FINANCIAL REPORT *fiscal year 2021*

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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) 2021 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:

1 MANAGEMENT'S DISCUSSION & ANALYSIS

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

2 FINANCIAL SECTION

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

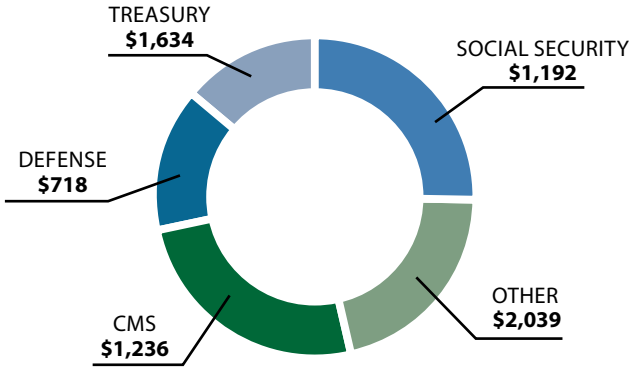
3 OTHER INFORMATION

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.

2021 FEDERAL OUTLAYS

CMS has outlays of approximately $1,236 billion (net of offsetting receipts and payments of the Health Care Trust Funds) in fiscal year (FY) 2021, approximately 18 percent of total Federal outlays.

CMS employs approximately 6,263 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 health care data in the United States (U.S.).

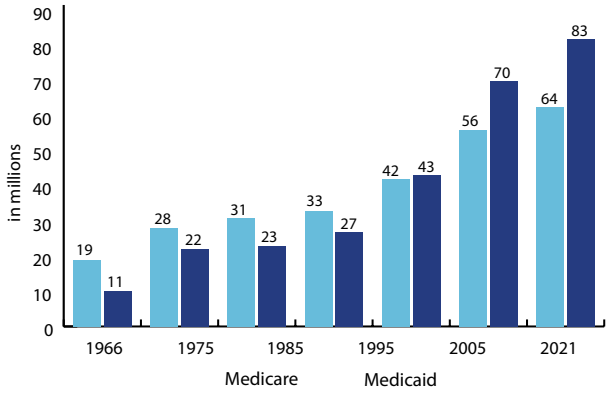


$ IN BILLIONS

SOURCE: U.S. DEPARTMENT OF THE TREASURY

2021 PROGRAM ENROLLMENT

CMS is one of the largest purchasers of health care in the world. Medicare, Medicaid, and Children's Health Insurance Program (CHIP) provide health care for one in four Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to approximately 64 million beneficiaries. Medicaid enrollment has increased from 11 million beneficiaries in 1966 to about 83 million beneficiaries.



A MESSAGE FROM THE ADMINISTRATOR

Chiquita Brooks-LaSure

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) Agency Financial Report for fiscal year (FY) 2021.

The past year has presented unparalleled challenges to our nation's health and healthcare system. The COVID-19 public health emergency has underscored the vital importance of CMS programs in ensuring Americans are able to receive healthcare when they need it most. Our programs have served as an essential safety net during the pandemic: over 11 million people have enrolled in Medicaid and the Children's Health Insurance Program (CHIP) since February 2020, leading to a record of more than 83 million people receiving coverage through Medicaid and CHIP. More than 2.8 million people enrolled in Marketplace coverage through HealthCare.gov and State-based Marketplaces during the 2021 Special Enrollment Period, with lower premiums and out-of-pocket costs due to provisions of the American Rescue Plan Act. Additionally, Medicare has offered essential supports that enable seniors and people with disabilities to receive life-saving care in their homes and communities.

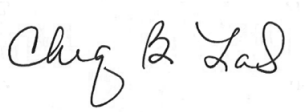
CMS is also providing essential access to life-saving COVID-19 vaccines, working with providers, states, and insurers to ensure they are free and easily available. Medicare payment policies have helped remove barriers to vaccinations, while CMS has delivered support to healthcare providers as they care for the hardest-hit communities.

As CMS continues to respond to the public health emergency and encourage vaccination, we are hard at work strengthening Americans' access to quality, affordable coverage. We continue to support consumers enrolling in Medicare, Medicaid and Marketplace plans. The agency released a series of regulations to protect patients from surprise medical bills. Further, we are charting a new course for CMS's Innovation Center, including a focus on health equity, in its work to improve the healthcare system.

CMS is also working to better serve the public as a trusted, transparent partner and steward in the years ahead. The public health emergency has laid bare and exacerbated longstanding health disparities. I have set several key priorities for CMS over the next several years: advancing health equity, expanding quality coverage and care, and improving health outcomes. We will engage our many partners at every opportunity as we achieve this vision, especially those directly served by our programs, driving innovation within the health system and promoting excellence in our agency operations.

I am honored to serve as Administrator alongside an exceptionally talented team. CMS staff have united to respond to the public health emergency, and their talents will enable us to achieve our unyielding focus of improving the health and livelihoods of all Americans. As the largest payer and purchaser of healthcare in the country, CMS is committed to meeting this moment.

Chiquita Brooks-LaSure



CMS Administrator
November 2021

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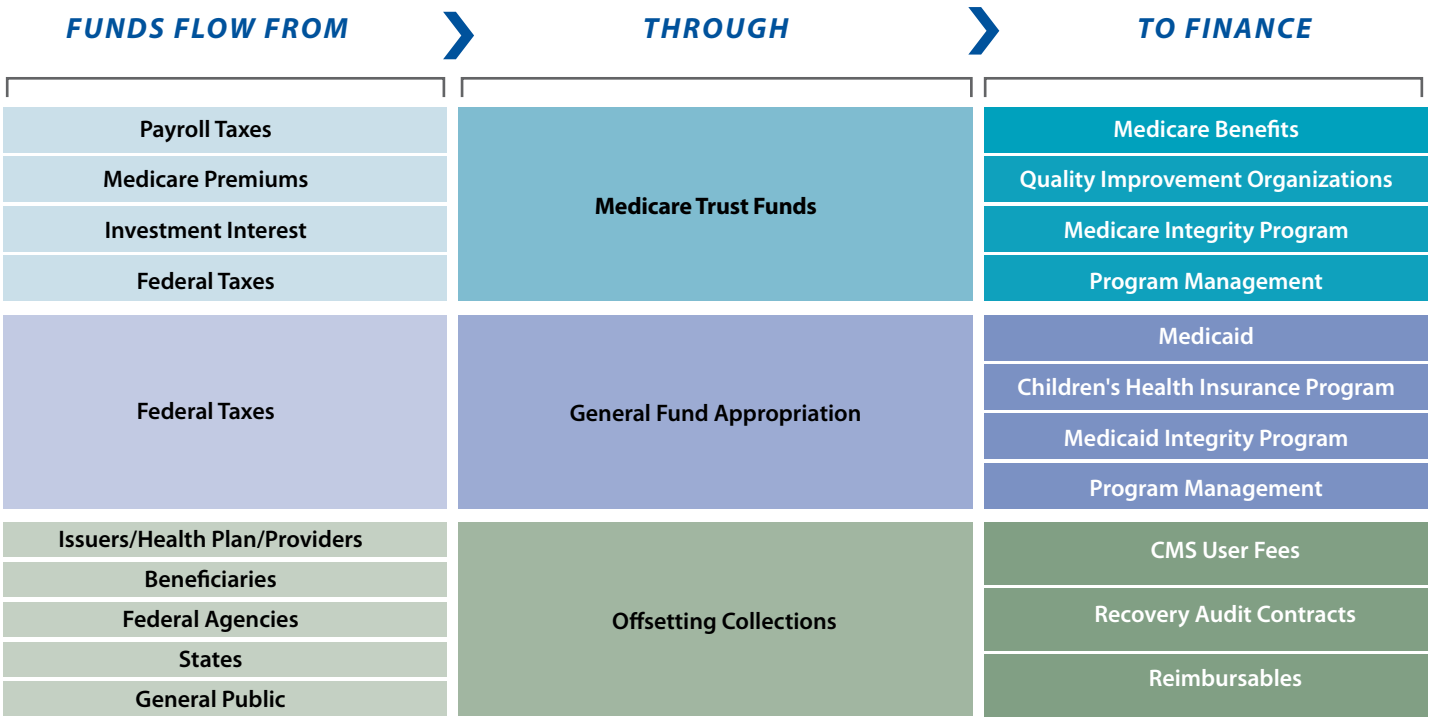
FINANCING OF CMS PROGRAMS & OPERATIONS



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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Approved leadership as of September 29, 2021

Chiquita Brooks-LaSure
Administrator

Jonathan Blum
Principal Deputy Administrator and Chief Operating Officer

Erin Richardson
Chief Operating Officer

Karen Jackson
Deputy Chief Operating Officer

OFFICE OF BURDEN REDUCTION & HEALTH INFORMATICS

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Director

Stella Mandl,
Deputy Director

OFFICE OF PROGRAM OPERATIONS & LOCAL ENGAGEMENT

Nancy O'Connor,
Director Of Drug Health Plan Operations

Vacant, *Dep. Dir. Of Drug Health Plan Opers.*

Gregory Dill,
Dep. Dir. For Innovation & Fin. Mgmt.

John Hammarlund,
Dep. Dir. For Local Eng. & Admin.

Ray Hurd, *Dep. Dir. For Strategy & Business Operations*

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Andy Shatto,
Deputy Director

OFFICE OF EQUAL OPPORTUNITY AND CIVIL RIGHTS

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Alaina Jenkins, *Deputy Director*

OFFICE OF COMMUNICATIONS

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Karen Aldana, *Dep. Dir. for Communications*

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Deputy Director

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Capt. Wanda Finch, *Deputy Director*

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Paul Spitalnic,
Director and Chief Actuary

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Kathleen Cantwell, *Director*

Olen Clybourn, *Deputy Director*

OPERATIONS

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Director

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Director & CMS Chief Information Officer (CIO)

Bobby Saxon,
Deputy Director

George Hoffmann,
Deputy Director & Deputy CIO

George Linares,
CMS Chief Technology Officer

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Director

Derrick Heard,
Deputy Director

OFFICES OF HEARINGS AND INQUIRIES

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James Slade,
Deputy Director

OFFICE OF FINANCIAL MANAGEMENT

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John Czajkowski,
Deputy Director

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Director

Vacant,
Deputy Director

OFFICE OF STRATEGY, PERFORMANCE AND RESULTS

Vacant,
Director

OFFICE OF SECURITY, FACILITIES AND LOGISTICS OPERATIONS

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Director

Elizabeth Mack,
Deputy Director

OFFICE OF HUMAN CAPITAL

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Stephanie Bovell,
Deputy Director

CENTER FOR CLINICAL STANDARDS AND QUALITY

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Deputy Director

Jeneen Iwugo,
Deputy Director

Shari Ling, M.D.,
Deputy Chief Medical Officer

Michelle Schreiber, M.D.,
Dep. Director for Quality & Value

OFFICE OF CLINICIAN ENGAGEMENT

Barry Marx, M.D.,
Director

CENTER FOR MEDICARE AND MEDICAID INNOVATION

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Deputy Administrator & Director

Amy Bassano,
Deputy Director

Arrah Tabe-Bedward,
Deputy Director

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Deputy Administrator and Director

Elizabeth Richter,
Deputy Center Director

Cheri Rice,
Deputy Director

CENTER FOR MEDICAID AND CHIP SERVICES

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Ann Marie Costello,
Deputy Director

Karen Shields,
Deputy Director

CENTER FOR PROGRAM INTEGRITY

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Deputy Administrator and Director

Bradley Hart,
Deputy Director

George Mills, Jr.,
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CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT

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Deputy Administrator and Director

Jeff Grant,
Deputy Director for Operations

Jeff Wu,
Deputy Director for Policy

Michael Jimenez,
Center Chief Technology Officer

* Acting

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MANAGEMENT'S DISCUSSION & ANALYSIS

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OUR ORGANIZATION

CMS, an operating division of the Department of Health and Human Services (HHS), employs approximately 6,263 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.

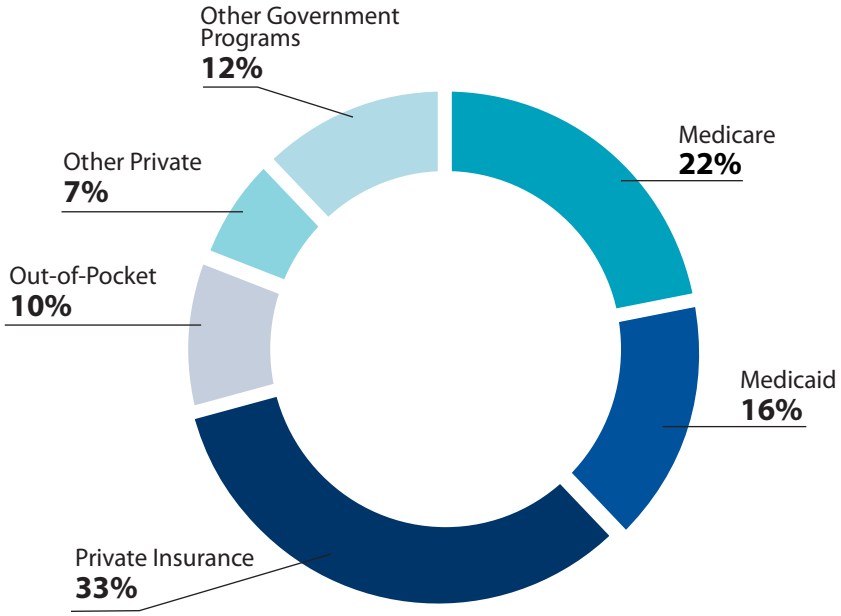
CMS's employees write policies and regulations that establish program eligibility and benefit coverage; set payment rates; safeguard the fiscal integrity of the programs it administers from improper payments including fraud, waste, and abuse; and develop quality measurement systems to monitor quality, 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.

OVERVIEW

CMS administers Medicare, Medicaid, CHIP, and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) program. The passage of the *Patient Protection and Affordable Care Act* (PPACA) led to the expansion of CMS's role in the healthcare arena beyond our traditional role of administering the Medicare, Medicaid, and CHIP Programs. Over the last 50 years, CMS evolved into the largest purchaser of healthcare and now maintains the nation's largest collection of healthcare data. Based on the latest 2021 projections, Medicare and Medicaid (including state funding) represent 38 cents of every dollar spent on healthcare in the United States (U.S.)—or looked at from three different perspectives: 52 cents of every dollar spent on nursing homes, 42 cents of every dollar received by U.S. hospitals, and 36 cents of every dollar spent on physician services.

The Nation's Health Care Dollar FY2021



Source: U.S. Treasury

Medicare

Medicare was established in 1965 as Title XVIII of the *Social Security Act*. 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 program was further expanded in 2003 with the *Medicare Prescription Drug, Improvement, and Modernization Act* (MMA), which included a prescription drug benefit for all Americans with Medicare beginning January 1, 2006.

Medicare routinely processes over one billion fee-for-service (FFS) claims a year and accounts for approximately 11 percent of the federal budget. 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 almost about 64 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 a spouse already paid for it through their payroll taxes while working. The HI program pays for hospital, skilled nursing facility (SNF), 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 helps cover doctors' services and outpatient care. The SMI program pays for physician care, outpatient hospital services, some home healthcare, laboratory tests, durable medical equipment, designated therapy, some outpatient prescription drugs, and other services not covered by HI, such as some of the services of physical and occupational therapists. SMI helps pay 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 Medicare Advantage 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 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. Individuals with Medicare have the option to choose to enroll in healthcare plans that contract with CMS instead of receiving services under traditional Medicare FFS arrangements offered under original Medicare. Many MA plans offer additional services such as prescription drugs, vision, and dental benefits, and also may cover some or all of an enrollee's out-of-pocket costs. 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 dual-eligible) are automatically enrolled in the Medicare Prescription Drug Benefit program; assistance with premiums and cost sharing is available to full-benefit dual-eligible, and other qualified low-income, individuals.

Medicaid

Enacted in 1965 as Title XIX of the *Social Security Act*, 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, states 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, elderly adults, and people with disabilities. Medicaid is the primary source of healthcare for more than 83 million individuals. Over 10 million people are dually eligible for both Medicare and Medicaid.

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. In fiscal year (FY) 2021, CMS projects that approximately 10 million children will be enrolled in CHIP for at least one month during the year.

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 312,360 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.

Health Insurance Marketplaces

CMS is charged with implementing many of the provisions of the PPACA that relate to private health insurance. CMS oversees compliance with federal market 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 Marketplace (Marketplaces) where health insurance issuers compete on the basis of price and quality.

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.

Permanent Risk Adjustment Transfers

The risk adjustment program 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. 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 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 that 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 can be extended. Waivers must not increase the federal deficit.

Enhanced Direct Enrollment

Enhanced Direct Enrollment allows consumers to apply for and enroll in health coverage through the Federal-facilitated Marketplaces and State-based Marketplaces that use the federal platform without needing to visit HealthCare.gov. This capability improves the consumer experience while shopping for, applying for, and enrolling in Marketplace coverage through third party websites. It allows consumers to interact directly with private enrollment partners and complete all steps in the eligibility and enrollment process for qualified health plans on an approved single website. Enhanced Direct Enrollment is the result of years of work between CMS, issuers, and other third party partners seeking to provide consumers a more tailored enrollment experience and ability to manage their information and coverage year-round.

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 is developing a new Strategic Plan (2022-2026), which will be released with the President's Budget in February 2022. Key CMS performance measures from the previous Strategic Plan are featured in the **FY 2022 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 of our ability to meet them.

Our FY 2021 performance measures track progress in our major program areas, including measuring error rates. In addition, we measure quality improvement initiatives geared toward 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 will be reported through the FY 2023 President's Budget process.

CMS'S FY 2021 VISION STATEMENT & 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 individuals dedicated 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 these six overarching goals:

1. Advance Health Equity by Addressing the Health Disparities that Underlie Our Health System
2. Build on the Affordable Care Act and Expand Access to Quality, Affordable Health Coverage and Care
3. Engage Our Partners and the Communities We Serve Throughout the Policymaking and Implementation Process
4. Drive Innovation to Tackle our Health System Challenges and Promote Value-based, Person-centered Care
5. Protect Our Programs' Sustainability for Future Generations by Serving as a Responsible Steward of Public Funds
6. Foster a Positive and Inclusive Workplace and Workforce, and Promote Excellence in All Aspects of CMS's Operations

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

Coverage to Care Initiative

Health literacy is important to any public health outreach and to better understand using any type of insurance or health coverage. Low levels of health literacy can be seen within any population and they are especially important to consider for people with limited English proficiency as well as other minority, underserved, and otherwise disadvantaged populations. To assist in this effort, CMS continued its outreach through the Coverage to Care (C2C) initiative. C2C is an initiative that helps consumers understand health coverage and use it to connect to primary care and preventive care services. While C2C is an initiative meant for any type of consumer with any type of health coverage, CMS outreach efforts are able to focus on minority and underserved consumers through trusted community partners. Addressing health disparities and health insurance literacy are increasingly necessary to support needs post 2019 Novel Coronavirus Disease (COVID-19) due to foregone care; new health issues; behavioral health concerns; new use of telehealth, care management, and remote monitoring; and even the long-term effects of COVID-19.

C2C maintains a suite of consumer-facing resources, partner resources, a website, and regular partner outreach. Staying in touch with partner needs, C2C also consistently examines the need for any new resources to reflect changes in telehealth, digital tools, and COVID-19. These are in addition to the main goal of the initiative to emphasize the importance of primary and preventive care. Specific examples of C2C resources developed in 2021 include the C2C Telehealth for Patients (available in eight languages) and the C2C telehealth for providers. Our outreach efforts in FY 2021 focused on minority health and outreach, and education to racial and ethnic minorities, people with disabilities, limited English proficiency, rural populations, and LGBTQ+ populations. To effectively reach minority populations, we must use trusted community partners and tailored resources. These efforts have been an essential part of C2C and equity-related activities. This best practice was underscored by Executive Order 13985, A*dvancing Racial Equity and Support for Underserved Communities through the Federal Government*.

Our FY 2021 work also included evaluation activities to ensure the initiative's effectiveness and to identify the best focus areas for future activities based on research. Part of this research has allowed for early work in the area of measuring return on investment, which is showing promising numbers for the effect of C2C on ultimate healthcare costs.

Minority Research Grant Program

CMS continues to support the Minority Research Grant Program (MRGP). This program supports researchers at minority serving institutions in exploring how CMS can better meet the healthcare needs of racial and ethnic minorities, people with disabilities,

members of the LGBTQ+ communities, individuals with limited English proficiency, individuals living in rural communities, and individuals adversely affected by persistent poverty and inequality. MRGP helps to develop capacity at minority serving institutions to research health disparities and social determinants of health. It also assists CMS and others in healthcare to identify and understand the root cause of particular health disparities--processes, practices, behaviors, burdens--and identify replicable interventions. For example, currently funded MRGP grantees are working to address health disparities among underserved African American men as well as racially and ethnically diverse preschoolers.

Additionally, in FY 2021, CMS worked to expand stakeholder engagement and outreach to increase awareness of the programs, resulting in an increase in the number of grant applications over past years. CMS also collaborated with CMS quality improvement stakeholders across the agency to share findings from the research and to translate research findings across CMS programs and quality initiatives. CMS enhanced the Notice of Funding Opportunity to require grantees to align health equity research projects with the CMS Disparities Impact Statement. This alignment will ensure that research funded through this initiative establishes a quality improvement approach to identify and address a minority barrier or underserved communities.

Mapping Medicare Disparities Tool

During FY 2021, CMS continued to enhance the Mapping Medicare Disparities (MMD) Tool, an interactive map that identifies geographic areas of disparities between subgroups of Medicare beneficiaries. The MMD Tool identifies disparities by geography, race, and ethnicity in chronic disease prevalence, costs, hospital and emergency department utilization, readmission and mortality rates, potentially disabling conditions, preventable hospitalizations, and preventive services, as well as over 50 quality measures for analyzing and comparing hospitals based on geography, hospital type, and hospital size.

CMS also continued to develop other new tools, including the Disparities Cost Calculator, an interactive tool that provides the cost of disparities among beneficiaries with select health conditions. The data can be used by organizations to build the business case to address disparities. Additionally, CMS continued to produce public facing annual reports detailing the quality of care received by people enrolled in Medicare Advantage. This allows for measurement and public reporting of the nature and extent of healthcare disparities. Strategic reporting by race, ethnicity, gender, and by rural and urban populations provides useful information for targeting quality improvement activities and resources, monitoring health and drug plan performance, and advancing the development of culturally and linguistically appropriate quality improvement interventions and strategies.

CMS worked to better understand emerging and persistent disparities related to the COVID-19 pandemic, producing data snapshots to publicly report Medicare data for COVID-19 hospitalizations stratified by race, ethnicity, dual status, and disability, among other factors. This analysis helps drive CMS's policy and identifies programmatic needs to address health equity concerns in our response to the current public health emergency (PHE). We aligned data collection across CMS survey instruments and programs related to demographic and social determinants of health data elements, which helped to increase collection, reporting, and use of social determinants of health data. This approach improves CMS's data collection and is critical to support CMS's understanding of disparities in healthcare and the drivers of these disparities across our programs and policies.

Health Care Payment Learning and Action Network

CMS is committed to developing a healthcare system that attains the highest level of health for all patients and eliminates health disparities. Achieving this goal requires centering equity in all stages of model design, operation, evaluation, and aligning these concepts with other CMS programs. It also requires engaging providers who have not previously participated in value-based care initiatives and ensuring that eligibility criteria and application processes encourage care for historically disadvantaged populations, including racial, ethnic and rural communities, as well as those with disabilities. A key part of this work is understanding the current impact of Innovation Center models across all patients. For instance, the characteristics of beneficiaries attributed to our models requires utilizing patient-level demographic data, standardized social needs data, as well as tracking data on penetration of Innovation Center models in underserved communities.

The Health Care Payment Learning and Action Network (LAN) is an active partnership between public and private healthcare leaders dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate our healthcare system's adoption of alternative payment models (APMs). The LAN mobilizes payers, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs as well as improve patient experiences and outcomes by encouraging public/private adoption of value-based approaches to healthcare payment and delivery. The LAN launched the Health Equity Advisory Team (HEAT) in June 2021 to help identify and prioritize opportunities to advance health equity through APMs. This increases health equity policy collaboration to influence design principles and to inform LAN priorities as well as initiatives.

CMS Affinity Groups

Improving health equity is a top priority at CMS. As such, we participated in a collaborative HHS health equity assessment focused on quality of care and disparities in the postpartum period among Medicaid and CHIP beneficiaries. In particular, we looked at postpartum visits and follow-up services for conditions associated with maternal morbidity and mortality, such as hypertension, diabetes, and postpartum depression. As part of this assessment, CMS engaged stakeholders through focus group conversations with nine state teams that are participating in the newly launched Improving Postpartum Care CMS Affinity Group. All state teams comprise Medicaid staff and most include other partners including providers, health plan representatives, other state staff and, in some cases, members of non-governmental groups.

Tribal Affairs – Outreach and Enrollment

CMS works with the Indian Health Service (IHS), Tribes and Tribal organizations, and urban Indian organizations to provide training and outreach and education to encourage enrollment of American Indians and Alaska Natives (AI/AN) in Medicare, Medicaid and CHIP, and the Marketplace. AI/AN populations continue to have the highest uninsured rates compared to other populations and experience significant health disparities. The majority of AI/ANs reside in rural and frontier communities where access to IHS healthcare might be limited. Increased outreach and enrollment of AI/ANs in CMS programs result in greater access to services that IHS might not be able to provide and bring in third party resources to support healthcare to the uninsured.

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

American Rescue Plan Implementation

CMS is charged with implementing many of the provisions of the *American Rescue Plan Act* (ARP) that relate to private insurance. In April 2021, CMS implemented ARP provisions for the Federally-facilitated Marketplaces that improve affordability for some consumers. Through the 2022 plan year, consumers with incomes over 400 percent of the federal poverty level may qualify for advanced payments of the premium tax credit (APTC). The provisions also update certain statutory payment parameters to provide increased subsidies to eligible consumers. In July 2021, CMS implemented another major ARP provision which enhanced affordability for consumers who received unemployment compensation in 2021. In August 2021, CMS implemented an automatic redetermination process so that many current enrollees who are eligible for increased APTC and had not actively applied for those increases would automatically receive them.

Expanding Access to Mental Health Services under Traditional Medicare

CMS is continuing to expand access to mental health services under Medicare by covering services that support behavioral health and wellness, including alcohol screening and counseling. The annual wellness visit now includes depression screening, behavioral health integration, bundled payments for opioid use disorder (OUD), chronic care management for patients with multiple chronic conditions, diagnostic psychological and neuropsychological evaluation and testing, and drug therapy or pharmacological management using medication(s) to treat disease.

2021 Marketplace Special Enrollment Period

CMS partnered with community and stakeholder organizations to conduct an outreach campaign promoting awareness of the 2021 Special Enrollment Period, from February 15, 2021 to August 15, 2021, to a broad and diverse range of consumers. Consumers were eligible to apply for coverage through the special enrollment period between February 15 and August 15, 2021. This campaign focused on education and awareness of this special enrollment period with a new opportunity to enroll in English, Spanish, and other languages. Outreach efforts also fostered awareness by encouraging the uninsured and those who come to HealthCare.gov to explore coverage to continue the process and enroll.

Social Determinants of Health

During 2021, CMS published *State Health Officer (SHO)# 21-001 RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health* (SDOH). SDOH letter to describe opportunities under Medicaid and CHIP to support states with designing programs, benefits, and services that could more effectively improve population health, reduce disability, and lower overall healthcare costs in the Medicaid and CHIP programs by addressing SDOH. The letter described: (1) several overarching principles that CMS expected states to adhere to within their Medicaid and CHIP programs when offering support and services that address SDOH; (2) services and supports that are commonly covered in Medicaid and CHIP programs to address SDOH; and (3) federal authorities and other opportunities under Medicaid and CHIP that states can use to address SDOH.

Money Follows the Person Capacity Building Supplemental Funding

In light of high rates of COVID-19 infection and death among persons residing in nursing facilities and other medical institutions, funding was made available to states implementing the Money Follows the Person (MFP) Capacity Building Supplemental Funding demonstration. Approximately $5 million was awarded per state for planning and capacity building activities to support long-term services, system transformation design and implementation, and expansion of home and community-based services (HCBS) capacity. MFP demonstrations used funds for activities such as:

- assessing HCBS system capacity and determining the extent to which additional providers and/or services might be needed;
- developing and implementing strategies to reduce institutional bed capacity and transition impacted individuals to more integrated settings;
- engaging stakeholders in system planning, development, and implementation activities;
- provider service worker and direct service worker recruitment, education, training, and technical assistance (including training people with disabilities to become direct service workers);
- caregiver training and education; and
- assessing and implementing changes to reimbursement rates and payment methodologies to expand HCBS provider capacity and/or improve HCBS and/or institutional service quality.

Enhancing Access to Medicaid and CHIP Coverage

CMS implemented streamlined processes and timelines to review and approve hundreds of state requests for flexibilities during the COVID-19 PHE, including state requests for state plan amendments, regulatory authorities, section 1135 and 1115 requests. Under these new protocols and timelines, CMS was able to be responsive to state requests to grant flexibilities that promoted access to Medicaid and CHIP coverage during the PHE. In doing so, CMS also developed multiple new streamlined templates and instructions to make it easier for states to submit these requests. CMS also provided extensive technical assistance to states as they have responded to the COVID-19 PHE. CMS utilized Medicaid.gov to provide information and technical assistance to states on complex policy issues.

To help Medicaid and CHIP agencies prepare for and respond to PHEs, disasters, and other emergencies, CMS and the Medicaid and CHIP Coverage Learning Collaborative updated a toolkit on the strategies available to support Medicaid and CHIP operations and beneficiaries. This toolkit was updated with additional strategies and lessons learned from the COVID-19 PHE, and now includes a new strategic framework for Medicaid and CHIP agencies as they prepare to respond to a future disaster or PHE.

Additionally, CMS released a State Medicaid Director Letter on Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions to provide guidance to states on Section 1001 of the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act*, which prohibits states from terminating Medicaid eligibility for eligible juveniles who become inmates of public institutions. Facilitating enrollment in Medicaid and supporting access to healthcare services upon release can be crucial to ensuring a successful transition to the community following incarceration.

Coverage post the Public Health Emergency ('Unwinding')

CMS released a State Health Officer Letter helping states understand expectations and timeliness standards for applications on all other COVID-related changes and the need for states to develop a Post-COVID Eligibility and Enrollment Operational Plan, which adopts one of four risk-based approaches to prioritize needed eligibility actions on individuals more likely to not have ongoing eligibility. CMS is developing a COVID-related Pending Eligibility and Enrollment Actions Resolution Planning Tool to assist states in the planning process. The agency will also release guidance specific to COVID-19 program integrity issues, including beneficiary eligibility, to assist states as they assess whether to make changes adopted during the PHE permanent.

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

Data Exchange Between CMS and the States

CMS finalized the Interoperability and Patient Access Rule, which mandates daily submission of certain Medicare Secondary Payer payments and dual eligibility status files by April 1, 2022. Currently, states are required to submit these files at least monthly to CMS. Without daily exchanges, CMS lags in its ability to automatically enroll individuals in Medicare drug plans; deem them automatically eligible for the low-income subsidy for Medicare Prescription Drug Benefit premiums, deductibles, and copayments; and terminate or activate state payment of Medicare premiums. Increasing the frequency of federal-state data exchanges will improve beneficiaries' experience with their Medicare benefits and ensure they are affordable. This will also reduce burden on states and providers to reconcile incorrect payments due to data lags, and improve provider compliance with the prohibition on biQualified Medicare Beneficiaries for Medicare HI and SMI cost-sharing.

By September 2021, 19 states submitted files on dual eligibility status daily, and 23 states exchanged data daily on state payment of Medicare premiums. CMS provides technical assistance to states through the State Data Resource Center, including tip sheets, frequently asked questions, and recorded webinars.

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. We updated the Medicaid Provider Enrollment Compendium in March 2021 to provide additional sub-regulatory guidance to assist states in applying the regulatory requirements. CMS also continues to offer the Data Compare Service to states, which allows them to rely on Medicare's screening in lieu of conducting a state screening particularly during revalidation. Using the data compare service, a state provides a Medicaid provider enrollment data extract to CMS, and then CMS returns information indicating which providers have undergone a Medicare screening on which the state can rely (thus reducing the state's or territory's work load). Data compare helps states identify providers who may need termination or deactivation. CMS also conducted a pilot process to screen Medicaid-only providers on behalf of states and produce a report of providers with licensure issues, criminal activity, as well as Do Not Pay activity.

Medicaid Integrity Institute

CMS offers training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute (MII). Despite the change to a virtual environment in FY 2021, state interest and participation was strong and consistent with previous years. CMS continued a robust virtual training program that continued throughout the COVID-19 PHE. For example, courses included topics such as COVID-19 Fraud, Waste, and Abuse; Payment Error Rate Measurement (PERM) Corrective Action Plan (CAP) Development and Monitoring program; integrity opportunities for the territories; and Medicaid managed care. More information is located at the **Medicaid Integrity Institute**.

State Education and Technical Assistance

CMS began new work in FY 2021 to conduct one-on-one state-specific education and technical assistance, beginning with Arkansas, North Dakota, and Wisconsin. Through this work, states self-identified areas of Medicaid and CHIP program oversight and monitoring with which they sought CMS support and technical assistance. CMS then created educational tools, training materials, and toolkits to assist the state with strengthening the oversight of its programs.

Medicaid Eligibility Quality Control Program

Under the Medicaid Eligibility Quality Control (MEQC) program, states design and conduct pilots to evaluate the 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"), which allow states to implement prospective improvements in eligibility determination processes prior to their next PERM review. In FY 2021, HHS worked with the Cycle 1 states to submit their MEQC summary-level reports and CAPs; the Cycle 2 states to complete their MEQC reviews and begin preparing summary-level reports and CAPs; and the Cycle 3 states to begin their MEQC reviews.

Rural Emergency Hospitals

CMS published a Request for Information (RFI) Outpatient Prospective Payment System Ambulatory Surgical Center Proposed Rule in July 2021, in response to Congress enacting Section 125 of the Consolidated Appropriations Act of 2021 (CAA). As

defined in the CAA, Rural Emergency Hospitals (REHs) are facilities that convert from either a critical access hospital or a rural hospital with less than 50 beds that does not provide acute care inpatient services. The CAA established a new provider type, REHs, to ensure access to emergency care for those living in rural communities. CMS will use the information obtained from the RFI to inform our policymaking as we establish health and safety requirements, payment policies quality measures, and reporting requirements for REHs via rulemaking. Furthermore, REHs will furnish emergency department services and observation care as well as other outpatient medical and health services as specified by HHS through rulemaking. The CAA requires that the statutory provisions for REHs be implemented on or after January 1, 2023.

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 CMS to improve the monitoring and oversight of Medicaid managed care programs.

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

Redesigned CMS Website

Central to driving innovation is ensuring CMS data is available for public use. This allows actors inside and outside of government to leverage CMS data to conduct research and derive new insights, as well as create new products and services to support value-based, person-centered care. In support of open data, CMS recently launched a redesigned website entitled **Data.CMS.gov** that makes it easier to discover, access, and understand CMS data. The goal of the redesign is to ensure the CMS data is readily available to public users in open, accessible, and machine-readable formats.

Promote New Innovative Technologies

CMS is committed to ensuring Medicare beneficiaries and their clinicians have timely access to novel medically necessary products and services that drive value-based, person-centered care. CMS is in a notable period of innovation in healthcare with new technologies that facilitate telehealth and remote monitoring, as well as advanced intelligence algorithms to support healthcare decisions, digital health products, novel diagnostic testing, and new types of cancer-fighting drugs and biologicals. To provide access to many types of beneficial new technologies, CMS must make timely decisions regarding Medicare coverage, coding, and payment. In FY 2021, CMS reorganized its workforce to support access and equity for Medicare beneficiaries to new, innovative products and healthcare services. For example, this workforce has seen a more than four-fold increase, compared to four years ago, in the number of submissions from manufacturers for new technology add-on payment in the inpatient hospital setting. In addition, our workforce is dedicated to customer service by streamlining navigation of our coverage, coding, and payment processes for manufacturers, providers, and other stakeholders who are involved in coordinating the care of our beneficiaries.

Creating New Opportunities for Innovative, 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 lack of coordination can lead to fragmented care for dually eligible individuals, misaligned incentives for payers and providers, as well as 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 beneficiaries. Last fiscal year, about 12 percent of full-benefit dually eligible individuals were in integrated care.[1] CMS will continue to work to increase this percentage in a variety of ways, including through existing and new platforms for integration.

In recent years, CMS has partnered with states to develop innovative, integrated care and financing models. CMS has focused on initiatives to better integrate and strengthen access to care for dually eligible individuals and to eliminate unnecessary cost shifting between the Medicare and Medicaid programs. There are a range of approaches to integrating Medicare and Medicaid benefits and/or financing, including through implementing new demonstrations and enhancing existing programs.

1 CMS analysis. Data on number of full-benefit duals: **https://www.cms.gov/files/document/ medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf**. Count of duals in integrated care from Integrated Care Resource Center analysis.

Increased Nursing Home Oversight

CMS's Survey and Certification program has continued to deploy federal surveyors and state surveyors (funded by CMS) to conduct onsite inspections to ensure minimum standards of care are met, particularly during COVID-19. Since March 2020, CMS and states have conducted over 67,000 focused infection control surveys. CMS will continue improving the consistent identification and remediation of non-compliance to protect resident health and safety through clear survey guidance. The guidance is responsive to changing needs influenced by COVID-19 outbreaks and the availability of vaccines, and the need for practical, easily accessible training. CMS will continue to develop policies and procedures to increase consistent enforcement across CMS locations, and the regular monitoring of key metrics of performance and outcomes.

As part of our response to the pandemic, beginning in April 2020, CMS announced a new requirement for nursing homes to report data on a weekly basis to the CDC about COVID-19 cases, deaths, and supply levels, among other metrics. The data posted by CMS on the COVID-19 Nursing Home Data Website is reported by nursing homes and collected at the federal level by the CDC through the National Healthcare Safety Network (NHSN) system. The CDC NHSN system is used to ensure a nationwide standardized process of collecting COVID-19 data from nursing homes in each state. CMS and CDC use this data in a coordinated effort to provide detailed information to state and local health departments and nursing homes to inform national infection prevention and control policies and other strategies to further support nursing home residents.

On May 11, 2021, CMS published an interim final rule with a comment period that added COVID-19 vaccination reporting requirements for nursing home staff and residents to the existing COVID-19 nursing home reporting requirements. This rule also requires that nursing homes educate staff, residents, and families on the COVID-19 vaccination, and offer the vaccine to staff and residents when available. The comment period ended on July 12, 2021.

Long-Term Services and Supports (LTSS) Rebalancing Toolkit

The Long-Term Services and Supports (LTSS) Rebalancing Toolkit supports states in their efforts to expand and enhance HCBS and to rebalance or recalibrate LTSS systems from institutional to community-based care. The toolkit identifies examples of innovative state models and best practices for strengthening state infrastructure to increase transitions from institutional settings to community-based settings, divert institutionalization, facilitate interaction of long-term care provider markets and states' Medicaid policies, and improve community living for individuals eligible for Medicaid HCBS.

Expanded Adoption of Blue Button 2.0

CMS is committed to promoting value-based, person-centered care by empowering patients to share their health information securely with any provider, application, or researcher they choose. In 2021, CMS led efforts to expand adoption of Blue Button 2.0, which allows beneficiaries to connect their data to applications and other tools developed by innovative companies. Information is then shared in an electronic, standards-based format that is commonly accepted and used across the healthcare system while also ensuring privacy and security. Using Blue Button 2.0, CMS vendors have designed innovative applications that support beneficiaries in multiple ways including helping beneficiaries organize and share their claims data, find health plans, make care appointments, and check symptoms.

Application Programming Interfaces

CMS has taken important steps to modernize how it shares data with Accountable Care Organizations and Medicare Prescription Drug Benefit Plan Sponsors to drive innovation. In 2021, CMS onboarded new partners to connect to application programming interfaces (APIs) that enable seamless access to claims data for their aligned beneficiaries or enrollees. In addition, CMS is piloting a new API to securely share structured and standardized data directly with providers. The Data at the Point of Care Pilot aims to test sharing claims data with providers through a standards-based API to provide a complete picture of a patient's medical history and to help fill the data gaps that often occur as patients move throughout the healthcare system.

Integrated Data Repository

The Integrated Data Repository (IDR) is a high-volume data warehouse comprising integrated views of data across Medicare HI, SMI, MA and Prescription Drug Benefit; 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 across the agency and externally with entities such as the Federal Bureau of Investigation, Office of Inspector General (OIG), and Department of Justice (DOJ) to facilitate investigative and litigious efforts focused on fighting Medicare and Medicaid fraud, waste, and abuse. As part of migrating the IDR to the cloud by December 2022, we have designed the IDR cloud system to be nimbler and more scalable to support advanced analytics such as Machine Learning for our customers and data scientists to make better data driven decisions. We are implementing additional data access capabilities such as API 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, we are also implementing secure data sharing capabilities within the IDR cloud so data is centrally stored and logically shared with internal and external customers.

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

Payment Error Rate Measurement Corrective Action Plans

In FY 2021, CMS implemented a more robust, state-specific CAP process that provides enhanced technical assistance and guidance to states. CMS continued working with the states to coordinate state development of CAPs to address each error and deficiency identified during the PERM cycle. After the CAP submissions, CMS monitored and followed up with all states on their progress in implementing effective corrective actions to address the errors and deficiencies. CMS continues to use lessons learned from this process to determine areas to evaluate for future guidance and education.

Major Case Coordination

CMS launched its Major Case Coordination (MCC) initiative, which includes 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. As a result of the MCC, there has been a marked increase in the number and quality of law enforcement referrals. Since implementation of the MCC, there have been over 3,200 cases reviewed at MCC and law enforcement partners have requested over 2,000 referrals as a result of MCC case reviews.

Prior Authorization

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. Prior authorization helps to ensure that all applicable Medicare coverage, payment, and coding rules are met before a service is furnished, which helps providers and suppliers address claim issues early and avoid denials and appeals. By utilizing prior authorization, CMS protects the Medicare Trust Fund from improper payments.

CMS works closely with providers and associations to share prior authorization guidelines and procedures. In FY 2021, CMS began to require prior authorization for certain outpatient hospital services, including blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation. In addition, CMS continued a prior authorization model for repetitive scheduled non-emergent ambulance transport in eight states and the District of Columbia and published a Federal Register Notice in August 2021 announcing the implementation dates for all remaining states and territories for the national expansion of the model. As prior authorization is an ongoing process, CMS will continue to explore additional opportunities to expand Medicare FFS's use of prior authorization.

Continued Program and Fiscal Oversight

By applying a targeted proactive response to federal spending, CMS built on its recent reorganization and Center-wide technology transformations to ensure proper program administration, fiscal operations, and program operations. Alignment of all Medicaid financial and program operations within CMS enabled staff to work collaboratively across groups to address disparities in payments for healthcare services and to drive efficiency and coordination of Medicaid and CHIP policy and operational activities across the country. This means that state and federal tax dollars are better used to ensure access to covered and appropriate services for eligible individuals. Additionally, the development of Medicaid and CHIP Financial, a modern, integrated product suite that will replace the current Medicaid Budget Expenditure System and incorporate and improve other existing business processes related to Medicaid and CHIP financial management. When fully implemented, this will allow for greater transparency and ability to provide proper oversight.

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

Identity Management Migration to Amazon Web Services Cloud-Hosting Environment

The Identity Management (IDM) System migration to AWS was completed in February 2021. In addition to the successful migration, CMS has modernized IDM with the use of an open-source business automation tool known as Activiti and has increased our application availability by leveraging multiple availability zones across AWS. IDM offers numerous services such as Authentication, Multi-Factor Authentication (MFA), Authorization, Identity Proofing, Help-Desk Services, Reporting, and User Interfaces as part of its Identity Management platform. There are currently over 200 applications that are integrated with IDM.

Unified Communications & Collaboration Tools - Zoom, Zscaler, & Human Center Design Tools

Considering CMS's remote work posture due to the COVID-19 pandemic, CMS had to quickly adapt to the available capacity of meeting and collaboration tools. A significant challenge to this effort arose with our existing primary meeting collaboration tool, which could not readily scale to the needs of over 6,000 CMS employees and contractors. CMS quickly pivoted to Zoom for Government, which was in a small pilot phase at CMS and under analysis for possible expansion. In addition, CMS adopted various human center design platforms and quickly deployed new collaboration tools, and made existing tools/services more resilient to reflect 100 percent virtual work for not only our employees but also over 40,000 contractors to enable operations to continue. CMS continues to modernize and improve the resilience of our Virtual Private Network with zero trust network architecture and to reduce CMS's exposure to security attacks as well as significantly improve resiliency of connectivity methods for CMS remote workers. CMS continues to identify ways to leverage emerging technology to achieve excellence in operations and ultimately the mission.

Business Intelligence Tools

CMS is modernizing the business intelligence (BI) tools to the cloud to reduce costs, provide increased functionality help with data visualization, and increase program excellence. CMS currently provides and maintains eight enterprise wide data analytic and visualization tools to support access to the agency data to transform the healthcare system, deliver innovative care, better value and results for patients. To date CMS has successfully completed migrating three of the six enterprise tools from the BDC to the cloud, and are in the process of migrating two other BI tools to the cloud by the end of 2021. CMS plans to migrate the remaining BI tools to the cloud in 2022. Additionally, CMS will add other new tools, such as Tableau and Python, to the BI suite of tools to provide additional data visualization capabilities.

Enterprise Data Lake

Enterprise Data Lake (EDL), with a central common megastore, allows users to streamline access to enterprise data hosted in the cloud, while eliminating data duplication, and reducing file transfer activities between CMS components. The initial phase focused on providing system-to-system access to the Provider and Beneficiary data, providing ongoing EDL operations and maintenance support, establishing governance model, and instituting cloud infrastructure and services in both AWS commercial and GovCloud. In its current state, the EDL team added five data areas, with four additional ones on the way. The EDL team also provided access to multiple data consumers and are onboarding additional ones regularly. EDL's current developments provides end-user level access to the enterprise data and to enable this capability, the EDL team implemented a data catalog and a data protection tool for role management and data security.

Visualization Tools

CMS has increased the utility and distribution of data in the development of visualization tools. Specifically, to support CMS's response to COVID-19 outbreaks in nursing homes, CMS developed and frequently disseminated a dashboard with data visualizations. The dashboard is used by CMS and state officials who rely on the tracking of active case counts, mortality rates, testing rates, and vaccination data shared by the CDC. These dashboards were imperative for CMS's QIO for their targeted interventions.

Direct Service Workforce

During a December 2020 summit, CMS launched a learning collaborative for state Medicaid agencies and others on the challenges that states face related to the direct service workforce (DSW) who provides home and community-based services. Through the DSW learning collaborative, state Medicaid agencies are participating in interactive, peer-to-peer learning opportunities to help address key DSW challenges related to capacity and demand, recruitment, retention, training, coordination with other agencies, workforce safety and well-being, and other emerging topics. The learning collaborative continues through December 2021 and provides an opportunity for developing solutions and identifying strategies that could be replicated in other states. CMS is also providing individualized coaching to states participating in the learning collaborative.

OneMAC

CMS adopted a digital service design process that ensures state users of CMS systems have a voice in the design of systems they use. This resulted in the recent implementation of the "OneMAC" portal for submission of many paper-based programs documents. "OneMAC" is being developed as part of the MACPro suite of products and went into production in less than 6 months.

Medicaid Section 1115 Workforce

CMS has been expanding the size and expertise of the Medicaid section 1115 workforce. For example, CMS has hired a team of doctorate prepared economists and health services researchers to strengthen its capacity to provide needed expertise to support states in their efforts to effectively monitor and evaluate their demonstrations, and to design and conduct cross-state analyses and federal evaluations of potentially high impact demonstrations in order to identify best practices and support learning diffusion across states. CMS continues to develop standard operating procedures (SOPs), job aids, training, and a demonstration management technology system. These efforts will improve the capacity, efficiency and effectiveness of staff responsible for the complex policy review, and improve programmatic/budget neutrality negotiations involved in approving section 1115 demonstrations. Similarly, we have developed SOPs, job aids, training and IT capabilities to support staff responsible for overseeing states' demonstration program and financial performance.

Performance Management Database and Analytics System

CMS is continuing to expand and refine the Performance Management Database and Analytics System, an IT system that collects section 1115 demonstration reports, budget neutrality data, program performance data and other deliverables from states. The system then applies analytics to assess trends on standardized data pertaining to state efforts to develop comprehensive care delivery to people with substance use disorder and severe mental illness, as well as for budget neutrality for all demonstrations. These data also support cross-state analyses that CMS is conducting and intends to release when data is in a more mature state. CMS is beginning to build a module that will support states and CMS in the efficient submission and review of section 1115 applications and expects to update the budget neutrality reporting and analytics module in the future.

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*. The responsibility for the financial information integrity included in these statements rests with CMS management. The OIG selects an independent certified public accounting firm to audit the CMS financial statements and related notes.

Consolidated Balance Sheets

The Consolidated Balance Sheets present, as of September 30, 2021 and 2020, 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 additional information. CMS's Consolidated Balance Sheets reported assets of $690.8 billion. The bulk of these assets are Investments totaling $308.1 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 next largest asset is the Fund Balance with Treasury of $284.5 billion, most of which is used for Medicaid, CHIP, and Payments to Health Care trust funds. Liabilities of $186.4 billion consist primarily of the Entitlement Benefits Due and Payable of $133.8 billion. CMS's Net Position totals $504.4 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, 2021 and 2020. 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 additional information. In FY 2021, CMS's total Net Cost of Operations was $1,272.4 billion encompassing net program/activity costs of $1,264.8 billion and operating costs of $7.5 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, 2021 and 2020. 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 $981.2 billion, which represents the Medicaid and CHIP appropriations, transfers from Payments to the Health Care 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 $299.1 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, 2021 and 2020. An additional 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 this statement.

CMS total budgetary resources were $2,140.1 billion. Obligations of $1,970.7 billion leave unobligated balances of $169.4 billion. Total outlays, net of collections, were $1,854.9 billion. When offset by $619.4 billion relating to collection of premiums and general fund transfers from the Payments to the Health Care Trust Funds, as well as refunds of MAC overpayments, the CMS net outlays were $1,235.5 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 *2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic. The amount of payroll taxes expected to be collected by the HI trust fund was greatly reduced due to the economic effects of the pandemic on labor markets. 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. More than offsetting these additional costs in 2020, spending for non-COVID care declined significantly (compared to both actual 2019 spending and expectations for 2020 spending in last year's Trustees Report). This decline was particularly true for elective services.

While the COVID-19 pandemic has significantly affected Medicare short-term financing and spending, it is not expected to have a large effect on the financial status of the trust funds after 2024. As discussed throughout the Trustees Report, the key measures of the financial adequacy for each trust fund are fairly comparable to those included in last year's report.

The Medicare Accelerated and Advance Payments (AAP) Program was significantly expanded during the COVID-19 public health emergency period. Total payments of approximately $107.1 billion were made: roughly $67.1 billion from the HI trust fund and $40.0 billion from the SMI Part B trust fund account. The Trustees assume that the accelerated and advance payments will be fully repaid by September of 2022, resulting in no net changes to trust fund expenditures, but the AAP program significantly affects the timing of expenditures from 2020 through 2022. It should be noted that there is an unusually large degree of uncertainty with these COVID-related impacts and that future projections could change significantly as more information becomes available. The pandemic is an example of the inherent uncertainty in projecting health care financing and spending over any duration.

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) decreased from $(4.8) trillion, determined as of January 1, 2020, to $(5.1) trillion, determined as of January 1, 2021.

When the combined HI and SMI trust fund assets are included, the present value increases. As of January 1, 2021, the future cash flow for all current and future participants was $(4.7) 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 $(13.1) 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 steadily dropped from 66 percent at the beginning of FY 2017 to 39 percent at the beginning of FY 2021.

TRUST FUND RATIO

Beginning of Fiscal Year[2]

	2017	2018	2019	2020	2021
HI	66%	66%	63%	50%	39%

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

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 calendar year are at least as large as program obligations for the year. Estimates in the 2021 Trustees Report indicate that the HI trust fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2021 Trustees Report, the HI trust fund ratio is estimated to decline steadily until the fund is depleted in calendar year 2026. Assets at the end of calendar year 2020 were $134.1 billion and are expected to decrease steadily until depleted in 2026.

Long-Term Financing

The short-range outlook for the HI trust fund is similar to what was projected last year. The trust fund ratio declines until the fund is depleted in 2026, the same date as projected in the 2018 through 2020 Trustees Reports. 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 91 percent in 2026 to 78 percent in 2045, and then to increase to about 91 percent by the end of the projection period.

The primary reasons for the projected long-term inadequacy of financing under current law relate to the fact that the ratio of the number of workers paying taxes relative to the number of individuals eligible for benefits drops from 2.9 in 2020 to about 2.2 by 2095. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $4.9 trillion, which is 0.7 percent of taxable payroll and 0.3 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 financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D account is financed by premiums, general revenues, and transfers from state governments. 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 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 $(43.2) 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 2020, SMI incurred expenditures were 2.3 percent of GDP. By 2095, SMI expenditures are projected to grow to 4.5 percent of the GDP.

The following table presents key amounts from our basic financial statements for fiscal year 2019 through 2021..

TABLE OF KEY MEASURES[3]

Dollars in billions

	2021	2020	2019
Net Position (end of fiscal year)			
Assets	**$690.8**	**$590.1**	**$502.0**
Less Total Liabilities	**$186.4**	**$133.4**	**$134.2**
Net Position (assets net of liabilities)	**$504.4**	**$456.7**	**$367.8**
Costs (end of fiscal year)			
Net Costs	**$1,272.4**	**$1,157.0**	**$1,087.3**
Total Financing Sources	**$1,285.0**	**$1,189.5**	**$1,079.0**
Net Change in Cumulative Results of Operations	**$12.7**	**$32.5**	**$(8.3)**
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	**$(5,057)**	**($4,800)**	**$(5,484)**
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	**$(4,800)**	**$(5,484)**	**$(4,708)**
Change in present value	**$(257)**	**$683**	**$(776)**

3 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, 2021, decreased by $166 billion due to advancing the valuation date by 1 year and including the additional year 2095, by $959 billion due to changes in economic and health care assumptions, and by $38 billion due to changes in the law. However, changes in the projection base and demographic assumptions increased the present value by $205 and $700 billion, respectively. The net overall impact of these changes is a decrease in the present value of $257 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 *2021 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.

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

I am honored to join Administrator Brooks-LaSure in issuing CMS's fiscal year 2021 Agency Financial Report. Ensuring the solvency of our trust funds is a high priority for CMS. We are dedicated to modernizing our programs and strengthening the integrity and sustainability of Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplaces. We strive to be financially responsible stewards of the Medicare Trust Funds and continue to strengthen our internal controls to improve program integrity and to manage and safeguard taxpayer dollars.

For the 23rd consecutive year, CMS obtained an unmodified "clean" opinion on four of our six principal financial statements. Due to the uncertainty in the long-range assumptions applied in our projection models, our auditors are still not able to express an opinion on the sustainability financial statements, which are comprised of the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. The auditors' issuance of an unmodified opinion indicates that our financial statements are presented fairly, in all material respects, and conform with generally accepted accounting principles. Receiving a "clean" unmodified opinion demonstrates CMS's achievement of financial management excellence and allows us to provide assurances to our stakeholders that the accompanying financial statements are free from material misstatements or errors. CMS remains committed to identifying opportunities to strengthen our internal controls and taking swift corrective actions for any identified weaknesses. The "Financial Section" of this report provides detailed information about CMS's financial statements and activities.

While CMS has always worked to improve its programs, COVID-19 reinforced the need to ensure our programs are accessible, reward high quality health care, and encourage lower health care costs. Our budget supports tools that permit patient control and provider sharing of secure health care data, allowing for better coordination of care and less duplication. Additionally, CMS is modernizing our programs further to address the increasing role of technology in seniors' lives while safeguarding their data. We will continue to make sound decisions to invest our resources to keep CMS on the leading edge of providing high quality health care that all Americans deserve, while also pursuing program integrity methods to better prevent fraudulent or improper payments.

Megan Worstell

Megan Worstell

CMS Chief Financial Officer

November 2021

Under the leadership of CMS Administrator Chiquita Brooks-LaSure, CMS pledges to serve the public as a trusted partner and financial steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes. Financial stewardship, transparency, and integrity are at the center of what we do. We remain committed to improving and reducing health care costs, operating more efficiently and effectively and providing the best value of the resources entrusted to us.

FINANCIAL STATEMENTS

CONSOLIDATED BALANCE SHEETS

as of September 30, 2021 and September 30, 2020

(in millions)

	FY 2021 Consolidated Totals	FY 2020 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury *(Note 2)*	$284,473	$240,476
Investments *(Note 3)*	308,133	222,134
Accounts Receivable, Net *(Note 4)*	542	477
TOTAL INTRAGOVERNMENTAL ASSETS	593,148	463,087
Accounts Receivable, Net *(Note 4)*	27,957	21,044
General Property, Plant and Equipment, Net	1,992	1,612
Advances and prepayments *(Note 5)*	67,184	103,781
Other	518	554
Total with public	97,651	126,991
TOTAL ASSETS	$690,799	$590,078
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$1,818	$1,536
Debt *(Note 6)*	36,781	1,361
Other Liabilities	79	376
TOTAL INTRAGOVERNMENTAL	38,678	3,273
With the public:		
Accounts Payable	337	928
Entitlement Benefits Due and Payable *(Note 7)*	133,777	116,935
Other Liabilities		
Contingencies *(Note 8)*	3,659	3,686
Other	9,969	8,542
Total with public	147,742	130,091
TOTAL LIABILITIES *(Note 9)*	$186,420	$133,364
Commitments and contingencies *(Note 8)*		
NET POSITION		
Unexpended Appropriations–Dedicated Collections *(Note 11)*	$134,944	$98,116
Unexpended Appropriations–Other Funds	76,618	78,507
TOTAL UNEXPENDED APPROPRIATIONS	211,562	176,623
Cumulative Results of Operations–Dedicated Collections *(Note 11)*	289,307	278,725
Cumulative Results of Operations–Other Funds	3,510	1,366
TOTAL CUMULATIVE RESULTS OF OPERATIONS	292,817	280,091
TOTAL NET POSITION	$504,379	$456,714
TOTAL LIABILITIES AND NET POSITION	$690,799	$590,078

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST

for the years ended September 30, 2021 and September 30, 2020

(in millions)

	FY 2021 Totals	Intra-CMS Eliminations	FY 2021 Consolidated Totals	FY 2020 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS GPRA PROGRAMS				
Medicare HI				
Benefit/Program	$350,255	$(630)	$349,625	$323,476
Program Management	1,228		1,228	1,422
Net Cost Medicare HI	$351,483	$(630)	$350,853	$324,898
Medicare SMI				
Benefit/Program (Part B)	$300,698	$(575)	$300,123	$262,686
Benefit/Program (Part D)	79,820		79,820	78,001
Program Management	2,458		2,458	2,428
Net Cost Medicare SMI	$382,976	$(575)	$382,401	$343,115
Medicaid				
Benefit/Program	$521,746		$521,746	$458,584
Program Management	136		136	133
Net Cost Medicaid	$521,882		$521,882	$458,717
CHIP				
Benefit/Program	15,991		$15,991	$16,937
Program Management	15		15	14
Net Cost CHIP	$16,006		$16,006	$16,951
Other				
Benefit/Program	$(505)	$1,205	$700	$12,754
Program Management	515		515	519
Net Cost Other	$10	$1,205	$1,215	$13,273
NET COST OF OPERATIONS *(Note 10)*	$1,272,357	$-	$1,272,357	$1,156,954

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2021

(in millions)

	Funds from Dedicated Collections *(Note 11)*	All Other Funds	FY 2021 Consolidated Total
UNEXPENDED APPROPRIATIONS			
Beginning Balances	$98,116	$78,507	$176,623
Appropriations Received	502,345	627,542	1,129,887
Appropriations Transferred-in/out		(3,766)	(3,766)
Other Adjustments	(23,947)	(86,033)	(109,980)
Appropriations Used	(441,570)	(539,632)	(981,202)
Change in Unexpended Appropriations	**36,828**	**(1,889)**	**34,939**
Total Unexpended Appropriations: Ending	**$134,944**	**$76,618**	**$211,562**
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	$278,725	$1,366	$280,091
Other Adjustments		(342)	(342)
Appropriations Used	441,570	539,632	981,202
Nonexchange Revenue:			
FICA and SECA Taxes	299,147		299,147
Interest on Investments	4,904	14	4,918
Other	3,226		3,226
Transfers-in/out Without Reimbursement	(4,796)	1,361	(3,435)
Imputed Financing	61		61
Other		306	306
Net Cost of Operations *(Note 10)*	**733,530**	**538,827**	**1,272,357**
Net Change and Cumulative Results of Operations	**10,582**	**2,144**	**12,726**
Cumulative Results of Operations: Ending	**$289,307**	**$3,510**	**$292,817**
NET POSITION	**$424,251**	**$80,128**	**$504,379**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2020

(in millions)

	Funds from Dedicated Collections *(Note 11)*	All Other Funds	FY 2020 Consolidated Total
UNEXPENDED APPROPRIATIONS			
Beginning Balances	$57,968	$62,316	$120,284
Budgetary Financing Sources:			
Appropriations Received	438,810	526,552	965,362
Appropriations Transferred-in/out		(4,562)	(4,562)
Other Adjustments	(6,458)	(23,906)	(30,364)
Appropriations Used	(392,204)	(481,893)	(874,097)
Change in Unexpended Appropriations	**40,148**	**16,191**	**56,339**
Total Unexpended Appropriations: Ending	**$98,116**	**$78,507**	**$176,623**
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	$252,377	$(4,869)	$247,508
Other Adjustments			
Appropriations Used	392,204	481,893	874,097
Nonexchange Revenue:			
FICA and SECA Taxes	295,913		295,913
Interest on Investments	6,404	174	6,578
Other	3,971		3,971
Transfers-in/out Without Reimbursement	(4,125)	1,092	(3,033)
Imputed Financing	12,348	5	12,353
Other		(342)	(342)
Net Cost of Operations *(Note 10)*	**680,367**	**476,587**	**1,156,954**
Net Change and Cumulative Results of Operations	**26,348**	**6,235**	**32,583**
Cumulative Results of Operations: Ending	**$278,725**	**$1,366**	**$280,091**
NET POSITION	**$376,841**	**$79,873**	**$456,714**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES *(NOTE 12)*

for the years ended September 30, 2021 and September 30, 2020

(in millions)

	FY 2021 Combined Totals Budgetary	FY 2020 Combined Totals Budgetary
Budgetary Resources:		
Unobligated balance from prior year budget authority, net (discretionary and mandatory)	$218,041	$139,670
Appropriations (discretionary and mandatory)	1,865,973	1,855,924
Borrowing authority (discretionary and mandatory)	46,028	2
Spending authority from offsetting collections (discretionary and mandatory)	10,103	11,733
TOTAL BUDGETARY RESOURCES	$2,140,145	$2,007,329
Status of Budgetary Resources:		
New Obligations and upward adjustments	$1,970,746	$1,873,445
Unobligated balance, end of year		
Apportioned, unexpired accounts	46,085	56,046
Exempt from Apportionment, unexpired accounts		3
Unapportioned, unexpired accounts	11,771	10,561
Unexpired unobligated balance, end of year	$57,856	$66,610
Expired unobligated balance, end of year	111,543	67,274
Unobligated balance, end of year (total)	$169,399	$133,884
TOTAL BUDGETARY RESOURCES	$2,140,145	$2,007,329
Outlays, net		
Outlays, net (discretionary and mandatory)	$1,854,897	$1,786,681
Distributed offsetting receipts	(619,388)	(532,083)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	$1,235,509	$1,254,598
DISBURSEMENTS, NET	$278	$(7)

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2021 and Prior Base Years

(in billions)

		Estimates from Prior Years (unaudited)			
	2021 (unaudited)	2020	2019	2018	2017
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	$13,017	$12,454	$11,995	$11,323	$10,679
SMI Part B	34,467	32,165	27,556	24,143	21,641
SMI Part D	6,881	6,975	7,181	7,176	6,929
Have attained eligibility age (age 65 or over)					
HI	664	637	559	525	492
SMI Part B	6,536	5,864	5,232	4,725	4,122
SMI Part D	1,061	1,016	1,052	1,015	958
Those expected to become participants					
HI	13,029	12,464	11,805	10,959	10,567
SMI Part B	9,010	8,567	6,864	5,586	5,019
SMI Part D	2,921	3,043	3,000	2,932	2,869
All current and future participants					
HI	26,710	25,554	24,359	22,807	21,738
SMI Part B	50,013	46,596	39,652	34,453	30,783
SMI Part D	10,863	11,035	11,232	11,124	10,756
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	$20,940	$20,103	$20,028	$18,604	$17,193
SMI Part B	34,075	31,819	27,270	23,832	21,392
SMI Part D	6,881	6,975	7,181	7,176	6,929
Have attained eligibility age (age 65 and over)					
HI	6,230	6,073	5,348	5,027	4,539
SMI Part B	6,892	6,194	5,741	5,180	4,531
SMI Part D	1,061	1,016	1,052	1,015	958
Those expected to become participants					
HI	4,597	4,179	4,467	3,884	3,539
SMI Part B	9,046	8,583	6,641	5,442	4,860
SMI Part D	2,921	3,043	3,000	2,932	2,869
All current and future participants:					
HI	31,767	30,355	29,843	27,515	25,270
SMI Part B	50,013	46,596	39,652	34,453	30,783
SMI Part D	10,863	11,035	11,232	11,124	10,756
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 13 and 14)					
HI	$(5,057)	$(4,800)	$(5,484)	$(4,708)	$(3,532)
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	$(5,057)	$(4,800)	$(5,484)	$(4,708)	$(3,532)
SMI Part B					
SMI Part D					
Trust Fund assets at start of period					
HI	$198	$195	$200	$202	$199
SMI Part B	133	100	96	80	88
SMI Part D	10	9	8	8	8
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	$(4,859)	$(4,606)	$(5,283)	$(4,506)	$(3,333)
SMI Part B	133	100	96	80	88
SMI Part D	10	9	8	8	8

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, 2021 and Prior Base Years

(in billions)

		Estimates from Prior Years (unaudited)			
	2021 (unaudited)	2020	2019	2018	2017
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)	$8,261	$7,517	$6,843	$6,266	$5,572
Expenditures	14,184	13,284	12,140	11,222	10,027
Income less expenditures	(5,922)	(5,766)	(5,297)	(4,957)	(4,455)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	54,364	51,594	46,731	42,643	39,250
Expenditures	61,895	58,897	54,479	49,612	45,514
Income less expenditures	(7,531)	(7,303)	(7,748)	(6,970)	(6,264)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(13,453)	(13,069)	(13,045)	(11,926)	(10,719)
Combined Medicare Trust Fund assets at start of period	341	303	305	290	295
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(13,112)	(12,766)	(12,740)	(11,637)	(10,425)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	$24,960	$24,074	$21,669	$19,477	$18,456
Expenditures	16,564	15,805	14,108	12,258	11,268
Income less expenditures	8,396	8,269	7,561	7,219	7,187
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(5,057)	(4,800)	(5,484)	(4,708)	(3,532)
Combined Medicare Trust Fund assets at start of period	341	303	305	290	295
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$(4,716)	$(4,497)	$(5,179)	$(4,418)	$(3,237)

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, 2020 to January 1, 2021

(in billions)

	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	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		
Total Medicare *(Note 15)*					
As of January 1, 2020	$83,185	$87,986	($4,800)	$303	($4,497)
Reasons for change					
Change in the valuation period	2,766	2,932	(166)	6	(160)
Change in projection base	(3,070)	(3,276)	205	32	237
Changes in the demographic assumptions	(947)	(1,648)	700		700
Changes in economic and health care assumptions	5,512	6,471	(959)		(959)
Changes in law	140	178	(38)		(38)
Net changes	4,401	4,658	(257)	38	(219)
As of January 1, 2021	$87,586	$92,643	$(5,057)	$341	$(4,716)
HI - Part A *(Note 15)*					
As of January 1, 2020	$25,554	$30,355	$(4,800)	$195	$(4,606)
Reasons for change					
Change in the valuation period	753	919	(166)	(9)	(175)
Change in projection base	(700)	(906)	205	13	218
Changes in the demographic assumptions	(110)	(810)	700		700
Changes in economic and health care assumptions	1,212	2,171	(959)		(959)
Changes in law		38	(38)		(38)
Net changes	1,156	1,412	(257)	4	(253)
As of January 1, 2021	$26,710	$31,767	$(5,057)	$198	$(4,859)
SMI - Part B *(Note 15)*					
As of January 1, 2020	$46,596	$46,596		$100	$100
Reasons for change					
Change in the valuation period	1,618	1,618		17	17
Change in projection base	(2,428)	(2,428)		16	16
Changes in the demographic assumptions	(665)	(665)			
Changes in economic and health care assumptions	4,751	4,751			
Changes in law	140	140			
Net changes	3,416	3,416		34	34
As of January 1, 2021	$50,013	$50,013		$133	$133
SMI - Part D *(Note 15)*					
As of January 1, 2020	$11,035	$11,035		$9	$9
Reasons for change					
Change in the valuation period	395	395		(2)	(2)
Change in projection base	58	58		3	3
Changes in the demographic assumptions	(173)	(173)			
Changes in economic and health care assumptions	(451)	(451)			
Changes in law					
Net changes	(171)	(171)		1	1
As of January 1, 2021	$10,863	$10,863		$10	$10

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

January 1, 2019 to January 1, 2020

(in billions)

	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	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		
Total Medicare *(Note 14)*					
As of January 1, 2019	$75,243	$80,727	$(5,484)	$305	$(5,179)
Reasons for change					
Change in the valuation period	2,691	2,926	(235)	(3)	(238)
Change in projection base	444	45	399	2	401
Changes in the demographic assumptions	(1,871)	(4,558)	2,687		2,687
Changes in economic and health care assumptions	7,455	9,170	(1,715)		(1,715)
Changes in law	(778)	(325)	(453)		(453)
Net changes	7,942	7,259	683	(1)	682
As of January 1, 2020	$83,185	$87,986	$(4,800)	$303	$(4,497)
HI: Part A *(Note 15)*					
As of January 1, 2019	$24,359	$29,843	$(5,484)	$200	$(5,283)
Reasons for change					
Change in the valuation period	799	1,034	(235)	(7)	(242)
Change in projection base	(17)	(415)	399	1	400
Changes in the demographic assumptions	(426)	(3,114)	2,687		2,687
Changes in economic and health care assumptions	1,386	3,101	(1,715)		(1,715)
Changes in law	(547)	(94)	(453)		(453)
Net changes	1,195	512	683	(6)	677
As of January 1, 2020	$25,554	$30,355	$(4,800)	$195	$(4,606)
SMI: Part B *(Note 15)*					
As of January 1, 2019	$39,652	$39,652		$96	$96
Reasons for change					
Change in the valuation period	1,449	1,449		3	3
Change in projection base	285	285			
Changes in the demographic assumptions	(1,049)	(1,049)			
Changes in economic and health care assumptions	6,414	6,414			
Changes in law	(154)	(154)			
Net changes	6,944	6,944		3	3
As of January 1, 2020	$46,596	$46,596		$100	$100
SMI: Part D *(Note 15)*					
As of January 1, 2019	$11,232	$11,232		$8	$8
Reasons for change					
Change in the valuation period	444	444			
Change in projection base	176	176		1	1
Changes in the demographic assumptions	(395)	(395)			
Changes in economic and health care assumptions	(345)	(345)			
Changes in law	(77)	(77)			
Net changes	(198)	(198)		1	1
As of January 1, 2020	$11,035	$11,035		$9	$9

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

FINANCIAL NOTES

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. For example, CMS has a child relationship with the Internal Revenue Service for the payment of 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 Health Care 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 Health Care Fraud and Abuse Control Account, 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 Health Care 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 Health Care Trust Funds account. The *Social Security Act* also prescribes that criminal fines and civil monetary penalties arising from health care cases be transferred to the Health Care Fraud and Abuse Control (HCFAC) account of the HI trust fund as well as payments to support FBI activities related to health care 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 Health Care 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 administered via grant awards, which limit the funds that can be drawn by the states to cover current expenses. Medicaid also provides funding for the Health Information Technology for Economic and Clinical Health 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*. This Act provides 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 declared by the Secretary of HHS for COVID-19, including any extensions, terminates. The increased FMAP was in effect through September 30, 2021.

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, Marketplace, 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 Marketplace 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 Health Care 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 Balances 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. The FASAB 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. 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 health care providers for their services. CMS recognizes the cost associated with payments in the period incurred and based on entitlement. In accordance with Public Law and existing federal accounting standards, no expense or liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare HI trust fund.

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. A transfer of general funds to the HI trust fund in an amount equal to SECA tax credits is made through the Payments to the Health Care 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.

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 has mandated that CMS report all Medicare cash collections as an offsetting receipt.

Imputed Financing Sources occur when costs are paid out of funds appropriated to other federal entities. For instance, certain legal judgments against CMS are paid from the Judgment Fund maintained by Bureau of Fiscal Service, Treasury. When costs are identifiable to CMS, directly attributable to CMS's operations, and paid by other agencies, CMS recognizes these amounts as imputed costs within the Consolidated Statements of Net Cost and as an imputed financing source on the Consolidated Statement of Changes in Net Position.

The PPACA

The PPACA provided funding for the establishment by CMS of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. It also allowed for the establishment of a Center for Consumer Information and Insurance Oversight (CCIIO). One of the main programs under CCIIO is the Health Insurance Marketplaces (the "Marketplaces"). A brief description of the remaining programs is presented below. There were two additional programs - Transitional Reinsurance and Risk Corridors – that are no longer in operation.

Health Insurance Marketplaces

Grants have been provided to the states to establish Health Insurance Marketplaces. The initial grants were made by HHS to the states "not later than 1 year after the date of enactment." Thus, HHS made the initial grants by March 23, 2011. Subsequent grants were issued by CMS through December 31, 2014, after which time no further grants could be made. All Marketplaces were launched on October 1, 2013.

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

Changes, Reclassifications and Adjustments

Effective FY 2021, changes have been made to the principal and supplementary Balance Sheet and Statement of Changes to Net Position, as well as various changes to the footnotes for current and prior year for comparability. Any changes and reclassifications have been made in order to comply with OMB Circular A-136.

NOTE 2:

FUND BALANCE WITH TREASURY

(Dollars in Millions)

	FY 2021	FY 2020
Status of Fund Balances with Treasury:		
Unobligated Balance:		
Available	**$46,085**	**$56,049**
Unavailable	**123,314**	**77,835**
Obligated Balance not yet Disbursed	**182,803**	**174,005**
Non-Budgetary FBWT	**(67,729)**	**(67,413)**
TOTAL	**$284,473**	**$240,476**

The Unobligated Balance Available includes $28,639 million ($29,812 million in FY 2020), which is restricted for future use and is not apportioned for current use for PPACA, CHIP, Program Management, Center for Medicare and Medicaid Innovation and State Grants and Demonstrations.

NOTE 3:

CMS INVESTMENT SUMMARY

(Dollars in Millions)

FY 2021 **Medicare Investments** *(Dedicated Collections)*	**Maturity Range**	**Interest Range**	**Value**
HI TF			
Certificates	June 2022	1.375 - 1.500%	$24,933
Bonds	June 2023 to June 2029	1.500 - 2.875%	111,235
Accrued Interest			615
Total HI TF Investments			**$136,783**
SMI TF			
Certificates	June 2022	1.375 - 1.500%	$25,829
Bonds	June 2024 to June 2036	.750 - 2.875%	144,848
Accrued Interest			673
Total SMI TF Investments			**$171,350**
Total Medicare Investments			**$308,133**

FY 2020 **Medicare Investments** *(Dedicated Collections)*	**Maturity Range**	**Interest Range**	**Value**
HI TF			
Certificates	June 2021	.75%	$25,333
Bonds	June 2022 to June 2029	.75 - 2.875%	108,401
Accrued Interest			566
Total HI TF Investments			**$134,300**
SMI TF			
Certificates	June 2021	.75%	$25,093
Bonds	June 2023 to June 2024	.75 - 2.875%	62,384
Accrued Interest			357
Total SMI TF Investments			**$87,834**
Total Medicare Investments			**$222,134**

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 U.S. 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 U.S. Treasury. Because the HI and SMI trust funds and the U.S. 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 U.S. 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

NOTE 3:

CMS INVESTMENT SUMMARY *(CONTINUED)*

(Dollars in Millions)

FY 2021	Medicare (Dedicated Collection)			Consolidated Total
	HI TF	SMI TF	Total	
Certificates	$24,933	$25,829	$50,762	$50,762
Bonds	111,235	144,848	256,083	256,083
Accrued Interest	615	673	1,288	1,288
Total Investments	**$136,783**	**$171,350**	**$308,133**	**$308,133**

FY 2020	Medicare (Dedicated Collection)			Consolidated Total
	HI TF	SMI TF	Total	
Certificates	$25,333	$25,093	$50,426	$50,426
Bonds	108,401	62,384	170,785	170,785
Accrued Interest	566	357	923	923
Total Investments	**$134,300**	**$87,834**	**$222,134**	**$222,134**

NOTE 4:

ACCOUNTS RECEIVABLE, NET

(Dollars in Millions)

FY 2021	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$542		$542		$542
Total Intragovernmental	**$542**		**$542**		**$542**
With the Public					
Entity					
Medicare FFS	$8,495		$8,495	$(3,704)	$4,791
Medicare Advantage/Prescription Drug Program	10,861		10,861	(5)	10,856
Medicaid	7,349		7,349	(1,027)	6,322
CHIP	137		137	(4)	133
Other	6,114		6,114	(286)	5,828
Non-Entity	4	$72	76	(49)	27
Total With the Public	**$32,960**	**$72**	**$33,032**	**$(5,075)**	**$27,957**

FY 2020	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$477		$477		$477
Total Intragovernmental	**$477**		**$477**		**$477**
With the Public					
Entity					
Medicare FFS	$8,242		$8,242	$(3,626)	$4,616
Medicare Advantage/Prescription Drug Program	7,689		7,689	(5)	7,684
Medicaid	5,359		5,359	(1,038)	4,321
CHIP	204		204		204
Other	4,594		4,594	(395)	4,199
Non-Entity	4	$72	76	(56)	20
Total With the Public	**$26,092**	**$72**	**$26,164**	**$(5,120)**	**$21,044**

Intragovernmental accounts receivable represent 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 Public Debt (BPD) are eliminated against BPD'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 with the public 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 Marketplace activities. Accounts receivable with the public 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 Marketplace activities.

NOTE 5:

ADVANCES AND PREPAYMENTS

(Dollars in Millions)

CMS has $67,184 million ($103,781 million in FY 2020) in total nonfederal advances and prepayments, mainly from accelerated payments made for the COVID-19 Accelerated and Advance Payment (AAP) program. The original AAP program was set up to help providers and suppliers who had cash flow concerns due to system issues causing delays in submissions or processing of claims or local emergencies (e.g., hurricanes). On March 30, 2020, the AAP program was expanded based on the language included in the Coronavirus Aid, Relief, and Economic Security Act for specific providers. Collections of these items began in April 2021 and comes from the offset of future claims.

NOTE 6:

DEBT

(Dollars in Millions)

CMS has $36,781 million ($1,361 million in FY 2020) in total debt due to Treasury. The majority of this debt is related to amounts borrowed to cover the advance/accelerated payments made for the COVID-19 AAP program. AAP program repayments are based on collections per Note 5. The remaining debt balance is for amounts borrowed to cover premium shortfalls. 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.

	2020 Beginning Balance	2020 Net Borrowing	2020 Ending Balance	2021 Net Borrowing	2021 Ending Balance
Debt to the Treasury:					
Transitional SMI Contribution	$3,152	$(1,998)	$1,154	$5,806	$6,960
COVID-19 Accelerated and Advance Payment Program				29,352	29,352
Other	207		207	262	469
TOTAL DEBT TO THE TREASURY	**$3,359**	**$(1,998)**	**$1,361**	**$35,420**	**$36,781**

NOTE 7:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(Dollars in Millions)

	FY 2021	FY 2020
Medicare FFS	$57,765	$49,262
Medicare Advantage/Prescription Drug Program	22,013	20,890
Medicaid	52,757	45,850
CHIP	1,242	933
TOTALS	**$133,777**	**$116,935**

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, 2021 and 2020 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 2021. 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, 2021.

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 at September 30, 2021 and 2020, but we believe these estimates to be reasonable.

NOTE 8:

CONTINGENCIES

(Dollars in Millions)

The contingencies balance as of September 30, 2021 is $3,659 million ($3,686 million in FY 2020), which includes $3,654 million for Medicaid ($3,674 million in FY 2020) for audit and program disallowances and reimbursement of state plan amendments. Additionally, 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. 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 for the AAP program (see Note 6), contingencies (see Note 8) and employee annual leave earned but not taken and amounts billed by the Department of Labor for F*ederal Employee's Compensation Act* (FECA) payments. For CMS revolving funds, all liabilities are funded as they occur.

Starting January 1, 2014, the PPACA provides for a permanent Risk Adjustment program and a temporary transitional Reinsurance program administered by CMS. With these programs, amounts may be owed to or due from private health insurers who participate in the Marketplaces that began on January 1, 2014, as well as the broader individual and small group markets. The Reinsurance program is no longer in operation; however, there are still funds left in the program to be paid to Treasury, and for administrative cost. An accrual has been recorded for this program as of September 30, 2021. The Risk Adjustment program will be administered in a budget neutral manner in any calendar year and collections will not be due and payments will not be made until the year following the calendar year for which the program operates. As of September 30, 2021, accruals were recorded to cover future payments, collections, sequestration, and for one appeal that is still due that pertain to program year 2017 for the Risk Adjustment program, and are reflected on the Other line below.

FY 2021 Intragovernmental	Medicare								
	HI TF	SMI TF	Medicaid	CHIP	Other	Program Mgmt.	Combined Total	Intra-CMS Eliminations	Consolidated Total
Debt		$36,312					$36,312		$36,312
Other					$99	$2	101	$(36)	65
Total Intragovernmental		**36,312**			**99**	**2**	**36,413**	**(36)**	**36,377**
Federal Employee and Veterans' Benefits	$5	1			14	74	94		94
Other					6,220		6,220		6,220
Contingencies	5		$3,654				3,659		3,659
Total Liabilities Not Covered by Budgetary Resources	**10**	**36,313**	**3,654**		**6,333**	**76**	**46,386**	**(36)**	**46,350**
Total Liabilities Covered by Budgetary Resources	81,259	94,587	52,790	$1,243	3,206	207	233,292	(94,148)	139,144
Total Liabilities Not Requiring Budgetary Resources	138	676			112		926		926
TOTAL LIABILITIES	**$81,407**	**$131,576**	**$56,444**	**$1,243**	**$9,651**	**$283**	**$280,604**	**$(94,184)**	**$186,420**

FY 2020 Intragovernmental	Medicare								
	HI TF	SMI TF	Medicaid	CHIP	Other	Program Mgmt.	Combined Total	Intra-CMS Eliminations	Consolidated Total
Debt		$1,154					$1,154		$1,154
Other					$704	$3	707	$(342)	365
Total Intragovernmental		**1,154**			**704**	**3**	**1,861**	**(342)**	**1,519**
Federal Employee and Veterans' Benefits	$5				13	74	92		92
Other					4,547		4,547		4,547
Contingencies	12		$3,674				3,686		3,686
Total Liabilities Not Covered by Budgetary Resources	**17**	**1,154**	**3,674**		**5,264**	**77**	**10,186**	**(342)**	**9,844**
Total Liabilities Covered by Budgetary Resources	69,806	84,502	45,963	$1,415	3,566	212	205,464	(82,498)	122,966
Total Liabilities Not Requiring Budgetary Resources	132	380			42		554		554
TOTAL LIABILITIES	**$69,955**	**$86,036**	**$49,637**	**$1,415**	**$8,872**	**$289**	**$216,204**	**$(82,840)**	**$133,364**

NOTE 10:

NET COST OF OPERATIONS

(Dollars in Millions)

	Medicare		Health			
FY 2021	**HI TF**	**SMI TF**	**Medicaid**	**CHIP**	**Other**	**Consolidated Total**
BENEFIT/PROGRAM COSTS						
Medicare						
Fee for Service	$208,024	$216,390				$424,414
Medicare Advantage/ Managed Care	144,373	196,110				340,483
Prescription Drug (Part D)		85,423				85,423
Medicaid/CHIP			$521,746	$15,987		537,733
Other					$10,981	10,981
Bad Debt Expense and Writeoffs	25	56	(11)	4	(142)	(68)
Total Benefit/Program Costs	**$352,422**	**$497,979**	**$521,735**	**$15,991**	**$10,839**	**$1,398,966**
OPERATING COSTS						
Medicare Integrity Program	$1,508					$1,508
Quality Improvement Organizations	466	$167				633
Program Management and Other Expenses	1,543	3,030	$148	$15	$646	5,382
Total Operating Costs	**3,517**	**3,197**	**148**	**15**	**646**	**7,523**
TOTAL COSTS	**$355,939**	**$501,176**	**$521,883**	**$16,006**	**$11,485**	**$1,406,489**
Less: Exchange Revenues:						
Medicare Premiums	$4,451	$118,183				$122,634
Other Exchange Revenues	5	17	$1		$11,475	11,498
Total Exchange Revenues	**4,456**	**118,200**	**1**		**11,475**	**134,132**
Intra-CMS Eliminations	**(630)**	**(575)**			**1,205**	
TOTAL NET COST OF OPERATIONS	**$350,853**	**$382,401**	**$521,882**	**$16,006**	**$1,215**	**$1,272,357**

NOTE 10:

NET COST OF OPERATIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare		Health			
FY 2020	**HI TF**	**SMI TF**	**Medicaid**	**CHIP**	**Other**	**Consolidated Total**
BENEFIT/PROGRAM COSTS						
Medicare						
Fee for Service	$190,171	$191,944				$382,115
Medicare Advantage/ Managed Care	135,994	177,826				313,820
Prescription Drug (Part D)		83,758				83,758
Medicaid/CHIP			$458,322	$16,936		475,258
Other					$8,252	8,252
Judgment Fund (Treasury)					12,306	12,306
Bad Debt Expense and Writeoffs	52	18	253		(45)	278
Total Benefit/Program Costs	**$326,217**	**$453,546**	**$458,575**	**$16,936**	**$20,513**	**$1,275,787**
OPERATING COSTS						
Medicare Integrity Program	$1,381					$1,381
Quality Improvement Organizations	464	$175				639
Program Management and Other Expenses	508	1,384	$143	$15	$722	2,772
Total Operating Costs	**2,353**	**1,559**	**143**	**15**	**722**	**4,792**
TOTAL COSTS	**$328,570**	**$455,105**	**$458,718**	**$16,951**	**$21,235**	**$1,280,579**
Less: Exchange Revenues:						
Medicare Premiums	$4,356	$112,961				$117,317
Other Exchange Revenues	8	17	$1		$6,282	6,308
Total Exchange Revenues	**4,364**	**112,978**	**1**		**6,282**	**123,625**
Intra-CMS Eliminations	**692**	**988**			**(1,680)**	
TOTAL NET COST OF OPERATIONS	**$324,898**	**$343,115**	**$458,717**	**$16,951**	**$13,273**	**$1,156,954**

For purposes of financial statement presentation, non-CMS administrative costs are considered expenses to the Medicare trust funds when outlayed 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 $2,271 million ($2,273 million in FY 2020) 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 2021 Part D expense of $85,423 million ($83,758 million in FY 2020) is net of State reimbursements of $11,919 million ($11,003 million in FY 2020). The gross expense would have been $97,342 million ($94,761 million in FY 2020).

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 Health Care Trust Funds appropriation and the HCFAC account. Other Non-Medicare includes user fees and program management (administrative) activities.

	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Dedicated Collections (Consolidated)
Balance Sheet as of September 30, 2021					
ASSETS					
Intragovernmental:					
Fund Balance with Treasury	$145,714	$8,924	$154,638		$154,638
Investments	308,133		308,133		308,133
Accounts receivable, net	86,056	7,308	93,364	$(92,821)	543
TOTAL INTRAGOVERNMENTAL	**539,903**	**16,232**	**556,135**	**(92,821)**	**463,314**
With the Public					
Accounts receivable, net	15,647	5,806	21,453		21,453
General property, plant & equipment, net	286	1,448	1,734		1,734
Advances and prepayments	67,012	76	67,088		67,088
Total with Public	**82,945**	**7,330**	**90,275**		**90,275**
TOTAL ASSETS	**$622,848**	**$23,562**	**$646,410**	**$(92,821)**	**$553,589**
LIABILITIES					
Intragovernmental:					
Accounts payable	$95,920	$33	$95,953	$(92,821)	$3,132
Debt	36,312		36,312		36,312
Other Liabilities	1	13	14		14
TOTAL INTRAGOVERNMENTAL	**132,233**	**46**	**132,279**	**(92,821)**	**39,458**
With the Public					
Accounts payable	143	159	302		302
Entitlement benefits due and payable	79,778		79,778		79,778
Other Liabilities					
Contingencies	5		5		5
Other	824	8,971	9,795		9,795
Total with the Public	**80,750**	**9,130**	**89,880**		**89,880**
TOTAL LIABILITIES	**$212,983**	**$9,176**	**$222,159**	**$(92,821)**	**$129,338**
NET POSITION					
Unexpended Appropriations-Funds from Dedicated Collections	$134,077	$867	$134,944		$134,944
Cumulative Results of Operations-Funds from Dedicated Collections	275,788	13,519	289,307		289,307
TOTAL NET POSITION	**$409,865**	**$14,386**	**$424,251**		**$424,251**
TOTAL LIABILITIES AND NET POSITION	**$622,848**	**$23,562**	**$646,410**	**$(92,821)**	**$553,589**
Statement of Net Cost for the year ended September 30, 2021					
Benefit and Program Expenses	$850,401	$9,861	$860,262		$860,262
Operating Costs	3,006	4,384	7,390	$(1,205)	6,185
Total Costs	**853,407**	**14,245**	**867,652**	**(1,205)**	**866,447**
Less Exchange Revenues	**(122,634)**	**(11,488)**	**(134,122)**	**1,205**	**(132,917)**
NET COST OF OPERATIONS	**$730,773**	**$2,757**	**$733,530**		**$733,530**

NOTE 11:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Dedicated Collections
Statement of Changes in Net Position for the year ended September 30, 2021					
UNEXPENDED APPROPRIATIONS					
Beginning Balances:	**$97,863**	**$253**	**$98,116**		**$98,116**
Budgetary Financing Sources:					
Appropriations received	**501,642**	**703**	**502,345**		**502,345**
Other Adjustments	**(23,947)**		**(23,947)**		**(23,947)**
Appropriations used	**(441,481)**	**(89)**	**(441,570)**		**(441,570)**
Change in Unexpended Appropriations	**36,214**	**614**	**36,828**		**36,828**
TOTAL UNEXPENDED APPROPRIATIONS: ENDING BALANCE	**$134,077**	**$867**	**$134,944**		**$134,944**
CUMULATIVE RESULTS OF OPERATIONS					
Beginning Balances:	**$266,988**	**$11,737**	**$278,725**		**$278,725**
Appropriations used	**441,481**	**89**	**441,570**		**441,570**
Nonexchange Revenue:					
FICA and SECA taxes	**299,147**		**299,147**		**299,147**
Interest on investments	**4,904**		**4,904**		**4,904**
Other	**3,226**		**3,226**		**3,226**
Transfers-in/out without reimbursement	**(9,185)**	**4,389**	**(4,796)**		**(4,796)**
Imputed financing		**61**	**61**		**61**
Net Cost of Operations	**730,773**	**2,757**	**733,530**		**733,530**
Net Change and Cumulative Results of Operations	**8,800**	**1,782**	**10,582**		**10,582**
CUMULATIVE RESULTS OF OPERATIONS: ENDING	**$275,788**	**$13,519**	**$289,307**		**$289,307**
NET POSITION	**$409,865**	**$14,386**	**$424,251**		**$424,251**

NOTE 11:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Dedicated Collections
Balance Sheet as of September 30, 2020					
ASSETS					
Intragovernmental:					
Fund Balance with Treasury	$107,525	$7,842	$115,367		$115,367
Investments	222,134		222,134		222,134
Accounts receivable, net	75,070	6,821	81,891	$(81,414)	477
TOTAL INTRAGOVERNMENTAL	**$404,729**	**$14,663**	**$419,392**	**$(81,414)**	**$337,978**
With the Public					
Accounts receivable, net	$12,300	$4,178	$16,478		$16,478
General property, plant & equipment, net	173	1,192	1,365		1,365
Advances and prepayments	103,640	9	103,649		103,649
Other Assets		82	82		82
Total with Public	116,113	5,461	121,574		121,574
TOTAL ASSETS	**$520,842**	**$20,124**	**$540,966**	**$(81,414)**	**$459,552**
LIABILITIES					
Intragovernmental:					
Accounts payable	$84,008	$24	$84,032	$(81,414)	$2,618
Debt	1,154		1,154		1,154
Other Liabilities	1	11	12		12
TOTAL INTRAGOVERNMENTAL	**$85,163**	**$35**	**$85,198**	**$(81,414)**	**$3,784**
With the Public					
Accounts payable	$144	$179	$323		$323
Entitlement benefits due and payable	70,152		70,152		70,152
Other Liabilities					
Contingencies	12		12		12
Other	520	7,920	8,440		8,440
Total with the public	70,828	8,099	78,927		78,927
TOTAL LIABILITIES	**$155,991**	**$8,134**	**$164,125**	**$(81,414)**	**$82,711**
NET POSITION					
Unexpended Appropriations-Funds from Dedicated Collections	$97,863	$253	$98,116		$98,116
Cumulative Results of Operations-Funds from Dedicated Collections	266,988	11,737	278,725		278,725
TOTAL NET POSITION	**$364,851**	**$11,990**	**$376,841**		**$376,841**
TOTAL LIABILITIES AND NET POSITION	**$520,842**	**$20,124**	**$540,966**	**$(81,414)**	**$459,552**
Statement of Net Cost for the year ended September 30, 2020					
Benefit and Program Expenses	$779,763	$19,666	$799,429		$799,429
Operating Costs	37	4,521	4,558	$1,680	6,238
Total Costs	**779,800**	**24,187**	**803,987**	**1,680**	**805,667**
Less Exchange Revenues	(117,317)	(6,303)	(123,620)	(1,680)	(125,300)
NET COST OF OPERATIONS	**$662,483**	**$17,884**	**$680,367**		**$680,367**

NOTE 11:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Dedicated Collections (Consolidated)
Statement of Changes in Net Position for the year ended September 30, 2021					
UNEXPENDED APPROPRIATIONS					
Beginning Balances:	**$57,895**	**$73**	**$57,968**		**$57,968**
Budgetary Financing Sources:					
Appropriations received	**438,607**	**203**	**438,810**		**438,810**
Other Adjustments	**(6,458)**		**(6,458)**		**(6,458)**
Appropriations used	**(392,181)**	**(23)**	**(392,204)**		**(392,204)**
Change in Unexpended Appropriations	**39,968**	**180**	**40,148**		**40,148**
TOTAL UNEXPENDED APPROPRIATIONS: ENDING BALANCE	**$97,863**	**$253**	**$98,116**		**$98,116**
CUMULATIVE RESULTS OF OPERATIONS					
Beginning Balances:	**$239,985**	**$12,392**	**$252,377**		**$252,377**
Appropriations used	**392,181**	**23**	**392,204**		**392,204**
Nonexchange Revenue:					
FICA and SECA taxes	**295,913**		**295,913**		**295,913**
Interest on investments	**6,404**		**6,404**		**6,404**
Other	**3,971**		**3,971**		**3,971**
Transfers-in/out without reimbursement	**(8,986)**	**4,861**	**(4,125)**		**(4,125)**
Imputed financing	**3**	**12,345**	**12,348**		**12,348**
Net Cost of Operations	**662,483**	**17,884**	**680,367**		**680,367**
Net Change and Cumulative Results of Operations	**27,003**	**(655)**	**26,348**		**26,348**
TOTAL DEDICATED COLLECTIONS (CONSOLIDATED)	**$266,988**	**$11,737**	**$278,725**		**$278,725**
NET POSITION	**$364,851**	**$11,990**	**$376,841**		**$376,841**

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, 2021 and 2020 consisted of the following:

Net Adjustment to Unobligated Balance Brought Forward	**FY 2021**	**FY 2020**
Budgetary Resources:		
Unobligated balance, brought forward, October 1	$133,884	$94,574
Recoveries of prior year unpaid obligations	43,295	32,144
Recoveries of prior year paid obligations	53,872	20,396
Appropriation temporarily precluded from obligations - prior year	(4,912)	(484)
Cancelled authority	(8,956)	(6,468)
Prior year adjustment	591	(634)
Other	267	142
Unobligated balance from prior year budget authority, net	**$218,041**	**$139,670**

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. This 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 currently become available for obligation as needed. The entire trust fund balances of $224,136 million ($146,530 million in FY 2020) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2021 and FY 2020 (in million):

	FY 2021 Combined Balance	**FY 2020 Combined Balance**
TRUST FUND BALANCE, BEGINNING	$146,530	$223,554
Receipts	896,253	750,699
Less Obligations	818,647	827,723
Excess (Shortage) of Receipts over Obligations	77,606	(77,024)
TRUST FUND BALANCE, ENDING	**$224,136**	**$146,530**

Explanations of Differences Between the Combined Statement of Budgetary Resources and the Budget of the United States Government for FY 2020 (Dollars in Millions)

CMS reconciled the amounts of the FY 2020 column of the SBR to the actual amounts for FY 2020 from the Appendix in the FY 2021 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 2021) will be available at a later date at https://www.whitehouse.gov/omb/budget/.

FY 2020	Budgetary Resources	New Obligations & Upward Adjustments	Distributed Offsetting Receipts	Net Outlays
Combined Statement of Budgetary Resources	$2,007,329	$1,873,445	$532,083	$1,786,681
Expired Accounts	(67,381)			
Other	4,579	4,580	4,851	3,296
Budget of the US Govt (2020 Actual)	**$1,944,527**	**$1,878,025**	**$536,934**	**$1,789,977**

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 OS statements and GTAS adjustments. The distributed offsetting receipts differences are due to a late adjustment for Medicare refunds offsetting collections that affected the Combined Statement of Budgetary Resources.

Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders totaled $111,364 million ($153,730 million FY 2020). The FY 2021 and FY 2020 Non-Federal paid amounts reflect the advance/accelerated payments made for the COVID-19 AAP program.

	FY 2021		FY 2020	
	Federal	Non-Federal	Federal	Non-Federal
Undelivered orders (unpaid)	$414	$43,766	$397	$49,553
Undelivered orders (paid)		67,184	2	103,778
Total	**$414**	**$110,950**	**$399**	**$153,331**

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 *2021 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.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic, however, given the uncertainty of the impacts at the time the Trustees Report was released, the pandemic was not factored into the SOSI projections until 2021. The amount of payroll taxes expected to be collected by the HI trust fund was greatly reduced due to the economic effects of the pandemic on labor markets. 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. More than offsetting these additional costs in 2020, spending for non-COVID care declined significantly (compared to both actual 2019 spending and expectations for 2020 spending in last year's Trustees Report). This decline was particularly true for elective services.

While the COVID-19 pandemic has significantly affected Medicare short-term financing and spending, it is not expected to have a large effect on the financial status of the trust funds after 2024. As discussed throughout the Trustees Report, the key measures of the financial adequacy for each trust fund are fairly comparable to those included in last year's report.

The Medicare Accelerated and Advance Payments (AAP) Program was significantly expanded during the COVID-19 public health emergency period. Total payments of approximately $107.1 billion were made: roughly $67.1 billion from the HI trust fund and $40.0 billion from the SMI Part B trust fund account. The Trustees assume that the accelerated and advance payments will be fully repaid by September of 2022, resulting in no net changes to trust fund expenditures.

It should be noted that there is an unusually large degree of uncertainty with these COVID-related impacts and that future projections could change significantly as more information becomes available. The pandemic is an example of the inherent uncertainty in projecting health care financing and spending over any duration.

In addition, the projections and analysis do not reflect the potential effects of Medicare coverage of Aduhelm, the Alzheimer's disease drug that has been recently approved by the Food and Drug Administration. Given the uncertainty associated with these impacts, the Trustees believe that it is not possible to adjust the estimates accurately before a coverage determination is made.

Furthermore, the projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. The present values 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 health care 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.

To develop projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. The estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on August 31, 2021, excluding the impact of Medicare coverage of Aduhelm and disregarding the payment reductions that would result from the projected depletion of the Medicare HI trust fund. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care costs, wages, and the consumer price index (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 health care 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 2021 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2021. 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.**[1]

1 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.

TABLE 1:

Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2021

					Annual percentage change in:						
								Per beneficiary cost[8]			
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI		Real-interest rate[11]
									B	D	
2021	**1.54**	**680,000**	**908.3**	**3.16**	**6.22**	**3.06**	**4.4**	**8.2[9]**	**13.1[9]**	**–0.2[10]**	**–2.0**
2030	**1.87**	**1,339,000**	**741.5**	**1.21**	**3.61**	**2.40**	**2.0**	**3.6**	**5.0**	**4.3**	**2.2**
2040	**1.98**	**1,288,000**	**683.0**	**1.19**	**3.59**	**2.40**	**1.9**	**4.2**	**4.5**	**4.1**	**2.3**
2050	**2.00**	**1,256,000**	**630.3**	**1.12**	**3.52**	**2.40**	**2.0**	**3.4**	**3.8**	**4.3**	**2.3**
2060	**2.00**	**1,240,000**	**583.7**	**1.16**	**3.56**	**2.40**	**2.0**	**3.3**	**3.8**	**4.2**	**2.3**
2070	**2.00**	**1,229,000**	**542.3**	**1.16**	**3.56**	**2.40**	**1.9**	**3.4**	**3.5**	**4.0**	**2.3**
2080	**2.00**	**1,222,000**	**505.5**	**1.13**	**3.53**	**2.40**	**2.0**	**3.5**	**3.7**	**4.1**	**2.3**
2090	**2.00**	**1,218,000**	**472.7**	**1.14**	**3.54**	**2.40**	**2.1**	**3.4**	**3.7**	**4.2**	**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 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 Difference between percentage increases in wages and the CPI.

5 Average annual wage in covered employment.

6 Consumer price index 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 the assumed return of health care services that were reduced or deferred in 2020 due to the COVID-19 pandemic.

10 Part D cost growth is projected to be negative in 2021 mainly due to higher assumed direct and indirect remuneration.

11 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 2021–2017

1 Average number

					Annual percentage change in:						
									Per beneficiary cost[8]		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI		Real-interest rate[9]
									B	D	
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**
FY 2019	**2.0**	**1,218,000**	**453.5**	**1.16**	**3.76**	**2.60**	**2.0**	**3.5**	**3.6**	**4.3**	**2.5**
FY 2018	**2.0**	**1,218,000**	**444.7**	**1.15**	**3.75**	**2.60**	**2.1**	**3.4**	**3.5**	**4.3**	**2.7**
FY 2017	**2.0**	**1,227,000**	**438.7**	**1.15**	**3.75**	**2.60**	**2.0**	**3.4**	**3.4**	**4.3**	**2.7**

1. Average number of children per woman. The ultimate fertility rate is assumed to be reached in 2056, later than last year due to using a cohort-based approach rather than the period-based used in the 2020 and prior Trustees Reports resulting in a much longer transition to ultimate birth rates from the current low birth rates.
2. Includes legal immigration, net of emigration, as well as other, non-legal, immigration. (Beginning with FY 2018 legal immigration is referred to as lawful permanent resident (LPR) immigration, and other, non-legal, immigration is referred to as other-than-LPR immigration.) The ultimate level of net legal immigration is 788,000 persons per year, and the assumption for annual net other immigration 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 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. Difference between percentage increases in wages and the CPI. The value presented is the average of annual real-wage differentials for the last 65 years of the 75-year projection period, is consistent with the annual differentials shown in table 1, 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.
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. Consumer price index 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.

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. Physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business multifactor productivity although these health providers have historically achieved lower levels of productivity growth. For those providers affected by the productivity adjustments and the specified updates to physician payments, sustaining the price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time.

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. The Trustees previously estimated that physician payment rates under current law will be lower than they would have been under the sustainable growth rate (SGR) formula by 2048 and will be about 30 percent lower by the end of the projection period. 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 this 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 5 percent bonuses for qualified physicians in advanced alternative payment models (advanced APMs) and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS), which are set to expire in 2025.[2] 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.

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	**$26,710**	**$26,779**
Part B	**50,013**	**56,228**
Part D	**10,863**	**10,863**
Expenditures		
Part A	**31,767**	**37,317**
Part B	**50,013**	**56,228**
Part D	**10,863**	**10,863**
Income less expenditures		
Part A	**(5,057)**	**(10,538)**
Part B	**0**	**0**
Part D	**0**	**0**

1 These amounts are not presented in the 2021 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 half 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 5-percent 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 17 percent and Part B expenditures would be higher than the current-law projections by roughly 12 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 12 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are the same under each projection because the services are not affected by the productivity adjustments or the physician updates.

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.

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

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, 2020 to the period beginning on January 1, 2021, and the reconciliation from the period beginning on January 1, 2019 to the period beginning on January 1, 2020. 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 health care 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 that 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 Trustees Reports for those years. Table 1 of note 13 summarizes these assumptions for the current year.

Period beginning on January 1, 2020 and ending January 1, 2021

Present values as of January 1, 2020 are calculated using interest rates from the intermediate assumptions of the 2020 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2021. 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 2020 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 health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2021 Trustees Report.

Period beginning on January 1, 2019 and ending January 1, 2020

Present values as of January 1, 2019 are calculated using interest rates from the intermediate assumptions of the 2019 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2020. 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 2019 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 health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2020 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2020 to the period beginning on January 1, 2021

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2020-94) to the current valuation period (2021-95) 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 2020, replaces it with a much larger negative net cash flow for 2095, and measures the present values as of January 1, 2021, 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 2020-94 to 2021-95. 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 2020 are realized. The change in valuation period resulted in a slight increase 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 $160 billion.

From the period beginning on January 1, 2019 to the period beginning on January 1, 2020

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2019-93) to the current valuation period (2020-94) 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 2019, replaces it with a much larger negative net cash flow for 2094, and measures the present values as of January 1, 2020, 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 2019-93 to 2020-94. 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 2019 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 $238 billion.

Change in Projection Base

From the period beginning on January 1, 2020 to the period beginning on January 1, 2021

Actual income and expenditures in 2020 were different from what was anticipated when the 2020 Trustees Report projections were prepared. For Part A and Part B income and expenditures in 2020 were lower than anticipated based on actual experience, mainly due to the impact of the COVID-19 pandemic. Part D was largely unaffected by the pandemic and total income and expenditures were only slightly higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is an increase of $237 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, 2020 and January 1, 2021 is incorporated in the current valuation and is more than projected in the prior valuation. In section III.B3 of the 2021 Trustees Report, the base change represented the impact of the change in the 2019 experience rather than the 2020 experience. This was done to accurately quantify the full impact of the COVID-19 pandemic by attributing much of the reduction in 2020 income and expenditures to it. For purposes of the SCSIA, we have reflected the impact of the change in the 2020 experience to the projection base change in order to be consistent with prior reporting.

From the period beginning on January 1, 2019 to the period beginning on January 1, 2020

Actual income and expenditures in 2019 were different from what was anticipated when the 2019 Trustees Report projections were prepared. Part A income and expenditures in 2019 were lower than anticipated based on actual experience. For both Part B and 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 $401 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, 2019 and January 1, 2020 is incorporated in the current valuation and is more than projected in the prior valuation.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2020 to the period beginning on January 1, 2021

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, 2021), there were two changes to the ultimate demographic assumptions and an associated change in methodology.

- The ultimate total fertility rate was increased from 1.95 to 2.00 children per woman. At the same time, the projection method was improved to project future birth rates using a cohort-based model, rather than a period-based model as used in the prior valuation.
- An additional cause of death category was added, by separating dementia out from the all-other-causes category, and ultimate mortality improvement rates were updated for cardiovascular disease for all age groups and for the all-other-causes category at ages 85 and over.

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

- Birth rate data through the third quarter of 2020 indicated somewhat lower birth rates than were assumed in the prior valuation.
- Death rates were increased significantly for 2020 and 2021, and to a lesser extent for 2022 and 2023, to account for the elevated deaths during the COVID-19 pandemic period.

These changes resulted in an increase in the estimated future net cash flow. The present values of estimated income and expenditures are lower for Parts A, Part B, and Part D. Overall, these changes increased the present value of the estimated future net cash flow by $700 billion.

From the period beginning on January 1, 2019 to the period beginning on January 1, 2020

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, 2020), there were two changes to the ultimate demographic assumptions.

- The ultimate total fertility rate was lowered from 2.00 to 1.95 children per woman, reflecting a continued decline in fertility rates since 2007.
- The ultimate disability incidence rate was lowered from 5.2 per thousand exposed in the prior valuation to 5.0 in the current valuation. In addition, near-term assumed disability incidence rates, in the period of transition from recent historical values to the ultimate rates, are somewhat lower in the current valuation than in the prior valuation.

In addition to these ultimate demographic assumption changes, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Final birth rate data for 2018 and the first quarter of 2019 indicated somewhat lower birth rates than were assumed in the prior valuation.
- Incorporating 2017 mortality data obtained from the National Center for Health Statistics (NCHS) for ages under 65 in addition to final 2016, preliminary 2017, and preliminary 2018 mortality data from Medicare experience for ages 65 and older resulted in higher death rates for all future years than were projected in the prior valuation.
- The latest valuation included the impact of time to death on Medicare expenditures. Previously, the valuation included only the impact of age and sex on the expenditures.

These changes, especially the time to death assumption lowered Medicare expenditures for the current valuation period, particularly for Part A, and resulted in a large increase in the estimated future net cash flow. The present values of estimated income and expenditures are lower for Parts A, Part B, and Part D. Overall, these changes increased the present value of the estimated future net cash flow by $2,687 billion.

Changes in Economic and Health Care Assumptions

For the period beginning on January 1, 2020 to the period beginning on January 1, 2021

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, 2021), there were two changes to the ultimate economic assumptions and an associated change in methodology.

- The ultimate average real wage differential was slightly increased from 1.14 percentage points in the prior valuation to 1.15 percentage points in the current valuation. Additionally, the real wage differential assumptions for the first ten years of the projection period were also increased.
- The ultimate age-sex-adjusted unemployment rate was reduced from 5.0 percent for the prior valuation to 4.5 percent in the current valuation. At the same time, the labor force participation model was updated to incorporate data from the latest complete economic cycle, thereby putting more weight on the recent relationships among the various factors affecting labor force participation.

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

- Near-term real interest rates were adjusted downward significantly. Real interest rates are now assumed to be negative for calendar years 2021 through 2024, with a gradual rise to the ultimate real interest rate after the economy has fully recovered from the recession.
- There were several changes in starting values and near-term economic growth assumptions primarily related to the COVID-19 pandemic and ensuing recession. In particular, the level of potential GDP is assumed to be roughly 1 percent lower than the level in the prior valuation beginning with the second quarter of 2020.

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

- Slightly faster projected spending growth for outpatient hospital services and for physician-administered drugs.
- Higher direct and indirect remuneration (DIR) and the continuing enrollment shift from Prescription Drug Plans to Medicare Advantage Prescription Drug Plans, which more than offset the higher gross drug prices assumed in this year's report.

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 $959 billion.

For the period beginning on January 1, 2019 to the period beginning on January 1, 2020

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, 2020), there were four changes to the ultimate economic assumptions.

- The ultimate rate of price inflation (CPI-W) was lowered by 0.2 percentage point, from 2.6 percent in the prior valuation to 2.4 percent in the current valuation.
- The ultimate average real-wage differential was decreased from 1.21 percentage points in the prior valuation to 1.14 percentage points in the current valuation. Most of this decrease is due to the repeal of the Affordable Care Act (ACA) excise tax, the effect of which is accounted for in the "Changes in Law or Policy" section. However, a small portion is due to faster assumed growth in employer-sponsored group health insurance premiums separate from this repeal.
- The ultimate age-sex-adjusted unemployment rate was reduced from 5.5 percent for the prior valuation to 5.0 percent in the current valuation. At the same time, long-term labor force participation rates were reduced by age and sex for the current valuation, such that projected employment rates remained essentially unchanged from the prior valuation to the current valuation.

- The ultimate real interest rate was lowered by 0.2 percentage point, from 2.5 percent in the prior valuation to 2.3 percent in the current valuation.

In addition to these changes in ultimate assumptions, the starting economic values and the way these values transition to the ultimate assumptions were changed. The most notable change was to include a 0.7 percent decrease in the estimated level of potential GDP for the fourth quarter of 2019 and thereafter. This and other smaller changes in starting values and near-term growth assumptions combined to decrease the present value of estimated future net cash flows.

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

- Higher projected spending growth for Medicare Advantage beneficiaries.
- Faster projected spending growth for Part B drugs.
- Slower overall drug price increases and higher direct and indirect remuneration.

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 $1,715 billion.

Changes in Law

For the period beginning on January 1, 2020 to the period beginning on January 1, 2021

Several pieces of legislation were enacted since the prior valuation date, however, most of the provisions had little or no impact on the program. Further, the impact of certain provisions is unknown and still others that in practice had no actual impact because they would have occurred anyway. The following provisions reflect those that had a significant financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow. See section V.A of the 2021 Medicare Trustees Report for the complete list of enacted provisions.

The Coronavirus Aid, Relief, and Economic Support (CARES) Act (Public Law 116-136, enacted on March 27, 2020) included provisions that affect the HI and SMI programs.

- From May 1, 2020 through December 31, 2020, the Medicare program is exempted from the sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines. In addition, the sequestration process is extended by 1 year, through fiscal year 2030. The benefit payment reductions of 4.0 percent for the first 6 months and 0.0 percent for the second 6 months that were ordered for fiscal year 2029 are now ordered instead for fiscal year 2030, while the reductions ordered for fiscal year 2029 are changed to a uniform 2.0 percent. (The sequestration order for a given fiscal year is applied to expenditures incurred from April 1 of that fiscal year through March 31 of the following fiscal year.)
- The Medicare Accelerated and Advance Payments (AAP) Program is significantly expanded during the COVID-19 public health emergency period. First, critical access, pediatric, and certain cancer hospitals are added to the list of eligible providers and suppliers. (The usual eligibility criteria—to have billed Medicare during the last 180 days, to not be in bankruptcy, to not be under review or investigation, and to not have any outstanding delinquent Medicare overpayments—will still apply.) Next, the maximum amounts available under the AAP program are increased during the emergency period to (i) 100 percent of Medicare payments made during the past 6 months—for inpatient acute care, pediatric, and certain cancer hospitals; (ii) 125 percent of Medicare payments made during the past 6 months—for critical access hospitals; and (iii) 100 percent of Medicare payments made during the past 3 months—for all other eligible entities. (The maximum available AAP amounts had been 70 percent and 80 percent for providers and suppliers, respectively, of Medicare payments made during the past 90 days.) In addition, recoupments begin 120 days after the accelerated or advance payment is issued, and repayment is due in full within 1 year. (Normally, recoupments begin shortly after the payment is issued, and repayment is due in full within 90 days.)

The Continuing Appropriations Act, 2021 and Other Extensions Act (Public Law 116-159, enacted on October 1, 2020) included provisions that affect the HI and SMI programs.

- For providers and suppliers who receive accelerated or advance payments under the AAP program during the COVID-19 public health emergency, the repayment terms are amended from those provided by, and discussed previously under, the

CARES Act. Specifically, recoupments are not to begin until 1 year has passed since the payment was issued, after which recoupments are to be 25 percent of the AAP amount over the first 11 months and 50 percent over the following 6 months. After that 29-month period has elapsed, the remaining balance will be due within 30 days. If not repaid, interest will accrue for each full 30-day period that the balance remains unpaid, but at an interest rate of 4 percent (instead of 10.25 percent). In addition, a $10 million limit on advance payments to Part B suppliers is established for the period from October 1, 2020 (the date of enactment) through December 31, 2020 and for each subsequent calendar year in which there is a COVID-19 public health emergency during all or part of the year.

The Consolidated Appropriations Act, 2021 (Public Law 116-260, enacted on December 27, 2020) included provisions that affect the HI and SMI programs.

- The CARES Act provision described above that temporarily exempts the Medicare program from sequestration beginning May 1, 2020 is extended through March 31, 2021 (from December 31, 2020).

An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes (Public Law 117-7, enacted on April 14, 2021) included provisions that affect the HI and SMI programs.

- The temporary exemption from sequestration for the Medicare program from May 1, 2020 to March 31, 2021 (as described previously under Public Laws 116-136 and 116-260) is extended through December 31, 2021. (This exemption extension applied retroactively as well, beginning April 1, 2021.) In addition, the sequestration amounts ordered for fiscal year 2030 are to be increased overall, with benefit payment reductions of 2.0 percent for the first 5.5 months, 4.0 percent for the next 6 months, and 0.0 percent for the final 0.5 months (instead of 4.0 percent for the first 6 months and 0.0 percent for the second 6 months). (The sequestration order for a given fiscal year is applied to expenditures incurred from April 1 of that fiscal year through March 31 of the following fiscal year.)

The net impact of all legislative changes was a decrease in the estimated future net cash flow for total Medicare. For Part A the present value of estimated expenditures is higher. The present values of estimated income and expenditures are higher for Part B. Overall, these changes decreased the present value of the estimated future net cash flow by $38 billion.

For the period beginning on January 1, 2019 to the period beginning on January 1, 2020

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 did have a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

The Bipartisan Budget Act of 2019 (Public Law 116-37, enacted on August 2, 2019) included one provision that affects 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 two years, through fiscal years 2028 and 2029.

The Further Consolidated Appropriations Act, 2020 (Public Law 116-94, enacted on December 20, 2019) included provisions that affect HI and SMI programs.

- The annual fee imposed on certain large health insurer providers, including those furnishing coverage under Medicare Advantage and Medicare Part D, is repealed for calendar years beginning after December 31, 2020.
- The excise tax on employer-sponsored group health insurance premiums above a specified level (commonly referred to as the "Cadillac Tax" and provided for by legislation in 2010) is repealed. This excise tax was expected to decrease the average cost of health insurance, thereby increasing the portion of employee compensation subject to the HI payroll tax, over both the short- and long-range projection periods. Although the implementation of this provision has been repeatedly delayed since inception, the 2010-2019 annual reports reflected the assumption that the excise tax would eventually be applied. Therefore, the repeal of this provision decreases the share of employee compensation that will be subject to the HI payroll tax.
- The 1.00 floor on the geographic index for physician work is extended through May 22, 2020 (from December 31, 2019).
- The clinical laboratory commercial payer data reporting requirement is delayed for 1 year (that is, until calendar year 2021).

The net impact of these changes was a decrease in the estimated future net cash flow for total Medicare. The present values of estimated income and expenditures are lower for Part A, Part B, and Part D. Overall, these changes decreased the present value of the estimated future net cash flow by $453 billion.

NOTE 16:

BUDGET AND ACCRUAL RECONCILIATION

(DOLLARS IN MILLIONS)

As of September 30, 2021	Intra-Government	With the Public	Total
NET COST OF OPERATIONS (SNC)	**$1,099**	**$1,271,258**	**$1,272,357**
Components of net cost not part of the budget outlays			
Property, plant, and equipment depreciation expense		$(569)	$(569)
Applied overhead/cost capitalization offset		949	949
		380	**380**
Increase/(Decrease) in Assets:			
Accounts receivable, net	$65	$6,911	$6,976
Securities and investments	366		366
Advances and Prepayments		(36,597)	(36,597)
Other assets		(37)	(37)
	$431	**$(29,723)**	**$(29,292)**
(Increase)/Decrease in Liabilities:			
Accounts payable	$(283)	$591	$308
Benefits due and payable		(16,843)	(16,843)
Debt	(35,420)		(35,420)
Contingencies and Commitments		27	27
Other Liabilities		(1,358)	(1,358)
	$(35,703)	**$(17,583)**	**$(53,286)**
Other Financing Sources:			
Imputed Cost	$(61)		$(61)
Transfers out (in) without reimbursement	3,435		3,435
Total Components of net operating cost not part of the budgetary outlays	**$(31,898)**	**$(46,926)**	**$(78,824)**
Misc Items			
Custodial/Non-exchange revenue	$(4,918)	$793	$(4,125)
Non-entity activity	342		342
Appropriated receipts for Trust/Special Funds		6,888	6,888
Reconciling items:			
Debt	35,420		35,420
Custodial/Non-exchange revenue	4,918	(793)	4,125
Investment interest receivable	(14)		(14)
Other reconciling items	637	(1,297)	(660)
Total Other Reconciling Items	$36,385	$5,591	$41,976
Total Net Outlays	**$5,586**	**$1,229,923**	**$1,235,509**
Budgetary Agency Outlays, net			**$1,235,509**

NOTE 16:

BUDGET AND ACCRUAL RECONCILIATION *(CONTINUED)*

(DOLLARS IN MILLIONS)

As of September 30, 2020	Intra-Government	With the Public	Total
NET COST OF OPERATIONS (SNC)	**$13,298**	**$1,143,656**	**$1,156,954**
Components of net cost not part of the budget outlays			
Property, plant, and equipment Depreciation		$(542)	$(542)
Other		694	694
		$152	**$152**
Increase/(Decrease) in Assets:			
Accounts receivable		$(2,299)	$(2,299)
Loans receivable		336	336
Other asset - Regulatory Assets		103,553	103,553
		$101,590	**$101,590**
(Increase)/Decrease in Liabilities:			
Accounts Payable	$3	$(7,530)	$(7,527)
Other liabilities (Salaries and Benefits, Unfunded Leave, Unfunded FECA, Actuarial FECA)	(395)	6,746	6,351
	$(392)	**$(784)**	**$(1,176)**
Other Financing Sources:			
Federal employee retirement benefit costs paid by OPM and imputed to the agency	$(47)		$(47)
Transfers out (in) without reimbursement	3,554		3,554
Other imputed finance	(12,306)		(12,306)
	$(8,799)		**$(8,799)**
Components of the budget outlays that are not part of net cost:			
Other	$(174)	$6,051	$5,877
	$(174)	**$6,051**	**$5,877**
NET OUTLAYS	**$3,933**	**$1,250,665**	**$1,254,598**
Related Amounts on the Statement of Budgetary Resources			
Outlays, net			**$1,786,681**
Distributed offsetting receipts			**(532,083)**
AGENCY OUTLAYS, NET			**$1,254,598**

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 over five 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 program and a discussion of trends revealed in the data.

RSI material is generally drawn from the *2021 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. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic, however, given the uncertainty of the impacts at the time the Trustees Report was released, the pandemic was not factored into the SOSI projections until 2021. The amount of payroll taxes expected to be collected by the HI trust fund was greatly reduced due to the economic effects of the pandemic on labor markets. 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; notably, the 3-day inpatient stay requirement to receive skilled nursing facility services was waived, payments for inpatient admission related to COVID-19 were increased by 20 percent, and the use of telehealth was greatly expanded. More than offsetting these additional costs in 2020, spending for non-COVID care declined significantly (compared to both actual 2019 spending and expectations for 2020 spending in last year's Trustees Report). This decline was particularly true for elective services.

Overall, the projections are based on actual experience through 2019. To account for the spending impacts of the pandemic, adjustment factors by type of service were developed through 2023. These factors are based on (i) projections of the pandemic; (ii) direct costs associated with the testing and treatment of COVID-19; (iii) projections for non-COVID costs; and (iv) costs for the vaccines. Certain services, such as prescription drugs, durable medical equipment, physician-administered drugs, and hospice, were not materially affected by the pandemic.

Because of the large wave of COVID-19 cases in early 2021, non-COVID-related spending is estimated to be lower than previously expected for the beginning of the year. As care that was reduced or deferred returns, the trend in the latter part of 2021 is slightly higher than anticipated previously. For 2022, the return of deferred care that is assumed to be more intensive results in spending that continues to be higher than previously estimated. The Trustees have not included any longer-term morbidity impacts, balancing (i) a potential increase in costs due to longer-lasting health needs from those who have had COVID-19 with (ii) a potential reduction in costs due to the higher mortality from COVID-19 among those with higher medical spending.

The estimates also incorporate the costs of the COVID-19 vaccines, which consist of both the payments for the vaccines themselves and the payments for their administration. The Trustees expect vaccine utilization to decrease somewhat over time, reflecting the likely reduction in the required number of doses and the possibility that the seriousness of COVID-19 will decrease.

It should be noted that there is an unusually large degree of uncertainty with these COVID-related impacts and that future projections could change significantly as more information becomes available.

The Medicare Accelerated and Advance Payments (AAP) Program was significantly expanded during the COVID-19 public health emergency period, by both legislative provisions and through administrative actions taken by CMS early on during the emergency. CMS first implemented an expedited process for eligible providers and suppliers to request and receive approval for these payments. Next, while the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act) added critical access, pediatric, and certain cancer hospitals to the list of eligible entities, CMS made several modifications to the AAP program that, in effect, expanded eligibility to all types of providers and suppliers.[1] The CARES Act increased the maximum amounts available under the AAP program during the emergency period to (i) 100 percent of Medicare payments made during the past 6 months—for inpatient acute care, pediatric, and certain cancer hospitals; (ii) 125 percent of Medicare payments made during the past 6 months—for critical access hospitals; and (iii) 100 percent of Medicare payments made during the past 3 months—for all other providers and suppliers.[2] In addition, under the *Continuing Appropriations Act, 2021 and Other Extensions Act*, recoupments are to begin 1 year after the accelerated or advance payment is issued, after which recoupments are to be 25 percent of the AAP amount over the first 11 months and 50 percent over the following 6 months; after that 29-month period has elapsed, the remaining balance will be due within 30 days. Total payments of approximately $107.1 billion were made: roughly $67.1 billion from the HI trust fund and $40.0 billion from the SMI Part B trust fund account. The Trustees assume that the accelerated and advance payments will be fully repaid by September of 2022, resulting in no net changes to trust fund expenditures.

1 The usual eligibility criteria—to have billed Medicare during the last 180 days, to not be in bankruptcy, to not be under review or investigation, and to not have any outstanding delinquent Medicare overpayments—still apply.

2 The maximum available AAP amounts had been 70 percent and 80 percent for providers and suppliers, respectively, of Medicare payments made during the past 90 days.

The projections and analysis do not reflect the potential effects of Medicare coverage of Aduhelm, the Alzheimer's disease drug that has been recently approved by the Food and Drug Administration. Given the uncertainty associated with these impacts, the Trustees believe that it is not possible to adjust the estimates accurately before a coverage determination is made.

While the COVID-19 pandemic has significantly affected Medicare short-term financing and spending, it is not expected to have a large effect on the financial status of the trust funds after 2024. The key measures of the financial adequacy for each trust fund shown in this year's Trustees Report are fairly comparable to those included in last year's report. This consistency is partly due to the offsetting effects of lower income and expenditures in the HI trust fund and partly due to the expectation that the effects of the pandemic will last only several years. The pandemic is an example of the inherent uncertainty in projecting health care financing and spending over any duration.

The projections presented here are based on current law, certain features of which may result in some challenges for the Medicare program. Physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. These 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. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business multifactor productivity[3] although these health providers have historically achieved lower levels of productivity growth. If the health sector cannot transition to more efficient models of care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process used to date, then the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private health insurance.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws: the *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); the 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; the Protecting Access to Medicare Act of 2014 (Public Law 113-93, enacted on April 1, 2014); the Bipartisan Budget Act of 2015* (Public Law 114-74, enacted on November 2, 2015); the *Bipartisan Budget Act of 2018* (Public Law 115-123, enacted on February 9, 2018); the Bipartisan Budget Act of 2019 (Public Law 116-37, enacted on August 2, 2019); the CARES Act (Public Law 116-136, enacted on March 27, 2020); the *Consolidated Appropriations Act, 2021 (Public Law 116-260, enacted on December 27, 2020);* and an *Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes (Public Law 117-7, enacted on April 14, 2021)*. The sequestration reduces benefit payments by 2 percent from April 1, 2013 through April 30, 2020, by 2 percent again from January 1, 2022 through September 15, 2030, and by 4 percent from September 16, 2030 through the first half of March 2031. Because of sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013 through September 30, 2030, excluding May 1, 2020 through December 31, 2021 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 health care 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 health care 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[4] payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for health care productivity; (ii) the average physician payment updates would transition from current law[5] to payment updates that reflect the Medicare Economic Index; and (iii) the 5-percent bonuses for qualified physicians in advanced alternative payment models (advanced APMs) and the $500-million payments for physicians in the merit-based incentive payment system (MIPS) would continue indefinitely rather

3 For convenience the term *economy-wide private nonfarm business multifactor productivity* will henceforth be referred to *as economy-wide productivity.*

4 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).

5 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.

than expire in 2025. 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 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 Medicare 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.

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 Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of health care 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 health care 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 four categories of health care 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, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year cost growth rates for these provider services start at 3.6 percent in 2045, or GDP plus 0 percent, declining gradually to 3.4 percent in 2095, or GDP minus 0.3 percent.

ii. ***Physician services***

Payment 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 *3.2 percent in 2045, or GDP minus 0.4 percent, to 2.8 percent in 2095, or GDP minus 0.9 percent.*

iii. ***Certain SMI Part B services that are updated annually by the Consumer Price Index (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 2.8 percent in 2045, or GDP minus 0.8 percent, to 2.6 percent in 2095, or GDP minus 1.1 percent.

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6 This assumed increase in the average expenditures per beneficiary excludes the impacts of the aging of the population, changes in the gender 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 2021 Medicare Trustees Report.

iv. ***All other Medicare services, for which payments are established based on market processes, such as prescription drugs provided through Part D and the remaining Part B services***

These Part B outlays constitute an estimated 15 percent of total Part B expenditures in 2030 and consist mostly of payments for laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.[9] The long-range cost growth rates for Part D and these Part B services are assumed to equal the growth rates as determined from the factors model. The corresponding year-by-year cost growth rates for these services decline from 4.3 percent in 2045, or GDP plus 0.7 percent, to 4.2 percent by 2095, or GDP plus 0.5 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 health care 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 health care is offset somewhat.[10] This is particularly the case for Part A services—such as inpatient hospital, skilled nursing, and home health 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 3.8 percent in 2045, or GDP plus 0.2 percent, declining to 3.7 percent by 2095, or GDP plus 0 percent. When Parts A, B, and D are combined, the weighted average cost growth rate for Medicare is 3.8 percent, or GDP plus 0.2 percent in 2045, declining to 3.7 percent, or GDP plus 0 percent by 2095.

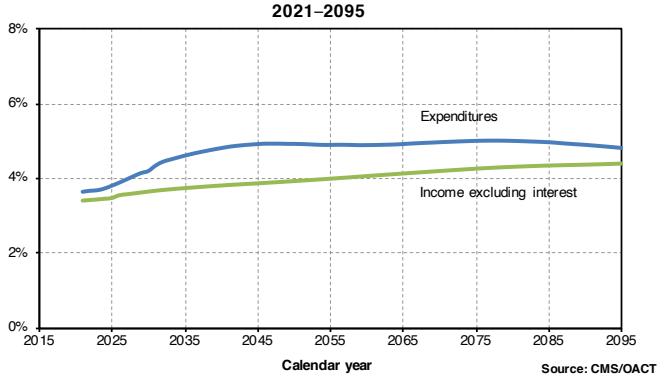
HI Cash Flow as a Percentage of Taxable Payroll

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 very similar to those from last year for nearly all years.

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 result 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 (CCPI-U), which increases at a slower rate than average wages.[11] Thus, as chart 1 shows, the income rate is expected to gradually increase over current levels.

Chart 1—HI Expenditures and Income Excluding Interest as a Percentage of Taxable Payroll 2021–2095



Source: CMS/OACT

9 For example, physician-administered Part B drugs are reimbursed at the level of the average sales price in the market plus 6 percent.

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

11 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. See section V.C7 of the *2021 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.*

In 2021 and beyond, as indicated in chart 1, the cost rate is projected to rise, primarily due to the continued retirements of those in the baby boom generation and partly 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 2030 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 5.3 percent in 2046 and 7.2 percent in 2095.

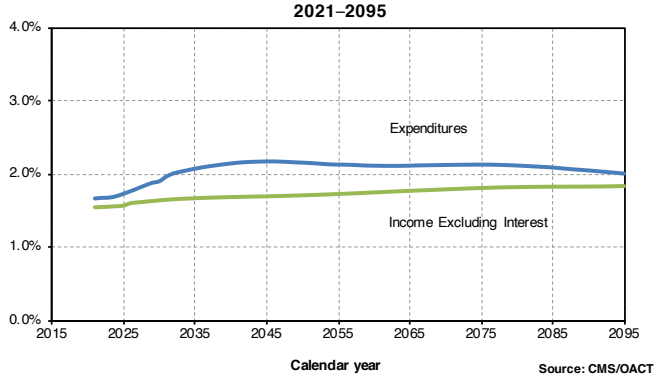
HI and SMI Cash Flow as a Percentage of GDP

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 2020, the expenditures were $402.2 billion, which was 1.9 percent of GDP. As chart 2 illustrates, this percentage is projected to increase steadily until about 2042 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 3.0 percent in 2095.

Chart 2—HI Expenditures and Income Excluding Interest as a Percentage of GDP 2021–2095



Source: CMS/OACT

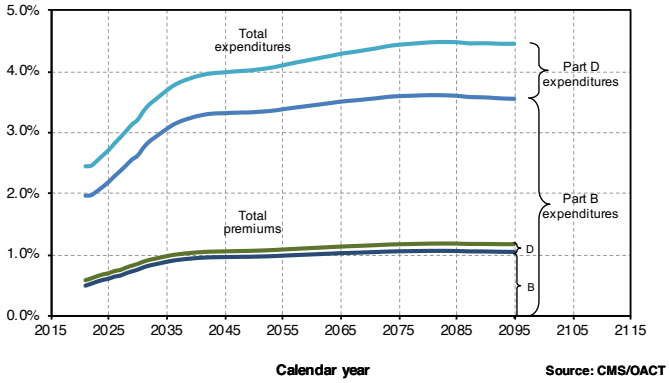
SMI

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 Federal general revenue payments.

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 2020, SMI expenditures were $523.6 billion, or about 2.5 percent of GDP. Under current law, they would grow to about 4.0 percent of GDP within 25 years and to 4.4 percent by the end of the projection period, as demonstrated in chart 3. Under the illustrative alternative, total SMI expenditures in 2095 would be 5.5 percent of GDP.

Chart 3—SMI Expenditures and Premiums as a Percentage of GDP 2021–2095



Source: CMS/OACT

To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, 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 2020 by about 4.3 percent annually. The associated beneficiary premiums—and general revenue 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. Then, after 2015, the State payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

HI

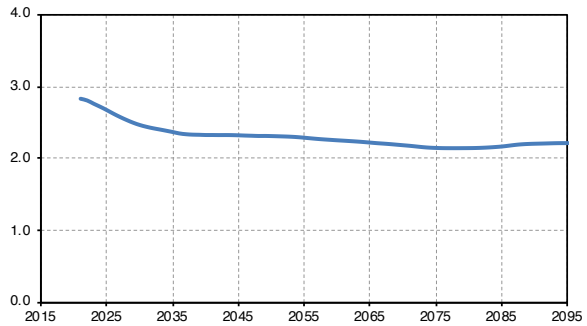
Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current workers pay for current benefits. The relatively smaller number of persons born after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

In 2020, every beneficiary had about 2.9 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 2.2 workers per beneficiary by 2095.

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.

Chart 4—Number of Covered Workers per HI Beneficiary 2021–2095



Source: CMS/OACT

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.[12] The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.[13]

For this analysis, the intermediate economic and demographic assumptions in the *2021 Medicare 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, 2021 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 20 to 25 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.

12 Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to 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.

13 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.

Health Care 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 health care 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

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

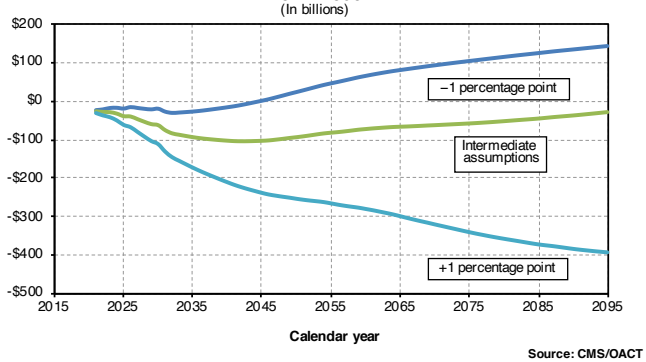
Annual cost/payroll relative growth rate	**–1 percentage point**	**Intermediate assumptions**	**+1 percentage point**
Income minus expenditures (in billions)	**$3,990**	**–$5,057**	**–$19,568**

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $9,047 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 $14,511 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.

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 due to 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 health care service costs.

Chart 5—Present Value of HI Net Cash Flow with Various Health Care Cost Factors 2021–2095
(In billions)



Source: CMS/OACT

Real-Wage Differential

Table 2 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate realwage differential assumptions: 0.53, 1.15, and 1.77 percentage points.[14] In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 2.93, 3.55, and 4.17 percent, respectively.

TABLE 2

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

Ultimate percentage increase in wages – CPI	**2.93 – 2.40**	**3.55 – 2.40**	**4.17 – 2.40**
Ultimate percentage increase in real-wage differential	**0.53**	**1.15**	**1.77**
Income minus expenditures (in billions)	**–$6,718**	**–$5,057**	**–$2,025**

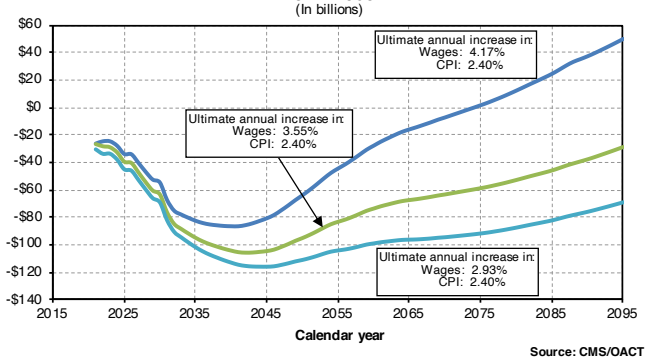
As indicated in table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately $2,445 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $1,340 billion.

14 The real-wage differential is the difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

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

Faster real-wage growth results in smaller HI cash flow deficits, when expressed in present-value dollars, as demonstrated in chart 6. A higher real-wage differential immediately increases both HI expenditures for health care 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 health care 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. Sustaining these price reductions will be challenging for health care providers, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services.

Chart 6—Present Value of HI Net Cash Flow with Various Real-Wage Assumptions 2021–2095
(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 assumed ultimate realwage differential is 1.15 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.15, 3.55, and 2.95 percent, respectively.

TABLE 3

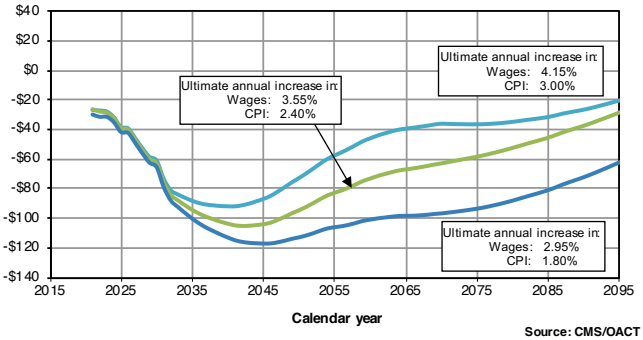
Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages – CPI	**4.15 – 3.00**	**3.55 – 2.40**	**2.95 – 1.80**
Income minus expenditures (in billions)	**–$3,862**	**–$5,057**	**–$6,676**

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.0 percent, the deficit decreases by $1,195 billion. On the other hand, if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $1,619 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.

Chart 7—Present Value of HI Net Cash Flow with Various CPI-Increase Assumptions 2021–2095
(In billions)



Source: CMS/OACT

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.

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.

TABLE 4

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

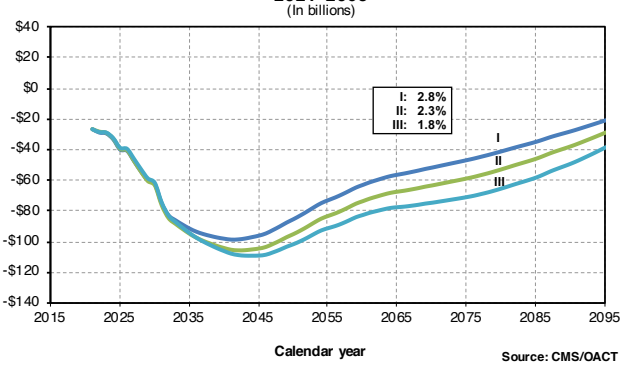
Ultimate real-interest rate	1.8 percent	2.3 percent	2.8 percent
Income minus expenditures (in billions)	**–$5,563**	**-$5,057**	**–$4,446**

As demonstrated in table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $110 billion.

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 2026. 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 2021–2095
(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: 1.69, 1.99, and 2.19 children per woman.

TABLE 5

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

Ultimate fertility rate[1]	1.69	1.99	2.19
Income minus expenditures (in billions)	**–$6,093**	**–$5,057**	**–$4,326**

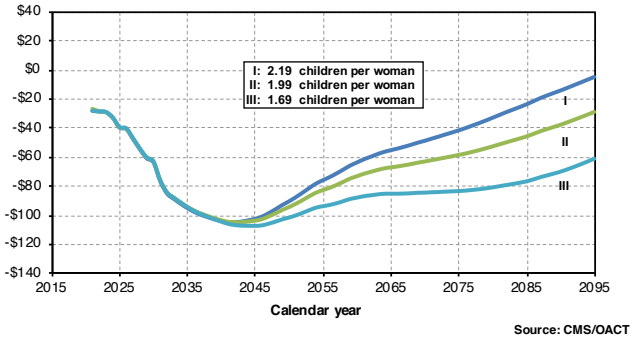
[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

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 $355 billion.

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

Chart 9—Present Value of HI Net Cash Flow with Various Ultimate Fertility Rate Assumptions 2021–2095
(In billions)



Source: CMS/OACT

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.

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: 844,000 persons, 1,280,000 persons, and 1,736,000 persons per year.

TABLE 6

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

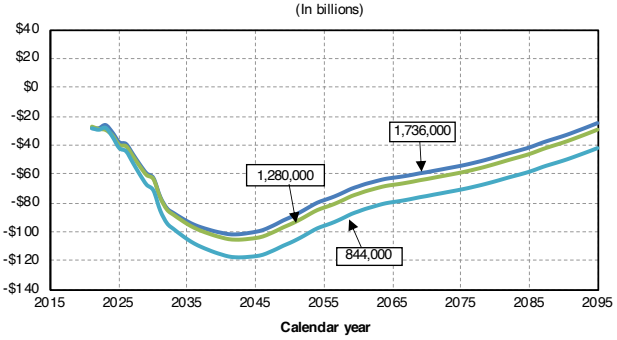
Average annual net immigration	**844,000**	**1,280,000**	**1,736,000**
Income minus expenditures (in billions)	**–$5,861**	**–$5,057**	**–$4,783**

As indicated in table 6, if the average annual net immigration assumption is 844,000 persons, the deficit—expressed in present-value dollars—increases by $803 billion. Conversely, if the assumption is 1,736,000 persons, the deficit decreases by $274 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 at working ages, 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 2021–2095
(In billions)



Source: CMS/OACT

Trust Fund Finances and Sustainability

HI

The short-range financial outlook for the HI trust fund is similar to the projections in last year's Medicare Trustees Report. The estimated depletion date for the HI trust fund is 2026, the same as in the 2018 through 2020 reports. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI income is projected to be lower than last year's estimates due to lower payroll taxes. HI expenditures are projected to be lower than last year's estimates because of lower projected provider payment updates and certain methodological improvements, including changes to the time-to-death factors used in the projection model.

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; these payments will be repaid to the trust fund over the next several years, which will lead to a much smaller deficit in 2021 and a surplus in 2022. After that, the Trustees project deficits in all future years until the trust fund becomes depleted in 2026. 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 health care 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. Policy makers 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 revenue 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[15] will exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2021–2027). For the 2021 Medicare Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2021, 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 2023 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 2020 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 2021 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to "work closely together with a sense of urgency to address these challenges."

15 Dedicated Medicare financing sources used in this year's determination include HI payroll taxes; income from taxation of Social Security benefits; State transfers 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, 2021

(in millions)

	Medicare			Payments to Trust Funds	Medicaid	CHIP	Other	Program Management	Combined Total
	HI TF	SMI TF	Part D						
BUDGETARY RESOURCES:									
Unobligated balance from prior year budget authority, net (discretionary and mandatory)	$22,764	$14,960	$2	$103,901	$39,172	$18,592	$16,865	$1,785	$218,041
Appropriations (discretionary and mandatory)	362,713	372,514	99,640	481,368	515,679	23,780	10,076	203	1,865,973
Borrowing authority (discretionary and mandatory)		45,697					331		46,028
Spending authority from offsetting collections (discretionary and mandatory)			1,807		1,360		2,574	4,362	10,103
TOTAL BUDGETARY RESOURCES	$385,477	$433,171	$101,449	$585,269	$556,211	$42,372	$29,846	$6,350	2,140,145
STATUS OF BUDGETARY RESOURCES:									
New Obligations and upward adjustments	$385,477	$433,171	$101,449	$459,323	$555,793	$18,152	$12,705	$4,676	$1,970,746
Unobligated balance, end of year									
Apportioned, unexpired accounts				15,510		15,899	14,215	461	46,085
Unapportioned, unexpired accounts				6,535	418	2,065	2,748	5	11,771
Unexpired unobligated balance, end of year				22,045	418	17,964	16,963	466	57,856
Expired unobligated balance, end of year				103,901		6,256	178	1,208	111,543
Unobligated balance, end of year (total)				125,946	418	24,220	17,141	1,674	169,399
TOTAL BUDGETARY RESOURCES	$385,477	$433,171	$101,449	$585,269	$556,211	$42,372	$29,846	$6,350	2,140,145
OUTLAYS, NET:									
Outlays, net (discretionary and mandatory)	$357,686	$416,938	$98,619	$439,674	$515,814	$16,093	$9,991	$82	$1,854,897
Distributed offsetting receipts	(59,172)	(559,406)				(14)	(796)		(619,388)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	$298,514	$(142,468)	$98,619	$439,674	$515,814	$16,079	$9,195	$82	1,235,509
DISBURSMENTS, NET							$278		$278

SUPPLEMENTARY INFORMATION

CONSOLIDATING BALANCE SHEET
CONSOLIDATING STATEMENT OF NET COST
CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

CONSOLIDATING BALANCE SHEET

as of September 30, 2021

(in millions)

	Medicare		Health				Combined Totals	Intra-CMS Eliminations	Consolidated Totals
	HI TF	SMI TF	MEDICAID	CHIP	Other	Program Management			
ASSETS									
Intragovernmental Assets:									
Fund Balance with Treasury	$1,199	$144,515	$69,642	$47,257	$21,307	$553	$284,473		$284,473
Investments	136,783	171,350					308,133		308,133
Accounts Receivable, Net	39,880	46,176	1,318		2,316	5,036	94,726	$(94,184)	542
Total Intragovernmental Assets	**177,862**	**362,041**	**70,960**	**47,257**	**23,623**	**5,589**	**687,332**	**(94,184)**	**593,148**
With the Public:									
Accounts receivable, net	836	14,811	6,322	133	5,853	2	27,957		27,957
General Property, Plant & Equipment, Net	286				552	1,154	1,992		1,992
Advances and prepayments	43,264	23,748			103	69	67,184		67,184
Other Assets									
Other			31		487		518		518
Total with Public	44,386	38,559	6,353	133	6,995	1,225	97,651		97,651
TOTAL ASSETS	**$222,248**	**$400,600**	**$77,313**	**$47,390**	**$30,618**	**$6,814**	**$784,983**	**$(94,184)**	**$690,799**
LIABILITIES									
Intragovernmental Liabilities:									
Accounts Payable	$45,249	$50,671	$4		$9	$33	$95,966	$(94,148)	$1,818
Debt associated with Loans		36,312			469		36,781		36,781
Other Liabilities	1				102	12	115	(36)	79
Total Intragovernmental Liabilities	**45,250**	**86,983**	**4**		**580**	**45**	**132,862**	**(94,184)**	**38,678**
Accounts Payable	64	79		1	84	109	337		337
Entitlement Benefits Due and Payable	35,940	43,838	52,757	1,242			133,777		133,777
Other Liabilities							-		-
Contingencies	5		3,654				3,659		3,659
Other Liabilities	148	676	29		8,987	129	9,969		9,969
Total with Public	36,157	44,593	56,440	1,243	9,071	$238	147,742		147,742
TOTAL LIABILITIES	**$81,407**	**$131,576**	**$56,444**	**$1,243**	**$9,651**	**$283**	**$280,604**	**$(94,184)**	**$186,420**
Commitments and contingencies									
NET POSITION									
Unexpended Appropriations-Funds from Dedicated Collections	$1,099	$132,978			$546	$321	$134,944		$134,944
Unexpended Appropriations-Funds other than those from Dedicated Collections			$18,200	$45,510	12,908		76,618		76,618
Total Unexpended Appropriations	1,099	132,978	18,200	45,510	13,454	321	211,562		211,562
Cumulative Results of Operations-Dedicated Collections	139,742	136,046			7,309	6,210	289,307		289,307
Cumulative Results of Operations-Other Funds			2,669	637	204		3,510		3,510
Total Cumulative Results of Operations	139,742	136,046	2,669	637	7,513	6,210	292,817		292,817
TOTAL NET POSITION	**$140,841**	**$269,024**	**$20,869**	**$46,147**	**$20,967**	**$6,531**	**$504,379**		**$504,379**
TOTAL LIABILITIES AND NET POSITION	**$222,248**	**$400,600**	**$77,313**	**$47,390**	**$30,618**	**$6,814**	**$784,983**	**$(94,184)**	**$690,799**

CONSOLIDATING STATEMENT OF NET COST

for the year ended September 30, 2021

(in millions)

	Program	Program Management	Intra-CMS Eliminations	Total
Medicare HI				
Benefit/Program Expenses	**$352,422**			**$352,422**
Operating Expenses	**2,284**	**$1,233**	**$(630)**	**2,887**
Total Cost	**354,706**	**1,233**	**(630)**	**355,309**
Less: Exchange Revenues	**(4,451)**	**(5)**		**(4,456)**
Net Cost Medicare HI	**$350,255**	**$1,228**	**$(630)**	**$350,853**
Medicare SMI				
Benefit/Program Expenses (Part B)	**$412,556**			**$412,556**
Benefit Expenses (Part D)	**85,423**			**85,423**
Operating Expenses	**722**	**$2,475**	**$(575)**	**2,622**
Total Cost	**498,701**	**2,475**	**(575)**	**500,601**
Less: Exchange Revenues	**(118,183)**	**(17)**		**(118,200)**
Net Cost Medicare SMI	**$380,518**	**$2,458**	**$(575)**	**$382,401**
Medicaid				
Benefit/Program Expenses	**$521,735**			**$521,735**
Operating Expenses	**11**	**$137**		**148**
Total Cost	**521,746**	**137**		**521,883**
Less: Exchange Revenues		**(1)**		**(1)**
Net Cost Medicaid	**$521,746**	**$136**		**$521,882**
CHIP				
Benefit/Program Expenses	**$15,991**			**$15,991**
Operating Expenses		**$15**		**15**
Total Cost	**15,991**	**15**		**16,006**
Less: Exchange Revenues				
Net Cost CHIP	**$15,991**	**$15**		**$16,006**
Other				
Program Expenses	**$10,839**			**$10,839**
Operating Expenses	**128**	**$518**		**646**
Total Cost	**10,967**	**518**		**11,485**
Less: Exchange Revenues	**(11,472)**	**(3)**	**$1,205**	**(10,270)**
Net Cost Other	**$(505)**	**$515**	**$1,205**	**$1,215**
NET COST OF OPERATIONS	**$1,268,005**	**$4,352**		**$1,272,357**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2021

(in millions)

	Dedicated Collections					All Other Funds				
	Medicare		Health		Total Funds From Dedicated Collections	Health (Other Funds)			Total All Other Funds	Consolidated Total
	HI TF	SMI TF	Other	Program Management		Medicaid	CHIP	Other		
UNEXPENDED APPROPRIATIONS										
Beginning Balances	$1,048	$96,815	$58	$195	$98,116	$24,907	$39,949	$13,651	$78,507	$176,623
Budgetary Financing Sources:										
Appropriations Received	26,689	474,953	500	203	502,345	597,231	29,760	551	627,542	**1,129,887**
Appropriations Transferred-in/out					-	(3,785)		19	(3,766)	**(3,766)**
Other Adjustments		(23,947)			(23,947)	(77,747)	(8,279)	(7)	(86,033)	**(109,980)**
Appropriations Used	(26,638)	(414,843)	(12)	(77)	(441,570)	(522,406)	(15,920)	(1,306)	(539,632)	**(981,202)**
Change in Unexpended Appropriations	51	36,163	488	126	36,828	(6,707)	5,561	(743)	(1,889)	34,939
Total Unexpended Appropriations	$1,099	$132,978	$546	$321	$134,944	$18,200	$45,510	$12,908	$76,618	$211,562
CUMULATIVE RESULTS OF OPERATIONS										
Beginning Balances	$164,715	$102,273	$5,575	$6,162	$278,725	$648	$694	$24	$1,366	$280,091
Other Adjustments								(342)	(342)	(342)
Appropriations used	26,638	414,843	12	77	441,570	522,406	15,920	1,306	539,632	981,202
Nonexchange Revenue:										
FICA and SECA taxes	299,147				299,147					299,147
Interest on investments	2,487	2,417			4,904		14		14	4,918
Other	443	2,783			3,226					3,226
Transfers-in/out without reimbursement	(3,433)	(5,752)	127	4,262	(4,796)	1,361			1,361	(3,435)
Imputed financing				61	61					61
Other								306	306	306
Net Cost of Operations	350,255	380,518	(1,595)	4,352	733,530	521,746	15,991	1,090	538,827	1,272,357
Net Change and Cumulative Results of Operations	(24,973)	33,773	1,734	48	10,582	2,021	(57)	180	2,144	12,726
Cumulative Results of Operations: Ending	$139,742	$136,046	$7,309	$6,210	$289,307	$2,669	$637	$204	$3,510	$292,817
Net Position	$140,841	$269,024	$7,855	$6,531	$424,251	$20,869	$46,147	$13,112	$80,128	$504,379

AUDIT REPORTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

November 5, 2021

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 FRONTZ
Date: 2021.11.05 09:23:34 -04'00'

SUBJECT: *Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2021*, A-17-21-53000

This memorandum transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2021 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and other matters. 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 U.S. 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, 2021 and 2020, and the related consolidated statements of net cost and changes in net position; (2) the combined statement of budgetary resources for the years then ended; and (3) the statement of social insurance as of January 1, 2021, 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 21-04, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2021 CMS consolidated balance sheets and the related consolidated statements of net cost and changes in net position and combined statement 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, 2021, 2020, 2019, 2018, and 2017, and the related statements of changes in social

insurance amounts for the periods ended January 1, 2021 and 2020. 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:

- *Financial Reporting Processes*—Ernst & Young noted that CMS continues its efforts to enhance internal controls as part of the financial reporting processes. Weaknesses in oversight of the Medicaid program included that although operational data is currently available, information contained within T-MSIS requires additional verification before it would be considered reliable to utilize in the financial accounting and reporting for the Medicaid program. In addition, the process to perform a detailed claims-level look-back analysis related to the Entitlement Benefits Due and Payable accrual, which would determine the reasonableness of the various State calculations of the incurred but not reported liability, should be further developed. Also, there were errors associated with the state plan amendment accrual, which includes accumulating the information from the states and applying a historical approval rate to determine the reported contingent liability at the end of the period. Specifically, amounts used in the calculation of the accrual did not agree to the underlying support and a portion of the amount accrued related to future periods beyond the balance sheet date.

  Ernst & Young also identified a weakness with regard to formula errors associated with various changes incorporated into the Statements of Social Insurance. These formula errors were not detected by the organization's monitoring and review function. These deficiencies collectively represent a significant deficiency in internal control.

- *Information Systems Controls*—Ernst & Young noted that deficiencies continue to be identified in implementing and monitoring access controls for CMS's information systems. While CMS has made progress in implementing greater oversight and uniformity in the design and operation of CMS's IT controls, it continues to encounter challenges with adherence to its established information systems control standards and processes. The deficiencies found continue to constitute a significant deficiency in internal control.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2021, CMS was not in full compliance with the requirements of the Payment Integrity Information Act of 2019 (P.L. No. 116-117). CMS has not calculated or reported an improper payment estimate for the Advance Premium Tax Credits program, which has been deemed susceptible to significant improper payments. Notably, the Medicaid, CHIP, and Medicare Advantage (Medicare Part C) programs reported error rates in excess of 10 percent. Neither the Medicaid program nor CHIP had an error rate target for FY 2021. CMS is incorporating a new eligibility measurement process that would defer the establishment of error rate reduction targets until a baseline measurement was in place. For the Medicare Part C

program, the 2021 measurement implemented refinements to the population of payments reviewed and at risk for diagnostic error, which led to the increase in FY 2021 error rate estimate. CMS has specific initiatives underway to address these results for Medicaid, CHIP and Part C.

CMS was not in compliance with section 6411 of the Affordable Care Act.[1] CMS had not yet implemented recovery activities for the identified improper payments for the Medicare Advantage (Part C) program. CMS management was notified during FY 2021 that it may have potential violations of the Federal Acquisition Regulation related to contracting matters and was notified during FY 2019 that it may have potential violations of the Antideficiency Act related to certain contract obligations for fiscal years 2014 and 2015. Ernst & Young disclosed no other instances of noncompliance that are required to be reported under *Government Auditing Standards* and OMB Bulletin 21-04.

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' reports; and
- reviewing CMS's "Management Discussion and Analysis," "Financial Statements and Footnotes," "Required Supplementary Information," "Supplementary Information," and "Other Information."

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

[1] The Patient Protection and Affordable Care Act (P.L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. No. 111-152) are collectively referred to as the Affordable Care Act.

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) 205-9125 or Carla.Lewis@oig.hhs.gov. Please refer to report number A-17-21-53000.

Attachment

cc:
Norris Cochran
Acting Assistant Secretary for Financial Resources

Sheila Conley
Deputy Assistant Secretary, Finance
and Deputy Chief Financial Officer

Jonathan Blum
Principal Deputy Administrator
and Chief Operating Officer

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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 Financial Statements

We have audited the accompanying financial statements of the Centers for Medicare and Medicaid Services (CMS), which comprise the consolidated balance sheets as of September 30, 2021 and 2020, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to the financial statements. We were also engaged to audit the sustainability financial statements, which comprise the statements of social insurance as of January 1, 2021, 2020, 2019, 2018, and 2017, and the related statements of changes in social insurance amounts for the periods ended January 1, 2021 and 2020, and the related notes to the sustainability financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes 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 Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. Except as discussed in the Basis for Disclaimer of Opinion paragraphs with respect to the accompanying statements of social insurance as of January 1, 2021, 2020, 2019, 2018, and 2017, and the related statements of changes in social insurance amounts for the periods ended January 1, 2021 and 2020, and the related notes to these financial statements, we conducted our audits 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 No. 21-04*, Audit Requirements for Federal Financial Statements*. Those standards and OMB Bulletin No. 21-04 require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements 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 the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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, 2021 and 2020, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to these financial statements.

Basis for Disclaimer of Opinion on the Statements of Social Insurance and the related Changes in the Social Insurance Program

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 statements of social insurance and 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

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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, 2021, 2020, 2019, 2018, and 2017, 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 intended to quantify the potential understatement of projected Medicare costs to the extent that certain payment provisions were not fully implemented in all future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 14, the ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. Absent a change in the health care delivery system or level of update by subsequent legislation, access to Medicare-participating providers may become a significant issue in the long term under current law. 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 this report. As a result of these limitations, we were unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2021, 2020, 2019, 2018, and 2017, and the related statements of changes in social insurance amounts for the periods ended January 1, 2021 and 2020.

Disclaimer of Opinion on the Statements of Social Insurance and the Related Changes in the Social Insurance Program

Because of the significance of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the CMS social insurance program as of January 1, 2021, 2020, 2019, 2018, and 2017, and the related changes in the social insurance program for the periods ended January 1, 2021 and 2020, and the related notes to these financial statements.

Opinion

In our opinion, the consolidated balance sheets, the consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources referred to above present fairly, in all material respects, the consolidated financial position of CMS as of September 30, 2021 and 2020, and their consolidated net cost, consolidated changes in net position, and combined budgetary resources for the years then ended in conformity with U.S. generally accepted accounting principles.

Other Matters

Required Supplementary Information

Generally accepted accounting principles in the United States of America require that Management's Discussion and Analysis and Required Supplementary Information as identified on CMS' Annual 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 which considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the 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 and Other Information

Our audit was conducted for the purpose of forming an opinion on the financial statements that collectively comprise CMS' financial statements. The Supplementary Information is presented for purposes of additional analysis and is not a required part of the financial statements.

The Supplementary 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. Such information has been subjected to the auditing procedures applied in the audit 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 Supplementary Information is fairly stated, in all material respects, in relation to the financial statements as a whole.

The Other Information has not been subjected to the auditing procedures applied in the audit of the financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

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Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 5, 2021, on our consideration of CMS' 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 those reports 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' internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering CMS' internal control over financial reporting and compliance.

Ernst & Young LLP

November 5, 2021

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Report of Independent Auditors on Compliance and Other Matters Based on an Audit of the 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 and Office of Management and Budget (OMB) Bulletin No. 21-04, *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, 2021, 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 to the financial statements, and we were engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2021, and the related statement of changes in social insurance amounts for the period ended January 1, 2021, and the related notes to the sustainability financial statements, and have issued our report thereon dated November 5, 2021. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2021, and the related statement of changes in social insurance amounts for the period ended January 1, 2021.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether CMS' financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the financial statements, as well as the requirements referred to in the *Federal Financial Management Improvement Act of 1996* (FFMIA) (P.L.104-208). 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. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to CMS. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 21-04, as described below:

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The *Payment Integrity Information Act of 2019* (P.L.116-117) (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. CMS has not calculated or reported an improper payment estimate for the Advance Premium Tax Credits program, which has been deemed susceptible to significant improper payments. In addition, although CMS has reported improper payment rates for each of its other high-risk programs, or components of such programs, the Medicaid, CHIP and Medicare Advantage (Part C) improper payment rates exceeded the statutorily required maximum of 10 percent. CMS was also not in full compliance with Section 6411 of the *Affordable Care Act* as CMS had not yet implemented recovery activities of the identified improper payments for the Part C program.

During FY 2019, CMS management was notified that it may have potential violations of the Federal Acquisition Regulation related to contracting matters. In addition, CMS management was notified in the prior fiscal year that it may have potential violations of the *Anti-Deficiency Act* related to certain contract obligations related to fiscal years 2014 and 2015.

CMS' Response to Findings

CMS' response to the findings identified in our audit is described in the accompanying letter dated November 5, 2021. CMS' response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of this Report

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

Ernst & Young LLP

November 5, 2021

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Report of Independent Auditors on Internal Control Over Financial Reporting 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 statement audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 21-04, *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, 2021, 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 to the financial statements, and we were engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2021, and the related statement of changes in social insurance amounts for the period ended January 1, 2021, and the related notes to the sustainability financial statements, and have issued our report thereon dated November 5, 2021. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2021, and the related statement of changes in social insurance amounts for the period ended January 1, 2021.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered CMS' 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' internal control. Accordingly, we do not express an opinion on the effectiveness of CMS' internal control.

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

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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. However, material weaknesses may exist that have not been identified. We did identify certain deficiencies in internal control as 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 financial results of actions taken, control over 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 scope and size. CMS is entrusted with the lead role in overseeing health services in the United States. 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.

CMS relies on a decentralized organization and a high number of complex financial management systems to operate and accumulate data for financial reporting. The business owners and users of the systems are located at contracted organizations, providers, branch offices, Centers and Offices outside of the Office of Financial Management (OFM). Providing oversight requires a common set of accounting and reporting standards, proper execution of those standards/policies, an integrated financial system, properly trained personnel, and meaningful collaboration within CMS and with the Department of Health and Human Services (HHS).

As CMS continues its efforts to enhance internal controls, the following areas identified in the current year audit merit continued focus as part of the financial reporting processes significant deficiency.

Medicaid Oversight

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.

Medicaid Entitlement Benefits Due and Payable (EBDP)

CMS previously completed 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. Although operational data is currently available, information contained within T-MSIS requires additional verification before it would be considered reliable to utilize in the financial accounting and reporting for Medicaid. CMS should 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. 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 appropriate use of a similar methodology. The Medicaid EBDP is a significant liability on the FY 2021 financial statements and is subject to volatility based on the complexity and judgment required in establishing this estimate. From time to time, claim processing cycle changes, such as a claims inventory buildup, may arise. As such, the lack of detailed claims data limits the ability to detect this type of situation on a timely basis or consider the potential volatility from this occurrence, presenting a risk that potential updates to CMS' analysis will not be reflected in CMS' financial statements in a timely manner.

Medicaid Contingencies

At the end of each quarter, an accrual is recognized for any pending state plan amendments (SPAs) which have not yet been approved but for which the approval would impact periods prior to the balance sheet date. The calculation of the SPA accrual includes accumulating the information from the states and applying a historical approval rate to determine the reported contingent liability at the end of the period. During our procedures, we identified errors in the SPA accrual calculation. Specifically, amounts used in the calculation of the accrual did not agree to the underlying support and a portion of the amount accrued improperly related to future periods beyond the balance sheet date.

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' 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. In the current year, CMS incorporated changes to the SOSI projection, resulting in changes to the inputs, formulas and macros, and outputs of certain spreadsheets. During our procedures, formula errors associated with certain of the changes 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 in the high-risk CMS programs of Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), Medicare Prescription Drugs (Part D), Medicaid and CHIP.

CMS builds time into their processes to allow all payments sampled for review sufficient time to allow for appeals of the errors and submission of additional documentation by the claimant. CMS believes that expediting the improper payment rate calculations would result in less time for sampled payments to complete the measurement process allowing errors to be cited solely due to the fact that not enough time was given for things such as appeals or documentation submission. Allowing the maximum amount of time for this development causes the processes to be completed very near the required annual reporting deadline. CMS remains committed to achieving reductions in improper payment rates. For Medicaid and CHIP, CMS reintegrated the eligibility component of the measurement in 2019, resulting in an increase in the improper payment rates; however, the 2021 rates are not comparable to the prior year as a result of this reintegration of the eligibility component which contributed to a further increase in the Medicaid and CHIP error rates in 2021. Rates between years will not be comparable until after a baseline is established in 2021, when all states have been measured under the new eligibility requirements. For Part C, the 2021 measurement implemented refinements to the population of payments reviewed and at risk for diagnostic error, which led to the increase in the FY 2021 error estimate. CMS has specific initiatives underway to address these results for Medicaid, CHIP and Part C.

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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 enhance the data analyses on Medicaid claims level data to develop robust analytical procedures and measures against 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 the approximately $52.8 billion liability.

- Enhance the control attributes, including the precision of controls, around the completeness and accuracy of underlying data as it relates to the Medicaid SPA contingencies. Re-evaluate the responsible parties best suited to review the accrual at the balance sheet date particularly when the accrual changes between quarters exceed a specified amount.

- 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' 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 System Access and Information Security 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

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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' information resources could be compromised. Additionally, information systems security controls are vital to safeguard the confidentiality, integrity and availability of data. As a result of evolving threats to information systems, continuous monitoring and scanning of security baselines is essential in identifying vulnerabilities and misconfiguration of system controls that could be exploited if they remain unremediated.

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

- Procedures for the removal of users who no longer required access were not consistently followed.

- Monitoring and/or recertification of privileged access for key applications and underlying IT infrastructure was not performed, or evidence of such monitoring or recertification activity was not retained.

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

Configuration Management

While progress has been made towards implementing greater oversight and uniformity in the design and operation of CMS' IT security configuration management controls, CMS continues to encounter challenges with adherence to CMS' established information systems control standards and processes by employees and contractors, particularly as it relates to the organization's access monitoring controls.

Deficiencies continued to be identified in the contractors' implementation of CMS' information systems control standards and processes.

CMS' risk management strategy is decentralized and lacks an enterprise viewpoint, which has resulted in several vulnerabilities related to system configurations with the CMS information systems. The remediation, mitigation of risks, or monitoring of these vulnerabilities was not performed or not performed timely. These include settings to disable inactive accounts and password requirements.

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The distributed nature of CMS' IT environment has resulted in the identification of control deficiencies stemming from inadequate implementation of controls related to access, security management and system configuration. Deficiencies related to these control areas were consistently noted within the OMB A-123 and OIG audit reports. Commonality in access, security management and system configuration control deficiencies across the business units indicates monitoring and oversight is an enterprise level risk for which standardized processes should be developed to allow the varying IT environments to implement common access controls.

Without sufficient and consistent compliance with its established information security and configuration management policies and procedures, Medicare and Medicaid systems and other enterprise-wide systems may be susceptible to error, fraud, and/or security vulnerabilities that may impact claims processing and financial reporting.

Recommendations

CMS should continue to improve the operating effectiveness of information security controls, including access controls, to ensure that:

- Relevant CMS guidance is followed for the removal of users to all systems and security configurations.

- Privileged access for key applications and the underlying IT infrastructure is monitored to detect and correct unauthorized access or activities, and evidence of such monitoring activities is retained. Specific to the governance over implementation of information systems controls standards and processes, CMS should continually assess the governance and oversight across its organizational units charged with responsibility for the information security of its systems and data at both Headquarters and the CMS Medicare FFS contractors. As such, an approach will require continued and active communication and integration of efforts by the OFM, OIT and CM.

An improved enterprise governance-based approach should result in strengthened control, monitoring, and oversight processes that will enhance the overall integrity and resiliency of CMS' information systems. Examples of such processes that should be improved include:

- Enhanced risk management procedures and practices that focus on significant IT systems that support financial management processes and a clear definition of responsibilities associated with the oversight and implementation of controls to address identified risks.

- Ensuring that remediation of findings identified as a part of OIG and OMB A-123 audits, including tests performed on CMS and its Medicare contractors' IT operations, is performed timely.

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CMS' Response to Findings

CMS' response to the findings identified in our audit is described in the accompanying letter dated November 5, 2021. CMS' response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of this Report

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

Ernst & Young LLP

November 5, 2021

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 5, 2021

Ernst & Young, LLP
1201 Wills Street
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Baltimore, MD 21231

Dear Sir/Madame:

We are pleased to receive an unmodified audit opinion on our fiscal year 2021 annual financial statements: Consolidated Balance Sheets, Consolidated Statements of Net Cost and Changes in Net Position, and the Combined Statements of Budgetary Resources.

As in previous years, you have reported 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 remains confident that our SOSI model projections are fairly presented in accordance with federal financial accounting standards and has properly disclosed and documented the nature and uncertainty surrounding these projections.

While the results of this year's audit identified no material weaknesses in our internal controls, you continue to report two significant deficiencies in financial reporting processes and information systems. Strengthening our internal controls remains a top agency priority for CMS and we are committed to taking swift corrective actions to address any identified weaknesses.

I would also like to take this opportunity to thank your office for its hard work and professionalism exhibited during the audit. I truly appreciate the strong partnership we have with you, our auditors, to work diligently to complete the audit and look forward to your continued support as we work to remediate the issues noted.

Sincerely,

Megan Worstell

Megan Worstell
Chief Financial Officer

OTHER INFORMATION

SUMMARY OF FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT REPORT AND OMB CIRCULAR NO. 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 NO. 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) Office of Inspector General (OIG) audits, and Government Accountability Office (GAO) audits and High-Risk reports; (4) Statement on Standards for Attestation Engagements (SSAE) 18 internal control audits; (5) evaluations and tests of Medicare contractor controls conducted pursuant to section 912 of the *Medicare Modernization Act*; (6) the annual *Chief Financial Officers* (CFO) *Act* audit; (7) security assessment and authorization of systems; and (8) Department Enterprise Risk Management efforts. As of September 30, 2021, 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 No. 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, 2021, with the exception of non-compliances with: the *Payment Integrity Information Act of 2019* (PIIA), and Section 6411 of the *Patient Protection Affordable Care Act* (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 implemented, others are in the early stages of implementation. CMS believes these major undertakings will have a larger impact over time.

CMS's fiscal year (FY) 2021 PIIA non-compliance stems from the following:

1. The 2021 Medicaid improper payment estimate was 21.69 percent, higher than the 10 percent threshold required by PIIA.
2. The 2021 Children's Health Insurance Program (CHIP) improper payment estimate was 31.84 percent, higher than the 10 percent threshold required by PIIA.
3. The 2021 Medicare Part C improper payment estimate was 10.28 percent, higher than the 10 percent threshold required by PIIA.

CMS continues its efforts, outlined in the FY 2021 Agency Financial Report (AFR), to comply with the requirements of PIIA and OMB's implementing guidance.

With regard to compliance with Section 6411 of the PPACA concerning development of the Medicare Part C Recovery Audit Contractor (RAC) program, CMS is exploring options in response to information received by HHS that Part C RACs are not an efficient use of program integrity resources. In 2015, CMS issued a Request for Information on the proposal to put the Contract-Level Risk Adjustment Data Validation (RADV) audits under the purview of a Medicare Part C RAC. The primary corrective action on Part C payment error has been the Contract-Level RADV audits. RADV verifies that diagnoses submitted by MA organizations

for risk adjusted payment are supported by medical record documentation. In the responses to the Request for Information, the MA industry expressed concerns of burden related to the high overturn rate in the early experience of the Parts A and B RAC programs. Potential RAC vendors expressed concerns with the unlimited delay in the contingency payment due to time frames not being established for appeal decisions in the MA appeal process (42 C.F.R. § 423.2600). Despite their success in Medicare FFS, RACs have found Medicare Part C to be an unattractive business model because of differing payment structures and a narrow scope of payment error.

CMS believes that the functions of the Part C RAC are currently being performed by the RADV program. The RADV program is currently operational with the support of contractors the government has procured. An updated RADV methodology that addresses recommendations in GAO audit report GAO-16-76 includes targeting payment errors using historical payment error data. CMS expects to initiate recovery of audit findings in FY 2023, pending finalization of the RADV proposed rule, CMS-4185-P.

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 lacking sufficient documentation to determine if proper.

Since FY 2012, CMS has complied with OMB's implementing guidance and instituted comprehensive processes that measure the payment error rates for the Medicare FFS, Medicare Advantage (Part C), Medicare Prescription Drug (Medicare Part D), Medicaid, and CHIP programs. Due to COVID-19, in FY 2020 HHS exercised its enforcement discretion to temporarily suspend all improper payment related engagement, communications, and data requests to providers and state agencies from HHS as disclosed in HHS's FY 2020 AFR. HHS adjusted the sample size for the FY 2021 Medicare FFS, Medicaid, and CHIP measurement programs to account for the ongoing challenges incurred by providers, suppliers, and states during COVID-19, while continuing to maintain appropriate accountability measures and meet the statutory obligations.

Medicare FFS

CMS measures the Medicare FFS improper payment estimate annually, through the CERT program. The Medicare FFS measurement methodology remains the same since FY 2012. The estimated percentage of Medicare FFS dollars paid correctly was 93.74 percent. This means Medicare paid an estimated $374.74 billion correctly in FY 2021.

The Medicare FFS improper payment estimate for FY 2021 is 6.26 percent or $25.03 billion. The improper payment estimate due to lacking or insufficient documentation is 4.32 percent or $17.26 billion, representing 68.95 percent of total improper payments. Improper payments for hospital outpatient, skilled nursing facility (SNF), home health, and hospice claims were the major contributing factors to the FY 2021 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 make sure 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 (Part C) and Prescription Drugs (Part D)

CMS measures the Medicare Part C improper payments made to Medicare Advantage (MA) contracts through the Part C Improper Payment Measurement process. The Part C improper payment estimate for FY 2021 is 10.28 percent, or $23.19 billion. The improper payment estimate due to lacking or insufficient documentation is 0.77 percent or $1.74 billion, representing 7.52 percent of total improper payments. The estimated percentage of Part C dollars paid correctly was 89.72 percent. This means Part C paid an estimated $202.42 billion correctly in FY 2021.

In FY 2021, CMS implemented refinements to the methodology to only include the population of MA payments reviewed and at risk for diagnostic error, which led to the increase in the FY 2021 error estimates. For prior years, the Part C methodology reflected total MA payments and included some payments that were non-risk adjusted or were based on a different model resulting in a reported error rate that was biased downward. Therefore, the FY 2021 reporting year is a baseline, and should not be compared with prior reporting years. .

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 2021 is 1.58 percent, or $1.37 billion. The improper payment estimate due to lacking or insufficient documentation is 0.65 percent or $0.56 billion, representing 41.19 percent of total improper payments. The estimated percentage of Part D dollars paid correctly was 98.42 percent. This means Part D paid an estimated $85.44 billion correctly in FY 2021.

Medicaid and CHIP

Medicaid and CHIP are susceptible to erroneous payments as well. Thus, the federal government and the states both have a strong financial interest in ensuring that claims are paid accurately. Through PERM, CMS measures three areas of Medicaid and CHIP: 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.

Between FY 2015 and FY 2018, states were not measured on the eligibility PERM component as states worked to come into compliance with new PPACA eligibility requirements. In 2019, the PERM program integrated these new PPACA Medicaid and CHIP eligibility requirements in the eligibility review methodology. CMS resumed the eligibility review component measurement under the PERM final rule (82 FR 31158, July 5, 2017) for the first cycle of 17 states and reported an updated national eligibility improper payment estimate for FY 2019. In FY 2021, CMS is reporting a baseline eligibility improper payment estimate including all three cycles of states.

The national Medicaid improper payment estimate for FY 2021 is 21.69 percent or $98.72 billion in improper payments based on measurements conducted in FYs 2019, 2020, and 2021. The improper payment estimate due to lacking or insufficient documentation is 19.13 percent or $87.08 billion, representing 88.21 percent of total improper payments. The estimated percentage of Medicaid dollars paid correctly was 78.31 percent. This means Medicaid paid an estimated $356.45 billion correctly in FY 2021.

The national improper payment estimate for each Medicaid component is:

- *Medicaid FFS*: 13.90 percent
- *Medicaid managed care*: 0.04 percent
- *Medicaid eligibility*: 16.62 percent

The national CHIP improper payment estimate for FY 2021 is 31.84 percent or $5.37 billion in improper payments based on measurements conducted in FYs 2019, 2020, and 2021. The improper payment estimate due to lacking or insufficient documentation is 24.79 percent or $4.18 billion, representing 77.85 percent of total improper payments. The estimated percentage of CHIP dollars paid correctly was 68.16 percent. This means CHIP paid an estimated $11.51 billion correctly in FY 2021.

The national improper payment estimate for each CHIP component is:

- *CHIP FFS*: 13.67 percent
- *CHIP managed care*: 0.48 percent
- *CHIP eligibility*: 28.71 percent

The majority of Medicaid and CHIP improper payments are a result of eligibility errors discovered through the reintegration of the PERM eligibility component, as mentioned above. A federal contractor[1] conducts the eligibility measurement, allowing for consistent insight into the accuracy of Medicaid and CHIP eligibility determinations and increased oversight of identified

1 Prior to FY 2014, states reviewed the eligibility component and reported to CMS for national improper payment reporting.

vulnerabilities. Based on the measurement of all three cycles of states, eligibility errors are mostly due to insufficient documentation to affirmatively verify eligibility or non-compliance with eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where:

- The required verification of eligibility data, such as income, was not done at all, and
- Where there is indication that the eligibility verification was initiated but there was no documentation to validate the verification process was completed.

The CHIP improper payment estimate was also driven by claims where the beneficiary was inappropriately deemed eligible for CHIP, but was eligible for Medicaid. Additionally, state non-compliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements is a major contributor to the Medicaid and CHIP improper payment estimates.

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 plans, with assistance and oversight from CMS.

Additional information on the Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, and CHIP improper payments can be found in the **HHS FY 2021 AFR** and **CMS websites**.

Exchanges

In FY 2021, CMS commenced the improper payment measurement program for the Federally-facilitated Exchange, and anticipates reporting an improper payment estimate for the Federally-facilitated Exchange in the FY 2022 AFR. 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. As with similar CMS programs, developing an effective and efficient improper payment measurement program requires multiple time-intensive steps, including contractor procurement; developing measurement policies, procedures, and tools; and extensive pilot testing to ensure an accurate improper payment estimate.

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 health care 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 and expenses are recorded when goods are received or services are performed, 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.

Advanced Alternative Payment Model (Advanced APM): An APM that meets certain standards for risk-bearing, use of health information technology, and quality.

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

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 with the amount of the actual premium tax credit they are eligible.

American Recovery and Reinvestment Act of 2009 (ARRA): An economic stimulus package enacted by the 111th U.S. Congress in February 2009. This act of Congress was based largely on proposals made by the President and was intended to stimulate the U.S. economy in the wake of the economic downturn. The act includes federal tax cuts, expansion of unemployment benefits and other social welfare provisions, and domestic spending in education, healthcare, and infrastructure, including the energy sector.

American Rescue Plan Act of 2021: An emergency legislative package to provide relief and additional resources for individuals and businesses affected by COVID-19 and to spur a strong economic recovery. 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: Expenses accrued or funds outlaid for services delivered to beneficiaries.

C

Chief Financial Officers Act of 1990 (CFO Act): Designated a Chief Financial Officer in each executive department and each major executive agency in 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.

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.

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 have an applicable certificate in effect.

Consumer Operated and Oriented Plan Program (CO-OP): The Patient Protection and Affordable Care Act calls for the establishment of the CO-OP Program, which fosters the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets.

Cost-Sharing Reduction (CSR) Payment: Payments to health insurance issuers on the Exchange on behalf of eligible insured individuals that lower the amount consumers pay for deductibles, copayments, and coinsurance. Eligibility is limited to those in silver plans receiving APTCs and is based on the amount of household income for the insured compared to the poverty line. These payments to issuers ceased in Fiscal Year 2018 in light of a legal opinion from the Attorney General of the U.S. that a valid appropriation does not exist for CSR payments. However, issuers are still required by law to reduce cost-sharing for eligible enrollees.

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 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 iron lungs, oxygen tents, 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 (ESRD): Permanent kidney failure requiring dialysis or a transplant.

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): 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 the U.S. Standard General Ledger (USSGL) at the transaction level.

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: A system of healthcare payment in which a provider is paid separately for each particular service rendered.

G

Government Performance and Results Act Modernization Act of 2010 (GPRA Modernization Act): 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.

Government Management Reform Act of 1994: Requires the auditing of executive agencies' annual financial statements prior to submission to OMB.

H

Health Information Technology for Economic and Clinical Health Act (HITECH): ARRA includes the HITECH Act, which established programs under Medicare and Medicaid to incentivize the meaningful use of certified electronic health record technology among eligible professionals, hospitals, and critical access hospitals.

Health Insurance Marketplaces (Marketplaces): A mechanism for facilitating the purchase of Qualified Health Plans and evaluating eligibility for APTCs and CSRs. States can establish their own Marketplace or the Federal government can operate a Marketplace 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 and Community Based Services (HCBS): Provide opportunities for Medicaid beneficiaries to receive services 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) (or Part A): The part of Medicare that pays hospital and other institutional provider benefit claims. Also referred to as Part A.

I

Information Technology (IT): The term commonly applied to maintenance of data through computer systems.

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 medical costs for persons with limited income and resources.

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). The 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 that were previously offered to Medicare beneficiaries by allowing for the establishment of new regional preferred provider organizations 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.

Medical Loss Ratio: 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 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): Also known as Medicare 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.

N

2019 Novel Coronavirus Disease (COVID-19): A new coronavirus that had not been previously identified. On February 11, 2020, the World Health Organization announced this official name for the disease causing the 2019 novel coronavirus outbreak, first identified 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.

Part B: The part of Medicare that pays physician and supplier claims, also referred to as Medicare Supplementary Medical Insurance or SMI.

Patient Protection and Affordable Care Act (PPACA) (P.I. 111-148): 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 the 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.

Payment Safeguards: Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, medical review/utilization review provider audits, and fraud and abuse detection.

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.

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.

Q

Qualified Health Plans (QHPs): Certified health insurance plans that meet minimum standards for health benefit coverage, as required by the PPACA.

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.

Quality Payment Program (QPP): Established by MACRA, which repeals the sustainable growth rate formula and streamlines multiple quality reporting programs into a new Merit-based Incentive Payment System. Under the QPP, incentive payments are provided to clinicians for their participation in Advanced Alternative Payment Models or the Merit-based Incentive Payment System. Clinicians can choose how they want to participate based on their practice size, specialty, location, or patient population.

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: 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) (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. The prescription drug benefit is funded through the SMI Trust Fund.

T

Transitional Reinsurance Program: The transitional reinsurance program stabilized premiums in the individual market inside and outside of the Marketplaces.

21st Century Cures Act (Cures Act): Legislation which promotes and funds the acceleration of research into preventing and curing serious illnesses, accelerates drug and medical device development, attempts to address the opioid abuse crisis, and tries to improve mental health service delivery. The act includes several provisions that push for greater interoperability, adoption of electronic health records and support for human services programs.

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