach and enrollment grants broadly targeting all eligible children in Medicaid and CHIP from FYs 2022 to 2025. Of the $12.0 million available for outreach and enrollment grants targeting the enrollment and retention of eligible AI/AN children in Medicaid and CHIP, CMS issued a Notice of Funding Opportunity to make available $6.0 million in cooperative agreements to eligibility entities on July 16, 2019. On January 13, 2020, CMS awarded nine new cooperative agreements, in six states, dedicated to the outreach and enrollment of AI/AN children.

Outreach to American Indian/Alaska Native Children

Section 2113(b)(2) of the Social Security Act set aside 10 percent of any amounts appropriated under that section to award grants to Indian health care providers to reduce the number of uninsured, low-income children in the United States through the enrollment and retention of eligible AI/AN children in Medicaid and CHIP. As noted above, on April 15, 2010, CMS awarded 41 grants for a total of $10.0 million. On November 12, 2014, CMS awarded a second round of Outreach and Enrollment Grants, from a $4.0 million Patient Protection and Affordable Care Act appropriation, to organizations serving Indian children. On June 15, 2017, CMS awarded eight new AI/AN cooperative agreements with $4.0 million in funds from MACRA. This set-aside also applies to appropriations provided in the HEALTHY KIDS and ACCESS Acts of 2018. Of the total $120.0 million in funding provided by the HEALTHY KIDS Act, CMS issued a notice of funding opportunity on July 16, 2019 to make available $6.0 million to eligible AI/AN entities. CMS announced these nine new awards on January 13, 2020. The performance period for these awards is three years.

National Enrollment Campaign

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

With the funding appropriated under the HEALTHY KIDS Act of 2018, CMS awarded a multi-year task order in May 2019 to continue the National Campaign; the next period will begin in May 2021 to run through May 2023. The National Campaign informs families that eligible children can enroll in Medicaid and CHIP any time of the year and directs them to InsureKidsNow.gov or 1-877-KIDS-NOW for additional information. Activities funded through the National Campaign include: conducting training webinars and meetings, developing newsletters and other tools on key topics for partners, creating and updating print and digital materials to support outreach and enrollment efforts, and producing new public service announcements. In FY 2015 - FY 2019, CMS also developed PSAs for tribal communities and aired these on Good Health TV®, a health education program serving in tribal hospitals and clinic waiting rooms.

Budget Overview

CHIPRA appropriated a total of $100.0 million for fiscal years 2009 through 2013. Section 10203(d)(2)(E) of Patient Protection and Affordable Care Act provided an additional $40.0 million in FY 2010 and extended the period of availability of all funds through fiscal year 2015. Of the total appropriated amount, 10 percent was set aside for the national enrollment campaign and another ten percent was for AI/AN outreach. CMS awarded $40.0 million in FY 2009 for outreach grants and approximately $10.0 million in FY 2010 for general outreach to AI/AN children. CMS awarded an additional $40.0 million of the remaining grant funds under CHIPRA on August 18, 2011. Under the Patient Protection and Affordable Care Act, in July 2013, CMS awarded a third round of outreach and enrollment grants (totaling $32.0 million) entitled “Connecting Kids to Coverage Outreach and Enrollment Grants (Cycle III)” and then in November 2014, awarded a second round of Outreach and Enrollment Grants, totaling $4.0 million to organizations serving AI/AN children. The $10.0 million appropriated through CHIPRA in combination with the $4.0 million appropriated through the Patient Protection and Affordable Care Act have been used to fund National Enrollment Campaign efforts, as required under the statutes.

MACRA appropriated an additional $40.0 million in FY 2016. Of this appropriated amount, $32.0 million was set aside for outreach grants, $4.0 million was set aside for outreach and enrollment grants specifically dedicated to the outreach and enrollment of AI/AN children, and $4.0 million was set aside for the National Enrollment Campaign. These additional funds were available for obligation through FY 2017. For the National Enrollment Campaign, over $3.0 million was obligated in FY 2016. In FY 2017, the remaining funds were obligated.

The HEALTHY KIDS Act of 2018 appropriated $120.0 million over FY 2018 through

FY 2023 to continue support for outreach and enrollment grants, including grants dedicated to the outreach and enrollment of AI/AN children and the National Enrollment Campaign. The ACCESS Act of 2018 appropriated an additional $48.0 million from FY 2024 through FY 2027 and established an additional 10 percent set-aside for evaluation and technical assistance to grantees. As part of the National Enrollment Campaign, CMS will continue outreach activities to Tribal communities by creating outreach materials, public service announcement and social media graphics between FY 2020 through FY 2022.

DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES

Program Description and Accomplishments

Section 223 of the Protecting Access to Medicare Act of 2014 (P. L. 113-93) required the Secretary to establish a two-year demonstration program no later than January 1, 2016 that would increase the Federal Matching Percentages for participating states to improve access to behavioral health services.

HHS has submitted annual reports to Congress in which the program is assessed on the basis of quality, scope, impact, and the use of funds.

Budget Overview

Section 223 authorized and appropriated $2.0 million in FY 2014 and $25.0 million for the planning grants in FY 2016. Amounts appropriated for this program remain available until expended. In FY 2016, $25.0 million in appropriated planning grant funding for this demonstration underwent a 6.8 percent sequestration cut which reduced the budget authority available for the planning grants to $23.3 million.

On May 20, 2015, SAMHSA, in conjunction with CMS, released a Request for Applications (RFA) for planning grants to states that intended to participate in the section 223 Protecting Access to Medicare Act (PAMA) Demonstration Programs to Improve Community Mental Health Services. On October 19, 2015, SAMHSA, in conjunction with CMS and ASPE, awarded approximately $22.9 million in planning grants to 24 states to support their efforts to improve behavioral health services under the Medicaid program by providing community-based mental health and substance use disorder treatment. SAMHSA, CMS, and ASPE provided robust technical assistance to grantee states throughout the FY 2016 one-year planning phase of the demonstration. When the planning grant phase ended in October 2016, eight states were selected to participate in the section 223 behavioral health demonstration to make services more widely available through certified community behavioral health clinics.

In December 2016, HHSannounced the selection of eight states: Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania to receive enhanced federal match for specific behavioral health services over a period of two years. Demonstration programs in selected states began between April and July 1, 2017. HHS reports annually to Congress an assessment of the quality, scope, and impact, and use of funds by demonstration programs, with a final report due no later than December 2021. The final report will provide recommendations for continuation, expansion, modification, or termination of demonstration projects under Section 223.

In October 2018, SAMHSA released the first annual Report to Congress which focuses on activities surrounding implementation of the demonstration, the one-year planning phase, states selected to participate in the 2-year demonstration and CCBHC program launch in the selected states. ASPE is continuing to conduct evaluations of the demonstration and is developing an Analysis Report to assess access to community-based mental health services under the Medicaid program, the quality and scope of services provided by CCBHCs, and the impact of the demonstration on federal and state costs of a full range of mental health services.

On April 18, 2019, H.R. 1839 Medicaid Services Investment and Accountability Act of 2019 (MSIA) P.L. 116-16 was signed into law which provided for a 90-day extension of Oklahoma and Oregon's CCBHC demonstration programs from April – June 2019. These states began their two-year demonstrations on April 1, 2017, 90 days prior to the additional six states. The MSIA allowed OK and OR to bring their program end date into alignment with Minnesota, Missouri, New York, New Jersey, Nevada and Pennsylvania's end date of June 30, 2019.

On July 5, 2019, S. 2047, P.L. 116-29, A bill to provide for a 2-week extension of the Medicaid community mental health services demonstration program was signed into law which provided for a 2-week extension of the demonstration for all eight states from June 30, 2019 to July 14, 2019.

On August 6, 2019, P.L. 116-39 the "Empowering Beneficiaries, Ensuring Access, and Strengthening Accountability Act of 2019," was signed into law by the President. This legislation extends the section 223 demonstration from 7/14/2019 – 9/13/2019.

On September 27, 2019 HR 4378, P.L. 116-59, the "Continuing Appropriations Act, 2020, and Health Extenders Act of 2019," was sign into law, which extended the section 223 demonstration from September 13, 2019 to November 21, 2019.

On November 21, 2019, H.R. 3055, P.L. 116-69, the "Further Continuing Appropriations Act of 2020, and Further Health Extenders Act of 2019," was signed into law, which extended the section 223 demonstration from November 21, 2019 to December 20, 2019.

On December 20, 2019, H.R. 1865, P.L. 116-94, the Further Consolidated Appropriations Act, 2020 was signed into law, which extended the section 223 demonstration from December 20, 2019 to May 22, 2020.

On March 27, 2020, H.R. 748, P.L. 116-136, the Coronavirus Aid, Relief, and Economic Security Act, or the CARES Act, was signed into law, which extended the end date of the section 223 demonstration from May 22, 2020 to November 30, 2020. The CARES Act also mandates the selection of two additional states to participate in the CCBHC demonstration that must be selected no later than September 27, 2020.

On August 5, 2020, CMS and SAMHSA announced the selection of Michigan and Kentucky as the two additional states to participate in the section 223 demonstration. CMS will work with the states to provide any needed technical assistance and will confirm start dates for demonstrations in Michigan and Kentucky as the statute did not specify a program start date. Both states are eligible to receive 8 quarters of enhanced FMAP for CCBHC programs in their state.

On October 1, 2020, The Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. 116-159) was signed into law, which extended the section 223 demonstration end date from November 30, 2020 to December 11, 2020.

On December 27, 2020, H.R. 133, the Consolidated Appropriations Act, 2021 (Public Law 116-260) was signed into law, which extends the section 223 demonstration from December 11, 2020 to September 30, 2023. This legislation allows the original eight participating states to continue receiving enhanced FMAP for expenditures covering dates of service through September 30, 2023 for services provided by CCBHCs approved in 2016 under section 223 of the Protecting Access to Medicare Act, as outlined at https://www.samhsa.gov/grants/grant-announcements/sm-16-001. The legislation also indicates that the two newly selected CCBHC states, Kentucky and Michigan, will receive enhanced FMAP for CCBHC expenditures for 2 years from the start of their respective demonstrations or September 30, 2023, whichever is longer. CMS will transfer funds to ASPE under an interagency agreement to evaluate the implementation and impact of the program in the two additional states, as well as look at the longer-term implications of the program in the original states selected for participation.

ASPE leads the development of the remaining CCBHC Reports to Congress and on July 22, 2019, ASPE released the second CCBHC report for Congressional review. The 2018 report can be found on ASPE's website: https://aspe.hhs.gov/pdf-report/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2018.

On September 12, 2020, ASPE released the third annual CCBHC report for Congressional review. The 2019 report is located on ASPE's website: https://aspe.hhs.gov/pdf-report/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2019.

In addition, ASPE released the following CCBHC detailed cost and quality evaluation reports, also located on their website at the following links:

- https://aspe.hhs.gov/pdf-report/preliminary-cost-and-quality-findings-national-evaluation-certified-community-behavioral-health-clinic-demonstration
- https://aspe.hhs.gov/pdf-report/implementation-findings-national-evaluation-certified-community-behavioral-health-clinic-demonstration

CMS is continuing to onboard the two new CCBHC states, Michigan and Kentucky into the section 223 CCBHC demonstration through a series of technical assistance workshops. Both states have indicated that they plan to launch CCBHC demonstrations in their state effective October 2021.

DEMONSTRATION PROJECT TO INCREASE SUBSTANCE USE PROVIDER CAPACITY UNDER THE MEDICAID PROGRAM

Program Description and Accomplishments

Section 1003 of the SUPPORT for Patients and Community Act (P. L. 115-271) requires the Secretary to create a five-year demonstration for the purposes of increasing the number and ability of providers participating in Medicaid to provide treatment for substance use disorders. The Secretary of HHS shall conduct this demonstration under the authority of Title XIX.

For the first 18-month period of the demonstration project, the Secretary shall award planning grants to at least 10 states (based on geographic diversity, with a preference to states with a prevalence of opioid use disorders comparable to or higher than the national average) to conduct the following activities:

- Activities that support the development of a behavioral health needs assessment; and
- Activities that, taking into account the results of the assessment, support the development of state infrastructure to recruit prospective providers to treat substance use disorders and training for those providers.

For the remaining 36-month period of the demonstration, the Secretary shall select no more than five states (based on information submitted by the state in an application to the Secretary) to continue the demonstration, and to receive an FMAP of 80 percent for expenditures attributable to substance use treatment or recovery services that exceed one-fourth of funds expended by the state in FY 2018.

This provision also requires CMS (in consultation with the Director of the Agency for Healthcare Research and Quality (AHRQ) and the Assistant Secretary for Mental Health and Substance Use) to submit an initial, interim, and final report to Congress based on data and reports submitted by the states on the process and outcomes of the demonstrations. CMS shall issue the reports by the following dates:

- Initial Report: October 1, 2020
- Interim Report: October 1, 2022
- Final Report: October 1, 2024

CMS released a Notice of Funding Opportunity (NOFO) for planning grants for the demonstration to increase substance use treatment provider capacity in the Medicaid program on June 25, 2019.

CMS selected and awarded $48.5 million in planning grants to 15 states on September 18, 2019. The statutory date for awarding planning grants was April 24, 2019. The target dates were pushed back to allow adequate time for statutorily required collaboration and clearances.

Selected state Medicaid agencies, were geographically diverse, and had a prevalence of substance use disorder (in particular opioid use disorder) that was comparable to or higher than the national average prevalence.

The project's timetable was modified based on an assessment of the impact of the COVID-19 public health emergency on grantee activities, as well as the April 21, 2020, extension renewal of Health and Human Services Secretary Alex M. Azar II's declaration of a public health emergency related to COVID-19. Pursuant to section 1135(b)(5) of the Social Security Act (Act), CMS modified the deadlines and timetables set forth in section 1903(aa) of the Act (which was added by section 1003 of the SUPPORT Act). Specifically, for all participating states, CMS modified the end date of the planning phase of the demonstration by 6 months to September 30, 2021. CMS also delayed the start of the 36-month post-planning demonstration phase by 6 months to October 1, 2021.

The Agency for Healthcare Research and Quality (AHRQ) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have met with and continue to collaborate with CMS on all activities to date.

Budget Overview

Section 1003 authorizes and appropriates $50.0 million for the planning grants and $5.0 million to support the administration of the demonstration in FY 2019 to carry out this section. Amounts appropriated for this program shall remain available until expended.

Evaluation Contract

On September 1, 2020, CMS procured the services of a contractor to support the design and implementation of the evaluation of the SUPPORT Act section 1003 Demonstration Project to Increase Substance Use Provider Capacity.

The primary objectives of the evaluation are as follows:

- assess the effectiveness of the SUPPORT Act Section 1003 Demonstration Project in increasing the capacity of providers participating under the Medicaid state plan (or a waiver of such plan) to provide substance use disorder treatment or recovery services under such plan (or waiver);
- describe the activities carried out under the planning grants and demonstration project;
- determine the extent to which participating states have achieved the stated goals;
- describe the strengths and limitations of the planning grants and demonstration project;
- develop a plan for sustainability of the project based on findings from the evaluation;
- facilitate data sharing and the sharing of best practices to support dissemination of effective strategies; and
- produce four Congressionally mandated reports:
    i. Initial Report to Congress;
    ii. Agency for Healthcare Research and Quality Report to Congress;
    iii. Interim Report to Congress; and
    iv. Final Report to Congress.

Post-Planning Period

CMS will issue a limited competition notice of funding opportunity (NOFO) for the post-planning period of the demonstration project in spring 2021. Eligibility for participation in the post-planning period is limited to five of the 15 planning grant states. The post-planning

period will begin in October 2021.

STATE OPTION TO PROVIDE QUALIFYING COMMUNITY-BASED MOBILE CRISIS INTERVENTION SERVICES

Program Description and Accomplishments

The American Rescue Plan Act of 2021 (Section 9813) amended Title XIX of the Social Security Act (the Act) by adding, after section 1946 (42 U.S.C. 1396w–5), the following new section: "SEC. 1947. State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services." In addition to authorizing a new, optional Medicaid service, this provision makes available planning grants to state Medicaid agencies to support the developing of this new state plan option: community-based mobile crisis intervention services for Medicaid recipients in the community who are experiencing a mental health or substance use disorder (MH/SUD) crisis.

A notice of funding opportunity (NOFO) is expected to be issued in July 2021, to make available planning grants for the purpose of developing state plan amendments (SPA), section 1115 demonstrations, section 1915(b) or 1915(c) waiver program requests (or amendments) to provide qualifying community-based mobile crisis intervention services under the Medicaid program. Activities necessary for developing qualifying community-based mobile crisis intervention services that meet the conditions specified in section 1947(b) of the Social Security Act (the Act) may be included.

The awarding of planning grants is expected prior to September 30, 2021.

Budget Overview

Section 9813 authorizes and appropriates $15 million for the purposes of implementing, administering, and making planning grants to states for purposes of developing a SPA or section 1115, 1915(b), or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services to remain available until expended.

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Information Technology

(Dollars in thousands)

Information Technology Portfolio	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Program Management	***$2,045,536***	***$2,011,225***	***$2,099,064***	***$87,839***
Coronavirus Supplement	$14,690	$14,958	$0	($14,958)
Federal Administration	$45,845	$40,727	$44,455	$3,728
Program Operations	$1,458,652	$1,306,214	$1,434,990	$128,776
Research	$6,910	$6,900	$0	($6,900)
Survey & Certification	$701	$7,684	$8,236	$552
Subtotal: Discretionary Appropriation	*$1,526,798*	*$1,376,483*	*$1,487,681*	*$111,198*
ACA Section 2701	$669	$558	$497	($61)
MACRA	$510	$0	$0	$0
Medicaid (4201)	$5,438	$3,474	$3,805	$331
PAMA Section 210 & 216	$2,218	$4,380	$3,575	($805)
Subtotal: Mandatory Appropriation	*$8,835*	*$8,412*	*$7,877*	*($535)*
CLIA	$39	$53	$60	$7
COB User Fees	$20,533	$10,431	$17,930	$7,499
Marketplace Risk Adjustment User Fees	$5,493	$17,902	$14,876	($3,026)
Marketplace User Fees	$434,181	$558,619	$490,563	($68,056)
RAC MSP & Parts A/B	$9,944	$23,800	$19,400	($4,400)
Quality Payment Programs	$20,479	$0	$0	$0
Sale of Data	$19,234	$15,525	$15,677	$152
Subtotal: Offsetting Collections	*$509,903*	*$626,330*	*$558,506*	*($67,824)*
Quality Improvement Organizations	***$278,934***	***$294,813***	***$279,652***	***($15,161)***
Innovation Center	***$183,380***	***$204,077***	***$211,855***	***$7,778***
Health Care Fraud & Abuse	***$486,230***	***$483,250***	***$451,874***	***($31,376)***
Mandatory	$230,542	$213,060	$183,288	($29,772)
Discretionary	$255,688	$270,190	$268,586	($1,604)
Total Information Technology Portfolio	**$2,994,080**	**$2,993,365**	**$2,997,445**	**$4,080**

Program Description

The Information Technology (IT) portfolio provides funding for all IT investments that support CMS operations. IT encompasses funding for the processing of Medicare Fee-For-Service (FFS) claims as well as infrastructure and operational support. CMS has continued to develop IT infrastructure to facilitate value-based payment arrangements and

provide state flexibility to expand outcome-based payments. It supports the Medicare Advantage and Medicare Prescription Drug programs, beneficiary and consumer outreach programs, quality improvement activities, and ongoing research. It also funds operations and enhancements in the Medicaid and CHIP programs and other areas such as insurance market reform, oversight, and operational contracts supporting the Marketplace. A key aspect of administering these programs is to ensure the security of CMS's data and IT infrastructure. In addition, IT supports CMS's efforts to decrease program payment error rates and increase the program integrity return on investment (ROI).

CMS continues to focus on implementing a cloud-hosting environment throughout the agency, while refining the single point of entry. Shifting CMS's IT infrastructure to the cloud will make the agency's operations more cost effective, make collaboration more efficient, and allow for business scalability. There are currently more than 80 different tools and applications running in the cloud throughout CMS. This represents both application migration and new efforts in support of CMS Cloud adoption. In FY 2020, CMS added an additional 19 applications and services to the CMS Cloud ecosystem. As of April 2021, we have approximately 40 applications and/or new services in the cloud pipeline. This trend of expanding the CMS's cloud hosting environment will continue in FY 2022 and beyond. CMS has also developed a Data Center Optimization Initiative (DCOI) Strategic Plan. The foundation of the DCOI is to maximize efficiencies through outreach, collaboration, and education to guide agency users in the adoption and implementation of cloud offerings.

This chapter covers Agency-wide IT spending across all funding sources and programs. The intention is to provide a portfolio view of major CMS IT investments to show how these investments relate to specific activities. While this chapter focuses on major investments, multiple non-major investments support each of the activities as well. Additional information on specific IT investments can be viewed on the IT Portfolio Dashboard located at: https://www.itdashboard.gov/drupal/summary/009

Funding History

Fiscal Year	Budget Authority
FY 2018	$2,944,097,000
FY 2019	$2,685,606,000
FY 2020	$2,994,080,000
FY 2021 Enacted	$2,993,365,000
FY 2022 President's Budget	$2,997,445,000

FY 2022 IT Funding Level: $2,997.4 million

The FY 2022 President's Budget for CMS-wide IT is $2,997.4 million, an increase of $4.1 million above the FY 2021 Enacted level. This funding supports all CMS essential IT investments. Below are three of CMS's top priorities within the IT portfolio that account for $190.1 million of the total request.

IT Security ($123.1 million): As the technical capacity of "bad actors" across the globe increases, CMS faces daily cybersecurity threats to our data. Threats continue to intensify, and CMS must enhance the robust IT security program to overcome these vulnerabilities. The increased threats coupled with the outdated security infrastructure requires CMS to continue to prioritize security. CMS has successfully implemented Continuous Diagnostics and Mitigation (CDM) at the core data center and has progressed beyond the Baltimore Data Centers, targeting Data Centers containing high value assets and large numbers of the Federal Information Security Management Act (FISMA) systems. This multiyear effort will require CMS to comply with OMB's mandate to fully implement CDM across the entire IT landscape. This process will require CMS to establish and maintain ongoing authorization, automate Indicators of Compromise (IOCs) sharing with data centers, increase the viability of cloud security, and maintain the development of security operations programs. OMB and HHS have accelerated the timeline for all CDM phases, which will require CMS to plan and execute multiple CDM phases simultaneously. CDM implementation and prioritization has increased program expansions for reporting, testing, training, and customer focused process changes.

The FY 2022 request of $123.1 million includes $115.2 million of Program Operations funding, along with $4.7 million in Federal Marketplace funding, $0.8 million of Program Integrity funding, $1.6 million of Federal Administration, and $0.8 million in Program Integrity/Innovation Center funding. This funding allows CMS to expand on its CDM work at a new, accelerated pace. Protecting beneficiary data continues to be a top priority at CMS.

Medicare Payment Systems Modernization (MPSM) ($37.3 million): CMS processes over 1.2 billion Medicare Fee for Service (FFS) claims a year for care provided to over 38.5 million beneficiaries. Medicare's claims processing systems have enabled Medicare to become the fastest, most reliable health insurance payer in the country. Medicare is an industry leader, with commercial payers often modeling their own payment methods and policies after Medicare. However, with 40+-year-old systems written in outdated computer languages, it is necessary to modernize to meet the changing world of healthcare. Medicare has evolved into a nationally managed program with more centralized policy; healthcare practices are shifting to focus on a holistic view of each patient's healthcare services and needs; and, health insurance payments are increasingly accounting for the quality of services being provided.

CMS has modernization efforts underway to move to a system designed for change and iteration, which reduces time and costs for making policy changes. Our systems need the ability to pay for value-based care, the flexibility and nimbleness to keep up with the pace of innovation and legislative changes, and the transparency to give access to information when needed in order to serve policymakers, beneficiaries, and providers. The benefits of this work are already being realized. Moving Medicare pricing software to a modern language on modern infrastructure has resulted in the ability to make changes at least twice as fast, demonstrating that modern technology, systems architecture, and software management processes will result in reduced costs in the long-run.

Modernization efforts focus on migrating software to the cloud, converting older computer languages such as COBOL into modern ones, such as Java, and implementing Application Programming Interfaces (APIs) that allow for easy, flexible access to data and system functionality. In addition, CMS is modernizing contracting and change management processes in order to fully realize the benefits that modern technology offers.

Through research and strategic design, CMS is laying out a vision of reusable and constantly available services that provide critical information for processing original Medicare claims and payments, such as provider data, beneficiary data, and quality measures while supporting new ways of paying for care that the Innovation Center develops. CMS will modernize strategic pieces of the Fee for Service (FFS) systems, fully integrating them with other modernized and legacy systems, to ensure continued delivery of speed and reliability as the nation's top health insurance payer. Relying on informed research, CMS will also prototype solutions where appropriate to ensure viability and intended outcomes before significant financial investments are made. Along the way, CMS will implement additional APIs that will continue to help increase efficiency of our Medicare Administrative Contractors. These contractors not only process claims, but also serve as Medicare's operational contact for providers enrolled in the program. While modernizing, CMS will look towards transparency and data availability that will give providers, beneficiaries, and health policy experts the information they need when they need it.

This funding will allow CMS to continue meeting existing contractual obligations, including: AWS infrastructure and other necessary environments; the Strategic Design (Human Centered Design (HCD)) contract, which enables us to make informed decisions on modernization opportunities; Application Development Organizations (ADOs) in place to perform development, site reliability, and security; and the introduction and maintenance of new software/technical tools. In addition, funding will allow us to accelerate the transformation of our older and more rigid change management and development processes by introducing agile principles and methods. These foundational changes will allow the agency to take full advantage of modernized infrastructure and software.

Continuity of Operations Disaster Recovery (COOP/DR) ($30.0 million): CMS continues to revitalize the agency-wide COOP and DR programs following audit findings in 2019 that determined the programs and systems that support CMS mission-essential functions require increased capabilities to meet federal requirements. CMS made major investments in DR in FY 2020 and FY 2021, which we expect to continue our significant progress leading into FY 2022 with closing recovery gaps and technology improvements. The CMS COOP program continues to make progress on preparedness and will implement a tool to automate the Business Process and Business Impact Analysis cycle in FY 2022. This effort will reduce the time needed to validate the CMS mission essential functions and update federally mandated plans. CMS will also implement an Emergency Operations Center platform to provide centralized enterprise information to collect, analyze, and share critical information as dictated by emergency situations.

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

IT Funding by Category	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Medicare Parts A & B	$181,213	$245,763	$273,783	$28,020
Medicare Parts C & D	$98,708	$91,841	$81,480	($10,361)
Medicare Outreach & Education	$57,035	$53,336	$54,688	$1,352
Medicaid and the Children's Health Insurance Program	$77,722	$80,602	$106,910	$26,308
Federal Marketplace	$550,398	$648,432	$583,319	($65,113)
Health Care Quality	$391,700	$336,589	$331,192	($5,397)
Enterprise IT	$1,637,304	$1,536,802	$1,566,073	$29,271
Total IT Portfolio	**$2,994,080**	**$2,993,365**	**$2,997,445**	**$4,080**

Medicare Parts A & B

Medicare Parts A & B investments support the Fee-For-Service (FFS) and durable medical equipment (DME) claims processing operations. For these activities, CMS acts as a traditional insurance company by verifying beneficiary eligibility, enrolling providers and suppliers, and processing and paying out claims. Additionally, CMS administers a number of incentive payment programs that reward eligible providers for improving quality, reducing unnecessary resource utilization, and adopting new technologies.

Funding Level: $273.8 million

The FY 2022 President's Budget request for Medicare Parts A and B investments is $273.8 million, an increase of $28.0 million above the FY 2021 Enacted level. The increase in funding supports enhanced testing for all unified modular testing for the Medicare Integrated Systems Testing (MIST). Currently, CMS does modular integrated testing (MIT), which solely focuses on modernization testing and the Single Testing Contract (STC). The STC solely focuses on FFS legacy system changes. MIST is a next-generation type testing that shifts from independent testing to integrated testing for both types of these changes. Funding increases will also support system maintenance and enhancements to the Common Working File.

Beneficiary Enrollment: CMS processes Medicare beneficiary enrollment and defines eligibility status. CMS works in coordination with the Social Security Administration (SSA) to verify eligibility, effectuate enrollment, and ensure that premiums are collected. CMS also works with the Railroad Retirement Board (RRB) to manage beneficiaries who receive assistance through those programs. These operations ensure consistent information on enrollment status, including whether premium payments are up-to-date, and that CMS makes appropriate claims payments.

- *Medicare Beneficiary Enrollment Data Management Systems* – These systems provide the authoritative source for Medicare beneficiary eligibility and enrollment status, ensuring that only claims for valid beneficiaries are paid. CMS manages the billing and collection of premiums for both beneficiaries and third party payers. In coordination with investments in *Beneficiary Enrollment and Plan Payment for Part C & D,* CMS ensures beneficiaries are appropriately enrolled in the various types of insurance coverage offered by the agency.

Provider Enrollment: These investments allow providers and suppliers to enroll in Medicare by verifying their eligibility to participate. In addition, they support collecting required information, establishing billing relationships, and screening providers to flag potential fraudulent actors.

- *Interoperability & Standardization - Provider Enrollment Chain and Ownership System (PECOS)* – Provides the authoritative national repository of all enrolled Medicare and Medicaid providers and suppliers. Entities providing payment under Medicare are required to verify provider participation before issuing payment. This PECOS investment includes collecting and maintaining data on initial enrollment, changes of information, reassignments, and mandated revalidations or re-enrollments. CMS collects information about ownership, authorized officials, delegated officials, managing employees, practice locations, practice types, and affiliated provider information.

- *Advanced Provider Screening* – Aggregates data from multiple sources to conduct pre- and post-enrollment provider screening. This investment provides the ability to both prospectively and retrospectively assess program eligibility criteria, as well as provide additional data to further assess provider eligibility in Medicare and Medicaid, such as automatically running criminal background checks. By flagging potentially ineligible providers, CMS can take appropriate action to eliminate a potential source of fraud, waste, and abuse.

Claims Processing: Medicare FFS relies on multiple IT investments running on an integrated infrastructure to successfully process and pay claims. Claims processing includes investments that support processing appeals and ensures that Medicare is the most appropriate payer. CMS conducts extensive testing to ensure this suite of investments operates efficiently and effectively.

- *Medicare Shared Systems (MSS)* – Supports a common environment for operating legacy claims processing systems for inpatient hospital services, outpatient services, and DME. A single data source with full individual beneficiary information allows contractors to verify beneficiary eligibility, conduct pre-payment review, and approve claims. These investments support the receipt of claims, editing, pricing, adjudication, correspondence, on-line inquiry, file maintenance, financial processing, and reporting. This investment captures the Certificate of Medical Necessity and supplier interfaces specific to DME claims. Claims are screened through the Fraud Prevention System (FPS) to identify potential waste, fraud, or abuse.

- *HIPAA Eligibility Transaction System (HETS)* – Allows providers to check beneficiary eligibility for Medicare Part A and B services using HIPAA-compliant

Accredited Standards Committee (ASC) X12 transactions. HETS processes close to 1.5 billion transactions per year.

- *Medicare Appeals System (MAS)* – Provides a unified appeals case-tracking system that facilitates maintenance and transfer of case-specific data with regard to FFS and Managed Care appeals. MAS is capable of docketing hearings, scheduling expert witnesses for testimony, compiling case notes, and facilitating adjudication. In addition, MAS provides the capability to report on appeals data, enabling more accurate and expedient reporting and allowing for more precise assessments and policy setting.

- *Medicare Secondary Payer System (MSPS)* – Ensures proper benefits coordination and payment recovery when Medicare is not the primary payer. MSPS collects and processes data from other insurers and employers, allowing CMS to make more accurate primary and secondary payment decisions.

- *Fraud Prevention System (FPS)* – Provides state-of-the-art analytical tools to help predict and prevent potentially wasteful, abusive, or fraudulent payments before they occur. Before Medicare fee-for-service claims are approved for payment, they are processed through FPS to identify high-risk claims for further review. Proven predictive models are used in risk scoring to generate alerts and triangulate the results to identify high-risk claims and providers.

Incentive Payment Programs: Providers and some suppliers can be eligible for payment adjustments based on participation in a variety of incentive programs. The most significant change to these programs in recent years is the Quality Payment Program (QPP), which replaced the previous physician incentive programs with a two-track system designed to modernize provider quality reporting and encourage participation in Alternative Payment Models (APMs).

- *Quality Payment Program (QPP)* – Includes two tracks for clinicians under Medicare, one through the Merit-based Incentive Payment System (MIPS), which adjusts clinicians' payment based on performance on cost, quality, improvement activities, promoting interoperability, and through participation in Advanced APMs. Clinicians who reach a certain level of participation in Advanced APMs are eligible for a 5 percent incentive payment from 2019 through 2024 and a higher payment update under the Medicare physician fee schedule starting in 2026. Implementing the QPP involves a significant investment to develop a single reporting portal that will allow participating clinicians to better understand the program, submit data, and review their information.

- *Hospital Quality Reporting (HQR) System* – Supports the collection and analysis of quality measures from participating hospitals in order to make appropriate payment adjustments based on performance.

- *Accountable Care Organizations (ACOs)* – Support the Medicare Shared Savings Program by providing ACO eligibility verification and beneficiary assignment, and by calculating annual expenditures, performance and quality scores, and shared savings.

- *End Stage Renal Disease (ESRD) Quality Reporting System* – Provides a comprehensive ESRD patient registry that tracks services provided to ESRD beneficiaries for calculating performance-based payments.

Medicare Parts C and D

Medicare beneficiaries have the option of purchasing prescription drug coverage or combining some or all of their coverage options through private issuers. Prescription drug coverage (Part D) and Medicare Advantage (Part C) have different operational profiles and present different challenges than Parts A and B. Instead of interacting with and paying providers through the claims process, CMS interacts and pays private issuers through specifically designed IT systems. Business processes and IT systems are designed to manage beneficiary enrollment, ensure issuer compliance with benefit design parameters, manage special benefits, and balance risk across issuers.

Funding Level: $81.5 Million

The FY 2022 President's budget request for Medicare Part C and D IT investments is $81.5 million, a decrease of $10.3 million below the FY 2021 Enacted level. The decrease in funding is attributed to finding efficiencies in cloud migration, specifically for the Risk Adjustment Suite of Systems (RASS) and the Medicare Advantage Prescription Drug System (MARx). This funding also continues to support the Agency's mission of serving beneficiaries through the investments listed below:

Beneficiary and Plan Management: Ensures that beneficiaries are able to enroll in Part C and D coverage. CMS works extensively with private issuers to review their plans, collect data, and ensure proper payment.

- *Beneficiary Enrollment and Plan Payment for Parts C and D* – Delivers enrollment and health plan payment for approximately 48.6 million Parts C and D enrollees. This investment is dependent upon certain beneficiary demographic and entitlement data in the *Medicare Beneficiary Enrollment Data Management* systems. CMS maintains, updates, tests, and monitors system operations for enrollment and payment functions, and provides technical assistance and customer service associated with audits and compliance.

- *Health Plan Management System (HPMS)* – HPMS is a web-enabled information system that supports the business operations of the Medicare Advantage (MA) and Prescription Drug (Part D) programs. Over 70 software modules collect data for and manage the MA and Part D program lifecycle. Funding for this system supports: application submission, formulary submission, bid and benefit package submissions, marketing material review, Part D drug pricing and pharmacy network submission, program audits and compliance oversight, performance monitoring, fraud, waste, and abuse tracking and reporting, improper payments, plan surveys, beneficiary complaint tracking, and data support for the Medicare & You handbook, Medicare Plan Finder, and Online Enrollment Center. HPMS also houses the Plan Management Dashboard, a visual platform that organizes HPMS data and presents key performance indicators for plan compliance, fiscal soundness, marketing, contract performance, enrollment operations, and account management.

Drug Subsidies: Many Medicare beneficiaries enrolled in Part D are entitled to discounts and rebates through various programs. These investments ensure that beneficiaries receive the correct discounts and support enrollees in managing out-of-pocket expenses.

- *Drug Claims Processing System (DCPS)* – Collects, processes, and stores data from Part D claims to ensure the appropriate payment of covered drugs. Records are submitted electronically on a monthly basis and validated through automatic and manual edits. The claims are used during the payment reconciliation process in order to compare actual expenditures, including discounts for applicable drugs provided at the point-of-sale, to prospective payments made during the year. CMS coordinates the collection of discount payments from manufacturers and participating issuers.

- *Coordination of Benefits/True Out-of-Pocket (TrOOP)* – Provides real-time primary and secondary coverage information to pharmacies and Part D plans via pharmacy industry telecommunications systems. This investment provides eligibility and coverage information to pharmacies to enable real-time billing, and routes information on payments made by secondary payers back to the Part D plans.

Risk Adjustment: Ensures that each Medicare private plan issuer's risk is adjusted based on the medical experiences of individuals enrolled in their plans. Risk adjustment ensures that participating plans are not incentivized to select for healthier enrollees by transferring premiums from low to high-risk issuers.

- *Risk Adjustment Data Collection* – Calculates the risk scores for over 60 million beneficiaries. Multiple risk adjustment factors are created by analyzing the diagnosis history for each beneficiary and using statistical models to adjust the risk experienced by each Part C & D plan. The risk factors are provided to HPMS for initial, mid-year, and final reconciliation payments, as well as reruns of prior years to process overpayments.

- *Encounter Data System* – Collects beneficiary level, per-visit health care encounter data from participating issuers to enable calculation of risk coefficients that accurately reflect the demographics, patterns of care, and the predicted costs of diseases for Part C enrollees.

- *Central Data Abstraction Tool (CDAT)* – Collects diagnosis information from participating issuers to support the risk adjustment data validation (RADV) audits. CMS uses the results of these audits to estimate and recover overpayments.

Medicare Outreach & Education

Medicare Outreach and Education IT systems support the National Medicare Education Program (NMEP). Beneficiary e-Services creates a virtual, enterprise-wide, multi-contact channel for handling beneficiaries' inquiries that maximizes resources and service effectiveness. These systems support medicare.gov and cms.gov websites.

Funding Level: $54.7 Million

The FY 2022 President's Budget request for Medicare Outreach and Education is $54.7 million, an increase of $1.3 million above the FY 2021 Enacted level. The increase in funding is for periodic system maintenance of HIPPA support systems.

- *Beneficiary e-Services* – Provides a virtual, enterprise-wide, one-stop service for handling Medicare beneficiary inquiries from multiple channels to meet the unique needs of our beneficiary population. Beneficiaries can contact CMS through beneficiary websites and portals, such as medicare.gov and 1-800 MEDICARE, that handle phone, written, and email communications. Using the Next Generation Desktop application, these processes can access CMS data systems to answer Medicare inquiries on enrollment, claims, health care options, preventive services, and prescription drug benefits. The websites offer beneficiaries interactive tools like Medicare Plan Finder and Care Compare, as well as personalized information, such as enrollment, preventive services, claims, and prescription drugs. 1-800 MEDICARE uses an interactive voice response system to provide beneficiaries with automated self-service information and options. Based on selections made, if the automated system cannot solve the caller's request, they are routed to the next available and best-qualified customer service agent to resolve their inquiry.

- *Medicare and Medicaid Financial Alignment* – Supports the implementation of State programs to integrate care for individuals enrolled in both Medicare and Medicaid. This investment focuses on technical assistance to the States who are engaged in this effort by creating and providing necessary Medicare data files, as well as guidance on the request process and the use of Medicare data.

Medicaid and the Children's Health Insurance Program (CHIP)

CMS serves as the operational and policy center for the formulation, coordination, and evaluation of national policies and operations for Medicaid and CHIP. Investments in data infrastructure and systems ensure an accurate, current, and comprehensive database containing standardized enrollment, eligibility, and paid claims. This data is used to produce statistical reports, support research, and assist in the detection of fraud, waste and abuse.

Funding Level: $106.9 million

The FY 2022 President's Budget request for Medicaid and CHIP IT is $106.9 million, a $26.3 million increase from the FY 2021 Enacted level. The increase in funding supports the MACBIS data system integrator through enhancing digital services and adopting an enterprise wide approach for data management, data governance, and data architecture

and data operations. The increase also supports the transition of systems such as MACFin to the cloud environment while continuing to operate in the legacy environment.

- *Medicaid and CHIP Business Information Solutions (MACBIS)* – Provides the data infrastructure and environment to facilitate collection of State-level programmatic claims data, including managed care options, beneficiary, and provider data. MACBIS automates the State plan approval process by collecting programmatic data on State Medicaid and CHIP operations. State plans support evaluation activities and ensure States remain in compliance with policies or waivers. Further, the investment supports a data analytics infrastructure for operational data about recipients, providers, claims, and encounters. This allows the States and CMS to better identify fraudulent activities and to integrate data across programs.

  There are four major information technology upgrades under MACBIS. First, the request supports ongoing operations and maintenance of the Transformed Medicaid Statistical Information System (TMSIS). Both GAO and the HHS OIG have identified the availability of quality claims and encounter data through TMSIS as a necessity of auditing and investigations and is a top priority for the Medicaid program. Second, the request supports completion of the Medicaid drug rebate system rebuild, which is critical for adequate oversight of the Medicaid drug rebate program. Third, the request supports continued work to replace the aging Medicaid financial system that tracks state financial reporting and administrative spending. And finally, the request will support the rollout of additional authorities in the Medicaid and CHIP Program (MACPro) system, which is a state-facing portal to capture states' submissions of state plan amendments, waivers, quality measures, advanced planning documents, and other documents. These MACBIS systems will give users improved access to data quality tools for analysis and evaluation for more informed decision making; allow for easier identification of priority, missing, and anomalous data; and enhance internal and external program monitoring and oversight.

- *Medicaid Data Information System* – Provides comprehensive data warehouse services with standardized enrollment, eligibility, and paid claims of dual-eligible, Medicare-Medicaid beneficiaries.

Federal Marketplace

CMS is responsible for operating the Federally-facilitated Marketplace (FFM) in States that do not elect to set up their own State-based Marketplace. The FFM enables individuals to compare health plan options, receive eligibility determinations for a number of health insurance programs, obtain financial assistance with premiums and cost-sharing, and shop and compare health insurance plans. As enumerated below, some of these platforms support activities beyond the Marketplace, to include risk adjustment, rate review, and MLR.

Funding Level: $583.3 million

The FY 2022 President's Budget request for Federal Marketplace IT is $583.3 million, a decrease of $65.1 million below the FY 2021 Enacted level. CMS continues to discover improved methods to reduce costs and increase operational efficiencies such as cloud implementation and data conversion management.

The funding supports:

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

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

- *Multidimensional Insurance Data Analytics System (MIDAS)* – Provides a central repository for capturing, organizing, and aggregating data for the Marketplaces.

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

- *HealthCare.gov Web Portal* – Allows individuals to search and compare health insurance plans, enroll in coverage, receive financial assistance determinations, upload documents, and submit appeals.

Health Care Quality

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

Funding Level: $331.2 million

The FY 2022 President's Budget request for Health Care Quality IT is $331.2 million, a decrease of $5.4 million below the FY 2021 Enacted level. The FY 2022 funding level will continue the development and hosting of the iQIES system supported by Amazon Web Services (AWS). The funding will also support the infrastructure, enterprise services and project management contracts to implement the QMARS system in 2022.

- *Health Care Quality Improvement and Evaluation System (QIES)* – QIES is the key source of CMS quality data, aggregating data from State Survey Agencies, Federal contractors, and QIOs to support research, analysis, and beneficiary information, such as the Nursing Home, Home Health, and Hospital Compare websites.

- *iQIES* –The iQIES system is the clinical umbrella web-based solution that has replaced a subset of legacy QIES systems. QIES is a single application that has three major capabilities that support Patient Assessments (PA), Survey and Certifications (S&C), and Reporting. Providers can either log onto iQIES and submit their data submissions or access a web-based application for assessment record submission.

- *Quality Management and Review System (QMARS)* - QMARS is the system of record that the Beneficiary & Family Centered Care (BFCC) use to review and resolve all

case review types including beneficiary complaints and appeals.

- *Quality Enterprise Services* – Provides a common architecture and system for the submission, parsing, staging, and processing of data from multiple quality programs to allow for streamlined measure reporting and calculation.

- *Quality Improvement Organizations (QIO) Information Systems* – Supports collaboration within the QIO community, coordination between CMS and the QIOs, and data collection to support operational analytics to improve the quality of care nationwide.

- *Innovation Core Systems* – Provides core IT systems that support models and demonstrations to manage their specific needs. Investments support a variety of activities, including beneficiary and provider enrollment, managing data collection, conducting analysis, and assisting in model evaluations.

Enterprise Information Technology

Enterprise IT encompasses investments, which span multiple program areas or provide CMS-wide services. Examples of enterprise-wide investments are those associated with dual-eligible, Medicare-Medicaid beneficiaries, as well as program integrity activities that integrate data from across CMS to identify bad actors. Other investments focus on providing CMS-wide support and solutions to ensure operating and security standards are applied across CMS. These activities achieve economies of scale and allow business owners to reuse existing processes to reduce cost.

Funding Level: $1,566.0 Million

The FY 2022 President's Budget request for Enterprise IT is $1,566.0 million, an increase of $29.3 million above the FY 2021 Enacted level. The FY 2022 request will continue ongoing IT operations, including making necessary investments in existing systems that support the effectiveness and efficiency of CMS operations. These activities provide the operational support to manage CMS's data environment for mission-critical and enterprise-wide CMS IT strategies. These solutions continue to maximize operational efficiencies through IT modernization and cloud migration.

In FY 2022, increased funding is needed to run the IDR in unison in the Baltimore Data Center and the Amazon Web Services (AWS) Cloud, until the IDR is stabilized and secured in the cloud environment.

This funding also supports necessary investments in existing systems, such as upgrades to key data centers and enterprise-wide software licenses. CMS will continue making these functional enhancements designed to optimize user interfaces, while facilitating improved compliance.

Healthcare Integrated General Ledger Accounting System (HIGLAS): Provides a centralized and integrated dual-entry accounting system that standardizes financial accounting functions for all CMS programs.

Infrastructure and Data Management: Supports core IT infrastructure and data management for use across CMS.

- *IT Infrastructure Ongoing Operations* – Provides vital infrastructure and services to CMS employees, researchers, contractors, and beneficiaries, including unified voice, video, and data technologies. This category of investments also supports overall management of data center resources by providing single, virtual entry for accessing hosting and technology offerings, such as private cloud technologies, standardization of architecture, and service management. Other activities in this category include supporting day-to-day operations of the mainframe, network, voice, and data communications, as well as backup and disaster recovery of mission critical applications. This investment provides an enterprise approach for managing information security and privacy, and supports the Large Scale Data Repository (LSDR), allowing for a robust, stable, and effective data repository environment.

- *Information Management and Analysis* – Supports data lifecycle management by providing guidance and technical assistance in the development, maintenance, administration, and enforcement of data asset reuse and metadata standards for over 820 databases. This investment also assures system performance, data availability, communication, and disaster recovery capabilities. Additionally, it supports coding changes and technical support for ongoing operations of legacy COBOL-based systems.

- *Systems Security* – Ensures that IT systems and data are adequately protected and meet IT security requirements. This investment includes required security control assessments and necessary employee security trainings, and also ensures that the Medicare Administrative Contractor (MACs) meet security requirements. Systems security investments also provide a full-time, enterprise cyber risk management program to maintain situational awareness of cyber threats and enables leadership to make informed decisions.

- *Integrated Data Repository (IDR)* – Provides a multi-view data warehouse orientation that is capable of integrating data on beneficiaries, providers, health plans, claims, and prescriptions, without relying on voluminous raw data extracts. The IDR provides a scalable system to meet current and expanding data volumes.

- *Chronic Condition Warehouse (CCW)* – Provides a centralized research database that combines Medicare, Medicaid, and Part D Prescription Drug Event data for individuals with chronic conditions readily available to support research activities. The CCW contains data dating back to 1999 for Medicare FFS, eligibility and enrollment, and assessments. The data is linked by a unique, unidentifiable beneficiary key, which allows researchers to analyze information across the continuum of care.

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

- *Enterprise Identity Management (EIDM)* – Ensures individuals have secure, authorized access to CMS business applications by providing a single point of entry and conducting remote identity proofing to confirm individual identities.
- *Master Data Management (MDM)* – This master directory provides a common identifier, which allows CMS to link and aggregate beneficiary, provider, program, and organization data from contrasting sources to create a trusted and authoritative data source. MDM is available to other investments, business processes, and applications, ensuring consistent display across CMS.

- *Enterprise Portal* – Provides a common portal for beneficiaries, providers, organizations, and States to access information and applications based on their roles and permissions. The portal combines and displays content and forms from multiple applications, and supports users with easy navigation, cross-enterprise search tools, simplified sign-on, and personalized, role-based access.

Crosscutting Program Integrity: Supports CMS-wide efforts to combat waste, fraud, and abuse by linking data across CMS programs via comprehensive and integrated investments that allow for better analysis and identification of bad actors.

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

- *Open Payments* – Collects information on payments from drug and device companies to physicians and teaching hospitals for things like travel, research, gifts, speaking fees, and meals. This includes ownership interests of physicians or their immediate family members in these companies. Applicable manufacturers and Group Purchasing Organizations are required to report on an annual basis. The data is publicly available in an easy to use, searchable, and downloadable format.

- *Healthcare Fraud Prevention Partnership (HFPP)* – Provides an opportunity for private and public payers to collaborate on health care fraud identification and prevention activities.

- *One Program Integrity (One PI)* – Provides an integrated data warehouse, which enables state Medicaid data to be combined with claims data from Medicare Parts A, B, and D. This allows for improved analytics to detect fraud, waste, and abuse activities across multiple Medicare programs.

- *The Unified Case Management System* – Serves as a central repository for contractor workload reporting, dashboards to monitor progress, and outcome measure calculations. This investment strategically positions CMS for a coordinated approach to Medicare and Medicaid audits and investigations.

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Federal Marketplaces
(Dollars in Thousands)

Treasury Account	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Program Management	$1,618,091	$1,859,609	$1,711,419	($148,190)
Discretionary Appropriation	$261,226	$158,076	$175,448	*$17,372*
Program Operations (non-add)	*$226,035*	*$135,140*	*$152,512*	*$17,372*
Federal Administration (non-add)	*$35,191*	*$22,936*	*$22,936*	*$0*
Offsetting Collections[1]	$1,335,768	$1,680,413	$1,514,851	($165,562)
Federally-facilitated Marketplace User Fee (non-add)	*$1,310,948*	*$1,626,741*	*$1,464,003*	*($162,738)*
Risk Adjustment User Fee (non-add)	*$24,820*	*$53,672*	*$50,848*	*($2,824)*
Other	$21,097	$21,120	$21,120	$0
Heath Care Fraud and Abuse Control	$47,684	$36,838	$38,580	$1,742
Discretionary Appropriation	$47,684	$36,838	$38,580	$1,742
Total Program Level	**$1,665,775**	**$1,896,447**	**$1,749,999**	**($146,448)**

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

Allocation Method – Direct, Contracts, and Competitive Grants

Program Descriptions and Accomplishments

The primary goal of the Affordable Care Act (ACA) is to ensure that people in every state have access to quality, affordable health care coverage and a fully functional Marketplace in which to purchase such coverage. The ACA gives states the option of establishing a Health Insurance Marketplace®. The Marketplace must facilitate the purchase of qualified health plans (QHPs) and meet other requirements specified in 1311(d) of the ACA. CMS operates a Federally-facilitated Marketplace (FFM) or State-Based Marketplace – Federal Platform (SBM-FP) in those states that elect not to pursue a State-based Marketplace (SBM). SBMs, together with FFM and SBM-FP states, have played a critical role in the Affordable Care Act's success in enabling people to enroll in affordable, high quality private health insurance plans.

Marketplaces provide millions of Americans access to affordable health insurance coverage. Since October 1, 2013, Marketplaces have helped individuals and small employers better understand their insurance options by assisting them in shopping for, selecting, and enrolling in high-quality, competitively-priced private health insurance plans.

[1] The user fee levels reflect updated estimates that are not reflected in the HHS Budget Appendix.

The Marketplaces also facilitate receipt of tax credits to offset premium costs for insurance, provide cost-sharing assistance to individuals, and help eligible individuals enroll in other federal or state insurance affordability programs. By providing one-stop shopping, Marketplaces make purchasing health insurance more understandable, giving individuals and small businesses access to increased options for, and control over, their health insurance.

CMS has worked with States and other stakeholders of interest to stabilize premiums for health plans offered on the FFM and bring more insurers back into the individual market. In the 2021 Open Enrollment Period, 8.3 million individuals selected plans in the FFM. Most recently, CMS launched a COVID-19 Special Enrollment Period (SEP) and implemented the first affordability provisions of the American Rescue Plan. As of May 11, 2021, over 1 million additional Americans have signed up for health insurance in the FFM and an additional 2 million individuals returned to the FFM to obtain improved benefits, both in terms of reduced premiums and more affordable cost sharing.

The successful full-scale implementation of Enhanced Direct Enrollment (EDE) over the past two and a half years has yielded outstanding results for the FFM. During the 2021 OEP, the EDE pathway more than doubled the number of plan selections from the prior OEP through these pathways—increasing from 521,000 to 1,130,000 plan selections. Direct Enrollment (DE) pathways as a whole, (including both Classic DE and EDE) saw dramatically greater utilization during the 2021 OEP, increasing from 29 percent of active 2020 plan selections to 37 percent for 2021.

In FY 2022, CMS will continue to conduct the following core responsibilities on behalf of all Marketplaces:

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

If a State elects to use the FFM, CMS will oversee these additional functions:

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

As a High Impact Service Provider (HISP), the Marketplace will continue to drive customer experience improvements by leveraging ongoing Marketplace consumer research, gathering feedback through surveys measuring customer satisfaction, and using research and feedback to identify opportunities to iteratively enhance consumer experience with Program services while leveraging human-centered design best practices.

Funding History

Fiscal Year	Program Level
FY 2018	$1,948,818,000
FY 2019	$1,635,054,000
FY 2020	$1,665,775,000
FY 2021 Enacted	$1,896,447,000
FY 2022 President's Budget	$1,749,999,000

Budget Request

The FY 2022 Budget request for FFM activities is $1,749.9 million at the program level, of which $1,711.4 million is funded from several Program Management funding sources and $38.6 million from the discretionary Health Care Fraud and Abuse Control (HCFAC) appropriation.

- *Health Plan Bid Review, Management, and Oversight:* $53.6 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, and providing technical assistance to issuers on certification requirements and certifies agents and brokers to participate in the FFM. CMS supports over 4,200 QHPs and nearly 1,700 SADPs each year.

- *Payment and Financial Management:* $52.7 million. States and issuers supply a range of enrollment, premium, and claims data for calculating financial payments across multiple Marketplace activities using the Health Insurance Oversight System (HIOS). Marketplace-related payments leverage CMS' Healthcare Integrated General Ledger Accounting System and financial management processes such as reporting and debt management.

  Each month, CMS receives enrollment information from issuers and Marketplaces and then calculates and pays the amount of APTC owed to issuers. The IRS reconciles APTC when the individual or family files a tax return.

  The Risk Adjustment program balances the risk pool of compliant plans in the individual and small group markets by transferring premium revenue from plans with below-average actuarial risk to plans with above-average actuarial risk within a market within a state. The Risk Adjustment Data Validation (RADV) program conducts reviews and audits of data that was used to calculate risk adjustment transfers. This funding supports the RADV program, through which CMS is working to strengthen financial oversight, by improving the accuracy and scope of these RADV medical records-based reviews.

- *Eligibility and Enrollment:* $379.4 million. This activity allows individuals to submit applications for health coverage during Open Enrollment throughout the year, and with Special Enrollment Periods (SEPs). Electronic applications are processed through HealthCare.gov where eligibility for financial assistance are verified through the Data Services Hub.

When consumer-provided information does not match electronic data sources, data match inconsistencies are generated. CMS reviews consumer-submitted supporting documentation to resolve the issue. Consumers have the opportunity to appeal determinations for financial assistance and SEP eligibility. Appeal activities include processing incoming documents, reviewing appeal requests and supporting documentation, requesting information and documents from appellants, and general case management.

CMS works with issuers to reconcile enrollment, resolving discrepancies identified through analytics or by issuers themselves. This process ensures only individuals and families who pay their monthly premium remain enrolled in coverage and that issuers receive the appropriate amount of financial assistance payments.

- *Consumer Information and Outreach:* $596.3 million. CMS ensures applicants and enrollees are fully supported not only during Open Enrollment, but throughout the plan year using mail, phone, digital communications, and HealthCare.gov. The consumer call center is the primary means for individuals to ask questions and get help with online tools, report life event changes and respond to Marketplace notices. The call center offers support in over 200 languages and is open 24 hours a day, 7 days a week. Outreach and education activities are critical to reach the uninsured and existing enrollees. Efforts focus on building awareness of the Marketplace, OEP dates and deadlines, coverage information and support, enrollment opportunities, and year-round consumer needs. Increased funding will enable the Marketplace to increase the reach and impact of education and outreach efforts for consumers.

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

  Year-round on the ground community-based support is available through Navigators that supply impartial information to individuals on eligibility applications and selecting a plan. Navigators conduct public education and outreach activities to raise awareness about the Marketplace, focused on harder-to-reach populations and the uninsured, and to meet the needs of underserved or vulnerable populations in order to promote health equity. Increased funding will result in a robust pool of eligible, experienced applicants, allowing CMS to comply with the statutory requirement of awarding at least one Navigator entity in each FFM state. This will also result in more consumers in more areas having access to year-round, one-on-one assistance to obtain and maintain health coverage.

- *Information Technology (IT):* $497.9 million. The Marketplace IT environment uses a cloud-based approach to support consumer facing websites, issuer facing electronic data exchanges, and back end systems. The IT infrastructure is designed to support peak volumes, while ensuring a smooth user experience. New technical architecture and software code is integrated into existing production environments using a comprehensive end-to-end testing methodology that ensures existing performance levels are maintained or improved. CMS administers a comprehensive IT security program that is designed to prevent and detect intrusions into the environments. The Marketplaces also leverage existing CMS Enterprise Shared Services. Major applications that support Marketplaces include:

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

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

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

- *HealthCare.gov Web Portal* – Allows individuals and families to learn about the Marketplace, complete an application, receive eligibility information including financial assistance determinations, search and compare plans, enroll in coverage, receive notices, upload documents, and manage their application and enrollment information year-round.

- *Small Business Health Option Program (SHOP):* $0.2 million. SHOPs provide small businesses, defined as those with fewer than 50 employees, with options for providing health insurance to their employees. CMS intends to continue to fund the operation of a toll-free telephone hotline to respond to requests for assistance related to the SHOP program in FY 2022.

- *Marketplace Quality:* $7.5 million. CMS provides quality rating information using a five-star rating scale based on clinical quality measures and an enrollee satisfaction survey to give individuals and families easy to compare quality metrics on QHPs. Each year, an overall quality rating and additional ratings for the three categories (Medical Care, Member Experience, Plan Administration), which comprise the overall rating, will be displayed during open enrollment to increase transparency and empower applicants to make informed health care decisions for themselves and their families.

- *Program Integrity:* $38.6 million. In coordination with efforts funded by the Health Care Fraud and Abuse Control account, this section includes work necessary to ensure program integrity in the Marketplaces. CMS is developing a methodology to measure and report estimated improper payments for APTC and will continue to strengthen oversight of State Marketplace operations. CMS will also continue to operate a consumer complaint call center, investigate complaints, and conduct investigations and data analytics using the FFM and other data sources. CMS operates focused fraud prevention efforts in areas that have high risk factors for enrollment fraud and provides oversight for agents and brokers to ensure they are in good standing with the state.

- *Planning and Performance:* $14.4 million. CMS supports general planning and oversight of Marketplace activities to ensure integration and coordination across CMS, with issuers, and Federal partners.

- *Administration:* $109.3 million. This funding supports staffing and administration expenses for work across the Federal Marketplace, State-based Marketplace, and payment programs.

Nonrecurring Expenses Fund
(Dollars in Thousands)

	FY 2020[1]	FY 2021[2]	FY 2022[3]
Notification[4]	--	$4,000	--

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

Program Description and Accomplishments

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

The FY 2021 NEF funds are planned to be used to right-size approximately 70,000 square feet of office space at CMS' 7111 Security Boulevard building, a leased non-main campus location. This effort (Phase 1A) is part of a larger project under way at CMS to consolidate the current real estate footprint. At the completion of this effort, CMS staff currently housed at 7210 Ambassador Road will relocate to 7111 Security Boulevard. Where possible, existing non-fixed furniture (e.g. - private office furniture, chairs, and conference room tables) will be relocated to 7111 Security Boulevard, reducing the overall need for this type of furniture. However, the purchase of new fixed furniture will be required to outfit the cubicles as well as some offices. Relocation of employees will allow CMS to terminate the 7210 Ambassador Road lease, reduce the overall CMS real estate footprint, and eliminate approximately $4.4 million in annual operating costs (security and rent).

Phase 1A Components (Dollars in Thousands)		
Renovations (demo/construction including electrical, HVAC and IT)	$	2,000
Replacing outdated furniture with new fixed GSA-approved items	$	1,800
Relocation	$	200
Total NEF	$	4,000

The Real Estate Consolidation (REC) project enables CMS to comply with the OMB Memorandum M-12-12 Section 3: Reduce the Footprint. This project is a priority as it enables CMS to comply with HHS, OMB, and GSA space utilization policies. These NEF funds will allow CMS to optimize and right-size the 7111 Security Boulevard office space to eliminate a more costly CMS non-federal lease and reduce CMS' footprint. The $4.0 million request is projected to support 100 percent of this portion of the REC project. This NEF Request is an estimate based on similar projects recently completed and will result in a fully usable product/completed Phase.

[1] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on July 20, 2020.
[2] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on October 22, 2020.
[3] HHS has not yet notified for FY 2022.
[4] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Drug Control Program
Department of Health and Human Services
Centers for Medicare & Medicaid Services (CMS)

(Dollars in millions except where indicated otherwise)

Resource Summary	FY 2020 Estimates	FY 2021 Estimates	FY 2022 Estimates
Drug Resources by Decision Unit and Function/Program			
Medicaid Treatment	$6,230.0	$6,870.0	$6,930.0
Total Decision Unit #1 Medicaid	**$6,230.0**	**$6,870.0**	**$6,930.0**
Medicare Treatment	$2,740.0	$2,920.0	$3,190.0
Total Decision Unit #2 Medicare	**$2,740.0**	**$2,920.0**	**$3,190.0**
Total Funding	**$8,970.0**	**$9,790.0**	**$10,120.0**
Drug Resources Personnel Summary			
Total FTEs (direct only)	--	--	--
Drug Resources as a Percent of Budget			
Total Agency Budget (in billions)[1]	$1,368.3	$1,407.1	$1,460.2
Drug Resources Percentage	0.7%	0.7%	0.7%

Program Summary

Mission

As an effective steward of public funds, the Centers for Medicare & Medicaid Services (CMS) is committed to strengthening and modernizing the nation's health care system to provide access to high quality care and improved health at a lower cost. Through its coverage of drug treatment services included within Medicare and Medicaid benefit payments, CMS helps support the goals of the Office of National Drug Control Policy (ONDCP) by providing substance use disorder (SUD) treatment to eligible beneficiaries.

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

Methodology

Medicaid
The projections provided in the above table were based on data from the Medicaid Analytic eXtract (MAX) for Fiscal Year (FY) 2007 through 2012, based on expenditures for claims with SUDs as a primary diagnosis. Managed care expenditures were estimated based on the ratio of SUD expenditures to all expenditures for fee-for-service by eligibility group. The estimates were trended forward to FY 2019 using the growth rate of expenditures by state and eligibility category from the form CMS-64**,** Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, MAX data, and estimates consistent with the FY 2022 President's Budget. The annual growth rates were adjusted by comparing the rate of SUD expenditure growth from FY 2007 through 2012 to all service expenditure growth and adjusting the growth rate proportionately.

Medicare
The projections of Medicare spending for the treatment of substance abuse are based on the FY 2022 President's Budget baseline. These projections reflect estimated Part A and Part B spending into FY 2022 and are based on an analysis of historical fee-for-service claims through 2019, using the primary diagnosis code[2] included on the claims. The historical trend is then used to make projections into FY 2022. These projections are very similar to those for the FY 2021 President's Budget and vary only due to changes in the baseline.

Within this methodology, an adjustment was made to reflect spending for beneficiaries who are enrolled in Medicare Advantage (MA) plans, since their actual claims are not available. It was assumed that the proportion of costs related to substance abuse treatment was similar for beneficiaries enrolled in MA plans as for those enrolled in fee-for-service Medicare.

These estimates do not include spending under Medicare Part D because there is not a straightforward way to get this information. There is no diagnosis code associated with prescription drug claims, and drugs used to treat SUD are often also used to treat other conditions.

Budget Summary

The total FY 2022 drug control outlay estimate for CMS is $10,120.0 million. This estimate reflects Medicaid and Medicare populations and an inflation to account for the MA plans population (excluding Part D) benefit outlays for SUD treatment. Overall, year-to-year projected growth in SUD spending is a function of estimated overall growth in Medicare and Medicaid spending.

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

Medicaid
FY 2022 outlay estimate: $6,930.0 million
(Reflects $60.0 million increase from FY 2021)

Medicaid is a means-tested health care entitlement program financed by the States and the Federal Government. Medicaid mandatory services include SUD services for detoxification and treatment for SUD needs identified as part of early and periodic screening, and diagnostic and treatment services for individuals under 21 years of age. Additional Medicaid SUD treatment services may be provided as optional services. The *Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act* also requires states to cover medication-assisted treatment (MAT) from FY 2020 – FY 2025.

Medicare
FY 2022 outlay estimate: $3,190.0 million
(Reflects $270.0 million increase from FY 2021)

Medicare provides coverage of hospital, physician, skilled nursing facility, home health care, and other medical care services, as well as prescription drug coverage, to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. Medicare benefits are permanently authorized. Medicare SUD treatment benefit payments are made by Medicare Part A and Medicare Part B. This benefit outlays total includes the estimated impact for services provided to beneficiaries enrolled in Medicare Advantage. As noted above, Medicare Part D prescription drug spending is not counted in these estimates.

Performance

Both Medicaid and Medicare contain quality measurement programs that relate to substance abuse screening and treatment. However, none of the programs require reporting of specific measures, nor do they set specific performance targets for the measures.

As one of the largest payers of healthcare services, CMS has a vital role in addressing the opioid epidemic within the Department of Health and Human Services (HHS). CMS is supporting HHS strategies by taking a number of steps to identify and stop inappropriate prescribing to help prevent the development of new cases of opioid use disorder (OUD) that originate from opioid prescriptions, while balancing the need for continued access to prescription opioids to support appropriate, individualized pain management.

CMS provides interactive online Opioid Prescribing Mapping Tools for Medicare Part D, which allows the public to search de-identified opioid prescription claims data at the state, county, and ZIP code levels, and Medicaid data at the state level. These tools allow users to see both the number and percentage of opioid claims, and helps users understand how this critical issue impacts communities nationwide.

Medicare Part B

In 2020, CMS implemented Section 2005 of the SUPPORT Act, which created a new Medicare benefit for OUD treatment services furnished by opioid treatment programs, including Medication-Assisted Treatment (MAT) with methadone. CMS implemented this benefit with flexibility for the delivery of OUD treatment counseling and therapy services

using two-way interactive audio-video communication technology as clinically appropriate. CMS also implemented new Medicare policies to expand treatment options for beneficiaries with OUD: a set of bundled episodes of care for management and counseling for OUD in a doctor's office that are payable under the Physician Fee Schedule.

Medicare Part D

CMS has incrementally adopted successful opioid policies in the Part D program to address opioid overutilization, while preventing the interruption of medically necessary drug therapy. Part D sponsors are now expected to implement improved opioid safety alerts at the point of service that alert a pharmacist of possible overutilization. CMS expects all Part D sponsors to limit initial opioid prescription fills for the treatment of acute pain to no more than a seven days' supply, consistent with the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain, to reduce the potential for chronic opioid misuse or abuse. CMS' Overutilization Monitoring System uses administrative data to identify potentially at-risk beneficiaries who meet certain clinical guidelines in quarterly reports to Part D plans. Part D plans may adopt drug management programs to address potential overutilization of frequently abused drugs by identified beneficiaries. If deemed necessary, a sponsor could limit at-risk beneficiaries' access to coverage for such drugs through pharmacy lock-in, prescriber lock-in, and/or a beneficiary-specific point-of-sale claim edit.

To increase access to MAT, which include a broad range of medications adjunctive to counseling and behavioral therapies to treat SUD; CMS requires that Medicare Part D formularies include covered Medicare Part D drugs used for MAT. In 2020, Part D plans had at least one MAT product on a non-branded tier.

Medicaid

The Federal Government establishes general guidelines for State Medicaid programs, while states have significant authority to design, implement and administer their own programs. CMS works to ensure that states have the tools they need and to share best practices to improve care for individuals with OUD. States have long been required to develop a Drug Utilization Review (DUR) program aimed, in part, at reducing inappropriate prescribing of outpatient prescription drugs covered under the State's Medicaid Program. The Medicaid DUR Program promotes patient safety through state-administered utilization management tools and systems that interface with the claims processing systems. In December 2020, CMS published the final regulation rule Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability Requirements (CMS 2482-F) which includes provisions to implement new minimum standards in state Medicaid DUR programs. Some of these provisions went into effect March 2021. In addition, pursuant to section 1010 of the SUPPORT Act, CMS has provided additional guidance to states seeking to promote non-opioid options for chronic pain management.

While Medicaid programs vary by state, all 50 states currently offer some form of MAT. To further expand coverage, Section 5022 of the SUPPORT Act makes behavioral health a mandatory benefit for children and pregnant women covered under the Children's Health Insurance Program, requiring that child health and pregnancy-related assistance include coverage of services necessary to prevent, diagnose, and treat SUDs. In addition, CMS issued guidance on best practices in Medicaid for covering MAT in a joint informational

bulletin with Substance Abuse and Mental Health Services Administration (SAMHSA), the CDC, and the National Institute on Drug Abuse.

CMS uses its demonstration authority under Section 1115 of the Social Security Act to provide a streamlined process for states interested in increasing access to the full continuum of care for beneficiaries with SUD. This opportunity allows coverage of services to Medicaid beneficiaries who are short-term residents in an institution for mental diseases, provided that coverage is part of a state's comprehensive OUD/SUD strategy. Over half of states have an approved SUD demonstration in place.

Models

Through the CMS Innovation Center's Maternal Opioid Misuse (MOM) Model, CMS awarded cooperative agreements designed to address fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with OUD. The primary goals of the model are to improve quality of care and reduce costs for pregnant and postpartum women with OUD and their infants. After an 18-month pre-implementation period, six states wil begin enrolling Medicaid beneficiaries on July 1, 2021. The remaining two will begin enrollment in January 2022. In addition, CMS entered into cooperative agreements with eight lead organizations and seven states for the Integrated Care for Kids (InCK) Model to support model planning and implementation. InCK aims to improve child health, reduce avoidable inpatient stays and out-of-home placement, and create sustainable payment models to coordinate physical and behavioral health care. The InCK model is still operating in the two-year pre-implementation period, which also began on January 1, 2020. Awardees are currently working to establish or modify any necessary Medicaid and Children's Health Insurance Program authorities, and develop the infrastructure and procedures necessary for model implementation across seven states. This includes data sharing, developing consents, screening tools, outreach strategies and stratification methods to begin serving beneficiaries on January 1, 2022.

In addition, CMS is implementing a new initiative, Value in Opioid Use Disorder Treatment (Value in Treatment). The Value in Treatment is a 4-year demonstration program authorized under section 1866F of the Social Security Act (Act), which was added by section 6042 of the SUPPORT Act. The purpose of the demonstration, as stated in the statute, is to "increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible, reduce [Medicare program expenditures]." The statute stipulates that a maximum of 20,000 applicable beneficiaries may participate in Value in Treatment at any given time, and makes available $10,000,000 from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Act available each of FYs 2021-2024 for care management fees and incentive payments under Value in Treatment. Specifically, as required by statute, Value in Treatment created two new payments for OUD treatment services furnished to applicable beneficiaries participating in the demonstration program: A per beneficiary per month care management fee and a performance-based incentive.

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

Object Class	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Direct Budget Authority			
Personnel compensation:			
Full-time permanent (11.1)	$ 514,675	$ 500,570	$ 566,639
Other than full-time permanent (11.3)	$ 10,910	$ 8,744	$ 8,831
Other personnel compensation (11.5)	$ 6,048	$ 8,850	$ 8,850
Military personnel (11.7)	$ 14,381	$ 14,095	$ 14,507
Special personnel services payments (11.8)	$ -	$ -	
Subtotal personnel compensation	**$ 546,014**	**$ 532,259**	**$ 598,827**
Civilian benefits (12.1)	$ 167,425	$ 184,686	$ 186,533
Military benefits (12.2)	$ 7,824	$ 7,616	$ 7,693
Benefits to former personnel (13.0)	$ -	$ -	
Subtotal Pay Costs	**$ 721,263**	**$ 724,561**	**$ 793,053**
Travel and transportation of persons (21.0)	$ 2,280	$ 5,282	$ 5,282
Transportation of things (22.0)			
Rental payments to GSA (23.1)	$ 5,100	$ 5,100	$ 5,100
Communication, utilities, and misc. charges (23.3)		$ -	
Printing and reproduction (24.0)	$ 3,513	$ 2,430	$ 2,430
Other Contractual Services:			
Advisory and assistance services (25.1)	$ -	$ -	$ -
Other services (25.2)	$ 2,020,033	$ 2,026,803	$ 2,208,720
Purchase of goods and services from government accounts (25.3)	$ 2,876	$ 2,492	$ 2,492
Operation and maintenance of facilities (25.4)		$ -	$ -
Research and Development Contracts (25.5)	$ 20,054	$ 20,054	$ 25,378
Medical care (25.6)	$ 1,199,183	$ 1,187,256	$ 1,272,622
Operation and maintenance of equipment (25.7)	$ -	$ -	$ -
Subsistence and support of persons (25.8)	$ -	$ -	$ -
Subtotal Other Contractual Services	**$ 3,242,146**	**$ 3,236,605**	**$ 3,509,212**
Supplies and materials (26.0)	$ 442	$ 766	$ 766
Equipment (31.0)	$ -	$ -	$ -
Land and Structures (32.0)	$ -	$ -	$ -
Investments and Loans (33.0)	$ -	$ -	$ -
Grants, subsidies, and contributions (41.0)	$ -	$ -	$ -
Interest and dividends (43.0)	$ -	$ -	$ -
Refunds (44.0)	$ -	$ -	$ -
Subtotal Non-Pay Costs	**$ 3,253,481**	**$ 3,250,183**	**$ 3,522,790**
Total Direct Budget Authority	**$ 3,974,744**	**$ 3,974,744**	**$ 4,315,843**
Average Cost per FTE			
Civilian FTEs	4,204	4,108	4,253
Civilian Average Salary	$ 165	$ 169	$ 179
Percent change	0%	2%	6%
Military FTEs	125	131	131
Military Average Salary	$ 178	$ 166	$ 169
Percent change	0%	-7%	2%
Total OPDIV FTEs	4,329	4,239	4,384
Total OPDIV Average Salary	$ 167	$ 171	$ 181
Percent change	0%	3%	6%

CMS Program Management
Salaries and Expenses
(Dollars in Thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$ 514,675	$ 500,570	$ 566,639
Other than full-time permanent (11.3)	$ 10,910	$ 8,744	$ 8,831
Other personnel compensation (11.5)	$ 6,048	$ 8,850	$ 8,850
Military personnel (11.7)	$ 14,381	$ 14,095	$ 14,507
Special personnel services payments (11.8)	$ -	$ -	$ -
Subtotal personnel compensation	**$ 546,014**	**$ 532,259**	**$ 598,827**
Civilian benefits (12.1)	$ 167,425	$ 184,686	$ 186,533
Military benefits (12.2)	$ 7,824	$ 7,616	$ 7,693
Benefits to former personnel (13.0)	$ -	$ -	$ -
Total Pay Costs	**$ 721,263**	**$ 724,561**	**$ 793,053**
Travel and transportation of persons (21.0)	$ 2,280	$ 5,282	$ 5,282
Transportation of things (22.0)	$ -	$ -	$ -
Rental payments to GSA (23.1)	$ 5,100	$ 5,100	$ 5,100
Rental payments to Others (23.2)	$ -	$ -	$ -
Communication, utilities, and misc. charges (23.3)	$ -	$ -	$ -
Printing and reproduction (24.0)	$ 3,513	$ 2,430	$ 2,430
Other Contractual Services:			
Advisory and assistance services (25.1)	$ -	$ -	$ -
Other services (25.2)	$ 2,020,033	$ 2,026,803	$ 2,208,720
Purchase of goods and services from government accounts (25.3)	$ 2,876	$ 2,492	$ 2,492
Operation and maintenance of facilities (25.4)	$ -	$ -	$ -
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Medical care (25.6)	$ 1,199,183	$ 1,187,256	$ 1,272,622
Operation and maintenance of equipment (25.7)	$ -	$ -	$ -
Subsistence and support of persons (25.8)	$ -	$ -	$ -
Subtotal Other Contractual Services	**$ 3,242,146**	**$ 3,236,605**	**$ 3,509,212**
Supplies and materials (26.0)	$ 442	$ 766	$ 766
Total Non-Pay Costs	**$ 3,253,481**	**$ 3,250,183**	**$ 3,522,790**
Total Salary and Expense	**$ 3,974,744**	**$ 3,974,744**	**$ 4,315,843**
Direct FTE	4,329	4,239	4,384

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2020 Actual Total	2021 Est. Total	2022 Est. Total
Office of the Administrator			
Direct FTEs	31	14	36
Reimbursable FTEs	1	0	0
Subtotal	32	14	36
Center for Clinical Standards and Quality			
Direct FTEs	424	430	434
Reimbursable FTEs	74	75	75
Subtotal	498	505	509
Center for Consumer Information and Insurance Oversight			
Direct FTEs	209	142	212
Reimbursable FTEs	191	274	274
Subtotal	400	416	486
Center for Medicaid and CHIP Services			
Direct FTEs	509	531	516
Reimbursable FTEs	0	0	0
Subtotal	509	531	516
Center for Medicare			
Direct FTEs	650	644	658
Reimbursable FTEs	6	6	6
Subtotal	656	650	664
Center for Medicare and Medicaid Innovation			
Direct FTEs	0	0	0
Reimbursable FTEs	0	0	0
Subtotal	0	0	0
Center for Program Integrity			
Direct FTEs	0	0	0
Reimbursable FTEs	31	30	31
Subtotal	31	30	31
Office of Acquisition & Grants Management			
Direct FTEs	149	150	151
Reimbursable FTEs	2	2	2
Subtotal	151	152	153
Office of the Actuary			
Direct FTEs	81	79	82
Reimbursable FTEs	0	0	0
Subtotal	81	79	82
Office of Communications			
Direct FTEs	199	215	201
Reimbursable FTEs	27	28	28
Subtotal	226	243	229
Office of Information Technology			
Direct FTEs	385	388	390
Reimbursable FTEs	4	4	4
Subtotal	389	392	394
Office of Equal Opportunity and Civil Rights			
Direct FTEs	28	26	28
Reimbursable FTEs	0	0	0
Subtotal	28	26	28
Federal Coordinated Health Care Office			
Direct FTEs	27	26	27
Reimbursable FTEs	0	0	0
Subtotal	27	26	27

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2020 Actual Total	2021 Est. Total	2022 Est. Total
Office of Financial Management			
Direct FTEs	226	202	229
Reimbursable FTEs	8	10	10
Subtotal	234	212	239
Office of Hearings and Inquiries			
Direct FTEs	120	117	122
Reimbursable FTEs	0	0	0
Subtotal	120	117	122
Office of Legislation			
Direct FTEs	53	52	54
Reimbursable FTEs	0	0	0
Subtotal	53	52	54
Digital Service at CMS			
Direct FTEs	5	9	5
Reimbursable FTEs	0	0	0
Subtotal	5	9	5
Office of Minority Health			
Direct FTEs	23	23	23
Reimbursable FTEs	0	0	0
Subtotal	23	23	23
Office of Human Capital			
Direct FTEs	159	159	161
Reimbursable FTEs	0	0	0
Subtotal	159	159	161
Office of Strategic Operations and Regulatory Affairs			
Direct FTEs	148	146	149
Reimbursable FTEs	4	4	4
Subtotal	152	150	153
Office of Enterprise Data and Analytics			
Direct FTEs	69	69	70
Reimbursable FTEs	0	0	0
Subtotal	69	69	70
Office off Burden Reductions & Health Informatics			
Direct FTEs	26	30	26
Reimbursable FTEs	0	0	0
Subtotal	26	30	26
Office of Program Operations & Local Engagement			
Direct FTEs	606	652	652
Reimbursable FTEs	15	25	25
Subtotal	621	677	677
Emergency Preparedness & Response Operations			
Direct FTEs	9	9	9
Reimbursable FTEs	15	0	29
Subtotal	24	9	38
Office of Security, Facilities and Logistics Operations			
Direct FTEs	88	87	89
Reimbursable FTEs	1	1	1
Subtotal	89	88	90
Office of Strategy, Performance, and Results			
Direct FTEs	31	36	32
Reimbursable FTEs	1	0	0
Subtotal	32	36	32
Total, CMS Program Management FTE 1/ 2/	**4,633**	**4,698**	**4,843**
Total, CMS Military Staffing - Disc. (Non-Add) 2/	*125*	*131*	*131*
Total, CMS Military Staffing - Reimbursable (Non-Add) 2/	*16*	*16*	*16*

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2020 Actual Total	2021 Est. Total	2022 Est. Total
American Recovery and Reinvestment Act (ARRA)	*49*	*40*	*35*
CMS Military Staffing - Direct	*0*	*0*	*0*
ACA Directly Appropriated	*11*	*15*	*15*
CMS Military Staffing - Direct	*1*	*1*	*1*
PAMA/IMPACT/MACRA	*49*	*5*	*5*
CMS Military Staffing - Direct	*8*	*5*	*5*
Total, CMS Program Management FTE	***118***	***66***	***61***

1/ FY 2020 reflects actual FTE consumption.

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

Average GS Grade

FY 2018	**13.4**
FY 2019	**13.4**
FY 2020	**13.7**
FY 2021	**13.7**
FY 2022	**13.7**

CMS Program Management
Detail of Positions
(Dollars in Thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Subtotal, EX	1	0	0
Total - Exec. Level Salary	$172	$172	$175
Subtotal	70	70	70
Total - ES Salaries	$13,343	$13,859	$14,056
GS-15	590	576	591
GS-14	604	590	605
GS-13	2,072	2,024	2,075
GS-12	562	549	563
GS-11	121	119	121
GS-10	0	0	0
GS-9	126	123	126
GS-8	1	1	1
GS-7	42	41	42
GS-6	2	2	2
GS-5	3	3	3
GS-4	9	9	9
GS-3	1	1	1
GS-2	0	0	0
GS-1	0	0	0
Subtotal 1/	4,133	4,038	4,138
Total - GS Salary 1/	$511,977	$495,282	$561,238
Average GS grade 1/	13.7	13.7	13.7
Average GS salary 1/	$123.875	$122.686	$134.203

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

CMS Program Management
Programs Proposed for Elimination

CMS has no programs proposed for elimination within the Program Management account.

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

Program	Section	FY 2012			FY 2013			FY 2014		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Health Insurance Consumer Information	1002		0			0			0	
Rate Review Grants	1003		0			0			0	
Pre-existing Condition Insurance Plan Program	1101		18			12			7	
Reinsurance for Early Retirees	1102		4			11			4	
Affordable Choices of Health Benefit Plans 2/	1311	$ 1,672,600	44		$ 2,147,742	56		$ 784,491	51	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322	$ (400,000)	6		$ (2,275,588)	18			15	
Adult Health Quality Measures 2/	2701	$ 60,000	5		$ 56,940	10		$ 40,680	9	
Medicaid Emergency Psychiatric Demonstration	2707								0	
Quality Measurement 2/	3014	$ 20,000	4		$ 18,980	6		$ 18,560	9	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		163			258			355	
Independence At Home Demonstration 2/	3024	$ 5,000	3		$ 4,745	2		$ 4,640	1	
Community Based Care Transitions	3026		2			1			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		2			1			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		1			1			1	
Community Prevention and Wellness	4202		1			1			0	
Graduate Nurse Education 2/	5509	$ 50,000	1		$ 47,450	0		$ 46,400	0	
Sunshine Act	6002		0		$ 16,050	11		$ 1,024	14	
Long Term Care (LTC) National Background Checks	6201		3			4			5	
Provider Screening & Other Enrollment Requirements 1/	6401		8		$ 5,000	10			12	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 10,000	2		$ 13,000	1		$ 3,000	1	
Expansion of the Recovery Audit Contractor Program 1/	6411		2		$ 3,300	1		$ 3,783	2	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323	$ 302,000	2		$ 417,560	1		$ 316,448	1	
Total ACA Direct Appropriated FTEs			**271**			**405**			**487**	

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

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), FY 2020 (-5.9%), FY 2021 (-5.7%), and FY 2022 (5.7%)

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

Program	Section	FY 2015			FY 2016			FY 2017		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Health Insurance Consumer Information	1002		0			0			0	
Rate Review Grants	1003		0							
Pre-existing Condition Insurance Plan Program	1101		5			0			0	
Reinsurance for Early Retirees	1102		4			0			0	
Affordable Choices of Health Benefit Plans	1311	$ 469,624	49		$ 20,163	34		$ 18,221	25	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322		0			0			0	
Adult Health Quality Measures 2/	2701		11			11			8	
Medicaid Emergency Psychiatric Demonstration	2707		1			0			0	
Quality Measurement 2/	3014		9			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		479			521			551	
Independence At Home Demonstration 2/	3024	$ 4,635	1			1			1	
Community Based Care Transitions	3026		0			1			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		1			0			0	
Community Prevention and Wellness	4202		0			0			0	
Graduate Nurse Education 2/	5509	$ 46,350	1			1			2	
Sunshine Act	6002	$ 21,399	16		$ 4,211	17		$ 5,615	22	
LTC National Background Checks	6201		5			6			6	
Provider Screening & Other Enrollment Requirements 1/	6401	$ 18,035	13		$ 3,509	14		$ 3,509	9	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 27,377	2		$ 468	2		$ 468	1	
Expansion of the Recovery Audit Contractor Program 1/	6411	$ 3,975	2		$ 468	2			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323	$ 548,548	1		$329	1			0	
Total ACA Direct Appropriated FTEs			**600**			**611**			**625**	

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

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), FY 2020 (-5.9%), FY 2021 (-5.7%), and FY 2022 (5.7%)

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

Program	Section	FY 2018			FY 2019			FY 2020		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Health Insurance Consumer Information	1002		0			0			0	
Rate Review Grants	1003		0			0			0	
Pre-existing Condition Insurance Plan Program	1101		0			0			0	
Reinsurance for Early Retirees	1102		0			0			0	
Affordable Choices of Health Benefit Plans	1311	$ 11,698	24			0			0	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322		0			0			0	
Adult Health Quality Measures 2/	2701		6			10			10	
Medicaid Emergency Psychiatric Demonstration	2707		0			0			0	
Quality Measurement 2/	3014		0			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		540			600		$ 10,000,000	528	
Independence At Home Demonstration 2/	3024		1			0			0	
Community Based Care Transitions	3026		0			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		0			0			0	
Community Prevention and Wellness	4202		0			0			0	
Graduate Nurse Education 2/	5509		2			0			0	
Sunshine Act	6002		0			0			0	
LTC National Background Checks	6201		4			6			6	
Provider Screening & Other Enrollment Requirements 1/	6401		0			0			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402		0			0			0	
Expansion of the Recovery Audit Contractor Program 1/	6411		0			0			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323		0			0			0	
Total ACA Direct Appropriated FTEs			**577**			**616**			**544**	

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

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), FY 2020 (-5.9%), FY 2021 (-5.7%), and FY 2022 (5.7%)

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

Program	Section	FY 2021			FY 2022		
		Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated							
Health Insurance Consumer Information	1002		0			0	
Rate Review Grants	1003		0			0	
Pre-existing Condition Insurance Plan Program	1101		0			0	
Reinsurance for Early Retirees	1102		0			0	
Affordable Choices of Health Benefit Plans	1311		0			0	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322		0			0	
Adult Health Quality Measures	2701		10			10	
Medicaid Emergency Psychiatric Demonstration	2707		0			0	
Quality Measurement	3014		0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		552			552	
Independence At Home Demonstration	3024		0			0	
Community Based Care Transitions	3026		0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		0			0	
Community Prevention and Wellness	4202		0			0	
Graduate Nurse Education	5509		0			0	
Sunshine Act	6002		0			0	
LTC National Background Checks	6201		6			6	
Provider Screening & Other Enrollment Requirements 1/	6401		0			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402		0			0	
Expansion of the Recovery Audit Contractor Program 1/	6411		0			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards	10323		0			0	
Total ACA Direct Appropriated FTEs			**568**			**568**	

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

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), FY 2020 (-5.9%), FY 2021 (-5.7%), and FY 2022 (5.7%)

Physicians' Comparability Allowance (PCA) Worksheet

1) Department and component:

DHHS: Centers for Medicare and Medicaid Services (CMS)

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

In order to attract and retain highly skilled and qualified physicians, CMS uses two special pay systems: Physician's Comparability Allowance (PCA) and the Physician's and Dental Pay (PDP). Details of the PDP are not included in this report. The majority of CMS physicians receive PCA and are recruited nationwide for the Central Office and Regional Offices to support the work of Medicare and Medicaid Programs. CMS has a continual need to access highly skilled physicians to carry out the unique mission of the agency. The biggest challenge is that even with the PCA, CMS is unable to match physician salary in the private sector. Generally speaking, physicians tend to accept more private sector opportunities due to the restrictions of the GS pay scale.

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

	FY 2020 (Final)	FY 2021 (Enacted) [1]	FY 2022 (President's Budget)
3a) Number of Physicians Receiving PCAs	31	32	35
3b) Number of Physicians with One-Year PCA Agreements	1	1	1
3c) Number of Physicians with Multi-Year PCA Agreements	30	31	34
4a) Average Annual PCA Physician Pay (without PCA payment)	$168,815	$168,868	$168,751
4b) Average Annual PCA Payment	$26,125	$26,125	$26,516

5) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

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

[1] FY 2021 data will be approved during the FY 2022 Budget cycle.

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

The average annual PCA physician pay (without PCA payment) may increase resultant of physicians being eligible for step increases during that timeframe. The average annual PCA amounts may increase slightly as one physician completes their 24 months as a government physician. Currently of the 32 Physicians, CMS has 19 at the maximum PCA amount of $30,000.

During FY 2021, CMS has continued to experience a decrease in our physician positions. So far in FY 2021, two physicians have separated (1-Retirement, 1-Resignation). During FY 2021, only two new physicians have been hired.

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

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

Modernization Efforts

In FY 2019 HHS engaged Department leadership and developed a Digital Communications Strategy that aligns with the requirements of IDEA. In FY 20, HHS Digital Communications Leaders began implementation of the Strategy in alignment with IDEA, beginning to align budgets to modernization requirements.

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

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

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Joint Explanatory Statement:

Total Parenteral Nutrition Cancer Access - The agreement requests that CMS provide the Committees an update within 180 days of enactment of this Act on any plans to revise the Durable Medical Equipment local policies to allow for parenteral nutrition for patients with head, neck, and gastrointestinal cancers.

Action Taken or To Be Taken

Medicare coverage of enteral and parenteral nutritional therapy as a Part B benefit is provided under the prosthetic device benefit provision, which requires that the patient must have a permanently inoperative internal body organ or function thereof. Medicare Administrative Contractors (MACs), the entities that make Local Coverage Determinations (LCDs), have the discretion to revise or retire their LCDs at any time on their own initiative, The Durable Medical Equipment MACs have retired the Parenteral Nutrition LCD (L33798) and related Policy Article (A52515), effective for claims with dates of service on or after November 12, 2020, due to the evolution of parenteral nutrition clinical paradigms. With the retirement of the LCD and Policy Article, providers and suppliers should refer to the National Coverage Determination (NCD) for Enteral and Parenteral Nutritional Therapy, which addresses coverage criteria for enteral and parenteral nutrition. The NCD states that parenteral nutrition is considered reasonable and necessary for a patient with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the patient's general condition.

Risk Corridor Program - The agreement continues to direct CMS to provide a yearly report to the Committees detailing any changes to the receipt and transfer of payments.

Action Taken or To Be Taken

The risk corridors program concluded in the 2016 Benefit Year. The requested information is available on the CMS website at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs

Claim Payment Coordination - The agreement requests updated information in the fiscal year 2022 congressional justification that provides options to reform the current system for the identification of Medicare beneficiaries enrolled in Medicare Advantage or Part D plans by third party payers in situations where no-fault or liability insurance or workers' compensation is involved.

Action Taken or To Be Taken

Section 1301 of the Further Continuing Appropriations Act, 2021, and Other Extensions Act, enacted on December 11, 2020, requires the Secretary to provide Medicare entitlement information and Medicare Advantage and Part D plan name and address information, as applicable, to no fault insurers, liability insurers, and worker's compensation plans in response to queries about individuals made by these entities on or after December 11, 2021 for coordination of benefits with Medicare. The Secretary is required to provide current information as well as information for the preceding three-year period. The Centers for Medicare & Medicaid Services is working on implementing this statutory requirement.

Health Insurance Exchange Transparency - The agreement continues bill language requiring CMS to provide cost information for the Health Insurance exchange, including all categories described under this heading in the explanatory statement accompanying division B of Public Law 115-245 (Federal Payroll and Other Administrative Costs; Marketplace related Information Technology [IT]; Non-IT Program Costs, including Health Plan Benefit and Rate Review, Marketplace Oversight, Payment and Financial Management, Eligibility and Enrollment; Consumer Information and Outreach, including the Call Center, Navigator Grants and Consumer Education and Outreach; Marketplace Quality Review; Small Business Health Options Program and Employer Activities; and Other Marketplace Activities), for each fiscal year since the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148), as well as estimated costs for fiscal year 2022.

Health Insurance Marketplaces Transparency Table

Dollars in Thousands

Activity	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Actual	FY 2020 Actual	FY 2021 Enacted 1/	FY 2022 President's Budget 1/
Health Plan Bid Review, Management and Oversight	$ -	$ 300	$ 21,936	$ 40,595	$ 33,497	$ 43,960	$ 40,520	$ 39,846	$ 37,910	$ 45,797	$ 45,480	$ 49,719	$ 53,615
Payment and Financial Management	$ -	$ 1,698	$ 24,998	$ 25,832	$ 49,615	$ 43,733	$ 51,325	$ 47,640	$ 45,141	$ 50,220	$ 39,178	$ 56,607	$ 52,700
Eligibility and Enrollment 2/	$ -	$ 2,218	$ 3,433	$ 275,501	$ 339,754	$ 363,768	$ 445,249	$ 484,144	$ 392,660	$ 348,488	$ 371,802	$ 356,478	$ 379,366
Consumer Information and Outreach	$ -	$ 2,427	$ 32,610	$ 701,075	$ 704,136	$ 753,238	$ 805,833	$ 640,232	$ 591,948	$ 579,088	$ 503,271	$ 695,956	$ 596,328
Call Center (non-add)	*$ -*	*$ -*	*$ 22,000*	*$ 505,446*	*$ 545,600*	*$ 566,178*	*$ 563,638*	*$ 540,197*	*$ 525,326*	*$ 499,053*	*$ 440,000*	*$ 459,400*	*$ 447,000*
Navigators Grants & Enrollment Assisters (non-add)	*$ -*	*$ -*	*$ -*	*$ 107,513*	*$ 97,152*	*$ 75,996*	*$ 99,677*	*$ 51,166*	*$ 12,720*	*$ 19,499*	*$ 19,689*	*$ 91,810*	*$ 89,545*
Consumer Education and Outreach (non-add)	*$ -*	*$ -*	*$ 7,043*	*$ 77,436*	*$ 49,334*	*$ 54,897*	*$ 101,048*	*$ 16,599*	*$ 10,744*	*$ 11,231*	*$ 14,082*	*$ 115,246*	*$ 28,495*
Information Technology	$ 2,346	$ 92,672	$ 166,455	$ 402,553	$ 770,957	$ 798,648	$ 664,083	$ 710,867	$ 767,413	$ 504,283	$ 549,369	$ 567,141	$ 497,956
Quality	$ -	$ -	$ -	$ -	$ 17,189	$ 15,634	$ 11,736	$ 7,301	$ 7,240	$ 7,334	$ 7,063	$ 6,393	$ 7,485
SHOP and Employer Activities	$ -	$ 366	$ 18,479	$ 25,076	$ 30,541	$ 42,717	$ 34,520	$ 16,500	$ 4,418	$ 2,117	$ 200	$ 197	$ 196
Other Marketplace	$ 1,879	$ 14,906	$ 13,738	$ 4,400	$ 6,728	$ 3,614	$ 12,032	$ 49,584	$ 31,196	$ 40,290	$ 63,579	$ 54,638	$ 53,037
Federal Payroll and Other Administrative Activities	$ 429	$ 10,805	$ 43,493	$ 68,429	$ 80,000	$ 80,000	$ 85,000	$ 79,602	$ 70,892	$ 77,750	$ 85,833	$ 109,317	$ 109,317
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	$ 1,655,367	$ 1,665,775	$ 1,896,446	$ 1,749,999

1/ The user fee levels reflect updated estimates that are not reflected in the HHS Budget Appendix.

2/ Funding for Enrollment Assisters ended in FY 2017.

NOTE: Fiscal years 2010 through 2020 include obligations as of September 30 of each year.

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

Home Visiting - The agreement directs CMS to build upon its 2016 Joint Informational Bulletin to clearly articulate how Medicaid dollars can be blended and braided appropriately in home visiting programs to reach eligible families, provide streamlined coverage options for home visiting services, and cover specific components of home visiting programs.

Actions Taken or To Be Taken

CMS continues to work with its HHS partners, including HRSA, which administers the Maternal, Infant, and Early Childhood Home Visiting Program. CMS assists states that choose to design a Medicaid benefit package to provide home visiting services for pregnant and postpartum women, and for families with young children. CMS believes states are in the best position to design solutions that address the unique needs of their Medicaid-eligible populations. There are various Medicaid authorities, including state plan amendments, Medicaid demonstration waivers, and managed care, that states can utilize to incorporate components of home visiting services into their Medicaid programs.

For example, CMS has approved state requests to pilot home visiting programs under section 1115 demonstrations, including requests from Maryland and Rhode Island. Section 1115 demonstrations offer states additional freedom to test and evaluate innovative solutions to improve the quality, accessibility, and health outcomes of women and infants enrolled in Medicaid. Under its “Maryland Health Choice” demonstration, Maryland is testing an evidence based Home Visiting Services (HVS) Pilot, through which Medicaid expenditures for evidence based home visiting services to promote enhanced health outcomes, whole person care, and community integration for high-risk pregnant women and children up to two years of age are permitted. Rhode Island operates a statewide family home visiting services program through its section 1115 demonstration, entitled the “Rhode Island Comprehensive Demonstration”. Under this demonstration, Medicaid expenditures for evidence-based home visiting services under the Nurse-Family Partnership and Healthy Families America for qualified beneficiaries are permitted.

Additionally, CMS launched the Maternal and Infant Health Initiative (MIHI) Value-Based Payment (VBP) Initiative through the Innovation Accelerator Program (IAP) to provide technical support opportunities for Medicaid/CHIP agencies. Through this initiative, states could select, design, and test VBP approaches in partnership with care delivery providers to sustain care delivery models that demonstrate improvement in maternal and infant health outcomes, including home visiting. The MIHI VBP track supported states’ efforts to develop VBP approaches that sustain innovations in the delivery of maternal and child health care. The track began in July 2017 and continued through July 2019. The final evaluation of the MIHI VBP Initiative and the other initiatives through the IAP were released in September 2020.

Survey and Certification - The agreement directs CMS to provide funding to States and territories through an expedited process and prioritize efforts to increase quality of care, infection control, and maintaining staff levels to protect patients and staff. The agreement urges CMS to coordinate with the Department of Veterans Affairs on oversight of long-term care facilities under the Department of Veterans Affairs, including surveys of such facilities.

Action Taken or To Be Taken

CMS is committed to taking the critical steps needed to protect vulnerable Americans and ensure America’s healthcare facilities are prepared to respond to the COVID-19 Public Health Emergency. Currently, States receive over $397 million to perform oversight surveys and certification of Medicare and Medicaid certified providers and suppliers.

In addition, Congress appropriated $100 million in supplemental funds in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136) for necessary expenses of the survey and certification program, prioritizing nursing home facilities in localities with community transmission of COVID-19. Of this amount, we expect to provide State Survey Agencies approximately $81 million, which will be available for spending through September 30, 2023. For FY 2020, CMS allocated $17 million of the $81 million of the supplemental CARES Act funding to be awarded to states. As of September 30, 2020, CMS has awarded $18.8 million of the planned $17 million of the supplemental CARES Act funding allocated for FY 2020 to 34 States. With this funding, states were able to complete focused infection control survey for nursing homes by July 2020, increase complaint surveys based on COVID-19 trend data reported by nursing homes to the Centers for Disease Control and Prevention (CDC), and perform "reopening" surveys of facilities with previous COVID-19 outbreaks using unique survey protocols to ensure the facilities have Infection Control systems if there is another phase of the outbreak.

CMS is closely coordinating with federal, state, local, and private sector stakeholders to make sure these efforts are complementary across programs, reflect evolving factors associated with the Coronavirus, and provide the highest priority response activities, without overly burdening facilities treating patients with COVID-19.

In May of 2020, the Department of Health and Human Services announced the release of $5 billion from the Provider Relief Fund, authorized under the CARES Act, to nursing homes. In July of 2020, the Department announced the release of an additional $5 billion from the Provider Relief Fund to help nursing homes address critical needs, including hiring additional staff, increasing testing, and providing additional services, such as technology so residents can connect with their families if they are not able to visit. Thus far, the Department has worked to support nursing homes financially during this challenging time, distributing over $21 billion to America's nursing homes – more than $1.5 million each on average.

Non-emergency Medical Transportation (NEMT) - The agreement continues to direct HHS to take no regulatory action on availability of NEMT service until the Medicaid and CHIP Payment and Access Commission completes the study requested in division A of Public Law 116-94. The agreement notes the Committees anticipate such study to be completed in fiscal year 2021.

Actions Taken or To Be Taken

No regulatory action has been taken on the availability of NEMT services. Further, the Consolidated Appropriations Act, 2021 (Pub. L. 116-260) codified the Medicaid assurance of necessary transportation, which includes NEMT, for beneficiaries to and from providers. The law also directed the Secretary, through CMS, to review prior CMS guidance to states on the federal requirements for NEMT and update such guidance as necessary within 24 months, to ensure States have appropriate and current guidance in designing and administering coverage under the Medicaid program of nonemergency transportation to medically necessary services.

House Explanatory Statement:

Liquid Oxygen - The Committee notes with continued concern beneficiary problems in accessing liquid oxygen. The Committee directs CMS to report within 60 days of enactment of this Act on current access to liquid oxygen, including data on recent trends in liquid oxygen use during the period 2010-2019 by Medicare beneficiaries, and to work with stakeholders to implement appropriate monitoring plans to ensure continued access to all appropriate oxygen therapy when the competitive bidding program resumes in 2021.

Action Taken or To Be Taken

CMS agrees that the cost of furnishing liquid oxygen and oxygen equipment is higher than the cost of furnishing other oxygen modalities. CMS increased the payment for portable liquid oxygen and oxygen equipment and portable oxygen contents for patients with high flow needs beginning in 2019 to help to address the higher costs of these modalities (83 FR 57041). We believe that adding this higher payment would encourage suppliers to furnish this modality when it is requested by beneficiaries. CMS is monitoring the effect of that these payment changes have on access to liquid oxygen and oxygen equipment to determine if additional changes are needed.

CMS has heard from a range of stakeholders requesting that the agency delay or cancel the Round 2021 DMEPOS CBP due to the ongoing COVID-19 Public Health Emergency. CMS considered that feedback in moving forward with the Round 2021 DMEPOS CBP. CMS is not awarding competitive bidding contracts for any of the 13 product categories which includes oxygen equipment for Round 2021 that were previously competed because the payment amounts did not achieve expected savings.

New Medical Residency Training Programs - Given the growing physician workforce shortage, the Committee strongly encourages CMS to utilize its discretion to extend the time period described in section 413.79(e) of title 42, Code of Federal Regulations, for new residency programs in areas facing physician shortages before a full-time equivalent resident cap is applied, as authorized in P.L. 105 33. The Committee looks forward to receiving CMS's report on these efforts within 60 days of the enactment of that Act, as directed in House Report 116–62.

Action Taken or To Be Taken

Section 1886(h)(4)(H)(i) of the Social Security Act requires the Secretary to prescribe rules for calculating the limitations on the number of residents in allopathic and osteopathic medicine, and the counting of interns and residents for teaching hospitals training residents in new programs established on or after January 1, 1995. CMS implemented these statutory requirements in the August 29, 1997 Federal Register (62 FR 46005) and in the May 12, 1998 Federal Register (63 FR 26333) by providing for a 3-year period in which a teaching hospital could "grow" its programs for the purpose of establishing its FTE resident caps. This 3-year period starts when the teaching hospital first begins to train residents in its first new program, typically on July 1, and it ends when the third program year of that first new program ends.

In the August 31, 2012 Federal Register (77 FR 53416), in response to provider concerns that 3 years is an insufficient amount of time primarily because a period of 3 years was not compatible with program accreditation requirements, CMS finalized an increase in the cap building period whereby a teaching hospital would have 5 years, or a "5-year window," in which to establish and grow new programs. At the end of the fifth program year of the first new program in which the teaching hospital participates, the teaching hospital's FTE resident caps would be determined, and set permanently, effective with the beginning of the sixth program year. The regulations implementing this policy are at 42 CFR 413.79(e)(1). CMS shares the Committee's goal of improved support for hospitals' efforts to train more residents in underserved areas and will take your comments into consideration as we develop policies for future rulemaking.

Non-Group Health Plans - The Committee directs CMS to submit a report within 60 days of enactment of this Act with options for modifying existing processes so that Non-Group Health Plans may receive query responses that include the name and address of any Medicare

Advantage or Part D plan in which the queried individual currently is enrolled, or, within the last three years, has been enrolled.

Action Taken or To Be Taken
Section 1301 of the Further Continuing Appropriations Act, 2021, and Other Extensions Act, enacted on December 11, 2020, requires the Secretary to provide Medicare entitlement information and Medicare Advantage and Part D plan name and address information, as applicable, to no fault insurers, liability insurers, and worker's compensation plans in response to queries about individuals made by these entities on or after December 11, 2021 for coordination of benefits with Medicare. The Secretary is required to provide current information as well as information for the preceding three-year period. The Centers for Medicare & Medicaid Services is working on implementing this statutory requirement.

Home Health Payment Systems - The Committee urges CMS to avoid home health payment systems that would risk patient access to home health providers in rural areas. The Committee requests a report within 90 days of enactment of this Act regarding the impact of implementation of home health payment systems on the delivery of home health services.

Action Taken or To Be Taken

The Bipartisan Budget Act of 2018 (BBA of 2018) included several requirements for home health payment reform, effective January 1, 2020. These requirements included the elimination of the use of therapy thresholds for case-mix adjustment and a change from a 60-day unit of payment to a 30-day period payment rate. The statutorily required provisions in the BBA of 2018 resulted in the Patient-Driven Groupings Model, or PDGM. The PDGM removes the payment incentive to overprovide therapy, and instead, is designed to focus more heavily on clinical characteristics and other patient information to better align Medicare payments with patients' care needs. While payment is adjusted for each 30-day period of care to reflect the beneficiary's health conditions and care needs, a special outlier provision exists to ensure appropriate payment for those beneficiaries that have the most expensive care needs. As noted in the calendar year 2019 Home Health Prospective Payment System final rule, rural facilities were estimated to receive a 3.8% increase in payments for calendar year 2020 under the PDGM payment model (83 FR 56406). The Centers for Medicare & Medicaid Services will continue to monitor patient access to home health services and the costs associated with providing home health care in rural versus urban areas.

Blue Button - The Committee directs CMS to submit a report within 90 days of enactment of this Act on the active participant levels in Blue Button since its inception and detailed information about what the agency is doing to promote participation in this program and educate beneficiaries about its benefits.

Action Taken or To Be Taken

CMS publicizes Blue Button 2.0 to Medicare beneficiaries in the Medicare & You handbook and on the Medicare.gov website (https://www.medicare.gov/manage-your-health/medicares-blue-button-blue-button-20/find-apps-to-use-with-medicares-blue-button). CMS announced that as of January 2020, over 53,000 Medicare beneficiaries have taken advantage of Blue Button. As of December 2020, there are 74 production applications and over 4,000 developers working in the Blue Button sandbox. CMS intends to continue outreach to beneficiaries about the availability of Blue Button.

Medicaid Dental Audits - The Committee raised concerns in House Report 116–62 that failure to use professional guidelines or established state Medicaid manual parameters in the auditing

process can result in inaccurate and unreasonable Medicaid dental audits, negatively impacting dentist participation in the program and patient access to care. While State Medicaid agencies (SMA) have significant responsibility in managing provider audits, the Committee believes that as part of CMS oversight of the Medicaid program it is appropriate to issue guidance to SMAs concerning best practices in dental audits and offer training in such practices. The Committee urges CMS to develop such guidance for SMAs, in collaboration with the American Academy of Pediatric Dentistry and American Dental Association, and report to the Committee within 90 days of enactment of this Act on steps taken to develop such guidance.

Action Taken or To Be Taken

The Medicaid program is jointly administered by CMS and states. State Medicaid Agencies (SMA) administer the program on a day-to-day basis. Accordingly, such states are responsible for establishing, within broad federal guidelines, various Medicaid program requirements such as who will be eligible for benefits, what benefits will be covered, who will be eligible to provide services and the payment policies pursuant to which payment will be made. This gives states tremendous flexibility in the design of their respective programs and results in great variation among Medicaid programs.

In addition to state efforts, CMS' Unified Program Integrity Contractors (UPICs) are authorized to conduct audits of Medicaid providers under section 1936 of the Social Security Act, including dental providers. The design of the Medicaid UPIC work reflects the dynamic of a state administered program. UPICs work collaboratively with SMAs to determine areas of audit, e.g., dental services, as well as the relevant coverage policies to be applied in connection with such audits. UPIC auditors follow the dental policies that are established by the SMA. These policies are the official policies providers are to follow in order to receive payment. If a SMA has incorporated the American Academy of Pediatric Dentistry or American Dental Association clinical guidelines, best practices, and/or policies into their state policy, then they would be considered part of the audit.

Limited Wraparound Coverage - The Committee is deeply concerned that the Administration did not extend the limited wraparound coverage pilot program or make the program permanent. This failure has caused significant uncertainty for patients who depended on this program for several years. The Committee directs CMS to submit a report within 90 days of enactment of this Act outlining a plan to ensure that participants impacted by the expiration of the pilot program will receive benefits equivalent to those of the limited wraparound coverage program. This report should include an analysis of the outcomes of the pilot program and an explanation for CMS’s decision not to extend it.

Action Taken or To Be Taken

CMS is committed to ensuring access to quality, affordable health care. The final rule on Health Reimbursement Arrangements (HRAs) and Other Account-Based Group Health Plans (84 FR 28888) issued on June 20, 2019, enabled employers to begin offering a new excepted benefit HRA to their employees on January 1, 2020. The final rule did not extend the pilot program for limited wraparound coverage due to its minimal take up and overlap with other benefit options, including excepted benefit HRAs. Like the limited wraparound coverage excepted benefit, the new benefit options can be used for cost sharing and expenses for services not covered by individual health insurance coverage, while not causing covered individuals to be ineligible for the premium tax credit. Any further changes to these policies would need to be made through rulemaking.

In 2019, CMS worked closely with plan sponsors participating in the limited wraparound coverage pilot program. CMS provided technical assistance to plan sponsors prior to the expiration of the pilot program about other benefit options to ensure that plan participants impacted by the expiration of the pilot program would receive benefits equivalent to those of the limited wraparound coverage program.

Radiation Oncology Model - The Committee is concerned that the Radiation Oncology (RO) Model as currently proposed could potentially reduce access to certain types of radiation therapy and negatively affect patient outcomes. The Committee requests CMS submit a report within 90 days of enactment of this Act on the impact of the RO Model on patient access and outcomes and the impact on therapy providers.

Action Taken or To Be Taken

The Consolidated Appropriations Act, 2021 enacted on December 27, 2020 includes a provision that prohibits implementation of the Radiation Oncology Model prior to January 1, 2022, effectively delaying the start date by 6 months. CMS intends to address the delay through notice and comment rulemaking.

Diabetes Technologies - The Committee is concerned about access to new technologies to treat diabetes. The Committee requests a report within 120 days of enactment of this Act outlining coverage and payment policies for new technologies for individuals with diabetes, including hybrid-closed loop technologies.

Action Taken or To Be Taken

With one in every three Medicare beneficiaries having diabetes, CMS understands the importance of giving Medicare beneficiaries and their physicians a wider range of technology and devices to choose from in managing diabetes. Taking steps to improve access to these medical technologies can empower patients to make the best healthcare decisions for themselves. For example, in the “Medicare Program; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Policy Issues and Level II of the Healthcare Common Procedure Coding System (HCPCS)” proposed rule, CMS proposed to classify all continuous glucose monitor (CGM) systems that use a receiver that meets the definition of durable medical equipment (DME) as DME (85 FR 70358). CGMs are systems that use disposable glucose sensors attached to the patient to monitor a patient's glucose level on a continuous basis. Thus far, Medicare's coverage policy for CGMs has supported the use of therapeutic CGMs in conjunction with a smartphone (with the durable receiver as backup), including the important data sharing function they provide for patients and their families. CMS proposed that both therapeutic and non-therapeutic CGMs, when used in conjunction with a smartphone, satisfy the definition of DME. CMS is currently reviewing comments on the proposed rule.

CMS agrees on the importance of innovative technologies to help patients better manage diabetes and improve health outcomes. There are currently no Medicare National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs) on closed loop systems such as the Artificial Pancreas system for use in the home. Because there are no NCDs or LCDs, Medicare coverage of and payment for these systems would be made at the individual claim level by the Durable Medical Equipment (DME) Medicare Administrative Contractors responsible for processing claims. However, Medicare does have an NCD for closed-loop blood glucose control devices (CBGCD) in a hospital inpatient setting. The CBGCD is a hospital bedside device designed for short-term management of patients with insulin dependent diabetes mellitus (Type I). Use of the CBGCD is covered for short-term management of insulin

dependent diabetics in crisis situations, in a hospital inpatient setting, and only under the direction of specially trained medical personnel (see NCD 40.3).

Medically Tailored Meals - The Committee is aware of peer-reviewed research showing that medically tailored meals can improve health outcomes and reduce health care utilization, and further understands that some Medicare Advantage plans have partnered with community-based organizations to incorporate medically tailored meals as a covered benefit. The Committee requests a report within 120 days of enactment of this Act outlining how Medicare Advantage and state Medicaid plans are using medically tailored meals and related nutrition interventions within their coverage plans.

Action Taken or To Be Taken

Medicare Advantage (MA) plans have the option to offer supplemental benefits, which are items or services not covered by original Medicare, that are primarily health related (i.e., the primary purpose of the item or service is to prevent, cure or diminish an illness or injury), and for which the MA plan must incur a non-zero direct medical cost. MA plans may offer meals on a limited basis as a supplemental benefit for a temporary period immediately following a surgery or an inpatient hospital stay or for a temporary period for a chronic condition. In those situations, meals as a supplemental benefit are permissible if the meals are: 1) needed due to an illness; 2) consistent with established medical treatment of the illness; and 3) offered for a short duration.

The Bipartisan Budget Act of 2018 (BBA 2018) expanded the types of supplemental benefits that may be offered by MA plans to chronically ill enrollees, which are referred to as Special Supplemental Benefits for the Chronically Ill (SSBCI). SSBCI include supplemental benefits that are not primarily health related and may be offered non-uniformly to eligible chronically ill enrollees. In general, MA organizations have broad discretion in developing items and services they may offer as SSBCI provided that the item or service has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee. MA organizations also have broad discretion in determining what may be considered ‘a reasonable expectation’ when choosing to offer specific items and services as SSBCI. Meals may be offered by MA plans beyond a limited basis as SSBCI to chronically ill enrollees. Food and produce to assist chronically ill enrollees in meeting nutritional needs may also be covered as SSBCI. Plans may include items such as (but not limited to) produce, frozen foods, and canned goods.

Additionally, through the MA Value-Based Insurance Design (VBID) Model that tests different payment and service delivery flexibilities in MA, MA organizations participating in the model have the ability to offer non-primarily health related supplemental benefits to certain targeted populations beyond those individuals meeting the definition of a chronically ill enrollee under the BBA 2018, provided that such benefits have a reasonable expectation of improving or maintaining the health or overall function of the targeted enrollee. Meals, beyond the current allowable limits, are within the scope of non-primarily health related supplemental benefits that can be provided by MA organizations under the VBID Model.

For purposes of Medicaid, under the mandatory home health benefit states can provide coverage for nutritional supplements for enteral and parenteral feeding or similar items that are administered through durable medical equipment (tube feeding) and not available over the counter. Additionally, medical foods which are specific to inherited diseases (e.g., metabolic disorders and Phenylketonuria (PKU)) and are not generally available in grocery stores, health food stores, or pharmacies and are not used as food by the general population are coverable. This coverage would not extend to regular foods prepared to meet particular dietary

restrictions/limitations/needs, such as meals designed to address the situation of individuals with diabetes or heart disease.

For purposes of Medicaid managed care, if the meals are authorized under a Medicaid authority – such as the State Plan, Section 1915(c) Waiver, or Section 1115 Demonstration – the meals can be appropriately included in the managed care contracts, and the costs can be appropriately included in the capitation rates. If the meals fall outside of what is permissible under a Medicaid authority, it may be possible for managed care plans to provide them via a value-added service. Under 42 C.F.R. § 438.3(e), a managed care plan may voluntarily cover, for enrollees, services that are in addition to those covered under the State Plan (or other Medicaid authority), although the cost of these services is not and may not be included in the capitation rates.

Regulatory Requirements Impacting Advanced Practice Registered Nurses and Physician Assistants - The Committee requests that CMS submit a report within 120 days of enactment of this Act on regulatory requirements that impact Advanced Practice Registered Nurses and Physician Assistants, including potential modifications that would reduce these requirements.

Action Taken or To Be Taken

In December 2019, CMS requested feedback to modify supervision and other requirements of the Medicare program that limit healthcare professionals from practicing at the top of their license seeking the public's help in identifying additional Medicare regulations which contain more restrictive supervision requirements than existing state scope of practice laws, or which limit health professionals from practicing at the top of their license. Through review of the feedback we received, we identified certain policies to address in rulemaking. For example, we amended regulations on a permanent basis to specify that supervision of diagnostic psychological and neuropsychological testing services can be done by nurse practitioners, clinical nurse specialists, physician assistants, certified registered nurse anesthetist, or certified nurse midwives to the extent that they are authorized to perform the tests under applicable State law and scope of practice, in addition to physicians and clinical psychologists who are currently authorized to supervise these tests (85 FR 84591).

Direct and Indirect Remuneration Penalties - The Committee directs CMS to review the amount of DIR penalties collected from pharmacies in Medicare Part D networks and assess the impact of these penalties on independent and specialty pharmacies—including the impact on 340B safety net providers like Ryan White clinics and Federally Qualified Health Centers. The Committee requests a report on the results of this review within 180 days of enactment of this Act.

Action Taken or To Be Taken

Data that Part D sponsors submit to CMS as part of the annual required reporting of DIR show that pharmacy price concessions, net of all pharmacy incentive payments, have grown faster than any other category of DIR received by sponsors and PBMs. This means that pharmacy price concessions account for a larger share than ever before of reported DIR and thus a larger share of total gross drug costs in the Part D program. The data show that pharmacy price concessions, net of all pharmacy incentive payments, grew more than 91,500 percent between 2010 and 2019.

Pharmacy price concessions are negotiated between pharmacies and Part D sponsors or their PBMs, independent of CMS, and are often tied to the pharmacy's performance on various measures defined by the sponsor or its pharmacy benefit manager. Beginning January 1, 2022,

Part D sponsors must disclose to CMS the pharmacy performance measures they use to evaluate pharmacy performance, as established in their network pharmacy agreement. Once collected, CMS will analyze the extent to which the pharmacy performance measures are applied, whether uniformly or specific to pharmacy type.

Drug Quality - The Committee is deeply concerned about the discovery of dangerous levels of carcinogens in frequently prescribed medications, including angiotensin II receptor blockers (ARBs) like losartan and valsartan, ranitidine, and metformin. As two of the country's largest payers for prescription medication, Medicare and Medicaid have a responsibility to help ensure the safety and quality of prescribed therapies. The Committee requests a report within 180 days of enactment on the amount of money that the Medicare and Medicaid programs spent on medication in the previous three fiscal years that was subsequently recalled by manufacturers due to the detection of contaminants (including NDMA), adverse event reports, and sterility concerns.

Action Taken or To Be Taken

CMS recognizes the Committee's concerns regarding medications that are subsequently recalled by manufacturers. CMS publishes and regularly updates the Medicare Part D, Medicare Part B and Medicaid Drug Spending Dashboards, which provide drug-specific spending data over time. To the extent there has been spending under Medicare Part D, Medicare Part B, or Medicaid for the drugs of interest to the Committee, the dashboards provide spending information. These dashboards are available on the CMS website, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Information-on-Prescription-Drugs. The Medicare Part D Drug Spending Dashboard displays, among other information, drug spending for Part D drugs based on gross drug cost, which represents total spending for the prescription claim, including Medicare Part D plan and beneficiary payments. The Medicare Part B Drug Spending Dashboard presents spending information for Medicare Part B drugs (for fee-for-service Medicare beneficiaries, but excluding beneficiaries in the Medicare Advantage program). Drug spending metrics for Part B drugs represent the full value of the product, including the Medicare payment and beneficiary liability. For Medicaid, the Drug Spending Dashboard displays Medicaid drug spending representing the total amount reimbursed by both Medicaid and non-Medicaid entities to pharmacies for the drug. Medicaid drug spending contains both the Federal and State Reimbursement and is inclusive of any applicable dispensing fees (and is not reduced or affected by Medicaid rebates paid to the states).

Medicare Reimbursement for Virtual Health Services - The Committee requests CMS submit a report within 180 days of enactment of this Act outlining Medicare's current policy for payment of virtual health services (including digital health tools and ancillary services) for chronic conditions. This report should include data and other pertinent information on current utilization of such services by Medicare beneficiaries using the most currently available data. The report should assess opportunities to expand access to services for chronically ill Medicare beneficiaries under current authority, which beneficiaries would benefit most from access to such services, and gaps or limitations on HHS's authority to expand access to these beneficiaries.

Action Taken or To Be Taken

Medicare pays for a number services furnished by physicians and other practitioners who are remote from the beneficiary's location, including telehealth services as well as other virtual services such as e-visits, remote physiologic monitoring services, and virtual check-ins. Section 1834(m) of the Act specifies for purposes of Medicare telehealth services the payment amounts

and circumstances under which Medicare makes payment for a discrete set of services, all of which must ordinarily be furnished in-person, when they are instead furnished using interactive, real-time telecommunication technology. Many of these specified Medicare telehealth services are still reported using codes that describe “face-to-face” services but are furnished using audio/video, real-time communication technology instead of in-person. There are approximately 270 services currently included on the list of Medicare telehealth services, including more than 160 that were added on a temporary basis during the COVID-19 public health emergency. The list of eligible telehealth services is published on the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.

Before the COVID-19 public health emergency (PHE), only 15,000 fee-for-service beneficiaries each week received a Medicare telemedicine service. Preliminary data show that between mid-March and mid-October 2020, over 24.5 million out of 63 million beneficiaries and enrollees have received a Medicare telemedicine service during the PHE.

In contrast, Medicare pays separately for other professional services that are commonly furnished remotely using telecommunications technology, but that do not usually require the patient to be present in-person with the practitioner when they are furnished. These services, including remote physician interpretation of diagnostic tests, care management services and virtual check-ins among many others, are considered physicians' services in the same way as services that are furnished in-person without the use of telecommunications technology. They are covered and paid in the same way as services delivered without the use of telecommunications technology, but are not considered Medicare telehealth services.

CMS has established separate payment for a number of services that can be furnished remotely in recent years, which can help physicians and practitioners manage treatment and care for beneficiaries with chronic conditions. In 2015, CMS began paying separately for chronic care management services furnished to Medicare beneficiaries with two or more chronic conditions. CMS believes that these separately billable codes more accurately describe, recognize, and make payment for non-face-to-face care management services furnished by practitioners and clinical staff to particular patient populations. Recognizing that clinicians across all specialties manage the care of beneficiaries with chronic conditions, in 2020 CMS created new coding for principal care management services, for patients with only a single serious and high-risk chronic condition. When CMS established separate payment for services like virtual check-ins and e-visits, CMS recognized that non-face-to-face services had become an important part of overall physician care of Medicare beneficiaries, especially relative to care for chronic conditions. CMS has also established separate payment for seven remote physiologic monitoring services, which involve the collection and analysis of patient physiologic data that are used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition.

Program Integrity - The Committee requests an update within 180 days of enactment of this Act on the Recovery Audit Validation Contractor program, National Correcting Coding Initiative, and related integrity programs, data reporting standards around these programs, and the feasibility or challenges of expanding these programs to other public payer programs. These or any enhanced recovery efforts must be implemented carefully so as not to inadvertently curb beneficiary access to care should health care providers come to fear retribution for minor billing errors or honest mistakes.

Action Taken or to be Taken

CMS is committed to program integrity that focuses on paying the right amount, to legitimate providers and suppliers, for covered, reasonable and necessary services provided to eligible beneficiaries while taking actions to eliminate fraud, waste and abuse.

The primary purpose of the Recovery Audit Contractor (RAC) Validation Contractor (RVC) is to review RAC claim determinations on Medicare claims that were paid under part A or B of title XVIII of the Social Security Act, and to ensure that RACs are not unnecessarily denying Medicare claims that were properly paid. The RVC focuses on the accuracy of the RACs' improper payment determinations. This typically includes the review of improper payments to determine if the determination was accurate. At CMS' discretion, the RVC shall also review no finding claims to assess the accuracy of those determinations.

CMS uses automated edits to help prevent improper payment without the need for manual intervention. CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims. NCCI Procedure-to-Procedure (PTP) edits prevent inappropriate payment for billing code pairs that should not be reported together by the same provider for the same beneficiary for the same date of service. NCCI Medically Unlikely Edits (MUEs) prevent payment for an inappropriate quantity of the same service rendered by the same provider for the same beneficiary on the same date of service. NCCI edit tables are refined and updated quarterly.

Under the Medicaid statute, states are required to use NCCI methodologies to process applicable Medicaid claims. CMS continues to provide assistance for State Medicaid Agencies (SMAs) to use NCCI methodologies in their Medicaid programs. Similar to that for Medicare, the Medicaid NCCI edit tables are refined and updated quarterly.

CMMI Strong Start Initiative - The Committee looks forward to the report, requested in House Report 116–62, that would build on the CMMI Strong Start Initiative to develop a proposal for CMS to increase access to birth centers and midwives in all state Medicaid programs, and incentivize this model of care for low-risk women.
Referenced House Report 116-62 language: *Birthing Centers* -- ....The Committee was pleased that the CMMI Strong Start Initiative was created to look at how three different models of care (Maternity Care Homes, Centering Group Model Prenatal Care, and Birth Centers) would impact these outcomes and the costs associated with childbirth. The Committee notes that findings of this five-year study showed no differences in cost or outcomes for the Maternity Care Home model, and some slight cost savings and improved rates of low birthweight for the Centering model. But the birth centers, which provided a midwife-led model of holistic care, showed significant cost savings and improved childbirth outcomes across all measures. The Committee urges CMS to widely disseminate these findings to payors and consumers. Since Medicaid is the primary payor for almost half of all childbearing women and newborns in this country, the Committee strongly urges CMS to develop a proposal for how it will increase access to birth centers and midwives in all state Medicaid programs, and incentivize this model of care for low-risk women. The Committee requests a report within 120 days of enactment of this Act. (page 130)

Actions Taken or To Be Taken

CMS is committed to improving health outcomes for all mothers and their children. CMS published its final evaluation of the Strong Start for Mothers and Newborns (Strong Start) Initiative in October 2018, and the final evaluation is available to the public at innovation.cms.gov, along with other helpful materials concerning Strong Start. On November 9, 2018, CMS issued an Informational Bulletin summarizing the evaluation findings and urging states to consider studying the availability of birth center care in their states. The Informational Bulletin also highlights mandatory coverage of nurse-midwife services under Medicaid (C.F.R. 440.165) and options for covering freestanding birth center services under Medicaid. Further, a

2016 State Health Official Letter (SHO#16-006) clarifies how freestanding birth center services can be incorporated into Medicaid managed care contracts.

Additionally, on March 11, 2021 as a part of the “Improving Postpartum Care Learning Collaborative”, CMS held a technical assistance webinar for states focused on strategies for providing women-centered care for Medicaid and CHIP beneficiaries and offer state examples of how these models can improve postpartum care for women at high risk of postpartum complications and also eliminate disparities in maternal and infant health outcomes. During the “Models of Women-Centered Care” webinar, the presenters discussed the use of doulas, team-based care, group care, and community partnerships to improve care. The presenters also discussed payment strategies to support these care models. The Postpartum Care Learning Collaborative is a part of the CMS’s Maternal and Infant Health Initiative (MIHI), and this learning collaborative offers technical assistance to states and their partners through webinars and an affinity group.

Homelessness - The Committee recognizes that homelessness can unnecessarily drive up Medicaid costs through excessive use of emergency room care, and that providing housing and resident services to this population can reduce such costs. The Committee directs HHS to report on the extent and types of waivers that exist to allow Medicaid funds to be used for affordable housing and resident services, in order to reduce Medicaid costs for families and individuals
with disproportionate levels of health care expenditures. Such report shall include any efforts HHS has made or plans to make that would encourage such use through guidance to states or use of demonstration projects.

Actions Taken or To Be Taken

As required by section 1017(b)(3) of the SUPPORT Act, CMS published a Report to Congress in November 2020 on homelessness that details innovative strategies and lessons learned by states with Medicaid waivers approved under sections 1115 or 1915 of the Social Security Act (Act). The report discusses challenges experienced by states in designing, securing, and implementing such waivers or plan amendments; how states developed partnerships with other organizations such as behavioral health agencies, state housing agencies, housing providers, health care services agencies and providers, community-based organizations, and health insurance plans to implement waivers or state plan amendments; and how and whether states plan to provide Medicaid coverage for housing-related services and supports in the future, including by covering such services and supports under state Medicaid plans or waivers.

In addition, CMS published a letter to states (SHO# 21-001) in January 2021 to describe opportunities in Medicaid and CHIP to address social determinants of health (SDOH) and to support states with designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid and CHIP programs by addressing SDOH. This letter describes: (1) several overarching principles that CMS expects states to adhere to within their Medicaid and CHIP programs when offering services and supports that address SDOH; (2) services and supports that are commonly covered in Medicaid and CHIP programs to address SDOH; and (3) federal authorities and other opportunities under Medicaid and CHIP that states can use to address SDOH. Examples to address homelessness like supportive housing, including through a waiver authority, are highlighted.

Disproportionate Share Hospitals - The Committee instructs CMS to compile publicly available information on hospitals that receive payments under Medicaid as disproportionate share hospitals. Such information shall include the Medicaid inpatient utilization rate and low-income utilization rate. Within each category, CMS should further identify such hospitals by rural or urban status; number of beds, and; status as a major teaching hospital.

Actions Taken or To Be Taken

Currently, federal law requires states that receive federal financial participation for Medicaid DSH payments to submit an independent certified audit and an annual report to the Secretary describing DSH payments made to each DSH hospital. Per the Medicaid statute, the report must identify each disproportionate share hospital that received a DSH payment adjustment, and provide any other information the Secretary needs to ensure the appropriateness of the payment amount. The annual certified independent audit includes specific verifications to make sure all DSH payments are appropriate.

State-specific annual DSH reports are posted on Medicaid.gov as submitted by states (based on their availability) and are arranged alphabetically by state under the corresponding State Plan Rate Year (SPRY) heading. To ensure that the DSH payments are appropriate as required by law, the state-specific reports include information on the Medicaid inpatient utilization rate and low-income utilization rate by hospital. CMS is committed to continuing to ensure that states submit necessary information on hospitals that receive Medicaid DSH payments.

Extravasations - The Committee is pleased CMS is engaging with outside stakeholders to consider using a variety of levers to encourage providers to engage in nuclear medicine injection quality control and assurance. The Committee requests an update on this issue in the fiscal year 2022 Congressional Budget Justification.

Action Taken or To Be Taken

Hospitals must meet Medicare conditions of participations (CoPs), which are the health and safety requirements established through rulemaking. The nuclear medicine CoPs (42 CFR 482.53) require that nuclear medicine services meet the needs of patients in accordance with acceptable standards of practice, which include compliance with applicable Federal and State law and regulations governing the use of nuclear medicine, as well as standards promoted by nationally recognized professional organizations. As part of these conditions, radioactive materials must be prepared, labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice. In addition, a hospital's nuclear medicine services must be integrated into the hospital's Quality Assessment and Performance Improvement program to monitor the quality and safety of nuclear medicine services. This program requires the hospital to track adverse events and medical errors to find their causes and undertake preventive actions.

CMS is committed to working and meeting with stakeholders to improve quality of care, including the quality of nuclear medicine services furnished to patients. We welcome input, feedback, and contributions from stakeholders, including the clinical community, and will continue to work together and solicit this feedback to determine how best to ensure adherence to the conditions of participation and the provision of quality healthcare, including with respect to nuclear medicine injection.

Hospital Acquired Conditions - The Committee continues its desire for CMS to take action to prevent hospital-acquired pressure ulcers and pressure injuries (HAPUIs) that impact about 2.5 million patients each year and kill more than 60,000 hospital patients per year. Most HAPUIs are

preventable with the application of evidence- based protocols. In November 2019, the International Pressure Injury Prevention and Treatment Clinical Practice Guidelines were released, which includes the Standardized Pressure Injury Prevention Protocol (SPIPP), a checklist that simplifies the guidelines into actionable steps. The Committee expects CMS to take specific steps to promote and incentivize the use of the SPIPP, especially in hospitals that care for Medicare patients. The Committee requests an update in the fiscal year 2022 Budget Request with a timeline and steps taken and planned to promote the use of the SPIPP to reduce the number of HAPUI's among Medicare beneficiaries.

Action Taken or To Be Taken

CMS is committed to ensuring beneficiaries have the highest quality of care, and pressure ulcers are a critical area to address. CMS has worked to add quality measures addressing pressure ulcers to its quality reporting and value-based payment programs. Specifically, in the hospital setting, we have one composite measure, the Patient Safety and Adverse Events composite measure, which provides a performance score based on how often patients have certain complications related to inpatient hospital care. There are ten complications that are part of this measure, one of which is Pressure Ulcer Rate. This composite measure is reported on Care Compare and is also included in the Hospital-Acquired Conditions Reduction program.

CMS is also developing a Pressure Injury electronic clinical quality measure. CMS did consider pressure injury guidelines from the National Pressure Injury Advisory Panel during measure development. In addition, there are quality measures addressing pressure ulcers in all of the quality reporting programs for post-acute care providers (long-term care hospitals, inpatient rehabilitation hospitals, skilled nursing facilities, and home health agencies).

Additionally, a payment policy was established in 2008 under which Medicare does not make additional payments for inpatient hospital care for selected hospital-acquired conditions if the condition was not present on admission, and if the condition could reasonably have been prevented through the application of evidence-based guidelines. CMS has selected certain conditions for this payment policy, and one category of conditions is Pressure Ulcer Stages III & IV. If a selected condition results in assignment of a case to a secondary diagnosis that would lead to a higher payment, hospitals will not receive the higher payment amount but will be paid as though the secondary diagnosis was not present. There is a similar provision in the Medicaid program implemented in 2011, under which States may not pay for services related to certain provider-preventable conditions in hospitals. This includes most hospital-acquired conditions selected under the Medicare provision described above, as well as provider-preventable conditions identified in a State Medicaid plan.

Sepsis - The Committee is pleased that CMS and the National Quality Forum plan to update the SEP 1 measure. A CMS study published in February reported an alarming 40 percent increase in the number of Medicare patients hospitalized with sepsis over the past seven years. Medicare spent more than $41.5 billion on sepsis care in 2018. The Committee supports this effort and encourages CMS to issue a Request for Information as part of this review to collect broad stakeholder input to help ensure the new SEP 1 measure improves health outcomes. The Committee requests an update on these activities in the fiscal year 2022 Budget Justification.

Action Taken or To Be Taken

CMS agrees that ensuring proper sepsis treatment is a critical area to focus on to improve quality of care in hospitals, other healthcare facilities, and the community at large. As stated in CMS' Measure Inventory Tool, the sepsis measure (SEP-1) focuses on a set of interventions some of which must occur within three hours of presentation of severe sepsis, and others within six hours of presentation of septic shock

(https://cmit.cms.gov/CMIT_public/ReportMeasure?measureRevisionId=300). Since the measure inception in 2015, the measure stewards have made many updates, which take into account evolving clinical practice and the measure specifications and data element definitions have continued to be refined and updated to increase clarity and reduce burden for abstractors. Additionally, CMS has begun work on development of a sepsis outcome measure.

Enhancing Tools to Detect Cognitive Impairment - The Committee remains concerned about the underutilization of the cognitive impairment detection component of the Medicare Annual Wellness Visit and is aware of multiple efforts to address this challenge. To support this effort, the Committee directs CMS to update educational materials for Medicare beneficiaries as to the availability of this benefit and the importance of regular assessments of cognitive health, including the value of establishing cognitive health baselines. The Committee also directs CMS to develop similarly updated materials for healthcare providers including information on the importance of baseline and regular assessments as well as tools available to conduct such assessments.

Action Taken or To Be Taken

Section 1861(hhh)(2)(D) of the Social Security Act includes "detection of any cognitive impairment" as a statutorily required element of the Annual Wellness Visit. CMS' Medicare Learning Network Medicare Wellness Visits guide includes information on the cognitive impairment detection element and refers readers to the National Institute on Aging's Alzheimer's and Dementia Resources for Professionals website (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html). In addition, Section 116 of the Consolidated Appropriations Act, 2021 requires the Secretary to conduct outreach to physicians and other appropriate Medicare-participating practitioners with respect to Medicare payment for cognitive assessment and care plan services, including a comprehensive, one-time education initiative. CMS is working to improve outreach on this important screening for cognitive impairment.

Measuring Incidence and Prevalence of Mild Cognitive Impairment and Alzheimer's Disease - The Committee remains interested in better understanding the impact of Mild Cognitive Impairment (MCI), Alzheimer's disease, and other related dementias on Medicare beneficiaries to ensure the Medicare program is able to address current and future needs. To gather such information, the Committee directs CMS to develop and incorporate within the Medicare Current Beneficiary Survey a module of questions pertaining to MCI, Alzheimer's disease, and other related dementias including if beneficiaries have received a diagnosis of either condition and how long it took for them to receive such a diagnosis; if their providers have used the cognitive detection component of the Annual Wellness Visit; and if the beneficiaries have been advised about Alzheimer's and dementia care planning services that are covered under Medicare.

Action Taken or To Be Taken

CMS agrees it is important to understand the impacts of Mild Cognitive Impairment and Alzheimer's Disease on Medicare beneficiaries. The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a nationally representative sample of the Medicare population. The MCBS primarily focuses on economic and beneficiary topics including health care use and health care access barriers, health care expenditures, and factors that affect health care utilization. The MCBS has included questions that ask beneficiaries if they have received an Annual Wellness Visit; ask beneficiaries if they have ever been told by a physician that they had Alzheimer's Disease or another form of dementia; assess beneficiary memory; and ask whether the beneficiary has had difficulty concentrating, remembering or deciding.

Medicare Promotion - The Committee directs CMS to avoid taking any action that actively promotes one form of Medicare coverage over another, particularly with respect to the choice between traditional Medicare and Medicare Advantage. The Committee further directs CMS to maintain its online coverage options tool in a manner that provides complete and unbiased information, particularly the redesigned Medicare Plan Finder. Furthermore, CMS should remain objective and neutral in its education and outreach materials concerning options that beneficiaries have during the open enrollment period and at any other time.

Action Taken or to be Taken

CMS has worked to ensure that Medicare beneficiaries have clear, accurate information for making choices about their Medicare coverage. CMS continually strives to improve its Medicare beneficiary outreach and education so as to support beneficiary decision making.

Our outreach goal during Medicare Open Enrollment has been to encourage beneficiaries to review and compare their Medicare coverage options. CMS conducts a multi-faceted campaign during Open Enrollment underpinned by this message.

The Medicare Plan Finder allows people to compare Original Medicare with Medicare Advantage Plans and Prescription Drug Plans in their area. Building on previous redesign and modernization efforts, and based on consumer feedback, CMS has continued to make changes to the Medicare Plan Finder that have focused on improving the experience for beneficiaries in using the Plan Finder to learn about different options and select coverage that best meets their health needs.

In addition, CMS has continued to update other resources for beneficiaries to use in learning about their Medicare coverage options. This includes the Medicare & You handbook mailed to beneficiary households each fall. The handbook clarifies the distinctions between Original Medicare and Medicare Advantage.

It is important that beneficiaries choose the Medicare coverage option that provides them with the care they need. CMS remains committed to making sure that Medicare beneficiaries have clear, accurate information for making that decision.

Regulatory and Payment Reforms - The Committee directs CMS to work with hospitals and community-based organizations to identify substantive regulatory delivery and payment reforms that, among other things, integrate behavioral health in primary care; create new and evaluates existing delivery models to improve spending efficiency and value-based care, and; incentivize the health care workforce to meet the unmet care needs of Medicare beneficiaries in underserved areas. The Committee also directs CMS to work with stakeholders, including Medicare beneficiaries and providers, to consider these goals.

Action Taken or To Be Taken

Through the CMS Innovation Center, CMS works with stakeholders, including hospitals and community-based organizations, to improve care delivery and integration in underserved areas and for underserved populations.

For example, with respect to patients with complex, chronic conditions and seriously ill populations, the Innovation Center’s Direct Contracting payment model options seek to reduce program expenditures and improve quality of care and health outcomes for Medicare beneficiaries through alignment of financial incentives and an emphasis on beneficiary choice and care delivery while maintaining access to care for beneficiaries.

With respect to patients in rural areas, the Community Health Access and Rural Transformation (CHART) Model aims to address disparities by providing a way for rural communities to transform their health care delivery systems by leveraging innovative financial arrangements as well as operational and regulatory flexibilities.

In addition to the Innovation Center, CMS engages with hospitals and community-based organizations on regulatory delivery and payment reform issues affecting underserved communities through notice-and-comment rulemaking process, through which CMS implements statutory changes as well as regular communications with stakeholders, such as Open Door Forums. With respect to rural areas, the Consolidated Appropriations Act, 2021 enacted on December 27, 2020 includes a provision establishing rural emergency hospitals as a new provider under Medicare that will serve patients in underserved rural patients. CMS will engage with stakeholders through the rulemaking process in implementing this provision.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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PROGRAM OPERATIONS

MCR9: Ensure Beneficiary Telephone Customer Service

Measure	FY	Target	Result
MCR9.1a: Quality Standards: Minimum of 90 percent pass rate for Adherence to Privacy Act*	2022	90%	October 31, 2022
	2021	90%	October 31, 2021
	2020	90%	99% (Target Exceeded)
	2019	90%	99% (Target Exceeded)
	2018	90%	98% (Target Exceeded)
	2017	90%	98% (Target Exceeded)
	2016	90%	98% (Target Exceeded)
MCR9.1b: Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment*	2022	90%	October 31, 2022
	2021	90%	October 31, 2021
	2020	90%	99% (Target Exceeded)
	2019	90%	94% (Target Exceeded)
	2018	90%	97% (Target Exceeded)
	2017	90%	97% (Target Exceeded)
	2016	90%	96% (Target Exceeded)
MCR9.1c: Quality Standards: Minimum of 90 percent meets expectations for Knowledge Skills Assessment*	2022	90%	October 31, 2022
	2021	90%	October 31, 2021
	2020	90%	93% (Target Exceeded)
	2019	90%	95% (Target Exceeded)
	2018	90%	97% (Target Exceeded)
	2017	90%	97% (Target Exceeded)
	2016	90%	95% (Target Exceeded)

Measure	FY	Target	Result
MCR9.3: Minimum of 90 percent pass rate for the Customer Satisfaction Survey*	2022	90%	October 31, 2022
	2021	90%	October 31, 2021
	2020	90%	94% (Target Exceeded)
	2019	90%	94% (Target Exceeded)
	2018	90%	94% (Target Exceeded)
	2017	90%	93% (Target Exceeded)
	2016	90%	92% (Target Exceeded)

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

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

For each fiscal year, the CCO has met or exceeded the target of 90 percent for each standard. Despite exceeding targets in previous reporting years, CMS will continue to maintain the quality standards target levels at 90 percent. In order to increase contact center quality standards, contact centers would need to increase the amount of quality assurance staff responsible for monitoring and coaching. This would mean additional costs for the contractors supporting the contact center. The resources required to ensure a higher quality metric would be better allocated to the increased contacts associated with the incoming baby boomer population.

Since FY 2009, the CCO has been assessed annually by an Independent Quality Assurance (IQA) contractor. The intent of this assessment is to gather more detail on where improvements can be made in handling telephone inquiries, to better serve the calling population. There is currently a parallel effort between the CCO and the IQA contractor to assess quality through quality monitoring tools – but for separate purposes.

The CCO contractor uses Quality Call Monitoring for coaching individual CSRs. Alternatively, CMS' IQA contractor uses Quality Call Monitoring to assess quality from a global perspective, as well as to identify processes and areas needing attention and make specific recommendations regarding quality improvements. Part of the IQA Plan addresses quality oversight of English and Spanish inbound and outbound telephone and written correspondence, as well as e-mail, web chat, and faxed inquiries. CMS will use the results of the IQA audits for root cause analysis and for

identifying areas of improvement for training and content materials as well as any other tools currently available to CSRs.

Since 2009, this performance measure has been based on survey methods designed by CMS, with questions approved by the Office of Management and Budget (OMB). The survey measures a variety of customer service dimensions, including overall satisfaction, program knowledge, clarity, rapport, customer effort, and First Call Resolution, capturing an aggregated score of these dimensions.

MCR12: Maintain CMS' Improved Rating on Financial Statements

Measure	FY	Target	Result
MCR12: Maintain an unmodified opinion*	2022	Maintain an unmodified opinion	November 15, 2022
	2021	Maintain an unmodified opinion	November 15, 2021
	2020	Maintain an unmodified opinion	Target Met
	2019	Maintain an unmodified opinion	Target Met
	2018	Maintain an unmodified opinion	Target Met
	2017	Maintain an unmodified opinion	Target Met
	2016	Maintain an unmodified opinion	Target Met
	2015	Maintain an unqualified opinion	Target Met

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

The Chief Financial Officers (CFO) Act of 1990 creates a framework for the federal government to focus on the integration of accounting, budget, and other financial activities under one umbrella. This is meant to reduce waste and to provide complete, reliable, timely, and consistent information to Congress on the financial status of the federal government.

CMS's annual goal is to maintain an unmodified opinion, which indicates that its financial statements fairly present, in all material respects, the financial position, net costs, changes in net position, budgetary resources, and the projected future value of Medicare's social insurance programs. An independent audit firm reviews the financial operations, internal controls, and compliance with laws and regulations at CMS and its contractors.

CMS met its FY 2020 target of maintaining an unmodified opinion on four out of the six principal financial statements. During FY 2020, the auditors could not express an opinion on the CMS Statement of Social Insurance (SOSI) or the CMS Statement of Changes in Social Insurance Amounts (SCSIA). CMS has been substantially compliant with the Federal Financial Management Improvement Act (FFMIA) since FY 2010. CMS considers its financial systems to be integrated in accordance with OMB Circular A-127, *Financial Management Systems.* The Healthcare Integrated General Ledger Accounting System (HIGLAS) is CMS's official financial system of record used to produce its financial statements. Overall, CMS continued to improve its financial management performance in many areas, as evidenced by no material weaknesses being reported as a result of the agency's CFO audit and OMB Circular A-123 review. In addition, CMS provided a FY 2020 Federal Managers' Financial Integrity Act (FMFIA) statement of reasonable assurance regarding the Agency's internal controls over financial reporting for June 30 and September 30.

MCR26: Reduce All-Cause Hospital Readmission Rates for Medicare Beneficiaries

Measure	CY	Target	Result
MCR26: Reduce all-cause hospital readmission rate by 1% per year from the prior year's actual rate[1] *	2022	17.5%	March 1, 2022 (based on CY 2020 data)
	2021	17.5%	17.8% (Target Not Met) (based on CY 2019 data)
	2020	17.5%	17.7% (Target Not Met) (based on CY 2018 data)
	2019	17.4%	17.7% (Target Not Met) (based on CY 2017 data)
	2018	17.8%	17.6% (Target Exceeded) (based on CY 2016 data)
	2017	17.4%	18.0% (Target Not Met) (based on CY 2015 data)
	2016	17.4%	17.6 % (Target Not Met) (based on CY 2014 data)
	2015	17.9%	17.6% (Target Exceeded) (based on CY 2013 data)

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

[1] CMS targets reduction of all-cause Medicare hospital readmissions by one percent (not to be confused with one percentage point) per year from the prior year's actual rate (if available) or the prior year's target for the time period when the prior year's actual rate is not yet known. To meet or exceed the Target, the Result must be less than or equal to the calculated Target.

A "hospital readmission" occurs when a patient who has recently been discharged from a hospital is once again readmitted to a hospital. A thirty-day period for readmission data has been standard across the quality measure industry for several years. One way that the Medicare statute incentivizes hospitals to reduce preventable readmissions is through the Hospital Readmissions Reduction Program (HRRP). Established by Congress beginning in FY 2013, the HRRP reduces a statutorily defined portion of Medicare's payment amounts for certain potentially preventable Medicare inpatient hospital readmissions covering three conditions: Acute Myocardial Infarction, Pneumonia, and Congestive Heart Failure. For FY 2015 and beyond, two additional readmission measures were added to the program: (1) Chronic Obstructive Pulmonary Disease and (2) Total Hip Arthroplasty and Total Knee Arthroplasty. For FY 2017 and beyond, CMS established an additional measure for patients readmitted following Coronary Artery Bypass Graft Surgery, and CMS refined the Pneumonia readmission measure cohort. Additionally, the 21st Century Cures Act requires CMS to assess a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid beginning in FY 2019.

In addition to the HRRP, CMS leverages efforts of other programs to reduce hospital readmissions. Among these are the Quality Improvement Network – Quality Improvement Organizations that work to reduce preventable complications (e.g. sepsis by proper diagnosis and treatment of bacterial infection while in the hospital) during a transition from one care setting to another, which includes partnership with the Community-Based Care Transitions Program and Quality Improvement Organizations. CMS' efforts to reduce readmissions also extend to Accountable Care Organizations, which must report on and meet targets for quality measures if they wish to receive incentives under the Medicare Fee-for-Service Shared Savings Program, and to CMS Innovation Center's Bundled Payments for Care Improvement Advanced Model, which includes a readmissions measure to encourage hospitals and their care teams to collaborate and ensure that they provide appropriate discharge planning, instructions, and follow up care to patients to help reduce the risk of readmission.

CMS did not meet its target for CYs 2019, 2020, and 2021 following one year, CY 2018, where its target was exceeded. This followed two years, CYs 2017 and 2016, where the targets were not met. Overall the readmission rates continue to appear to be relatively constant since CY 2015 following a historical pattern of slight reductions (the slight increase in CY 2017 appears to be an anomaly). It is unclear whether this trend will continue or whether rates will increase or decrease further. In light of these results, CMS set slightly less aggressive targets for CY 2021 and CY 2022. CMS set the 2022 target at 17.5 percent based on the CY 2021 result. CMS will continue to monitor the data and will report on the CY 2022 target in the first half of 2022.

Note: CMS recognizes that the COVID-19 Public Health Emergency (PHE) likely impacted hospital readmission, case mix, and admission volume trends since the early 2020 PHE declaration. We will incorporate this information into our CY 2022 report that measures calendar year 2020 discharge results.

MCR36: Shift Medicare Health Care Payments from Volume to Value

Measure	CY	Target	Result
MCR36: Increase the percentage of Traditional Medicare health care dollars tied to Alternative Payment Models (APMs) incorporating downside risk	2022	*TBD	*TBD
	2021	40%	*December 15, 2022
	2020	30%	*December 15, 2021
	2019	Baseline	20.21%

* The "Result" dates are subject to change and have been updated to reflect to be determined (TBD) due to the unknown impacts of the Coronavirus (COVID-19) pandemic, CMS cannot fully commit to specific future results dates at this time.

The Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS), through the Center for Medicare and Medicaid Innovation (CMMI), identifies, tests, evaluates, and expands, as appropriate, innovative payment and service delivery models. These innovative payment and service delivery models can reduce program expenditures for Medicare, Medicaid, and the Children's Health Insurance Program, while improving or preserving beneficiary health and quality of care. Under this authority, CMS is testing a variety of Alternative Payment Models (APMs) that create new incentives for clinicians to deliver better care at a lower cost and reward quality and efficiency of care.

To achieve the goals of better care, smarter spending, and healthier people, the United States (U.S.) health care system must substantially reform its payment structure to incentivize quality health outcomes and pay for value over volume. However, to change the entire U.S. health care system from a volume-incentivized system to a value-based system, commercial, Medicare Advantage, and Medicaid payers also need to adopt the same payment reform goals as Medicare. For this reason, HHS publicly announced in 2015 the aggressive goal to tie 30 percent of Traditional Medicare payments to APMs linked to quality and value by 2016 and 50 percent by 2018[1], while simultaneously establishing the Health Care Payment Learning and Action Network (HCP-LAN or LAN) to align the rest of the U.S. health care system with HHS' payment goals and jointly measure progress towards those goals. The LAN's nationwide measurement effort that developed in response has been highly successful—evolving to incorporate data from a large sample of payers (including Traditional Medicare) that represent nearly 80 percent of covered Americans, and now serving as the most comprehensive snapshot available for measuring progress on payment reform. In 2018 and 2019, the LAN began reporting payment data by line of business—Commercial, Medicaid, Medicare Advantage, and Traditional Medicare.[2]

[1] Announced publically in the CMS FY 2021 Congressional Justification page 333.
[2] The LAN's APM measurement results and methodology use for CY 2015-2020 can be found at: https://hcp-lan.org/apm-measurement-effort/

APMs and payment reforms that increasingly tie Fee-for-Service (FFS) payments to value are currently moving the health care system in the right direction. Nonetheless, current rates of health care spending are unsustainable, and there is an urgent need to substantially transform the way health care is paid for and delivered. Downside risk APMs hold promise for driving this fundamental change, because they promote incentives and flexibility to innovate and improve care delivery. In order to continue the advancement of value-based care, CMS aims to increase the adoption of downside risk APMs, which include the potential for participants to either gain or lose money based on their performance, giving them direct financial accountability for beneficiaries' costs and quality of care. Unlike the prior APM adoption performance goal, this updated goal does not include upside-only models.

Medicare is leading the way by publicly announcing, tracking, and reporting payments tied to APMs that are taking on downside risk, while working through the LAN to ensure that its large group of payers, providers, purchasers, patients, product manufacturers, and policymakers across the U.S. also adopt aligned goals to move towards downside risk APMs. To that end, at the annual LAN Summit on October 24, 2019, Secretary Azar and the LAN jointly announced a new goal for commercial, Medicare Advantage, Medicaid, and Traditional Medicare to accelerate the percentage of U.S. health care payments tied to quality and value in each of those market segments through the adoption of downside risk APMs[3]. Traditional Medicare set targets in that announcement to increase downside APM adoption to 30 percent by 2020 and 40 percent by 2021. These targets have been incorporated into this updated APM goal. The final CY 2019 baseline for this new downside risk APM goal is 20.21 percent.

Furthermore, the annual LAN summit was not held in its usual form in 2020 due to the impact of the COVID-19 pandemic; and there was no annual reporting on goals. It is unknown whether COVID-19 response will result in changes to resource allocations, increased data lag, and/or the inability to obtain comprehensive inputs for calculating targets and results on time.

[3] A livestream of this joint announcement can be found at: https://www.lansummit.org/

MCR37: Increase Patient Choice in Dialysis Treatment

Measure	CY	Target	Result
MCR37: Increase the percentage of new dialysis patients who choose home dialysis modalities	2022	22.57%	June 30, 2023
	2021	19.92	June 30, 2022
	2020	19.02	20.52% (Target Exceeded)
	2019	Baseline	*18.11%

This measure monitors the number of new End-Stage Renal Disease (ESRD) patients that start dialysis with a home modality within 180 days of initial dialysis. This measure focuses on increased patient choice to use of home dialysis. The U.S. Department of Health and Human Services (HHS) has a goal of 80 percent of new ESRD patients either receiving dialysis at home or receiving a transplant by 2025. The targets set for this measure up to 2021 are calculated based on a 10 percent relative increase in measure rate starting from the 2019 baseline to 2021. For example, CY 2020 target is 19.02 percent (5 percent relative increase over baseline) and CY 2021 target is 19.92 percent (10 percent relative increase over baseline). The target for 2022 is based on the observed measure rate in 2020 and uses a similar calculation. For example, the observed measure rate in 2020 was 20.52 percent, then a 10 percent relative increase over 2 years to 2020 yields a target of 22.57 percent. To calculate this measure, home dialysis is defined as receiving dialysis treatments in a home setting. This includes both peritoneal dialysis and home hemodialysis. The admission and treatment records data collected in ESRD Quality Reporting System (EQRS) is used as the data collection source for dialysis facilities. Other aligned CMS efforts around home dialysis include work on the Kidney Care Choices (KCC) Model and the ESRD Treatment Choices (ETC) Model.

Studies have shown that use of home dialysis results in better or equal clinical outcomes and reduced hospitalization as compared to In-Center Hemodialysis (ICHD). Patients who choose home dialysis for treatment report more energy, flexible treatment schedules, fewer diet and fluid restrictions and more freedom to travel. Despite these reported benefits, in 2018 home dialysis was underutilized in the U.S. with approximately 8 percent of the dialysis patients undergoing renal replacement therapy at home versus approximately 92 percent being treated with in-center hemodialysis ESRD Network Program Summary Reports. Home dialysis modalities includes:

- Peritoneal Dialysis (PD): This treatment uses the patients' peritoneum and dialysis fluid to filter waste and extra fluid utilizing a catheter that is placed in the abdomen. It can be done almost anywhere, including home, school, work and while traveling. A patient can complete this treatment without any assistance.

- Home Hemodialysis (HHD): Similar to in-center hemodialysis, HHD cleans a patients' blood utilizing a vascular access site (e.g., arteriovenous fistula, arteriovenous graft), dialysis machine and an artificial kidney (i.e., filter). The HHD machines are smaller and portable, allowing for patients to dialyze at home or when traveling. Most often a care partner is required for treatment, but some new technology allows for patients to dialyze unaided.

Data from the U.S. Renal Data System (USRDS) indicate that annual cost of home dialysis is substantially less than in-center dialysis for qualified patients. The annual cost of in- center therapy for all modalities is approximately $78,049 a year versus approximately $66,751 for therapy at home—a difference of $11,298 per year.

There are a number of barriers related to increasing the use of home dialysis. Key examples include: lack of patient and provider education about home dialysis modalities, provider hesitancy to refer patients due to lack of familiarity, and lack of psychosocial and financial support for patients and care partners.[4] Current ESRD Network projects in conjunction with other Network of Quality Improvement & Innovation Contractors (NQIIC) work in tandem to mitigate these challenges. As a result of the ongoing work of the ESRD Network Program Summary Reports, specifically the 2018 home dialysis quality improvement activity, in which Networks partnered with 30 percent of dialysis facilities nationwide, 5,252 ESRD patients transitioned from ICHD to a home dialysis modality representing an approximate cost savings of $59 million. CMS continues to promote increased use of home dialysis modalities through the ESRD Networks' Quality Improvement Activity (QIA) projects and other collaborative activities with the renal community.

However, as of March 2020, the COVID-19 outbreak added new vulnerabilities that may negatively impact the agency's ability to meet performance targets. Note, a dialysis patient starting dialysis on a home modality in the time of COVID could actually be protective, and reduce the chances of the beneficiaries contracting the virus that causes COVID, compared to in center hemodialysis. Currently, dialysis staff have been redirected to focus on the needs of the pandemic (e.g., increased infection prevention activities). Specifically, there is a shortage of dialysis staff to train patients to utilize a home modality or participate in ESRD Networks quality improvement efforts to support the patient's choice of a home modality. Although the ESRD Networks are continuing to provide educational materials to patients and dialysis facility staff, and are maintaining communication with the renal community in an effort to increase the number of patients dialyzing at home, the Home Dialysis LANs have been suspended, as well as the Home Dialysis (QIA) goal for home dialysis and collection of all self-reported data in order to further support mitigation efforts regarding the COVID-19 outbreak.

[4] Chan, Christopher T. et al. Exploring Barriers and Potential Solutions in Home Dialysis: An NKF-KDOQI Conference Outcomes Report. American Journal of Kidney Diseases (March 2019), Volume 73, Issue 3, 363-371

MMB2: Reduce All-Cause Hospital Readmission Rate for Medicare-Medicaid Enrollees

Measure	CY	Target	Result
MMB2: Reduce All-Cause Hospital Readmission Rate for Medicare-Medicaid Enrollees*	2022	0.25% Reduction from 2021 Actual	April 30, 2024
	2021	0.25% Reduction From 2020 Actual	April 30, 2023
	2020	0.5% Reduction From 2019 Actual	April 30, 2022
	2019	1% Reduction From 2018 Actual	84.6 per 1000 (Target Not Met) (1.07% above 2018 actual)
	2018	1% Reduction From 2017 Actual	83.7 per 1000 (Target Not Met) (0.9% below 2017 actual)
	2017	Historical Actual	84.5 per 1000 (0.8% above 2016 actual)
	2016	Historical Actual	83.7 per 1,000 (0.4% below 2015 actual)
	2015	Historical Actual	84.0 per 1,000 (0.8% above 2014 actual)
	2014	Historical Actual	83.4 per 1,000 (2.7% below 2013 actual)
	2013	Historical Actual	85.7 per 1,000 (7.5% below 2012 baseline)
	2012	Baseline (Readmissions per 1,000 Beneficiaries)	92.7[1]

[1] The methodology for this goal was updated in 2017 to reflect changes in the Yale readmissions measure used in Medicare's Hospital Readmissions Reduction Program (HRRP). This is the measure upon which this goal was developed. As a result of the revised methodology that eliminated the old data coding, CMS re-calculated the prior years' reports (including the 2012 baseline), since they were based on outdated Yale measure specifications. The new calculation ensures consistent methodology across all years.

A "hospital readmission" occurs when a patient who has recently been discharged from a hospital is once again readmitted to a hospital. A thirty-day period for readmission data has been standard across the quality measure industry for several years. Discharge from a hospital is a critical transition point in a patient's care; incomplete handoffs at discharge can lead to adverse events for patients and avoidable readmissions. Hospital readmissions may indicate poor care or missed opportunities to better coordinate care, and may result in unnecessary costs.

While many studies have pointed to opportunities for improving hospital readmission rates, the rate of readmissions for individuals who are dually eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees) is often higher than for Medicare beneficiaries overall. In 2019, an estimated 12.3 million beneficiaries were dually eligible for Medicare and Medicaid.

Compared to non-dually eligible Medicare beneficiaries, dually eligible individuals have higher rates of chronic and co-morbid conditions and higher rates of institutionalization, in addition to challenges posed by low socioeconomic status. As a result, CMS seeks to assess the impact of interventions on this sub-population.

CMS calculates this measure using the number of readmissions per 1,000 eligible beneficiaries. Eligible beneficiaries are dually eligible individuals of any age.

CMS found an increase in the readmissions rate from 2018 to 2019 was 1.07 percent. Similarly, MCR26 found a slight increase in its readmission rate and an overall stabilization of the rate among those with dually eligible status in recent years. We continue to believe the experience from 2015-2019 demonstrates a similar "plateauing" of readmissions around the 84.0 per 1000 rate. Therefore, CMS recommends maintaining the target reduction rate of 0.25 percent in the future based on this measure's apparent plateau and national trends (https://www.hcup-us.ahrq.gov/reports/statbriefs/sb248HospitalReadmissions-2010-2016.pdf) reflecting a slowing in readmissions reductions for all Medicare beneficiaries (after a number of years of larger declines. COVID-19 Public Health Emergency (PHE) impacts are not reflected in this year's report, which only captures data through December 31, 2019.

At CMS there are a number of programs and innovations aimed at incentivizing a reduction in Medicare fee-for-service hospital readmissions, including for dually eligible individuals. While we are seeing a plateauing in the measure results, we continue to focus on reductions through, for example:

- The Medicare-Medicaid Financial Alignment Initiative managed fee-for-service demonstration in Washington State, which focuses on improving care coordination for high-risk dually eligible beneficiaries and holds the state accountable for readmission and associated costs;
- The Medicare Hospital Readmissions Reduction Program (HRRP), which in FY 2019 began assessing a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full Medicaid benefits;
- The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) program, which rewards SNFs with incentive payments based on hospital readmissions;
- Accountable care organizations, including the Medicare Shared Savings Program (MSSP); and
- An array of CMS Innovation Center models with financial incentives to reduce utilization and readmissions, including the Bundled Payments Care Improvement (BPCI) initiative, the Next Generation ACO model, and Primary Care First.

CMS continues to improve our existing quality programs and develop new models focused on value-based care. These initiatives create strong incentives to reduce hospital readmissions, including for dually eligible individuals.

MMB3: Support Integrated Care for Medicare-Medicaid Dually Eligible Individuals

Measure	FY	Target	Result
MMB3: Number of full benefit dually eligible individuals in Medicare Medicaid integrated care nationally	2022	Contextual Measure	Nov 30, 2022
	2021	Contextual Measure	Nov 30, 2021
	2020	Contextual Measure	1,107,518
	2019	Contextual Measure	1,006,927
	2018	Baseline	832,494

Over 12 million Americans are concurrently enrolled in both the Medicare and Medicaid programs. Overall, dually eligible individuals have a higher prevalence of many health conditions than their Medicare-only and Medicaid-only peers. These individuals must navigate two separate programs: Medicare for the coverage of most preventive, primary, and acute health care services and drugs, and Medicaid for coverage of long-term services and supports (LTSS), certain behavioral health services, and for help with Medicare premiums and cost sharing.

A lack of alignment and cohesiveness between the Medicare and Medicaid programs can lead to fragmented and episodic care for dually eligible individuals and misaligned incentives for both payers and providers. This may result in reduced quality and increased costs to both programs and to enrollees. Dually eligible individuals could benefit from more integrated systems of care that meet all of their needs – primary, acute, long-term, behavioral, and social – in a high quality, cost-effective manner. Better alignment of the administrative, regulatory, statutory, and financial aspects of these two programs holds promise for improving the quality and cost of care for this complex population.

In recent years, CMS has partnered with states to develop innovative, integrated care and financing approaches. CMS has focused on initiatives to better integrate and strengthen access to care for dually eligible individuals and to eliminate unnecessary cost shifting between the Medicare and Medicaid programs. There are a range of approaches to integrating Medicare and Medicaid benefits and/or financing, including through Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), the Programs of All-inclusive Care for the Elderly (PACE), and integrated care models and demonstrations such as the Medicare-Medicaid Financial Alignment Initiative. Promoting integrated care through these approaches, and maximizing their value to beneficiaries, is a high priority for CMS.

Since 2011, the number of full-benefit dually eligible individuals in integrated care and/or financing models has increased by more than 600 percent.[5] Still, fewer than 15 percent of full benefit dually eligible individuals are enrolled in integrated care

[5] https://www.cms.gov/files/document/mmco-report-congress.pdf

programs. Data for FY 2021 for this contextual measure will be available in fall 2021, following an annual process through which CMS works with contractors, state officials, and public data sources to update the total number of people in integrated care.

MEDICARE SURVEY & CERTIFICATION PROGRAM

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

Measure	CY	Target	Result
MSC5: Decrease the percentage of long-stay nursing home residents receiving an antipsychotic medication*	2022	15.0%	April 30, 2023
	2021	15.3%	April 30, 2022
	2020	15.4%	July 31, 2021
	2019	15.5%	14.0% (Target Exceeded)
	2018	16.0%	14.6% (Target Exceeded)
	2017	16.0%	15.4% (Target Exceeded)
	2016	16.7%	16.7% (Target Met)
	2015	17.9%	17.1% (Target Exceeded)

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

The purpose of this performance measure is to decrease the use of antipsychotic medications in nursing homes with an emphasis on improving dementia care. These medications have common and dangerous side effects when used for the behavioral and psychological symptoms of dementia.

In 2012, CMS began a nationwide initiative - the National Partnership to Improve Dementia Care in Nursing Homes – to improve dementia care and reduce the use of antipsychotic medications. CMS staff works with partners, including state coalitions, provider associations, nursing home resident advocates, and stakeholders, to decrease the use of these drugs. Some of this work includes developing and conducting trainings for nursing home providers, surveyors, and consumers; conducting research; raising public awareness; using regulatory oversight; improving surveyor guidance; national calls with the public; and public reporting, to increase transparency. CMS hopes to enhance person-centered care for all nursing home residents, particularly for individuals living with dementia.

A number of evidence-based, non-pharmacological interventions and approaches have been reviewed by national scientists and thought leaders through the National Partnership to Improve Dementia Care. These have been incorporated into clinical practice guidelines and various tools and resources and are now posted on the CMS website at National Partnership to Improve Dementia Care in NH . State Coalitions are reaching out to providers in every state and encouraging the use of these resources, as well as Hand in Hand, the training for nursing home staff developed by CMS. A number of meta-analyses have reviewed the use of non-pharmacological approaches to behaviors in people with dementia. Studies have shown that these interventions may be effective in reducing behaviors associated with dementia that may be distressing to residents or families.

Person-centered care is an approach that focuses on residents as individuals, and supports caregivers, working most closely with them. It utilizes a continual process of listening, testing new approaches, and changing routines and organizational strategies in an effort to individualize and de-institutionalize the care environment. Person-centered care is the central theme of the Hand in Hand training.

In July 2012, CMS began posting on the Nursing Home Compare website, quality measures of antipsychotic use in long-stay and short-stay nursing home residents, excluding residents with schizophrenia, Tourette's syndrome, or Huntington's disease. In 2015, CMS added the quality measures to the Five-Star Quality Rating System on the website.

For this goal, CMS reports the prevalence of antipsychotic use in the last three months of the fiscal year. The numerator consists of long stay residents receiving an antipsychotic medication on the most recent assessment. The denominator is all long-stay nursing home residents, excluding residents with schizophrenia, Tourette's syndrome, or Huntington's disease. Residents are considered to be long-stay residents if they have resided in the nursing home for 101 or more days. The baseline number reflects the prevalence of use in the last quarter of the calendar year 2011. It was selected because it was the last quarter in the pre intervention period.

In 2011 Q4, 23.9 percent of long-stay nursing home residents were receiving an antipsychotic medication; since then there has been a decrease of 41 percent to a national prevalence of 14.1 percent in 2020 Q2. Success has varied by state and CMS region, with some states and regions having seen a reduction of greater than 45 percent.

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	2022	98% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2023
	2021	98% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2022
	2020	98% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2021
	2019	98% of hospice facilities are surveyed within the required 36 month timeframe	98.3% (Target Exceeded)
	2018	95% of hospice facilities are surveyed within the required 36 month timeframe	96.5% (Target Exceeded)

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

Although some hospices are part of a hospital, nursing home, or home health agency, all hospices must meet specific federal requirements and be separately certified and approved for Medicare participation. There are approximately 5,000 Medicare certified hospice agencies in the U.S providing care to over 1.5 million Medicare beneficiaries annually.

The Social Security Act mandates the establishment of minimum health and safety standards for all participating hospice providers. These standards are further defined in the Medicare Conditions of Participation (COPs), which establish the minimum requirements that a hospice agency must meet in order to participate in Medicare. State Survey Agencies (SAs), under agreements between the state and CMS, evaluate hospice compliance through the survey and certification process. However,

approximately half of the Medicare-certified hospices participate through deemed status with a CMS-approved accrediting organization in lieu of oversight by State Survey Agencies.

The *Improving Medicare Post-Acute Care Transformation Act of 2014* (the IMPACT Act) mandates the frequency of hospice recertification surveys to be not less frequently than once every 36 months. Prior to the IMPACT Act, CMS did not have a legislative or regulatory standard for the frequency of hospice recertification surveys. Annual targets for these surveys were established by agency policy based on available resources each year and had been every 72 months. In addition to mandating a 36-month frequency of hospice recertification surveys, the IMPACT Act provides funding to support CMS in meeting this requirement. The shorter duration for hospice recertification surveys mandated by the IMPACT Act ensures hospice providers are more frequently assessed against the minimum requirements for quality of care, providing greater oversight of these providers by CMS.

The purpose of this measure is to ensure that the statutory requirement for the hospice survey interval is met nationally. Although the CMS target is 100 percent compliance with the statutory requirement, the stated measure represents a realistic expectation, considering the resources required to achieve the new survey interval. The data to confirm compliance with the requirements of the Act was not available until September 30, 2019. This data delay is a result of necessary follow up survey activity and data entry into the Automated Survey Processing Environment system. A post-September 30, 2019 review of the data indicates that as of May 13, 2020, 98.3 percent of all certified hospice agencies were surveyed in compliance with the requirements of the Impact Act.

The targets set beginning in FY 2018 are concise and clearly indicative of whether or not the work, as required by the Act, is being accomplished. CMS believes that the goal is responsive to the IMPACT Act requirement that all hospice agencies nationwide be surveyed every 36 months. CMS cautions that the FY 2020 goal of 98% may be difficult to achieve due to the COVID-19 Public Health Emergency (PHE). During the current PHE, recertification surveys of all providers, including hospices, were temporarily suspended while states focused on infection control surveys. On August 17, 2020, CMS established resumption of normal survey activities for all providers/suppliers according to guidance in the mission and priority document, while prioritizing their survey backlog. The restart of surveys has been gradual due to ongoing variation in COVID-19 activity across the country.

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)*	2022	97.9%	December 31, 2022
	2021	96.9%	December 31, 2021
	2020	95.8%	95.8% (Target Met)
	2019	95.6%	96.7% (Target Exceeded)
	2018	Baseline	95.2%

*Defined as the percentage of providers whose data meet the criteria to be included in the public use file.

This measure aims to improve CMS' ability to publically report information about the staffing in long-term care (LTC) facilities, and ultimately improve care. Staffing levels, turnover, and tenure can have a significant impact on the quality of care provided by LTC facilities. This information is also very important to consumers when selecting or evaluating a LTC facility.

As of July 1, 2016, LTC providers are required to electronically submit staffing data that is auditable back to payrolls and other verifiable information in accordance with 42 Code of Federal Regulations (CFR) §483.70(q) under current law. Receiving complete staffing data from providers is essential in order to calculate and publically report accurate staffing measures, which is the primary intent of the new program.

To publish accurate information, it is critical for CMS to obtain complete data from providers, which this measure seeks to address. In April 2018, CMS began using this data to calculate staffing measures and star ratings as part of the *Five Star Quality Rating System*. Stakeholders and LTC facilities use the published information to identify targets for staffing that lead to better outcomes for residents.

To incentivize improvement, CMS adjusts how a provider is reported on Nursing Home Compare and in the Nursing Home Five Star Quality Rating System (e.g., suppress or reduce ratings). This has proven to be an effective method to improve reporting in the past. Also, CMS is conducting audits of the data submitted by providers, and will use the results of those audits to evaluate other actions that may be needed to improve the data submitted.

Baseline data for FY 2017 indicated 90.3 percent (14,162) of facilities submitted

staffing data. CMS notes that this is a new program, and therefore difficult to predict the trajectory of performance. CMS will adjust the targets (lower or higher) as needed to ensure realistic and appropriate goals. Results will be calculated after the end of the first quarter for each fiscal year. For FY 2019, 96.7 percent of facilities submitted staffing data, exceeding the target of 95.6 percent. CMS believes this positive result is attributed to actions CMS has taken to rapidly improve reporting, such as suppressing or downgrading facilities' star ratings if their data is not reported or inaccurate. Due to this result, CMS has increased the targets for FYs 2020 and 2021 slightly because the trend for improvement decreased the second half of FY 2019 and the percent of providers reporting may be nearing a threshold of a maximum achievable level (i.e., ceiling). For 2020, 95.8 percent of facilities submitted data, meeting the target of 95.8 percent.

Due to the COVID-19 public health emergency (PHE), CMS waived the deadline to report the 2020 Fiscal Quarter 2 PBJ data (January 1, 2020 through March 31, 2020). Facilities were encouraged to report data as they were able to and maintain a lower target percentage due to the challenges nursing homes faced during this PHE. Although they were expected to report staffing thru PBJ using the waiver guidelines, there were issues with hard hit nursing homes. Therefore, CMS did not impose penalties, and there were no negative impacts to staffing ratings not submitted by May 15, 2020. It should be noted that 60 percent of all nursing homes did submit staffing data during this quarter, and all data received will be publicly posted but not applied to ratings.

The PBJ waiver was removed at the end of June 2020, and all nursing homes are now expected to report staffing for the remaining three quarters of CY 2020. Even with three quarters of reported data applied to the 2020 target prediction, the risk projection is not being changed. This is because these predictions are based on CY fourth quarter reports, and historically, adjacent quarters of calendar years have reported very similar results.

MEDICAID

MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (CHIP) through Implementation of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality initiatives

Measure	FY	Target	Result
MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (CHIP) through Implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Initiatives*	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	March 31, 2023
	2021	Work with States to ensure that 90% of States report on at least twelve quality measures in the CHIPRA children's core set of quality measures	March 31, 2022
	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	**July 31, 2021
	2019	Work with States to ensure that 90% of States report on at least eleven quality measures in the CHIPRA children's core set of quality measures	94% of States reported on at least eleven quality measures (Target Exceeded).
	2018	Work with States to ensure that 90% of States report on at least eleven quality measures in the CHIPRA children's core set of quality measures	86% of States reported on at least eleven quality measures (Target Not Met)
	2017	Work with States to ensure that 90% of States report on at least eleven quality measures in the CHIPRA children's core set of quality measures	88.2% of States reported on at least eleven quality measures (Target Not Met)

* Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets.
** To accommodate the submission of data from alternate years and other changes due to COVID, CMS needs to make changes to MACPro (the system used to collect states' quality measures data). As a result, this delayed the release of updates for 2020 quality measures reporting and has resulted in a subsequent delay in reporting results for this goal.

The purpose of this measure is to improve the quality of children's health care across Medicaid and CHIP.

CMS exceeded the goal of 90 percent of states reporting on at least eleven quality measures through FY 2019, with 94 percent of states reporting at least eleven measures. A new target for FY 2022 was set for 90 percent of states reporting on at least thirteen quality measures.

Section 1139A of the Social Security Act establishes a national pediatric quality measures program. The first step in the development of this program was the publication of an initial core set (Child Core Set) of 24 children's quality measures in 2010. The 2020 Child Core Set contains 24 measures. While the use of the Child Core Set is voluntary for states until FY 2024, CMS encourages all states to use and report on the Child Core Set to collect data that will lead to improved health outcomes and enhance the accuracy and applicability of the pediatric quality measures program. By encouraging states to report the core measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for children in Medicaid and CHIP.

Since 2014, CMS has hosted a Medicaid and CHIP track at annual CMS Quality Conferences. The conference agendas included in-person interactive sessions on the core measures related to data collection, reporting, and quality improvement. CMS also annually releases an updated Child Core Set Technical Specifications and Guidance for Reporting Manual, which contains technical instructions for collecting and calculating the core set measures for Medicaid and CHIP programs.

CMS will continue to work with its Technical Assistance/Analytic Support (TA/AS) contracting team to provide states with specific clarifications on measurement collection questions, hold all-state webinars as well as one-on-one calls with states around specific measurement challenges, and publish technical assistance briefs designed to provide states with guidance on measurement collection and reporting.

By using a multi-pronged approach to providing Technical Assistance (TA), CMS targets States that are already reporting multiple measures as well as those that are just beginning to understand how to collect and report them. Further, as the TA/Analytic Support program continues to mature, CMS is also expanding the scope of the TA to help states understand how to use the data they collect to drive quality improvement at the state and programmatic levels.

CMS also anticipates that states may want to prioritize certain voluntary core measures for collection and reporting in order to target improvement strategies, rather than reporting on a large volume of measures.

It is significant to note that the Bipartisan Budget Act of 2018 (P.L. 115-123), also referred to as the ACCESS Act, requires state reporting on Child Core Set measures starting in 2024. This new requirement will likely result in an uptick in child core set reporting by states.

Findings from state reporting on the Child Core Set are published annually and available on the Children's Health Care Quality Measures webpage

(www.medicaid.gov/medicaid/qualityof-care/performance-measurement/child-core-set/index.html) of Medicaid.gov and on https://data.medicaid.gov/.
CMS continues to partner with the Office of the National Coordinator and other stakeholders to address opportunities for use of electronic quality measures for potential inclusion in future annual updates to child core measures collected through Electronic Health Records (EHRs).

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

Measure	FY	Target	Result
MCD7: Increase the national rate of low income children and adolescents, who are enrolled in Medicaid and Medicaid expansion Children's Health Insurance Programs (CHIP), who receive any preventive dental service*	2022	+9 percentage points over 2011 baseline	October 15, 2023
	2021	+8 percentage points over 2011 baseline	October 15, 2022
	2020	+7 percentage points over 2011 baseline	October 15, 2021
	2019	+6 percentage points over 2011 baseline	52% (Target Exceeded)
	2018	+5 percentage points over 2011 baseline	51% (Target Exceeded)
	2017	+4 percentage points over 2011 baseline	51% (Target Exceeded)

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

CMS exceeded the FY 2019 goal with 52 percent of children ages 0-20 years receiving a preventive dental or oral health service by a dental or other licensed professional. This is an improvement over FY 2018, and a nine percentage point increase over the baseline year of FY 2011.

States' efforts over the past decade have resulted in improved access to dental care for children covered by Medicaid and Medicaid expansion CHIP programs. Between FY 2007 and FY 2019, 38 states achieved at least a ten percentage point increase in the proportion of enrolled children, ages 1-20, who received a preventive dental service during the reporting year. Despite this improvement, only 52 percent of all enrolled children nationally received a preventive dental or oral health service in FY 2019. CMS engaged in a vigorous fact-finding process in the late 2000s to understand the issues related to state performance on children's access to dental care. To help improve performance, from 2010 to 2015 CMS implemented the Oral Health Initiative 1.0. This initiative worked with federal and state partners, the dental and medical provider communities, children's advocates, and other stakeholders to expand the number of dental professionals participating in Medicaid and to increase the awareness of the need for dental care among beneficiaries in order to continue to improve children's access to dental care, with an emphasis on prevention. Since 2016, the Oral Health Initiative (OHI) 2.0 has taken an integrated approach to quality measurement and improvement, including identifying opportunities across CMCS to engage with states through existing levers such as Section 1115 demonstration renewals and State Plan Amendment reviews and approvals, and providing technical support to promote oral health's importance within broader Medicaid and CHIP program objectives. For example, CMS has been deeply engaged with California's Dental Transformation Initiative, which dedicates $740 million to test several strategies to improve oral health in the state's 1115 demonstration. The State reports that the proportion of children ages 1-20 who have received preventive dental services has risen from 37 percent in FY 2015 to 47

percent in FY 2019.

In 2020, as part of the OHI 2.0, CMS launched an oral health technical assistance opportunity, including webinars and a learning network, on preventive oral health care, with direct technical assistance to states beginning in early 2021. Through this opportunity, participating states will receive assistance in planning and carrying out quality improvement projects focused on increasing access to two evidence-based preventive strategies: fluoride varnish, which can be provided in settings outside the dental office, and silver diamine fluoride, a promising new modality to arrest tooth decay.

CMS continues to work closely with other stakeholders who engage in improvement efforts with states. For example, CMS provides technical support to the Dental Quality Alliance to support states in developing and implementing performance improvement projects, which deliver dental services through managed care contracts. CMS continues to host regular Oral Health Technical Advisory Group (OTAG) calls with state Medicaid and CHIP programs to share information on core measure data collection, reporting, and related quality improvement efforts. Recent OTAG topics includes dental quality measure development, coordinating management of oral conditions in medical and dental settings, and the intersection of oral health with other systemic conditions.

MCD8: Improve Adult Health Care Quality across Medicaid

Measure	FY	Target	Result
MCD8: Improve Adult Health Care Quality Across Medicaid *	2022	Work with States to ensure that 85% of States report on at least twelve quality measures in the Adult Medicaid core set of quality measures	March 31, 2023
	2021	Work with States to ensure that 80% of States report on at least twelve quality measures in the Adult Medicaid core set of quality measures	March 31, 2022
	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	**July 31, 2021
	2019	Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures	84% (Target Exceeded)
	2018	Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures	76% (Target Exceeded)
	2017	Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures	75% (Target Met)

* Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets
** To accommodate the submission of data from alternate years and other changes due to COVID, CMS needs to make changes to MACPro (the system used to collect states' quality measures data). As a result, this delayed the release of updates for 2020 quality measures reporting and has resulted in a subsequent delay in reporting results for this goal.

The purpose of this measure is to improve health care quality for adults across Medicaid.

The target for the adult core set has been met or exceeded since 2014. In 2019, the target was exceeded with 43 states reporting eleven or more Adult Core Set measures. CMS will continue to work with states to ensure that 75 percent of states report on at least twelve quality measures through FY 2020, 80 percent of states report on at least twelve quality measures in FY 2021, and 85 percent report on at least twelve quality measures in FY 2022.

Section 1139B of the Social Security Act established a national adult quality measures program for Medicaid. The 2019 Adult Core Set contains 33 measures. While the use of the Adult Core Set is voluntary for states, CMS encourages all states to use and report on the Adult Core Set to collect data that will lead to improved health outcomes and enhance the accuracy and applicability of the adult quality measures

program. By encouraging states to report the core measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid.

Since 2014, CMS has hosted a Medicaid and CHIP track at annual CMS Quality Conferences. The conference agendas include in-person interactive sessions on the core measures related to data collection, reporting, and quality improvement. CMS also annually releases an updated Adult Core Set Technical Specifications and Guidance for Reporting Manual, which contains technical instructions for collecting and calculating the core set measures for Medicaid and CHIP programs.

CMS will continue to work with its Technical Assistance/Analytic Support (TA/AS) contracting team to provide states with specific clarifications on measurement collection questions, hold all-state webinars and one-on-one calls with states around specific measurement challenges, and publish technical assistance briefs designed to provide states with guidance on measurement collection and reporting.

By using a multi-pronged approach to providing TA, CMS targets states that are already reporting multiple measures as well as those that are just beginning to understand how to collect and report them. Further, as the TA/AS program continues to mature, CMS is also expanding the scope of the TA to help states understand how to use the data they collect to drive quality improvement at the state and programmatic levels.

CMS has also anticipated that states may want to prioritize certain voluntary core measures for collection and reporting in order to target improvement strategies, rather than reporting on a large volume of measures.

It is significant to note that the Bipartisan Budget Act of 2018 (P.L. 115-123), also referred to as the ACCESS Act, requires state reporting on Child Core Set measures starting in 2024. This new requirement will likely result in an uptick in child core set reporting by states. It does not require mandatory reporting of the adult core set but may positively influence improved adult core set reporting. Additionally, the *Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018*, requires state reporting on measures in the Behavioral Health Core Set (a subset of behavioral health measures from the Adult and Child Core Sets) starting in 2024. CMS is assessing the potential impact of these statutory changes.

Findings from state reporting on the Adult Core Set are published annually and available on the Adult Health Care Quality Measures webpage of Medicaid.gov (https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html#AnnualReporting) and on https://data.medicaid.gov.

CMS continues to partner with the Office of the National Coordinator and other stakeholders to address opportunities for use of electronic quality measures for potential inclusion in future annual updates to adult core measures collected through Electronic Health Records (EHRs).

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

Measure	FY	Target	Result
MCD9.2 Improve Capacity to Collect Quality and Other Performance Data for Monitoring Substance Use Disorder (SUD) 1115 Demonstrations	2022	CMS produce SUD performance trends across time and states for at least 25 demonstrations	September 30, 2022
	2021	CMS produce SUD performance trends across time and states for at least 16 demonstrations	September 30, 2021
	2020	CMS produce SUD performance trends across time and states for at least 10 states	Reports from 13 states submitted (Target Exceeded)
	2019	Require states to submit the SUD metric data in the reporting platform from a minimum of 10 states	Reports from 14 states submitted (Target Exceeded)
	2018		Built new SUD-specific data collection instrument and trained states with approved 1115 SUD demonstrations on use of the instrument and system

Section 1115 of the Social Security Act (the Act) provides broad authority to the HHS Secretary to grant demonstrations to states for testing innovative reforms in Medicaid and the Children's Health Insurance Program (CHIP). These measures track the development of an automated infrastructure to support section 1115 Medicaid demonstrations by focusing on comprehensive treatment for substance use disorders (SUDs) (MCD9.2).

States are using 1115 demonstration authority to achieve Medicaid reform through innovative approaches to eligibility and coverage, and alternative models of service delivery and/or financing. These reforms aim at improving the quality of their Medicaid programs and their capacity to serve more people and to find alternatives to eligibility, enrollment, and coverage, to promote health improvement and independence. CMS is making significant investments in these types of demonstrations in order to study the results on a state-based and national level. However, to accomplish these goals, CMS needed an automated system for data collection and analysis of demonstration

performance metrics, analytics, or reporting to assess quality performance of demonstrations. CMS developed several sets of performance metrics for high priority 1115 demonstrations, including but not limited to SUDs and Serious Mental Illness section 1115 demonstrations. These sets have been reviewed by Medicaid State Technical Advisory Groups (TAGs) and are being rolled-out to states working with CMS to implement applicable demonstrations. Additional improvements include the development of a monitoring report template, as well as templates for reporting these metrics. CMS is focused on improving the quality and structure of data, both quantitative and qualitative, for section 1115 demonstrations, through a more automated process that will improve federal monitoring of demonstration progress and performance. This initiative aligns with the Medicaid and CHIP Program System (MACBIS) initiative to receive more complete and timely Medicaid and CHIP related data from states to support better program oversight, administration, and program integrity.

Our targets reflect the increasing scope of the work to incorporate the standard metric sets into more Medicaid section 1115 demonstrations, to improve CMS' capability to monitor outcomes for demonstrations across states that are testing similar innovative approaches (e.g. to improve service delivery for people with SUD). As new demonstrations are approved and existing demonstrations are extended, CMS will work with states to incorporate the appropriate metrics into state reporting to CMS.

CMS has shifted its focus to the opioid crisis and toward state performance in improving access to, and health outcomes related to, comprehensive treatment for people with Substance Use Disorders (SUDs) under Medicaid. CMS has introduced a more recent measure, MCD9.2, to reflect these efforts. In 2018, CMS focused on developing a metric set for the SUD demonstrations, including drafting a metric data collection template and a quarterly reporting template for qualitative information. CMS was delayed in finalizing the SUD metric specifications until September 2018. The Performance Metrics Database and Analytics (PMDA) is being adjusted to collect these data and monitoring reports, assuring internal controls. In the Spring, 2019, the SUD metrics and reporting template were approved under the Paperwork Reduction Act (PRA). CMS is providing technical assistance on these templates and metrics to states with SUD applications and approved SUD demonstrations. As of December 31, 2020, there are 31 approved SUD demonstrations. These 30 states and the District of Columbia are in various phases of understanding and adopting the SUD metrics and reporting template, and the uptake by each state has taken longer than initially expected. Thirteen of the 31 states submitted to CMS monitoring, reports using the SUD templates. Due to the current Public Health Emergency (PHE), states are submitting monitoring reports to us later than originally anticipated. CMS exceeded the 10 state target. We anticipate adding many more states to the analysis by the end of FY 2021, and therefore CMS expects to meet the FY 2021 target of 16 states.

HEALTH CARE FRAUD AND ABUSE CONTROL (HCFAC)

MIP1: Reduce the Improper Payment Rate in the Medicare Fee-for-Service (FFS) Program

Measure	FY	Target	Result
MIP1: Reduce the Improper Payment Rate in the Medicare Fee-for-Service (FFS) Program*	2022	TBD **	November 15, 2022
	2021	6.17%	November 15, 2021
	2020	7.15%	6.27% (Target Exceeded)
	2019	8.00%	7.25% (Target Exceeded)
	2018	9.40%	8.12% (Target Exceeded)
	2017	10.40%	9.51% (Target Exceeded)
	2016	11.50%	11.00% (Target Exceeded)
	2015	12.5%	12.09% (Target Exceeded)

* Prior years' targets and results (including baseline) for this goal can be found in previous CMS Budgets and HHS AFRs.
** Starting in FY 2017, per OMB guidance, CMS establishes improper payment rate targets only for the next fiscal year. Therefore, while the FY 2020 target of 7.15 percent was established in the FY 2019 AFR, the FY 2021 target will be established in the FY 2020 HHS AFR and the FY 2022 target will be established in the FY 2021 HHS AFR.

The Medicare Fee-for-Service (FFS) improper payment rate is calculated by the Comprehensive Error Rate Testing (CERT) program and reported in the Department of Health and Human Services (HHS) Agency Financial Report (AFR) on an annual basis. Information on the Medicare FFS improper payment methodology can be found in the 2020 HHS AFR.

In response to the COVID-19 Public Health Emergency (PHE), HHS exercised its enforcement discretion to provide temporary administrative relief to all providers and suppliers. Effective March 27, 2020, the CERT program stopped sending documentation request letters to or conducting phone calls with providers or suppliers to request medical documentation or other data for claims in the 2020 report period (claims submitted July 1, 2018, through June 30, 2019). HHS had sufficient data to estimate the FY 2020 Medicare FFS program improper payment rate based on the data that HHS had or that providers or suppliers voluntarily submitted and still complied with the OMB requirements for a statistical sample plan and confidence interval.

CMS exceeded its FY 2020 target. The Medicare FFS improper payment estimate for FY 2020 is 6.27 percent, or $25.74 billion. This year's estimate decreased from the prior year's reported 7.25 percent improper payment estimate due to a reduction in improper payments for home health, and SNF claims. Although the improper payment rate for these services and the gross Medicare FFS improper payment rate

decreased, improper payments for hospital outpatient, IRF, SNF, and home health claims were major contributing factors to the FY 2020 Medicare FFS improper payment rate, comprising 34.22 percent of the overall estimated improper payment rate. While the factors contributing to improper payments are complex and vary by year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors as described in the following four driver service areas:

- Insufficient documentation continues to be the major error reason for hospital outpatient claims. The improper payment rate for hospital outpatient claims decreased from 4.37 percent in FY 2019 to 4.02 percent in FY 2020. The primary reason for the errors was that the order (or the intent to order for certain services) or medical necessity documentation was missing or insufficient (42 United States Code [U.S.C.] §1395y, 42 Code of Federal Regulations [CFR] §410.32).
- Medical necessity (i.e., services billed were not medically necessary) continues to be the major error contributor for IRF claims. The IRF claims improper payment rate decreased from 34.87 percent in FY 2019 to 30.81 percent in FY 2020. The primary reason for these errors was that the IRF coverage criteria for medical necessity were not met. Medicare coverage of IRF services requires a reasonable expectation that the patient meets all coverage criteria at the time of IRF admission (42 CFR §412.622(a)(3)).
- Insufficient documentation continues to be the major error reason for SNF claims. The SNF claims improper payment rate decreased from 8.54 percent in FY 2019 to 5.43 percent in FY 2020. The primary reason for these errors was missing or insufficient certification/recertification statements and the medical record did not contain the required missing elements. Medicare coverage of SNF services requires certification and recertification for these services (42 CFR §424.20).
- Insufficient documentation for home health claims continues to be prevalent, despite the improper payment rate decrease from 12.15 percent in FY 2019 to 9.30 percent in FY 2020. The primary reason for the errors was missing or insufficient documentation to support the certification of home health eligibility requirements. Medicare coverage of home health services requires physician certification of the beneficiary's eligibility for the home health benefit (42 CFR §424.22).

CMS uses data from the CERT program and other sources of information to develop various corrective actions for the purpose of reducing improper payments. CMS has developed a number of preventive and detective measures for specific service areas with high improper payment rates, including SNF, hospital outpatient, IRF and home health claims. CMS believes implementing targeted corrective actions will continue to prevent and reduce improper payments in these areas and reduce the overall improper payment rate. Detailed information on corrective actions can be found in the 2020 HHS AFR.

MIP5: Reduce the Percentage of Improper Payments Made under Medicare Part C, the Medicare Advantage (MA) Program

Measure	FY	Target	Result
MIP5: Reduce the Percentage of Improper Payments Made under Medicare Part C, the Medicare Advantage (MA) Program*	2022	TBD	November 15, 2022
	2021	TBD	November 15, 2021
	2020	7.77% (target in FY 2019 AFR)	6.78% (Target Exceeded)
	2019	7.90% (target in FY 2018 AFR)	7.87% (Target Exceeded)
	2018	8.08% (target in FY 2017 AFR)	8.10%** (Target Met)
	2017	9.50% (target in FY 2016 AFR)	8.31% (Target Exceeded)
	2016	9.14% (target in FY 2015 AFR)	9.99% (Target Not Met)
	2015	8.5% (target in FY 2013 AFR)	9.5% (Target Not Met)

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

** CMS uses Payment Integrity Information Act (PIIA) standards, rather than GPRAMA standards, for performance reporting on improper payments. According to A-123 guidance, programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

In FY 2020, CMS met its Part C Medicare Advantage (MA) error rate target of 7.77 percent, reporting an actual improper payment estimate of 6.78 percent or $16.27 billion. This is a decrease from the prior year's estimate of 7.87 percent.

The FY 2021 target has not been established. Due to HHS's temporary policy to stop documentation requests to providers as a result of the Public Health Emergency (PHE) for COVID-19 pandemic, the Medicare Part C Improper Payment Measurement medical record submission did not follow the same pattern as in previous years. As a result, HHS made significant changes 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 given the situation with the current year data as compared to prior year's data. The FY 2022 target will be established in the FY 2021 Agency Financial Report (AFR); per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year. OMB allows for this exception for not reporting out-year targets in the OMB Circular A-123, Appendix C.

The Part C methodology estimates improper payments resulting from errors in beneficiary risk scores. The primary component of most beneficiary risk scores is clinical diagnoses submitted by the plan. If medical records do not support the diagnoses submitted to HHS, the risk scores may be inaccurate and resulting in payment errors. The Part C estimate is based on medical record reviews conducted under HHS's annual Part C Improper Payment Measurement process, where HHS

identifies unsupported diagnoses and calculates corrected risk scores. The Part C Improper Payment Measurement calculates the beneficiary-level payment error for the sample and extrapolates the sample payment error to the population subject to risk adjustment, resulting in a Part C gross payment error amount. In FY 2020, HHS selected a stratified random sample of beneficiaries with a risk adjusted payment in calendar year 2018 (where the strata are high, medium, and low risk scores) and reviewed medical records of the diagnoses submitted by plans for the sample beneficiaries. The root causes of FY 2020 Medicare Part C improper payments consist of administrative or process errors made by another party (51.92 percent in Overpayments and 45.92 percent in Underpayments), with a smaller portion of overpayments resulting from missing documentation (2.16 percent). Monetary loss results from administrative or process errors by other party, specifically, when medical record documentation submitted by the MA organization does not substantiate a condition for which it received payment. The non-monetary loss component is comprised of conditions identified during the medical review process that the MA organization did not submit for payment, while unknown is comprised of situations in which sufficient information was not available to make a determination.

The factors contributing to improper payments are complex and vary from year to year. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments in Medicare Part C. Detailed information on corrective actions can be found in the 2020 HHS AFR.

MIP6: Reduce the Percentage of Improper Payments Made under the Part D Prescription Drug Program

Measure	FY	Target	Result
MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program*	2022	TBD	November 15, 2022
	2021	1.14% (Target in FY 2020 AFR)	November 15, 2021
	2020	0.74% (target in FY 2019 AFR)	1.15% (Target Not Met)
	2019	1.65% (target in FY 2018 AFR)	0.75% (Target Exceeded)
	2018	1.66% (target in FY 2017 AFR)	1.66% (Target Met)
	2017	3.30% (target in FY 2015 AFR)	1.67% (Target Exceeded)
	2016	3.40% (target in FY 2013 AFR)	3.41%** (Target Met)
	2015	3.5% (target in FY 2013 AFR)	3.6% (Target Not Met)

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

** CMS uses Improper Payments Elimination and Reduction Act (IPERA) standards, rather than GPRAMA standards, for performance reporting on improper payments. According to A-123 guidance on IPERA, programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

In FY 2020, CMS did not meet its target of 0.74 percent, reporting an actual improper payment estimate of 1.15 percent, or $927.50 million. The increase from the prior year's estimate of 0.75 percent is due to year-over-year variability. As the rate is already low, any variation can cause shifts that are relatively (but not absolutely) large. All Medicare Part D estimated improper payments were made by the federal government or its representatives.

The FY 2021 target is 1.14 percent. The FY 2022 target will be established in the FY 2021 Agency Financial Report (AFR); per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year.

The Part D program payment error estimate measures the payment error related to Prescription Drug Event (PDE) data, where most errors for the program exist. CMS measures inconsistencies between information reported on PDEs and supporting documentation submitted by Part D sponsors: prescription record hardcopies (or medication orders as appropriate) and detailed claims information. Based on these reviews, each PDE in the audit sample is assigned a gross drug cost error. A representative sample of beneficiaries undergoes a simulation to determine the Part D improper payment estimate.

For FY 2020, in order to reduce burden on providers due to the COVID-19 Public Health Emergency (PHE), CMS exercised its enforcement discretion and directed Part D Sponsors to cease requests for documentation from providers and pharmacies regarding the improper payment measures. Without further contact with providers and pharmacies, plans were unable to obtain necessary documentation to support the measures; plans were, however, allowed to continue submitting documentation already on hand or that had been previously requested. In order to report accurate improper payment measures, CMS calculated the Medicare Part D improper payment measure excluding the small portion of the sample that was not submitted at the time of CMS's enforcement discretion. CMS then conducted analysis to compare with prior years' results to determine if additional adjustment was needed.

The factors contributing to improper payments are complex and vary from year to year. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments in Medicare Part D. Detailed information on corrective actions can be found in the 2020 HHS AFR.

MIP9: Reduce the Improper Payment Rates in the Medicaid Program and the Children's Health Insurance Program (CHIP)

Measure	FY	Target	Result
MIP9.1: Reduce the Improper Payment Rate in the Medicaid Program*	2022	TBD[1]	November 15, 2022
	2021	N/A[1]	N/A[1]
	2020	N/A[1]	21.36%[1]
	2019	N/A[1]	14.90%[1]
	2018	7.93%	9.79% (Target Not Met)
	2017	9.57%	10.10% (Target Not Met)
	2016	11.53%	10.48% (Target Exceeded)
	2015	6.7%	9.78% (Target Not Met)
MIP9.2: Reduce the Improper Payment Rate in the Children's Health Insurance Program (CHIP)*	2022	TBD[1]	November 15, 2022
	2021	N/A[1]	N/A[1]
	2020	N/A[1]	27.00%[1]
	2019	N/A[1]	15.83%[1]
	2018	8.20%	8.57% (Target Not Met)
	2017	7.38%	8.64% (Target Not Met)
	2016	6.81%	7.99% (Target Not Met)
	2015	6.5%	6.80% (Target Not Met)

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

[1] 2020 is the second year the eligibility component measurement was included; therefore, results do not reflect all states under the new eligibility methodology. Also, targets will not be established until all three cycles have been measured for eligibility. The FY 2021 AFR will report a target established for 2022.

The Payment Error Rate Measurement (PERM) program measures improper payments for the Fee-For-Service (FFS), Managed Care, and eligibility components in both Medicaid (MIP9.1) and the Children's Health Insurance Program (CHIP) (MIP9.2). CMS measures improper payments in 17 states each year to calculate a rolling, three-year national improper payment rate for both Medicaid and CHIP. The national Medicaid and CHIP improper payment rates reported in the FY 2020 HHS AFR is based on measurements that were conducted in FYs 2018, 2019, and 2020. Information on the Medicaid and CHIP statistical sampling process and review period can be found in the 2020 HHS AFR.

Due to the COVID-19 Public Health Emergency (PHE), CMS exercised its enforcement discretion by temporarily suspending all improper payment related engagement/communications and data requests to providers and state agencies from CMS. In order to complete reviews for FY 2020 national reporting and maintain a consistent review of all states, CMS only reviewed claims that had been fully completed before implementation of the COVID-19 response measures and that CMS could complete without additional outreach to states or providers. CMS incorporated documentation voluntarily submitted by states and/or providers during the period of enforcement discretion into the reviews.

The national Medicaid improper payment estimate for FY 2020 is 21.36 percent or $86.49 billion. The national Medicaid component rates are 16.84 percent for Medicaid FFS, 0.06 percent for Medicaid managed care, and 14.94 percent for the Medicaid eligibility component.

An area driving the FY 2020 Medicaid improper payment estimate is the continued reintegration of the PERM eligibility component, which was revamped to incorporate the Patient Protection and Affordable Care Act (PPACA) requirements in the PERM eligibility reviews. A federal contractor conducts the eligibility measurement, allowing for consistent insight into the accuracy of Medicaid eligibility determinations, and increases the oversight of identified vulnerabilities. Based on the measurement of the first two cycles of states, eligibility errors are mostly due to insufficient documentation to affirmatively verify the eligibility determination or noncompliance with federal eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification of eligibility data, such as income, was not done at all and where there is an indication that eligibility verification was initiated but the state provided no documentation to validate the verification process was completed. CMS will complete the measurement of all states under the new eligibility component and establish a baseline in FY 2021.

Since FY 2014, the Medicaid improper payment estimate has also been driven by errors due to state noncompliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements. Most improper payments cited on claims are those where a newly enrolled provider had not been appropriately screened by the state, a provider did not have the required NPI on the claim, or a provider was not enrolled.

Finally, while the screening errors described above are for newly enrolled providers, states also must revalidate the enrollment and rescreen all providers at least every 5 years. States were required to complete the revalidation process of all existing providers by September 25, 2016. In FY 2020, HHS measured the third cycle of states for compliance with requirements for provider screening at revalidation. Improper payments cited on claims where a provider had not been appropriately screened at revalidation is a new major error source in the Medicaid improper payment rate. CMS completed the measurement of all states for compliance with provider revalidation requirements in FY 2020 in order to establish a baseline. Moving forward, CMS will be able to track improvement in compliance with revalidation requirements as each cycle of states is measured a second time.

The national CHIP gross improper payment estimate for FY 2020 is 27.00 percent or $4.78 billion. The national CHIP component rates are 14.15 percent for CHIP FFS,

0.49 percent for CHIP managed care and 23.53 percent for the CHIP eligibility component.

One area driving the FY 2020 CHIP improper payment estimate is the continued reintegration of the PERM eligibility component, which was revamped to incorporate the PPACA requirements in the PERM eligibility reviews. A federal contractor conducts the eligibility measurement, allowing for consistent insight into the accuracy of CHIP eligibility determinations, and increases the oversight of identified vulnerabilities. Based on the measurement of the first two cycles of states, eligibility errors are mostly due to insufficient documentation to affirmatively verify the eligibility determination or noncompliance with eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification of eligibility data, such as income, was not done at all and where there is indication that the eligibility verification was initiated but the state provided no documentation to validate the verification process was completed. The CHIP improper payment rate was also driven by claims where the beneficiary was ineligible for CHIP, but was eligible for Medicaid, mostly related to beneficiary income, third party insurance, or household composition/tax filer status. CMS will complete the measurement of all states under the new eligibility component and establish a baseline in FY 2021.

Additionally, since FY 2014, improper payments cited on claims where a newly enrolled provider or a provider due for revalidation had not been appropriately enrolled and screened by the state or a provider did not have the required NPI on the claim have also driven the CHIP rate (see Section 11.4 for further description of CMS's review of these errors). CMS has completed the measurement of all states for compliance with provider revalidation requirements in FY 2020 in order to establish a baseline. Moving forward, CMS will be able to track improvement in compliance with revalidation requirements as each cycle of states is measured a second time.

The factors contributing to improper payments are complex and vary from year to year. In order to reduce the national Medicaid and CHIP improper payment rates, states are required to develop and submit states-specific Corrective Action Plans (CAPs) to CMS. Each year, CMS also outlines actions the agency will implement to prevent and reduce improper payments for all error categories on a national level. Detailed information on corrective actions can be found in the 2020 HHS AFR.

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

Measure	FY	Target*	Result
MIP11: Increase the proportion of providers performing initial enrollment in the Medicare Program online	2022	52%	April 30, 2023
	2021	50%	April 30, 2022
	2020	46%	59.08% (Target Exceeded)
	2019	44%	53.23% (Target Exceeded)
	2018	38.7%	49.11% (Target Exceeded)
	2017	36.7%	42.51% (Target Exceeded)
	2016	34%	34.7% (Target Exceeded)
	2015	Baseline	30.1%

* This is a CY goal. The baseline was established in CY 2015 when the result was measured at 30.1 percent. The CY 2016 target was established at 34 percent, based on the expectation of a modest increase over the baseline result. Consistent with this concept, the subsequent years have been based on a 2-4 percent per year increase. Due to the planned PECOS 2.0 release in late 2022, the PECOS system will be in a transition out phase which is the reason for the increase of 2% for that year.

The Medicare Provider Enrollment, Chain, and Ownership System (PECOS) is the CMS national repository and system of record for all enrollment information on Medicare providers and suppliers. Providers and suppliers are required to enroll in the Medicare program in order to bill and receive payment for items and services provided to program beneficiaries. More information about PECOS can be found at https://pecos.cms.hhs.gov/. As an online electronic application system, PECOS helps to improve operational efficiency in CMS' enrollment process, reduce the cost associated with processing paper enrollment applications, and improve beneficiary access to care by reducing the time needed to issue provider certifications. This measure identifies annual improvement (increases) in electronic applications for initial enrollments that provide savings.

The purpose of the measure is to increase online submission of enrollment applications and reduce the number of paper applications, thereby increasing operational efficiency. Further information or explanation for paper applications necessitates the return of an estimated 50 to 70 percent of applications. This process unnecessarily lengthens the provider enrollment timeframe and increases the CMS enrollment contractors' time and effort when processing enrollment applications. This added time and expense negatively impacts CMS' operational efficiency and can affect program beneficiaries' access to services. The average time to process an electronic enrollment application is 45 days. This compares favorably to the 60 days' average time for processing a paper enrollment. The annual average of more than a million enrollment applications processed by CMS further amplifies this difference.

This measure improves operational efficiency by reducing the number of hours needed to process enrollment applications by Medicare Contractors through PECOS, resulting in reduction of operating costs and improvement of access to care through timelier provider certification. Increasing usability of online enrollment submissions by providers will also result in more complete applications and faster screening results through real time data verification to the Medicare contractors, reducing overall processing time. The online enrollment application supplies information needed by the provider with quick and easy access to update the information. The electronic enrollment process also enhances CMS' capacity to perform its responsibilities under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP). The QPP relies on PECOS data for Merit-Based Incentive Payment System (MIPS) eligibility. States leverage PECOS data for screening and enrollment of Medicaid fee-for-service providers. Faster processing and timely updates of enrollment information in PECOS facilitates data sharing and the identification and determination of the eligibility of providers and groups in MACRA programs such as MIPS, Alternative Payment Models, and State Medicaid Agencies.

CMS is measuring the increase in the proportion of providers enrolling online. The baseline measurement was established in CY 2015 and goal implementation occurred in the calendar year (CY) 2016.

The CY 2016 result was 34.7 percent, which exceeded the target of 34 percent. The CY 2017 result was 42.51 percent, which exceeds the target of 36.7 percent. The CY 2018 result was 49.11 percent which exceeds the target of 38.77 percent. The CY 2019 result was 53.23 percent, which exceeds the target of 44 percent. Targets set for CY 2020 (46 percent), CY 2021 (50 percent) and CY 2022 (52 percent) with subsequent measurements available by April of the year following the calendar year measured.

MIP12: Savings from the Prevention of Improper Medicare Payments by Successful Implementation of Fraud Prevention System (FPS) Edits

Measure	FY	Target*	Result
MIP12: Maintain or increase 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	2022	$45.0 million	April 30, 2023
	2021	$40.0 million	April 30, 2022
	2020	$33.5 million	$61.1 million (Target exceeded)
	2019	$33.5 million	$69.4 million (Target exceeded)
	2018	$33.0 million	$57.8 milliom (Target exceeded)
	2017	Baseline	$32.1 million

To protect the integrity of the Medicare Trust Funds, CMS must ensure Medicare payments are correct and made to legitimate providers for covered, appropriate, and reasonable services for eligible beneficiaries. This goal targets CMS's ability to prevent improper payments by measuring the dollar savings resulting from claims rejected or denied based on Fraud Prevention System (FPS) edits. For the purpose of this measure, savings measured by this goal include rejected claims that are not resubmitted, and denied claims not overturned on appeal within three months after the end of the reporting period.

FPS edits screen Medicare fee-for-service (FFS) claims on a pre-payment basis for improper billing, which could result from miscoding, or could indicate intentional fraud, waste, or abuse. The FPS has the capability to prevent payment of certain improper claims by communicating a denial or rejection message to the claims payment systems. CMS tested FPS's ability to successfully integrate with several legacy claims processing systems in early 2014. This test validated the capabilities of the FPS system to prevent improper payments in an automated fashion, without the need for human intervention.

CMS has also identified ways that FPS edits could address vulnerabilities in other systematic edits. Through collaboration with many stakeholders, CMS has developed a process to identify opportunities for the FPS to standardize editing across all MACs for certain billing scenarios. For example, if multiple Medicare Administrative Contractors (MACs) have similar Local Coverage Determinations, the FPS can implement a single edit on a nationwide basis, in lieu of having each MAC implement a local edit. The first such edit was launched in 2015.

The FY 2017 baseline for this goal is $32.1 million. The targets for FY 2018 through FY 2021 are based on previous years' results, coupled with expected changes in the program. These targets are expressed as dollar savings achieved through prevention, and represent a percentage change from the previous year. CMS calculates the

savings metric three months after the end of the fiscal year. This three-month run out time is due to the fact that CMS' methodology captures denials/rejections that were resubmitted or overturned on appeal within the three months after the end of the fiscal year. The FPS edits methodology was certified by the Office of Inspector General in the FPS 3rd Implementation Year Report to Congress.

The decrease in savings from FY 2019 to FY 2020 was primarily driven by flexibilities instituted by CMS in response to the COVID-19 public health emergency (PHE). Due to the PHE, CMS issued a number of waivers, allowing for certain billing scenarios which normally would be prohibited. This resulted in the deactivation of numerous FPS Edits, leading to fewer FPS edit denials and a decrease in savings. Although overall FPS edit savings declined, CMS continued to maintain and add FPS edits where appropriate. In FY 2020, CMS added two new edits that performed strongly: respiratory virus panel tests ($6.2 million in savings) and continuous glucose monitors ($6.1 million in savings). When the PHE is declared over, CMS anticipates that the deactivated edits will be reactivated.

MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS (QIO)

QIO8: Strengthening Person and Family Engagement in Beneficiary Health Care Quality by Increasing Satisfaction of Quality of Care Complaint Resolution

Measure	FY	Target	Result
QIO8: Increase beneficiary satisfaction with the resolution of all beneficiary initiated quality of care complaints.	2022	83% QIO Satisfaction	January 15, 2023
	2021	80% QIO Satisfaction	January 15, 2022
	2020	80% QIO Satisfaction	80.8% (Target Exceeded)
	2019	75% QIO Satisfaction	81.1% (Target Exceeded)
	2018	75% QIO Satisfaction	83.3% (Target Exceeded)
	2017	70% QIO satisfaction	67.8% (Target Not Met)
	2016	62% - Baseline	65.7% (Target Met)

The primary focus of Beneficiary and Family Centered Care (BFCC) is to improve healthcare services for Medicare beneficiaries, through the Quality Improvement Organization (QIO) performance of statutory review functions. This includes, but is not limited to: quality of care reviews, beneficiary complaint reviews, discharge and termination of service appeals in various provider settings, medical necessity reviews, and the Emergency Medical Treatment and Labor Act (EMTALA) reviews. Beneficiary satisfaction with the QIO review process has been mixed over the course of the past several years, with concerns raised by patients and families regarding the quality of the reviews and the impartiality of the reviewers.

The BFCC QIOs develop activities that engage patients and families, with the goal of increasing patient knowledge, skill, and confidence in taking an active role in managing patient health care. Engagement in these activities is captured on the Beneficiary Satisfaction surveys. The current survey measures satisfaction for Quality of Care Reviews and Appeals Reviews. The BFCC Oversight and Review Center (ORC) began administering the satisfaction survey in April 2016, beginning with cases closed in November 2015 and continuing to the present. CMS began receiving QIO performance data for satisfaction in July 2016. The 11th Scope of Work (SOW) survey scoring was used to develop the targets for this goal prior to FY 2020 and the 12th SOW is being used for target development as of FY 2020.

The survey is mailed monthly to randomly-chosen Medicare beneficiaries, who file a Quality of Care Complaint or Appeal, and agree to participate in the survey.

Beneficiaries share their views about their experience with the BFCC-QIO and the Medicare Complaint or Appeal process.

The survey assesses beneficiary satisfaction in three domains which include:

(1) Effectiveness of the QIO review process;
(2) Courtesy & Respect of BFCC-QIO staff in handling a beneficiary's complaint; and
(3) Responsiveness of BFCC QIO staff.

BFCC QIOs continue to sustain good levels of performance. The FY 2020 target was exceeded.

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

Measure	FY	Target	Result
QIO12: Reduce Infection Control Deficiencies of F880 of TR-QII	2023	15% reduction from baseline	January 31, 2024
	2022	10% reduction from baseline	January 31, 2023
	2021	5% reduction from baseline	January 31, 2022
	2020	Developmental (Baseline)	30.7%

The purpose of this goal is to make nursing home care safer by providing targeted interventions to those nursing homes that have previously been cited as having deficiencies in proper infection control when surveyed. The requirements for infection control are contained in 42 CFR § 483.80.

Currently, more than 1.3 million residents live in approximately 15,450 Medicare and Medicaid certified nursing homes in the United States that must meet federal quality standards. These standards include compliance with establishing and maintaining an infection prevention and control program. Under an agreement with CMS, state agencies perform surveys to determine whether nursing homes meet specified program requirements, known as Federal participation requirements. Based on the result of these surveys, state agencies may certify nursing homes' compliance with those requirements.

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection. The facility must establish an infection prevention and control program that must include, at a minimum, the following elements: A system for preventing, identifying, reporting, investigating, controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment…" Appendix PP November 22, 2017 State Operations Manual (SOM), A statement of deficiency document uses a federal tag numbering system (F-tag) that addresses the degree to which a facility meets minimal federal standards. correspond to specific stipulations within the Code of Federal Regulations. During the survey process, when a facility is out of compliance, in infection prevention and control, they receive a F880 tag, it is noted on Form CMS-2567, Statement of Deficiencies and Plan of Correction.

Each deficiency is given a letter rating of A through L based on the State agency's determination of the scope and severity of the deficiency. A-rated deficiencies are the

least serious, and L-rated deficiencies are the most serious. F880 maintains its position as the one of the most frequently cited survey tag across the country. Nursing home surveys are conducted in accordance with survey protocols and Federal requirements to determine whether a citation of non-compliance is appropriate. Deficiencies are based on violations of the regulations based on observations of the nursing home's performance or practices. Nursing homes struggling to comply with infection control requirements may be subjected to fines and/or termination from federal programs.

CMS data shows that infection prevention and control deficiencies were the most common type of deficiency cited in surveyed nursing homes, with most homes having an infection prevention and control deficiency cited in one or more years from 2013 through 2017 (13,299 nursing homes, or 82 percent of all surveyed homes. Recently, nursing homes are a major source of U.S. coronavirus disease 2019 (COVID-19) cases. According to the CDC, COVID-19 is known to be particularly lethal to adults in their 60s and older who have underlying health conditions. It can spread more easily through congregate facilities, where many people live in a confined environment and workers move from room to room. QIN-QIOs have been addressing the COVID-19 pandemic by monitoring NHSN data for outbreaks and infection rates in nursing homes and providing targeted technical assistance to those nursing homes.

The baseline for this measure will be set by analyzing the universe of nursing homes that received a survey and identifying the nursing homes that received multiple infection control deficiencies using the, Quality, Certification & Oversight Reports Nursing homes that receive additional infection control survey deficiencies after receiving a TR-QII will constitute the numerator at baseline. CMS' anticipates reducing the number of infection control deficiencies over the course of the 5 year period of performance for the QIN-QIO 12th Scope of Work. This is a new process, so CMS did not have program data on which to set reduction targets. Therefore, CMS' set this ambitious goal to reduce deficiencies by 15 percent from baseline by considering both the barriers to quality improvement in this particular area and quality improvement achievements from similar programs in prior years. Assuming reduction is linear, we set a progression of 5 percent per year towards a 15 percent goal after 4 years of implementation.

The Quality Innovation Network-Quality Improvement Organization (QIN-QIO) program is targeting nursing homes with infection control deficiencies by providing timely education and technical assistance through its TR-QIIs. Technical assistance includes a complete assessment and root cause analysis, development of an implementation plan, implementation of best practice interventions, and monitoring outcome metrics. The QIN-QIOs will work with facilities to improve compliance using the CDC infection control assessment tools. This high degree of technical assistance will provide the nursing home with a one-on-one action plan developed in conjunction with the QIO experts and infection preventionists. QIN-QIOs may complete onsite assistance at the request of CMS. Upon completion of the TR-QII, performance is tracked using Care Compare and/or the next CMS or state survey. CMS refers QIOs to nursing homes based on infection control deficiencies identified through the regulatory process over the last 12-15 months for the initial cycle of referrals.

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

Measure	CY	Target	Result
QIO13.1: Reduce CAUTI SIR in critical access hospitals	2024	4.5% reduction from baseline	June 30, 2025
	2023	3.3% reduction from baseline	June 30, 2024
	2022	2.2% reduction from baseline	June 30, 2023
	2021	1.1% reduction from baseline	June 30, 2022
	2020	Historical Actual	June 30, 2021
	2019	Baseline	0.59
QIO13.2: Reduce CDI SIR in critical access hospitals	2024	4.5% reduction from baseline	June 30, 2025
	2023	3.3% reduction from baseline	June 30, 2024
	2022	2.2% reduction from baseline	June 30, 2023
	2021	1.1% reduction from baseline	June 30, 2022
	2020	Historical Actual	June 30, 2021
	2019	Baseline	0.81

The purpose of this performance goal is to identify and reduce Healthcare-associated infections (HAIs) that are a threat to patient safety in Critical Access Hospitals (CAHs). CAHs are an important element to achieving the objectives of the CMS Rural Health Strategy, given that many of individuals they serve are at risk for increased comorbidities and mortality.

The two HAIs that will be reduced are Catheter-Associated Urinary Tract Infections (CAUTI) and Clostridium difficile Infections (CDI). These infections are the most common type of HAI reported to the National Healthcare Safety Network (NHSN), which is the nation's most widely used HAI tracking system.

A urinary tract infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney. The CDC states, overall, among all acute care hospitals, between 15-25 percent of hospitalized patients receive urinary catheters during their hospital stay. Among UTIs acquired in the hospital, approximately 75 percent are associated with a urinary catheter.

Clostridiodes Difficile is a germ (bacterium) that causes life-threatening diarrhea. It is usually associated with taking antibiotics. It affects older patients taking antibiotics

who receive hospital medical care and have weakened immune systems. Based on the Centers for Disease Control and Prevention (CDC) biggest threat list, in 2017, CDI accounts for 223,900 infections and 12,800 deaths per year.

Both CAUTI and CDI are major concerns for patients in healthcare facilities and associated with increased morbidity, mortality, hospital cost, and length of stay. The standardized infection ratio (SIR) is a summary measure used to track CAUTI and CDI at a national, state, or local level over time. The SIR adjusts for various facility and/or patient-level factors that contribute to HAI risk within each facility. SIR compares the actual number of HAIs reported to the number that would be predicted, given the standard population, adjusting for several risk factors that have been found to be significantly associated with differences in infection incidence. Overall, the purpose of the goal is to reduce hospital infections as measured by SIR and these two measures (CAUTI and CDI) are fully developed and endorsed by the National Quality Forum (NQF).

Since there is no CMS requirement for CAHs to report these infections to NHSN, this effort supports CAHs in reporting HAIs to NHSN, thus providing a better national picture of HAIs in CAHs. In addition, this aligns with the Medicare Rural Hospital Flexibility Program, which has an NHSN reporting requirement for CAHs. This initiative supports CMS's work to reduce patient harm, using the two most commonly occurring NHSN infections and the most widely reported NHSN metrics. Given the COVID-19 pandemic, the metrics are especially timely with regards to infection control and prevention and antibiotic stewardship.

The two NHSN Patient Safety metrics CMS will be monitoring/tracking include the following:

- Catheter utilization ratio (catheter days per 10,000 patient days)
- NHSN C. difficile Outcome Measure (NQF 1717) (SIR) hospital-acquired CDI laboratory identified events.

Quality Improvement Organizations (QIOs) will work with facilities to implement evidenced- based interventions to reduce CAUTI and CDI, such as prevention of inappropriate short term catheters; timely removal of urinary catheters, and catheter care during placement, as well as best practices for antibiotic stewardship. This work dovetails with related ongoing infection prevention and control work related to the coronavirus pandemic.

The data system for collection and reporting are high functioning and the systems are in place to receive the data, consistent with the CMS's Inter-Agency Agreement (IAA) with the CDC. Both metrics are reported by CAHs with more than 800 CAHs reporting on each of the two metrics. CMS will be working with approximately 44 percent of CAHs. CDC uses knowledge gained through activities to detect infections and develop new strategies to prevent HAIs. Public health action by CDC and other healthcare partners has led to improvements in clinical practice, medical procedures, and the ongoing development of evidence-based infection control guidance and prevention successes. In addition, proven and effective intervention strategies have been known, in some cases for decades, on how to reduce or eliminate these infections. Effective control of these infections does not require the discovery of new

drugs, new treatments, or the development of any vaccines. The requirements for hospitals and other health care facilities is to establish an effective infection prevention program, generate awareness among all Health Care Practitioners and for leaders to commit to measure and reduce their hospital infection rates.

MEDICARE BENEFITS

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

Measure	FY	Target	Result
MCR1.1a: Maintain or exceed percent of beneficiaries in Medicare Fee-for-Service (FFS) who report access to care*	2022	Contextual Indicator	December 31, 2022
	2021	Contextual Indicator	December 31, 2021
	2020	Contextual Indicator	Not Available**
	2019	Contextual Indicator	92%
	2018	Contextual Indicator	91%
	2017	Contextual Indicator	91%
	2016	Contextual Indicator	90%
	2015	90%	91% (Target Exceeded)
MCR1.1b: Maintain or exceed percent of beneficiaries in Medicare Advantage (MA) who report access to care *	2022	Contextual Indicator	December 31, 2022
	2021	Contextual Indicator	December 31, 2021
	2020	Contextual Indicator	Not Available**
	2019	Contextual Indicator	90%
	2018	Contextual Indicator	91%
	2017	Contextual Indicator	91%
	2016	Contextual Indicator	90%
	2015	90%	90% (Target Met)

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

CMS monitored Medicare FFS and MA access to care as measures of beneficiary satisfaction since the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. CMS is continuing to monitor FFS and MA access to care in order to maintain the same high rates for its beneficiaries. To measure these rates, beneficiaries respond to the following question in the Medicare Consumer Assessment of Healthcare Providers and Systems survey: "Percent of persons with FFS (or MA Plans) that report they usually or always get needed care right away, as soon as they needed it." CMS has met or exceeded its targets for this goal since the inception of the goal. Since FY 2016, CMS has reported the data trend annually as a contextual measure. High rates have continued for this measure. CMS is undertaking many efforts to address risk management within the agency's programs. For FY 2020 we will not have data to determine the impact of the pandemic on scores since the survey operations had to be curtailed due to the public health risk of continuing to administer the surveys. Going forward it is hard to predict how COVID-19 will influence these types of measures given the significant impact of the pandemic on the health care system.

MCR23: Reduce the Average Out-of-Pocket Share of Prescription Drug Costs while in the Medicare Part D Prescription Drug Benefit Coverage Gap for Non-Low Income Subsidy (LIS) Medicare Beneficiaries who Reach the Gap and have no Supplemental Coverage in the Gap

Measure	FY	Target	Result
MCR23: Reduce the Average Out-of-Pocket Share of Prescription Drug Costs while in the Medicare Part D Prescription Drug Benefit Coverage Gap for Non-Low Income Subsidy (LIS) Medicare Beneficiaries who Reach the Gap and have no Supplemental Coverage in the Gap*	2022	25%	April 30, 2024
	2021	25%	April 30, 2023
	2020	25%	April 30, 2022
	2019	28%	27% (Target Exceeded)
	2018	37%	36.7% (Target Exceeded)
	2017	43%	42% (Target Exceeded)
	2016	48%	48% (Target Met)
	2015	50%	49% (Target Exceeded)

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

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), amends Title XVIII (Medicare) of the Social Security Act by adding a Voluntary Prescription Drug Benefit Program (Medicare Part D). Since its inception, Medicare Part D has significantly increases the number of beneficiaries with comprehensive drug coverage, and enhanced access to medicines.

While Medicare Part D offers substantial insurance coverage for prescription drugs, it does not offer complete coverage. Prior to 2010, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the out-of-pocket threshold (or catastrophic limit). Only once the beneficiary reached the catastrophic limit, did Medicare coverage recommence. This is known as the coverage gap (or "donut hole"). The Affordable Care Act began closing the coverage gap through a combination of manufacturer discounts and gradually increasing federal subsidies until it closed in 2020. For CY 2020 and beyond, this means that non-LIS beneficiaries who reach this phase of Medicare Part D coverage will pay no more than 25 percent of costs for all covered Part D drugs. For 2021, beneficiaries reach this phase when total drug costs amount to $4,130 and stay in this phase until they pay $6,550 in qualified out-of-pocket costs. CMS' tracking of this measure has shown that that in most years non-LIS out-of-pocket costs have decreased beyond the targets required by statute (2019 exceeded the target goal).

The statute which established the Coverage Gap Discount Program gave CMS the authority to authorize exceptions to the requirement that manufacturers have their applicable drugs be covered under a Coverage Gap Discount Program agreement (Section 1860D-43 (C)) in extenuating circumstances. However, CMS successfully

encourages all manufacturers of applicable drug products to participate in the program, which results in the consistent application of discounts for all branded products. Furthermore, the infrastructure which has been put in place treats manufacturers fairly, which has resulted in manufacturers choosing to stay in the Part D program. Specifically, it: 1) allows public access to information about which manufacturers are participating in the program, and 2) offers an equitable process for manufacturers to dispute invoiced amounts. This has occurred without any meaningful decreases in manufacturer participation in the Part D market. As generic utilization in the Part D program has remained static, and very high (over 75 percent since 2012), that is not a strong contributor to the success of this goal. Rather, CMS' application and management of the Coverage Gap Discount Program, coupled with the strong incentives for manufacturers to participate in the Part D program, are the primary drivers of this goal's success.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

CHIP3: Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in CHIP and Medicaid

Measure	FY	Target	Result
CHIP3: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid*	2022	46,206,146 children (Medicaid – 36,964,931/CHIP – 9,241,233)	March 31, 2023
	2021	46,672,893 children (Medicaid – 37,338,314/CHIP – 9,334,579)	March 31, 2022
	2020	46,672,893 children (Medicaid – 37,338,314/CHIP – 9,334,579)	44,098,421 children (Medicaid-35,055,383/CHIP-9,043,038 (Target Not Met)
	2019	46,556,502 children (Medicaid - 37,245,202/CHIP - 9,311,300)	44,745,129 children (Medicaid – 35,090,387/CHIP – 9,654,742) (Target Not Met)
	2018	46,440,401 children (Medicaid – 37,152,321/CHIP – 9,288,080)	45,919,430 children (Medicaid - 36,287,063/CHIP - 9,632,367) (Target Not Met)
	2017	46,062,581 children (Medicaid – 36,850,065/CHIP – 9,212,516	46,322,217 children (Medicaid – 36,862,057/CHIP – 9,460,160) (Target Exceeded)

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

The purpose of this measure is to increase enrollment in CHIP and Medicaid from 43,542,385 children in FY 2011 to 46,206,164 children by the end of FY 2022. Under the CHIP and Medicaid programs, States submit quarterly and annual statistical forms, which report the number of children who are enrolled in Medicaid, separate CHIP programs, and Medicaid expansion CHIP programs. The enrollment counts reflect an unduplicated number of children ever enrolled during each year, and are not reflective of point-in-time enrollment.

The preliminary FY 2020 enrollment result of 44,089,421 children enrolled in Medicaid and CHIP does not meet the FY 2020 enrollment target of 46,672,893 children enrolled in Medicaid and CHIP. The program specific enrollment targets of 37,338,314 children enrolled in Medicaid and 9,334,579 children enrolled in CHIP were also not met by the preliminary enrollment results, which indicate that 35,055,383 children were enrolled in Medicaid, and 9,043,038 children were enrolled in CHIP during FY 2020.

The current FY 2020 Medicaid child and CHIP enrollment results are representative of preliminary data. Several states need to submit or make updates to their FY 2020 data.

The COVID -19 public health emergency (PHE) resulted in some states being delayed in submission of their final enrollment data. CMS is in the process of working with states to resolve any outstanding issues regarding the completeness and accuracy of states' FY 2020 data. As states finalize their FY 2020 enrollment submissions, we expect that the Medicaid child and CHIP enrollment result totals will increase.

It is also important to note that many states' enrollment totals were impacted by changes to policies and state operations as a result of the COVID-19 PHE. For example, the Families First Coronavirus Response Act (FFCRA) makes available to states a temporary 6.2 percent Federal Medical Assistance Percentage (FMAP) bump that includes a requirement to maintain Medicaid enrollment (for continuous coverage requirement) starting in March 2020. This requirement increased retention in Medicaid and potentially reduced churn in and out of the Medicaid program throughout the second half of FY 2020. The continuous coverage requirement in the FFCRA does not apply to CHIP. Therefore, the FY 2020 preliminary enrollment result shows a large enrollment decline in CHIP over FY 2019. The decline in CHIP enrollment may largely be due to losses in family incomes throughout FY 2020, resulting in children becoming ineligible for Medicaid coverage. Once the FY 2020 enrollment totals are finalized, we still expect to see a decline in CHIP enrollment but anticipate that the updated data may show and an increase in Medicaid child enrollment.

The FY 2020 enrollment results should be considered in the context of a recent Urban Institute Analysis highlighting 2018 data that show that nationally, 92.8 percent of children eligible for Medicaid and CHIP are enrolled in these programs, with participation rates at or above 90 percent in 42 states. In contrast, in 2008, only five States had participation rates of at least 90 percent. With such gains in increasing children's participation in Medicaid and CHIP, it is important to note that the remaining eligible uninsured children will be the hardest to reach. CMS' strategy to increase the availability and accessibility of health insurance coverage for children includes collaborating with its State and Federal partners, continuing to implement statutory provisions that encourage program simplification, supporting CHIP outreach grantees, and bolstering its data collection activities.

The HEALTHY KIDS Act, as included in P.L. 115-120, extended CHIP funding for six years through FY 2023, and the Advancing Chronic Care, Extenders and Social Services Act (referred to as the ACCESS Act and included in Pub. L. No. 115-123), provides CHIP funding for an additional four years, for FY 2024 through FY 2027. The HEALTHY KIDS Act and the ACCESS Act also included provisions related to the extension and reduction of federal financial participation for CHIP and maintenance of effort for children's Medicaid and CHIP coverage, the extension of express lane eligibility and the Connecting Kids to Coverage Outreach and Enrollment Program.[6] Through the HEALTHY KIDS Act and the ACCESS Act, the Connecting

[6] Key provisions of the HEALTHY KIDS Act and the ACCESS Act are described in State Health Official Letter# 18-010. Enrollment grants have been awarded to a variety of community organizations—such as health care providers, schools, tribal organizations, and other types of nonprofits—through four, two-year funding cycles since 2009. Thus far, 294 Connecting Kids to Coverage grant awards have been issue to eligible entities. The National Campaign conducts training webinars and

Kids to Coverage Outreach and Enrollment grants and National Campaign received $120 million in funding for outreach and enrollment activities through FY 2023, and $48 million for FY 2024 to FY 2027.

The Connecting Kids to Coverage grants and the National Campaign fund activities that are aimed at reducing the number of children who are eligible for Medicaid and CHIP but are not enrolled, and improving retention of eligible children who are currently enrolled. On November 30, 2018, CMS issued the Connecting Kids to Coverage HEALTHY KIDS 2019 Outreach and Enrollment Cooperative Agreement Notice of Funding Opportunity, which made available $48 million in cooperative agreements to states, local governments, Indian tribes, tribal consortium, urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act, federal health safety net organizations, community-based organizations, faith-based organizations, and schools. On June 19, 2019, CMS awarded 39 new cooperative agreements, with awarded amounts ranging from just over $360,000 to $1,500,000. These grants have a 3-year period of performance which began on July 1, 2019. On July 17, 2019, CMS issued the Connecting Kids to Coverage HEALTHY KIDS American Indian/ Alaska Native (AI/AN) 2020 Outreach and Enrollment Cooperative Agreement Notice of Funding Opportunity, which made available $6 million in cooperative agreements to enroll and retain AI/AN children in Medicaid and CHIP. Eligible entities for this funding opportunity include Indian Health Service providers, Tribes and Tribal organizations operating a health program under a contract or compact with the Indian Health Service under the Indian Self Determination and Education Assistance Act, and Urban Indian organizations operating a health program under the Indian Health Care Improvement Act. CMS awarded nine cooperative agreements on January 13, 2020, with award amounts ranging from $297,533 to $750,002 over a 3-year performance period.

With 92.8 percent of eligible children enrolled in Medicaid and CHIP in 2018, effective and targeted strategies are needed to enroll the remaining 7.2 percent of eligible uninsured children. As noted above, the remaining eligible but uninsured children are the hardest to reach.

works with partners on outreach, creates and updates existing outreach print materials, produces new social media graphics, and publishes a newsletter that has over 30,000 subscribers

CENTER OF MEDICARE AND MEDICAID INNOVATION (CMMI)

CMMI2: Identify, Test, and Improve Payment and Service Delivery Models

Measure	FY	Target	Result
CMMI2.1: Increase the number of model tests that currently indicate: 1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost.	2022	*TBD	*TBD
	2021	8.0	November 30, 2021
	2020	8.0	9.0 (Target Exceeded)
	2019	7.0	7 (Target Met)
	2018	6.0	6 (Target Met)
	2017	5.0	5 (Target Met)
	2016	4.0	4 (Target Met)
	2015	3.0	3 (Target Met)
	2014	Baseline	1.0

*Due to the Coronavirus (COVID-19) pandemic, CMS cannot determine the impact to determine setting a future target and result date at this time.

CMS routinely and rigorously assesses the impact of each model on quality and cost. To formally evaluate models, evaluators employ advanced statistical methods and carefully define and select comparison groups, as appropriate, to ensure that models deemed to be successful, represent high-value investments of taxpayer dollars. Similarly, model teams often employ implementation contractors to apply rigorous self-monitoring methodologies that assess the performance of models and generate value-based payments.

The purpose of measure CMMI2.1 is to identify those models, based on available data that indicate cost savings and/or quality improvements. This measure reflects the documented progress that CMS is making toward sustainable success of its models. As of November 19, 2020, nine Section 1115A model[7] tests, [Pioneer Accountable Care Organization (ACO), Diabetes Prevention Program (DPP), Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT), Comprehensive Care for Joint Replacement Model (CJR), Home Health Value-Based Purchasing Model (HHVBP), Maryland All-Payer, Accountable Care Organization Investment Model (AIM), Financial Alignment Initiative for Medicare-Medicaid Enrollees (FAI), and Medicare Care Choices Model (MCCM)], met this goal, according to data received to date. For the Pioneer ACO, DPP, and RSNAT models, the CMS Office of the Actuary (OACT) certified that they produced measurably positive improvements in quality and/or reductions in net program spending such that they could be expanded under Section 1115A of the Social Security Act. The CJR model, during its first three years

[7] For Section 1115A models please refer to: https://innovation.cms.gov

(2016-2018), achieved a statistically significant decrease in average payments for all lower extremity joint replacements (LEJRs), including inpatient and outpatient for mandatory CJR hospitals. After accounting for net reconciliation payments, estimated net savings for LEJRs was $61.6 million. Evaluation data for the Home Health Value-Based Purchasing (HHVBP) Model showed cumulative Medicare savings of $422 million in the first three years of the model (2016-2018). This value-based purchasing program has led to higher home health agency quality compared to non-participating states, and is reduction in unplanned hospitalizations and use of skilled nursing facilities. For the Maryland All-Payer model, evaluation data showed a $975 million decrease in total cost of care savings over the first four and half years of the model, amounting to almost a three percent reduction in Medicare spending. The ACO Investment Model (AIM) evaluation showed $526 million in gross Medicare spending reductions in the first three years of the model (2016-2018). After accounting for up-front and shared savings payments to participating ACOs, the net savings to Medicare were $382 million. For the Financial Alignment Initiative (FAI), the Health Homes Managed Fee-for-Service Model in Washington State[8] achieved $97.6 million in gross Medicare savings in the first three demonstration years (June 2013-December 2016). For the Medicare Care Choices Model (MCCM), the initial impact findings indicate that MCCM led to substantial reductions in total Medicare spending for the deceased MCCM enrollees during the first four years of the model (2016-2019). Total Medicare expenditures decreased by 25% percent, generating $26 million in gross savings and $21.5 million in net savings.

For other 1115A models, CMS continues to assemble and assess the evidence as it becomes available. Note that results can fluctuate based on new and updated evaluation results and policy decisions. The CMS 2021 target was intended to maintain the number of models indicating positive results at eight in FY 2021, consistent with the evidence available to date. At this time, due to the unknown impacts of the COVID-19 pandemic, CMS cannot set the FY 2022 CMMI 2.1 target and FY 2021 and FY 2022 result dates. It is unknown whether the COVID-19 response will result in, increased data lag, and/or the inability to obtain comprehensive inputs for calculating targets and results on time.

[8] For more information on models refer to: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalReport3.pdf

CMMI3: Accelerate the Spread of Successful Practices and Models

Measure	FY	Target	Result
CMMI3.1: Percentage of Medicare beneficiaries impacted by Innovation Center models	2022	Contextual Indicator	*TBD
	2021	Contextual Indicator	November 30, 2021
	2020	Contextual Indicator	13%
	2019	Contextual Indicator	15%
	2018	Contextual Indicator	17%
	2017	Contextual Indicator	13%
	2016	Contextual Indicator	9%
	2015	Contextual Indicator	9%
	2014	Baseline	5%
CMMI3.2: Number of states developing and implementing a health system transformation and payment reform plan	2022	Discontinued	N/A
	2021	13	November 30, 2021
	2020	7	7 (Target Met)
	2019	15	14 (Target Not Met)
	2018	16	16 (Target Met)
	2017	17	20 (Target Exceeded)
	2016	38	38 (Target Met)
	2015	38	38 (Target Met)
	2014	Baseline	25%

Measure	FY	Target	Result
CMMI3.3: Number of providers participating in Innovation Center models	2022	Contextual Indicator	*TBD
	2021	Contextual Indicator	November 30, 2021
	2020	Contextual Indicator	136,682
	2019	Contextual Indicator	261,767
	2018	Contextual Indicator	574,467
	2017	Contextual Indicator	219,719
	2016	Contextual Indicator	103,291
	2015	Contextual Indicator	61,000
	2014	Baseline	< 60,000
CMMI3.4: Increase the percentage of active model participants who are highly engaged in Innovation Center or related learning activities	2018	Discontinued	N/A
	2017	59.7%	47.6% (Target Not Met)
	2016	64.5%	56.9% (Target Not Met)
	2015	61.0%	58.6% (Target Not Met)
	2014	Baseline	56%
CMMI3.5: Percentage of Model awardees participating in learning activities	2022	*TBD	*TBD
	2021	50%	November 30, 2022
	2020	50%	November 30, 2021
	2019	50%	54.2% (Target Exceeded)
	2018	Baseline	61%

*To be determined (TBD) in table reflects the unknown impacts of the Coronavirus (COVID-19) pandemic and CMS cannot set future targets and result dates at this time.

CMS' Center for Medicare and Medicaid Innovation (CMMI) aims to test innovative payment and service delivery models to reduce program expenditures, while improving health outcomes and quality of healthcare delivery to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. Every CMS test of a new service delivery or payment model also includes a plan of action to ensure that the lessons learned and promising practices identified during the test can be spread as

widely and effectively as possible to support improvement for both CMS and the health care system at large.

CMS strives to understand the level of participation and engagement from beneficiaries, providers, states, payers, and other stakeholders to effectively design, test, and evaluate its portfolio of models.

To date, CMS has introduced a wide range of Medicare initiatives, involving a broad array of Medicare Fee-for-Service (FFS) beneficiaries, health care providers, states, payers, and other stakeholders. As a contextual indicator, CMMI3.1 provides a snapshot of the impact on the Medicare beneficiary population of CMMI's models at a given point in time (not cumulative impact), for models that have been operational for more than 6 months. The FY 2020 result of 13 percent was a decrease compared to FY 2019 result of 15 percent. The COVID-19 response has resulted in several models generating lower overall numbers in FY 2020 for goal CMMI 3.1. COVID-19 flexibilities have resulted in delayed performance period start dates for new CMMI models (Emergency Triage, Treat, and Transport Model, End-Stage Renal Disease Treatment Choices Model, Integrated Care for Kids Model, Maternal Opioid Model, and Radiation Oncology Model).

States play a critical role in determining the effectiveness of the health care system and the health of their populations. In addition to being health care payers for Medicaid, CHIP, and state employee populations, states affect the delivery of care through several different levers, including legislation, policy development and implementation, educational institutions, public health activities, and convening ability. From 2014 to 2017, CMS provided funding and technical assistance to states to test states' ability to utilize these levers in the design or testing of new payment and service delivery models that have the potential to reduce health care costs and increase the quality of care delivery in Medicare, Medicaid, CHIP, in collaboration with commercial healthcare systems. In FY 2014, 25 participating SIM states designed or implemented a health system transformation and multi-payer payment reform strategy. In FY 2015, CMS reported an additional 9 states, 3 territories, and the District of Columbia (38 in total), were committed to designing or testing new SIM payment and service delivery models in exchange for financial and technical support. By FY 2016, these 38 states continued designing and testing new payment and service delivery models. In FY 2017, the state count was 20, which included three All-Payer models with formal Medicare Alternative Payment Models (APM) participation, and 17 SIM states that continued testing and improving their health system transformation and payment reform plans. CMS saw a reduction in the number of SIM states in FY 2017, due to the design award project period ending, as intended by the program. In FY 2018, the CMMI3.2 target of 16 states, which included the All-Payer models, was met. In FY 2019, CMS continued model implementation in 11 SIM and 3 All-Payer states. CMS's strategic shift away from custom state models to a focus on new models that could be implemented more uniformly, across multiple states resulted in no new states targeted for implementation in FY 2020. Rather, the four existing SIM states, one Multi-Payer state, and two All-Payer states comprised our seven total target states for FY 2020. Given the change in strategy away from SIM-like models and moving towards the new "state-based initiatives", which are different in size and scope, CMS will discontinue CMMI3.2 starting in FY 2022. For FY 2021, the CMMI3.2 target includes the two existing All-Payer states, one existing Multi-Payer state, and

ten states targeted in the new Community Health Access and Rural Transformation (CHART) Model.

To accelerate the development and testing of new payment and service delivery models, CMS recognizes that many robust ideas will come from a broad array of health care providers, states, payers, and other stakeholders in communities across the country. CMMI3.3 seeks to understand the level of interest and participation among providers in CMS' model portfolio. CMS estimated that the number of participating providers in its payment and service delivery models was more than 60,000 in FY 2014, approximately 61,000 in FY 2015, 103,291 in FY 2016, 219,719 in FY 2017, 574,467 in FY 2018, 261,767 in FY 2019, and 136,682 in FY 2020. COVID response has resulted in several models generating lower overall numbers in FY 2020 for goal CMMI 3.3. The COVID-19 flexibilities have resulted in delayed performance period start dates for new CMMI models (Emergency Triage, Treat, and Transport Model, End-Stage Renal Disease Treatment Choices Model, Integrated Care for Kids Model, Maternal Opioid Model, and Radiation Oncology Model).

CMS has created collaborative learning systems for providers and other model participants in order to promote the broad and rapid dissemination of lessons learned and promising practices to deliver better health outcomes, higher quality and lower cost of care for Medicare, Medicaid, and CHIP beneficiaries. Most new service delivery or payment models include a plan of action to ensure that the lessons learned and promising practices identified during the test can be spread as widely and effectively as possible. For measure CMMI3.5, CMS is reporting the FY 2018 baseline of 61 percent. In FY 2019, CMMI3.5 achieved 54.2 percent (exceeding the target of 50 percent). As we move into future model support, CMS continues to optimize measurement of the content and delivery of learning events, to deliver information to support innovation using participant-centered, evidenced-based methodologies designed to optimize adult learning.

At this time, due to the unknown impacts of the COVID-19 pandemic, CMS cannot set the CMMI 3.5 target and provide the CMMI 3.1 and CMMI 3.3 result dates for FY 2022. It is unknown whether the COVID-19 response will result in, increased data lag, and/or the inability to obtain comprehensive inputs for calculating targets and results on time.

CMS DISCONTINUED PERFORMANCE MEASURES

Medicaid Discontinued Measures

MCD10: Improve Access for People with Disabilities and Older Adults, by Increasing the Proportion of Public Funding Directed to Home and Community-Based Services (HCBS) as a Portion of Long Term Services and Supports (LTSS) Expenditures

Home and community-based services (HCBS) are more cost-effective than institutional care for many beneficiaries (https://www.medicaid.gov/medicaid/ltss/downloads/moneyfollows-the-person/mfp-2015annual-report.pdf). Several statutory programs, in addition to §1915(c) HCBS waiver programs, provide options for people to receive long-term services and supports in the community. These include the Community First Choice state plan option, flexibilities in §1915(i) state plan HCBS, the extension of and improvements to the Money Follows the Person (MFP) Rebalancing Demonstration, and an extension of spousal impoverishment protections to people who receive HCBS.

CMS is discontinuing these measures which are reaching their end dates in 2020; however, CMS is exploring the development of new measures to reflect future progress related to Long Term Services and Supports (LTSS) rebalancing, which refers to the extent to which LTSS spending and use are for services delivered in home and community-based settings rather than institutional settings. CMS will continue to report on these goals through 2022. Further, data associated with these goals have been incorporated into CMS's Medicaid and Children's Health Insurance Program (CHIP) Scorecard: Percentage of Long-Term Services and Supports Expenditures on Home & Community Based Services by State. The Scorecard serves to increase public transparency and accountability about the Medicaid programs' administration and outcomes. Information in the Scorecard spans all life stages covered by Medicaid and CHIP. The Scorecard includes information on selected health and program indicators. It also describes the Medicaid and CHIP programs and how they operate (https://www.medicaid.gov/state-overviews/scorecard/ltss-expenditures-onhcbs/index.html). CMS plans to establish a new GPRA measure before final reporting of the current measures ends. Federal and state Medicaid policies have had a major impact on shifting service modalities for people who need LTSS away from institutional services and toward community-based services. These policies have not only increased the quality of life for people with LTSS needs, but they also have been successful in using limited Medicaid resources more effectively[9] [10] .

[9] https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html
[10] https://www.medicaid.gov/sites/default/files/2019-12/ltss-toptenreport.pdf

Measure	FY	Target	Result
MCD10.1: Increase the percentage of Medicaid spending on long-term services and supports for home and community based services (HCBS) to 65 percent by 2020.	2021	Discontinued	Discontinued
	2020	65%	April 30, 2022
	2019	63%	April 30, 2021 59% (Target Not Met)
	2018	61%	56% (Target Not Met)
	2017	59%	58% (Target Not Met)
Measure	**FY**	**Target**	**Result**
MCD10.2: Increase the Number of States that Utilize at least 50 percent of Medicaid Spending on Long-Term Services and Supports for Home and Community Based Services (HCBS) by 2020.*	2021	Discontinued	Discontinued
	2020	38 States and District of Columbia (76.5%)*	April 30, 2022
	2019	37 States and District of Columbia (74.5%)*	April 30, 2021 29 States and District of Columbia 58.8% (Target Not Met)
	2018	36 States and District of Columbia (72.5%)*	26 States and District of Columbia 52.9% (Target Not Met)
	2017	35 States and District of Columbia (70.6%)*	28 States and District of Columbia 56.9% (Target Not Met)

* The target and result percentages for MCD10.2 have been corrected from previous versions appearing in past versions of the CMS budget.

Medicare Quality Improvement Organizations Discontinued Measures

QIO7: Make Nursing Home Care Safer via the National Nursing Home Quality Care Collaboration (NNHQCC)

There are 1.3 million Americans who reside in the nation's more than 15,000 nursing homes on any given day. Current law requires CMS to develop a strategy that will guide local, state, and national efforts to improve the quality of care in nursing homes. CMS' approach to oversight of nursing homes is constantly evolving and is an agency priority.

The purpose of this measure "quality improvement in one-star nursing homes" was to track the change in the percentage of nursing homes with a one-star quality rating, over time. CMS monitors quality improvement progress in the 9,162 homes eligible for technical assistance from the Quality Innovative Network-Quality Improvement Organization (QIN-QIOs). The QIN-QIO program has a focus on improving quality in vulnerable populations, including those from rural areas, and also improving poor performance where the only available beds are in poor performing nursing homes.

In April 2019, CMS made improvements to each of the rating system domains under the Five Star Quality Rating System. In October 2019, CMS removed quality measures (QMs) related to residents' reported experience with pain. As a result, CMS set a new baseline for the period describing performance from 2019 through 2021. CMS advised providers that thresholds for quality measure ratings will be updated every six months beginning April 2020, however CMS is no longer able to calculate future targets or results based on the former methodology, therefore this goal is non-viable for continued monitoring beyond 2021. CMS will discontinue reporting on this goal as of FY 2022. CMS has developed a new goal. (QIO12) that will focus on making nursing home care safer by providing targeted interventions to those nursing homes that have previously been cited as having deficiencies in proper infection control.

Measure	FY	Target	Result
QIO7.3: Demonstrate improvement in nursing home health care quality by reducing the number of one-star nursing homes	2022	Discontinued	N/A
	2021	8.8%	*October 1, 2022
	2020	Baseline	9.4% (based on 4Q 2018- 3Q 2019 data)

*Note: The result reported will be based on the newer methodology and not consistent with the previously reported target.

QIO9: Improve Health Outcomes for Medicare Beneficiaries by Providing Technical Assistance (TA) Support Related to Value-Based Payment and Quality Improvement Programs to the Eligible Clinician Population Working in Ambulatory Care Settings

The purpose of this measure was to ensure broad-reaching national access to technical assistance (TA) for clinicians in clinical practices, in order to support successful participation in value-based payment and quality improvement programs. Programs provided TA through Learning and Action Network (LAN) events and/or direct TA. These LAN events included topics related to improving health outcomes for beneficiaries and improving care coordination and costs, related to care. Measuring the reach of TA across programs ensured these programs achieved successful outcomes. CMS will discontinue reporting on this goal as of FY 2020.

Measure	FY	Target	Result
QIO9: Increase Clinician Practice Technical Support	2020	Discontinued	N/A
	2019	90%	16.25% (Target Not Met)
	2018	*540,000 (90% of 600,000 eligible clinicians)	39.51% (Target Not Met)
	2017	*510,000 (85% of 600,000 eligible clinicians)	77% (Target Not Met)

* The FY 2017 and FY 2018 actual and confirmed data, for FY 2017, using the validated denominator (eligible clinician count), was 511,590 and 254,635 respectively. The FY 2018 target of 540,000 was not met as the denominator is less than half of the target. Using the target denominator number for FY 2018 and the validated numerator FY18 data of 237,086 resulted in 39.51%, target not met in FY 2018.

QIO11: Improve Hospital Patient Safety by Reducing Preventable Patient Harms

The purpose of this measure was to track national progress on harm reduction in acute care hospitals and assess the impact of patient safety efforts by using a national chart abstracted sample and counting the number of patient harms that take place per 1,000 discharges. Examples of some of the patient harms that were included in this measure are:

- Adverse Drug Events (ADEs)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line-Associated Bloodstream Infections (CLABSI)
- Falls
- Pressure Ulcers (PrU), also known as Pressure Injuries
- Surgical Site Infections (SSI)
- Ventilator-Associated Pneumonia/Events (VAP/VAE)
- Venous Thromboembolism (VTE) and
- Hospital Readmissions

Beginning FY 2018 the result is listed as data unavailable/not collected due to analytic issues surrounding the preliminary 2018 all cause harm metrics. Due to the inability to collect, track and report on data in accordance to the specified methodology as well as inconsistencies in availability of patient charts due to COVID-19, CMS will discontinue reporting on this goal as of CY 2020. CMS has developed a new goal (QIO13) that will focus on identifying and reducing Healthcare-associated infections (HAIs) that are a threat to patient safety in Critical Access Hospitals (CAHs). As a result of COVID-19, data at this time is uncertain and doesn't reflect the usual state or processes. There may be reduced admissions or COVID admissions rather than the usual reasons for hospital admission.

Measure	CY	Target	Result
QIO11: Hospital Patient Safety Harm Reduction	2020	Discontinued	N/A
	2019	78 harms per 1,000 discharges	Data unavailable/Not Collected
	2018	82 harms per 1,000 discharges	Data unavailable/Not Collected
	2017	86 harms per 1,000 discharges	86 (Target Met)
	2016	Historical Actual	88
	2015	Historical Actual	92
	2014	Baseline	(98 harms per 1,000 discharges)