FISCAL YEAR

2024

FINANCIAL REPORT

CMS

CENTERS FOR MEDICARE & MEDICAID SERVICES

Original Publication:
November 2024

Publication Number:
12074

AT A GLANCE

The Centers for Medicare & Medicaid Services (CMS) is an operating division within the Department of Health and Human Services (HHS). The CMS Agency Financial Report for fiscal year (FY) 2024 presents the agency's detailed financial information relative to our mission and the stewardship of those resources entrusted to us. This report is organized into the following three sections:

MANAGEMENT'S DISCUSSION & ANALYSIS

This section gives an overview of our organization, programs, performance goals, and overview of financial data.

FINANCIAL SECTION

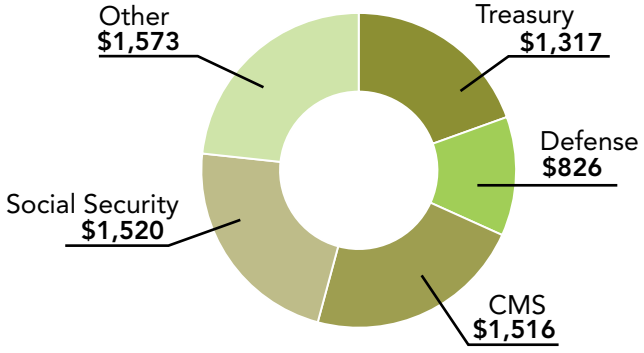
This section contains the message from our Chief Financial Officer, financial statements and notes, required supplementary information, and audit reports.

OTHER INFORMATION

This section includes the Summary of the Federal Managers' Financial Integrity Act Report and the Office of Management and Budget (OMB) Circular A-123 Management Responsibility for Enterprise Risk Management and Internal Control.

2024 FEDERAL OUTLAYS

CMS has outlays of approximately $1,516 billion (net of offsetting receipts and Payments to the Healthcare Trust Funds) in fiscal year (FY) 2024, 22 percent of total Federal outlays. CMS employs approximately 6,710 Federal employees, but does most of its work through third parties. CMS and its contractors process over one billion Medicare claims annually, monitor quality of care, provide the states with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. CMS also assures the safety and quality of medical facilities, provides health insurance protection to workers changing jobs, and maintains the largest collection of healthcare data in the United States (U.S.).

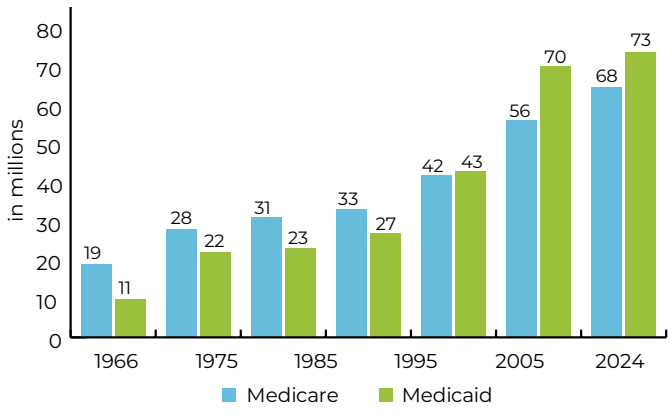


$ in billions

Source: U.S. Department of the Treasury

2024 PROGRAM ENROLLMENT

CMS is one of the largest purchasers of healthcare in the world. Medicare, Medicaid, and Children's Health Insurance Program (CHIP) provide healthcare for one in four Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to approximately 68 million beneficiaries. Medicaid enrollment has increased from 11 million beneficiaries in 1966 to about 73 million beneficiaries.



A MESSAGE FROM THE ADMINISTRATOR

CHIQUITA BROOKS-LASURE

I am proud to present the Centers for Medicare & Medicaid Services' (CMS) annual Agency Financial Report for fiscal year (FY) 2024. Over the past 12 months, CMS has continued to make meaningful progress toward our mission of advancing health equity, expanding coverage, improving health outcomes, and driving innovation. Over 160 million Americans now receive health coverage through Medicare, Medicaid and CHIP, and the Health Insurance Exchanges, highlighting the vital role that CMS programs play in helping people achieve their highest level of health and well-being, and ensuring access to quality, affordable healthcare.

As an ongoing priority, advancing health equity and addressing the disparities in our healthcare system is embedded in everything we do. To strengthen maternity care access, CMS has worked with states to extend continuous postpartum Medicaid coverage to 12 months, compared to the statutory minimum coverage of 60 days. Nearly 700,000 individuals in 46 states, the District of Columbia, and the U.S. Virgin Islands are estimated to now be eligible for these extended postpartum benefits. Additionally, the Transforming Maternal Health (TMaH) Model announced in late 2023 will provide funding and technical assistance to help up to 15 state Medicaid agencies develop a whole-person approach to pregnancy, childbirth, and postpartum care, addressing physical, mental health, and social needs.

Furthering our goals in advancing health equity, CMS has taken important actions to ensure healthcare systems can serve patients holistically by accounting for Social Determinants of Health, including food insecurity, housing instability, transportation needs, utility difficulties, and

interpersonal safety. In late 2023, CMS released guidance and a framework regarding opportunities for states to cover clinically appropriate and evidence-based services and supports that address health-related social needs under Medicaid and CHIP. For example, for people with specific clinical conditions, states can cover housing transition and navigation services, home remediations like air filtration improvements, and medically-tailored meals. In 2024, CMS hosted its second Health Equity Conference, where over 5,500 in-person and virtual participants learned about the importance of acknowledging historical and persistent injustices, addressing the social drivers of health, and partnering with diverse communities and organizations to reduce health disparities.

CMS also continues to make progress expanding access to affordable coverage. A record 21 million people selected health insurance coverage through the ACA Exchanges during the 2024 Open Enrollment Period, compared to 12 million in 2021. As of 2024, 45 million Americans have coverage under the Affordable Care Act, including Exchange plans, Medicaid expansion, and Basic Health plans, the most on record. This represents 14.1 million more people than in 2021, a 46 percent increase. Most Exchange consumers either qualify for $0 premiums or are saving at least $800 per year on their premiums after Exchange financial assistance provided through the American Rescue Plan (ARP) and the Inflation Reduction Act. CMS also took decisive action to protect Exchange consumers from agents and brokers who might try to enroll them in or change plans without their consent, implementing new procedures to block unauthorized changes to Exchange enrollments by agents and brokers. Also in 2024, CMS finalized a rule allowing Deferred Action for Childhood Arrivals (DACA) recipients to enroll in a health plan through the Health Insurance Marketplace® or Basic Health Program if they meet other eligibility criteria, which could help an estimated 100,000 previously uninsured DACA recipients gain coverage.

Two years in, our team is working hard to implement the *Inflation Reduction Act* and lower health care costs for millions of Americans. As a result of this law, we've achieved something decades in the making: putting Medicare on a level playing field by negotiating for lower drug prices. The *Inflation Reduction Act* provides meaningful financial relief for millions of people by improving access to affordable treatments and strengthening the Medicare program both now and in the future. For the first time, Medicare negotiated prices directly with participating drug companies for some of the costliest and most dispensed brand-name drugs used by people with Medicare. In August 2024, CMS announced negotiated prices for the first ten drugs selected for negotiation. The agency estimates that people with Medicare prescription drug coverage will save about $1.5 billion in out-of-pocket costs when the negotiated prices go into effect in 2026.

In addition, this year CMS expanded eligibility for full benefits under the Low-Income Subsidy ("Extra Help") program, which helps people with Medicare Part D afford their prescription drugs. As of early 2024, nearly 300,000 low-income people with Medicare enrolled in Extra Help benefited from this additional assistance under the Inflation Reduction Act, like no deductible, no premium, and fixed or lower copayments for certain medications. They save up to $300 per year on average.

CMS is also working hard to keep eligible people covered as pandemic-era protections for Medicaid enrollment have ended and states across the country have resumed regular eligibility and enrollment operations in Medicaid and CHIP. Since 2023, when Medicaid and CHIP eligibility renewals restarted, CMS has taken multiple actions to help eligible people renew Medicaid or CHIP eligibility and help others transition to different coverage options, like Exchange plans. As a result of these and other actions, since December 2023, coverage for over 60% of individuals due for renewal was successfully renewed. Total Medicaid and CHIP enrollment in May 2024 was 14% higher, or 10 million people above, enrollment in February 2020, just before the COVID-19 pandemic.

Responding to Executive Orders to strengthen Medicaid and improve access to affordable, quality health coverage, CMS released a final rule that will make it easier for millions of people to enroll in and retain coverage in Medicaid, CHIP, and the Basic Health Program. The rule allows children with CHIP to re-enroll without a lock-out period when a family fails to pay a CHIP premium, and prohibits waiting periods that delay CHIP enrollment. CMS also, for the first time, established appointment wait time standards for enrollees in Medicaid managed care organizations, so they can count on getting a doctor's appointment without waiting several weeks or months.

[1]Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

CMS has also strengthened access to Medicaid-covered home and community-based services (HCBS) by creating opportunities for states to address existing HCBS structural issues like supporting the direct care workforce, expanding the capacity of critical services, and meeting the needs of people on HCBS waiting lists and family caregivers. As a result of the ARP, state Medicaid programs plan to invest $37.1 billion in activities to enhance, expand, or strengthen HCBS. And under the final Ensuring Access to Medicaid Services final rule released in 2024, states are required to generally ensure a minimum of 80% of Medicaid payments for certain HCBS (homemaker, home health aide, and personal care services) be spent on compensation for the direct care workers furnishing these services, as opposed to administrative overhead or profit, subject to certain flexibilities and exceptions.

In 2024, CMS also issued the first national minimum nurse staffing standards for nursing homes to ensure access to safe, high-quality care for over 1.2 million nursing home residents. For the first time, long-term care facilities certified by Medicare and Medicaid generally must have a Registered Nurse on site 24 hours a day, 7 days a week to provide skilled nursing care. CMS likewise took steps that will provide greater transparency on who owns a nursing home and whether the ownership includes a private equity firm or real estate investment trust.

CMS continues to work in close partnership with the American Indian and Alaska Native communities and leaders to advance access to culturally competent healthcare to people eligible for Medicaid and CHIP coverage. This year, CMS approved demonstration project amendments to allow, for the first time, Medicaid and CHIP to cover traditional healthcare practices provided by Indian Health Service (IHS) facilities, tribal facilities, and urban Indian organization facilities. CMS has also proposed to allow coverage for Medicaid clinic services provided outside the "four walls" of IHS or tribal clinics, behavioral health clinics, and clinics located in rural areas, which would expand access to essential healthcare for people receiving services from these clinics.

In addition, CMS is taking decisive action to ensure that essential healthcare is extended to incarcerated individuals by providing new state flexibilities to use Medicaid and CHIP funds for certain pre-release healthcare to incarcerated individuals to help them succeed and thrive during re-entry. As of August 2024, CMS has approved reentry demonstrations in 11 states.

To help improve health outcomes, under the Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule published in 2024, states will be required to establish a quality rating system for Medicaid and CHIP managed care plans. This Medicaid and CHIP Quality Rating System will provide a "one-stop-shop" where people will be able to access information about Medicaid and CHIP eligibility and managed care, compare managed care plans based on quality and other factors key to decision making, and ultimately select a plan that meets their needs

Addressing the nation's health mental health crisis continues to be a priority. As part of the Administration's effort to ensure that more than 150 million people with private health coverage have greater access to mental health and substance use disorder care, the Departments of Labor, Health and Human Services, and the Treasury issued final rules to expand equitable access to benefits for mental health conditions and substance use disorders as compared to medical and surgical benefits and reduce barriers to accessing these services. Additionally, by the end of 2024, CMS approved Medicaid plans in 20 states and D.C. to support 24/365 community-based mobile crisis intervention services for individuals experiencing a behavioral health or substance use crisis, made possible by the American Rescue Plan.

Medicaid and CHIP provide health coverage to almost half of all children in the country and are together the largest payers of public mental health services. CMS has taken significant actions to strengthen Medicaid and CHIP coverage of behavioral health services for children and youth, such as by releasing new, comprehensive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit guidance to support states in providing robust and comprehensive health coverage for eligible children and youth enrolled in Medicaid.

In early 2024, CMS finalized the CMS Interoperability and Prior Authorization final rule, which will improve electronic data exchange and streamline prior authorization of care in Medicare Advantage, Medicaid and CHIP fee-for-service and managed care, and certain Exchange plans on the Federally-facilitated Exchanges – leading to more timely access

to healthcare and health information. The rule will reduce provider burden, allow clinicians more quality time with patients, ensure patients get the care they need, and save about $15 billion in administrative costs over 10 years.

To drive innovation across the health system, CMS in 2024 announced the GUIDE Model to improve the quality of life for people living with dementia, reduce strain on their unpaid caregivers, and help people living with dementia stay in their homes and communities. The model is among the first CMS efforts to focus on longitudinal, condition-specific comprehensive care. CMS also announced the six states participating in the 11-year States Advancing All-Payer Health Equity and Development (AHEAD) Model, which aims to improve the total health of a state population and lower costs, largely by strengthening primary care and care coordination. CMS also continues to advance value-based care through Accountable Care Organizations (ACOs), which are groups of healthcare professionals that take responsibility for giving patients high-quality, coordinated care, improving outcomes, and managing costs. In 2024, CMS announced that 19 new ACOs in the Medicare Shared Savings Program are participating in a new option enabling them to receive more than $20 million in advance payments for caring for underserved populations. An additional 50 ACOs are new to the program in 2024, bringing the total to 480 ACOs in the Shared Savings Program.

In 2024, the agency finalized the Transitional Coverage for Emerging Technologies (TCET) Pathway, to help people with Medicare access the latest medical advances. The initiative enables doctors and other clinicians to provide the best care for their patients, and benefits manufacturers who create innovative technologies. With this initiative, CMS aims to improve the quality of life for people with Medicare while encouraging innovation.

In the last two years, as cyberattacks in the healthcare sector have increased, CMS has taken a proactive role in advocating for improved national healthcare cyber resiliency across the Healthcare and Public Health (HPH) Sector. Given the risks to patient safety, CMS is taking action to encourage all healthcare providers and suppliers, technology vendors, and other members of the healthcare ecosystem to double down on cybersecurity, with urgency.

Internally, over the last four years, CMS has strengthened its cybersecurity posture by implementing emerging industry best practices, improving security processes, and building new foundational capabilities that help protect our systems and data against cyberthreats. In response to an Executive Order and OMB guidance directing cybersecurity improvements and adoption of a zero trust strategy, CMS built the Security Data Lake. This central data repository provides real-time visibility and access to cybersecurity information and analytical tools, including artificial intelligence (AI). This better protects the agency against risks and cyberthreats.

Recognizing both the potential power of AI and the government's need to responsibly harness its capability, CMS has been moving forward with several initiatives to position the agency for the future. During 2024, CMS has established a new AI cross-cutting initiative to provide strategic coordination on policy and explore opportunities to integrate AI technology into our operations while protecting security and privacy and mitigating bias.

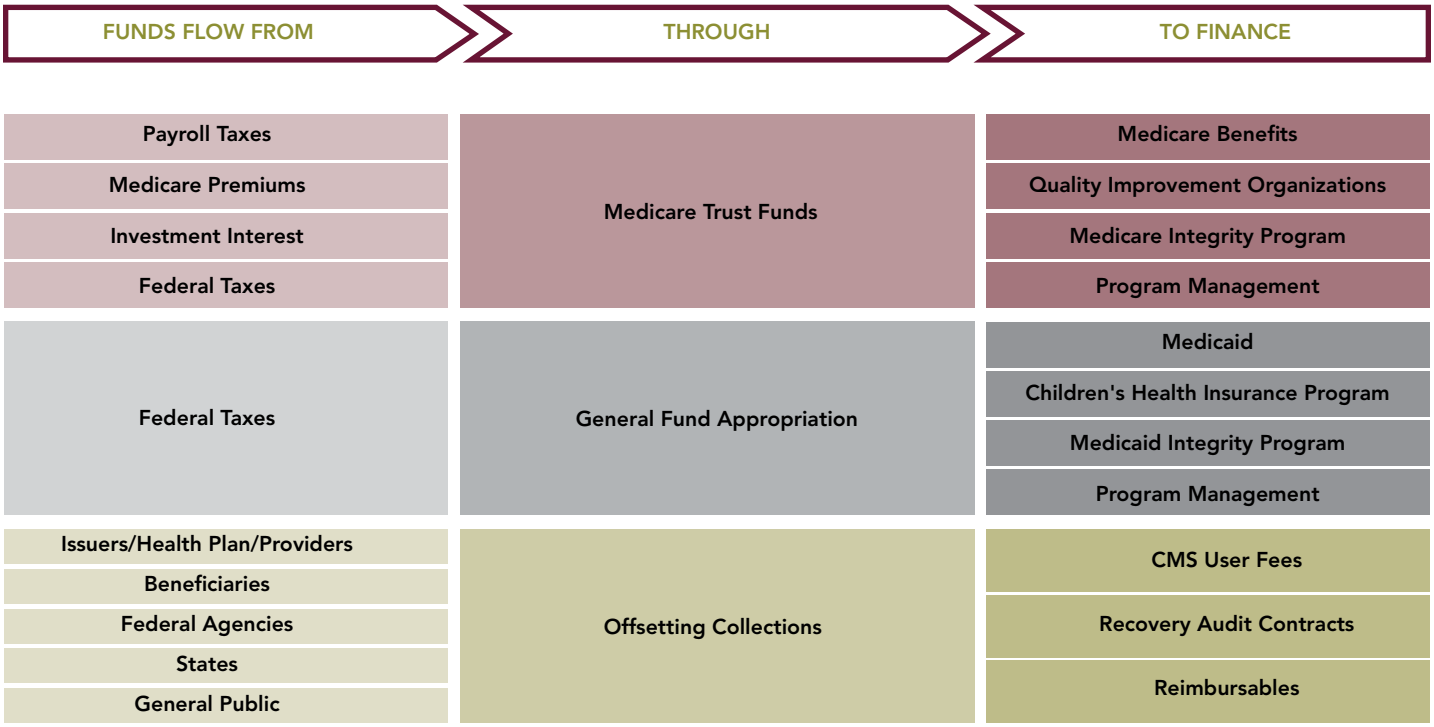
CMS is committed to promoting excellence in all aspects of CMS operations and fostering a positive and inclusive workplace and workforce. I am proud to say that CMS ranks in the top 30 percent of "Best Places to Work" among federal agencies as measured by the Federal Employee Viewpoint Survey and the Employee Engagement Index. The agency ranks in the top 20 percent for work-life balance.

The work we do is complex and challenging, but opportunities for reflection like this illustrate the impressive progress we are making toward our goals of advancing health equity, expanding coverage, improving health outcomes, and driving innovation as a trusted partner and steward. I am grateful for the dedication of our fantastic team, all working hard together to move forward towards our ideal of positive health system transformation and better health across the nation.

Chiquita Brooks-LaSure

CMS Administrator
November 2024

FINANCING OF CMS PROGRAMS & OPERATIONS



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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED LEADERSHIP
as of October 3, 2024 *Acting

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Principal Deputy Administrator and Chief Operating Officer

Erin Richardson
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Arielle Woronoff,
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John Czajkowski,
Deputy Chief Operating Officer

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Suzanne Martin-Devroye, *Deputy Director*
Alex Mugge, *Chief Health Infomatics Officer*

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Tiffany Swygert, *Dep. Dir. For Innovation & Fin. Mgmt.*
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Katie Hitchcock, *Deputy Director*

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Alaina Jenkins, *Deputy Director*

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Deputy Director for Operations
Karen Aldana,
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Kerry Branick, *Deputy Director*

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Pamela Gentry, *Deputy Director*

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RodneyWaltersdorff, *Deputy Director*

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OFFICE OF SECURITY, FACILITIES AND LOGISTICS OPERATIONS
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Jeff Wu, *Deputy Director for Policy*
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MANAGEMENT'S DISCUSSION & ANALYSIS

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PERFORMANCE MANAGEMENT // CMS STRATEGIC GOALS
INITIATIVES & OBJECTIVES //
OVERVIEW OF FINANCIAL DATA //
OVERVIEW OF SOCIAL INSURANCE DATA

OUR ORGANIZATION

CMS, an operating division of the Department of Health and Human Services (HHS), employs approximately 6,710 federal employees in Maryland, Washington, DC, and many other states throughout the country. CMS provides direct services to state agencies, healthcare providers and suppliers, individuals with Medicare, sponsors of group health plans, Medicare health and prescription drug plans, and the general public.

CMS's employees write policies and regulations that establish program eligibility and benefit coverage; set payment rates; safeguard the fiscal integrity of the programs it administers from improper payments including fraud, waste, and abuse; and develop quality measurement systems to monitor quality, performance, and compliance. In addition, CMS's staff provides technical assistance to Congress, the Executive branch, universities, and other private sector researchers.

CMS also contracts and/or partners with third parties to operate many of its important activities. Each state administers a Medicaid program and a Children's Health Insurance Program (CHIP). States inspect hospitals, nursing homes, and other facilities to ensure that health and safety standards are met. The Medicare Administrative Contractors (MACs) process claims, provide technical education to providers, review medical records, enroll providers, perform a host of financial audit and overpayment recovery services, adjudicate first level appeals and answer inquiries from Medicare providers. Additionally, Quality Improvement Organizations (QIOs) conduct a wide variety of quality improvement programs to ensure quality of care is provided to individuals with Medicare. The CMS Tribal Technical Advisory Group (TTAG) assists the agency to optimize Tribal Healthcare working with QIOs and the priorities set forth by the TTAG, and with the Center for Clinical Standards and Quality's ongoing quality engagement.

OVERVIEW

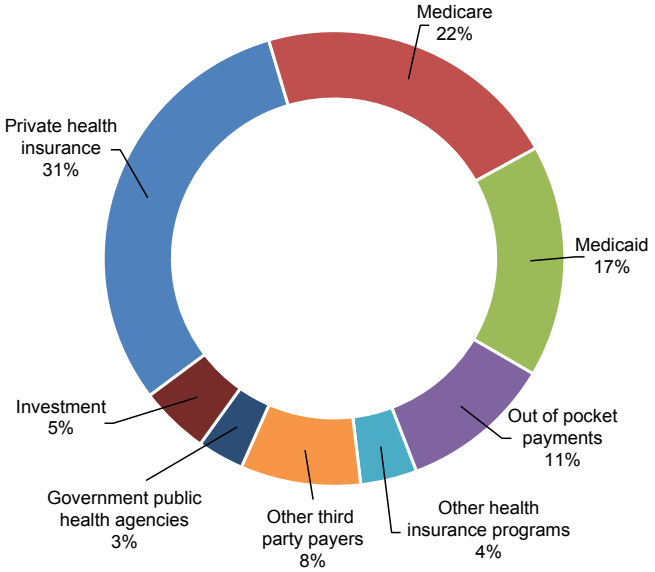
As the largest single health payer in the U.S., CMS administers Medicare, Medicaid, CHIP, the Federally Facilitated Exchange, and the *Clinical Laboratory Improvement Act of 1988* (CLIA) program. CMS now maintains the nation's largest collection of healthcare data.

According to 2024 projections[1], Medicare and Medicaid (including state funding) represent 39 cents of every dollar spent on healthcare in the U.S.— or looked at from three different perspectives: 49 cents of every dollar spent on nursing homes, 42 cents of every dollar received by U.S. hospitals, and 37 cents of every dollar spent on physician services.

Medicare

Title XVIII of the *Social Security Act* established Medicare in 1965. It was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people aged 65 and over. In 1972, the program expanded to cover people with disabilities and people with End-Stage Renal Disease (ESRD). The *Medicare Prescription Drug, Improvement, and Modernization Act* (MMA) further expanded the Medicare program, which included a prescription drug benefit for all Americans with Medicare beginning January 1, 2006.

THE NATION'S HEALTHCARE DOLLAR **FISCAL YEAR 2024**



*Totals may not add up to 100% due to rounding

1 CMS, National Health Expenditure Projections, 2023-2032. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected

Medicare routinely processes over one billion fee-for-service (FFS) claims a year and accounts for approximately 13 percent of total federal outlays. Medicare is a combination of four programs: Hospital Insurance (HI), Supplementary Medical Insurance (SMI), Medicare Advantage (MA), and Medicare Prescription Drug Benefit. Since 1966, Medicare enrollment has increased from 19 million to roughly 68 million individuals.

Hospital Insurance

Hospital Insurance, also known as HI, is provided to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most people entitled to Social Security or Railroad Retirement benefits. Most people do not pay a premium for HI because they or their spouse already paid for it through their payroll taxes while working (generally at least 10 years). The HI program pays for inpatient hospital, skilled nursing facility (SNF), certain home health, and hospice care, and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current individuals with Medicare.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI, is voluntary and available to nearly all people aged 65 and over, people with disabilities, and people with ESRD who are entitled to HI benefits. Medicare SMI pays for doctors' services and outpatient care, certain home healthcare, laboratory tests, ambulance services, durable medical equipment, designated therapy, and certain drugs. SMI pays for these covered services and supplies when they are medically necessary. The SMI coverage is optional, and individuals who elect SMI are subject to monthly premium payments.

Medicare Advantage

The *Balanced Budget Act of 1997* established the Medicare+Choice program, now known as the MA program, to provide more healthcare coverage choices for individuals with Medicare. Those who are eligible because of age (65 or older) or disability may choose to join a MA commercial plan servicing their area if they are entitled to HI and enrolled in SMI. Those who are eligible for Medicare because of ESRD could join a MA plan beginning January 1, 2021. Medicare beneficiaries have the option to choose to enroll in healthcare plans that contract with CMS instead of receiving services under FFS arrangements offered under original Medicare. Many MA plans offer supplemental benefits such as prescription drugs, vision, and dental benefits, and offer different out-of-pocket cost sharing arrangements. MA plans assume full financial risk for care provided to their Medicare enrollees. Individuals with Medicare can also enroll in cost plans where they can receive services through the cost plan's network or original Medicare.

Medicare Prescription Drug Benefit

The Medicare Prescription Drug Benefit is an optional prescription drug benefit created by the MMA for individuals with Medicare. Eligible individuals have the opportunity to enroll in either a stand-alone prescription drug plan to supplement their traditional Medicare coverage, or in a MA prescription drug plan, which integrates basic medical coverage with added prescription drug coverage. Individuals who qualify for both Medicare and Medicaid (full-benefit dually eligible) are automatically enrolled in the Medicare Prescription Drug Benefit program; assistance with premiums and cost sharing is available to full-benefit dually eligible, and other qualified low-income, individuals.

Medicaid

Title XIX of the *Social Security Act* established the Medicaid program in 1965. Medicaid is administered by CMS in partnership with the states. Although the federal government establishes certain parameters for all states to follow, each state administers its Medicaid program differently, resulting in variations in Medicaid coverage across the country. States have flexibility in determining Medicaid benefit packages within federal guidelines; however, all states' Medicaid programs are required to cover certain mandatory benefits. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community-based services (HCBS) and children in state-funded foster care. States and the federal government jointly fund the Medicaid program. CMS provides matching payments to the states and territories for Medicaid program expenditures and related administrative costs.

Medicaid provides access to comprehensive health coverage that may not be affordable otherwise for millions of Americans, including eligible low-income adults, children, pregnant women, older adults, and people with disabilities. Medicaid is the primary source of healthcare for over 70 million individuals. Over 13 million people are dually eligible for both Medicare and Medicaid. Medicaid is also the largest payer across the nation for long-term care.

CHIP

CHIP was created through the *Balanced Budget Act of 1997* and provides health coverage to low-income uninsured children and pregnant women whose income is too high to qualify for Medicaid. Title XXI of the *Social Security Act* outlines the program's structure and establishes a partnership between federal and state governments. States administer CHIP according to federal requirements while working closely with CMS, Congress, and other federal agencies. CMS ensures state programs meet statutory requirements designed to ensure meaningful coverage. CMS provides extensive guidance and technical assistance so states can further develop their CHIP state plans and use federal funds to provide healthcare coverage to as many children as possible. CHIP funds cover the cost of healthcare services, reasonable costs for administration, and outreach services to enroll children.

States are given broad flexibility in designing their programs, such as choosing to provide benchmark coverage, benchmark-equivalent coverage, or Secretary-approved coverage. In addition, states can create or expand their own separate CHIP programs, expand Medicaid, or combine both approaches. Important cost-sharing protections in CHIP safeguard families from incurring unaffordable out-of-pocket expenses. Over 7 million individuals are enrolled in CHIP.

CLIA

CLIA legislation expanded the survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens for health purposes, regardless of location. CMS regulates all laboratory testing on patients, including those performed in physicians' offices, for a total of 316,702 facilities.

The CLIA program is 100 percent user-fee financed and is jointly administered by three HHS operating divisions: CMS, the Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA). CMS manages the overall CLIA program, including its regulatory and financial aspects. This includes enrollment, regulation, and policy development; approval of accrediting organizations and exempt states; proficiency testing and certification of providers; and enforcement. CDC provides research, technical support, and coordination of the Clinical Laboratory Improvement Advisory Committee, while FDA performs test categorization.

Private Health Insurance and Health Insurance Exchanges

CMS oversees compliance with private health insurance reforms and works with health insurance issuers to increase industry transparency. CMS also facilitates access to private health insurance through the oversight of the Health Insurance Exchange (Exchanges) where health insurance issuers compete based on price and quality. Through these activities, CMS expands access to quality, affordable health coverage and care.

CMS works with states to ensure issuers comply with market reforms through policies like the federal prohibition on denying coverage for pre-existing conditions, the prohibition on annual and lifetime dollar limits on essential health benefits, and rating requirements. CMS also implements a process for states or CMS to review rates of non-grandfathered health insurance products in the individual and small group markets to determine compliance with federal health insurance rating rules. CMS is also responsible for enforcing compliance with a federal minimum Medical Loss Ratio (MLR) requiring health insurance issuers to spend a predetermined portion of premium revenues on clinical services and quality improvement or provide a rebate to policyholders if the MLR standard is not met. By ensuring issuer compliance with specific market reforms, CMS is expanding consumers' access to quality, affordable health coverage and care.

Permanent Risk Adjustment Transfers

The Health Insurance Exchange risk adjustment program is a budget neutral program that transfers funds from plans with lower risk enrollees to plans with higher risk enrollees (such as those with chronic conditions) in a state market to incentivize health insurance issuers that attract high risk enrollees. Additionally, the high-cost risk pool component of the risk adjustment program helps ensure that risk adjustment transfers better reflect average actuarial risk, while also stabilizing premiums and reimbursing issuers for a portion of costs for exceptionally high-cost enrollees. In doing so, this program continues to help provide access to quality, affordable healthcare coverage and care. The program is designed to reduce the incentives for issuers to avoid those enrollees. The risk adjustment program also lessens the

potential influence of risk selection on the premiums that plans charge. The risk adjustment program is designed to support plans offering a wide range of benefits available to consumers.

Section 1332 Waivers for State Innovation

Under Section 1332 of the *Patient Protection and Affordable Care Act* (PPACA), states can apply for a Section 1332 Waiver for State Innovation (also referred to as a "Section 1332 waiver" or "1332 waiver") from HHS and the Department of the Treasury (collectively, the Departments). If approved, the waiver allows states to implement innovative programs to provide access to quality healthcare. Through Section 1332 waivers, the Departments aim to assist states with developing health insurance markets that offer expanded coverage, lower costs, and ensure healthcare is truly accessible for all. State innovation waivers became available January 1, 2017, and can be approved for up to a 5-year period and extended. Waivers must not increase the federal deficit.

PERFORMANCE MANAGEMENT

Performance measurement results provide valuable information on the success of CMS's programs and activities. CMS uses performance information for improvement opportunities and to shape its programs. Performance measures clearly communicate CMS's programmatic objectives to the public and our 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 *Government Performance and Results Act of 1993* (GPRA) mandates that cabinet-level agencies have strategic plans, annual performance goals, and annual performance reports that encourage accountable stewardship of public programs.

As required by the *GPRA Modernization Act of 2010*, HHS developed a Strategic Plan (FYs 2022-2026), which was released with the President's Budget in February 2022. Key CMS performance measures that support the HHS Strategic Plan are featured in the FY 2025 HHS Annual Performance Plan and Report. Consistent with GPRA principles, the CMS GPRA performance goals reinforce the mission, goals, and objectives of the Administration. We look forward to the challenges represented by our performance goals and are optimistic in our ability to meet them.

Our FY 2024 performance measures track progress in our major program areas, including measuring error rates. In addition, we measure quality improvement initiatives geared towards older adults, children, and people with disabilities, who are served by the Medicare, Medicaid, CHIP, and the QIO programs. Detailed CMS performance measure information and available results are included in the CMS Budget. Progress on our measures has been reported through the FY 2025 President's Budget process.

The *Foundations for Evidence-based Policymaking Act of 2018* (also referred to as the *Evidence Act*) was established to advance evidence-building in the federal government by improving access to data and expanding evaluation capacity. The *Evidence Act* requires changes to how the federal government manages and uses the information it collects, emphasizing strong agency coordination for the strategic use of data.

CMS coordinates with HHS to submit Evidence-Building Plans (also known as Learning Agendas), Evaluation Plans, and Capacity Assessments. The FY 2023-2026 Evidence-Building Plan is a 4-year plan submitted in conjunction with the 4-year Strategic Plan. This plan outlines evidence-building priorities for the next 4 years, including priority questions and the methods and data required to answer them. The FY 2025 HHS Evaluation Plan is an annual plan that outlines evaluations and analyses agencies aim to undertake to answer the questions outlined in the Evidence-Building Plans. This plan includes priority questions, data needs, methods, anticipated challenges, and plans for dissemination and use of results. The FY 2023-2026 HHS Capacity Assessment is an agency evaluation and evidence-building capacity and functions conducted every 4 years and is submitted in conjunction with the Annual Performance Plan.

CMS'S FY 2024 VISION STATEMENT AND OVERARCHING GOALS

CMS'S VISION IS STRAIGHT FORWARD:

CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes

CMS achieves this vision through the work of thousands of dedicated individuals who are committed to improving people's lives through public policy aimed at making the U.S. healthcare system work better for everyone. It is important to lay out the strategy for how the agency will achieve this vision and how it should judge success. Everything we do at CMS should be aligned with one or more of the agency's overarching strategic pillars.

Strategic Pillars

CMS continues its ambitious agenda and bold plan to meet our mission in FY 2024 and beyond. Our work is organized and managed along six CMS strategic pillars that promote the establishment of broad programmatic goals and objectives. Inherent in our work is an unyielding focus on the customer experience to expand coverage and equitable access to those who are covered by one or more of our programs. Also essential is a focus on continuous improvement of CMS's operations to ensure they are best in class and set a benchmark for health system transformation.

All of CMS's centers and offices are actively developing and implementing projects to collaboratively advance these pillars across the agency. The following pages provide examples of some of the initiatives we have taken to achieve these goals.

Advance Health Equity by Addressing the Health Disparities that Underlie Our Health System

Advancing Health Equity

CMS infuses health equity in everything it does. CMS is working to advance health equity so each person has a fair and just opportunity to attain the highest level of health regardless of their age, race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

CMS programs cover more than 160 million people across the country through Medicare, Medicaid, CHIP, and the Exchanges. In all, CMS provides health coverage to nearly 1 in 2 Americans. CMS's programs are critical to helping ensure individuals and families have access to quality healthcare. CMS's goal is to ensure every person can access the care they seek at an affordable cost. Health equity is foundational to the CMS Strategic Plan and addressed within each of its pillars. The CMS health equity strategy builds on the Biden-Harris Administration's commitment to advancing racial equity and support for underserved communities through the federal government, as described in president's Executive Orders 13985 and 14091.

Furthermore, CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all people. The agency does this by considering the perspectives and life experiences of individuals and healthcare professionals, and by integrating safety net providers and community-based organizations into CMS's programs. By understanding and removing barriers to healthcare, CMS aims to eliminate avoidable differences in health outcomes and provide the care and support people need to thrive.

CMS continues to pursue its bold health equity goals through many actions:

- Closing the gaps in healthcare access, quality, and outcomes for all patients, including, but not limited to, those who are members of underserved populations.
- Promoting culturally and linguistically appropriate services to ensure healthcare services and supports are understandable, respectful, and responsive to preferred languages, health literacy, and other diverse communication needs.
- Building on outreach efforts to enroll eligible people across CMS programs.
- Expanding and standardizing the collection and analysis of data, including data on race, ethnicity, preferred language, sexual orientation, gender identity, disability, income, geography, health-related social needs, and other factors.
- Evaluating policies to determine how CMS can support safety net providers and partner with providers in underserved communities to ensure every person and family can access the care they need.
- Engaging with and also being accountable to the communities CMS serves with two-way communication on policy development and program implementation.
- Incorporating screening and support to address health-related social needs through quality measurement, coordinating with community-based organizations, opportunities for payment, and collection of social needs data in standardized formats across CMS programs.

Health Equity Measurement

CMS maintains a series of data snapshots, data highlights, and other reports with a health equity focus. During FY 2024, CMS released the following health equity measurement items:

- Improving Care for People with Limited English Proficiency Infographic – This infographic highlights the challenges people with Limited English proficiency (LEP) experience while getting care, including misdiagnosis, higher hospital admission rates, and difficulty getting regular screenings.

- Recognizing Health Disparities in the LGBTQI+ Community Infographic – This infographic calls attention to the unique healthcare challenges and barriers that members of the Lesbian, Gay, Bisexual, Transgender, Queer and Questioning, Intersex, Asexual, and Two Spirit (LGBTQI+) face and the work that is being done to help ensure that LGBTQI+ individuals have access to quality healthcare.

- Guide for Reducing Disparities in Readmissions – This updated resource is designed to assist users in understanding root causes of avoidable readmissions and identifying solutions for preventing and addressing avoidable readmissions and disparities in avoidable readmissions among individuals with Medicare coverage. Throughout the guide, key issues, strategies, and implementation examples are provided to guide organizations along their path to advancing health equity in the communities that they serve.

- Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes Infographic – This infographic explains how ICD-10-CM Z codes can help improve the collection of SDOH data. It also outlines ways that collection of SDOH data can improve equity in healthcare delivery and research.

- Socio-demographic and Health Characteristics of Medicare Beneficiaries Living in the Community by Dual Eligibility Status in 2021 – This new public use file uses data from the Medicare Current Beneficiary Survey and contains estimates on socio-demographic characteristics, functional limitations, chronic conditions, mental health, and oral health of people with Medicare living in the community as well as those with both Medicare and Medicaid.

- CMS's Resource of Health Equity-related Data Definitions, Standards, and Stratification Practices – A new resource document that offers a table of suggested health equity-related data definitions, standards, and stratification practices for 9 health equity-related data elements as well as several Frequently Asked Questions (FAQs) on the purpose and usage of the document. It may also clarify differences in results that may arise when different data standards and definitions are used.

- Tenth edition of the Disparities in HealthCare in Medicare Advantage by Race, Ethnicity, and Sex Report – This 2024 report provides a summary of the quality of healthcare received by people enrolled in MA across the United States, focusing on differences in patient experience and clinical care quality based on race, ethnicity, and sex. The report also highlights a range of aspects regarding the quality of patient care. It includes seven measures of patient experience from the MA and Prescription Drug Plan Consumer Assessment of Healthcare Provider and Systems survey, along with 41 clinical care quality measures covering nine domains of care from the Health Effectiveness Data and Information Set. These measures were stratified by race and ethnicity, sex, and the combination of race and ethnicity within sex to highlight areas where disparities exist.

- CMS updated the Mapping Medicare Disparities (MMD) Tool to include 2018 MA encounter data, social determinants of health data, and new visual enhancements. Previously, the MMD Tool used only Medicare FFS data but will now include MA encounter data as well.

Health Equity Dashboard and Briefs

Medicaid and CHIP provide essential healthcare coverage for millions of people across a wide breadth of the U.S. population, including, but not limited to, low-income adults, parents, seniors, individuals with disabilities, pregnant women, and children. CMS has developed a well-validated, evidenced-based method for combining high-quality, self-reported race and ethnicity data with indirect estimates. As a result of this new imputation method, CMS is developing and releasing multiple data briefs describing the composition of the Medicaid and CHIP program. These data enhancements and briefs reflect CMS's commitment to evidence-based, data-driven health policy and investments, and increased transparency into and prioritization of data to identify disparities in access, quality of care, and health outcomes.

Rewarding Excellent Care for Underserved Populations

CMS is rewarding excellent care for underserved populations in several care settings to further promote equity across quality and value programs. In FY 2024, CMS built on previously finalized policies for Accountable Care Organizations (ACOs) and MA Star Ratings by finalizing similar policies for the Hospital and Skilled Nursing Facility Value-Based Purchasing Programs. Through these policies, CMS gives providers an opportunity to earn upside-only monetary awards if they deliver high-quality care and serve a high proportion of underserved populations. These policies support high-quality care for underserved populations and enhance equitable payment opportunities for providers disproportionately serving underserved communities.

Improving Access to Care in Rural Communities

CMS continues to implement policies that support rural providers, improve access to care in rural areas, and support the transformation of the rural health delivery system. CMS is improving workforce training in underserved areas through Graduate Medical Education (GME) allocations. CMS is allocating 1,200 GME slots, phased in over multiple years, to enhance the physician workforce and fund additional residencies in hospitals serving underserved communities. CMS has prioritized training slots in areas that demonstrate the greatest need for additional providers, as measured by Health Professional Shortage Areas Impact. Clinicians who train in residency programs in underserved areas are more likely to continue their practice nearby after graduation. Following the enactment of the *Consolidation Appropriations Act of 2023*, CMS finalized through the end of 2024 several policies related to Medicare telehealth that enable individuals in rural and underserved communities to have improved access to care. These provisions expire at the end of CY 2024.

Furthermore, to improve access to care in rural communities, CMS also proposed a separate payment to small independent hospitals, including many rural hospitals, for establishing and maintaining access to a buffer stock of essential medicines to foster a more reliable and resilient supply of these medicines to help safeguard and improve the care hospitals can provide.

Collecting Sexual Orientation and Gender Identity (SOGI) Data on the Exchange Application

In response to Executive Order 14075 directing agencies to enhance data collection to measure and address disparities for LGBTQI+ individuals, the Exchange began asking three new sexual orientation and gender identity questions on all applications starting with Plan Year 2024. The new optional questions are asked for all individuals on the application ages 12 and older. The questions will be used for demographic data reporting for the purposes of analyzing health disparities in access to coverage.

Sickle Cell Disease Action Plan

CMS has completed a plan for how to address barriers and challenges faced by patients with Sickle Cell Disease who are also enrolled in CMS programs. This plan highlights CMS actions in four key areas: expanding coverage and access; improving quality and the continuum of care; advancing equity and engagement; and examining data and analytics.

This plan can help reduce barriers and challenges for people with Sickle Cell Disease, which disproportionately impacts people of color, including Black and Hispanic communities. CMS programs are taking actions outlined in this plan to improve equitable access, outcomes, and quality of care for people living with Sickle Cell Disease and their families.

Provider Inclusion and Diversity

During 2024, CMS published a federal register notice that announces the addition of gender data elements or options when providers are acquiring their National Provider Identifier (NPI).

By expanding gender code options beyond Male (M) and Female (F), these additional codes align with CMS diversity, equity, and inclusion initiatives. These changes promote improved accuracy in publicly available data and support unique identification and enumeration of healthcare providers. Furthermore, these changes empower patients with greater knowledge when making decisions regarding their care and selection of a healthcare provider.

Increasing Healthcare for People Leaving Carceral Facilities

On January 1, 2023, CMS implemented a new Special Enrollment Period (SEP) for Medicare-eligible individuals re-entering the community post incarceration. This SEP allows individuals to enroll or re-enroll in Medicare Parts A and/or B within the first year of re-entry as opposed to waiting until the next available general enrollment period. Prior to the establishment of this new SEP, beneficiaries were often subject to late enrollment penalties, gaps in coverage upon release, and other enrollment challenges placing undue hardship on the recently released population and in some cases making Medicare coverage cost prohibitive and difficult to access. To promote awareness of this SEP, CMS established an internal and external workgroup in November 2023 to identify outreach and education needs and strengthen relationships with partners who assist individuals re-entering the community. Activities during FY 2024 included providing education to approximately 1,182 individuals and partners through events and webinars, in addition to multiple ad hoc meetings. Such activities include presenting an HHS-wide Learning Session in honor of Second Chance Month: "Community Members Returning from Incarceration and Your Work at HHS," conducting a CMS Health Equity Assessment on the new Medicare SEP (on-going), and providing targeted "Incarcerated to Insured" outreach to partners to promote understanding of how those re-entering can enroll in Exchange, Medicare, and/or Medicaid. These activities aim to increase understanding about incarceration and challenges related to re-entry, as well as providing strategies that partners can use to help address those challenges.

Addressing Health-Related Social Needs for Medicare Beneficiaries

Under Medicare in FY 2024, CMS finalized coding and payment policy for Social Determinants of Health Risk Assessment, Community Health Integration, and Principal Illness Navigation services to help patients with health-related social needs and those diagnosed with a serious medical condition to access resources they need to carry out their treatment plan. These policy changes better account for resources involved in furnishing patient-centered care with a multidisciplinary team of clinical staff and other auxiliary personnel, such as community health workers, care Navigators, and peer support specialists. These types of services are expected to be disproportionately used to help individuals in underserved communities. For example, the new coding and payment policy for social determinants of health risk assessment recognizes when practitioners spend time and resources assessing social determinants of health risk that may impact their ability to treat the patient. CMS also finalized payment policy to practitioners for training caregivers to support patients with certain diseases or illnesses (e.g., dementia) as part of a treatment plan. This policy supports care for Medicare enrollees by better training caregivers. Members of underserved communities, including people with disabilities, are more likely to have family caregivers.

Also, CMS continues to build on these policies in FY 2024 by finalizing a policy that would better account for hospital resource costs involved in furnishing care to individuals experiencing housing insecurity. For 2025, CMS proposed allowing eligible ACO participants in the Medicare Shared Savings Program (MSSP) to receive prepaid shared savings payments to encourage investment in various health related social needs. CMS also proposed a new health equity benchmark adjustment to encourage ACOs to participate in underserved communities. Additionally, CMS proposed a new payment policy for caregiver training services related to direct care services and supports.

In MA, beneficiaries can get access to services to address health-related social needs through Special Supplemental Benefits for the Chronically Ill (SSBCI). In 2024, CMS finalized a policy to require MA plans to issue a "Mid-Year Enrollee Notification of Unused Supplemental Benefits" annually, between June 30 and July 31 of the plan year, that is personalized to each enrollee and includes a list of any supplemental benefits not accessed by the individual during the first six months of the year.

Expanding HCBS through the Money Follows the Person Demonstration

During FY 2024, $488.7 million was awarded to states to transition older adults and people with disabilities from institutions to home and community-based settings through the Money Follows the Person (MFP) Demonstration. For the full year, in FY 2023, grants to states to increase HCBS through MFP totaled $484.0 million. MFP grant recipients have transitioned 112,883 people to community living through MFP from the time transitions began in 2008 to the end of 2021.

In 2024, CMS charged MFP Demonstrations with pioneering the HCBS Quality Measure Set (HCBS QMS) in their states. Implementation of the HCBS QMS will assist CMS and states in ensuring the services received by beneficiaries are responsive to their changing needs and choices, maximize independence and self-direction, and facilitate a community-supported life. To guide these efforts, CMS published an Informational Bulletin: Implementing the HCBS QMS under MFP (https://www.medicaid.gov/federal-policy-guidance/downloads/cib04112024.pdf). States participating in MFP can leverage MFP funding to implement the HCBS QMS as required in the recently finalized regulation ensuring access to Medicaid services.

Build on the *Affordable Care Act* and Expand Access to Quality, Affordable Health Coverage and Care

Expanding Affordable Coverage Through the Inflation Reduction Act

Building on the subsidy expansions under the *American Rescue Plan Act of 2021* (ARP), the *Inflation Reduction Act of 2022* extends provisions that continue to improve health insurance affordability and access through 2025. These provisions reduced the amount of income individuals are required to contribute to their health insurance premiums and eliminated the 400 percent income cap of the federal poverty level for premium assistance eligibility, also known as the "subsidy cliff." Under these provisions, millions of Americans have been able to access health insurance with low- or zero-cost monthly premiums. Additionally, households over 400 percent of the federal poverty level were able to obtain eligibility for Exchange subsidies. The 2024 annual Open Enrollment Period was a record-breaking success, in part due to the expansion of these subsidies. From November 1, 2023, to January 15, 2024 (and later for State-based Exchanges with longer open enrollment periods), more than 21.3 million Americans signed up for health insurance, including more than 5 million Americans who signed up for new coverage. Four out of five people returning to HealthCare.gov were able to find plans for $10 or less a month after accounting for premium assistance.

Enhancing Consumer Options and Choice on the Exchanges

This year, CMS advanced the goal of health equity by finalizing proposals to address the health disparities that underlie our health system, such as strengthening network adequacy standards and extending the SEP for consumers with household incomes at or below 150 percent of the federal poverty level, among others. Network adequacy time and distance standards will expand to apply to State-based Exchanges starting in Plan Year 2026. CMS has also taken additional steps to strengthen network adequacy of Quality Health Plans (QHPs) on the Federally Facilitated Exchange by requiring issuers to meet appointment wait time standards. CMS also expanded access to dental benefits by finalizing measures to allow states the option to add routine adult dental services as an essential health benefit (EHB). CMS also took steps to advance health equity by finalizing an exceptions process for the non-standardized plan limit to allow issuers to offer additional non-standardized plans that facilitate the treatment of chronic and high-cost conditions that disproportionately impact disadvantaged populations.

The No Surprises Act

The *No Surprises Act*, effective January 1, 2022, protects people covered by group health plans or health insurance issuers offering group or individual health insurance coverage, including Federal Employees Health carriers, from receiving surprise medical bills when they receive emergency services from out-of-network providers, including air ambulance providers, or at out-of-network facilities. Under the law, individuals are only responsible for their in-network cost sharing. The remaining payment amount may be settled between health plans or issuers and providers or facilities, in accordance with the process outlined in statute. In the event plans, issuers, providers, and facilities cannot agree on a payment amount, the law establishes an independent dispute resolution (IDR) process to resolve payment disputes. The *No Surprises Act* also offers protections to individuals without insurance or who are not using insurance to pay for care (uninsured or self-pay individuals). It entitles these individuals to a "good faith estimate" of the cost of healthcare

items and services in advance of receiving care. If the ultimate cost of those items and services is substantially greater (more than $400) than the "good faith estimate," uninsured and self-pay individuals may dispute the cost of those services through the Patient Provider Dispute Resolution process. Protecting consumers from unexpected medical bills will decrease the percentage of people that forgo needed care due to cost and ensure consumers have access to quality, affordable health coverage and care.

Mental Health and Substance Use Disorder Parity Implementation

The *Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA) generally provides that financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits (M/S) in a classification. In addition, MHPAEA prohibits separate treatment limitations that apply only to MH/SUD benefits. MHPAEA also imposes several important disclosure requirements on group health plans and health insurance issuers.

The *Consolidated Appropriations Act (CAA), 2021* amended MHPAEA to provide important new consumer protections. Group health plans or health insurance issuers offering group or individual health insurance coverage that provides both M/S and MH/SUD benefits and that impose non-quantitative treatment limitations (NQTLs) on MH and SUD benefits must perform and document comparative analyses of the design and application of their NQTLs and make their comparative analyses available to CMS or the Department of Labor (DOL), as applicable upon request. CMS and DOL are responsible for reviewing these comparative analyses and identifying any compliance concerns and they work with the group health plan or health insurance issuer to ensure compliance. CMS, in collaboration with DOL and Treasury, also reports these analysis findings to Congress annually.

On September 23, 2024, DOL, together with HHS, and Treasury released new final rules implementing MHPAEA. The final rules amend certain provisions of the existing MHPAEA regulations to better ensure that plan participants and beneficiaries receive the full benefit of protections under MHPAEA so that they can access mental health and substance use disorder benefits in parity with medical/surgical benefits. The final rules add additional protections against more restrictive NQTLs for mental health and substance use disorders as compared to medical/surgical benefits and prohibit plans from using biased or non-objective information and sources that might negatively impact access to mental health and substance use disorder care when designing and applying an NQTL. The final rules also make clear that health plans and issuers must evaluate the impact of their NQTLs on access to mental health and substance use disorder benefits as compared to medical/surgical benefits. The rules also include HHS-only regulatory amendments to implement the sunset provision for self-funded, non-Federal governmental plan elections to opt out of compliance with MHPAEA, as adopted by the CAA 2023.

Short-Term, Limited-Duration Insurance and Independent, Non-coordinated Excepted Benefits Coverage

Short-Term, Limited-Duration Insurance (STLDI) is a type of health insurance coverage that is primarily designed to fill temporary gaps in coverage when an individual is transitioning from one plan or coverage to another. STLDI is excluded from the definition of "individual health insurance coverage" under the *Public Health Service Act*; therefore, it is generally not subject to federal individual market consumer protections and requirements for comprehensive coverage.

In 2024, HHS, in partnership with the DOL and Treasury, released final rules amending the federal definition of STLDI to limit the length of the initial contract term to no more than 3 months and the maximum coverage period to no more than 4 months, considering any renewals or extensions. Previously, the rules defined STLDI as coverage that has an initial contract term of fewer than 12 months and a maximum total coverage period of up to 36 months, including renewals and extensions. The final rules also amended the federal notice standard to help consumers better distinguish between comprehensive coverage and STLDI.

Hospital indemnity and other fixed indemnity insurance has traditionally been used as a form of income replacement upon the occurrence of a health-related event. The final rule also revised the consumer notice currently required for

fixed indemnity excepted benefits coverage in the individual market and established a new requirement to provide a consumer notice in the group market.

Prescription Drug Data Collection

Spending on prescription drugs is rising more quickly than total spending on healthcare services. To understand the increase, we need to know more about prescription drug costs and how rebates and incentives from drug manufacturers influence healthcare expenses. Under Section 204 (of Title II, Division BB) of the CAA 2021, group health plans and health insurance issuers offering group or individual health insurance coverage must submit information about prescription drugs and healthcare spending to CMS. CMS, on behalf of HHS, DOL, and Treasury will publish findings about prescription drug pricing trends and the impact of prescription drug rebates on patient out-of-pocket costs.

CMS also continued collecting prescription drug data through the annual QHP Pharmacy Benefit Manager (PBM) Drug Data, Pricing, and Rebate Review. The ACA added Section 1150A of the *Social Security Act*, which requires the reporting of certain prescription drug data to HHS. This data allows CMS to gain greater insight into the prescription drug supply chain. Issuers or their PBMs report on rebates, financial discounts, price concessions, PBM spread amounts, and amounts paid and received.

Access to Medicaid and CHIP Services

Ensuring beneficiaries can access covered services is a critical function of the Medicaid and CHIP programs and it remains a top priority for CMS. In 2024, CMS released two final rules, Ensuring Access to Medicaid Services (known as the "Access Rule;" CMS-2442-F) and Managed Care Access, Finance, and Quality (known as the "Managed Care Rule" CMS-2439-F). The Access Rule creates historic national standards that will allow people enrolled in Medicaid to better access care when they need it and strengthens HCBS, which millions of older adults and people with disabilities rely upon to live in the community. This landmark final rule will set minimum threshold standards for the percentage of Medicaid payments for certain services to be spent on compensation to direct care workforce, create meaningful engagement with Medicaid consumers, and advance provider rate transparency. The Managed Care Rule will improve access to care, accountability, and transparency for the more than 70 percent of Medicaid and CHIP beneficiaries who are enrolled in a managed care plan. It will require a limit on how long enrollees have to wait for an appointment, allow people to compare plan performance based on quality and access to providers, and streamline some payment and quality processes for plans, states, and beneficiaries. These rules build on Medicaid's already strong foundation as an essential program for millions of families and individuals, especially children, pregnant people, older adults, and people with disabilities.

Resources on Strengthening the Direct Service Workforce

On April 22, 2024, in recognition of the association between sufficient staffing in institutional settings and the delivery of high-quality institutional care, CMS released the Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting final rule (referred to as the "Minimum Staffing Rule," CMS-3442-F). In addition to establishing comprehensive minimum nursing staffing requirements in Medicare- and Medicaid-certified nursing homes, the Minimum Staffing Rule included new requirements that state Medicaid agencies report to CMS the percentage of Medicaid payments for services in nursing facilities and intermediate care facilities for individuals with intellectual disabilities that is spent on compensation to facilities' direct care workers and support staff. Data collected through this new reporting requirement will help demonstrate that state Medicaid agencies and facilities are ensuring that Medicaid payments are being spent in ways to support the institutional workforce and prioritize residents' health, safety, and quality of care.

Section 9817 of the American Rescue Plan Act of 2021, Temporary Federal Medical Assistance Percentage Increase for HCBS

Section 9817 of the ARP provided qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage for certain Medicaid expenditures for home and HCBS beginning April 1, 2021, and ending March 31, 2022. This increased funding represented an opportunity for states to identify and implement changes aimed at addressing existing HCBS workforce and structural issues, expand the capacity of critical services, and begin to meet the needs of people on HCBS waiting lists and family caregivers. This funding also provided states an important opportunity to enhance individual autonomy and community integration in accordance with the home and community-based settings regulation, Olmstead implementation, and other rebalancing efforts. According to states' spending plans for the quarter ending December 31, 2023, states have spent approximately $18.8 billion to-date and expect to spend a total of $37.1 billion in state and federal funds on activities that enhance, expand, or strengthen HCBS under Medicaid as a result of ARP Section 9817. Of this, total planned spending specifically on activities to recruit and retain the HCBS workforce is expected to reach $26.3 billion.

Collaboration for Cell and Gene Therapy Related to Sickle Cell

Born out of President Biden's Executive Order 14087, "Lowering Prescription Drug Costs for Americans," the Cell and Gene Therapy (CGT) Access Model was created by CMS. It aims to improve the lives of people with Medicaid who live with rare and severe diseases by increasing access to potentially transformative treatments. Cell and gene therapies have high upfront costs but have the potential to reduce healthcare spending over time by addressing the underlying causes of disease, reducing the severity of illness, and reducing healthcare utilization. Since the early stages of the model's development, CMS has been actively collaborating and providing expertise on Medicaid and Pharmacy issues.

Improving Drug Affordability

CMS remains on track with its implementation of the *Inflation Reduction Act of 2022*. The *Inflation Reduction Act* provides meaningful financial relief for millions of people with Medicare by expanding benefits, lowering drug costs, keeping prescription drug premiums stable, and improving the strength of the Medicare program. In FY 2024, CMS achieved several key milestones including (i) implementation of updates to the catastrophic phase of the Medicare prescription drug benefit to remove cost-sharing for certain beneficiaries; (ii) stabilization of Part D Premium increases; (iii) expansion of the Low Income Subsidy Program which provides extra help for prescription drug cost sharing and premiums to certain people with Medicare with limited resources; and (iv) capping Part B payment for new biosimilar drugs when certain pricing data is not available. CMS also issued final guidance on the Part B and Part D Inflation Rebates, which require drug companies that raise the prices of certain drugs covered under Part B and Part D faster than the rate of inflation to pay Medicare a rebate. CMS also continues to make significant strides in preparation for implementation of the many provisions of *Inflation Reduction Act* that go into effect in 2025 such as (i) releasing final guidance on the $2,000 out-of-pocket limit for prescription drugs under Medicare Part D; (ii) releasing final guidance of the Medicare Prescription Payment Plan that offer enrollees the option to pay out-of-pocket prescription drug costs in the form of capped monthly payments; and (iii) releasing final guidance on the Manufacturer Discount Program, which requires manufacturer discounts for applicable drugs. For the Medicare Drug Price Negotiation Program, CMS published the maximum fair prices negotiated for the first 10 Medicare Part D drugs selected for negotiation which go into effect in 2026. CMS issued draft negotiation guidance for 2027, the second year of the program, and will release final guidance in the fall of 2024.

Strengthening Access to Behavioral Health

In FY 2024, CMS finalized policies that created some of the most significant changes to promote access to behavioral health in the history of the Medicare program. Under the CAA 2023, CMS finalized policies allowing Marriage and Family Therapists and Mental Health Counselors to enroll as Medicare providers, increasing the number of providers who would be able to independently treat people with Medicare and be paid directly. CMS also finalized policies to implement a new benefit for Intensive Outpatient Program services, which fills a gap in coverage when people with Medicare require levels of service more frequent than individual therapy outpatient visits, but less intensive than a partial hospitalization program. CMS also finalized policies increasing payment for crisis care, substance use disorder treatment, and psychotherapy. CMS made similar conforming changes in MA to help ensure that people with a MA plan can receive essential treatments for MH/SUD. CMS expanded network adequacy evaluation requirements to a new outpatient behavioral health specialty type, which includes marriage and family therapists and mental health counselors, as well as addiction medicine clinicians, opioid treatment providers, and other behavioral health practitioners providing psychotherapy or medication for substance use disorder.

As part of its efforts to strengthen behavioral health, CMS finalized policies established under the CAA 2023 and effective for 2025 that would award 200 Medicare-funded residency positions to train physicians and increase the behavioral health workforce. At least half of those residency positions would be psychiatry and psychiatry subspecialties.

Furthermore, for 2025 CMS also proposed additional policies that would further increase behavioral health access, such as through new coding and payment to assist people at high risk of suicide or overdose; new coding and payment to make it easier for practitioners to consult behavioral health specialists; new coding and payment for the use of digital tools that support the delivery of specific behavioral health treatments; and policies for the treatment of opioid use disorder. Policies for CY 2025 will be finalized during FY 2025.

Additionally, CMS disseminated an interim Report to Congress for Section 1003 of the *Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L 115-271) (SUPPORT Act)*. The *SUPPORT Act* Section 1003 demonstration project was designed to increase the capacity of qualified Medicaid providers to deliver SUD treatment or recovery services. This report describes (i) the activities carried out by the five demonstration states, (ii) the extent to which these states achieved the stated goals in their applications, (iii) the strengths and limitations of each state's demonstration project, and (iv) plans for the sustainability of the *SUPPORT Act* project. Key findings from the demonstration include the following: demonstration states increased the number of providers qualified to provide buprenorphine or methadone as part of medication for opioid use disorder; implemented plans to increase provider capacity based on statewide needs assessments; and trained providers to address gaps in services for special populations. In addition, cross-state agency collaborations increased through collecting, reporting, and sharing data on SUD providers and populations needing access to SUD services.

T-MSIS SUD Data Book

The Transformed Medicaid Statistical Information System (T-MSIS) SUD Data Book is congressionally mandated through the *SUPPORT Act* and now the CAA 2023. The CAA 2023 will continue the prior focus on addressing the pressing need for substance use disorder treatment and prevention services, with a focus on opioid use. In addition, the CAA 2023 will be expanding focus on mental health with a focus on treatment, prescriptive practices for children and adults. Data book publication for both SUD and MH will be in 2025.

Providing Comprehensive Service Delivery to Individuals with Substance Use Disorders and Severe Mental Illness

In FY 2023, CMS approved one new SUD demonstration in Nevada and one new Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) demonstration in New Mexico, along with extending four states' demonstrations, with SUD and SMI/SED demonstrations totaling 35 and 12 states (including the District of Columbia) respectively[2]. Key findings from publicly available reports show that SUD demonstrations were associated with increases in the number of SUD treatment users[3]. States faced key challenges in implementing Section 1115 SUD demonstrations, such as a lack of provider experience with Medicaid, workforce shortages, difficulty benchmarking new payment rates for services,

2 Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: Cross State Analysis (September 2022): https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/sud-1115-rcr-analysis.pdf

3 Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: Implementation Challenges Across States (November 2022): https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/sud-1115-rcr-impl-chalngs.pdf

and stigma related to Medication Assisted Treatment. Findings on utilization and follow-up after a SUD-related emergency department visit were mixed across states[2]. CMS anticipates releasing additional reports on SUD and SMI/SED demonstrations by the end of the CY 2024.

Increasing Medicaid Provider Rates under Section 1115 Demonstrations

CMS is committed to improving access to quality care for all Medicaid beneficiaries and is engaged in an "all of Medicaid" approach to improve coverage, access to, and quality of care, as well as to improve health outcomes for all beneficiaries consistent with Medicaid's statutory objectives. CMS expects that such policies will also have the effect of mitigating health disparities. Research shows that increasing Medicaid payments to providers improves beneficiaries' access to healthcare services and the quality of care received. To that end, as a condition of CMS approval, including throughout FY 2024 for Section 1115 demonstrations that provide expenditure authority for designated state health programs, health related social needs or certain comprehensive health equity initiatives, states are required to increase and (at least) sustain higher Medicaid FFS provider base payment rates and Medicaid managed care payment rates in primary care, behavioral health, and obstetrics care.

Improving Access to Oral Health

CMS continues to build on past policies to expand Medicare payment for dental services when a service is integral to medically necessary services required to treat a beneficiary's primary medical condition. For CY 2024, CMS finalized that payment can be made for certain dental services prior to and during several different cancer treatments. For CY 2025, CMS proposed that payment can be made for certain dental services associated with dialysis treatment for end-stage renal disease. Policies for CY 2025 would be finalized during FY 2025.

Accepting the Dental Claim Format

To support CMS's Oral Health Cross Cutting Initiative and regulatory clarifications, CMS is building a new, modern claims processing system that will allow dental providers to submit claims using the American Dental Association paper claim and the *Health Insurance Portability and Accountability Act* standard electronic dental claim version (837d) to the original Medicare program. Currently, Medicare accepts, processes, and pays professional and institutional versions of health insurance claims, which many dentists may not use. Using modern technology and system development methodologies, CMS launched the first iteration of the dental claims system, known in the software development industry as a minimum-viable product, in CY 2024. CMS will continue to enhance the system to better serve dental providers and beneficiaries and in order to meet its strategic objectives. Finally, CMS plans to leverage the research, technology, and system design of the dental system to improve and further our efforts to modernize existing claims systems.

Engage Our Partners and the Communities We Serve Throughout the Policymaking and Implementation Process

Essential Health Benefits Regulatory Changes

In response to comments to CMS's December 2022 Request for Information (RFI) on the EHB, CMS proposed and finalized several changes to EHB policy to make it easier for states to add benefits to their EHB-benchmark plans. These changes will promote access to benefits that are not covered or that are covered but are not considered EHB. CMS also finalized a requirement for issuers' Pharmacy & Therapeutics (P&T) Committees to include a patient representative.

User Research Project on the Advanced Explanation of Benefits

In 2024, CMS has undertaken a user research project to help CMS and its Departmental partners better understand what consumers need to fully understand and make use of the advanced explanation of benefits (AEOB). Through three rounds of interviews with consumers from a diverse range of backgrounds, CMS will get valuable feedback to guide policy decisions, particularly for requirements around the components and format of AEOBs.

Rulemaking to Improve Accessibility and Operational Efficiency of the Federal Independent Dispute Resolution Process

In November 2023, CMS (on behalf of HHS), DOL, Treasury, and Office of Personnel Management published a proposed rule to improve the accessibility and operational efficiency of the Federal Independent Dispute Resolution process (Federal ICR) created by the National Security Agency. In the first 2 years of its implementation, the Departments have gained significant knowledge and have received substantial feedback from interested parties regarding how best to implement the Federal IDR process. The Federal IDR Operations proposed rule aims to act on these lessons to streamline how CMS oversees and implements various aspects of the Federal IDR process and create new processes to improve its accessibility and usability to providers, payers, and certified IDR entities.

Partner Engagement

In June 2024, CMS announced that it would be continuing its robust investment in Navigators by announcing the availability of $500 million in grants over the next five years, provided in five budget periods of 12 months each. For the first 12-month budget period, to be awarded this fall, $100 million is available, the largest investment in the Navigator program to date. Navigators would help people across the country, especially those in underserved communities, to sign up for healthcare coverage. Navigators have been incredibly effective, contributing to the record-breaking number of 21.4 million people who signed up for healthcare coverage through the Exchanges during the 2024 Open Enrollment Period.

The Navigators' effectiveness is demonstrated by how many people in underserved communities have signed up for Exchange coverage in 2024:

- Twenty-two percent of enrollees who report their race/ethnicity are Latino. If the percentage is the same among those not reporting, the estimated number of Latino Americans with Exchange coverage in 2024 would be approximately 5 million.

- Nine percent of enrollees who report their race/ethnicity are Black. If the percentage is the same among those not reporting, the estimated number of Black Americans with Exchange coverage in 2024 would be almost 2 million.

- About 12 percent of enrollees who report their race/ethnicity are Asian American, Native Hawaiian, and Pacific Islander (AANHPI). If the percentage is the same among those not reporting, the estimated number of AANHPI Americans with Exchange coverage in 2024 would be over 2.5 million.

- One percent of enrollees who report their race/ethnicity are American Indian/Alaska Native. If the percentage is the same among those not reporting, the estimated number of American Indian/Alaska Native Americans with Exchange coverage in 2024 would be 200,000.

Stakeholder Engagement

Stakeholder engagement-related activities continued in FY 2024 throughout the policymaking and implementation process. Some of the stakeholder-related activities in the fiscal year included the following:

- In the first half of 2024, CMS hosted calls with external partners to discuss plan display topics. The calls consisted of several workgroup calls, representing 76 partner organizations. CMS used the data collected to improve our understanding of how stakeholders interpret and use different plan display information. Between January through March 2024, CMS organized a series of calls aimed at fostering more transparency to inform CMS's decision-making for plan display and choice architecture priorities, which reflect CMS's health equity goals. The call cycle consisted of 8 workgroup calls, made up of 129 participants representing 76 partner organizations. Partner organizations included State-based exchanges that do and do not offer standardized plan options, as well as agents and brokers, Navigators and assistors, consumer advocates, Direct Enrollment/Enhanced Direct Enrollment Partners, and issuers from the QHP Workgroup for Issuer Testing. The findings from these calls provided more insight into the consumer experience on HealthCare.gov, stakeholder understanding of medical and dental benefit display standardized plan display, and cost-sharing reduction silver plan enrollment. Furthermore, throughout FY 2024, CMS engaged with our Tribal partners through a series of All Tribes Calls, monthly Long-Term Support Services webinars, HHS Tribal Consultation meetings and Tribal Technical Advisory Group and Secretary's Tribal Advisory Committee meetings.

- CMS continues to provide intensive technical assistance to states, and regularly engaged with federal partners, state associations and various HCBS stakeholders including advocates, providers, and researchers to ensure successful and effective implementation of the HCBS settings rule issued in 2014, including conducting site visits in seven states guided by stakeholder input.

- As a result of extensive ongoing state partner and stakeholder engagement, CMS released multiple resources in an effort to help eligible individuals maintain Medicaid and CHIP eligibility including;

    - an informational bulletin and slide deck to address questions received from states, stakeholders, and external partners on the permissibility of certain practices during Medicaid and the CHIP renewals;

    - streamlining the Medicaid, CHIP, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes final rule that builds on key lessons learned during Medicaid unwinding and involves a series of provisions to simplify enrollment and renewal processes by standardizing them nationwide and making it easier for eligible children and adults to stay covered; and extension of a temporary special enrollment period (SEP) to help people who were no longer eligible for Medicaid or CHIP transition to Exchange coverage in states using HealthCare.gov; and other new guidance and resources to help protect coverage.

- Public feedback has been instrumental to implementing the *Inflation Reduction Act* and CMS is continuing this engagement in its transparent, collaborative, and thoughtful implementation of the law. CMS has met with dozens of representatives from manufacturers, health plans, providers, and patient advocates. In addition to releasing guidance documents and information collection requests for public comment, CMS also conducted Patient Focused Listening Sessions to further inform the implementation of the Medicare Drug Price Negotiation Program. CMS is also holding monthly technical meetings with manufacturers; holds regularly scheduled meetings with manufacturers, trade associations, pharmacy groups, and provider groups; and maintains an "open door" policy for ad-hoc meetings. Additionally, CMS posts implementation guidance resources on the *Medicare Inflation Reduction Act* webpage.

- CMS continues to engage with stakeholders through the Health and Welfare technical assistance site reviews which includes protection and other advocacy organizations and providers from the waiver program of focus.

Medicare Advantage Data Request for Information

CMS issued a RFI to solicit feedback from the public on how best to enhance MA data capabilities and increase public transparency. Transparency is especially important now that MA has grown to over 50 percent of Medicare enrollment, and the government is expected to pay MA health insurance companies over $7 trillion over the next decade. The information solicited by the RFI supports efforts for MA plans to best meet the needs of people with Medicare and for people to have timely access to care. In addition, it ensures that MA plans appropriately use taxpayer funds and for the market to have healthy competition.

Learning Collaborative

The Medicaid Drug Price Transparency and Access Learning Collaborative was created in September 2022 and continues to be effective. It is designed to assist states to better manage their pharmacy and drug benefits in Medicaid (FFS and managed care). The collaborative activities focus on a state's management of the high costs associated with gene and cell therapy drugs, as well as specialty drugs. The learning collaborative also assists with educating states on the processes and requirements for the implementation of value-based purchasing (VBP) in the states, either via supplemental rebate agreements or multiple best-price, commercial VBP arrangements. The collaborative also works with states to increase drug price transparency when states contract with Medicaid managed care plans, which subcontract with pharmacy benefit managers (PBMs) to manage their pharmacy benefits.

National Average Drug Acquisition Cost

Section 1927(f) of the *Social Security Act* provides, in part, that CMS may contract with a vendor to conduct monthly surveys with respect to retail community pharmacies of retail prices for covered outpatient drugs. CMS developed

the National Average Drug Acquisition Cost (NADAC) to provide a national reference file to assist state Medicaid programs in pricing covered outpatient drug claims to reflect the actual acquisition cost of drugs. CMS publishes the file as a national reference benchmark that state Medicaid programs may use when determining their reimbursement to pharmacy providers. To further improve drug affordability, CMS added a technical change to NADAC methodology to allow a 12-month review of some existing NADAC rates that have not been updated due to limited monthly survey data thereby ensuring that more products will be accurately reimbursed.

Providing Technical Assistance to Advance Health Equity

CMS provides technical assistance through the CMS Health Equity Technical Assistance Program to support healthcare professionals, health plans and systems, State Medicaid Agencies, federal, state, Tribal and territorial, local health agencies, universities, community partners, and all other stakeholders working together to advance health equity through CMS programs. CMS health equity technical assistance builds capacity among healthcare professionals to identify and eliminate barriers experienced by members of underserved communities. It provides quality improvement tools to organizations, providers, and plans who serve underserved communities and helps CMS partners work together to ensure that all CMS benefits, services, supports, and coverage are available to every individual who is eligible for CMS programs.

Enhanced Assistance on State Medicaid Provider Screening and Enrollment

CMS provides ongoing guidance, education, and outreach to states about federal requirements for Medicaid provider screening and enrollment through monthly technical assistance calls, sub-regulatory updates in the Medicaid Provider Enrollment Compendium, and in-person visits. In FY 2024, CMS worked closely with states to assist in ensuring their managed care organizations fully implement screening and enrollment requirements for in-network providers. CMS continues to offer the Data Compare Service to states, which allows states to rely on Medicare's screening in lieu of conducting a state screening particularly during revalidation. Using the data compare service, a state provides Medicaid provider enrollment data extracts to CMS, and then CMS returns information indicating which providers have undergone a reliable Medicare screening, thereby reducing the state's or territory's workload. Data compare helps states identify providers for termination or deactivation.

Medicaid Integrity Institute

CMS offers training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute (MII) at no cost to states. In FY 2024, CMS returned to in-person learning while continuing to offer virtual training. For example, courses included such topics as various Medicaid Coding Boot Camps; CMS Data Experts Symposium; Medicaid Provider Audits & Investigative Skills Symposium; Coding for Non-Coders; HHS-OIG Fraud Schemes & Trends; Medicaid Provider Enrollment and Terminations; Program integrity Opportunities for the Territories; Program Integrity Directors' Symposium; and Program Integrity in Medicaid Managed Care. More information is located at the MII website: https://www.cms.gov/medicaid-integrity-institute.

Payment Error Rate Measurement Corrective Action Plan Oversight and Monitoring

To identify and address root causes of payment errors identified by the Payment Error Rate Measurement (PERM) program, CMS provides support, technical assistance, and training to states as they develop and implement their PERM corrective action plans (CAPs). CMS requires states to meet more stringent PERM CAP requirements if they have consecutive PERM eligibility improper payment rates exceeding the 3 percent standard described by Section 1903(u) of the *Social Security Act*.

Beginning in CY 2024, states will be required to develop and submit their PERM CAP to CMS's new Medicaid and CHIP Program Integrity Reporting Portal (MCPIRP). MCPIRP serves as a correspondence and communication platform, data repository that can synthesize and analyze reports submitted to CMS, and tracker for important milestones.

Medicaid Eligibility Quality Control Program

Under the Medicaid Eligibility Quality Control (MEQC) program, states design and conduct pilots to evaluate processes that determine an individual's eligibility for Medicaid and CHIP benefits. States have flexibility in designing pilots to focus on vulnerable or error-prone areas identified by the PERM program and the state. The MEQC program also

reviews eligibility determinations that are not reviewed under the PERM program, such as denials and terminations. MEQC pilots are conducted during the 2-year intervals that occur between states' triennial PERM review years ("off-years"). This allows states to implement prospective improvements in eligibility determination processes prior to their next PERM review. Beginning in CY 2024, states will be required to utilize CMS' MCPIRP as part of its MEQC program.

Medicaid Managed Care Oversight

CMS published guidance on June 28, 2021, to announce its Medicaid managed care monitoring and oversight strategy designed to improve access to services by supporting federal and state access monitoring for Medicaid beneficiaries within a Medicaid managed care delivery system. This guidance introduced a series of tools and toolkits for states to use and to help CMS improve the monitoring and oversight of Medicaid managed care programs. In FY 2024, CMS published Managed Care toolkits on four program integrity topics, including compliance, overpayment recoveries, fraud referrals, and payment suspensions. CMS is also piloting a new audit approach using the Unified Program Integrity Contractors to review and evaluate the effectiveness of the Medicaid managed care plans program integrity efforts. The approach will identify vulnerabilities at the plan level and opportunities to assist states in improving oversight of managed care plans. CMS has completed one pilot in West Virginia and has expanded to five other states.

Drive Innovation to Tackle Our Health System Challenges and Promote Value-based, Person-centered Care

Value-based Care and Payments

CMS continues to promote whole-person value-based care by growing participation in the MSSP, the largest ACO program in the country. In FY 2024, CMS finalized changes that promote access to accountable care for individuals who see nurse practitioners, physician assistants, and clinical nurse specialists for their primary care services. CMS also finalized changes to the financial methodology to better encourage participation by ACOs serving complex populations, as well as changes that continue to support ACOs in their transition to digital quality measurement and use of interoperable digital data. As of January 2024, nearly half of people with traditional Medicare are in an ACO and 19 new ACOs are receiving more than $20 million in advance investment payments for caring for underserved populations.

Furthermore, CMS proposed additional policies to continue growing participation in the MSSP such as by allowing certain ACO participants to receive prepaid shared savings payments to encourage investment in various health related social needs. CMS also proposed to implement a health equity adjustment to payment calculations to further incentivize participation by ACOs that serve people who are members of rural and underserved communities. CMS also proposed to move the Shared Savings Program towards the Universal Foundation of quality measures, creating better quality measure alignment for providers and driving care transformation. Policies for CY 2025 will be finalized during FY 2025.

Transparency in Coverage

CMS's Transparency in Coverage final rules, published by HHS, DOL and Treasury, require most group health plans, and health insurance issuers offering group or individual health insurance coverage to disclose personalized price and cost-sharing information to participants, beneficiaries, and enrollees, in real-time, through an internet based self-service tool. This information is intended to empower consumers to shop and compare costs between specific providers before receiving care, promoting more value-based consumer decisions about their healthcare. Starting in 2024, the internet-based self-service tool must give pricing information for all covered items and services, not just 500 items and services. Also under these rules, plans and issuers are also required to disclose on a public website their in-network negotiated rates, allowed amounts, and historical billed charges for out- of-network providers. Making this information available to the public will drive innovation in developing advanced consumer shopping tools, support informed, price-conscious decision-making, and ultimately promote competition in the healthcare industry to move towards quality, affordable health coverage and care. CMS has been providing ongoing technical assistance to, and receiving valuable feedback from both producers and users of the machine-readable files, promoting greater compliance with the disclosure requirements.

Comprehensive 1115 Demonstrations to Advance Value-based, Person-centered Care

Almost all states have at least one CMS-approved Medicaid Section 1115 demonstration. The Secretary (1) may, under Section 1115(a)(1), waive provisions in Section 1902 of the *Social Security Act*; and/or (2) may, under Section 1115(a)(2)(A),

authorize federal financial participation (FFP) for state expenditures that would not qualify for FFP under Section 1903 of the *Social Security Act* (i.e., provide "expenditure authority"). Section 1902 of the *Social Security Act* lists what elements the Medicaid state plan must include, such as provisions relating to eligibility, beneficiary protections, benefits, services, and premiums. An important FY 2024 example of states leveraging this important authority is the Medicaid and CHIP Section 1115 Demonstration Initiative to include pre-release services for incarcerated individuals who are soon to be released to their communities. This complex initiative is of great interest to states due to the significant health disparities, including substance use disorders and serious mental illness that incarcerated individuals experience. It has been approved in 11 states as of August 2024 and CMS is reviewing 13 additional state applications. There are several other initiatives and delivery system reforms being implemented under Section1115 authority to assist in improving health coverage and equitable access to high quality care for Medicaid beneficiaries and other low-income individuals. These other Section 1115 initiatives are described below.

- Health- Related Social Needs (HRSN) – CMS has approved medically appropriate, evidence based, and time-limited housing and nutrition supports for individuals with specific clinical and social risk factors. Other HRSN services can include case management, outreach, and health education, as well as infrastructure investments and certain transportation services, to support access to those services. Ten states have approved demonstrations as of August 2024.

- Workforce Initiatives – CMS has authorized provider workforce recruitment and retention activities in a few states that could include healthcare provider student loan repayment programs. This program is intended to reduce shortages of qualified healthcare providers and expand access to care for beneficiaries by requiring that participants in these Medicaid-funded programs provide services in community-based settings serving substantial Medicaid and uninsured populations.

- Continuous Eligibility – CMS is also encouraging states to provide continuous eligibility to targeted populations, including but not limited to, individuals upon release from correctional settings (including youth), and individuals with a confirmed status of homelessness. Continuous eligibility supports consistent coverage and continuity of care by keeping beneficiaries enrolled, regardless of income fluctuations or other changes that otherwise would affect eligibility.

Integrated Data Repository

The Integrated Data Repository (IDR) is a high-volume data warehouse comprising integrated views of data across Medicare Parts A, B, C, and D; beneficiary entitlement; enrollment and utilization data; provider reference information; drug data; contracts for plans; and Medicaid and CHIP. The IDR data is leveraged by various components and offices across the agency and externally by entities such as the Federal Bureau of Investigation, OIG, and Department of Justice (DOJ). The IDR allows for a variety of complex data analytic workloads such as investigative and litigious efforts focused on fighting Medicare and Medicaid fraud, waste, and abuse, Medicare and Medicaid program cost estimations, and innovative healthcare model(s) development. As part of migrating the IDR to the cloud by December 2023, CMS has designed the IDR Cloud system to be nimbler and more scalable to enhance system throughput, workload isolation and support advanced analytics such as Machine Learning for our customers and data scientists. These would enable them to make better data driven decisions. We are implementing additional data access capabilities such as Data-as-a-Service Application Programming Interface in the IDR cloud for the downstream applications to consistently and securely access the IDR data. To support the agency's overarching goal to eliminate data duplication, CMS is also implementing secure data sharing capabilities within the IDR cloud so data is centrally stored and logically shared with internal and external customers.

Advancing Integrated Care

Medicare and Medicaid were originally created as distinct programs with different purposes and have operated as separate systems despite a growing number of people who depend on both programs for their healthcare needs. This can lead to fragmented care for dually eligible individuals, misaligned incentives for payers and providers, and administrative inefficiencies and programmatic burdens for all.

Integrated care leads to delivery system and financing approaches that maximize Medicare-Medicaid care coordination and mitigate cost-shifting incentives, including total-cost-of-care accountability across Medicare and Medicaid. Most importantly, it means a seamless experience for individuals.

In 2023, about 22 percent of full-benefit dually eligible individuals were enrolled in integrated care. Overall, the number of dually eligible individuals in integrated care and/or financing models has increased over time. In 2011, just 161,777 individuals were enrolled in integrated care, compared to 1.98 million in 2023. Of those, 1.26 million were in programs where all enrollees received Medicare and Medicaid services through the same organization. In March 2024, CMS released a final rule aimed at further increasing the percentage of dually eligible managed care enrollees who receive Medicare and Medicaid services from the same organization.

Protect Our Programs' Sustainability for Future Generations by Serving as a Responsible Steward of Public Funds

Major Case Coordination

CMS launched its Major Case Coordination (MCC) initiative, with representation from the HHS's OIG, DOJ, and CMS. This initiative provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials, and fraud investigators to collaborate before, during, and after the development of fraud leads and investigations. This collaboration contributed to several successfully coordinated law enforcement actions and helped CMS better identify national fraud trends and program vulnerabilities, and better apply applicable administrative actions, when appropriate. In FY 2024, CMS reviewed 1,005 cases at Medicare MCC meetings, and law enforcement partners made 465 requests for CMS to refer reviewed cases. Additionally in FY 2024, CMS reviewed 74 cases at Medicaid MCC meetings, and law enforcement partners made 51 requests for CMS to refer reviewed cases from 18 different states.

Prior Authorization and Pre-Claim Review

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before a service is furnished to a Medicare patient and before a claim is submitted for payment. Pre-claim review is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. Both methods help to ensure that all applicable Medicare coverage, payment, and coding rules are met before an item/service is furnished and a claim is submitted, which helps providers and suppliers address claim issues early and avoid denials and appeals. By utilizing these methods, CMS protects the Medicare trust fund from improper payments. CMS works closely with providers and associations to share prior authorization and pre-claim review guidelines and procedures.

In FY 2024, CMS expanded prior authorization for certain lower limb orthoses, lumbar sacral orthoses, and osteogenesis stimulators. CMS completed nationwide expansion of prior authorization for certain lower limb and lumbar sacral orthoses. Prior authorization for the osteogenesis stimulator codes also began this fiscal year in California, Florida, Pennsylvania, and Ohio. Expansion to all remaining states and territories will occur in FY 2025. Additionally, CMS extended the Review Choice Demonstration (RCD) for Home Health Services for an additional five years. The demonstration will be continuing in the current demonstration states of Illinois, Ohio, Texas, North Carolina, Florida, and Oklahoma. Lastly, CMS has expanded the RCD for Inpatient Rehabilitation Facility (IRF) services in Pennsylvania to provide flexibility and choice for IRFs, as well as a risk-based approach to reduce burden on providers demonstrating compliance with Medicare IRF rules. CMS also continued prior authorization of Repetitive, Scheduled Non-Emergent Ambulance Transports and prior authorization for Certain Hospital Outpatient Department services. As prior authorization is an ongoing process, CMS continues to explore additional opportunities to expand Medicare FFS's use of prior authorization and pre-claim review.

Medicare Part C and Part D Oversight

Effective January 1, 2024, CMS required MA Organizations (MAOs) to implement new requirements to protect MA enrollees from improper delays and inappropriate denials for medically necessary items and services caused by MAOs' application of burdensome utilization management criteria. CMS took unprecedented steps in 2024 to ensure MAOs were complying with the new requirements by redesigning our audits to target compliance, thereby significantly increasing the number of audits we could conduct. The enhanced audits will ensure enrollees receive the care they need without excessive burden or delays. Furthermore, as required under the *SUPPORT Act*, CMS developed the Health Plan Management System (HPMS) Program Integrity (PI) Portal for Fraud, Waste and Abuse (FWA) Reporting. The HPMS PI Portal for FWA Reporting is a web-based portal that allows for the reporting of certain information related to FWA in the Medicare Part C and Part D programs and for sharing of this information between CMS, Medicare Part C and Part D plan sponsors, and the Investigations Medicare Drug Integrity Contractor (I-MEDIC) to assist in combatting FWA. Information that must be reported into the PI

Portal includes payment suspensions based on credible allegations of fraud against pharmacies under the Medicare Part D program, and inappropriate prescribing of opioids. Plan sponsors may also report any referrals of substantiated or suspicious activities of FWA.

Increasing Protections for People with Medicare Advantage

For MA for 2025, CMS finalized that certain types of supplemental benefits, available only to chronically ill enrollees, must be supported by evidence that they improve health outcomes in the bid review process, to ensure that these supplemental benefits offered by a MA plan meet the health needs of people with Medicare. The rule also requires MA plans to send a mid-year, personalized communication to their enrollees about accessing unused supplemental benefits. These actions ensure that the large federal investment of over $65 billion per year of taxpayer dollars in supplemental benefits will meet enrollee needs and will not be used just for marketing.

Mitigating the Impact of Significant, Anomalous, and Highly Suspect Billing Activity on the Medicare Shared Savings Program

CMS issued a standalone proposed rule and complementary policies in the CY 2025 Physician Fee Schedule to address significant, anomalous, and highly suspect billing activity which could, if unaddressed, adversely impact the accuracy, fairness, and integrity of calculations under the MSSP. These policies would account for the impact of these potential improper payments, and would continue to encourage partnership with healthcare providers in identifying significant, anomalous, and highly suspect billing activity.

Medicare Secondary Payer

The Medicare Secondary Payer (MSP) program plays a significant role in safeguarding the sustainability of the Medicare program for future generations by ensuring Medicare identifies other responsible payers and only pays for care after any other primary payers. CMS realized $9.04 billion in Medicare savings through the MSP program in FY 2024 (through August 2024). The MSP program contributes to CMS's ability to protect the Medicare program's sustainability through the following key mechanisms:

1. Cost Containment: Under the MSP provisions, the program compiles information that is used when processing payments to help prevent Medicare from paying for healthcare costs that should be covered by other primary payers such as employer-sponsored group insurance, workers' compensation, or liability insurance. This coordination of benefits is the largest source of savings under the MSP program, reducing burden on the Medicare program, preserving funds for essential services and ensuring its long-term financial viability.

2. Recovery of Funds: The MSP program allows CMS to recover payments made by Medicare when another primary payer should have been responsible. Through robust recovery efforts, including identification, verification, and collection of conditional payments, CMS recoups funds that can be reinvested back into the Medicare program, contributing to its sustainability. From October 2023 through August 2024, over $1.05 billion were recovered through the MSP recovery process.

3. Compliance and Enforcement: By ensuring compliance with MSP and other debt management regulations, enforcing the program's requirements and holding liable entities accountable for their responsibilities as primary payers, CMS can uphold the integrity of the Medicare program and prevent inappropriate shifting of costs onto Medicare, thus protecting its financial resources. One such process is the Administrative Wage Garnishment (AWG) process, which serves as a protective measure for the Medicare program by providing a mechanism to recover unpaid Medicare debts from individuals who have not fulfilled their financial obligations. By utilizing AWG, CMS enforces payment obligations on individuals who have not voluntarily repaid their Medicare debts.

4. Data Analysis and Improvement: Data analysis is conducted on primary payer status, payment accuracy, and recovery efforts to identify trends, gaps, and areas for improvement. By leveraging this data-driven approach, CMS strengthens the MSP program's effectiveness at detecting vulnerabilities and implementing strategies to enhance the program's ability to protect Medicare's sustainability over time.

In essence, the Medicare Secondary Payer program serves as a critical component of CMS's commitment to responsible stewardship of public funds. By ensuring that Medicare remains a secondary payer where appropriate, recovering funds from primary payers, enforcing compliance, and continually improving program efficiency, CMS through the MSP program helped safeguard the future financial health of the Medicare program, ensuring its ability to serve generations to come.

Premium Refunds

CMS continues to be a responsible steward of public funds, continuously improving methods of protecting the nation's purse. As of June 2024, CMS refunded approximately $11.3 million to over 14,000 beneficiaries. The refunds represent overpayments made by beneficiaries for Medicare Parts A, B, D and/or Income-related Monthly Adjusted Amounts (IRMAA). A beneficiary who is directly billed for Medicare premiums may be due a refund for several reasons including changes in eligibility or enrollment status. Examples include:

- Beneficiaries affected by IRMAA-D life changing events: These individuals experienced qualifying life events that altered their income or marital status, prompting adjustments in their Medicare Part D prescription drug coverage premiums. Refunds in this context likely result from overpayments or adjustments due to reduced IRMAA-D surcharges.

- Beneficiaries who transitioned from paying premiums for Part A to receiving it for free: This group consists of beneficiaries who previously paid premiums for Medicare Part A but later qualified to receive it at no cost. Reasons for this transition can include reaching retirement age and having sufficient work history or qualifying under specific circumstances.

Overall, the refunds reflect adjustments made to ensure beneficiaries are paying accurate amounts based on their current circumstances and eligibility statuses under Medicare programs. CMS will continue to process refunds as expeditiously as possible and continue to hold its role as a responsible steward of public funds.

Vulnerability Collaboration Council

CMS utilizes a centralized vulnerability management process to identify, prioritize, track, and mitigate vulnerabilities that affect the integrity of federal health programs. The centralized component of this process, known as the Vulnerability Collaboration Council (VCC), comprises CMS leadership and subject matter experts that work collaboratively to identify and mitigate vulnerabilities in payment and coverage policies. CMS aligned the VCC's risk-based approach with Government Accountability Office's (GAO) Fraud Risk Management Framework. In FY 2024, CMS conducted three program integrity risk assessments on multiple topics, including nursing facilities and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). The VCC also collaborated with the Office of Financial Management to present a series on Improper Payments for Medicare, MA, the Prescription Drug Plan, and Medicaid programs.

Payment Error Rate Measurement Independent Verification Initiative

CMS enhanced reporting on Medicaid and CHIP improper payment data by implementing the PERM independent verification process to better analyze the insufficient documentation findings. CMS was able to independently verify the missing elements, using the same data sources available to states to determine if the beneficiary or provider would have been eligible, had the state performed the required verifications or maintained documentation at the time the state made the determination. The agency now has sufficient information to determine that the individual or provider was eligible for the payment in certain cases and use the information to provide greater clarity around technically improper versus "true" improper payments. Although this will not have a direct impact on the improper payment rates reported, this new data will allow for targeted work with states to address their greatest areas of non-compliance and focus on correcting these programmatic vulnerabilities.

Foster a Positive and Inclusive Workplace and Workforce, and Promote Excellence in All Aspects of CMS's Operations

Culture of Care

CMS is committed to building and maintaining a culture of care in order to provide a safe, productive, engaging, and equitable work environment for all staff. We continue to modernize our workspace to support the workplace of the future. The effort is intended to provide a safe and inspiring work environment that enables employees to thrive in a hybrid workplace, foster greater integration and collaboration among our Centers and Offices, and advance CMS's Diversity, Equity and Inclusion (DEI) principles.

CMS Future of Work

As we emerge from the pandemic with a continued focus on enhancing collaboration, strengthening relationships between our CMS components, external stakeholders, and government partners, CMS is transitioning from a pandemic 'remote first' mindset to a post-pandemic 'telework first' mindset. The changes are being designed to ensure that CMS can best meet its mission, better serve those enrolled in our programs, and recruit and retain exceptional staff. CMS has communicated this vision to the workforce and is now working with its DOL partners to develop a plan to bring that vision to fruition.

Workforce Resilience

To promote resilience among customer-facing staff, CMS developed an internal process to continue supporting improved customer experiences by using internal resources, including a licensed clinician and staff trainers, to support and train components in topics of human resilience through forums such as the internal CMS Customer Liaison Program (CLP) Quarterly Community of Practice and various staff meetings. This effort provided training on challenging customer situations including de-escalation techniques, responding to customers with care and empathy, and tools for managing stress and building resilience in individuals' professional and personal lives. The CLP also provides opportunities for staff to participate in case consultations with CMS colleagues, providing support to casework staff by offering moral support, suggestions, and help preparing customer responses. A SharePoint site is maintained to provide resources including a Human Resilience Podcast Series and short PowerPoint presentations which staff can access at their convenience.

Section 508 Program

The Section 508 Program strengthens and coordinates the agency's Section 508 compliance activities by providing leadership, guidance, and oversight to ensure all electronic content is accessible in order to foster a positive and inclusive workplace and workforce. The Section 508 Program focuses on demonstrating inclusion and transparency of Section 508 in the governance framework, policies, and risk management processes, as well as creating awareness through communication and education. The Section 508 Program's current initiatives continue to focus on the following: improving service delivery, increasing awareness regarding the program and its regulatory requirements; increasing collaboration and partnership across the enterprise regarding accessibility, and increasing alignment with our existing governance processes to help ensure solutions and accessibility tools to meet our needs. These efforts will help ensure solutions meet the needs of all users and continue to drive CMS into a culture of greater awareness, and applications built with accessibility considerations embedded.

Data to Drive Decision Making Cross Cutting Initiative

The Data to Drive Decision Making Cross Cutting Initiative (Data CCI) aims to accelerate the appropriate use of data to deliver on CMS's mission and serve the public while protecting security and privacy. This initiative brings together data subject matter experts from across the agency to tackle CMS's greatest data challenges. Last year, the Data CCI developed a set of CMS Data Principles that serve as a framework to guide all CMS employees and contractors in their use, governance, and interactions with CMS data. In 2024, the Data CCI focused efforts on operationalizing the Data Principles by standing up three workgroups and developing action plans focused on enhancing CMS's use and management of our own data. In particular, the workgroups are focused on improving the procurement and management of CMS data contracts, advancing internal analytic capabilities by strengthening CMS Data User Community, and promoting data transparency through enhancing CMS public data websites.

Training Resources to Advance Health Equity

CMS strives to provide all employees and contractors with an understanding of the agency's goals to advance health equity and eliminate disparities. CMS has several externally and internally available resources to train contracting officers, program leads, contractors, and partners on key health equity concepts, interventions to reduce disparities, and barriers and opportunities underserved communities may face in accessing CMS programs. CMS training resources support ongoing education among employees across programs. This helps employees across operations, policy, and programs understand actions they can take to support CMS strategic pillar to advance health equity.

Enterprise Data Lake

The Enterprise Data Lake (EDL) Data Mesh, with a central common metastore, allows users to streamline access to enterprise data hosted in the cloud while eliminating data duplication and reducing/eliminating file transfer activities between CMS components. The EDL Data Mesh program provides system-to-system access to the provider and beneficiary data.

Given advances in industry, the agency is upgrading the EDL Data Mesh capability to a more robust platform, making it part of CMS's IDR in the Cloud to provide a consolidated, and more efficient means to access CMS data assets. All existing EDL Data Mesh users will be seamlessly migrated to the IDR in the Cloud, which provides scalable capacity and central data storage coupled with secure data sharing capabilities. Once this transition period has been completed over the next year, the EDL Data Mesh will be decommissioned.

OVERVIEW OF FINANCIAL DATA

Sound financial management is an integral part of CMS's efforts to deliver services and administer our programs. CMS maintains strong financial management operations and continues to improve its financial management and reporting processes to provide timely, reliable, and accurate financial information. CMS management and other decision makers use this information to make timely and accurate program and administrative decisions.

The basic financial statements in this report are prepared pursuant to the requirements of the *Government Management Reform Act of 1994*, the *Chief Financial Officers Act of 1990*, and other requirements, including the

Office of Management and Budget Circular A-136, *Financial Reporting Requirements*. CMS management is responsible for the integrity of the financial information in these statements. The OIG selects an independent certified public accounting firm to audit CMS's financial statements and related notes.

Consolidated Balance Sheets

The Consolidated Balance Sheets present, as of September 30, 2024 and 2023, amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). A Consolidating Balance Sheet by Major Program is provided as supplementary information. CMS's Consolidated Balance Sheets reported assets of $884.4 billion. A major asset is Investments totaling $401.9 billion, which are invested in Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing obligations of the U.S. or in obligations guaranteed as to both principal and interest by the U.S. The largest asset is the Fund Balance with Treasury of $442.1 billion, most of which is used for Medicaid, CHIP, and Payments to Healthcare Trust Funds. Liabilities of $169.5 billion consist primarily of the Entitlement Benefits Due and Payable of $141.6 billion. CMS's Net Position totals $714.9 billion and reflects primarily the Cumulative Results of Operations for the Medicare trust funds and the unexpended balances for Medicaid and CHIP.

Consolidated Statements of Net Cost

The Consolidated Statements of Net Cost present the actual net cost of CMS's operations by program for the years ended September 30, 2024 and 2023. The three major programs that CMS administers are Medicare, Medicaid, and CHIP. The majority of CMS's expenses are in these programs. Both Medicare and Medicaid program integrity and fraud and abuse funding are included under the HI trust fund. The net cost of operations under "Other" includes State Grants and Demonstrations and Other Health.

Program Management expenses are allocated and shown separately under each major program. A Consolidating Statement of Net Cost shows the Medicare funds as Dedicated Collection versus Other Fund components of net cost as supplementary information. In FY 2024, CMS's total Net Cost of Operations was $1,521.1 billion encompassing gross benefit/program costs of $1,676.9 billion and operating costs of $8.1 billion.

Consolidated Statements of Changes in Net Position

The Consolidated Statements of Changes in Net Position present the change in net position (i.e., difference between assets and liabilities) for the years ended September 30, 2024 and 2023. Changes in the Cumulative Results of Operations and Unexpended Appropriations affect CMS's net position balance. Funds From Dedicated Collections are shown in a separate column from Other Funds. The bulk of the change pertains to Appropriations Used of $1,145.8 billion, which represents the Medicaid and CHIP appropriations, transfers from Payments to the HealthCare Trust Funds to HI and SMI, and State Grants and Demonstrations and general fund-financed Program Management appropriations. Medicaid and CHIP are financed by general fund appropriations provided by Congress. Employment tax revenue is Medicare's portion of payroll and self-employment taxes collected under the *Federal Insurance Contributions Act* and the *Self Employment Contributions Act for the HI trust fund* and totaled $391.9 billion.

Combined Statements of Budgetary Resources

The Combined Statements of Budgetary Resources provide information about the availability of budgetary resources, as well as the status for the years ended September 30, 2024 and 2023. A supplementary Schedule of Budgetary Resources is provided as Required Supplementary Information (RSI) to present budgetary information by program. In this statement, Program Management is shown separately and Other includes State Grants and Demonstrations, Other Health and Medicare and Medicaid program integrity, and fraud and abuse activities. Also, there are no intra-CMS eliminations in these statements.

CMS total budgetary resources were $2,618.3 billion. New obligations of $2,305.2 billion leave unobligated balances of $313.1 billion. Total outlays, net of collections, were $2,215.7 billion. When offset by $699.8 billion relating to collection of premiums and general fund transfers from the Payments to the Healthcare Trust Funds, as well as refunds of Medicare Administrative Contractors overpayments, the CMS net outlays were $1,515.9 billion.

OVERVIEW OF SOCIAL INSURANCE DATA

Statement of Social Insurance

The Statement of Social Insurance (SOSI) presents the 75-year actuarial present value of the income and expenditures of the HI and SMI trust funds. Future expenditures are expected to arise for current and future program participants. This projection is considered important information in evaluating the potential future cost of the program. These projected potential future obligations are not included in the Consolidated Balance Sheets, Statements of Net Cost, Statements of Changes in Net Position, or Combined Statements of Budgetary Resources.

Actuarial present values are computed under the intermediate set of assumptions specified in the 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. With two exceptions, the projections are based on the current-law provisions[4] of the *Social Security Act* as of the date of release of the Medicare Trustees Report. The first exception is that the Part A projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the Trustees Report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted.

The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November of 2020, is not reflected in the Part D projections. This final rule imposed a January 1, 2022, effective date; however, implementation was initially delayed until January 1, 2023. Since then, enacted legislation has three times imposed a moratorium on implementation, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The Medicare projections have been significantly affected by the enactment of the *Inflation Reduction Act*. This legislation has wide-ranging provisions, including those that restrain price growth and negotiate drug prices for certain Part B and Part D drugs and that redesign the Part D benefit structure to decrease beneficiary out-of-pocket costs. The law takes several years to implement, resulting in very different effects by year. The Part D benefit enhancements are implemented by 2025, for example, before the negotiation provisions that are effective in 2026 can have any spending reduction impact. The total effect of the *Inflation Reduction Act* is to reduce government expenditures for Part B, to increase expenditures for Part D from 2027 through 2030, and to decrease Part D expenditures beginning in 2031. Part B savings are due to the substantial lowering of payments, relative to current reimbursement, as a result of negotiated prices. Part D ultimately generates cost savings at the end of the 10-year period, but many of the gains from negotiated prices and lower trends are initially more than offset by increased benefits and decreased manufacturer rebates.

The Board of Trustees assumes that the *Inflation Reduction Act* will affect the ultimate long-range growth rates for Part B and Part D drug spending differently. For Part B drugs, since the Trustees do not anticipate that the market pricing dynamics will be much different from those prior to the implementation of the *Inflation Reduction Act*, they continue to assume that per capita spending growth rates will be similar to those for overall per capita national health expenditures. On the other hand, for Part D drugs, the Trustees assume that per capita spending will grow 0.2 percentage point more slowly than per capita national health expenditures, since the inflation provisions of the *Inflation Reduction Act* are likely to result in price growth that is lower than overall health prices and closer to the Consumer Price Index (CPI).

Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic. Spending was directly affected by the coverage of testing and treatment of the disease. In addition, several regulatory policies and legislative

4 Due to the timing and the limited effect on the financial outlook of the trust funds, the projections do not reflect the impact of the Medicare provisions in the *Consolidated Appropriations Act, 2024* (Public Law 118-42), which was enacted on March 9, 2024. The provisions included were temporary extensions of prior policies, the elimination of the Medicare Improvement Fund, and a 1-month extension of the sequestration of Medicare benefits through November of 2032. The estimated impact is less than 0.05 percent of Medicare benefits over FYs 2024 through 2033, and there is no impact beyond 2033.

provisions were enacted during the public health emergency that increased spending, and the use of telehealth was greatly expanded. More than offsetting these additional costs during the pandemic, spending for non-COVID care declined significantly.

Now that the public health emergency has ended and Medicare fee-for-service per capita spending has stabilized, the Trustees place a greater reliance on recent experience when developing the cost projections. However, they continue to make three pandemic-related adjustments to the projections. The first is to account for the morbidity improvement in the surviving population, which is expected to continue to affect spending levels through 2029. The second adjustment accounts for the ending of the waiver regarding the 3-day inpatient stay requirement to receive SNF services. The per capita spending projections typically include factors for price updates and changes in the utilization and mix of services. As a result of the expiration of this waiver, the Trustees have increased their inpatient spending growth factor by 1.9 percentage points and decreased the SNF spending growth factor by 7.5 percentage points in 2024. Finally, the third adjustment is to account for home health spending that was still, in 2023, significantly lower than estimated prior to the pandemic. As a result of the recent home health staffing shortages, the Trustees continue to consider the spending level for this service to be suppressed. Thus, they have increased their home health spending growth factor by 2.9 percentage points in each of the next 3 years (2024–2026).

The SOSI presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period;
- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;
- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period; and
- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) increased from $(4.6) trillion, determined as of January 1, 2023, to $(2.6) trillion, determined as of January 1, 2024.

When the combined HI and SMI trust fund assets are included, the present value increases. As of January 1, 2024, the future cash flow for all current and future participants is $(2.2) trillion for the 75-year valuation period. The comparable cash flow for the closed group of participants, including the combined HI and SMI trust fund assets, is $(12.6) trillion.

HI Trust Fund Solvency

Pay-as-you-go Financing

The HI trust fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive trust fund assets. In recent years, current expenditures have exceeded program income for the HI program; thus, the HI trust fund assets have been declining. The following table shows the HI trust fund assets, expressed as a ratio of the assets at the beginning of the fiscal year to the expenditures for the year. This ratio declines from 50 percent at the beginning of FY 2020 to 39 percent at the beginning of FY 2022, after which it rises in 2023 and 2024. The ratio is estimated to increase in 2024 as a result of (i) a

policy change to exclude medical education expenses associated with MA enrollees from the fee-for-service per capita costs used in the development of MA spending, as described in section IV.C of the Trustees Report, and (ii) lower spending for inpatient hospital and home health agency services due to a greater reliance on recent experience, as described in section I of the Trustees Report.

TRUST FUND RATIO

Beginning of Fiscal Year[5]

	2020	2021	2022	2023	2024
HI	50%	40%	39%	45%	48%

Short-Term Financing

The HI trust fund is deemed adequately financed for the short term when actuarial estimates of trust fund assets for the beginning of each CY are at least as large as program obligations for the year. Under the intermediate assumptions of the 2024 Trustees Report, the HI trust fund ratio is estimated to increase in 2024 through 2027 before decreasing for the rest of the projection period until the fund is depleted in CY 2036. The assets were $208.8 billion at the beginning of 2024, representing about 50 percent of expenditures projected for 2024, which is below the Trustees' minimum recommended level of 100 percent. The HI trust fund has not met the Trustees' formal test of short-range financial adequacy since 2003.

Long-Term Financing

The short-range financial outlook for the HI trust fund is more favorable than what was projected last year. After 2027, the trust fund ratio declines until the fund is depleted in 2036, five years later than projected in 2023. HI financing is not projected to be sustainable over the long-term with the projected tax rates and expenditure levels. Program cost is expected to exceed total income in all years. When the HI trust fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to decrease from 89 percent in 2036 to 87 percent in 2048, and then to increase to about 100 percent by the end of the projection period.

The primary reason for the projected long-term inadequacy of financing under current law relates to the fact that the ratio of the number of workers paying taxes relative to the number of individuals eligible for benefits drops from 2.8 in 2023 to about 2.1 by 2098. In addition, healthcare costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $2.4 trillion, which is 0.3 percent of taxable payroll and 0.1 percent of Gross Domestic Product (GDP) over the same period. Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. For more information, please refer to the Required Supplementary Information: Social Insurance disclosures required by the Federal Accounting Standards Advisory Board.

SMI Trust Fund Solvency

The SMI trust fund consists of two accounts – Part B and Part D. In order to evaluate the financial status of the SMI trust fund, each account needs to be assessed individually, since financing rates for each part are established separately, and their program benefits are quite different in nature.

While differences between the two accounts exist, the SMI trust fund is expected to be adequately financed over the next 10 years and beyond because income from premiums and government contributions for Parts B and D—which are contributions of the Federal Government that the law authorizes to be appropriated and transferred from the general fund of the Treasury—are reset each year to cover projected program costs and ensure a reserve for Part B to provide a contingency for unexpected program variation.

Unlike the Part B account, the appropriation for Part D has generally been set such that amounts can be transferred to the Part D account on an as-needed basis; under this process, there is no need to maintain a contingency reserve. In September 2015, a new policy was implemented to transfer amounts from the Treasury into the account 5 business

5 Assets at the beginning of the year to expenditures during the year.

days before the benefit payments to the plans. As a result, the Trustees expect the Part D account to include a more substantial balance at the end of most months to reflect this policy. Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement, the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is $0. However, from a government-wide perspective, general fund transfers, as well as interest payments to the Medicare trust funds and asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government wide perspective, the corresponding estimate of future income less expenditures for the 75-year projection period is $(50.2) trillion.

Even though from a program perspective the unfunded liability is $0, there is concern over the rapid increase in cost of the SMI program as a percent of GDP. In 2023, SMI incurred expenditures were 2.3 percent of GDP. By 2098, SMI expenditures are projected to grow to 4.3 percent of the GDP.

Financial Challenges

These Medicare projections continue to demonstrate the need for timely and effective action to address the remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in expenditures. The Board of Trustees believes that solutions can and must be found to ensure the financial integrity of HI in the short and long term and to reduce the rate of growth in Medicare costs through viable means. The Trustees recommend that Congress and the executive branch work closely together to expeditiously address these challenges. The sooner solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including healthcare providers, beneficiaries, and taxpayers—to adjust their expectations and behavior.

The following table presents key amounts from our basic financial statements for FY 2022 through 2024.

TABLE OF KEY MEASURES[6]

Dollars in billions

	2024	2023	2022
NET POSITION (END OF FISCAL YEAR)			
Assets	**$884.4**	**$873.7**	**$765.4**
Less Total Liabilities	**$169.5**	**$199.5**	**$171.9**
Net Position (assets net of liabilities)	**$714.9**	**$674.2**	**$593.5**
COSTS (END OF FISCAL YEAR)			
Net Costs	**$1,521.1**	**$1,499.6**	**$1,383.6**
Total Financing Sources	**$1,548.8**	**$1,477.6**	**$1,430.4**
Net Change in Cumulative Results of Operations	**$27.7**	**$(22.0)**	**$46.8**
STATEMENT OF SOCIAL INSURANCE (CALENDAR YEAR BASIS)			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	**$(2,618)**	**$(4,630)**	**$(5,094)**
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation	**$(4,630)**	**$(5,094)**	**$(5,057)**
Change in present value	**$2,012**	**$464**	**$(37)**

6 The table or other singular presentation showing the measures described above. Although, the closed group measure is not required to be presented in the table or other singular presentation, CMS presents the closed group measure and open group measure. Totals do not necessarily equal the sums of rounded components.

Statement of Changes in Social Insurance Amounts

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation period and the prior valuation period) in the present value of future tax income less future cost for current and future participants (the open group measure) over the next 75 years. This reconciliation identifies those components of the change that are significant and provides reasons for the changes. In general, an increase in the present value of net cash flow represents a positive change (improving financing), while a decrease in the present value of net cash flow represents a negative change (worsening financing).

The present value as of January 1, 2024, decreased by $144 billion as a result of advancing the valuation date by 1 year and including the additional year 2098 and by $698 billion because of changes in demographic assumptions. However, changes in the projection base and economic and healthcare assumptions increased the present value by $747 billion and $2,106 billion, respectively. The net overall impact of these changes is an increase in the present value of $2,011 billion.

Required Supplementary Information

As required by Statement of Federal Financial Accounting Standards (SFFAS) 17, Accounting for Social Insurance (as amended by *SFFAS 37*, Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements), CMS has included information about the Medicare trust funds – HI and SMI. The RSI presents required long-range cash-flow projections, the long-range projections of the ratio of contributors to individuals with Medicare (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does not eliminate or otherwise affect the *SFFAS 17* requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the RSI. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

Limitations of the Financial Statements

The principal financial statements are prepared to report the financial position, financial condition, and results of operations, pursuant to the requirements of 31 U.S.C. § 3515(b). The statements are prepared from records of Federal entities in accordance with Federal generally accepted accounting principles (GAAP) and the formats prescribed by OMB. Reports used to monitor and control budgetary resources are prepared from the same records. Users of the statements are advised that the statements are for a component of the U.S. Government.

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FINANCIAL SECTION

A Message from the Chief Financial Officer // Financial Statements // Notes to the Financial Statements // Required Supplementary Information // Supplementary Information // Audit Reports

A MESSAGE FROM THE CHIEF FINANCIAL OFFICER

MEGAN WORSTELL

As CMS's Chief Financial Officer, I am pleased to present our fiscal year (FY) 2024 Agency Financial Report (AFR). CMS is steadfast in its solemn commitment and dedication to fiscal accountability and financial management over its programs that work to advance health equity, expand coverage, and improve health outcomes for all Americans.

To this end, CMS received its 26th consecutive unmodified audit opinion on four of the six principal financial statements. An unmodified audit opinion confirms that our financial statements present fairly our financial position, are free from material misstatement and conforms with generally accepted accounting principles. However, as in previous years, the auditors were not able to express an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts due to the uncertainty in the long-range assumptions applied in our projection models. Nonetheless, CMS remains confident that the projections made are sound and have properly disclosed the purpose of our projections and that they are fairly presented.

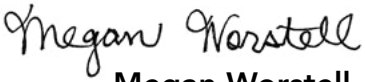
CMS remains committed and resolute as responsible financial stewards, while promoting fiscal excellence in all aspects of our operations by seeking innovative ways to manage our ever-changing complex programs. We continue to work diligently to improve our financial management performance in many areas, including those areas identified as internal control weaknesses by our auditors. Consequently, there were many initiatives undertaken in FY 2024 to further enhance and improve CMS's financial management performance. The following highlights some of our FY 2024 accomplishments:

- Accelerated and Advance Payments (AAP) - During FY 2024, CMS implemented two incident-specific AAP programs to address cash flow needs of providers and suppliers impacted by recent large-scale cybersecurity incidents. In this regard, CMS advanced over $3.5 billion to approximately 9,000 providers and suppliers while they were unable to bill Medicare. As of the end of September 2024, CMS has recovered approximately 99.9 percent of these AAPs and were credited back to the Medicare Trust Funds.

- Medicare Secondary Payer (MSP) Savings - As of the end of August 2024, CMS reported MSP savings of $9 billion for the current fiscal year. MSP savings are recognized through cost avoidance and recovery. Medicare Trust Fund cost avoidance savings occur when Medicare pays secondary on a medical claim versus paying primary because an identified MSP occurrence prevented payment as primary. Recovery savings reflect actual monies returned to CMS because Medicare incorrectly paid the claim when another entity had primary payer responsibility. The total savings reflect pre-pay (cost avoidance) savings of $7.6 billion and post-pay (recovery) savings of $1.4 billion.

- Reductions in Improper Payments and Increase Program Integrity Efforts - As part of our strategic plan initiatives to protect our programs, we continue to achieve success in our program integrity efforts that led to reductions in improper payments. The Medicare FFS estimated improper payment rate was below the 10 percent compliance threshold for the eighth consecutive year. The Medicare home health improper payment rate decreased from 9.30 percent in 2020 to 6.69 percent in 2024, representing a $684 million decrease in projected improper payments. Also, the durable medical equipment improper payment rate decreased from 31.80 percent in 2020 to 21.41 percent in 2024, representing a $849 million decrease in projected improper payments. Furthermore, while CMS continues to support state activities through our Medicaid Integrity Program, CMS's Medicare Recovery Audit Program also resulted in the recovery of overpayments.

Our successes in financial management have been, and will continue to be, a joint effort between our dedicated employees and the internal and external stakeholders of our programs. The improvements we made over the last year, underscored by another unmodified audit opinion, demonstrate that we take our responsibility for stewardship of the Medicare Trust Funds very seriously and my commitment remains unshaken. We will continue to build on this monumental milestone in the coming years and work diligently as responsible stewards of public funds to protect our program's sustainability for future generations and in pursuit of our commitment to operational excellence.



Megan Worstell
CMS Chief Financial Officer
November 2024

CONSOLIDATED BALANCE SHEETS

As of September 30, 2024 and September 30, 2023

(in millions)

	FY 2024 Consolidated Totals	FY 2023 Consolidated Totals
ASSETS		
Intragovernmental:		
Fund Balance with Treasury *(Note 2)*	$442,064	$430,592
Investments *(Note 3)*	401,956	355,929
Accounts Receivable, Net *(Note 4)*	654	634
Advances and Prepayments	7	
Total Intragovernmental	844,681	787,155
Other than Intragovernmental:		
Accounts Receivable, Net *(Note 4)*	37,474	38,580
General Property, Plant and Equipment, Net	1,787	2,342
Advances and Prepayments *(Note 5)*	1	45,119
Other Assets	440	532
Total Other than Intragovernmental	39,702	86,573
TOTAL ASSETS	$884,383	$873,728
LIABILITIES		
Intragovernmental:		
Accounts Payable	$1,677	$1,900
Debt *(Note 6)*	1,091	3,272
Other Liabilities	67	121
Total Intragovernmental	2,835	5,293
Other than Intragovernmental:		
Accounts Payable	447	509
Entitlement Benefits Due and Payable *(Note 7)*	141,597	159,543
Other Liabilities		
Contingencies and Commitments *(Note 8)*	5,328	18,560
Other	19,278	15,560
Total Other than Intragovernmental	166,650	194,172
TOTAL LIABILITIES *(Note 9)*	$169,485	$199,465
NET POSITION		
Unexpended Appropriations–Funds from Dedicated Collections *(Note 11)*	$263,916	$275,307
Unexpended Appropriations-Funds from Other than Dedicated Collections	105,661	81,328
Total Unexpended Appropriations	369,577	356,635
Cumulative Results of Operations–Funds from Dedicated Collections *(Note 11)*	340,801	317,578
Cumulative Results of Operations-Funds from Other than Dedicated Collections	4,520	50
Total Cumulative Results of Operations	345,321	317,628
TOTAL NET POSITION	$714,898	$674,263
TOTAL LIABILITIES AND NET POSITION	$884,383	$873,728

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST

For the Years Ended September 30, 2024 and September 30, 2023

(in millions)

	FY 2024 Totals	Intra-CMS Eliminations	FY 2024 Consolidated Totals	FY 2023 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS				
GPRA PROGRAMS				
Medicare HI				
Benefit/Program	$380,102	$98	$380,200	$411,798
Program Management	1,385		1,385	1,411
Net Cost Medicare HI	$381,487	$98	$381,585	$413,209
Medicare SMI				
Benefit/Program (Part B)	$399,729	$55	$399,784	$362,649
Benefit/Program (Part D)	107,026		107,026	89,885
Program Management	3,129		3,129	3,060
Net Cost Medicare SMI	$509,884	$55	$509,939	$455,594
Medicaid				
Benefit/Program	$608,241		$608,241	$610,969
Program Management	186		186	196
Net Cost Medicaid	$608,427		$608,427	$611,165
CHIP				
Benefit/Program	$19,444		$19,444	$17,923
Program Management	21		21	22
Net Cost CHIP	$19,465		$19,465	$17,945
Other				
Benefit/Program	$1,227		$1,227	$1,101
Program Management	584	$(153)	431	615
Net Cost Other	$1,811	$(153)	$1,658	$1,716
NET COST OF OPERATIONS *(Note 10)*	$1,521,074		$1,521,074	$1,499,629

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

For the Year Ended September 30, 2024

(in millions)

	Funds From Dedicated Collections *(Note 11)*	Funds From Other than Dedicated Collections	FY 2024 Consolidated Total
UNEXPENDED APPROPRIATIONS			
Beginning Balances	$275,307	$81,328	$356,635
Appropriations received	579,570	742,128	1,321,698
Appropriations transferred-in/out		(7,179)	(7,179)
Other Adjustments	(76,104)	(79,722)	(155,826)
Appropriations used	(514,857)	(630,894)	(1,145,751)
Change in Unexpended Appropriations	(11,391)	24,333	12,942
Total Unexpended Appropriations: Ending Balance	$263,916	$105,661	$369,577
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	$317,578	$50	$317,628
Other Adjustments		(87)	(87)
Appropriations used	514,857	630,894	1,145,751
Nonexchange Revenue:			
FICA and SECA taxes	391,904		391,904
Interest on investments	10,626	1,029	11,655
Other	3,131		3,131
Transfers-in/out without reimbursement	(5,506)	1,718	(3,788)
Imputed financing	105	12	117
Other		84	84
Net Cost of Operations *(Note 10)*	891,894	629,180	1,521,074
Net Change in Cumulative Results of Operations	23,223	4,470	27,693
Cumulative Results of Operations: Ending Balance	$340,801	$4,520	$345,321
NET POSITION	$604,717	$110,181	$714,898

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

For the Year Ended September 30, 2023

(in millions)

	Funds From Dedicated Collections *(Note 11)*	Funds From Other than Dedicated Collections	FY 2023 Consolidated Total
UNEXPENDED APPROPRIATIONS			
Beginning Balances	$178,704	$75,185	$253,889
Appropriations received	593,543	716,967	1,310,510
Appropriations transferred-in/out		(5,231)	(5,231)
Other Adjustments	(19,047)	(78,702)	(97,749)
Appropriations used	(477,893)	(626,891)	(1,104,784)
Change in Unexpended Appropriations	96,603	6,143	102,746
Total Unexpended Appropriations: Ending Balance	$275,307	$81,328	$356,635
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	$338,604	$1,046	$339,650
Other Adjustments			
Appropriations used	477,893	626,891	1,104,784
Nonexchange Revenue:			
FICA and SECA taxes	362,511		362,511
Interest on investments	9,868	679	10,547
Other	3,233		3,233
Transfers-in/out without reimbursement	(5,043)	1,586	(3,457)
Imputed financing	66	8	74
Other		(85)	(85)
Net Cost of Operations *(Note 10)*	869,554	630,075	1,499,629
Net Change in Cumulative Results of Operations	(21,026)	(996)	(22,022)
Cumulative Results of Operations: Ending Balance	$317,578	$50	$317,628
NET POSITION	$592,885	$81,378	$674,263

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES *(NOTE 12)*

For the Years Ended September 30, 2024 and September 30, 2023

(in millions)

	FY 2024 Combined Totals Budgetary	FY 2023 Combined Totals Budgetary
BUDGETARY RESOURCES:		
Unobligated balance from prior year budget authority, net *(discretionary and mandatory)*	$351,502	$286,779
Appropriations *(discretionary and mandatory)*	2,262,268	2,285,964
Borrowing authority *(discretionary and mandatory)*	86	
Spending authority from offsetting collections *(discretionary and mandatory)*	4,452	6,272
TOTAL BUDGETARY RESOURCES	**$2,618,308**	**$2,579,015**
STATUS OF BUDGETARY RESOURCES:		
New Obligations and upward adjustments	$2,305,236	$2,251,779
Unobligated balance, end of year		
Apportioned, unexpired accounts	39,706	119,452
Exempt from Apportionment, unexpired accounts	1,412	1,607
Unapportioned, unexpired accounts	16,586	13,154
Unexpired unobligated balance, end of year	57,704	134,213
Expired unobligated balance, end of year	255,368	193,023
Unobligated balance, end of year (total)	$313,072	$327,236
TOTAL BUDGETARY RESOURCES	**$2,618,308**	**$2,579,015**
OUTLAYS, NET:		
Outlays, net *(discretionary and mandatory)*	$2,215,703	$2,142,269
Distributed offsetting receipts	(699,790)	(658,008)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	**$1,515,913**	**$1,484,261**
DISBURSEMENTS, NET	**$72**	**$(70)**

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2024 and Prior Base Years

(in billions)

		Estimates from Prior Years			
	2024 (unaudited)	2023 (unaudited)	2022 (unaudited)	2021 (unaudited)	2020 (unaudited)
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 13 and 14)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$16,189	$15,360	$14,767	$13,029	$12,454
SMI Part B	40,323	39,008	39,039	34,467	32,165
SMI Part D	7,097	6,865	7,372	6,881	6,975
Have attained eligibility age (age 65 or over)					
HI	953	862	793	664	637
SMI Part B	8,181	7,683	7,447	6,536	5,864
SMI Part D	1,517	1,315	1,164	1,061	1,016
Those expected to become participants					
HI	15,360	15,046	14,603	13,017	12,464
SMI Part B	10,161	9,934	10,131	9,010	8,567
SMI Part D	2,393	2,372	3,094	2,921	3,043
All current and future participants					
HI	32,502	31,268	30,163	26,710	25,554
SMI Part B	58,665	56,625	56,618	50,013	46,596
SMI Part D	11,008	10,551	11,630	10,863	11,035
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 13 and 14)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$22,970	$23,622	$23,211	$20,940	$20,103
SMI Part B	39,853	38,539	38,605	34,075	31,819
SMI Part D	7,097	6,865	7,372	6,881	6,975
Have attained eligibility age (age 65 and over)					
HI	7,357	7,215	7,010	6,230	6,073
SMI Part B	8,508	8,038	7,825	6,892	6,194
SMI Part D	1,517	1,315	1,164	1,061	1,016
Those expected to become participants					
HI	4,794	5,061	5,036	4,597	4,179
SMI Part B	10,304	10,048	10,188	9,046	8,583
SMI Part D	2,393	2,372	3,094	2,921	3,043
All current and future participants:					
HI	35,120	35,897	35,257	31,767	30,355
SMI Part B	58,665	56,625	56,618	50,013	46,596
SMI Part D	11,008	10,551	11,630	10,863	11,035
Actuarial present value for the 75-year projection period of estimated future excess of income excluding interest) over expenditures (Notes 13 and 14)					
HI	$(2,618)	$(4,630)	$(5,094)	$(5,057)	$(4,800)
SMI Part B					
SMI Part D					
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 13 and 14)					
HI	$(2,618)	$(4,630)	$(5,094)	$(5,057)	$(4,800)
SMI Part B					
SMI Part D					
Trust Fund assets at start of period					
HI	$209	$198	$177	$198	$195
SMI Part B	172	194	163	133	100
SMI Part D	16	18	20	10	9
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 13 and 14)					
HI	$(2,410)	$(4,432)	$(4,917)	$(4,859)	$(4,606)
SMI Part B	172	194	163	133	100
SMI Part D	16	18	20	10	9

Totals do not necessarily equal the sum of the rounded components. The accompanying notes are an integral part of these financial statements. Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both.

STATEMENT OF SOCIAL INSURANCE *(CONTINUED)*

75-Year Projection as of January 1, 2024 and Prior Base Years

(in billions)

		Estimates from Prior Years			
	2024 (unaudited)	2023 (unaudited)	2022 (unaudited)	2021 (unaudited)	2020 (unaudited)
Medicare Social Insurance Summary					
Current Participants: *Actuarial present value for the 75-year projection period from or on behalf of:*					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	$10,651	$9,860	$9,404	$8,261	$7,517
Expenditures	17,383	16,567	15,998	14,184	13,284
Income less expenditures	(6,731)	(6,707)	(6,595)	(5,922)	(5,766)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	63,609	61,232	61,178	54,377	51,594
Expenditures	69,920	69,026	69,188	61,895	58,897
Income less expenditures	(6,310)	(7,794)	(8,010)	(7,519)	(7,303)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(13,042)	(14,501)	(14,605)	(13,441)	(13,069)
Combined Medicare Trust Fund assets at start of period	397	410	360	341	303
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(12,645)	(14,091)	(14,244)	(13,100)	(12,766)
Future Participants: *Actuarial present value for the 75-year projection period:*					
Income (excluding interest)	$27,914	$27,352	$27,828	$24,948	$24,074
Expenditures	17,491	17,480	18,318	16,564	15,805
Income less expenditures	10,423	9,871	9,510	8,384	8,269
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(2,618)	(4,630)	(5,094)	(5,057)	(4,800)
Combined Medicare Trust Fund assets at start of period	397	410	360	341	303
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(2,222)	(4,220)	(4,734)	(4,716)	(4,497)

Totals do not necessarily equal the sum of the rounded components. The accompanying notes are an integral part of these financial statements. Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both.

STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS (UNAUDITED) MEDICARE HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE

January 1, 2023 to January 1, 2024

(in billions)

	Actuarial present value over the next 75 years (open group measure)				Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	
	January 1, 2023 to January 1, 2024				
Total Medicare *(Note 15)*					
As of January 1, 2023	$98,444	$103,074	($4,630)	$410	($4,220)
Reasons for change					
Change in the valuation period	2,839	2,983	(144)	(13)	(157)
Change in projection base	944	197	747	(1)	746
Changes in the demographic assumptions	(34)	664	(698)		(698)
Changes in economic and healthcare assumptions	(3)	(2,109)	2,106		2,106
Changes in law	(16)	(16)			
Net changes	3,731	1,719	2,011	(13)	1,998
As of January 1, 2024	$102,175	$104,793	($2,618)	$397	($2,222)
HI - Part A *(Note 15)*					
As of January 1, 2023	$31,268	$35,897	($4,630)	$198	($4,432)
Reasons for change					
Change in the valuation period	815	959	(144)	4	(140)
Change in projection base	413	(334)	747	7	755
Changes in the demographic assumptions	(561)	137	(698)		(698)
Changes in economic and healthcare assumptions	567	(1,539)	2,106		2,106
Changes in law					
Net changes	1,234	(777)	2,011	11	2,023
As of January 1, 2024	$32,502	$35,120	($2,618)	$209	($2,410)
SMI - Part B *(Note 15)*					
As of January 1, 2023	$56,625	$56,625		$194	$194
Reasons for change					
Change in the valuation period	1,728	1,728		(9)	(9)
Change in projection base	115	115		(13)	(13)
Changes in the demographic assumptions	129	129			
Changes in economic and healthcare assumptions	84	84			
Changes in law	(16)	(16)			
Net changes	2,040	2,040		(22)	(22)
As of January 1, 2024	$58,665	$58,665		$172	$172
SMI - Part D *(Note 15)*					
As of January 1, 2023	$10,551	$10,551		$18	$18
Reasons for change					
Change in the valuation period	296	296		(7)	(7)
Change in projection base	416	416		4	4
Changes in the demographic assumptions	398	398			
Changes in economic and healthcare assumptions	(653)	(653)			
Changes in law					
Net changes	456	456		(3)	(3)
As of January 1, 2024	$11,008	$11,008		$16	$16

Totals do not necessarily equal the sum of the rounded components. The accompanying notes are an integral part of these financial statements.

STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS (UNAUDITED) MEDICARE HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE *(CONTINUED)*

January 1, 2023 to January 1, 2024

(in billions)

	Actuarial present value over the next 75 years (open group measure)				Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	
January 1, 2022 to January 1, 2023					
Total Medicare *(Note 15)*					
As of January 1, 2022	$98,410	$103,504	($5,094)	$360	($4,734)
Reasons for change					
Change in the valuation period	2,206	2,331	(124)	(2)	(126)
Change in projection base	(1,961)	(3,148)	1,186	52	1,238
Changes in the demographic assumptions	(375)	(60)	(315)		(315)
Changes in economic and healthcare assumptions	2,873	3,156	(283)		(283)
Changes in law	(2,709)	(2,710)	1		1
Net changes	34	(431)	465	50	515
As of January 1, 2023	$98,444	$103,074	($4,630)	$410	($4,220)
HI - Part A *(Note 15)*					
As of January 1, 2022	$30,163	$35,257	($5,094)	$177	($4,917)
Reasons for change					
Change in the valuation period	571	696	(124)	(5)	(129)
Change in projection base	(174)	(1,361)	1,186	25	1,212
Changes in the demographic assumptions	(115)	200	(315)		(315)
Changes in economic and healthcare assumptions	824	1,107	(283)		(283)
Changes in law		(1)	1		1
Net changes	1,105	641	465	21	485
As of January 1, 2023	$31,268	$35,897	($4,630)	$198	($4,432)
SMI - Part B *(Note 15)*					
As of January 1, 2022	$56,618	$56,618		$163	$163
Reasons for change					
Change in the valuation period	1,355	1,355		13	13
Change in projection base	(2,135)	(2,135)		18	18
Changes in the demographic assumptions	(330)	(330)			
Changes in economic and healthcare assumptions	2,386	2,386			
Changes in law	(1,269)	(1,269)			
Net changes	7	7		31	31
As of January 1, 2023	$56,625	$56,625		$194	$194
SMI - Part D (Note 15)					
As of January 1, 2022	$11,630	$11,630		$20	$20
Reasons for change					
Change in the valuation period	280	280		(10)	(10)
Change in projection base	348	348		8	8
Changes in the demographic assumptions	71	71			
Changes in economic and healthcare assumptions	(337)	(337)			
Changes in law	(1,440)	(1,440)			
Net changes	(1,079)	(1,079)		(1)	(1)
As of January 1, 2023	$10,551	$10,551		$18	$18

Totals do not necessarily equal the sum of the rounded components. The accompanying notes are an integral part of these financial statements.

NOTE 1:

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting and Presentation

The financial statements were prepared from CMS's accounting records in accordance with accounting principles generally accepted in the United States (GAAP) and the form and content specified by the Office of Management and Budget (OMB) in OMB Circular A-136, *Financial Reporting Requirements*. GAAP for federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB). In accordance with Statement of Federal Financial Accounting Standards (SFFAS) 47, *Reporting Entity*, CMS has included all consolidation entities for which it is accountable in this general purpose federal financial report.

The financial statements have been prepared to report the financial position, net cost, changes in net position, and budgetary resources for all programs administered by CMS. CMS's fiscal year (FY) ends September 30. These financial statements reflect both accrual and budgetary accounting transactions. Under the accrual method of accounting, revenues are recognized when earned and expenses are recognized when incurred, without regard to the receipt or payment of cash. Budgetary accounting is designed to recognize the obligation of funds according to legal requirements that, in many cases, is made prior to the occurrence of an accrual-based transaction. Budgetary accounting is essential for compliance with legal constraints and controls over the use of federal funds. Accounting standards require all reporting entities to disclose that accounting standards allow certain presentations and disclosures to be modified, if needed, to prevent the disclosure of classified information.

Use of Estimates

Financial statements prepared in accordance with GAAP are based on a selection of accounting policies and the application of significant accounting estimates. Some estimates require management to make significant assumptions. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist in understanding the effect of changes in assumptions to the related information.

Parent/Child Reporting

CMS is a party to allocation transfers with other federal agencies as both a transferring (parent) entity and/or a receiving (child) entity. Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. Financial activity related to these allocation transfers (e.g., budget authority, obligations, outlays) is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations and budget apportionments are derived. CMS allocates funds as the parent to the Center for Disease Control and Prevention for children's vaccines. CMS has a child relationship with the Internal Revenue Service for the Advance Premium Tax Credit and Basic Health Program payments; these payments are not included in CMS's financial statements.

Funds from Dedicated Collections

Funds from dedicated collections are financed by specifically identified revenues, often supplemented by other financing sources, which remain available over time. Funds from dedicated collections meet the following criteria:

- A statute committing the federal government to use specifically identified revenues and/or other financing sources that are originally provided to the federal government by a non-federal source only for designated activities, benefits or purposes;
- Explicit authority for the fund to retain revenues and other financing sources not used in the current period for future use to finance the designated activities, benefits, or purposes; and
- A requirement to account for and report on the receipt, use, and retention of the revenues and other financing sources that distinguishes the fund from the federal government's general revenues.

CMS's major funds from dedicated collections include:

Medicare Hospital Insurance Trust Fund – Part A

Section 1817 of the *Social Security Act* established the Medicare Hospital Insurance (HI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part A services, as well as administrative costs, are charged to the HI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include HI trust fund activities administered by the Department of the Treasury (Treasury). The HI trust fund has permanent indefinite authority.

Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the *Federal Insurance Contribution Act* (FICA) and *Self-Employment Contribution Act* (SECA). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The *Social Security Act* requires the transfer of these contributions from the U.S. Government (general fund) to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from the Social Security Administration (SSA) records of wages established and maintained by SSA in accordance with wage information reports.

Medicare Supplementary Medical Insurance Trust Fund – Part B

Section 1841 of the *Social Security Act* established the Supplementary Medical Insurance (SMI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part B services, as well as administrative costs, are charged to the SMI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. The SMI trust fund has permanent indefinite authority.

SMI benefits and administrative expenses are financed primarily by monthly premiums paid by Medicare beneficiaries with matching by the Federal government through the general fund appropriation, Payments to the Healthcare Trust Funds. Section 1844 of the *Social Security Act* authorizes appropriated funds to match SMI premiums collected and outlines the ratio for the match as the method to fully compensate the trust fund if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Medicare Supplementary Medical Insurance Trust Fund – Part D

The *Medicare Modernization Act of 2003* (MMA), established the Medicare Prescription Drug Benefit – Part D. Medicare also helps employers or unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy (RDS). In addition, the Low Income Subsidy (LIS) helps those with limited income and resources.

The *Patient Protection and Affordable Care Act* (PPACA) provided that beneficiary cost sharing in the Part D coverage gap be reduced for brand-name and generic drugs to a 25 percent coinsurance. Part D is considered part of the SMI trust fund and is reported in the SMI column of the financial statements.

Medicare and Medicaid Integrity Programs

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) established the Medicare Integrity Program at section 1893 of the *Social Security Act*. HIPAA section 201 also established the Healthcare Fraud and Abuse Control Account (HCFAC), which provides a dedicated appropriation for carrying out the Medicare Integrity Program. The Medicare Integrity Program is funded by the HI trust fund.

Separately, the Medicaid Integrity Program was established by the *Deficit Reduction Act of 2005* (DRA) and codified at section 1936 of the *Social Security Act*. The Medicaid Integrity Program represents the federal government's first national strategy to detect and prevent Medicaid fraud and abuse.

Payments to the Healthcare Trust Funds Appropriation

The *Social Security Act* provides for payments to the HI and SMI trust funds for SMI (e.g., appropriated funds to provide for federal matching of SMI premium collections) and HI (e.g., for the Uninsured and Federal Uninsured Payments). The Act also prescribes that funds covering the Medicare Prescription Drug Benefit and associated administrative costs, retiree drug coverage, reimbursements to the states and Transitional Assistance benefits be transferred from the general fund to the SMI trust fund; this occurs via the Payments to the Healthcare Trust Funds account. *The Social Security Act* also prescribes that criminal fines and civil monetary penalties arising from healthcare cases be transferred to the HCFAC account of the HI trust fund as well as payments to support the Federal Bureau of Investigation activities related to healthcare fraud and abuse activities. There is permanent indefinite authority for the transfer of general funds containing criminal fines and civil monetary penalties to the HCFAC account of the HI trust fund. In addition, funds are provided by the Payments to the Healthcare Trust Funds account to cover CMS's administrative costs that are not related to the Medicare program. To prevent duplicative reporting, the Fund Balance, Unexpended Appropriation, Financing Sources and Expenditure Transfers of this appropriation are reported only in the Medicare HI and SMI columns of the financial statements.

There is permanent indefinite authority for the transfer of general funds to the HI trust fund in amounts equal to SECA tax credits and receipts from taxation of Old Age Survivors and Disability Insurance (OASDI) beneficiaries. The Social Security Amendments of 1994, provided for additional tax payments from Social Security OASDI benefits and Tier 1 Railroad Retirement beneficiaries.

The **Health (Other Funds)** programs managed by CMS include:

Medicaid

Medicaid is funded through annual appropriations from Congress and is administered via grant awards, which limit the funds that can be drawn by the states and territories to cover current expenses. Medicaid also provides funding for the Health Information Technology for Economic and Clinical Health (HITECH) incentive payments made to the states. Beginning January 1, 2014, the PPACA expanded eligibility (based upon a state's choice) for Medicaid to certain low-income adults with the federal government paying 90 percent of claims for those newly eligible under Medicaid expansion for calendar year (CY) 2020 and beyond. On March 18, 2020, the President signed into law H.R. 6021, the *Families First Coronavirus Response Act* (FFCRA). The FFCRA provided a temporary 6.2 percentage point increase to each qualifying state and territory's Federal Medical Assistance Percentage (FMAP) effective beginning January 1, 2020, and extending through the last day of the calendar quarter in which the public health emergency (PHE) declared by the Secretary of HHS for COVID-19. The COVID-19 PHE ended on May 11, 2023. Pursuant to Section 5131(a) of the *Consolidated Appropriations Act* (CAA), 2023 which amended section 6008(a) of FFCRA, the increased FMAP gradually decreased beginning April 1, 2023, and ended December 31, 2023. In March 2023, Congress ended the continuous enrollment period under the PHE, and required states to resume full eligibility redeterminations, including disenrollments, which is ongoing.

CHIP

CHIP is administered via grant awards, which limit the funds that can be drawn by the states to cover current expenses.

The *Children's Health Insurance Program Reauthorization Act of 2009* (CHIPRA) established a Child Enrollment Contingency Fund to cover shortfalls in funding for the states. This fund is invested in interest-bearing Treasury securities.

State Grants and Demonstrations

Several grant programs have been established through the 75-0516 State Grants and Demonstrations appropriation fund group. With the passage of the PPACA, several new grants were included in the account and the availability of funds for other grants was extended.

The *Deficit Reduction Act* Section 6201 provided Federal payments for several projects, including the Money Follows the Person demonstration, the Medicaid Integrity Program, and the establishment of alternative non-emergency providers.

CHIPRA provided for transition grants to provide funding to states to assist them in transitioning to a prospective payment system and grants to improve outreach and enrollment.

Program Management User Fees: Medicare Advantage, Clinical Laboratory Improvement Program, Exchange, and Other User Fees

This account operates as a revolving fund without fiscal year restriction. Medicare Advantage plans are required to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The *Clinical Laboratory Improvement Amendments of 1988* (CLIA) marked the first comprehensive effort by the federal government to regulate medical laboratory testing. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Beginning January 1, 2014, the PPACA requires the collection of a user fee from each issuer offering coverage through a Federally-facilitated Exchange to offset operating costs. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys, for coordination of benefits for the Part D program, and for new providers of medical or other items or services. Proceeds from the sale of data from the public use files and publications under the *Freedom of Information Act* are also credited to this fund.

Program Management Appropriation

The Program Management Appropriation provides CMS with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this activity are provided from the HI and SMI trust funds, the general fund, and reimbursable activities. The Payments to the Healthcare Trust Funds Appropriation reimburses the Medicare HI trust fund to cover the Health programs' share of CMS administrative costs. User fees collected from Medicare Advantage plans seeking federal qualification and funds received from other federal agencies to reimburse CMS for services performed for them are credited to the Program Management Appropriation.

The cost related to the Program Management Appropriation is allocated based on the CMS cost allocation system. It is reported under the Program Management (administrative) and Other (user fees) columns in the supplemental statements in the Supplementary Information section. Both of these activities are reported as dedicated collections.

The PPACA provides additional funding for Program Management to address activities such as Medicaid adult health quality measures, a nationwide program for national and state background checks on long-term care employees, evaluations of community prevention and wellness programs, quality measurements, state health insurance programs, the Medicare Independence at Home Demonstration program, and the complex diagnostic laboratory tests demonstration project.

Description of Concepts Unique to CMS and/or the Federal Government

Fund Balance with Treasury are funds with Treasury that are primarily available to pay current liabilities. Cash receipts and disbursements are processed by Treasury. CMS also maintains lockboxes at commercial banks for the deposit of SMI premiums from the states and third parties.

Investments consist of trust fund (Dedicated collections) investments, which are investments (plus the accrued interest on investments) held by Treasury. SFFAS 27 prescribes certain disclosures concerning dedicated collections investments, such as the fact that cash generated from funds from dedicated collections is used by the U.S. Department of the Treasury (Treasury) for general government purposes and that, upon redemption of investments to make expenditures, the Treasury will finance those expenditures in the same manner that it finances all other expenditures. Additionally, investments consist of the CHIP Child Enrollment Contingency Fund investments (net of any accrued amortized or unrealized discounts) also held by Treasury (see Note 3).

Unexpended Appropriations include the portion of CMS's appropriations represented by undelivered orders and unobligated balances.

Benefit Payments are payments made by Medicare contractors, CMS, and state Medicaid agencies to healthcare providers for their services. CMS recognizes the cost associated with payments in the period incurred and based on entitlement.

State Phased-Down Contributions are reimbursements to the SMI trust fund for the federal assumption of Medicaid prescription drug costs for dually eligible beneficiaries pursuant to the MMA. The MMA prescribes a formula for computing the states' contributions and allows states to make monthly payments. Amounts billed and collected under the State Phased-Down provision are recognized as a reduction to expense.

Medicare Premiums Collected are used to help finance benefits and administrative expenses. Premiums collected are for Part A, Part B, Medicare Advantage and Part D.

Budgetary Financing Sources (Other than Exchange Revenues) arise primarily from the exercise of the government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties). These include appropriations used, transfers of assets from other government entities, donations, and imputed financing. The major sources of Budgetary Financing Sources are as follows:

- **Appropriations Used and Federal Matching Contributions** are described in the Medicare Premiums Collected section above. For financial statement purposes, appropriations used are recognized as a financing source as expenses are incurred. Federal matching contributions consist of transfers of general funds to the HI trust fund in an amount equal to SECA tax credits made through the Payments to the Healthcare Trust Funds account.

- **Nonexchange Revenues** arise primarily from the exercise of the Government's power to demand payment from the public (e.g., taxes, duties, fines and penalties), but also include donations. Employment tax revenue is the primary source of financing for Medicare's HI program. Interest earned on HI and SMI trust fund investments, as well as on the Child Enrollment Contingency Fund investments, are also reported as nonexchange revenue.

Appropriations provide budget authority that permits government officials to incur obligations that result in immediate or future outlays of government funds.

Budgetary Resources consist of new budget authority and unobligated balances from prior year budget authority and available for obligation in a given year.

Offsetting Collections are payments to the government which, by law are credited to expenditure accounts and deducted from gross budget authority and outlays of the expenditure account, rather than added to receipts. Offsetting collections are to be spent for the purposes of the account usually without further action by Congress. They result from business-like transactions with the public (i.e., including payments from the public in exchange for goods and services, reimbursements for damages, and gifts or donations of money to the government) and from intragovernmental transactions.

Offsetting Receipts are payments to the government which are credited to offsetting receipt accounts and deducted from gross budget authority and outlays, rather than added to receipts. They are not authorized to be credited directly to expenditure accounts, since the legislation that authorizes the offsetting receipts may designate them for a specific purpose or appropriate them for expenditure for that purpose or require them to be appropriated in annual appropriations acts before they can be spent. Similar to offsetting collections, they usually result from business-like transactions with the public and from intragovernmental transactions with other government accounts.

Obligations are actions that create a legal liability to disburse funds, immediately or in the future. Budgetary resources must be available before obligating actions can be taken legally. In entitlement programs, obligations may arise under operation of law.

Outlays are payments to liquidate an obligation. Outlays generally are equal to cash disbursements. Outlays are the measure of government spending. Net outlays are gross outlays reduced by offsetting collections.

Obligations Incurred consists of expended authority and the change in undelivered orders. OMB has exempted CMS from the Circular No. A-11 requirement to report Medicare's refunds of prior year obligations separately from refunds of current year obligations on the SF-133, Report on Budget Execution and Budgetary Resources. OMB issued a waiver mandating that CMS report all Medicare cash collections as an offsetting receipt.

Health Insurance Exchange Risk Adjustment Program

The Risk Adjustment program is a permanent program. It applies to non-grandfathered individual and small group plans inside and outside the Exchanges. It provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions) and transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection. States that operate a

State-based Exchange are eligible to establish a risk adjustment program. States operating a risk adjustment program may have an entity other than the Exchange perform this function. CMS operates a risk adjustment program for each state that does not operate its own risk adjustment program.

NOTE 2:

FUND BALANCE WITH TREASURY

(Dollars in Millions)

	FY 2024	FY 2023
Status of Fund Balance with Treasury:		
Unobligated Balance:		
Available	$41,118	$121,059
Unavailable	271,954	206,177
Obligated Balance not yet Disbursed	213,089	200,049
Non-Budgetary FBWT	(84,097)	(96,693)
TOTAL	$442,064	$430,592

The Unobligated Balance Available includes $43,230 million ($42,867 million in FY 2023), which is restricted for future use and is not apportioned for current use for CHIP, Program Management, Center for Medicare and Medicaid Innovation, and State Grants and Demonstrations.

NOTE 3:

INVESTMENTS

(Dollars in Millions)

FY 2024 Medicare Investments	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2025	4.00%	$26,962
Bonds	June 2026 to June 2036	1.875 – 4.625%	207,998
Accrued Interest			1,843
Total HI TF Investments			$236,803
SMI TF			
Certificates	June 2025	4.000 – 4.125%	$34,480
Bonds	June 2027 to June 2038	1.500 – 4.625%	129,933
Accrued Interest			740
Total SMI TF Investments			$165,153
Total Medicare Investments			$401,956

FY 2023 Medicare Investments	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2024	4.250%	$20,882
Bonds	June 2025 to June 2032	1.875 – 3.875%	173,479
Accrued Interest			1,214
Total HI TF Investments			$195,575
SMI TF			
Certificates	June 2024	4.250%	$3,129
Bonds	June 2025 to June 2037	1.500 – 3.000%	156,408
Accrued Interest			817
Total SMI TF Investments			$160,354
Total Medicare Investments			$355,929

Sections 1817 for HI and 1841 for SMI of the *Social Security Act* require that trust fund investments not necessary to meet current expenditures be invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and was adjusted to include an accrual for interest earned from July 1 to September 30.

The federal government does not set aside assets to pay future benefits or other expenditures associated with the HI trust fund or the SMI trust fund. The cash receipts collected from the public for a fund from dedicated collections are deposited in the Treasury, which uses the cash for general government purposes. Treasury securities are issued to the HI and SMI trust funds as evidence of their receipts. Treasury securities are an asset to the HI and SMI trust funds and a liability to the Treasury. Because the HI and SMI trust funds and the Treasury are both parts of the federal government, these assets and liabilities offset each other from the standpoint of the federal government as a whole. For this reason, they do not represent an asset or a liability in the U.S. government-wide financial statements.

Treasury securities provide the HI and SMI trust funds with authority to draw upon the Treasury to make future benefit payments or other expenditures. When the HI and SMI trust funds require redemption of these securities to make expenditures, the government finances those expenditures out of accumulated cash balances, by raising taxes, raising the federal match of SMI premiums or other receipts, by borrowing from the public or repaying less debt, or by curtailing other expenditures. This is the same way that the government finances all other expenditures.

CMS INVESTMENT SUMMARY

FY 2024	Medicare (Dedicated Collections)			Consolidated Total
	HI TF	SMI TF	Total	
Certificates	$26,962	$34,480	$61,442	$61,442
Bonds	207,998	129,933	337,931	337,931
Accrued Interest	1,843	740	2,583	2,583
Total Investments	$236,803	$165,153	$401,956	$401,956

FY 2023	Medicare (Dedicated Collections)			Consolidated Total
	HI TF	SMI TF	Total	
Certificates	$20,882	$3,129	$24,011	$24,011
Bonds	173,479	156,408	329,887	329,887
Accrued Interest	1,214	817	2,031	2,031
Total Investments	$195,575	$160,354	$355,929	$355,929

NOTE 4:

ACCOUNTS RECEIVABLE, NET

(Dollars in Millions)

FY 2024	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net Receivables
Intragovernmental					
Entity	$654		$654		$654
Total Intragovernmental	$654		$654		$654
Other than Intragovernmental					
Entity					
Medicare FFS	$12,124		$12,124	$(5,286)	$6,838
Medicare Advantage/Prescription Drug Program	16,297		16,297	(15)	16,282
Medicaid	6,962		6,962	(766)	6,196
CHIP	230		230		230
Other	9,375		9,375	(1,503)	7,872
Non-Entity	4	$153	157	(101)	56
Total Other than Intragovernmental	$44,992	$153	$45,145	$(7,671)	$37,474

FY 2023	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net Receivables
Intragovernmental					
Entity	$634		$634		$634
Total Intragovernmental	$634		$634		$634
Other than Intragovernmental					
Entity					
Medicare FFS	$10,069		$10,069	$(4,394)	$5,675
Medicare Advantage/Prescription Drug Program	18,894		18,894	(14)	18,880
Medicaid	7,365		7,365	(787)	6,578
CHIP	138		138		138
Other	8,301		8,301	(1,019)	7,282
Non-Entity	4	$85	89	(62)	27
Total Other than Intragovernmental	$44,771	$85	$44,856	$(6,276)	$38,580

Intragovernmental accounts receivable represents CMS claims for payment from other federal agencies. CMS accounts receivable for transfers from the HI and SMI trust funds maintained by the Treasury Bureau of the Fiscal Service (BFS) are eliminated against BFS's corresponding liabilities to CMS in the Consolidated Balance Sheets. No allowance for uncollectible amounts is established for intragovernmental accounts receivable because they are considered fully collectible.

Accounts receivable from other than intragovernmental are primarily composed of provider and beneficiary overpayments, Medicare Prescription drug overpayments, Medicare premiums, State phased-down contributions, Medicaid/CHIP overpayments, audit disallowances, civil monetary penalties and restitutions, the recognition of Medicare secondary payer (MSP) accounts receivable, and Exchange activities. The accounts receivable is presented net of an allowance for uncollectible amounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, the allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years. The Medicaid accounts receivable has been recorded at a net realizable value based on a historic analysis of actual recoveries and the rate of disallowances found in favor of the states. The other accounts receivable has been recorded to account for amounts due related to collections for Exchange activities.

NOTE 5:

ADVANCES AND PREPAYMENTS

CMS has $1 million ($45,119 million in FY 2023) in advances and prepayments. The $45,119 million reported in FY 2023 represents Prescription Drug and Medicare Advantage benefit payments for October 1, 2023, that occurred on September 29th since October 1st was on a weekend.

NOTE 6:

DEBT

(Dollars in Millions)

CMS has $1,091 million ($3,272 million in FY 2023) in total debt due to Treasury. From that total, $486 million is for amounts borrowed to cover premium shortfalls from 2021. The *Balanced Budget Act of 2015* (Section 601) authorized a transfer from the general fund to SMI, to temporarily replace the reduction in Part B premiums for calendar years 2016 and 2017. Section 601 created an "additional premium" charged alongside the normal Part B monthly premiums, which will be used to pay back the general fund transfer without interest. The *Continuing Appropriations Act, 2021 and Other Extensions Act* (H.R. 8337 enacted on October 1, 2020) made similar changes for 2021. These repayments are transferred quarterly. The $118 million is related to amounts borrowed to cover for the advance/accelerated payments made for the COVID-19 Accelerated and Advance Payment (CAAP) program. CAAP program repayments are based on collections.

	2023 Beginning Balance	2023 Net Borrowing	2023 Ending Balance	2024 Net Borrowing	2024 Ending Balance
Debt to the Treasury:					
Transitional SMI Contributions	$4,863	$(2,163)	$2,700	$(2,214)	$486
COVID-19 Accelerated and Advance Payment Program	2,884	(2,730)	154	(36)	118
Other	509	(91)	418	69	487
TOTAL DEBT TO THE TREASURY	$8,256	$(4,984)	$3,272	$(2,181)	$1,091

NOTE 7:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(Dollars in Millions)

	FY 2024	FY 2023
Medicare FFS	$61,125	$88,660
Medicare Advantage/Prescription Drug Program	27,707	17,560
Medicaid	51,460	52,028
CHIP	1,305	1,295
Totals	$141,597	$159,543

Entitlement Benefits Due and Payable represents a liability for Medicare FFS, Medicare Advantage and the Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims incurred but not reported (IBNR) as of the end of the reporting period.

The Medicare FFS liability is primarily an actuarial liability which represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year and (e) an estimate of retroactive settlements of cost reports. The September 30, 2024 and 2023 estimates also include amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals, as well as, amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represents amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment related adjustments including the estimate for the first nine months of calendar year 2024. In addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2024.

The Medicaid and CHIP estimates represent the net federal share of expenses that have been incurred by the states but not yet reported to CMS based on data from the states' latest audited Comprehensive Annual Financial Report. Each state's estimate is subject to variability due to the variety of programs offered by the respective states and the data required to formulate these estimates. Accordingly, the ultimate outcome of these estimates could vary from the amounts recorded on September 30, 2024 and 2023; however, we believe these estimates to be reasonable.

NOTE 8:

CONTINGENCIES AND COMMITMENTS

The contingencies balance as of September 30, 2024 is $5,328 million ($18,560 million in FY 2023) that consists of $4,278 million for audit and program disallowances and reimbursement of state plan amendments along with $1,050 million for legal contingent liabilities. CMS is a party in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the federal government. CMS accrues contingent liabilities where a loss is determined to be probable and the amount can be estimated. CMS may owe amounts to providers for previous years' disputed cost reports and claims adjustments. Additionally, other contingencies exist where losses are reasonably possible, and an estimate can be determined or an estimate of the range of possible liability has been determined. CMS does not record an accrual for a contingent liability if it is not estimable and probable, but does disclose those contingencies in the financial statements, if the future settlement could be material to the financial statements.

NOTE 9:

LIABILITIES NOT COVERED BY BUDGETARY RESOURCES

(Dollars in Millions)

Liabilities not covered by budgetary resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. CMS recognizes such liabilities for debt (see Note 6), contingencies (see Note 8), employee annual leave earned but not taken, amounts billed by the Department of Labor for *Federal Employee's Compensation Act* (FECA) payments, and the Risk Adjustment program (reflected in the Other line). For CMS revolving funds, all liabilities are funded as they occur.

	Medicare		Health						
FY 2024	**HI TF**	**SMI TF**	**Medicaid**	**CHIP**	**Other**	**Program Management**	**Combined Total**	**Intra-CMS Eliminations**	**Consolidated Total**
Intragovernmental									
Debt		$604					$604		$604
Other					$61	$3	64	$(2)	62
Total Intragovernmental		604			61	3	668	(2)	666
Federal Employee and Veterans Benefits	$7	1			18	73	99		99
Other					8,430		8,430		8,430
Contingencies	1,050		$4,278				5,328		5,328
Total Liabilities Not Covered by Budgetary Resources	1,057	605	4,278		8,509	76	14,525	(2)	14,523
Total Liabilities Covered by Budgetary Resources	80,425	121,808	51,461	$1,305	5,140	228	260,367	(108,445)	151,922
Total Liabilities Not Requiring Budgetary Resources	250	2,371			419		3,040		3,040
TOTAL LIABILITIES	$81,732	$124,784	$55,739	$1,305	$14,068	$304	$277,932	$(108,447)	$169,485

	Medicare		Health						
FY 2023	**HI TF**	**SMI TF**	**Medicaid**	**CHIP**	**Other**	**Program Management**	**Combined Total**	**Intra-CMS Eliminations**	**Consolidated Total**
Intragovernmental									
Debt		$2,854					$2,854		$2,854
Other					$200	$2	202	$(87)	115
Total Intragovernmental		2,854			200	2	3,056	(87)	2,969
Federal Employee and Veterans Benefits	$6	1			16	72	95		95
Other					7,750		7,750		7,750
Contingencies	10,400		$8,160				18,560		18,560
Total Liabilities Not Covered by Budgetary Resources	10,406	2,855	8,160		7,966	74	29,461	(87)	29,374
Total Liabilities Covered by Budgetary Resources	120,072	114,236	52,028	$1,295	6,019	250	293,900	(126,051)	167,849
Total Liabilities Not Requiring Budgetary Resources	237	1,621			384		2,242		2,242
TOTAL LIABILITIES	$130,715	$118,712	$60,188	$1,295	$14,369	$324	$325,603	$(126,138)	$199,465

NOTE 10:

NET COST OF OPERATIONS

(Dollars in Millions)

FY 2024	Medicare		Health			
	HI TF	SMI TF	Medicaid	CHIP	Other	Consolidated Total
BENEFIT/PROGRAM COSTS						
Medicare						
Fee for Service	$180,036	$237,518				$417,554
Medicare Advantage/ Managed Care	203,018	299,383				502,401
Prescription Drug (Part D)		112,921				112,921
Medicaid/CHIP			$608,253	$19,442		627,695
Other					$15,315	15,315
Bad Debt Expense and Write-offs	126	432	(22)		472	1,008
Total Benefit/Program Costs	$383,180	$650,254	$608,231	$19,442	$15,787	$1,676,894
OPERATING COSTS						
Medicare Integrity Program	$1,652					$1,652
Quality Improvement Organizations	701	$159				860
Program Management and Other Expenses	1,042	3,124	$198	$23	$1,062	5,449
Total Operating Costs	$3,395	$3,283	$198	$23	$1,062	$7,961
TOTAL COSTS	$386,575	$653,537	$608,429	$19,465	$16,849	$1,684,855
Less: Earned Revenues:						
Medicare Premiums	$5,080	$143,616				$148,696
Other Earned Revenues	8	37	$2		$15,038	15,085
Total Earned Revenues	$5,088	$143,653	$2		$15,038	$163,781
Intra-CMS Eliminations	98	55			(153)	
TOTAL NET COST OF OPERATIONS	$381,585	$509,939	$608,427	$19,465	$1,658	$1,521,074

FY 2023	Medicare		Health			Consolidated Total
	HI TF	SMI TF	Medicaid	CHIP	Other	
BENEFIT/PROGRAM COSTS						
Medicare						
Fee for Service	$228,806	$230,395				$459,201
Medicare Advantage/ Managed Care	185,631	262,729				448,360
Prescription Drug (Part D)		95,993				95,993
Medicaid/CHIP			$610,958	$17,922		628,880
Other					$13,262	13,262
Bad Debt Expense and Write-offs	100	173	1		724	998
Total Benefit/Program Costs	$414,537	$589,290	$610,959	$17,922	$13,986	$1,646,694
OPERATING COSTS						
Medicare Integrity Program	$1,676					$1,676
Quality Improvement Organizations	646	$166				812
Program Management and Other Expenses	1,123	3,099	$208	$23	$897	5,350
Total Operating Costs	$3,445	$3,265	$208	$23	$897	$7,838
TOTAL COSTS	$417,982	$592,555	$611,167	$17,945	$14,883	$1,654,532
Less: Earned Revenues:						
Medicare Premiums	$4,765	$136,929				$141,694
Other Earned Revenues	8	34	$2		$13,165	13,209
Total Earned Revenues	$4,773	$136,963	$2		$13,165	$154,903
Intra-CMS Eliminations		2			(2)	
TOTAL NET COST OF OPERATIONS	$413,209	$455,594	$611,165	$17,945	$1,716	$1,499,629

For purposes of financial statement presentation, non-CMS administrative costs included in the line of Program Management and Other Expenses that consist of the MAC administrative cost and the Bureau of the Fiscal Service administrative costs are considered expenses to the Medicare trust funds when outlaid by Treasury even though some funds may have been used to pay for assets, such as property and equipment. CMS administrative costs have been allocated to programs based on the CMS cost allocation system. Program Management costs allocated to the Medicare program include $2,261 million ($2,334 million in FY 2023) paid to Medicare contractors to carry out their responsibilities as CMS's agents in the administration of the Medicare program.

For reporting purposes, Medicare Part D expense has been reduced by actual and accrued reimbursements made by the states pursuant to the State Phased-Down provision. The FY 2024 Part D expense of $112,921 million ($95,993 million in FY 2023) is net of state reimbursements of $17,893 million ($15,321 million in FY 2023). The gross expense would have been $130,814 million ($111,314 million in FY 2023) without these reimbursements.

NOTE 11:

FUNDS FROM DEDICATED COLLECTIONS

(Dollars in Millions)

CMS has designated as funds from dedicated collections the Medicare HI and SMI trust funds, which also include the Payments to the Healthcare Trust Funds appropriation and the HCFAC account. Other Non-Medicare includes user fees and program management (administrative) activities.

Balance Sheet as of September 30, 2024	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Funds from Dedicated Collections (Consolidated)
ASSETS					
Intragovernmental:					
Fund Balance with Treasury	$267,906	$15,345	$283,251		$283,251
Investments, net	401,956		401,956		401,956
Accounts receivable, net	100,435	6,237	106,672	$(106,018)	654
Advances and Prepayments	1	5	6		6
Total Intragovernmental Assets	770,298	21,587	791,885	(106,018)	685,867
Other than Intragovernmental:					
Accounts receivable, net	23,120	7,837	30,957		30,957
General property, plant & equipment, net	311	1,353	1,664		1,664
Advances and prepayments	1		1		1
Total Other than Intragovernmental	23,432	9,190	32,622		32,622
TOTAL ASSETS	$793,730	$30,777	$824,507	$(106,018)	$718,489
LIABILITIES					
Intragovernmental:					
Accounts payable	$110,009	$33	$110,042	$(106,018)	$4,024
Debt	604		604		604
Other Liabilities		7	7		7
Total Intragovernmental Liabilities	110,613	40	110,653	(106,018)	4,635
Other than Intragovernmental:					
Accounts payable	163	247	410		410
Entitlement benefits due and payable	88,832		88,832		88,832
Other Liabilities					
Contingencies	1,050		1,050		1,050
Other	5,858	12,987	18,845		18,845
Total Other than Intragovernmental	95,903	13,234	109,137		109,137
TOTAL LIABILITIES	$206,516	$13,274	$219,790	$(106,018)	$113,772
NET POSITION					
Unexpended Appropriations-Funds from Dedicated Collections	$260,565	$3,351	$263,916		$263,916
Cumulative Results of Operations-Funds from Dedicated Collections	326,649	14,152	340,801		340,801
TOTAL NET POSITION	$587,214	$17,503	$604,717		$604,717
TOTAL LIABILITIES AND NET POSITION	$793,730	$30,777	$824,507	$(106,018)	$718,489
Statement of Net Cost for the Year Ended September 30, 2024					
Benefit and Program Expenses	$1,033,434	$14,507	$1,047,941		$1,047,941
Operating Costs	2,119	5,604	7,723		7,723
Total Costs	1,035,553	20,111	1,055,664		1,055,664
Less Earned Revenues	(148,696)	(15,074)	(163,770)		(163,770)
NET COST OF OPERATIONS	$886,857	$5,037	$891,894		$891,894

NOTE 11:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(Dollars in Millions)

Statement of Changes in Net Position for the Year Ended September 30, 2024	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Funds from Dedicated Collections (Consolidated)
UNEXPENDED APPROPRIATIONS					
Beginning Balances:	$271,601	$3,706	$275,307		$275,307
Budgetary Financing Sources:					
Appropriations received	579,500	70	579,570		579,570
Other Adjustments	(76,104)		(76,104)		(76,104)
Appropriations used	(514,432)	(425)	(514,857)		(514,857)
Change in Unexpended Appropriations	(11,036)	(355)	(11,391)		(11,391)
TOTAL UNEXPENDED APPROPRIATIONS: ENDING BALANCE	$260,565	$3,351	$263,916		$263,916
CUMULATIVE RESULTS OF OPERATIONS					
Beginning Balances:	$303,812	$13,766	$317,578		$317,578
Appropriations used	514,432	425	514,857		514,857
Nonexchange Revenue:					
Intragovernmental Nonexchange Revenue	405,319		405,319		405,319
Other than Intragovernmental Nonexchange Revenue	342		342		342
Transfers-in/out without reimbursement	(10,407)	4,901	(5,506)		(5,506)
Imputed financing	8	97	105		105
Net Cost of Operations	886,857	5,037	891,894		891,894
NET CHANGE IN CUMULATIVE RESULTS OF OPERATIONS	22,837	386	23,223		23,223
CUMULATIVE RESULTS OF OPERATIONS: ENDING BALANCE	$326,649	$14,152	$340,801		$340,801
NET POSITION	$587,214	$17,503	$604,717		$604,717

NOTE 11:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(Dollars in Millions)

Balance Sheet as of September 30, 2023	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Funds from Dedicated Collections (Consolidated)
ASSETS					
Intragovernmental:					
Fund Balance with Treasury	$280,536	$15,704	$296,240		$296,240
Investments, net	355,929		355,929		355,929
Accounts receivable, net	118,269	6,467	124,736	$(124,102)	634
Total Intragovernmental Assets	754,734	22,171	776,905	(124,102)	652,803
Other than Intragovernmental:					
Accounts receivable, net	24,555	7,230	31,785		31,785
General property, plant & equipment, net	432	1,716	2,148		2,148
Advances and prepayments	45,119		45,119		45,119
Total Other than Intragovernmental	70,106	8,946	79,052		79,052
TOTAL ASSETS	$824,840	$31,117	$855,957	$(124,102)	$731,855
LIABILITIES					
Intragovernmental:					
Accounts payable	$127,912	$38	$127,950	$(124,102)	$3,848
Debt	2,854		2,854		2,854
Other Liabilities		7	7		7
Total Intragovernmental Liabities	130,766	45	130,811	(124,102)	6,709
Other than Intragovernmental:					
Accounts payable	173	303	476		476
Entitlement benefits due and payable	106,220		106,220		106,220
Other Liabilities					
Contingencies	10,400		10,400		10,400
Other	1,868	13,297	15,165		15,165
Total Other than Intragovernmental	118,661	13,600	132,261		132,261
TOTAL LIABILITIES	$249,427	$13,645	$263,072	$(124,102)	$138,970
NET POSITION					
Unexpended Appropriations-Funds from Dedicated Collections	$271,601	$3,706	$275,307		$275,307
Cumulative Results of Operations-Funds from Dedicated Collections	303,812	13,766	317,578		317,578
TOTAL NET POSITION	$575,413	$17,472	$592,885		$592,885
TOTAL LIABILITIES AND NET POSITION	$824,840	$31,117	$855,957	$(124,102)	$731,855
Statement of Net Cost for the Year Ended September 30, 2023					
Benefit and Program Expenses	$1,003,827	$12,976	$1,016,803		$1,016,803
Operating Costs	2,197	5,447	7,644	$2	7,646
Total Costs	1,006,024	18,423	1,024,447	2	1,024,449
Less Earned Revenues	(141,694)	(13,199)	(154,893)	(2)	(154,895)
NET COST OF OPERATIONS	$864,330	$5,224	$869,554		$869,554

NOTE 11:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(Dollars in Millions)

Statement of Changes in Net Position for the Year Ended September 30, 2023	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Funds From Dedicated Collections (Consolidated)
UNEXPENDED APPROPRIATIONS					
Beginning Balances:	$174,874	$3,830	$178,704		$178,704
Budgetary Financing Sources:					
Appropriations received	593,419	124	593,543		593,543
Other Adjustments	(19,035)	(12)	(19,047)		(19,047)
Appropriations used	(477,657)	(236)	(477,893)		(477,893)
Change in Unexpended Appropriations	96,727	(124)	96,603		96,603
TOTAL UNEXPENDED APPROPRIATIONS: ENDING BALANCE	$271,601	$3,706	$275,307		$275,307
CUMULATIVE RESULTS OF OPERATIONS					
Beginning Balances:	$324,469	$14,135	$338,604		$338,604
Appropriations used	477,657	236	477,893		477,893
Nonexchange Revenue:					
Intragovernmental Nonexchange Revenue	375,176		375,176		375,176
Other than Intragovernmental Nonexchange Revenue	436		436		436
Transfers-in/out without reimbursement	(9,602)	4,559	(5,043)		(5,043)
Imputed financing	6	60	66		66
Net Cost of Operations	864,330	5,224	869,554		869,554
Net Change in Cumulative Results of Operations	(20,657)	(369)	(21,026)		(21,026)
CUMULATIVE RESULTS OF OPERATIONS: ENDING BALANCE	$303,812	$13,766	$317,578		$317,578
NET POSITION	$575,413	$17,472	$592,885		$592,885

NOTE 12:

STATEMENT OF BUDGETARY RESOURCES DISCLOSURES

(Dollars in Millions)

Net Adjustments to Unobligated Balance, Brought Forward, October 1

Net adjustments to unobligated balance, brought forward, October 1 as of September 30, 2024 and September 30, 2023 consisted of the following:

Net Adjustment to Unobligated Balance Brought Forward	FY 2024	FY 2023
Budgetary Resources:		
Unobligated balance, brought forward, October 1	$327,241	$224,636
Recoveries of prior year unpaid obligations	46,164	55,822
Recoveries of prior year paid obligations	25,898	28,023
Appropriation withdrawn		(6,595)
Appropriation temporarily precluded from obligations - prior year		(2,519)
Cancelled authority	(41,260)	(12,653)
Prior year adjustment		5
Other	(6,541)	60
UNOBLIGATED BALANCE FROM PRIOR YEAR BUDGET AUTHORITY, NET	$351,502	$286,779

Legal Arrangements Affecting Use of Unobligated Balances

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources (SBR). The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation, as of September 30. The excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and can become available for obligation as needed. The entire trust fund balances of $294,385 million ($236,425 million in FY 2023) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2024 and FY 2023 (in millions):

	FY 2024 Combined Balance	FY 2023 Combined Balance
TRUST FUND BALANCE, BEGINNING	$236,425	$261,475
Receipts	972,833	907,732
Less Obligations	(914,873)	(932,782)
Excess (Shortage) of Receipts Over Obligations	57,960	(25,050)
TRUST FUND BALANCE, ENDING	$294,385	$236,425

NOTE 12:

STATEMENT OF BUDGETARY RESOURCES DISCLOSURES

(Dollars in Millions)

Explanations of Differences Between the Combined Statement of Budgetary Resources and the Budget of the United States Government for FY 2023

CMS reconciled the amounts of the FY 2023 column of the SBR to the actual amounts for FY 2023 from the Appendix in the FY 2025 President's Budget for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections). The Budget with the actual amounts for the current year (FY 2024) will be available at a later date.

FY 2023	Budgetary Resources	New Obligations & Upward Adjustments	Distributed Offsetting Receipts	Net Outlays
Combined Statement of Budgetary Resources	$2,579,015	$2,251,779	$658,008	$2,142,269
Expired Accounts	(193,115)			
Other	5,217	5,214		4,936
Budget of the US Govt (2023 Actual)	**$2,391,117**	**$2,256,993**	**$658,008**	**$2,147,205**

For the budgetary resources' reconciliation, the amount used from the President's Budget was the total budgetary resources available for obligation. The Expired Accounts line included expired authority, recoveries and other amounts included in the Combined SBR that are not included in the President's Budget. The Other line, contained in the SBR and not in the President's Budget for budgetary resources, obligations incurred and net outlays, are CMS amounts reported on CDC and Office of Secretary (OS) statements and Governmentwide Treasury Account Symbol Adjusted Trial Balance System.

Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders for FY 2024 totaled $62,064 million ($78,010 million FY 2023). The FY 2023 paid amounts include the Medicare Advantage and Prescription Drug benefit payments for October 2023 that occurred on September 29.

	FY 2024		FY 2023	
	Federal	Non-Federal	Federal	Non-Federal
Undelivered orders (unpaid)	$506	$61,551	$478	$32,414
Undelivered orders (paid)	6	1		45,118
Total	$512	$61,552	$478	$77,532

NOTE 13:

STATEMENT OF SOCIAL INSURANCE (UNAUDITED)

The Statement of Social Insurance (SOSI) presents, for the 75-year projection period, the present values of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds for both the open group and closed group of participants. The open group consists of all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program. The closed group comprises only current participants—those who attain age 15 or older in the first year of the projection period.

Actuarial present values are computed under the intermediate set of assumptions specified in the *2024 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and healthcare-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent completed review occurred with the 2016-2017 Technical Review Panel.

With two exceptions, the projections are based on the current-law provisions[1] of the *Social Security Act* as of the date of release of the Medicare Trustees Report. The first exception is that the Part A projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted. The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November of 2020, is not reflected in the Part D projections. This final rule imposed a January 1, 2022 effective date; however, implementation was initially delayed until January 1, 2023. Since then, enacted legislation has three times imposed a moratorium on implementation, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The Medicare projections have been significantly affected by the enactment of the *Inflation Reduction Act of 2022*. This legislation has wide-ranging provisions, including those that restrain price growth and negotiate drug prices for certain Part B and Part D drugs and that redesign the Part D benefit structure to decrease beneficiary out-of-pocket costs. The law takes several years to implement, resulting in very different effects by year. The Part D benefit enhancements are implemented by 2025, for example, before the negotiation provisions that are effective in 2026 can have any spending reduction impact. The total effect of the *Inflation Reduction Act* is to reduce government expenditures for Part B, to increase expenditures for Part D from 2027 through 2030, and to decrease Part D expenditures beginning in 2031. Part B savings are due to the substantial lowering of payments, relative to current reimbursement, as a result of negotiated prices. Part D ultimately generates cost savings at the end of the 10-year period, but many of the gains from negotiated prices and lower trends are initially more than offset by increased benefits and decreased manufacturer rebates.

The Board of Trustees assumes that the *Inflation Reduction Act* will affect the ultimate long-range growth rates for Part B and Part D drug spending differently. For Part B drugs, since the Trustees do not anticipate that the market pricing dynamics will be much different from those prior to the implementation of the *Inflation Reduction Act*, they continue to assume that per capita spending growth rates will be similar to those for overall per capita national health expenditures. On the other hand, for Part D drugs, the Trustees assume that per capita spending will grow 0.2 percentage point more slowly than per capita national health expenditures, since the inflation provisions of the *Inflation Reduction Act* are likely to result in price growth that is lower than overall health prices and closer to the Consumer Price Index (CPI).

Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic. Spending was directly affected by the coverage of testing and treatment of the disease. In addition, several regulatory policies and legislative provisions were enacted during the public health emergency that increased spending, and the use of telehealth was greatly expanded. More than offsetting these additional costs during the pandemic, spending for non-COVID care declined significantly.

1 Due to the timing and the limited effect on the financial outlook of the trust funds, the projections do not reflect the impact of the Medicare provisions in the *Consolidated Appropriations Act*, 2024 (Public Law 118-42), which was enacted on March 9, 2024. The provisions included were temporary extensions of prior policies, the elimination of the Medicare Improvement Fund, and a 1-month extension of the sequestration of Medicare benefits through November of 2032. The estimated impact is less than 0.05 percent of Medicare benefits over FYs 2024 through 2033, and there is no impact beyond 2033.

Now that the public health emergency has ended and Medicare fee-for-service per capita spending has stabilized, the Trustees place a greater reliance on recent experience when developing the cost projections. However, they continue to make three pandemic-related adjustments to the projections. The first is to account for the morbidity improvement in the surviving population, which is expected to continue to affect spending levels through 2029. The second adjustment accounts for the ending of the waiver regarding the 3-day inpatient stay requirement to receive skilled nursing facility services. The per capita spending projections typically include factors for price updates and changes in the utilization and mix of services. As a result of the expiration of this waiver, the Trustees have increased their inpatient spending growth factor by 1.9 percentage points and decreased the skilled nursing facility spending growth factor by 7.5 percentage points in 2024. Finally, the third adjustment is to account for home health spending that was still, in 2023, significantly lower than estimated prior to the pandemic. As a result of the recent home health staffing shortages, the Trustees continue to consider the spending level for this service to be suppressed. Thus, they have increased their home health spending growth factor by 2.9 percentage points in each of the next 3 years (2024–2026).

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. They are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments and administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of *FICA* and *SECA* payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, premiums paid by, or on behalf of, aged uninsured beneficiaries, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury. Fees related to brand-name prescription drugs are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, those who are expected to become participants in the future. Current participants are the closed group of individuals who are at least age 15 at the start of the projection period and are expected to participate in the program as either taxpayers, beneficiaries, or both.

The SOSI sets forth, for each of these three groups, the projected actuarial present values of all future expenditures and of all future non-interest income for the next 75 years. The SOSI also presents the net present values of future net cash flows, which are calculated by subtracting the actuarial present value of estimated future expenditures from the actuarial present value of estimated future income. The HI trust fund is expected to have an actuarial deficit indicating that, under these assumptions as to economic, demographic, and healthcare cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar deficits because each account is automatically in financial balance every year due to its statutory financing mechanism.

In addition to the actuarial present value of the estimated future excess of income (excluding interest) over expenditures for the open group of participants, the SOSI also sets forth the same calculation for the closed group of participants. The closed group consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64. In order to calculate the actuarial net present value of the excess of estimated future income over estimated future expenditures for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted from the actuarial present value of estimated future income (excluding interest) for current participants.

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these inherently uncertain factors and by the application of future payment updates. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program.

The estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary healthcare costs, wages, and the CPI; fertility rates; mortality rates; immigration rates; and interest rates. In most cases, these assumptions vary from year-to-year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary healthcare costs vary throughout the projection period.

The following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2024 SOSI actuarial projections are drawn from the Medicare Trustees Reports for 2024. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Similar detailed information for the prior years is publicly available on the CMS website.[2]

TABLE 1:

SIGNIFICANT ASSUMPTIONS AND SUMMARY MEASURES USED FOR THE STATEMENT OF SOCIAL INSURANCE 2024

					Annual percentage change in: Per beneficiary cost[8]						
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage growth[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI B	SMI D	Real-interest rate[12]
2024	1.67	1,809,000	784.1	0.99	3.78	2.76	1.7	2.2[9,10]	3.7[10,11]	9.3[11]	1.4
2030	1.83	1,349,000	735.3	1.89	4.33	2.40	2.0	5.0	6.0	1.6	1.7
2040	1.90	1,293,000	676.9	1.21	3.64	2.40	1.9	4.3	5.1	2.9	2.2
2050	1.90	1,260,000	624.6	1.09	3.51	2.40	1.9	3.4	3.8	4.1	2.3
2060	1.90	1,244,000	578.2	1.14	3.57	2.40	1.9	3.4	3.8	4.0	2.3
2070	1.90	1,230,000	537.2	1.14	3.57	2.40	1.8	3.4	3.5	3.8	2.3
2080	1.90	1,221,000	500.6	1.13	3.55	2.40	1.9	3.4	3.7	3.9	2.3
2090	1.90	1,216,000	468.1	1.13	3.56	2.40	2.0	3.5	3.7	3.9	2.3

1 Average number of children per woman.

2 Includes legal immigration, net of emigration, as well as other, non-legal, immigration.

3 The age-sex-adjusted death rate per 100,000 that would occur in the enumerated total population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.

4 Annual percentage change in average wages adjusted for the average percentage change in the CPI.

5 Average annual wage in covered employment.

6 The CPI represents a measure of the average change in prices over time in a fixed group of goods and services.

7 The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.

8 These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

9 Reflects policy change to exclude medical education expenses associated with Medicare Advantage (MA) enrollees from the fee-for-service per capita costs used in the development of MA spending, as described in section IV.C of the 2024 Medicare Trustees Report.

10 Reflects lower spending for hospital and home health agency services.

11 Reflects *Inflation Reduction Act of 2022.*

12 Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

The projections presented in the SOSI are based on various economic and demographic assumptions. The values for each of these assumptions move from recently experienced levels or trends toward long-range ultimate values. Table 2 below summarizes these ultimate values assumed for the current year and the prior 4 years, based on the intermediate assumptions of the respective Medicare Trustees Reports.

TABLE 2:

SIGNIFICANT ULTIMATE ASSUMPTIONS USED FOR THE STATEMENT OF SOCIAL INSURANCE, FY 2024-2020

					Annual percentage change in: Per beneficiary cost[8]						
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage growth[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI B	SMI D	Real-interest rate[9]
FY 2024	1.9	1,216,000	468.1	1.13	3.56	2.40	2.0	3.5	3.7	3.9	2.3
FY 2023	2.0	1,216,000	469.9	1.12	3.55	2.40	2.1	3.5	3.7	4.0	2.3
FY 2022	2.0	1,217,000	469.9	1.14	3.54	2.40	2.1	3.5	3.7	4.2	2.3
FY 2021	2.0	1,218,000	472.7	1.14	3.54	2.40	2.1	3.4	3.7	4.2	2.3
FY 2020	1.95	1,218,000	460.5	1.13	3.53	2.40	2.0	3.3	3.6	4.1	2.3

1 Average number of children per woman. The ultimate fertility rate is assumed to be reached in 2040.

2 Includes lawful permanent resident (LPR) immigration, net of emigration, as well as other-than-LPR immigration. The ultimate level of net LPR immigration is 788,000 persons per year, and the assumption for annual net other-than-LPR varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.

3 The age-sex-adjusted death rate per 100,000 that would occur in the enumerated total population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2090.

4 Beginning with the 2023 Trustees Report, for consistency with other growth rate measures, the real-wage growth is defined as the annual percentage change in average wages adjusted for the average percentage change in the CPI. In the 2022 and earlier Trustees Reports it is presented as the difference between percentage increases in wages and the CPI and referred to as real-wage differential. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.

5 Average annual wage in covered employment. The value presented is the average annual percentage change from the 10th year of the 75-year projection period to the 75th year and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.

6 The CPI represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.

7 The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2090.

8 These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. Since the annual rate of growth declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2090.

9 Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached soon after the 10th year of each projection period.

2 The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation and is likewise not subject to audit by independent auditors.

NOTE 14:

ALTERNATIVE SOSI PROJECTIONS (UNAUDITED)

The Medicare Board of Trustees, in its annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results.

Certain features of current law may result in some challenges for the Medicare program. With the end of the COVID-19 public health emergency, uncertainty related to the effects of the pandemic on the economy, demographics, and healthcare delivery has been significantly reduced. Uncertainty remains, however, regarding adherence to current-law payment updates, particularly in the long range. This concern is more immediate for physician services, for which a negative payment rate update is projected for 2025 and updates are projected to be below the rate of inflation in all future years. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business total factor productivity[3] although these health providers have historically achieved lower levels of productivity growth. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law.

The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term. Overriding the price updates in current law, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in the Medicare Trustees Report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative. This scenario illustrates the impact that would occur if the payment updates that are affected by the productivity adjustments transition from current law to the payment updates assumed for private health plans over the period 2028–2042. It also reflects physician payment updates that transition from current law to the increase in the Medicare Economic Index over the same period. Finally, the scenario assumes the continuation of the bonuses for qualified physicians in advanced alternative payment models (advanced APMs), which are expected to end after 2025, and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS), which are set to expire in 2024.[4] This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician updates under Medicare and of the broad range of uncertainty associated with such impacts.

3 Beginning with the November 18, 2021 release of the productivity data, the Bureau of Labor Statistics replaced the term multifactor productivity with the term total factor productivity, a change in name only as the underlying methods and data were unchanged.

4 The illustrative alternative projections included changes to the productivity adjustments starting with the 2010 annual report, following enactment of the *PPACA*. The assumption regarding physician payments is being used because the enactment of MACRA in 2015 replaced the SGR with specified physician updates.

Table 3 below contains a comparison of the Medicare 75-year present values of estimated future income and estimated future expenditures under current law with those under the illustrative alternative scenario.

TABLE 3:
MEDICARE PRESENT VALUES

(in billions)

	Current law (Unaudited)	Alternative Scenario[1, 2] (Unaudited)
Income		
Part A	**$32,502**	**$32,573**
Part B	**58,665**	**67,210**
Part D	**11,008**	**11,005**
Expenditures		
Part A	**35,120**	**41,547**
Part B	**58,665**	**67,210**
Part D	**11,008**	**11,005**
Income less expenditures		
Part A	**(2,618)**	**(8,974)**
Part B	**0**	**0**
Part D	**0**	**0**

1 These amounts are not presented in the 2024 Trustees Report.

2 A set of illustrative alternative Medicare projections has been prepared under a hypothetical modification to current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.

The difference between the current-law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly 40 percent of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.0-percent reduction in annual cost growth each year for these providers. If the payment updates that are affected by the productivity adjustments were to gradually transition from current law to the payment updates assumed for private health plans, the physician updates transitioned to the Medicare Economic Index, and the bonuses paid to qualified physicians in advanced APMs did not expire, as illustrated under the alternative scenario, the estimated present values of Part A would be higher than the current-law projections by roughly 18 percent and Part B expenditures would be higher than the current-law projections by roughly 15 percent. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario, and the present value of Part B income is 15 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are similar under each projection because the services are not affected by the productivity adjustments or the physician updates. The very small difference is the result of a slight change in the discount rates that are used to calculate the present values.

The extent to which actual future Part A and Part B costs exceed the projected amounts due to changes to the productivity adjustments and physician updates depends on what specific changes might be legislated and whether Congress would pass further provisions to help offset such costs. As noted, these examples reflect only hypothetical changes to provider payment rates.

NOTE 15:

STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS (UNAUDITED)

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future non-interest income less estimated future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The SCSIA shows the reconciliation from the period beginning on January 1, 2023 to the period beginning on January 1, 2024, and the reconciliation from the period beginning on January 1, 2022 to the period beginning on January 1, 2023. The reconciliation identifies several significant components of the change and provides reasons for the change.

Because of the financing mechanism for Parts B and D of Medicare, any change to the estimated future expenditures has the same effect on estimated total future income, and vice versa. Therefore, change has no impact on the estimated future net cash flow. In order to enhance the presentation, the changes in the present values of estimated future income and estimated future expenditures are presented separately.

The five changes considered in the SCSIA are, in order, as follows:

- change in the valuation period,
- change in projection base,
- changes in the demographic assumptions,
- changes in economic and healthcare assumptions, and
- changes in law.

All estimates in the SCSIA represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions, represent the additional effect these assumptions have once the effects from the change in the valuation period and projection base have been considered. In general, an increase in the present value of net cash flows represents a positive change (improving financing), while a decrease in the present value of net cash flows represents a negative change (worsening financing).

Assumptions Used for the Statement of Changes in Social Insurance Amounts

The present values included in the SCSIA are for the current and prior years and are based on various economic and demographic assumptions used for the intermediate assumptions in the Medicare Trustees Reports for those years. Table 1 of Note 13 summarizes these assumptions for the current year.

Period beginning on January 1, 2023 and ending January 1, 2024

Present values as of January 1, 2023 are calculated using interest rates from the intermediate assumptions of the 2023 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2024. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2023 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and healthcare assumptions are calculated using the interest rates under the intermediate assumptions of the 2024 Trustees Report.

Period beginning on January 1, 2022 and ending January 1, 2023

Present values as of January 1, 2022 are calculated using interest rates from the intermediate assumptions of the 2022 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2023. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2022 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and healthcare assumptions are calculated using the interest rates under the intermediate assumptions of the 2023 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2023 to the period beginning on January 1, 2024

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2023-97) to the current valuation period (2024-98) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2023, replaces it with a much larger negative net cash flow for 2098, and measures the present values as of January 1, 2024, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (was made more negative) when the 75-year valuation period changed from 2023-97 to 2024-98. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming that all values projected in the prior valuation for the year 2023 are realized. The change in valuation period resulted in a small decrease in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $157 billion.

From the period beginning on January 1, 2022 to the period beginning on January 1, 2023
The effect on the 75-year present values of changing the valuation period from the prior valuation period (2022-96) to the current valuation period (2023-97) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2022, replaces it with a much larger negative net cash flow for 2097, and measures the present values as of January 1, 2023, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (was made more negative) when the 75-year valuation period changed from 2022-96 to 2023-97. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming that all values projected in the prior valuation for the year 2022 are realized. The change in valuation period resulted in a slight decrease in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $126 billion.

Change in Projection Base

From the period beginning on January 1, 2023 to the period beginning on January 1, 2024
Actual income and expenditures in 2023 were different from what was anticipated when the 2023 Trustees Report projections were prepared. Part A income was higher and expenditures were lower than estimated based on actual experience. For Part B and Part D, income and expenditures were both higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is an increase of $746 billion in the present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2023 and January 1, 2024 is incorporated in the current valuation and is less than projected in the prior valuation.

From the period beginning on January 1, 2022 to the period beginning on January 1, 2023
Actual income and expenditures in 2022 were different from what was anticipated when the 2022 Trustees Report projections were prepared. For Part A and Part B income and expenditures were lower than estimated based on actual experience. Part D total income and expenditures were higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is an increase of $1,238 billion in the present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2022 and January 1, 2023 is incorporated in the current valuation and is less than projected in the prior valuation.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2023 to the period beginning on January 1, 2024
The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

For the current valuation (beginning on January 1, 2024), there was one change to the ultimate demographic assumptions.

- The ultimate total fertility rate (TFR) was lowered from 2.0 children per woman to 1.9 children per woman, and at the same time, the year the ultimate TFR is reached was changed from 2056 to 2040.

In addition to this change to the ultimate demographic assumptions, the starting demographic values and the way these values transition to the ultimate assumptions were changed. The most significant changes are identified below.

- Final birth rate data for calendar year 2022 and preliminary data for 2023 indicated slightly lower birth rates than were assumed in the prior valuation, leading to slightly lower assumed birth rates during the period of transition to the ultimate level.

- Updates to near-term mortality assumptions to better reflect the effects of the COVID-19 pandemic led to an increase in death rates through 2024 compared to the prior valuation.

- Mortality data, historical population data, other-than-lawful permanent resident (LPR) immigration data, and divorce data were updated since the prior valuation.

There was one notable change in demographic methodology. The method for projecting fertility rates during the transition period to the ultimate rate was modified to produce more reasonable paths to the ultimate assumed rates by age group than had been previously used.

These changes resulted in a decrease in the estimated future net cash flow. For Part A, the present value of estimated income is lower, and the present value of estimated expenditures is higher. The present values of estimated expenditures and income for both Part B and Part D are higher. Overall, these changes decreased the present value of the estimated future net cash flow by $698 billion.

From the period beginning on January 1, 2022 to the period beginning on January 1, 2023

The demographic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2023) are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Projected birth rates through 2055, during the period of transition to the ultimate level, were slightly lower than in the prior valuation.

- Updates to near-term mortality assumptions to better reflect the effects of the COVID-19 pandemic led to an increase in death rates through 2024 compared to the prior valuation.

- Historical population data, other-than-LPR immigration data, and marriage and divorce data were updated since the prior valuation.

There was one notable change in demographic methodology. The method for projecting the age distributions of LPR new arrival and adjustment-of-status immigrants was updated reflecting recent data showing a slightly older population at the time of attaining LPR status than had previously been estimated.

These changes resulted in a decrease in the estimated future net cash flow. For Part A the present values of estimated income are lower and the present values of estimated expenditures are higher. The present values of estimated expenditures and income for Part B are lower and are higher for Part D. Overall, these changes decreased the present value of the estimated future net cash flow by $315 billion.

Changes in Economic and Healthcare Assumptions

For the period beginning on January 1, 2023 to the period beginning on January 1, 2024

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate economic assumptions for the current valuation (beginning on January 1, 2024) are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed. The most significant changes are identified below.

- An update to educational attainment data caused a change in labor force participation rates at ages 55 and older for men and 50 and older for women.
- Historical OASDI covered employment for 2021 was higher than assumed under the prior valuation. Specifically, covered employment for 2021 was significantly higher than previously estimated at the youngest and oldest working ages, and lower for men at early prime working ages.
- Economic growth through 2023 was higher than assumed under the prior valuation, which led to a higher assumed level of labor productivity over the projection period.

The healthcare assumptions are specific to the Medicare projections. The following healthcare assumptions were changed in the current valuation.

- Lower Part A projected spending growth due to (i) a policy change to exclude medical education expenses associated with Medicare Advantage (MA) enrollees from the fee-for-service per capita costs used in the development of MA spending, as described in section IV.C of the 2024 Medicare Trustees Report, and (ii) lower projected spending for hospital and home health agency services.
- Lower Part D growth mainly beyond the short-range period.

The net impact of these changes was an increase in the estimated future net cash flow for total Medicare. For Part A, these changes increased the present value of estimated future income and decreased the present value of expenditures. For Part B, these changes resulted in an increase in the present value of estimated expenditures (and income) and for Part D they resulted in a decrease in the present value of estimated expenditure (and income). Overall, these changes increased the present value of the estimated future net cash flow by $2,106 billion.

For the period beginning on January 1, 2022 to the period beginning on January 1, 2023

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2023), there was one change to the ultimate economic assumptions.

- The annual percentage change in the average OASDI covered wage, adjusted for inflation, is assumed to average 1.14 percentage points over the last 65 years of the 75-year projection period. This is 0.02 percentage point higher than the value assumed for the prior valuation.

In addition to this change to the ultimate economic assumptions, the starting economic values and the way these values transition to the ultimate assumptions were changed. The most significant changes are identified below.

- The levels of GDP and labor productivity are assumed to be about 3.0 percent lower by 2026 and for all years thereafter relative to the prior valuation.

- The assumed real interest rates over the first 10 years of the projection period are generally higher than those assumed for the prior valuation.

There was one notable change in economic methodology. The method for estimating the level of OASDI taxable wages for historical years 2000-21 was improved by adopting a more consistent approach for estimating completed values across various types of wages.

The healthcare assumptions are specific to the Medicare projections. The following healthcare assumptions were changed in the current valuation.

- Lower projected spending growth because of the anticipated effects of negotiating drug prices and other price growth constraints, as specified in the *Inflation Reduction Act of 2022*, and updated expectations with regard to the pandemic recovery.

The net impact of these changes was a decrease in the estimated future net cash flow for total Medicare. For Part A and Part B, these changes increased the present value of estimated future income and expenditures. For Part D, these changes resulted in a decrease in the present value of estimated expenditures (and income). Overall, these changes decreased the present value of the estimated future net cash flow by $283 billion.

Changes in Law

For the period beginning on January 1, 2023 to the period beginning on January 1, 2024
Most of the provisions enacted as part of Medicare legislation since the prior valuation date had little or no impact on the program. The following provisions had a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

The *Further Continuing Appropriations and Other Extensions Act, 2024* (Public Law 118-22, enacted on November 16, 2023) included provisions that affect the HI and SMI programs.

- The funding amount of $180 million that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 117-328 in last year's report, is increased to $466,795,056. This fund is intended to be available for improvements to the original fee-for-service program under Parts A and B, and funding is provided from the HI and SMI trust funds in such proportions as deemed appropriate by the Secretary of Health and Human Services.

- The 1.00 floor on the geographic index for physician work (which increases the work component for physicians who practice in locations where labor costs are lower than the national average) is extended through January 20, 2024 (from January 1, 2024).

- For clinical diagnostic laboratory tests that are not categorized as advanced diagnostic laboratory tests, changes are made to the market-based system used to update the Medicare clinical laboratory fee schedule. First, laboratories are exempted for another year from the requirement that they report private payer rates; the next data-reporting period is now the first quarter of 2025 (instead of the first quarter of 2024). Next, for the caps in place to limit reductions in fee schedule payments during the phase-in period, the timing is changed. Specifically, tests furnished during 2021–2024 (rather than 2021–2023) are to be paid at the same rates as under the 2020 fee schedule, and payments for tests provided during 2025–2027 (rather than 2024–2026) may not be reduced by more than 15 percent per year.

The *National Defense Authorization Act for Fiscal Year 2024* (Public Law 118-31, enacted on December 22, 2023) included provisions that affect the HI and SMI programs.

- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by 1 month, through October 31, 2032. (In other words, the benefit payment reductions for the month of October 2032 are changed from 0 percent to 2 percent.)

- The funding amount of $466,795,056 that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 118-22, is increased to $2,250,795,056.

The *Further Continuing Appropriations and Other Extensions Act, 2024* (Public Law 118-35, enacted on January 19, 2024) included provisions that affect the HI and SMI programs.

- The funding amount of $2,250,795,056 that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 118-31, is reduced to $2,197,795,056.

- The 1.00 floor on the geographic index for physician work is extended through March 9, 2024 (from January 20, 2024).

For Part A and Part D there was no change in the present values of estimated income and expenditures. For Part B, these changes resulted in a slight decrease in the present value of estimated expenditures (and income). Overall, these changes had no impact on the present value of the estimated future net cash flow for total Medicare.

For the period beginning on January 1, 2022 to the period beginning on January 1, 2023

Most of the provisions enacted as part of Medicare legislation since the prior valuation date had little or no impact on the program. The following provisions had a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

The *Postal Service Reform Act of 2022* (Public Law 117-108, enacted on April 6, 2022) included one provision that affects Parts B and D of the SMI program.

- A new Postal Service Health Benefits (PSHB) program, which will provide health insurance to United States Postal Service (USPS) employees, annuitants, and their eligible family members, is established, with an implementation date of January 1, 2025. The program will be structured similarly to, and established within, the Federal Employees Health Benefits (FEHB) program, with a selection of health insurance plans from which to choose. To participate in the PSHB program, most USPS annuitants and eligible family members who are newly entitled to premium-free Medicare Part A as of January 1, 2025 must be enrolled in Part B as well. Prior to this new PSHB program, enrollment in Part B was voluntary for these individuals. (Those who turn age 64 on or before January 1, 2025 are exempted from this requirement. Also exempted are individuals who are current annuitants as of January 1, 2025, those living abroad, those enrolled in Veterans Administration coverage, and those eligible for services from the Indian Health Service.) In addition, PSHB plans will be required to offer Medicare Part D coverage for these newly entitled, Part D-eligible USPS annuitants and Part D-eligible family members. This legislation is expected to increase Part B enrollment somewhat and to increase Part D enrollment more significantly (particularly in employer/union-only group waiver plans).

The *Inflation Reduction Act of 2022* (Public Law 117-169, enacted on August 16, 2022) included provisions that affect the SMI programs.

- The Secretary of HHS is required to negotiate prices for certain prescription drugs covered under Medicare. Specifically, CMS (on behalf of the Secretary) must negotiate maximum fair prices for certain high-expenditure single-source Part B or Part D drugs (brand-name drugs without generic or biosimilar equivalents). The maximum fair prices that are negotiated for the first set of drugs subject to negotiation will be in effect beginning in 2026. The number of drugs subject to negotiation is phased in, such that CMS must negotiate the prices of (i) 10 drugs covered under Part D for 2026; (ii) 15 drugs covered under Part D for 2027; (iii) 15 drugs covered under Part B or Part D for 2028; and (iv)

20 drugs covered under Part B or Part D for 2029 and each year thereafter. The selected drugs must be among the 50 drugs with the highest total expenditures over the most recent 12-month period under Part B or Part D and must have been approved or licensed, as applicable, by the Food and Drug Administration for at least 7 years (for drug products) or 11 years (for biologics). Excluded are (i) certain orphan drugs that are approved to treat only one rare disease or condition; (ii) plasma-derived products; (iii) drugs that account for less than $200 million in annual Medicare spending (in 2021 and adjusted annually for inflation); and (iv) certain small biotech drugs (for 2026, 2027, and 2028). Manufacturers of drugs selected for negotiation that fail to comply with negotiation requirements are subject to civil penalties and/or excise taxes. If certain requirements are met, negotiations for certain biologics may be delayed for up to 2 years upon request by a manufacturer of a biosimilar for which the biologic is the reference product. Funds in the amount of $3 billion in FY 2022 are provided to CMS, and are to remain available until expended, for the implementation of this provision.

- For Part B, with respect to each quarter beginning January 1, 2023, and for Part D, with respect to each 12-month applicable period beginning October 1, 2022, drug manufacturers must pay rebates to Medicare if they increase drug prices for a rebatable Part B or Part D drug at a rate that is faster than the rate of consumer inflation. In general, for both Part B and Part D, rebatable drugs include certain drugs and biologics that meet the statutory criteria and have an average cost of $100 or more per year per person, as determined by the Secretary. Manufacturers that fail to comply are subject to civil penalties. Beginning April 1, 2023, beneficiary coinsurance under Part B for a Part B rebatable drug will be adjusted downward to reflect inflation-adjusted payment amounts if the drug price increased more rapidly than the rate of inflation. Funds in FY 2022–2031 are provided to CMS for the implementation of this provision.

- For insulin furnished under Part B through durable medical equipment, the Part B deductible is waived, and cost sharing is not to exceed $35 per monthly prescription, effective July 1, 2023.

- For insulin products covered under each Part D plan and during all phases of the Part D benefit, beginning January 1, 2023, the deductible does not apply with respect to such products, and cost sharing for a 1-month supply of each covered insulin product must not exceed $35. (For plan year 2023, plans will receive retrospective subsidies equal to the difference between the plans' benefit packages, as submitted and approved under their 2023 bids, and the $35 statutory limit.) For plan years 2026 and later, when the negotiated maximum fair prices for selected drugs will be in effect, the cost sharing for each month's supply for covered insulin under Part D must be limited to the least of (i) the $35 copayment; (ii) 25 percent of the insulin's negotiated price under the plan; or (iii) 25 percent of the insulin's negotiated maximum fair price.

- For biosimilar products separately payable under Part B and administered in physician offices, hospital outpatient departments, and ambulatory surgical centers with an average sale price (ASP) of not more than the price of their associated reference biological product, the add-on payment (which is paid in addition to the biosimilar's ASP) is temporarily raised from 6 percent to 8 percent of the reference product's ASP for 5 years. The add-on payment for biosimilars that do not meet the ASP qualification will continue to be 6 percent of the reference biological product's ASP. (For existing qualifying year biosimilars for which payment was based on the ASP as of September 30, 2022, the 5-year period began on October 1, 2022. For new qualifying biosimilars for which payment based on the ASP is first made between October 1, 2022 and December 31, 2027, the 5-year period begins on the first day of the calendar quarter during which such payment is made).

- For new biosimilar products furnished under Part B on or after July 1, 2024, the payment rate during the initial period, when an ASP is unavailable, will be the lesser of (i) the biosimilar's wholesale acquisition cost plus 3 percent or (ii) 106 percent of the associated reference biological product's ASP.

- The standard Part D benefit design (for beneficiaries not eligible for cost sharing and/or premium subsidies) is restructured as follows:

(i) In 2024 and later, the 5-percent cost sharing currently required from the beneficiary during the catastrophic coverage phase (that is, after the beneficiary reaches the out-of-pocket threshold) is eliminated, thereby capping previously unlimited out-of-pocket costs for the beneficiary at the out-of-pocket threshold level. The allowed costs in the catastrophic coverage phase will be borne by the drug plan and by Medicare, at 20 percent and 80 percent, respectively, in 2024 (as opposed to the current catastrophic cost distribution of 5 percent from the beneficiary, 15 percent from the drug plan, and 80 percent from Medicare).

(ii) Beginning in 2025, enrollees will have a $2,000 limit on their out-of-pocket costs for covered Part D drugs; that is, neither the initial coverage limit nor the period currently referred to as the coverage gap (the phase between the initial coverage limit and the out-of-pocket threshold)[5] will continue to exist, and the out-of-pocket cap for entering the catastrophic coverage phase (during which there will no longer be beneficiary cost sharing, as described above) will be reduced to $2,000. For 2026 and later, this $2,000 limit will be increased by the annual percentage increase used for other Part D benefit parameters.

(iii) Also beginning in 2025, for the entire period starting after the deductible is met and ending when the catastrophic coverage phase begins, beneficiary cost sharing will be 25 percent for drugs that are neither insulins nor specified vaccines. The remaining allowed costs (after the 25-percent beneficiary cost sharing) will be covered, in general, as follows: (i) for applicable drugs, by a 10-percent discount paid by the drug manufacturer[6] and a 65-percent benefit from the beneficiary's Part D plan, and (ii) for non-applicable drugs, by a 75-percent benefit from the beneficiary's Part D plan. (In contrast, through 2024, the Part D plan covers 75 percent of the remaining allowed costs until the beneficiary enters the coverage gap; then, during the coverage gap, the remaining allowed costs are covered as follows: (i) for applicable drugs, by a 70-percent discount paid by the drug manufacturer and a 5-percent benefit from the Part D plan, and (ii) for non-applicable drugs, by a 75-percent benefit from the Part D plan.) Applicable drugs are generally covered brand-name Part D drugs and biologics, including biosimilars; *non-applicable* drugs are generally covered non-brand-name—that is, generic—Part D drugs.

The 10-percent discount paid by the manufacturer will not count toward the out-of-pocket threshold. (In contrast, the dollar value of the 70-percent manufacturer discount for applicable drugs in 2024 is included in a beneficiary's progression toward meeting the out-of-pocket threshold, even though the beneficiary does not pay it. However, certain third-party payments will count as the beneficiary's own out-of-pocket spending, including amounts reimbursed by insurance (which is not the case through 2024). The low-income subsidies currently provided under Part D and from State Pharmacy Assistance programs will continue to count toward the out-of-pocket amount.

(iv) In addition, and also beginning in 2025, the cost coverage distribution during the catastrophic coverage phase will change (from the distribution in 2024, which was previously described). Specifically, (i) Medicare's share will decrease from 80 percent (for all covered prescription drugs) to 20 percent for applicable drugs and to 40 percent for non-applicable drugs; (ii) drug manufacturers[7] will be required, in general, to provide a 20-percent discount on applicable drugs (whereas no manufacturer discount is required in the catastrophic phrase prior to 2025); and (iii) the 20-percent share borne by Part D plans will increase to 60 percent.

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5 Originally, when the Part D program began, the beneficiary had to pay the full cost of prescription drugs while in this phase (hence the term *coverage gap*). However, legislation enacted in 2010 and 2018 phased down the out-of-pocket cost-sharing percentage for beneficiaries in the coverage gap over the period 2010–2020 such that, beginning in 2020, the coverage gap was fully closed, with the beneficiary responsible for 25 percent of all prescription drug costs (that is, the same percentage that is paid by the beneficiary during the initial coverage phase, when the beneficiary has met the deductible but has not yet reached the initial coverage limit).

6 For most applicable drugs, the 10-percent responsibility will be paid by the manufacturer, but for selected drugs there will be a government subsidy for this amount rather than a manufacturer discount. Additionally, for low-income beneficiaries and for small biotech drugs, this amount will be phased in gradually.

7 For most applicable drugs, the 20-percent responsibility will be paid by the manufacturer, but for selected drugs there will be a government subsidy for this amount rather than a manufacturer discount. Additionally, for low-income beneficiaries and for small biotech drugs, this amount will be phased in gradually.

(v) Starting in 2025, all enrollees will have the option from their Part D plans to pay out-of-pocket costs spread out in capped, monthly amounts over the plan year (instead of paying as the costs are incurred).

- For each of plan years 2024–2029, the base beneficiary premium increase is to be limited to no more than 6 percent from the prior year. Premiums for some Part D plans may increase by more than 6 percent per year during this period, but the national average is constrained. For plan years 2030 and later, CMS may determine a new beneficiary premium percentage, based on the 2029 constrained premiums, to replace the current value of 25.5 percent. This new percentage may not be less than 20 percent.

- Effective January 1, 2024, Part D low-income subsidies are expanded. Specifically, (i) the income limit for individuals to qualify for the full subsidy will increase from 135 percent to 150 percent of the Federal poverty level (FPL) (whereas, previously, individuals with incomes between 135 percent and 150 percent of the FPL had been eligible for only a partial subsidy); and (ii) the limit on resources required for the full subsidy will also increase (from the limit that had been in place for the partial subsidy, which will no longer exist).

- Effective January 1, 2023, Part D plans may not apply a deductible, coinsurance, or other enrollee cost-sharing amount for Part D-covered adult vaccines recommended by the Advisory Committee on Immunization Practices, such as the shingles (herpes zoster) vaccine. (By comparison, preventive vaccines required by statute to be covered under Part B already have no enrollee cost sharing, except for those vaccines used to treat an injury or exposure to a disease.)

The *Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023* (Public Law 117-180, enacted on September 30, 2022) included provisions that affect the HI and SMI programs.

- Medicare inpatient hospital add-on payments for certain low volume hospitals (those with fewer than 3,800 total discharges annually and located 15 road miles or more from the nearest like hospital) are extended through December 16, 2022 (from September 30, 2022). The sliding scale used to determine the add-on percentages is also extended.

- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after September 30, 2022, is extended through December 16, 2022. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals, in light of what had been the impending expiration of the MDH program, may decline this reclassification and reinstate their MDH status.)

The *Further Continuing Appropriations and Extensions Act, 2023* (Public Law 117-229, enacted on December 16, 2022) included provisions that affect the HI and SMI programs.

- Medicare inpatient hospital add-on payments for certain low-volume hospitals (those with fewer than 3,800 total discharges annually and located 15 road miles or more from the nearest like hospital) are extended through December 23, 2022 (from December 16, 2022). The sliding scale used to determine the add-on percentages is also extended. (See Public Law 117-180.)

- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after December 16, 2022 (as described under Public Law 117-180), is extended through December 23, 2022. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals, in light of what had been the impending expiration of the MDH program, may decline this reclassification and reinstate their MDH status.)

The *Consolidated Appropriations Act, 2023* (Public Law 117-328, enacted on December 29, 2022) included provisions that affect the HI and SMI programs.

- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by 1 year, through FY 2032 (which, for sequestration purposes, covers April 1, 2032 through March 31, 2033). The benefit payment reductions for this newly added 12-month period are set at 2 percent for the first 6 months and 0 percent for the final 6 months. In addition, the benefit payment reductions for FY 2030 and 2031 (covering April 1, 2030 through March 31, 2032) are changed back to a uniform 2 percent for the entire period (from 2.25 percent, 3 percent, 4 percent, and 0 percent for the first, second, third, and final 6-month periods, respectively).

- The 1-percent add-on payment is extended for 1 year (through December 31, 2023) for those home health agencies that serve beneficiaries in rural areas and that are classified in the low-population-density tier. (This tier is one of three used for determining rural add-on adjustments. The tiers are based on Medicare home health utilization and population density.)

- Medicare inpatient hospital add-on payments for certain low-volume hospitals (those with fewer than 3,800 total discharges annually and located 15 road miles or more from the nearest like hospital) are extended through September 30, 2024 (from December 23, 2022). The sliding scale used to determine the add-on percentages is also extended. (See Public Law 117-229.)

- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after December 23, 2022 (as described under Public Law 117-229), is extended through September 30, 2024. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals, in light of what had been the impending expiration of the MDH program, may decline this reclassification and reinstate their MDH status.)

- Beginning in 2026, an additional 200 Medicare graduate medical education (GME) residency positions are provided for, half of which are to be reserved for psychiatry and psychiatry-subspecialty residencies.

- In the formula for determining payment rates under the physician fee schedule, the updates to the conversion factor are changed to be −0.5 percent, −1.2 percent, and −1.2 percent in 2023, 2024, and 2025, respectively (replacing −2.9 percent for 2023 and 0 percent for 2024 and 2025).

- Certain ground ambulance add-on payments that had been extended through December 31, 2022 under previous legislation are now extended through December 31, 2024. These add-on payments include a 3-percent bonus for services originating in rural areas, a 2 percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.

- For physicians participating in advanced alternative payment models, a 1-year extension of incentive payment availability is provided, but the payments will be at 3.5 percent. (In recent years, physicians could earn a 5-percent incentive payment, but only through the end of performance year 2022, which is payment year 2024.) In addition, the current freeze on participation thresholds that must be met to qualify for the incentive payments is extended for an additional year (that is, for payment year 2025, which is performance year 2023).

- For the market-based system used to update the Medicare clinical laboratory fee schedule, laboratories are exempted for another year from the requirement that they report private payer rates. The next data-reporting period is now the first quarter of 2024 (instead of the first quarter of 2023). Also, during the phase-in period for this system, the caps in place to limit reductions in fee schedule payments from year to year are changed to 0 percent for 2022–2023 and 15 percent for 2024–2026 (as opposed to the previous statutory parameters of 0 percent for 2021–2022 and 15 percent for 2023–2025). That is, tests furnished under the fee schedule during 2022–2023 are to be paid at the same rates as under the 2021 fee schedule, and payments may not be reduced by more than 15 percent for services provided during 2024–2026.

- Marriage and family therapists and mental health counselors are allowed to receive payment from Part B for providing covered mental health services to beneficiaries, beginning January 1, 2024. (The qualifications for these professions are defined in the provision.)

- Effective January 1, 2024, Medicare's partial hospitalization benefit (which provides a structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care) is revised to provide coverage of intensive outpatient services.

- The use of blended payment rates for durable medical equipment in certain non-competitive bid areas, as provided for during the public health emergency by Public Law 116-136, is extended through December 31, 2023.

- Compression garments furnished on or after January 1, 2024 for the treatment of lymphedema are covered under Part B as durable medical equipment.

The net impact of all legislative changes was a small increase in the estimated future net cash flow for total Medicare. For Part A the present value of estimated expenditures is slightly lower. The present values of estimated income and expenditures are much lower for Part B and Part D. Overall, these changes increased the present value of the estimated future net cash flow by $1 billion.

NOTE 16:

BUDGET AND ACCRUAL RECONCILIATION

(DOLLARS IN MILLIONS)

As of September 30, 2024

	Intragovernmental	Other than Intragovernmental	Total
NET COST OF OPERATIONS (SNC)	**$1,407**	**$1,519,667**	**$1,521,074**
Components of net cost not part of the budgetary outlays			
Property, plant, and equipment depreciation expense		$(748)	$(748)
Applied overhead/cost capitalization offset		192	192
		$(556)	$(556)
Increase/(Decrease) in Assets:			
Accounts receivable, net	$20	$(1,118)	$(1,098)
Securities and investments	554		554
Advances and Prepayments	7	(45,118)	(45,111)
Other assets		(92)	(92)
	$581	$(46,328)	$(45,747)
(Increase)/Decrease in Liabilities:			
Accounts Payable	$223	$62	$285
Benefits due and payable		17,946	17,946
Federal employee and veteran benefits payable		(9)	(9)
Debt associated with loans	(69)		(69)
Accrued Grant Liabilities		(4)	(4)
Contingencies and Commitments		13,232	13,232
Other liabilities	(2)	(3,668)	(3,670)
	$152	$27,559	$27,711
Other Financing Sources:			
Imputed Cost	$(117)		$(117)
Transfers out (in) without reimbursement	3,788		3,788
Total Components of net operating cost not part of the budgetary outlays	$4,405	$(19,325)	$(14,921)
Miscellaneous Items			
Custodial/Non-exchange revenue	$(11,654)	$844	$(10,810)
Non-entity activity	87		87
Appropriated receipts for Trust/Special Funds		11,201	11,201
Reconciling items:			
Debt associated with loans	69		69
Custodial/Non-exchange revenue	11,654	(844)	10,810
Investment interest receivable	(554)		(554)
Other reconciling items	(504)	(539)	(1,043)
Total Other Reconciling Items	$(902)	$10,662	$9,760
TOTAL NET OUTLAYS	**$4,909**	**$1,511,004**	**$1,515,913**

NOTE 16:

BUDGET AND ACCRUAL RECONCILIATION *(CONTINUED)*

(DOLLARS IN MILLIONS)

As of September 30, 2023

	Intragovernmental	Other than Intragovernmental	Total
NET COST OF OPERATIONS (SNC)	**$1,293**	**$1,498,336**	**$1,499,629**
Components of net cost not part of the budgetary outlays			
Property, plant, and equipment depreciation expense		**$(978)**	**$(978)**
Applied overhead/cost capitalization offset		**663**	**663**
		$(315)	**$(315)**
Increase/(Decrease) in Assets:			
Accounts receivable, net	**$99**	**$(1,169)**	**$(1,070)**
Securities and investments	**128**		**128**
Advances and Prepayments		**6,112**	**6,112**
Other assets		**22**	**22**
	$227	**$4,965**	**$5,192**
(Increase)/Decrease in Liabilities:			
Accounts Payable	**$(208)**	**$(150)**	**$(358)**
Benefits due and payable		**(18,367)**	**(18,367)**
Federal employee and veteran benefits payable		**(3)**	**(3)**
Debt associated with loans	**4,984**		**4,984**
Accrued Grant Liabilities		**(2)**	**(2)**
Contingencies and Commitments		**(11,605)**	**(11,605)**
Other liabilities	**(1)**	**(2,093)**	**(2,094)**
	$4,775	**$(32,220)**	**$(27,445)**
Other Financing Sources:			
Imputed Cost	**$(75)**		**$(75)**
Transfers out (in) without reimbursement	**3,457**		**3,457**
Total Components of net operating cost not part of the budgetary outlays	**$8,384**	**$(27,570)**	**$(19,186)**
Miscellaneous Items			
Custodial/Non-exchange revenue	**$(10,546)**	**$1,218**	**$(9,328)**
Non-entity activity	**3**		**3**
Appropriated receipts for Trust/Special Funds		**9,418**	**9,418**
Reconciling items:			
Debt associated with loans	**(4,984)**		**(4,984)**
Custodial/Non-exchange revenue	**10,546**	**(1,218)**	**9,328**
Investment interest receivable	**(128)**		**(128)**
Other reconciling items	**(1,341)**	**850**	**(491)**
Total Other Reconciling Items	**$(6,450)**	**$10,268**	**$3,818**
TOTAL NET OUTLAYS	**$3,227**	**$1,481,034**	**$1,484,261**

REQUIRED SUPPLEMENTARY INFORMATION

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for almost six decades. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) trust fund and Supplementary Medical Insurance (SMI, or Parts B and D) trust fund is included in this financial report.

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for almost six decades. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) trust fund and Supplementary Medical Insurance (SMI, or Parts B and D) trust fund is included in this financial report.

The Required Supplementary Information (RSI) contained in this section is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are descriptions of the long-term sustainability and financial condition of the Medicare program and a discussion of trends revealed in the data.

RSI material is generally drawn from the *2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (the Trustees Report), which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

With two exceptions, the projections are based on the current law provisions[1] of the *Social Security Act*. The first exception is that the Part A projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the Trustees Report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted.

The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November of 2020, is not reflected in the Part D projections. This final rule imposed a January 1, 2022, effective date, however, implementation was initially delayed until January 1, 2023. Since then, enacted legislation has three times imposed a moratorium on implementation, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The Medicare projections have been significantly affected by the enactment of the *Inflation Reduction Act of 2022*. This legislation has wide-ranging provisions, including those that restrain price growth and negotiate drug prices for certain Part B and Part D drugs and that redesign the Part D benefit structure to decrease beneficiary out-of-pocket costs. The law takes several years to implement, resulting in very different effects by year. The Part D benefit enhancements are implemented by 2025, for example, before the negotiation provisions that are effective in 2026 can have any spending reduction impact. The total effect of the *Inflation Reduction Act* is to reduce government expenditures for Part B, to increase expenditures for Part D from 2027 through 2030, and to decrease Part D expenditures beginning in 2031. Part B savings are due to the substantial lowering of payments, relative to current reimbursement, as a result of negotiated prices. Part D ultimately generates cost savings at the end of the 10-year period, but many of the gains from negotiated prices and lower trends are initially more than offset by increased benefits and decreased manufacturer rebates.

The Board of Trustees assumes that the *Inflation Reduction Act* will affect the ultimate long-range growth rates for Part B and Part D drug spending differently. For Part B drugs, since the Trustees do not anticipate that the market pricing dynamics will be much different from those prior to the implementation of the *Inflation Reduction Act*, they continue to assume that per capita spending growth rates will be similar to those for overall per capita national health expenditures. On the other hand, for Part D drugs, the Trustees assume that per capita spending will grow 0.2 percentage point more slowly than per capita national health expenditures, since the inflation provisions of the *Inflation Reduction Act* are likely to result in price growth that is lower than overall health prices and closer to the Consumer Price Index (CPI).

Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic. Spending was directly affected by the coverage of testing and treatment of the disease. In addition, several regulatory policies and legislative provisions were enacted during the public health emergency that increased spending, and the use of

telehealth was greatly expanded. More than offsetting these additional costs during the pandemic, spending for non-COVID care declined significantly.

Now that the public health emergency has ended and Medicare FFS per capita spending has stabilized, the Trustees place a greater reliance on recent experience when developing the cost projections. However, they continue to make three pandemic-related adjustments to the projections. The first is to account for the morbidity improvement in the surviving population, which is expected to continue to affect spending levels through 2029. The second adjustment accounts for the ending of the waiver regarding the 3-day inpatient stay requirement to receive skilled nursing facility services. The per capita spending projections typically include factors for price updates and changes in the utilization and mix of services. As a result of the *Inflation Reduction Act* of this waiver, the Trustees have increased their inpatient spending growth factor by 1.9 percentage points and decreased the skilled nursing facility spending growth factor by 7.5 percentage points in 2024. Finally, the third adjustment is to account for home health spending that was still, in 2023, significantly lower than estimated prior to the pandemic. As a result of the recent home health staffing shortages, the Trustees continue to consider the spending level for this service to be suppressed. Thus, they have increased their home health spending growth factor by 2.9 percentage points in each of the next 3 years (2024–2026).

Certain features of current law may result in some challenges for the Medicare program. This concern is more immediate for physician services, for which a negative payment rate update is projected for 2025 and updates are projected to be below the rate of inflation in all future years. Furthermore, additional payments totaling $500 million per year and annual bonuses are scheduled to expire in 2025 and 2026, respectively. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business total factor productivity[2] although these health providers have historically achieved lower levels of productivity growth. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws:

- *Budget Control Act of 2011* (Public Law 112-25, enacted on August 2, 2011), as amended by the American Taxpayer Relief Act of 2012 (Public Law 112-240, enacted on January 2, 2013);
- *Continuing Appropriations Resolution, 2014* (Public Law 113-67, enacted on December 26, 2013);
- Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014;
- *Protecting Access to Medicare Act of 2014* (Public Law 113-93, enacted on April 1, 2014);
- *Bipartisan Budget Act of 2015* (Public Law 114-74, enacted on November 2, 2015);
- *Bipartisan Budget Act of 2018* (Public Law 115-123, enacted on February 9, 2018);
- *Bipartisan Budget Act of 2019* (Public Law 116-37, enacted on August 2, 2019);
- *Coronavirus Aid, Relief, and Economic Security Act* (Public Law 116-136, enacted on March 27, 2020);
- *Consolidated Appropriations Act, 2021* (Public Law 116-260, enacted on December 27, 2020);
- *Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes* (Public Law 117-7, enacted on April 14, 2021);
- *Infrastructure Investment and Jobs Act* (Public Law 117-58, enacted on November 15, 2021);
- Protecting *Medicare and American Farmers from Sequester Cuts Act* (Public Law 117-71, enacted on December 10, 2021);
- *Consolidated Appropriations Act, 2023* (Public Law 117-328, enacted on December 29, 2022); and
- *National Defense Authorization Act for Fiscal Year 2024* (Public Law 118-31, enacted on December 22, 2023).

The sequestration reduces benefit payments by the following percentages: 2 percent from April 1, 2013 through April 30, 2020; 1 percent from April 1, 2022 through June 30, 2022; and 2 percent from July 1, 2022 through October 31, 2032. Because of sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013 through October 31, 2032, excluding May 1, 2020 through March 31, 2022 when it was suspended.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from current-law provisions that lower increases in Medicare payment rates to most categories of healthcare providers, but such adjustments would probably not be viable indefinitely without fundamental change in the current delivery system. It is conceivable that providers could improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent challenges in projecting healthcare cost growth over time. The expenditure projections reflect the cost-reduction provisions required under current law. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes that (i) there would be a transition from current-law[3] payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for healthcare productivity; (ii) the average physician payment updates would transition from current law[4] to payment updates that reflect the Medicare Economic Index; and (iii) the bonuses for qualified physicians in advanced alternative payment models (advanced APMs), which are expected to end after 2025, and the $500-million payments for physicians in the merit-based incentive payment system (MIPS), which are set to expire after 2024, would both continue indefinitely. The difference between the illustrative alternative and the current-law projections continues to demonstrate that the long-range costs could be substantially higher than shown throughout much of the Trustees Report if the cost-reduction measures prove problematic and new legislation scales them back.

Additional information on the current-law and illustrative alternative projections is provided in Note 14 in these financial statements, in section V.C of this year's Trustees Report, and in a memorandum prepared by the CMS Office of the Actuary.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410 786-6386) or can be downloaded from the CMS website.[5]

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1 Due to the timing and the limited effect on the financial outlook of the trust funds, the projections do not reflect the impact of the Medicare provisions in the *Consolidated Appropriations Act, 2024* (Public Law 118-42), which was enacted on March 9, 2024.

2 For convenience the term economy-wide private nonfarm business total factor productivity will henceforth be referred to as economy-wide productivity. Beginning with the November 18, 2021 release of the productivity data, the Bureau of Labor Statistics replaced the term multifactor productivity with the term total factor productivity, a change in name only as the underlying methods and data were unchanged.

3 Medicare's annual payment rate updates for most categories of provider services would be reduced below the increase in providers' input prices by the growth of economy-wide productivity (1.0 percent over the long range).

4 The law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter for physicians in advanced alternative payment models (advanced APMs) or the merit-based incentive payment system (MIPS), respectively. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.05 percent per year in the long range.

5 The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation and is likewise not subject to audit by independent auditors.

ACTUARIAL PROJECTIONS

Long-Range Medicare Cost Growth Assumptions

Beginning with the 2013 report, the Trustees used the statutory price updates and the volume and intensity assumptions from the "factors contributing to growth" model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period.[6] The Trustees assume that the productivity reductions to Medicare payment rate updates will reduce volume and intensity growth by 0.1 percent below the factors model projection.[7]

For some time, the Trustees have assumed that it is reasonable to expect over the long range that the drivers of health spending will be similar for the overall health sector and for the Medicare program. This view was affirmed by the 2010–2011 Technical Review Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of healthcare services for the total health sector and for Medicare. Therefore, the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions.

Medicare payment rates for most non-physician provider categories are updated annually by the increase in providers' input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the healthcare goods and services. These updates are then reduced by the 10-year moving average increase in economy-wide productivity, which the Trustees assume will be 1.0 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for five categories of healthcare provider services:

(i) *All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.*
HI services are inpatient hospital, skilled nursing facility, home health agency, and hospice. The primary Part B services affected are outpatient hospital, home health agency, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year cost growth rates for these provider services start at 3.7 percent in 2048, or GDP plus 0.0 percent, declining gradually to 3.4 percent in 2098, or GDP minus 0.3 percent.

(ii) *Physician services*
Payment rate updates are 0.75 percent per year for those qualified physicians assumed to be participating in advanced APMs and 0.25 percent for those assumed to be participating in MIPS. The year-by-year cost growth rates for physician payments are assumed to decline from 3.3 percent in 2048, or GDP minus 0.4 percent, to 2.8 percent in 2098, or GDP minus 0.9 percent.

(iii) *Certain SMI Part B services that are updated annually by the CPI increase less the increase in economy-wide productivity.*
Such services include durable medical equipment that is not subject to competitive bidding,[8] care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the year-by-year cost growth rates for these services to decline from 2.9 percent in 2048, or GDP minus 0.8 percent, to 2.6 percent in 2098, or GDP minus 1.1 percent.

6 This assumed increase in the average expenditures per beneficiary excludes the impacts of the aging of the population, changes in the sex composition of the Medicare population, and changes in the distribution of the Medicare population on the basis of proximity to death, as the Trustees estimated these factors separately. For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate.

7 The Trustees' methodology is consistent with Finding III-2 and Recommendation III-3 of the 2010–2011 Medicare Technical Review Panel (final report available here) and with Finding 3-2 of the 2016–2017 Medicare Technical Review Panel (final report available here).

8 The portion of durable medical equipment that is subject to competitive bidding is included with all other Medicare services since the price is determined by a competitive bidding process. For more information on the bidding process, see section IV.B of the 2024 Trustees Report.

(iv) *The remaining Part B services, which consist mostly of physician-administered drugs, laboratory tests, and small facility services.*
The Trustees assume that per beneficiary outlays for these other Part B services, which constitute about 35 percent of total Part B expenditures in 2033, grow at the same rate as the overall health sector as determined from the factors model. The services are assumed to grow similarly because their payments are established through market processes. For physician-administered Part B drugs, the key inflation provisions in the *Inflation Reduction Act* are not anticipated to affect such payments over the long range. The corresponding year-by-year cost growth rates decline from 4.4 percent in 2048, or GDP plus 0.7 percent, to 4.1 percent by 2098, or GDP plus 0.4 percent.

(v) *Prescription drugs provided through Part D.*
Medicare payments to Part D plans are based on a competitive-bidding process, and prior to the *Inflation Reduction Act* these payments were assumed to grow at the same rate as the overall health sector as determined from the factors model. While the negotiation provisions of the *Inflation Reduction Act* are not anticipated to affect the long-range growth rates for Part D drugs, the inflation provisions would likely lower these trends relative to previous expectations. Specifically, the *Inflation Reduction Act* requires the change in prices (before rebate adjustments) to be limited to the rate of growth in the CPI. Analysis of Part D pricing trends over recent years has consistently shown price growth in excess of the CPI, with a portion of these trends offset by increasing rebate percentages, and it was assumed, prior to the *Inflation Reduction Act*, that such trends would continue over the long range. The inflation provisions in the *Inflation Reduction Act* would likely lower these price trends, though it is expected that they would outpace the CPI due to certain manufacturer adaptations to the new law that may mitigate some of the pricing constraints, including new approaches regarding the development and release of new drugs. As a result, they are assumed to grow over the long range slightly more slowly than would be the case if they were determined strictly through market processes. The corresponding year-by-year cost growth rates decline from 4.2 percent in 2048, or GDP plus 0.5 percent, to 3.9 percent by 2098, or GDP plus 0.2 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. Beginning with the 2020 Trustees Report, these impacts reflect the changing distribution of Medicare enrollment by age, sex, and the beneficiary's proximity to death, which is referred to as a time-to-death (TTD) adjustment. The TTD adjustment reflects the fact that the closer an individual is to death, the higher his or her healthcare spending is. Thus, as mortality rates improve and a smaller portion of the Medicare population is likely to die at any given age, the effect of individuals getting older and spending more on healthcare is offset somewhat.[9] This is particularly the case for Part A services—such as inpatient hospital, skilled nursing facility, and home health agency services—for which the distribution of spending is more concentrated in the period right before death. For Part B services and Part D, the incorporation of the TTD adjustment has a smaller effect.

After combining the rates of growth from the four long-range assumptions, the weighted average cost growth rate for Part B is 3.9 percent in 2048, or GDP plus 0.2 percent, declining to 3.6 percent by 2098, or GDP minus 0.1 percent. When Parts A, B, and D are combined, the weighted average cost growth rate for Medicare is 3.9 percent, or GDP plus 0.2 percent in 2048, declining to 3.6 percent, or GDP minus 0.1 percent by 2098.

9 More information on the TTD adjustment is available on the CMS website.

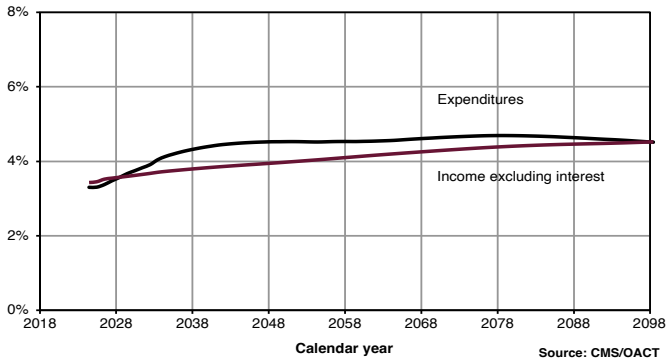
HI Cash Flow as a Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. It is difficult to meaningfully compare dollar values for different periods without some type of relative scale; therefore, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as taxable payroll).

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI cost rates are lower than those from last year for all years because of (i) a policy change to exclude medical education expenses associated with Medicare Advantage (MA) enrollees from the fee-for-service per capita costs used in the development of MA spending, as described in section IV.C of the Trustees Report, and (ii) lower spending for inpatient hospital and home health agency services due to a greater reliance on recent experience, as described in section I of the Trustees Report.

CHART 1

HI Expenditures and Income Excluding Interest as a Percentage of Taxable Payroll // 2024 – 2098



Since the standard HI payroll tax rates are not scheduled to change in the future under current law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. In addition, starting in 2013, high-income workers pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns). Because income thresholds for determining eligibility for the additional HI tax are not indexed, over time an increasing proportion of workers will become subject to a higher HI tax rate, and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation; this outcome will occur because the income thresholds determining taxable benefits are not indexed for price inflation and because the income tax brackets are indexed to the chained CPI (C CPI-U), which increases at a slower rate than average wages. After the 10th year of the projection period, income tax brackets are assumed to rise with average wages, rather than with the C-CPI-U as specified in the Internal Revenue Code. As a result of this assumption, income from the taxation of Social Security benefits increases at a similar rate as, rather than significantly faster than, taxable payroll.[10] Thus, as chart 1 shows, the income rate is expected to gradually increase over current levels.

After remaining steady in 2023 through 2025, as indicated in chart 1, the cost rate is projected to rise in 2026 and beyond primarily due to an acceleration of health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.5 percent through 2033 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 4.9 percent in 2049 and 6.8 percent in 2098.

10 See section V.C7 of the *2024 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds* for more detailed information on the projection of income from taxation of Social Security benefits.

HI and SMI Cash Flow as a Percentage of GDP

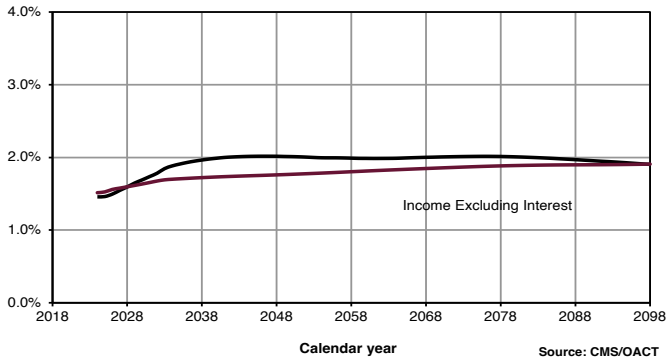
Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

HI

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2023, the expenditures were $403.1 billion, which was 1.5 percent of GDP. As chart 2 illustrates, this percentage is projected to increase steadily until about 2046 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 2.9 percent in 2098.

CHART 2

HI Expenditures and Income Excluding Interest as a Percentage of GDP // 2024 – 2098



SMI

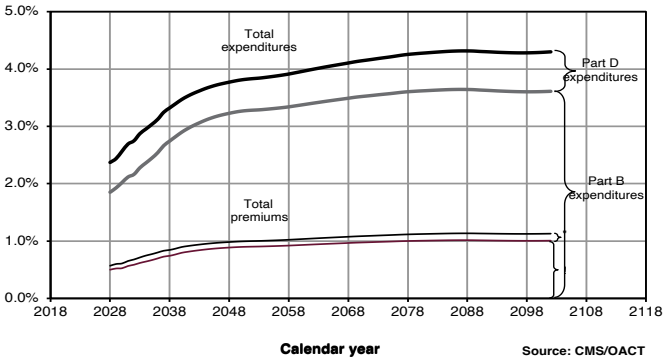
Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and government contributions, which are transfers from the general fund of the Treasury.

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption described previously.

In 2023, SMI expenditures were $633.9 billion, or about 2.3 percent of GDP. Under current law, they would grow to about 3.8 percent of GDP within 25 years and to 4.3 percent by the end of the projection period, as demonstrated in chart 3. Under the illustrative alternative, total SMI expenditures in 2098 would be 5.5 percent of GDP.

CHART 3

SMI Expenditures and Premiums as a Percentage of GDP // 2024 – 2098



To match the faster growth rates for SMI expenditures, government contributions and beneficiary premiums would increase more rapidly than GDP over time but at a slower rate compared to the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2023 by about 4.2 percent annually. The associated beneficiary premiums—and general fund financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. State payments have increased faster than GDP for most years since 2015 and are projected to do so for most of the long-range period; for most of the short-range period, however, they are projected to increase more slowly than GDP.

Worker-to-Beneficiary Ratio

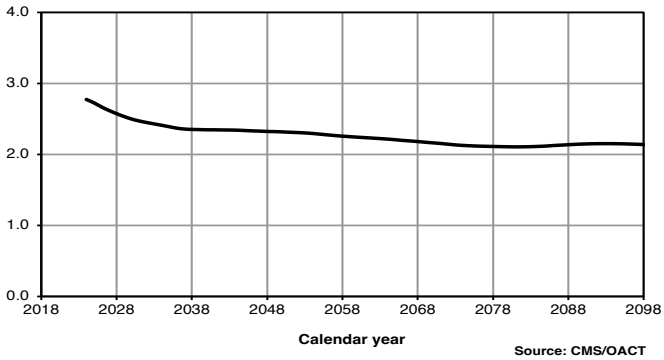
HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation.

In 2023, every beneficiary had about 2.8 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.5 workers for each beneficiary, as indicated in chart 4. The projected ratio continues to decline until there are only 2.1 workers per beneficiary by 2098.

CHART 4

Number of Covered Workers per HI Beneficiary // 2024 – 2098



Sensitivity Analysis

To prepare projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under current law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[11] The assumptions varied are the healthcare cost factors, real-wage growth, CPI, real interest rate, fertility rate, and net immigration.[12]

For this analysis, the intermediate economic and demographic assumptions in the 2024 Trustees Report are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2024, and are based on estimates of income and expenditures during the 75-year projection period.

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values decrease through the first 15 to 20 years of the projection period, at which point they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process for computing present values, which is used to help interpret the net cash flow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

11 Sensitivity analysis is not done for Parts B or D of the SMI trust fund because of the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cash flow, since the change would affect income and expenditures equally.

12 The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.

HealthCare Cost Factors

Table 1 shows the net present value of cash flow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered healthcare services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as assumed for the intermediate projections.

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $9,985 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $15,988 billion.

Chart 5 shows projections of the present value of the estimated net cash flow under the three alternative annual growth rate assumptions presented in Table 1.

TABLE 1

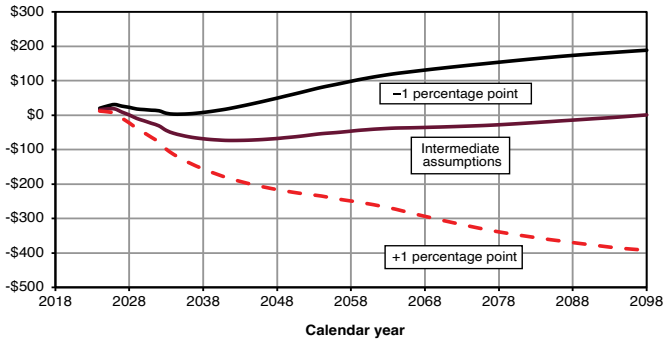
Present Value of Estimated HI Income Less Expenditures under Various Healthcare Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	–1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$7,367	–$2,618	–$18,606

This assumption has a dramatic impact on projected HI cash flow. The present value of the net cash flow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus because of the improved financial outlook for the HI trust fund as a result of the cost-reduction provisions required under current law. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As chart 5 indicates, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for healthcare service costs.

CHART 5

Present Value of HI Net Cash Flow with Various HealthCare Cost Factors // 2024 – 2098 (In billions)



Real-Wage Growth

Table 2 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage growth assumptions: 0.53, 1.14, and 1.74 percentage points.[13] In each case, the assumed ultimate annual increase in the CPI is 2.4 percent.

TABLE 2

Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Growth Assumptions

Ultimate percentage increase in real-wage growth	0.53	1.14	1.74
Income minus expenditures (in billions)	–$5,262	–$2,618	$1,364

As indicated in table 2, for a 0.6 percentage point increase in the ultimate real-wage growth assumption, the deficit—expressed in present-value dollars—decreases by approximately $3,983 billion. Conversely, for a 0.6 percentage point decrease in the ultimate real-wage growth assumption, the deficit increases by about $2,600 billion.

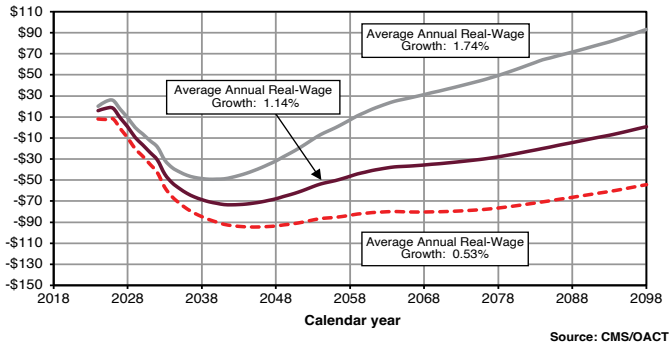
13 Real-wage growth is the annual percentage change in average covered wages adjusted for the average percentage change in the CPI.

Chart 6 shows projections of the present value of the estimated net cash flow under the three alternative real-wage growth assumptions presented in Table 2.

When expressed in present-value dollars, faster real-wage growth results in smaller HI cash flow deficits, as demonstrated in chart 6. Higher real-wage growth immediately increases both HI expenditures for healthcare and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all healthcare costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI trust fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI trust fund under the cost-reduction provisions depends critically on the sustainability of the lower Medicare price updates for hospitals and other HI providers.

CHART 6

Present Value of HI Net Cash Flow with Various Real-Wage Growth Assumptions // 2024 – 2098 (In billions)



Source: CMS/OACT

Consumer Price Index

Table 3 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.0, 2.4, and 1.8 percent. In each case, the ultimate real wage growth assumption is 1.14 percent.

TABLE 3

Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in CPI	3.00	2.40	1.80
Income minus expenditures (in billions)	–$1,346	–$2,618	–$4,408

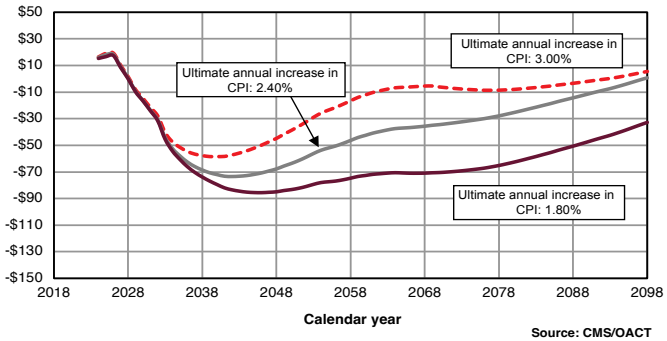
Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.0 percent, the deficit decreases by about $1,273 billion. On the other hand, if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $1,790 billion.

Chart 7 shows projections of the present value of net cash flow under the three alternative CPI rate-of-increase assumptions presented in Table 3.

This assumption has a small impact when the cash flow is expressed as present values, as Chart 7 indicates. The projected present values of HI cash flow are relatively insensitive to the assumed level of general price inflation because price inflation has about the same proportionate effect on income as it does on costs. In present value terms, a smaller deficit is the result under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios; under high-inflation conditions, however, the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice versa.

CHART 7

Present Value of HI Net Cash Flow with Various CPI-Increase Assumptions // 2024 – 2098 (In billions)



Source: CMS/OACT

Real-Interest Rate

Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real interest assumptions: 1.8, 2.3, and 2.8 percent. In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, which results in ultimate annual yields of 4.2, 4.8, and 5.3 percent, respectively.

As demonstrated in table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $70 billion.

TABLE 4

Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumption

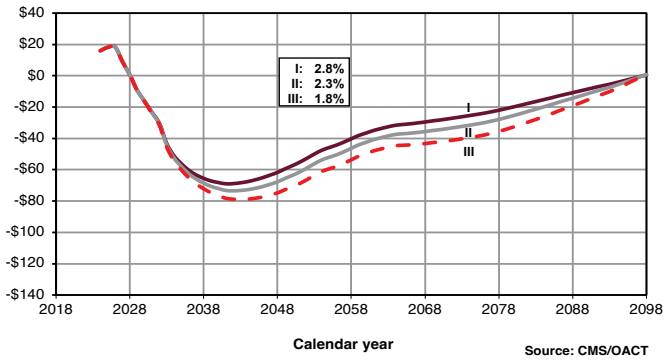
Ultimate real-interest rate	1.8 percent	2.3 percent	2.8 percent
Income minus expenditures (in billions)	–$3,003	–$2,618	–$2,310

Chart 8 illustrates projections of the present value of the estimated net cash flow under the three alternative real-interest assumptions presented in Table 4.

The projected HI cash flow when expressed in present values is fairly sensitive to the interest assumption, as shown in chart 8. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2036. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

CHART 8

Present Value of HI Net Cash Flow with Various Real-Interest Rate Assumptions // 2024 – 2098 (In billions)



Source: CMS/OACT

Fertility Rate

Table 5 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.6, 1.9, and 2.1 children per woman.

As table 5 demonstrates, for every increase of 0.1 percentage point in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $425 billion.

TABLE 5

Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.6	1.9	2.1
Income minus expenditures (in billions)	–$3,861	–$2,618	–$1,755

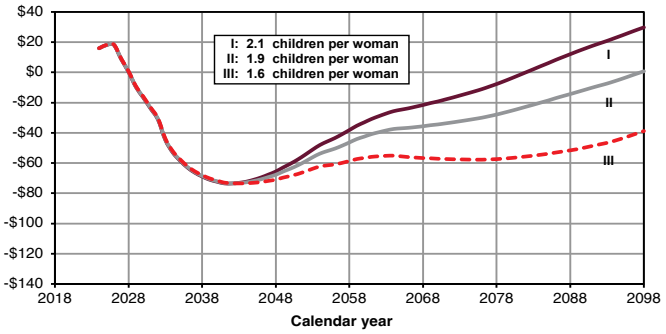
[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

Chart 9 shows projections of the present value of the net cash flow under the three alternative fertility rate assumptions presented in Table 5.

The fertility rate assumption has a substantial impact on projected HI cash flows, as chart 9 indicates. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, and many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-dollar basis. On the other hand, under the lower fertility rate assumptions, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit. It is important to point out that if a longer projection period were used, the impact of a fertility rate change would be more pronounced.

CHART 9

Present Value of HI Net Cash Flow with Various Ultimate Fertility Rate Assumptions // 2024 – 2098 (In billions)



Source: CMS/OACT

Net Immigration

Table 6 illustrates the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 837,000 persons, 1,269,000 persons, and 1,723,000 persons per year.

TABLE 6

Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	837,000	1,269,000	1,723,000
Income minus expenditures (in billions)	–$3,330	–$2,618	–$1,927

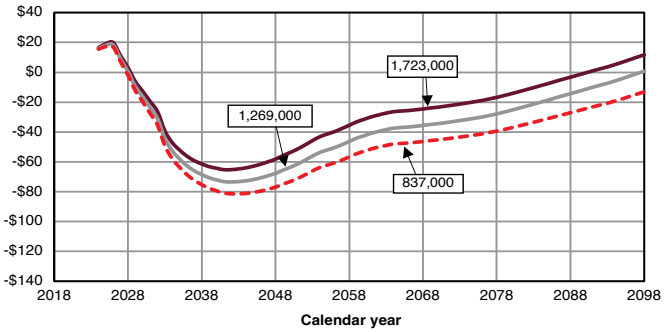
As indicated in table 6, if the average annual net immigration assumption is 837,000 persons, the deficit— expressed in present-value dollars—increases by approximately $711 billion. Conversely, if the assumption is 1,723,000 persons, the deficit decreases by $691 billion.

Chart 10 shows projections of the present value of net cash flow under the three alternative average annual net immigration assumptions presented in table 6.

Higher net immigration results in smaller HI cash flow deficits, as demonstrated in chart 10. Since immigration tends to occur most often among people who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.

CHART 10

Present Value of HI Net Cash Flow with Various Net Immigration Assumptions // 2024 – 2098 (In billions)



Source: CMS/OACT

Trust Fund Finances and Sustainability

HI

The short-range financial outlook for the HI trust fund is more favorable than the projections in last year's Medicare Trustees Report. The estimated depletion date for the HI trust fund is 2036, 5 years later than projected in last year's Trustees Report. HI income is projected to be higher than last year's estimates because both the number of covered workers and average wages are projected to be higher. HI expenditures are projected to be lower than last year's estimates through the short-range period mainly as a result of (i) a policy change to exclude medical education expenses associated with MA enrollees from the fee-for-service per capita costs used in the development of MA spending and (ii) spending for inpatient hospital and home health agency services that is lower than previously estimated due to a greater reliance on recent experience.

HI expenditures exceeded income each year from 2008 through 2015. In 2016 and 2017, however, there were fund surpluses amounting to $5.4 billion and $2.8 billion, respectively. In 2018, 2019, and 2020, expenditures again exceeded income, with trust fund deficits of $1.6 billion, $5.8 billion, and $60.4 billion, respectively. The large deficit in 2020 was mostly due to accelerated and advance payments to providers from the trust fund. In 2021, there was a small surplus of $8.5 billion as these payments began to be repaid to the trust fund, and this continued repayment resulted in a larger surplus in 2022 of $53.9 billion. There was another small surplus of $12.2 billion in 2023. The Trustees project that surpluses will continue through 2029, followed by deficits until the trust fund becomes depleted in 2036. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to healthcare services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

The HI trust fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. Policymakers should determine effective solutions to ensure the financial integrity of HI in the long term and should also consider the likelihood that the price adjustments in current law may prove difficult to adhere to fully and may require even more changes to address this challenge.

SMI

The SMI trust fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. There is no provision in the law for transferring assets between the Part D and Part B accounts; therefore, it is necessary to evaluate each account's financial adequacy separately.

The nature of the financing for both parts of SMI is similar in that the law establishes a mechanism by which income from the Part B premium and the Part D premium, and the corresponding general fund transfers for each part, are sufficient to cover the following year's estimated expenditures. Accordingly, each account within SMI is automatically in financial balance under current law. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth. A critical issue for the SMI trust fund is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

Medicare Overall

Federal law requires that the Board of Trustees issue a determination of excess general revenue Medicare funding if they project that under current law the difference between program outlays and dedicated financing sources[14] will exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2024–2030). For the 2024 Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2027, and therefore the Trustees are issuing this determination. Since this determination was made last year as well, this year's determination triggers a Medicare funding warning, which (i) requires the President to submit to Congress proposed legislation to respond to the warning within 15 days after the submission of the Fiscal Year 2026 Budget and (ii) requires Congress to consider the legislation on an expedited basis. Such funding warnings were previously issued in each of the 2007 through 2013 reports and in the 2018 through 2023 reports. To date, elected officials have not enacted legislation responding to these funding warnings.

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2024 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policymakers to "work closely together to expeditiously address these challenges."

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14 Dedicated Medicare financing sources used in this year's determination include HI payroll taxes; income from taxation of Social Security benefits; State payments for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare trust funds.

COMBINING STATEMENT OF BUDGETARY RESOURCES

For the Year Ended September 30, 2024

(in millions)

	Medicare			Payments to Trust Funds	Medicaid	CHIP	Other	Program Management	Combined Total
	HI	SMI	Part D						
BUDGETARY RESOURCES:									
Unobligated balance from prior year budget authority, net (discretionary and mandatory)	$153	$199	$1,607	$239,799	$47,428	$41,846	$18,885	$1,585	$351,502
Appropriations (discretionary and mandatory)	388,681	525,840	125,990	548,372	633,231	25,818	14,333	3	2,262,268
Borrowing authority (discretionary and mandatory)							86		86
Spending authority from offsetting collections (discretionary and mandatory)			(5,053)		1,718		2,874	4,913	4,452
TOTAL BUDGETARY RESOURCES	$388,834	$526,039	$122,544	$788,171	$682,377	$67,664	$36,178	$6,501	2,618,308
STATUS OF BUDGETARY RESOURCES:									
New Obligations and upward adjustments	$388,834	$526,039	$121,132	$542,896	$682,336	$20,805	$17,825	$5,369	$2,305,236
Unobligated balance, end of year									
Apportioned, unexpired accounts				5,488	41	20,662	13,203	312	39,706
Exempt from Apportionment, unexpired accounts			1,412						1,412
Unapportioned, unexpired accounts year				5		11,995	4,542	44	16,586
Unexpired unobligated balance, end of year			1,412	5,493	41	32,657	17,745	356	57,704
Expired unobligated balance, end of year				239,782		14,202	608	776	255,368
Unobligated balance, end of year (total)			1,412	245,275	41	$46,859	18,353	1,132	$313,072
TOTAL BUDGETARY RESOURCES	$388,834	$526,039	$122,544	$788,171	$682,377	$67,664	$36,178	$6,501	$2,618,308
OUTLAYS, NET:									
Outlays, net (discretionary and mandatory)	$407,378	$525,704	$116,946	$519,483	$610,988	$19,526	$15,661	$17	$2,215,703
Distributed offsetting receipts	(54,033)	(644,013)				(1,029)	(715)		(699,790)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	$353,345	(118,309)	$116,946	$519,483	$610,988	$18,497	$14,946	$17	1,515,913
DISBURSMENTS, NET							$72		$72

SUPPLEMENTARY INFORMATION

CONSOLIDATING BALANCE SHEET

CONSOLIDATING STATEMENT OF NET COST

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

CONSOLIDATING BALANCE SHEET

As of September 30, 2024

(in millions)

	Medicare		Health				Combined Totals	Intra-CMS Eliminations	Consolidated Totals
	HI	SMI	MEDICAID	CHIP	Other	Program Management			
ASSETS									
Intragovernmental:									
Fund Balance with Treasury	$2,214	$265,692	$73,889	$73,639	$25,970	$660	$442,064		$442,064
Investments	236,803	165,153					401,956		401,956
Accounts Receivable, Net	39,979	60,456	2,347		2,059	4,260	109,101	$(108,447)	654
Advances and Prepayments	1				3	3	7		7
Total Intragovernmental	278,997	491,301	76,236	73,639	28,032	4,923	953,128	(108,447)	844,681
Other than intragovernmental:									
Accounts Receivable, Net	1,151	21,969	6,196	230	7,928		37,474		37,474
General Property, Plant & Equipment, Net	311				552	924	1,787		1,787
Advances and Prepayments	1						1		1
Other Assets			31		409		440		440
Total Other than Intragovernmental	1,463	21,969	6,227	230	8,889	924	39,702		39,702
TOTAL ASSETS	$280,460	$513,270	$82,463	$73,869	$36,921	$5,847	$992,830	$(108,447)	$884,383
LIABILITIES									
Intragovernmental:									
Accounts Payable	$44,139	$65,870			$80	$33	$110,122	$(108,445)	$1,677
Debt		604			487		1,091		1,091
Other Liabilities					62	7	69	(2)	67
Total Intragovernmental	44,139	66,474			629	40	111,282	(108,447)	2,835
Other than intragovernmental:									
Accounts Payable	82	81			112	172	447		447
Entitlement Benefits Due and Payable	34,340	54,492	$51,460	$1,305			141,597		141,597
Other Liabilities									
Contingencies and Commitments	1,050		4,278				5,328		5,328
Other	2,121	3,737	1		13,327	92	19,278		19,278
Total Other than Intragovernmental	37,593	58,310	55,739	1,305	13,439	264	166,650		166,650
TOTAL LIABILITIES	$81,732	$124,784	$55,739	$1,305	$14,068	$304	$277,932	$(108,447)	$169,485
NET POSITION									
Unexpended Appropriations-Funds from Dedicated Collections	$2,174	$258,391			$3,264	$87	$263,916		$263,916
Unexpended Appropriations-Funds from Other than Dedicated Collections			$24,775	$70,030	10,856		105,661		105,661
Total Unexpended Appropriations	2,174	258,391	24,775	70,030	14,120	87	369,577		369,577
Cumulative Results of Operations-Funds from Dedicated Collections	196,554	130,095			8,696	5,456	340,801		340,801
Cumulative Results of Operations-Funds from Other than Dedicated Collections			1,949	2,534	37		4,520		4,520
Total Cumulative Results of Operations	196,554	130,095	1,949	2,534	8,733	5,456	345,321		345,321
TOTAL NET POSITION	$198,728	$388,486	$26,724	$72,564	$22,853	$5,543	$714,898		$714,898
TOTAL LIABILITIES AND NET POSITION	$280,460	$513,270	$82,463	$73,869	$36,921	$5,847	$992,830	$(108,447)	$884,383

CONSOLIDATING STATEMENT OF NET COST

For the Year Ended September 30, 2024

(in millions)

	Program	Program Management	Intra-CMS Eliminations	Total
Medicare HI				
Benefit/Program Expenses	$383,180			$383,180
Operating Expenses	2,002	$1,393	$98	3,493
Total Cost	385,182	1,393	98	386,673
Less: Earned Revenues	(5,080)	(8)		(5,088)
Net Cost Medicare HI	$380,102	$1,385	$98	$381,585
Medicare SMI				
Benefit/Program Expenses (Part B)	$537,333			$537,333
Benefit Expenses (Part D)	112,921			112,921
Operating Expenses	117	$3,166	$55	3,338
Total Cost	650,371	3,166	55	653,592
Less: Earned Revenues	(143,616)	(37)		(143,653)
Net Cost Medicare SMI	$506,755	$3,129	$55	$509,939
Medicaid				
Benefit/Program Expenses	$608,231			$608,231
Operating Expenses	10	$188		198
Total Cost	608,241	188		608,429
Less: Earned Revenues		(2)		(2)
Net Cost Medicaid	$608,241	$186		$608,427
CHIP				
Benefit/Program Expenses	$19,442			$19,442
Operating Expenses	2	$21		23
Total Cost	19,444	21		19,465
Less: Earned Revenues				
Net Cost CHIP	$19,444	$21		$19,465
Other				
Program Expenses	$15,787			$15,787
Operating Expenses	471	$591		1,062
Total Cost	16,258	591		16,849
Less: Earned Revenues	(15,031)	(7)	$(153)	*(15,191)*
Net Cost Other	$1,227	$584	*$(153)*	$1,658
NET COST OF OPERATIONS	**$1,515,769**	**$5,305**		**$1,521,074**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

For the Year Ended September 30, 2024

(in millions)

	Dedicated Collections					*Funds from Other than Dedicated Collections*				
	Medicare		*Health*		*Total Funds From Dedicated Collections*	*Health (Other Funds)*			*Total Funds from Other than Dedicated Collections*	*Consolidated Total*
	HI	*SMI*	*Other*	*Program Management*		*Medicaid*	*CHIP*	*Other*		
UNEXPENDED APPROPRIATIONS										
Beginning Balances	$1,833	$269,768	$3,538	$168	$275,307	$1,508	$68,312	$11,508	$81,328	$356,635
Budgetary Financing Sources:										
Appropriations Received	41,504	537,996	67	3	579,570	716,419	24,991	718	742,128	1,321,698
Appropriations Transferred-in/out						(7,179)			(7,179)	(7,179)
Other Adjustments		(76,104)			(76,104)	(75,950)	(3,738)	(34)	(79,722)	(155,826)
Appropriations Used	(41,163)	(473,269)	(341)	(84)	(514,857)	(610,023)	(19,535)	(1,336)	(630,894)	(1,145,751)
Total Budgetary Financing Sources	341	(11,377)	(274)	(81)	(11,391)	23,267	1,718	(652)	24,333	12,942
Total Unexpended Appropriations: Ending Balance	$2,174	$258,391	$3,264	$87	$263,916	$24,775	$70,030	$10,856	$105,661	$369,577
CUMULATIVE RESULTS OF OPERATIONS										
Beginning Balances	$140,321	$163,491	$8,024	$5,742	$317,578	$(1,551)	$1,414	$187	$50	$317,628
Other adjustments								(87)	(87)	(87)
Appropriations Used	41,163	473,269	341	84	514,857	610,023	19,535	1,336	630,894	1,145,751
Nonexchange Revenue:										
FICA and SECA Taxes	391,904				391,904					391,904
Interest on Investments	6,683	3,943			10,626		1,029		1,029	11,655
Other	395	2,736			3,131					3,131
Transfers-in/out Without Reimbursement	(3,818)	(6,589)	52	4,849	(5,506)	1,718			1,718	(3,788)
Imputed Financing	8		11	86	105			12	12	117
Other								84	84	84
Net Cost of Operations	380,102	506,755	(268)	5,305	891,894	608,241	19,444	1,495	629,180	1,521,074
Net Change in Cumulative Results of Operations	56,233	(33,396)	672	(286)	23,223	3,500	1,120	(150)	4,470	27,693
Cumulative Results of Operations: Ending Balance	$196,554	$130,095	$8,696	$5,456	$340,801	$1,949	$2,534	37	$4,520	$345,321
Net Position	$198,728	$388,486	$11,960	$5,543	$604,717	$26,724	$72,564	$10,893	$110,181	$714,898

AUDIT REPORTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

November 7, 2024

TO: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

FROM: Amy J. Frontz
Deputy Inspector General for Audit Services

Amy Frontz

Digitally signed by Amy J Frontz
Date: 2024.11.07 14:48:57 -05'00'

SUBJECT: *Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2024*, A-17-24-53000

This memo transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2024 financial statements, and on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the CMS financial statements in support of the Department of Health and Human Services audit.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP to audit the CMS: (1) consolidated balance sheets as of September 30, 2024 and 2023, and the related consolidated statements of net cost and changes in net position; (2) the combined statements of budgetary resources for the years then ended; and (3) the statement of social insurance as of January 1, 2024, 2023, 2022, 2021, and 2020, and related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 24-02, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2024 CMS consolidated balance sheets and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. Ernst & Young was unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2024, 2023, 2022, 2021, and 2020, and the related statements of changes in social insurance amounts for the periods ended January 1, 2024, and 2023. As a result, Ernst & Young

was not able to, and did not, express an opinion on the financial condition of the CMS social insurance program and related changes in the social insurance program for the specified periods.

Ernst & Young also noted two matters involving internal controls with respect to the financial reporting. Under the standards established by the American Institute of Certified Public Accountants and *Government Auditing Standards*, Ernst & Young identified significant deficiencies in CMS's financial reporting processes and information systems controls. Specifically:

Financial Reporting Processes—Ernst & Young noted that the following areas merit continued focus as part of CMS's financial reporting processes. The deficiencies noted below collectively represent a significant deficiency in internal control.

- Limitations as to the reliability of the information contained within the Transformed Medicaid Statistical Information System requires additional verification before it would be considered reliable to use in the financial accounting and reporting for the Medicaid program, and specifically in Medicaid Entitlement Benefits Due and Payable (EBDP) with regard to estimation of the accrual and look-back of prior year estimates.

- As it relates to the Medicare EBDP estimate, CMS continues to lack the ability to accumulate the payment data in a way that would enable the isolation of outliers that exist in the cost report population that should be considered for the purposes of developing the EBDP estimate.

- A weakness with regard to formula errors associated with various changes incorporated into the Statements of Social Insurance were not detected by the organization's monitoring and review function.

Information Systems Controls—Ernst & Young noted that deficiencies continue to be identified in implementing and monitoring controls, including controls over privileged access to CMS's information systems. Weaknesses in the monitoring or recertification of privileged access for key applications and underlying information technology infrastructure was not consistently performed, and/or evidence of such monitoring or recertification activity was not retained. In addition, CMS did not consistently follow logical access control procedures related to the timely removal of access for terminated personnel supporting CMS. The deficiencies found continue to constitute a significant deficiency in internal control.

Ernst & Young also identified instances of noncompliance with other matters. During FY 2024, CMS was not in full compliance with the requirements of the Payment Integrity Information Act of 2019 (PIIA P.L. No. 116-117). CMS reported an error rate of 1.01 percent for the Federally Facilitated Exchange component of the Advance Payment Tax Credit program, however it has not calculated and reported an improper payment estimate for the State-based Exchanges. CMS was also not in full compliance with PIIA as its recovery activities of identified improper payments for the Part C are delayed.

CMS management was notified during prior FYs that it may have a potential violation of the Anti-Deficiency Act related to certain contract obligations which are reported as a potential

violation within Ernst & Young's report. Ernst & Young disclosed no other instances of noncompliance that must be reported under *Government Auditing Standards* and OMB Bulletin 24-02.

Evaluation and Monitoring of Audit Performance

We reviewed the audit of the CMS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audit;
- attending key meetings with auditors and CMS officials;
- monitoring the progress of the audit;
- examining audit documentation, including that related to the review of internal controls over financial reporting;
- reviewing the auditors' opinion and report on internal controls and compliance with other matters; and
- reviewing the CMS *FY 2024 Agency Financial Report.*

Ernst & Young is responsible for the attached reports and the conclusions expressed in those reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on CMS's financial statements, the effectiveness of internal controls, whether financial management systems substantially complied with the Federal Financial Management Improvement Act of 1996 (P.L. No. 104-208), or compliance with other laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which Ernst & Young did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Carla J. Lewis, Assistant Inspector General for Audit Services, at (202) 834-5992 or Carla.Lewis@oig.hhs.gov. Please refer to report number A-17-24-53000.

Attachment

cc:
Lisa Molyneux
Principal Deputy Assistant Secretary for Financial Resources,
Performing the Delegable Duties of the Assistant Secretary for
Financial Resources

Page 4—Chiquita Brooks-LaSure

Teresa Miranda
Deputy Assistant Secretary, Finance
and HHS Deputy Chief Financial Officer

Jonathan Blum
Principal Deputy Administrator
and Chief Operating Officer

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Building a better working world

Report of Independent Auditors

The Administrator and Chief Financial Officer of the Centers for Medicare and Medicaid Services and the Inspector General of the U.S. Department of Health and Human Services

Report on the Audit of the Financial Statements

Opinion

We have audited the consolidated financial statements of the Centers for Medicare and Medicaid Services (CMS), which comprise the consolidated balance sheets as of September 30, 2024 and 2023, and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources for the years then ended, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of CMS at September 30, 2024 and 2023, and the results of its net cost of operations, its changes in net position and its budgetary resources for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts

We were also engaged to audit the sustainability financial statements of CMS, which comprise the statement of social insurance as of January 1, 2024, 2023, 2022, 2021, and 2020, and the related statement of changes in social insurance amounts for the periods ended January 1, 2024 and 2023, and the related notes (collectively referred to as the "sustainability financial statements").

We do not express an opinion on the accompanying sustainability financial statements. Because of the significance of the matters described in the Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts section of our report, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the sustainability financial statements.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS), in accordance with the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States (*Government Auditing Standards*), and in accordance with the provisions of Office of Management and Budget (OMB) Bulletin No. 24-02, *Audit Requirements for Federal Financial Statements*. Our responsibilities under those standards and the provisions of OMB Bulletin No. 24-02 are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of CMS and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2024 and 2023, and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources for the years then ended.

Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts

As discussed in Note 13 to the financial statements, the statement of social insurance presents the actuarial present value of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from, or on behalf of, the participants and estimated future expenditures to be paid to, or on behalf of, participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. The sustainability financial statements are intended to aid users in assessing whether future resources will likely be sufficient to sustain public services and to meet obligations as they come due. The statement of social insurance and the related statement of changes in social insurance amounts are based on income and benefit formulas in current law and assume that scheduled benefits will continue after any related trust funds are exhausted. The sustainability financial statements are not forecasts or predictions. The sustainability financial statements are not intended to imply that current policy or law is sustainable. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of

the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA).

With respect to the estimates for the social insurance program presented as of January 1, 2024, 2023, 2022, 2021, and 2020, the current-law expenditure projections reflect the physicians' payment levels expected under the MACRA payment rules and the ACA-mandated reductions in other Medicare payment rates. Management has developed an illustrative alternative scenario and projections, using certain alternative payment provisions, intended to quantify the potential understatement of projected Medicare costs in future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 14, certain features of current law may result in some challenges for the Medicare program. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. As a result of these matters, we were unable to obtain sufficient audit evidence for the amounts presented in the statement of social insurance as of January 1, 2024, 2023, 2022, 2021 and 2020 and the related statement of changes in social insurance amounts for the periods ended January 1, 2024 and 2023.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibilities for the Audit of the Financial Statements

Except as described in the Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts section of our report, our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* and the provisions of OMB Bulletin No. 24-02 will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards* and the provisions of OMB Bulletin No. 24-02, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of CMS's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about CMS's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis and Required Supplementary Information, as identified on CMS's Agency Financial Report Table of Contents, be presented to supplement the financial statements. Such information is the responsibility of management and, although not a part of the financial statements, is required by the Federal Accounting Standards Advisory Board who considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic or historical context. We were unable to apply certain limited procedures to the Required Supplementary Information related to the sustainability financial statements in accordance with auditing standards generally accepted in the United States of America because of the significance of the matters described in the Basis for Disclaimer of Opinion section of our report. We do not express an opinion or provide any assurance on the Required Supplementary Information related to the sustainability financial statements. We have applied certain limited procedures to the Management's Discussion and Analysis and other required supplementary information in accordance with auditing standards generally accepted in the United

States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the financial statements, and other knowledge we obtained during our audit of the financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The Supplementary Information, as identified on CMS's Agency Financial Report Table of Contents, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Information

Management is responsible for the other information included in the annual report. The other information comprises introduction information on pages i through viii, A Message From the Chief Financial Officer, Other Information, Glossary and CMS Key Management Officials, as identified on CMS's Agency Financial Report Table of Contents, but does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information, and we do not express an opinion or any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and consider whether a material inconsistency exists between the other information and the financial statements, or the other information otherwise appears to be materially misstated. If, based on the work performed, we conclude that an uncorrected material misstatement of the other information exists, we are required to describe it in our report.

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Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 7, 2024 on our consideration of CMS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of CMS's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering CMS's internal control over financial reporting and compliance.

Ernst & Young LLP

November 7, 2024

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Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

The Administrator and Chief Financial Officer of the Centers for Medicare and Medicaid Services and the Inspector General of the U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*) and the provisions of Office of Management and Budget (OMB) Bulletin No. 24-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the Centers for Medicare and Medicaid Services (CMS), which comprise the consolidated balance sheet as of September 30, 2024, and the related consolidated statements of net cost and changes in net position and the combined statement of budgetary resources for the fiscal year then ended, and the related notes (collectively referred to as the "financial statements"), and our report dated November 7, 2024 expressed an unmodified opinion thereon. We also were engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2024, and the related statement of changes in social insurance amounts for the period ended January 1, 2024, and the related notes (collectively referred to as the "sustainability financial statements"), and our report dated November 7, 2024 disclaims an opinion on the sustainability financial statements because of the significance of the matters described in the Basis for Disclaimer of Opinion section of our Report of Independent Auditors as we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on these statements.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered CMS's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of CMS's internal control. Accordingly, we do not express an opinion on the effectiveness of CMS's internal control. We did not consider all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982, such as those controls relevant to preparing performance information and ensuring efficient operations.

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A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. We identified certain deficiencies in internal control described below that we consider to be significant deficiencies.

Significant Deficiencies

Financial Reporting Processes

Financial management in the Federal government requires accountability of financial and program managers for the reporting of financial results related to the Federal government's financial resources and protection of Federal assets. To enable these requirements to be met, financial management systems and internal controls must be in place to process and record financial events effectively and efficiently and to provide complete, timely, reliable and consistent information for decision-makers and the public. CMS is a very large organization that is responsible for the management of complex programs that are continuing to increase in complexity and size. Financial reporting of the cost of health programs and the oversight role is important as the country continues to make decisions about this critical mission.

The following areas identified in the current year audit merit continued focus as part of the financial reporting processes significant deficiency.

Entitlement Benefits Due and Payable (EBDP)

Medicaid Entitlement Benefits Due and Payable (EBDP)

The Medicaid program is the primary source of medical assistance for low-income Americans. Medicaid operates as a partnership between the states and the Federal government. The Federal government establishes the minimum requirements and provides oversight for the program and the states design, implement, administer and oversee their own Medicaid programs within the Federal parameters.

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In prior years, CMS completed the implementation of the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS modernizes and enhances the way states submit operational data about beneficiaries, providers, health plans, claims and encounters. As of the end of fiscal year 2024, while data maintained within T-MSIS is utilized for operational purposes, management continues to evaluate the reliability and completeness of the claims level information maintained within T-MSIS, prior to determining how this could be utilized in the financial accounting and reporting for Medicaid, and specifically Medicaid EBDP. CMS should continue to evaluate whether financial reporting risks can be addressed by using T-MSIS data to identify outliers and unusual or unexpected results that demonstrate abnormalities in state-related Medicaid expenditures that may require consideration in determining the Medicaid EBDP as of year-end, even if this data ultimately never becomes the basis for the EBDP estimate. Given the claims level detail is not yet considered reliable for financial accounting and reporting, CMS is unable to perform a claims-level detailed look-back analysis for the Medicaid EBDP to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability calculated during prior periods which could serve to validate the continued use of a similar methodology. The Medicaid EBDP is a significant liability on the FY 2024 financial statements and is subject to volatility based on the complexity and judgment required in establishing this estimate. The lack of detailed claims data limits the ability to detect the impact of such a change, or other changes such as those related to the claims processing timing, on a timely basis or consider the potential impact of these items on the EBDP estimate, presenting a risk that potential updates to CMS's analysis will not be reflected in CMS's financial statements in a timely manner.

Medicare Entitlement Benefits Due and Payable (EBDP)

The estimate of retroactive settlements of cost reports is a portion of the EBDP liability for the Medicare program. This estimate includes amounts which may be due from or owed to providers for previous years' cost report for disproportionate share hospitals and teaching hospitals, as well as amounts which may be due/owed to hospitals for adjusted prospective payments. There are different departments within CMS involved in managing the cost report activity and developing the estimated liability without a defined process to verify the completeness and accuracy of the underlying data and to identify how changes in cost report activity impact the resulting estimate. In addition, CMS updated the reports utilized to develop this estimate during FY 2024, however, CMS continues to lack the ability to accumulate the payment data in a way that would enable the isolation of outliers that exist in the cost report population that should be considered for the purposes of developing the EBDP estimate.

Statements of Social Insurance

The Statements of Social Insurance (SOSI) for CMS presents a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from, or on behalf of, those same individuals. The SOSI models are complex, 75-year projections that contain a high degree of estimation. The models and their results are heavily reviewed by actuaries and others

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within CMS. The veracity of the underlying data remains critical to the accuracy of the model, and as a result the reviews of the underlying data is robust, in line with CMS's policies and procedures. As part of this review, the input into the spreadsheet is checked against the original data sources to ensure that no input errors have been made. In addition, output data, including those that are generated from updating and running any macro in the spreadsheet, are checked by the reviewer. These checks include a comparison to the results from the year before and testing of the formulas that are part of the spreadsheet or macro, to ensure that the projection output from the program is as expected and reasonable. During our procedures, formula errors were identified that were not detected by the organization's monitoring and review function, and accordingly, the related control was not functioning at the level of precision as designed.

Improper Payments

The nature and volume of its expenditures present a substantial challenge to CMS in the quantification, evaluation and remediation of improper payments. Health insurance claims represent the vast majority of the CMS payments. These payments are complex and involve the evaluation of the program eligibility of both the recipient of the services and of the health provider, oversight of the medical necessity of each covered treatment and concurrence with the cost to be paid, some of which is based on complex financial formulas and/or coding decisions. CMS has developed sophisticated sampling processes for estimating improper payment rates CMS programs deemed susceptible to significant improper payments: Medicare Fee-for-Service (Medicare FFS), Medicare Advantage (Part C), Medicare Prescription Drugs (Part D), Medicaid, CHIP and Advance Premium Tax Credits (APTC).

CMS remains committed to achieving reductions in all improper payment rates through various corrective actions. The eligibility component of the reported Medicaid and CHIP improper payment rates continue to be significantly impacted by flexibilities afforded by the PHE, such as postponed eligibility determinations and eased requirements around provider enrollment/validations. While the Medicaid and CHIP improper payment rates continued to decline in the current year, including the CHIP improper payment rate falling below the statutory threshold of 10 percent, there is an increased risk that the rate could exceed this 10 percent threshold as these flexibilities expire. In addition, while management continued to implement corrective actions to reduce the Medicare FFS and APTC improper payment rates, the rates increased from the prior year.

Recommendations

We recommend that CMS continue to develop, refine and adhere to its financial management systems and processes to improve its accounting, analysis and oversight of financial management activity. Specifically, we recommend that CMS implement the following:

- Continue to evaluate how the Medicaid claims level data can be refined to analyze trends at a claims level to enable the performance of robust analytical procedures and measures against

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benchmarks to monitor and identify risks associated with the financial accounting and reporting of the Medicaid program.

- Establish a process to perform a claims-level detailed look-back analysis on the Medicaid EBDP to determine the reasonableness of the methodology utilized to record this liability.

- Continue to collaborate to assess the appropriateness of the data used to develop the cost report liability estimate and whether the resulting output of the methodology appears reasonable in light of current year activity. Continued focus in this area including documentation of analyses performed should be documented prior to finalizing the estimate. In addition, CMS should develop a periodic validation of the completeness and accuracy of data that is included in these reports as part of maintaining a full suite of controls for this portion of the EBDP liability.

- Continue to adhere to established policies and procedures to ensure that the SOSI model methodology and related calculation and estimates are reviewed at a level of sufficient precision. When changes are made, such as changes to the methodology or key assumptions, management should require an enhanced review specific to these changes.

- Consider additional opportunities to further reduce improper payments, which are consistent with the organization's objectives of improving payment accuracy levels.

Information Systems Controls

Information systems controls are a critical component of the Federal government's operations to manage the integrity, confidentiality and reliability of its programs and activities and assist with reducing the risk of errors, fraud or other illegal acts. The nature, size and complexity of CMS's operations require the organization to administer its programs under a decentralized business model by using numerous geographically dispersed contractors operating complex and extensive information systems.

As CMS continues its efforts to enhance its internal controls, the following items identified in the current year audit merit continued focus on the information systems controls and processes.

Controls Over Information System Access and Least Privileged Controls

CMS has a large number of users requiring access to CMS systems in order to process claims and to support beneficiaries in a timely and effective manner. Accordingly, properly implemented system access controls, including user and system account management and monitoring of system access, are critical to preventing and detecting unauthorized usage of CMS information resources and program and data files. Without maintaining an appropriate level of access controls within CMS systems, the integrity of CMS's information resources could be compromised.

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Deficiencies continued to be identified in the implementation and monitoring of controls, including controls over privileged access to the CMS information systems. Examples included:

- Provisioning and/or recertification of privileged access for key applications and underlying IT infrastructure was not consistently performed, and/or evidence of provisioning and/or recertification was not retained.

- Logical access control procedures related to the timely removal of access for terminated personnel supporting CMS were not consistently followed.

Appropriate consideration over the design of controls for access and the monitoring of access is essential to provide a suitable framework for subsequent implementation and operation of the controls. Without adequate controls over monitoring and managing access to critical systems the risk of errors, fraud or other illegal acts is increased.

Recommendations

CMS should continue to improve the operating effectiveness of information security access controls to validate that:

- Privileged access for key applications and the underlying IT infrastructure is in accordance with the principle of least privilege and monitored to detect and correct unauthorized access or activities.

- User access provisioning as well as reviews and recertification of access are being performed timely and by appropriate personnel with the requisite knowledge and experience of the employee access requirements and necessary system functionality. Additionally, evidence of provisioning/recertification should be retained.

- CMS guidance and contractual requirements are followed for the separation of workforce personnel, including the removal of any associated user account for CMS IT systems and/or applications as well as facilities.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether CMS's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements as well as the requirements referred to in the *Federal Financial Management Improvement Act of 1996* (FFMIA), noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and the provisions

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of OMB Bulletin No. 24-02 which are described below and disclosed no instances of noncompliance in which CMS's financial management systems did not substantially comply with the Section 803(a) requirements of FFMIA.

The *Payment Integrity Information Act of 2019* (hereinafter, the Act) requires federal agencies to identify programs and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. However, CMS is not in full compliance with the Act. While CMS has calculated and reported an improper payment estimate for the Federally-facilitated Exchange of the APTC program, it has not calculated and reported an improper payment estimate for the State-based Exchanges, which has been deemed susceptible to significant improper payments. CMS was also not in full compliance with PIIA as recovery activities of the identified improper payments for the Part C program are delayed.

During prior fiscal years, CMS management was notified that it may have a potential violation of the *Anti-Deficiency Act* related to certain contract obligations related to fiscal years 2014 and 2015. This potential violation is still being evaluated.

CMS's Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on CMS's response to the findings identified in our audit and described in the accompanying letter dated November 7, 2024. CMS's response was not subjected to the other auditing procedures applied in the audit of the financial statements and accordingly, we express no opinion on the response.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

November 7, 2024

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

November 7, 2024

Ernst & Young, LLP
1101 New York Avenue, N.W.
Washington, DC 20005

Dear Sir/Madame:

We have reviewed your audit report on the Centers for Medicare & Medicaid Services' fiscal year 2024 financial statements and annual Agency Financial Report. We are pleased to receive our 26th unmodified opinion on our Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position, and the Combined Statement of Budgetary Resources.

We understand that you are still not able to express an opinion on the Statement of Social Insurance (SOSI) and the Statement of Changes in Social Insurance Amounts (SCSIA) due to the uncertainty of the long-range assumptions used in the model. CMS has properly disclosed and documented the nature and uncertainty surrounding these projections and remains confident that our SOSI model projections are fairly presented. We remain fully committed to continuing our partnership with you to find a solution to reporting the SOSI projections that will allow you to opine on these statements in the future.

We acknowledge that your audit identified no material weaknesses in our internal controls and reported two significant internal control deficiencies in our financial reporting processes and information systems. We view these as opportunities to improve our stewardship over taxpayer dollars that are entrusted to us, and remain dedicated to establishing corrective actions that will continue to strengthen our internal controls and remediate the deficiencies you have noted.

We understand the tremendous undertaking it is to audit our financial statements due to the complexity of our programs. We are truly appreciative of the efforts and professionalism displayed by your audit team in conducting this year's audit.

Sincerely,

Megan Worstell

Megan Worstell

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OTHER INFORMATION

SUMMARY OF FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT REPORT AND OMB CIRCULAR A-123, MANAGEMENT'S RESPONSIBILITY FOR ENTERPRISE RISK MANAGEMENT AND INTERNAL CONTROL // IMPROPER PAYMENTS

SUMMARY OF FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT REPORT AND OMB CIRCULAR A-123, MANAGEMENT'S RESPONSIBILITY FOR ENTERPRISE RISK MANAGEMENT AND INTERNAL CONTROL

CMS assesses its internal controls through: (1) management self-assessments, including annual tests of security controls; (2) Office of Management and Budget (OMB) Circular A-123, Appendix A self-assessments; (3) OIG audits, and GAO audits and High-Risk reports; (4) Statement on Standards for Attestation Engagements (SSAE) 18 internal control audits; (5) evaluations and tests of MACs' controls conducted pursuant to section 912 of the *Medicare Modernization Act*; (6) the annual *CFO Act* audit; (7) security assessment and authorization of systems; and (8) Department Enterprise Risk Management efforts. As of September 30, 2024, the internal controls and financial management systems of CMS provided reasonable assurance that the objectives of the *Federal Managers' Financial Integrity Act of 1982* (FMFIA) were achieved with the exception of two instances of non-compliance described below.

OMB Circular A-123 Statement of Assurance

CMS management is responsible for managing risks and maintaining effective internal control to meet the objectives of Sections 2 and 4 of the FMFIA. These objectives are to ensure: (1) effective and efficient operations, (2) reliable reporting, and (3) compliance with applicable laws and regulations.

CMS conducted its assessment of risk and internal control in accordance with OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. Based on the results of the assessment, CMS provides reasonable assurance that internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2024 with the exception of material non-compliances with: the *Payment Integrity Information Act of 2019* (PIIA), and Section 6411 of the PPACA.

Assurance for the Federal Financial Management Improvement Act of 1996

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires agencies to implement and maintain financial management systems that substantially comply with Federal financial management systems requirements, Federal accounting standards, and the United States Standard General Ledger at the transaction level. CMS conducted its evaluation of financial management systems for compliance with FFMIA in accordance with OMB Circular A-123, Appendix D. Based on the results of this assessment, CMS provides reasonable assurance that its overall financial management systems substantially comply with FFMIA and substantially conform to the objectives of FMFIA, Section 4.

Noncompliance – Actions and Accomplishments

CMS did not fully comply with the requirements of PIIA and Section 6411 of PPACA. CMS has developed several corrective actions to reduce improper payments. While some corrective actions have been fully implemented, others are in the early stages of implementation. CMS believes these major undertakings will have a larger impact over time.

PIIA Noncompliance

Although CMS has calculated and reported an improper payment estimate for the Federally-facilitated Exchange of the Advance Premium Tax Credits program, CMS's noncompliance stems from not calculating and reporting an improper payment estimate for the State-based Exchanges. CMS continues to develop the improper payment measurement methodology for the State-based Exchanges and will continue to update the AFR with the measurement program development status.

Section 6411 of the PPACA Noncompliance

CMS is not compliant with Section 6411 of the PPACA that expanded the Recovery Audit Contractor (RAC) program to Medicare Part C. Despite their success in Medicare FFS, RACs have found that Medicare Part C does not represent an appealing business case for them because of differing payment structures, a narrow scope of payment error, and unlimited appeal time frames. Although CMS has not procured a Part C RAC, CMS's primary corrective action for identifying Medicare Part C payment errors has been the contract-level audits performed under the Risk Adjustment Data Validation (RADV) program. The RADV program is operational with the support of contractors. Given the purpose of RADV audits, CMS believes that the RADV audit program already performs the intended functions of a Medicare Part C RAC.

IMPROPER PAYMENTS

PIIA includes requirements for identifying programs susceptible to significant improper payments, annually reporting estimates of improper payments, and implementing corrective actions to reduce improper payments. PIIA defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). Improper payments also include payments to ineligible recipients, payments for ineligible services, duplicate payments, and payments for services not received, as well as payments that are missing sufficient documentation to determine if proper.

CMS has instituted comprehensive processes that measure improper payments for the Medicare FFS, Medicare Advantage (Part C), Medicare Prescription Drug (Medicare Part D), Medicaid, CHIP, and Advance payment of the Premium Tax Credit (APTC) programs.

Medicare FFS

CMS measures the Medicare FFS improper payment estimate annually, through the Comprehensive Error Rate Testing (CERT) program. The estimated percentage of Medicare FFS dollars paid correctly was 92.34 percent. This means Medicare paid an estimated $382.02 billion correctly in FY 2024.

The Medicare FFS improper payment estimate for FY 2024 is 7.66 percent or $31.70 billion. The improper payment estimate due to missing or insufficient documentation is 5.21 percent or $21.56 billion, representing 68.00 percent of total improper payments. Improper payments for SNF, hospital outpatient, IRF, and hospice claims were the major contributing factors to the FY 2024 Medicare FFS rate. While the factors contributing to improper payments are complex and vary by year, the primary causes continue to be insufficient documentation and medical necessity errors.

CMS uses data from the CERT program and other sources of information to address improper payments in Medicare FFS through various corrective actions, such as policy clarifications and simplifications, when appropriate, as well as targeted probe and educate reviews, which include more individualized education through smaller probe reviews, followed by specific education based on the findings of these reviews. CMS is also continuing prior authorization initiatives, as appropriate, which help to ensure that applicable coverage, payment, and coding rules are met before services are rendered while ensuring access to and quality of care. CMS has developed several preventative measures for specific service areas with high improper payments. CMS believes implementing targeted corrective actions in these areas will prevent and reduce improper payments in these areas and reduce the overall improper payment rate.

Medicare Advantage and Prescription Drugs

CMS measures the Medicare Part C improper payments made to MA contracts through the Part C improper payment measurement process. The Part C improper payment estimate for FY 2024 is 5.61 percent, or $19.07 billion. The improper payment estimate due to missing or insufficient documentation is 0.32 percent or $1.09 billion, representing 5.69 percent of total improper payments. The estimated percentage of Part C dollars paid correctly was 94.39 percent. This means Part C paid an estimated $320.87 billion correctly in FY 2024. In FY 2024, CMS implemented sampling refinements to ensure the sample population is representative of the MA population. Applying the technical refinements and following the prior methodology, the FY 2024 rate is comparable to the baseline established with the FY 2023 improper payment rate.

CMS measures the Medicare Part D improper payments related to prescription drug event data through the Part D improper payment measurement process. The Part D improper payment estimate for FY 2024 is 3.70 percent, or $3.58 billion. The improper payment estimate due to missing or insufficient documentation is 2.70 percent or $2.61 billion, representing 72.99 percent of total improper payments. The estimated percentage of Part D dollars paid correctly was 96.30 percent. This means Part D paid an estimated $92.95 billion correctly in FY 2024. In FY 2023, CMS implemented several methodology changes, and FY 2024 establishes a baseline.

CMS uses data from the improper payment measurement processes to address improper payments in Medicare Part C and D through various corrective actions. Contract-level RADV audits are CMS's primary strategy to recover Part C overpayments. RADV uses medical record reviews to confirm the accuracy of diagnoses submitted by MAOs for risk-adjusted payments. These audits are expected to improve data quality because they incentivize MAOs to provide valid and accurate diagnosis information. CMS also uses activities such as trainings, outreach to plan sponsors for incomplete or invalid documentation, program integrity and other audits, and investigations to address improper payments in Part C and Part D. CMS believes implementing targeted corrective actions in these areas will prevent and reduce improper payments and reduce the overall improper payment rates.

Medicaid and CHIP

CMS measures Medicaid and CHIP improper payments through the Payment Error Rate Measurement (PERM) program, measuring three components: FFS claims, managed care payments, and eligibility determinations. PERM uses a 17 states-per-year, 3-year rotation to produce and report national program improper payment rates.

The national Medicaid improper payment estimate for FY 2024 is 5.09 percent or $31.10 billion in improper payments based on measurements conducted in FYs 2022, 2023, and 2024. The improper payment estimate due to missing or insufficient documentation is 4.03 percent or $24.60 billion, representing 79.11 percent of total improper payments. The estimated percentage of Medicaid dollars paid correctly was 94.91 percent. This means Medicaid paid an estimated $579.73 billion correctly in FY 2024.

The national improper payment estimate for each Medicaid component is:

- Medicaid FFS: 4.83 percent
- Medicaid managed care: 0.00 percent
- Medicaid eligibility: 3.31 percent

The national CHIP improper payment estimate for FY 2024 is 6.11 percent or $1.07 billion in improper payments based on measurements conducted in FYs 2022, 2023, and 2024. The improper payment estimate due to missing or insufficient documentation is 3.76 percent or $0.66 billion, representing 61.56 percent of total improper payments. The estimated percentage of CHIP dollars paid correctly was 93.89 percent. This means CHIP paid an estimated $16.51 billion correctly in FY 2024.

The national improper payment estimate for each CHIP component is:

- CHIP FFS: 4.72 percent
- CHIP managed care: 0.72 percent
- CHIP eligibility: 4.44 percent

The decrease in the FY 2024 national Medicaid and CHIP improper payment estimates reflect: 1) improved state compliance with program requirements; and 2) reviews that considered certain flexibilities given to states during COVID-19 public health emergency (PHE), such as suspending eligibility determinations and reducing requirements for provider enrollment and revalidations, which were typically included in the PERM review prior to the COVID 19 PHE. The areas driving the FY 2024 Medicaid and CHIP improper payment estimates are:

- Insufficient Documentation: States failed to provide documentation that required verification of eligibility, such as income, were completed; or medical records were not submitted or were missing required documentation to support the medical necessity of the claim. However, these payments do not necessarily represent payments to ineligible providers or on behalf of ineligible beneficiaries. If the missing information had been on the claim and/or the state had complied with the enrollment or redetermination requirements, then the claim may have been payable. Conversely, if the missing documentation had been available, it could have affirmatively indicated whether a provider or beneficiary was ineligible for Medicaid or CHIP reimbursement and, therefore, the payment was improper.
    - For FY 2024, CMS worked with states to independently verify certain situations where the state could not provide documentation to support state actions. This process included CMS independently accessing databases and reviewing submitted eligibility determination information that had been produced after the original claim payment or determination date to evaluate if a provider or beneficiary would have been eligible. Of the 702 claims eligible for independent verification, CMS independently verified 525. Of these 525 claims, CMS deemed all 525 claims as technically improper (i.e, the payment was to the right recipient for the correct amount, but the payment process did not comply with applicable regulations and statutes).

- State Non-Compliance: States did not comply with federal eligibility redetermination requirements; did not appropriately screen enrolled providers; paid providers that were not enrolled; or paid claims that lacked the required National Provider Identifier.

- Improper Determinations (CHIP-specific): States inappropriately claimed beneficiaries under Title XXI (CHIP) rather than Title XIX (Medicaid), mostly related to incorrect state calculations based on beneficiary income, the presence of third-party insurance, household composition, or tax filer status. Improper determinations accounted for approximately 18.19 percent or $0.15 billion of total errors cited in CHIP eligibility in FY 2024.

CMS works closely with states to develop state-specific corrective action plans to reduce improper payments. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their corrective action plans, with assistance and oversight from CMS.

APTC

Through the Exchange Improper Payment Measurement Program, CMS measures Advance payment of the Premium Tax Credit (APTC) improper payments. A statistically valid random sample of health insurance applications are reviewed to determine if the Federally-facilitated Exchange properly paid APTC benefits under the statutory and regulatory requirements relating to eligibility and payment determinations.

The Federally-facilitated Exchange improper payment estimate for FY 2024, for measurement of calendar year 2022, is 1.01 percent or $562.93 million. The improper payment estimate is made up of 73 percent of technically improper payments ($408.56 million). Technically improper payments are payments made to eligible recipients for correct amounts but failed to satisfy all legally applicable requirements relevant to the payment. For CY 2022, technically improper payments are associated with failures to conduct required periodic eligibility validations where had the periodic eligibility validation occurred the consumer would have maintained eligibility. The improper payment rate, excluding the effect of technically improper payments, is 0.28 percent, and consists entirely of overpayments ($154.38 million). The estimated percentage of APTC dollars paid correctly was 98.99 percent. The Federally- facilitated Exchange paid an estimated $55.14 billion correctly in FY 2024.

Automated process errors generally relate to the Federally-facilitated Exchange's processing of application information and eligibility verification information provided by trusted data sources. The nature of automated process errors may vary between reporting periods. For calendar year 2022, the primary driver of automated errors related to the Federally-facilitated Exchange failing to conduct periodic verifications of consumer eligibility due to technical problems interacting with trusted data sources. The improper payment estimate due to the automated process errors is $425.79 million, representing 75.64 percent of total improper payments.

Manual administrative errors generally relate to the Federally-facilitated Exchange's processing of additional documentation provided by consumers in situations where the Federally-facilitated Exchange was unable to verify consumer eligibility using automated processes. Manual eligibility verification involves complex rules and a large variety of documentation types and formats, and therefore has a heightened risk of error. The nature of manual administrative errors may vary between reporting periods. For calendar year 2022, the primary driver of manual errors related to the Federally-facilitated Exchange accepting consumer-submitted documents which did not contain elements required by policy. The improper payment estimate due to the administrative errors is $137.15 million, representing 24.36 percent of total improper payments.

The improper payment rate and amounts estimated herein do not reflect APTC payments made by State-based Exchanges. CMS started the Improper Payment Pretesting and Assessment program in 2024 to prepare states for the upcoming measurement. CMS will continue to provide updates on the status of the State-based Exchange improper payment program implementation.

Combined Improper Payment Data

The second payment stream relates to additional Premium Tax Credit amounts claimed by taxpayers at the time of their tax filings, referred to as "Net Premium Tax Credits" (Net PTC).[1] That is, total Premium Tax Credit outlays/claims are equal to APTC payments plus Net PTC claims. The Internal Revenue Service (IRS) measures improper payments associated

with Net PTC claims, and for calendar year 2022 reported Net PTC claims of 1.27 billion, improper payments of $362.73 million, and an improper payment rate of 28.54 percent. The combined APTC and Net PTC improper payment estimate is $925.66 million out of $56.98 billion total Premium Tax Credit outlays/claims, or 1.62 percent. Similar to the APTC improper payment information provided above, this combined APTC and Net PTC improper payment information does not reflect payments made by State-based Exchanges.

In the ordinary course of preparing their tax filing, a consumer may claim a total Premium Tax Credit that is less than the APTC payments made on behalf of the consumer for the respective tax year. For example, a consumer's income for the tax year may exceed what the consumer anticipated when the consumer enrolled in health insurance coverage, resulting in eligibility for a lesser Premium Tax Credit benefit than expected. Amounts paid in APTC exceeding the total Premium Tax Credit a consumer is entitled to are referred to as "Excess APTC." A consumer may have an obligation to repay

Excess APTC amounts, and such repayments may relate to amounts that are recognized as improper payments. The combined APTC and Net PTC improper payment information does not reflect any effects related to the repayment of Excess APTC.

Additional information on the Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, and APTC improper payments can be found in the HHS Agency Financial Reports and CMS Improper Payments Measurement Programs websites.

1 The Treasury Annual Financial Report can be found at U.S. Department of the Treasury: Agency Financial Report.

GLOSSARY

A

Accelerated and Advance Payments (AAP) Program: A Medicare loan program that allows the Centers for Medicare & Medicaid Services (CMS) to make accelerated payments to Part A and Part B providers and advance payments to Part B suppliers when there is a disruption in claims submission and/or claims processing. CMS can also offer these payments in circumstances, such as national emergencies or natural disasters, in order to accelerate cash flow to the affected healthcare providers and suppliers.

Accountable Care Organization (ACO): A group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) who work together to coordinate care for the patients they serve.

Accrual Accounting: A system of accounting in which revenues are recorded when earned (when goods are delivered or services are performed) and expenses are recorded when incurred (when goods or services are received), even though the actual receipt of revenues and payment for goods or services may occur, in whole or in part, at a different time.

Administrative Costs: General term that refers to Medicare and Medicaid administrative costs, as well as CMS administrative costs. Medicare administrative costs are composed of the Medicare-related outlays and non-CMS administrative outlays. Medicaid administrative costs refer to the federal share of the states' expenditures for administration of the Medicaid program. CMS administrative costs are the costs of operating CMS (e.g., salaries, expenses, facilities, equipment, rent and utilities). These costs are accounted for in the Program Management account

Administrative Outlays: Medicaid administrative costs refer to the federal share of the states' expenditures for administration of the Medicaid program. CMS administrative costs are the costs of operating CMS (e.g., salaries, expenses, facilities, equipment, rent and utilities). These costs are accounted for in the Program Management account.

Advance Premium Tax Credit (APTC): Payment amounts calculated by the Exchange and paid to an eligible consumer's insurance company on the consumer's behalf to lower the consumer's out-of-pocket cost for health insurance premiums. The amount the consumer is eligible for is based on the cost of the second lowest silver plan available through the applicable Exchange and the consumer's estimated annual household income compared to the Federal poverty line. Consumers that receive the benefit of APTC payments must file a tax return to reconcile the amount of APTC payments received with the amount of the actual premium tax credit for which they are eligible.

Alternative Payment Model (APM): A program or model (except for a healthcare innovation award model) implemented by the Center for Medicare and Medicaid Innovation at CMS; a demonstration under the Healthcare Quality Demonstration Program; an ACO model participating in the Medicare shared savings program; or a Medicare demonstration required by law.

***American Rescue Plan Act of 2021* (ARP):** An emergency legislative package to provide economic relief and additional resources for individuals and businesses affected by COVID-19. The act also includes funding for state, local, and tribal governments, as well as education and COVID-19-related testing, vaccination support, and research.

B

***Balanced Budget Act of 1997* (BBA):** Major provisions of the BBA provided for the Children's Health Insurance Program, Medicare + Choice (currently known as the Medicare Advantage program), and expansion of preventive benefits.

Benefit Payments: Benefits consumed or funds outlaid for services delivered to beneficiaries.

C

***Chief Financial Officers Act of 1990* (CFO Act):** The *CFO Act* was enacted to improve the financial management and accountability of the federal government. It provides for production of complete, reliable, timely, and consistent financial information for use by the executive branch of the government and the Congress in the financing, management, and evaluation of federal programs. It also designated a Chief Financial Officer in each executive department and each major executive agency in the federal government.

Children's Health Insurance Program (CHIP) (also known as Title XXI): CHIP (previously known as the State Children's Health Insurance Program, or SCHIP) was originally created in 1997 as Title XXI of the *Social Security Act*. CHIP is a state and federal partnership that targets uninsured children and pregnant women in families with incomes too high to qualify for Medicaid, but often too low to afford private coverage.

***Children's Health Insurance Program Reauthorization Act of 2009* (CHIPRA):** CHIPRA extended and expanded CHIP, which was enacted as part of the BBA. CHIPRA increased CHIP funding, strengthened and expanded healthcare for children, reduced the number of uninsured, and promoted outreach, education, and preventative healthcare.

Clinical Laboratory Improvement Amendments of 1988 (CLIA): Requires any laboratory that performs testing on specimens derived from humans to meet the requirements established by the Department of Health and Human Services and to have an applicable certificate in effect.

D

***Deficit Reduction Act of 2005*:** The *Deficit Reduction Act* restrains federal spending for entitlement programs (i.e., Medicare and Medicaid) while ensuring that Americans who rely on these programs continue to get needed care. Provisions of the act require wealthier seniors to pay higher premiums for Medicare coverage; a restraint on Medicaid spending by reducing federal overpayment for prescription drugs so that taxpayers do not pay inflated markups; and increased benefits to students and to those with the greatest need.

Demonstrations: Projects that allow CMS to test various or specific attributes, such as payment methodologies, preventive care, and social care, and to determine if such projects/pilots should be continued or expanded to meet the healthcare needs of the nation. Demonstrations are used to evaluate the effects and impact of various healthcare initiatives and the cost implications to the public.

Direct and Indirect Remuneration (DIR): Payments primarily consisting of drug manufacturer rebates and pharmacy rebates that Medicare Part D plans negotiate.

Disproportionate Share Hospital (DSH): A hospital with a disproportionately large share of low-income patients. Under Medicaid, states augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Durable Medical Equipment (DME): Purchased or rented items, such as ventilators, hospital beds, and wheelchairs used in the patient's home, as well as blood glucose monitors for individuals with diabetes. DME is equipment which: (1) can withstand repeated use; (2) has an expected life of at least 3 years if classified as DME after January 1, 2012; (3) is primarily and customarily used to serve a medical purpose; (4) generally is not useful to a person in the absence of an illness or injury; and (5) is appropriate for use in the home.

E

End Stage Renal Disease: Permanent kidney failure requiring dialysis or a transplant.

***Evidence-based Policymaking Act of 2018*:** The *Evidence Act*, as it is simply known, was established to advance evidence building in the federal government by improving access to data and expanding evaluation capacity.

Expenditure: Budgeted funds that are actually spent. When used in the discussion of the Medicaid program, expenditure refers to funds actually spent as reported by the states.

Expense: An outlay or an accrued liability for services incurred in the current period.

F

***Federal Financial Management Improvement Act of 1996* (FFMIA):** FFMIA requires agencies to have financial management systems that substantially comply with federal management systems requirements, standards promulgated by the Federal Accounting Standards Advisory Board (FASAB), and standards of the U.S. Standard General Ledger (USSGL) at the transaction level). The primary purpose of FFMIA is to enhance the accuracy, reliability, and usefulness of federal financial information.

Federal General Revenues: Federal tax revenues (principally individual and business income taxes) not identified for a particular use.

***Federal Insurance Contribution Act* (FICA) Payroll Tax:** Medicare's share of payroll taxes used to fund the Hospital Insurance (HI) trust fund. Employers and employees each contribute 1.45 percent of taxable wages, with no compensation limits, to the HI trust fund.

***Federal Managers' Financial Integrity Act of 1982* (FMFIA):** Requires agencies to establish internal control and financial systems that provide reasonable assurance of achieving control objectives, including the effectiveness and efficiency of operations; compliance with laws and regulations; and reliability of financial reporting. FMFIA requires agency heads to conduct an annual evaluation and report on the adequacy of internal control systems.

Fee-for-Service (FFS): A system of healthcare payment in which a provider is paid separately for each particular service rendered.

G

***Government Management Reform Act of 1994* (GMRA):** GMRA aims to improve the management, operation, and accountability of federal agencies. It requires the auditing of executive agencies' annual financial statements prior to submission to OMB.

***Government Performance and Results Act Modernization Act of 2010* (GPRA Modernization Act):** Aims to improve the performance management, accountability, and transparency of federal agencies. It amends the *Government Performance and Results Act of 1993* to require each executive agency to make its strategic plan available on its public website and to Office of Management and Budget (OMB) on the first Monday in February of any year following that in which the term of the President commences, and to notify the President and Congress that the strategic plan is available.

H

Health Insurance Exchanges (Marketplaces): A mechanism for facilitating the purchase of Qualified Health Plans and evaluating eligibility for APTCs and Cost Sharing Reductions (CSRs). States can establish their own Exchange or the Federal government can operate a Exchange on their behalf.

Healthcare Fraud Prevention Partnership (HFPP): Voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations.

Home - Community Based Services (HCBS): Programs that provide opportunities for Medicaid-eligible older adults and people with disabilities to receive long term services and support in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

Hospital Insurance (HI) Trust Fund: Also known as Part A. The part of Medicare that covers specified inpatient hospital services, post-hospital skilled nursing care, home health services, and hospice care for aged and disabled individuals who meet the eligibility requirements.

I

***Inflation Reduction Act of 2022*:** Aims to lower prescription drugs costs by allowing Medicare to negotiate prices with drug companies through the imposition of an inflation cap on drug prices; also extends provisions geared toward improving health insurance affordability and access through 2025.

Information Technology (IT): Any equipment or interconnected system or subsystem of equipment that is used in the automatic acquisition, storage, manipulation, management, movement, control, display, switching, interchange, transmission, or reception of data or information by the executive agency.

Internal Control: Process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. Management's tools, such as the organization's policies and procedures, that help program and financial managers achieve results and safeguard the integrity of their programs. Such controls include program, operational, and administrative areas, as well as accounting and financial management.

M

Material Weakness: A deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis.

Medicaid: A joint federal and state program that helps with healthcare costs for people with limited income and resources.

Medical Loss Ratio (MLR): Requires health insurance companies to spend 80 to 85 percent of premium dollars on medical care and healthcare quality improvement, rather than on administrative costs. When they do not, health insurance companies are required to provide a rebate to their customers.

Medicare: The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with ESRD.

***Medicare Access and CHIP Reauthorization Act of 2015* (MACRA):** Legislation passed to strengthen Medicare, extend CHIP, and make numerous other improvements to the healthcare system.

Medicare Administrative Contractor (MAC): A private entity that CMS contracts with under section 1874A of the *Social Security Act*, as added by the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA). Part A and Part B MACs handle Medicare Part A and Medicare Part B claims processing and related services under the MMA, and DME MACs handle Medicare claims for DME.

Medicare Advantage (MA) Program (Part C): This program reforms and expands the availability of private health options previously offered to Medicare beneficiaries by allowing for the establishment of new regional preferred provider organization plans, as well as a new process for determining beneficiary premiums and benefits. Title II of MMA modified and renamed the existing Medicare + Choice program established under Title XVIII of the *Social Security Act* to the MA program.

Medicare Integrity Program (MIP): A program established by HIPAA to promote the integrity of the Medicare program, as specified in Section 1893 of the *Social Security Act*.

***Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA):** Legislation that established a new Medicare program (Medicare Part D) to provide a prescription drug benefit. Additionally, MMA sets forth numerous changes to existing programs, including a revised managed care program, certain payment reforms, rural healthcare improvements, and other changes involving administrative improvements, regulatory reduction, administrative appeals, and contracting reform.

Medicare Prescription Drug Program (Part D): An optional prescription drug benefit created by the MMA for individuals with Medicare who are entitled to benefits under Part A or enrolled in Part B. Eligible individuals can enroll in either a stand- alone prescription drug plan to supplement their traditional Medicare coverage, or in an MA prescription drug plan, which integrates basic medical coverage with added prescription drug coverage. Individuals who qualify for both Medicare and Medicaid (full-benefit dual-eligible) are automatically enrolled in the Part D program; assistance with premiums and cost sharing is available to full-benefit dual-eligible and other qualified low-income individuals.

Medicare Secondary Payer (MSP): A statutory requirement that private insurers who provide general health insurance coverage to Medicare beneficiaries must pay beneficiary claims as primary payers.

Medicare Trust Funds: Treasury accounts established by the *Social Security Act* for the receipt of revenues, maintenance of reserves, and disbursement of payments for Medicare.

***Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA):** This legislation requires insurance coverage for mental health conditions, including substance use disorders, to be no more restrictive than insurance coverage for other medical conditions.

Merit-Based Incentive Payment System (MIPS): A system for adjusting payments under the Medicare physician fee schedule to nonadvanced alternative payment model (APM) providers based on metrics assessing provider quality, resource use, meaningful use of electronic health records, and clinical practice improvement activities.

N

***No Surprises Act*:** Protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers.

2019 Novel Coronavirus Disease (COVID-19): A respiratory disease caused by SARS-CoV-2, a coronavirus discovered in 2019 in Wuhan, China.

O

Obligation: Legal requirement to pay funds.

OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control (OMB Circular A-123)*: Provides guidance to federal managers on improving the accountability and effectiveness of federal programs and operations by establishing, assessing, correcting, and reporting on management's controls. The Circular is issued under the authority of the FMFIA.

Outlay: Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the states for Medicaid benefits.

P

Part A: The part of Medicare that pays hospital and other institutional provider benefit claims, also referred to as Medicare Hospital Insurance or HI trust fund.

Part B: The account within the Medicare Supplementary Medical Insurance or SMI trust fund that pays for a portion of physician and supplier claims.

***Patient Protection and Affordable Care Act* (PPACA):** A federal statute enacted in 2010 to drive health insurance reforms. The law requires insurers to accept all legal applicants, to cover a specific list of benefits, and to charge the same rates regardless of pre-existing conditions.

***Payment Integrity Information Act of 2019* (PIIA):** A law that requires government agencies to identify, report, and reduce improper payments in the government's programs and activities. The implementation guidance in Appendix C of OMB Circular A-123 requires executive branch agency heads to review their programs and activities annually and identify those that may be susceptible to significant improper payments.

Program Integrity (PI): Encompasses the operations and oversight necessary to ensure that accurate payments are made to legitimate providers for appropriate and reasonable services for eligible beneficiaries of the Medicare, Medicaid, CHIP, and PPACA programs. PI activities target the range of causes of improper payments, errors, fraud, waste, and abuse.

Program Management: The CMS operational account which supplies CMS with the resources to administer Medicare, the federal portion of Medicaid, and other CMS responsibilities. The components of Program Management are program operations, survey and certification, research, and federal administrative costs.

Provider: A healthcare professional or organization that provides medical services.

Public Health Emergency (PHE): An emergency need for healthcare [medical] services to respond to a disaster, significant outbreak of an infectious disease, bioterrorist attack, or other significant or catastrophic event.

Q

Quality Improvement Organizations (QIOs): Formerly known as Peer Review Organizations (PROs), QIOs monitor the quality of care provided to Medicare beneficiaries to ensure that healthcare services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

R

Recipient: An individual covered by the Medicaid program. Also referred to as a beneficiary.

Retiree Drug Subsidy (RDS) Program: The RDS is one of several options available under Medicare that is designed to encourage employers and unions to continue to provide high-quality prescription drug coverage to their retirees.

Revenue: An inflow of resources that the government earns, demands, or receives by donation. Resources arise when the government entity provides goods and services, or from the government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties).

Risk Adjustment (private health insurance market): The risk adjustment program is designed to protect issuers that attract a high-risk population, such as those with chronic conditions. Under this program, money is transferred from issuers with lower-risk enrollees to issuers with higher-risk enrollees. This is a state-based program that applies to non-grandfathered plans in the individual and small group markets, inside and outside of Exchanges.

S

***Self-Employment Contribution Act* (SECA) Payroll Tax:** A tax on self-employed individuals of 2.9% of taxable net income, with no limitation. Medicare's share of SECA is used to fund the HI Trust Fund.

Significant Deficiency: A deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Statement on Standards for Attestation Engagements 18 (SSAE 18): For the purposes of CMS, a report on the internal controls of a servicing organization issued by an independent public accountant in accordance with standards promulgated by the American Institute of Certified Public Accountants (AICPA). The AICPA SSAE 18 defines the professional standards to assess the internal controls at a service organization.

***Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment* (SUPPORT) *for Patients and Communities Act of 2018*:** Legislation that includes Medicaid, Medicare, and public health reforms to combat the opioid crisis by advancing treatment and recovery initiatives, improving prevention, protecting communities, and bolstering efforts to combat illicit synthetic drugs.

Supplementary Medical Insurance (SMI) Trust Fund: Also known as Part B. The part of Medicare that pays physician services, outpatient hospital services, other related medical and health services for voluntarily insured aged and disabled individuals, as well as private plans to provide prescription drug coverage.

T

Transitional Assistance: An interim benefit for 2004 and 2005 that provided up to $600 per year to assist low-income beneficiaries who had no drug insurance coverage with prescription drug purchases. This benefit also paid the enrollment fee in the Medicare Prescription Drug Discount Card program.

Transitional Assistance Account: The separate account within the SMI trust fund that managed revenues and expenditures for the transitional assistance drug benefit in 2004 and 2005.

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