Department of Health and Human Services

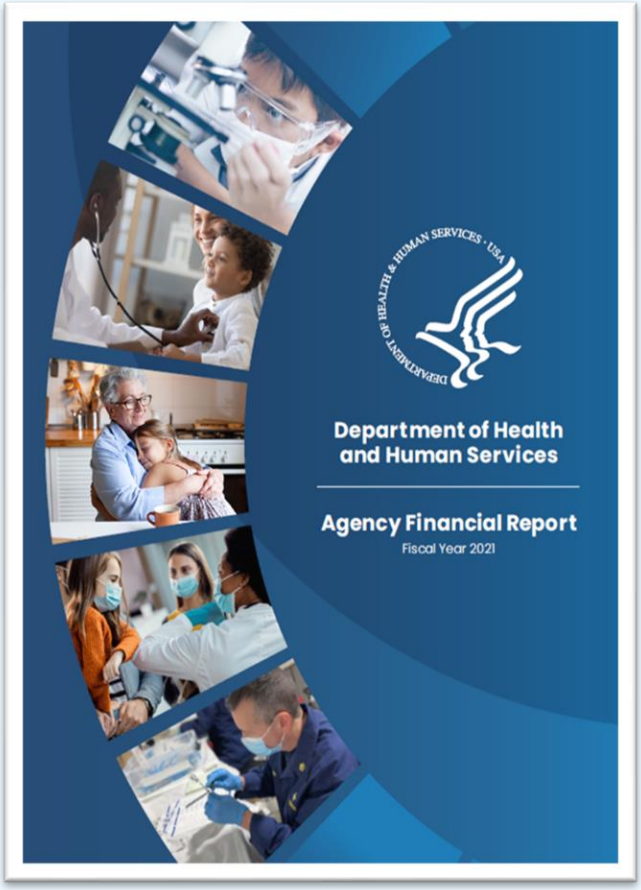
Agency Financial Report

Fiscal Year 2022

Certificate of Excellence in Accountability Reporting

The Department of Health and Human Services (HHS) promotes effective and responsible financial management by producing award-winning financial reports, aligning with its strategic plan. For 9 consecutive years, the AGA (formerly known as Association of Government Accountants) has recognized HHS's Agency Financial Report (AFR) through the Certificate of Excellence in Accountability Reporting (CEAR) Program. The CEAR Program was established in collaboration with the Chief Financial Officers Council and Office of Management and Budget to assist federal government agencies with performance and accountability reporting. Through this program, agencies improve accountability by streamlining reporting and enhancing the effectiveness of reports to clearly highlight what an agency accomplished during a fiscal year (FY) and to discuss any challenges that remain.

The FY 2021 AFR's success exemplifies our dedication, spirit, and commitment to the HHS mission. Through another year of pandemic challenges, HHS's perseverance and efforts continue to demonstrate award-winning results and achieve HHS goals.




AGA

Certificate of Excellence in Accountability Reporting

BEST-IN-CLASS AWARD

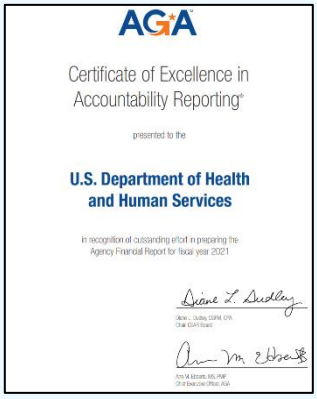
presented to the

U.S. Department of Health and Human Services

in recognition of

the Inspector General's summary of the most serious management and performance challenges

in the Agency Financial Report for fiscal year 2021


AGA

Certificate of Excellence in Accountability Reporting

presented to the

U.S. Department of Health and Human Services

in recognition of outstanding effort in preparing the Agency Financial Report for fiscal year 2021

HHS's FY 2021 AFR was honored with a Best-in-Class Award for "Inspector General's Summary of The Most Serious Management and Performance Challenges."

This is the second time HHS has been recognized in this area for producing a comprehensive and well-written report that included detailed explanations and extensive footnotes related to the supporting evidence.

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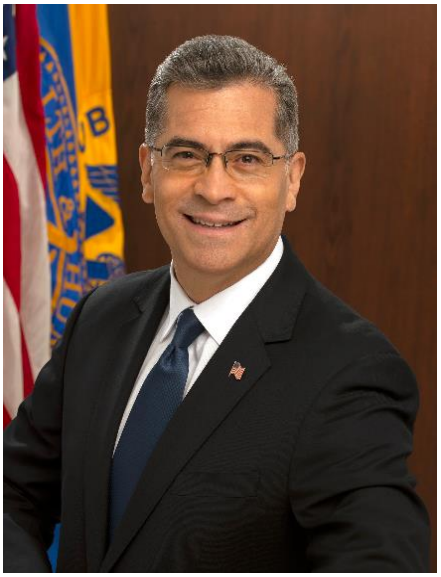
Message from the Secretary



Xavier Becerra

I am pleased to present the Fiscal Year (FY) 2022 Agency Financial Report (AFR) for the U.S. Department of Health and Human Services (HHS). I am confident you will find the information in this report insightful and encouraging, and you will agree our FY 2022 results prove we are making the most of the resources entrusted to us. We are accomplishing our mission to enhance the health and well-being of all Americans through effective health and human services, and by fostering sound, sustained advances underlying medicine, public health, and social services. Earlier this year we published HHS Strategic Plan FY 2022 – 2026 to focus our efforts as we carry out this crucial mission.

HHS's first strategic goal is to protect and strengthen equitable access to high-quality and affordable health care. A record-breaking 14.5 million people signed up for 2022 health care coverage during this year's Marketplace Open Enrollment Period, including 5.8 million people who benefited from *American Rescue Plan Act of 2021* (ARP) subsidies. Beneficiaries saw their average monthly premiums fall by 23 percent, and the increased enrollment helped drop the national uninsured rate to an all-time low of eight percent.

In 2022, the *Dobbs v. Jackson Women's Health Organization* decision threatened women's access to reproductive health care. Leading up to and following that decision, HHS took several actions to protect women's access to critical care, including abortions. HHS's reproductive health care action plan includes five priorities: 1) increasing access to medication abortion; 2) protecting patients and providers from discrimination and ensuring privacy for patients and providers; 3) protecting emergency abortion care; 4) ensuring providers have family planning training and resources; and 5) strengthening family planning care, including emergency contraception. Federal law ensures women have the right to stabilizing emergency room care, including abortions, and HHS will continue its work with the U.S. Department of Justice to enforce federal law protections.

Strengthening Americans' mental health is a central HHS focus and we are committed to providing critical mental health service for all who need it. In America, we experience one suicide death every 11 minutes. To better serve those suffering a mental health crisis, HHS's Substance Abuse and Mental Health Services Administration (SAMHSA), in cooperation with the Federal Communications Commission and the U.S. Department of Veterans Affairs, transitioned the Suicide Prevention Lifeline to the 988 Suicide & Crisis Lifeline. HHS invested $432 million to scale capacity for more than 200 crisis call centers and ensure all Americans have access to help. SAMHSA is also establishing a National Center of Excellence on Social Media and Mental Wellness to develop information and guidance on the impact social media use has on our youth, and how to mitigate the risks. Behavioral health plays a vital role in our daily life and HHS is working on over 300 initiatives to advance behavioral health for children, youth, and their families, improving access, promoting equity, and fostering innovation. We are committed to promoting behavioral health treatments and support by investing in programs that improve care services, advance research, and enhance outreach and education.

HHS's second strategic goal is to safeguard and improve public health preparedness, conditions, and outcomes nationally and globally. This goal drives us to protect individuals and families from preventative and non-preventative injuries, illnesses, and diseases relating to emergencies, disasters, and threats domestically and abroad. HHS, through the Health Resources and Services Administration (HRSA), distributed nearly $12 billion in Provider

Message from the Secretary

Relief Funds to more than 82,000 providers impacted by the COVID-19 pandemic, in addition to nearly $7.5 billion in ARP rural funding to more than 44,000 providers. HHS is committed to offering relief to these essential health care providers who help protect Americans from illness. These professionals are also helping address the emerging threat of the monkeypox virus. On August 4, I declared a Public Health Emergency (PHE) to accelerate our response to monkeypox. Through this PHE, we can expand testing capacity, increase access to treatments, and better scale the production and availability of vaccines, including granting emergency use authorizations for vaccines. On another front, I quickly invoked *Defense Production Act* authorities to help expedite and expand the nation's supply of baby formula through Operation Fly Formula. By the end of the FY, Operation Fly Formula transported more than 97.9 million 8-ounce bottle equivalents to the U.S., helping to ensure children are well-fed and cared for nationwide.

This Administration has been clear about its commitment to diversity, equity, and inclusion, and HHS fully supports this commitment through our third strategic goal—strengthening social well-being, equity, and economic resilience. We made significant progress to close the COVID-19 vaccination gap in minority communities through dedicated resources, education, and hard work. We invested nearly $7.3 billion in community health centers, which lead the hands-on vaccination efforts in minority communities and have helped achieve full primary series rates of over 80 percent for adult Black and Brown communities. HHS established the Office of Environmental Justice to better protect the health of disadvantaged communities and vulnerable populations who continue to bear the brunt of pollution from surrounding public and private infrastructure. To further support the vulnerable, HHS proposed a rule change related to Section 1557 of the *Patient Protection and Affordable Care Act* (PPACA) to ensure people with disabilities have equitable access to all the health programs funded or administered by HHS. These and other HHS programs that aim to improve Americans' economic resilience continue to benefit from ARP funding, which has contributed to keeping 20.1 million people out of poverty, including 7.8 million children.

Innovation is a key activity of our fourth strategic goal, restoring trust and accelerating advancements in science and research. The Department prioritizes science, evidence, and inclusion to improve the design, delivery, and outcomes of HHS programs. The 2022 *PandemicX Accelerator* cohort is collaborating to address health inequities and deploy resources to mitigate the effects of the COVID-19 pandemic and to address inequities made worse by the virus. Continuing our efforts to reduce the number of new HIV infections in the U.S. by at least 90 percent by 2030, HHS awarded nearly $115 million through HRSA to implement the *Ending the HIV Epidemic in the U.S.* initiative; this effort supports innovative strategies that help people with HIV live longer, healthier lives. These are just a few of the many innovation efforts HHS sponsors to improve Americans' future health and well-being.

Finally, HHS is dedicated to advancing strategic management across the Department to build trust, transparency, and accountability in support of our fifth strategic goal. We are actively implementing lessons we learned from our response to the pandemic and we will be better prepared to face and respond to future health emergencies. The Centers for Disease Control and Prevention announced a series of changes to prioritize public health action to help equitably protect and promote the health of the American people. HHS elevated our emergency response staff division to a full operating division, the Administration for Strategic Preparedness and Response, allowing the division to prepare for and mobilize coordinated national responses more effectively during future disasters and emergencies. Within days of the first case of monkeypox in the U.S., HHS activated a multi-pronged response, significantly increasing vaccines, tests, treatments, and awareness. To help counter health care misinformation and better connect people to care, HHS is investing in training community health workers to be trusted voices through the ARP-funded *Community Health Worker Training Program*. Our efforts supporting the fifth strategic goal also include sustaining strong financial stewardship of HHS resources, as we discuss next.

Stewardship

HHS maintained its reputation for excellence in budgetary and financial practices for FY 2022. For the 24th consecutive year, we obtained an unmodified (clean) opinion on the Consolidated Balance Sheets, Statements of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors disclaimed an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts due to the uncertainties surrounding provisions of the PPACA and the impact of potential legal changes affecting underlying assumptions of financial projections. These statements were developed based on current law using information from the 2022 Medicare Trustees Report, as required by standards issued by the Federal Accounting Standards Advisory Board. The "Financial Section" of this report includes more detailed information.

We evaluate our internal controls and financial management systems every year, as required by the *Federal Managers' Financial Integrity Act* and the Office of Management and Budget's Circular A-123, *Management's Responsibility for ERM and Internal Control*. We identified material noncompliances with the *Payment Integrity Information Act of 2019* and the *Social Security Act*. The "Management's Discussion and Analysis" section includes details. Based on our assessments, I can provide reasonable assurance the financial and performance information contained in this report is complete, reliable, and accurate.

Moving Forward

HHS once again placed in the top five large government agencies in the annual "The Best Places to Work in the Federal Government" rankings. I am not surprised, because every day I see the devotion, excellence, and attention the HHS team puts into taking care of the mission and each other. I have touched on the overall goals of HHS Strategic Plan FY 2022 – 2026, and more information on the objectives we will focus on in the coming years is found in the "Looking Ahead" section. In addition to those priorities, our complex department can always find improvement opportunities, as the Office of Inspector General describes in our most significant management and performance challenges in the "Other Information" section. Moving forward, we will partner with our stakeholders to address these challenges.

Conclusion

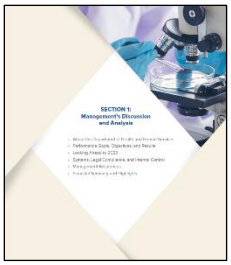
HHS worked tirelessly in FY 2022 to carry out our mission of improving the health and well-being of all Americans. Our stewardship culture is strong, we are making the most of the resources entrusted to us, and we have clear goals for our Department. The dedicated professionals on the HHS team will continue accomplishing great things for the American people in the future.

/Xavier Becerra/

Xavier Becerra
Secretary
November 14, 2022

About the Agency Financial Report

The HHS FY 2022 Agency Financial Report (AFR) provides fiscal and summary performance results that enable the President, Congress, and the American people to assess our accomplishments for the reporting period October 1, 2021 through September 30, 2022. This report provides an overview of our programs, achievements, challenges, and management's accountability for the resources entrusted to us in accordance with the requirements of Office of Management and Budget Circular A-136, *Financial Reporting Requirements.* The AFR consists of three primary sections and a supplemental section for the appendices.



Section 1: Management's Discussion and Analysis

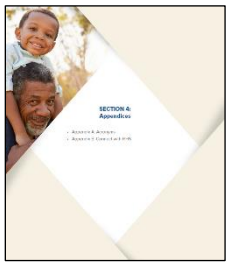
This section provides an overview of HHS's mission, activities, organizational structure, and program performance. Section 1 also includes an overview of the systems environment; a summary of HHS's financial results and compliance with laws and regulations; and management's assurances on HHS's internal controls.

Section 2: Financial Section

This section begins with a message from the Chief Financial Officer. Section 2 continues with the independent auditor's report, management's response to the audit report, financial statements with accompanying notes, and required supplementary information, including the Combining Statement of Budgetary Resources, Deferred Maintenance and Repairs, and Social Insurance information.

Section 3: Other Information

This section contains additional information, such as other financial information, the summary of the financial statement audit and management assurances, civil monetary penalties, grant closeout reporting, and a detailed payment integrity report. Section 3 concludes with the Office of Inspector General's assessment of the Top Management and Performance Challenges Facing HHS.



Section 4: Appendices

This section includes information that supports the sections of the AFR, such as the glossary of acronyms used throughout the report and additional resources for connecting with HHS.

Additional reports will be released on the HHS website in February 2023 including:

- FY 2024 *Annual Performance Plan and Report*
- FY 2024 *Congressional Budget Justification*

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SECTION 1:
Management's Discussion and Analysis

- About the Department of Health and Human Services
- Performance Goals, Objectives, and Results
- Looking Ahead to 2023
- Systems, Legal Compliance, and Internal Control
- Management Assurances
- Financial Summary and Highlights

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About the Department of Health and Human Services

Our Mission

The mission of the United States (U.S.) Department of Health and Human Services (HHS or the Department) is to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

Who We Are

HHS is the U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS accomplishes its mission through a variety of programs, initiatives, and activities working together to promote and protect the American people.

HHS is responsible for approximately a quarter of all federal outlays and administers more grant dollars than all other federal agencies combined. HHS's Medicare program is the nation's largest health insurer, handling more than one billion claims per year. Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) together provide care for more than 135 million Americans.

What We Do

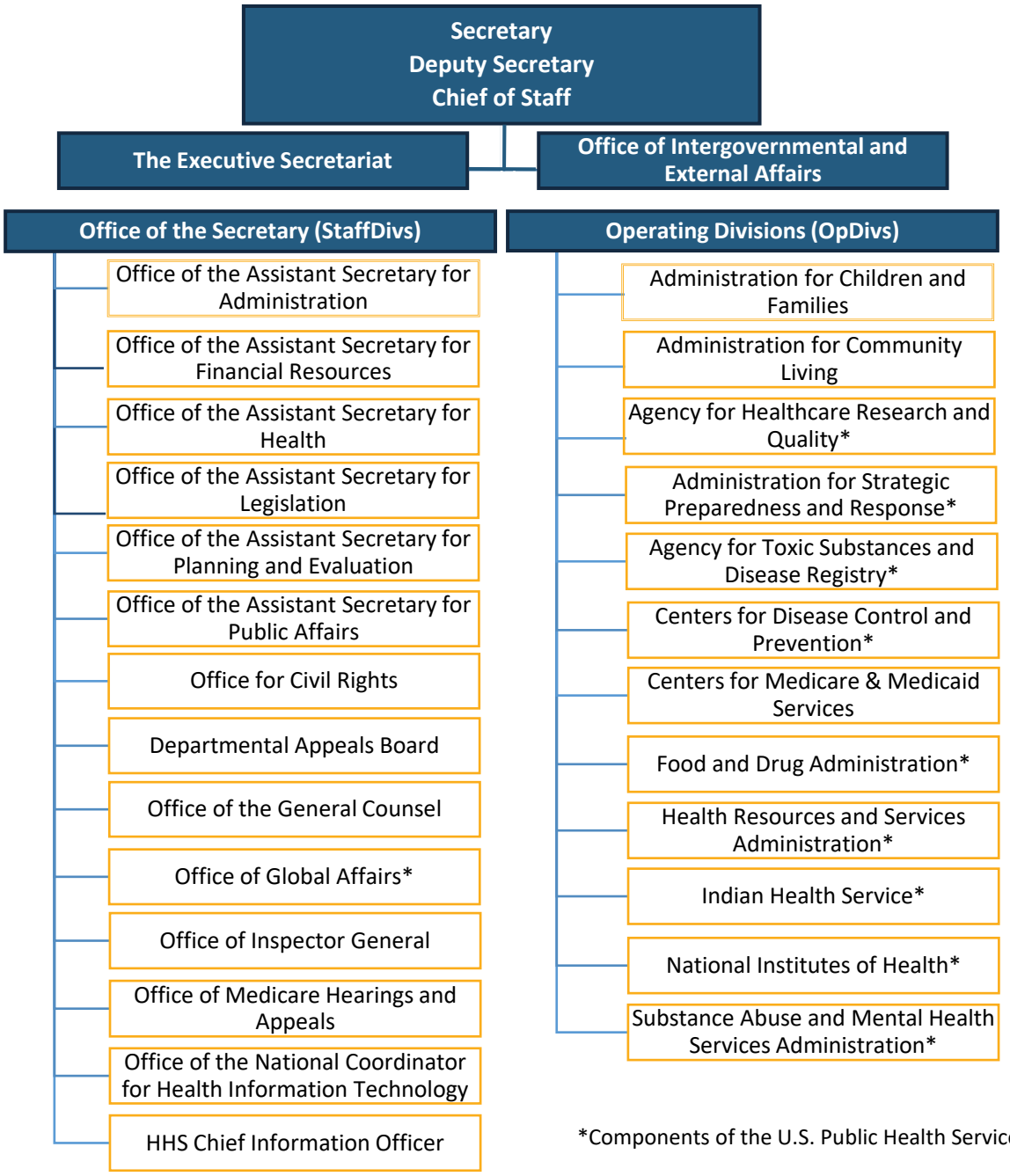
HHS works closely with U.S. state, local, territorial, and tribal governments and agencies; private sector recipients; tribes; tribal and urban Indian organizations that provide many HHS-funded services at the local level. While HHS is a domestic agency working to protect and promote the health and well-being of the American people, the interdependence of our world requires that HHS engage globally to fulfill its mission. The HHS Office of the Secretary (OS) and the 12 Operating Divisions (OpDivs), nine in the U.S. Public Health Service and three providing human services OpDivs, administer a wide variety of HHS's programs and conduct life-saving research for the nation. In addition, Staff Divisions (StaffDivs) within the OS provide leadership, direction, and policy and management guidance to the Department.

Through its programs and partnerships, HHS:

- Prepares and protects Americans by providing comprehensive responses to health, safety, and security threats, both foreign and domestic, whether natural or deliberate;
- Continues to invest in affordable healthcare coverage; this year a record-breaking 14.5 million people signed up for 2022 healthcare coverage, including 6 million people who newly gained coverage;
- Promotes patient safety and healthcare quality in healthcare settings and through healthcare providers by ensuring the safety, efficacy, and security of human and veterinary drugs, foods, biological products, and medical devices;
- Conducts health, social science, and medical research while creating thousands of jobs for scientists in universities and research institutions in every state across America and around the globe;
- Leverages health information technology (IT) to improve the quality of care and to use data to drive innovative solutions to address the breadth of human services and healthcare challenges across HHS programs and its stakeholders;
- Improves maternal and infant health; promotes the safety, well-being, and healthy development of children and youth; and supports young people's successful transition to adulthood; and
- Supports wellness efforts across the life span, from protecting mental health, to preventing risky behaviors such as tobacco use and substance abuse, to promoting better nutrition and physical education.

Organizational Structure

HHS's organizational structure is designed to accomplish its mission and provide a framework supporting sound business operations and management controls. Led by the HHS Secretary, the OS establishes the overarching vision and strategic direction for the Department and its OpDivs to provide a wide range of services and benefits to the American people. For more information, refer to HHS's website.



*Components of the U.S. Public Health Service

About the Department of Health and Human Services

Each OpDiv contributes to the HHS mission and vision as follows:

The Administration for Children and Families (ACF) is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities. ACF programs aim to empower families and individuals to increase their economic independence and productivity, and encourage strong, healthy, supportive communities that have a positive impact on quality of life and the development of children. ACF seeks to establish partnerships with front-line service providers, states, localities, and tribal communities to identify and implement solutions that transcend traditional program boundaries. Through their Strategic Plan, ACF demonstrates commitment to improve access to services through planning, reform, and integration, and to address the needs, strengths, and abilities of vulnerable populations, including refugees and migrants.

The Administration for Community Living (ACL) was created around the fundamental principle that all people, regardless of age or disability, should be able to live independently and fully participate in their communities. By advocating across the federal government for older adults, people with disabilities, and families and caregivers; funding services and supports primarily provided by networks of community-based organizations; and investing in training, education, research, and innovation, ACL helps make this principle a reality for millions of Americans.

The Agency for Healthcare Research and Quality (AHRQ) produces evidence to make healthcare safer, higher quality, more accessible, equitable, and affordable, and works within HHS and with other partners to make sure that evidence is understood and used. This mission is supported by focusing on three core competencies: (1) Health Systems Research; (2) Practice Improvement; and (3) Data & Analytics.

The mission of the Administration for Strategic Preparedness and Response (ASPR) is to save lives and protect the nation from 21st century health security threats. ASPR leads the nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies. ASPR collaborates with hospitals, healthcare coalitions, biotech firms, community members, state, local, tribal, and territorial governments, and other partners across the country to improve readiness and response capabilities.

The Agency for Toxic Substances and Disease Registry (ATSDR) supports the CDC in the prevention of exposure to toxic substances and the resulting adverse health effects, including diminished quality of life, associated with exposure to hazardous substances from waste sites, unplanned releases, and other sources of pollution present in the environment.

Did You Know?

ACL was established 10 years ago on April 18, 2012, with the intention of expanding community living for the more than 77 million people over the age of 60, and 61 million people with disabilities living in the U.S. People who live in their own communities are generally happier and healthier; in addition, expanding community living is essential to lowering overall healthcare costs.

For more information, visit ACL's website.

The Centers for Disease Control and Prevention (CDC) unified vision is equitably protecting health, safety, and security. CDC's Strategic Plan leverages five core capabilities that reflect the commitment to equity and diversity in addition to highlighting CDC's investments through the pandemic. The CDC works around the clock to protect Americans from health, safety, and security threats, both foreign and domestic. CDC's cutting-edge health security helps confront global disease threats through advanced computing and lab analysis of large amounts of data to quickly identify solutions and puts science into action by tracking diseases to determine what makes people sick and identify effective prevention methods.

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, Medicaid, CHIP, and the *Clinical Laboratory Improvement Amendments of 1988* program. Over the last 50 years, CMS evolved into the largest purchaser of healthcare and now houses the nation's largest collection of healthcare data. The agency also has lead responsibility for the Federally facilitated Health Insurance Marketplace, which provides access to private health insurance coverage to individuals and families in more than 30 states. In addition to these programs, CMS is responsible for advancing health equity, expanding coverage, and improving health outcomes. CMS's strategic vision focuses on the delivery of meaningful, person-centered, and equitable care to the people they serve through the implementation of six strategic pillars.

The Food and Drug Administration (FDA) is responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices; and ensuring the safety of our nation's food supply, cosmetics, and products that emit radiation. FDA advances public health through speedy innovations that make medicines more effective, safer, and more affordable. The FDA provides accurate science-based information to help consumers effectively maintain and improve their health through medicines and foods. FDA regulates the manufacturing, marketing, and distribution of tobacco products to protect the public health and to reduce tobacco use by minors. Finally, FDA plays a significant role in the nation's counterterrorism capability by ensuring the security of the food supply and by fostering development of medical products to respond to deliberate and naturally emerging public health threats.

The Health Resources and Services Administration (HRSA)'s mission is to improve health outcomes and achieve health equity through access to quality services, a skilled health workforce, and innovative, high-value programs. This includes programs that deliver health services to people in need, people with the human immunodeficiency virus, pregnant people, parents and their families, those with low incomes, residents of rural areas, transplant patients, other underserved communities, and the health workforce, systems, and facilities that care for them. Through HRSA programs and grants, tens of millions of Americans receive quality, affordable healthcare and other services. This includes affordable primary care provided by HRSA-supported health centers; HRSA-funded prenatal and postnatal care; human immunodeficiency virus care and treatment services; rural primary care and substance use treatment programs; discounted prescription drugs; organ transplants; and community-based Coronavirus Disease (COVID-19) testing, treatment, and vaccine administration.

The Indian Health Service (IHS) is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. IHS is the principal federal healthcare provider and health advocate for the Indian people, with the mission of raising the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. IHS provides a comprehensive health service delivery system for approximately 2.6 million American Indians and Alaska Natives who belong to 574 federally recognized tribes in 37 states.

The National Institutes of Health (NIH) provides leadership and direction to programs designed to improve the health of the nation by seeking fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. NIH is the primary agency responsible for biomedical and public health research for the U.S. Government. NIH fosters fundamental creative discoveries, innovative research strategies, and their applications as a basis for ultimately protecting and improving health. The NIH-Wide Strategic Plan outlines their vision, direction, capacity, and stewardship.

The Substance Abuse and Mental Health Services Administration (SAMHSA) mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes. SAMHSA accomplishes its mission by providing leadership, developing service capacity, communicating with the public, setting standards, and improving behavioral health practice in communities, in both primary and specialty care settings. SAMHSA's efforts prioritize equity, trauma-informed approaches, recovery, and a commitment to data and evidence and are guided by five key priority areas of its Strategic Plan: (1) Preventing overdose; (2) Enhancing access to suicide prevention and crisis care; (3) Promoting resilience and emotional health for children, youth, and families; (4) Integrating behavioral and physical healthcare; and (5) Strengthening the behavioral health workforce.

Did You Know?

NIH's HEALthy Brain and Child Development Study supports research to better understand brain development from the perinatal period through early childhood. The research examines variability in development and how it contributes to cognitive, behavioral, social, and emotional function. The goal of NIH's HEALthy Brain and Child Development Study is to understand how brain trajectory can be affected by exposure to opioids and other substances, stressors, trauma, and other environmental influences, including those that promote resilience.

For more information, visit NIH's website

About the Department of Health and Human Services

The following StaffDivs report directly to the Secretary, manage programs and support the OpDivs in carrying out the Department's mission:

The Immediate Office of the Secretary is responsible for operations and coordination of the work of the Secretary through two offices: the Executive Secretariat and the Office of Intergovernmental and External Affairs. The Executive Secretariat manages the Department's policy review and decision-making processes, coordinating the development, clearance, and submission of all policy documents for the Deputy Secretary and Secretary's review and approval. The Office of Intergovernmental and External Affairs represents both the government and external perspective in federal policymaking and clarifies the federal perspective to government officials and external parties.

The Assistant Secretary for Administration provides leadership for HHS departmental management, including human resource policy and departmental operations. The Program Support Center, a component of the Assistant Secretary for Administration, is a shared services organization dedicated to providing support services to help its customers achieve mission-oriented results.

The Office of the Assistant Secretary for Financial Resources (ASFR) provides advice and guidance to the Secretary on budget, financial management, acquisition policy and support, grants management, and small business programs. ASFR also directs and coordinates these activities throughout the Department.

The Office of the Assistant Secretary for Health (OASH) advises on the nation's public health and oversees the Department's key public health offices and programs, several Presidential and Secretarial advisory committees, 10 regional health offices across the nation, the Office of the Surgeon General, and the U.S. Public Health Service Commissioned Corps.

The Office of the Assistant Secretary for Legislation is responsible for the development and implementation of the HHS's legislative agenda. The Office of the Assistant Secretary for Legislation also provides advice on legislation and facilitates communication between the Department and Congress.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) advises on policy development and is responsible for major activities in policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis.

The Office of the Assistant Secretary for Public Affairs serves as the principal counsel on public affairs and provides centralized leadership and guidance on public affairs for HHS's StaffDivs, OpDivs, and regional health offices. The Office of the Assistant Secretary for Public Affairs also manages digital communication and administers the *Freedom of Information Act*.

The Office for Civil Rights (OCR) enforces federal laws that prohibit discrimination based on race, color, national origin, disability, sex, age, religion, or conscience by healthcare and human services providers that receive funds from HHS, as well as the federal laws and regulations governing the privacy and security of health information and the rights of individuals with respect to their health information.

About the Department of Health and Human Services

The Departmental Appeals Board provides impartial, independent review of disputed legal decisions in a wide range of Department programs for more than 60 statutory provisions. The Departmental Appeals Board resolves disputes with outside parties such as state agencies, Head Start recipients, universities, nursing homes, doctors, and Medicare beneficiaries. The Departmental Appeals Board conducts *de novo* reviews of administrative law judge action from the Office of Medicare Hearings and Appeals (OMHA).

The Office of the General Counsel supports the development and implementation of the Department's programs by providing the highest quality legal services to the Secretary of HHS and the organization's various agencies and divisions.

The Office of Global Affairs (OGA) provides leadership and expertise in global health diplomacy and policy to protect the health and well-being of Americans; foster critical global relationships; coordinate international engagement across HHS and the U.S. government, and provide leadership and expertise in global health diplomacy and policy to contribute to a safer, healthier world. .

The Office of Inspector General (OIG) provides oversight to promote the economy, efficiency, effectiveness, and the integrity of HHS programs, as well as the health and welfare of the program participants.

The OMHA administers nationwide hearings for the Medicare program for appeals arising from individual claims for Medicare coverage and payment for items and services furnished to beneficiaries under Medicare Parts A, B, C, and D. The OMHA also hears appeals arising from claims for entitlement to Medicare benefits and disputes of Medicare Part B and Part D premium surcharges. The OMHA operates separately from the other agencies involved in the Medicare claims appeal process.

The Office of the National Coordinator for Health Information Technology (ONC) coordinates nationwide efforts to implement and uses the most advanced health IT and the electronic exchange of health information. ONC focuses on two objectives: advancing the development and use of health IT capabilities and establishing expectations for data sharing.

The Office of the Chief Information Officer provides support for e-government initiatives, IT operations management, investment analysis, security and privacy, performance measurement, and the HHS mission by leading the development and implementation of IT infrastructure across the agency.

For more information regarding our organization, visit HHS's website.

Performance Goals, Objectives, and Results

Overview of Strategic and Agency Priority Goals

The *Government Performance and Results Act of 1993* and the *Grants Performance and Results Act Modernization Act of 2010* require federal agencies to update their Strategic Plan every 4 years. A strategic plan presents the long-term objectives an agency hopes to accomplish. It describes the agency's goals and objectives, what actions the agency will take to realize those goals, and how the agency will deal with potential challenges to achieving desired results.

The HHS Strategic Plan also describes how the Department will measure its progress to address complex, multifaceted, and evolving healthcare, public health, and human services issues. The Department's OpDivs and StaffDivs contribute to the development and success of the HHS Strategic Plan.

Strategic Goals

The HHS Strategic Plan Fiscal Year (FY) 2022-2026 (Strategic Plan) comprises five strategic goals, representing input from all HHS OpDivs and StaffDivs, as well as public comments. HHS aligns its focus, strategies, and activities to achieve these strategic goals and objectives. The Department's five strategic goals are:

1. Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare;
2. Safeguard and Improve National and Global Health Conditions and Outcomes;
3. Strengthen Social Well-Being, Equity, and Economic Resilience;
4. Restore Trust and Accelerate Advancements in Science and Research for All; and
5. Advance Strategic Management to Build Trust, Transparency, and Accountability.

Strategic Goal 1:
Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare

1.1 Increase choice, affordability, and enrollment in high-quality healthcare coverage

1.2 Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs

1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally competent healthcare services while addressing social determinants of health

1.4 Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and SUD treatment and recovery services for individuals and families

1.5 Bolster the health workforce to ensure delivery of quality services and care four potential issues and remains fully committed to resolving these matters appropriately in compliance with all aspects of the law.

Supporting Divisions – ACL, AHRQ, CDC, CMS, FDA, HRSA, IHS, NIH, ASPE, OASH, OCR, OGA, ONC, and SAMHSA

Strategic Goal 2:
Safeguard and Improve National and Global Health Conditions and Outcomes

2.1 Improve capabilities to predict, prevent, prepare for, respond to, and recover from disasters, public health and medical emergencies, and threats across the nation and globe

2.2 Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines

2.3 Enhance promotion of health behaviors to reduce occurrence of and disparities in preventable injury, illness, and death

2.4 Mitigate the impacts of environmental factors, including climate change, on health outcomes

Supporting Divisions – ACF, ACL, AHRQ, ATSDR, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, OCR, ASPE, ASFR, ASPR, OGA, ONC, SAMHSA

Strategic Goal 3:
Strengthen Social Well-Being, Equity, and Economic Resilience

3.1 Provide effective and innovative pathways leading to equitable economic success for all individuals and families

3.2 Strengthen early childhood development and expand opportunities to help children and youth thrive equitably within their families and communities

3.3 Expand access to high-quality services and resources for older adults and people with disabilities, and their caregivers to support increased independence and quality of life

3.4 Increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experiences trauma or violence

Supporting Divisions – ACF, ACL, AHRQ, CDC, CMS, FDA, HRSA, IHS, NIH, OA, ASPE, OCR, OASH, OGA, SAMHSA

Strategic Goal 4:
Restore Trust and Accelerate Advancements in Science and Research for All

4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.

4.2 Invest in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and human services resulting in more effective interventions, treatments, and programs

4.3 Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions

4.4 Improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience

Supporting Divisions – All HHS divisions are working to achieve Strategic Goal 4

Strategic Goal 5:

Advance Strategic Management to Build Trust, Transparency, and Accountability

5.1 Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices

5.2 Sustain strong financial stewardship of HHS resources, accountability, and public trust

5.3 Upload effective and innovative human capital resource management resulting in an engaged, diverse workforce with the skills and competencies to accomplish the HHS mission

5.4 Ensure the security and climate resiliency of HHS facilities, technology, data, and information, while advancing environment-friendly practices

Supporting Divisions – All HHS divisions are working to achieve Strategic Goal 5

Agency Priority Goals

Agency Priority Goals (APGs) are a set of ambitious but realistic performance objectives that the Department expects to achieve within a 24-month period. APGs are HHS-wide goals that provide cohesive themes for the Secretary's priorities and support multiple objectives of the HHS Strategic Plan. APGs include multiple performance measures reporting on HHS progress and provide a strong representation of how the Department coordinates to meet the HHS mission. APG results rely on strong agency implementation and do not require new legislation or additional funding. General areas of focus for APGs include customer service, efficiencies, and advances in progress toward longer-term, outcome-focused strategic goals and objectives. The FY 2022 – 2023 APGs are:

1. **Behavioral Health**: Increase equitable access to and utilization of prevention, treatment, and recovery services to improve health outcomes for those affected by behavioral health conditions;
2. **Child Well-being**: Improve child well-being, especially in underserved or marginalized populations and communities;
3. **Emergency Preparedness**: While promoting equitable access, strengthen the systems for domestic and global health, human services, and public health to protect the nation's well-being before, during, and after disasters and Public Health Emergencies (PHEs);
4. **Equity**: Advance progress toward equity in health and human services by optimizing opportunities and access for underserved and marginalized populations and addressing drivers of inequities throughout the life course to remove barriers, reduce disparities, and improve outcomes; and
5. **Maternal Health**: Improve maternal health and advance health equity across the life course by assuring the equitable provision of evidence-based high-quality care and addressing racism, discrimination, and other biases.

For more information on HHS's APGs, visit Performance.gov.

Performance Management

Performance goals and measures are powerful tools to advance an effective, efficient, and productive government. HHS regularly collects and analyzes performance data to inform decisions, gauge meaningful progress toward objectives, and identify cost-efficient ways to achieve results. Responding to opportunities afforded by the *Grants Performance and Results Act Modernization Act of 2010*, HHS continues to institute significant performance management improvements that include:

- Developing, analyzing, reporting, and managing APGs, and conducting performance reviews between OpDivs, StaffDivs, and HHS leadership to monitor progress toward achieving key performance objectives;

- Conducting the Strategic Reviews process to support decision-making and performance improvement across the Department;
- Coordinating performance measurement, budgeting, strategic planning, enterprise risk management (ERM), and evidence building activities within the Department;
- Fostering a network of OpDiv/StaffDiv Performance Officers who support, coordinate, and implement performance management efforts across HHS; and
- Sharing best practices in performance management at HHS through webinars and other media.

Data Quality

HHS follows the *Grants Performance and Results Act Modernization Act of 2010* guidelines for reporting data quality. For all measures that appear in APGs reporting or in the HHS Strategic Plan, HHS publicly reports:

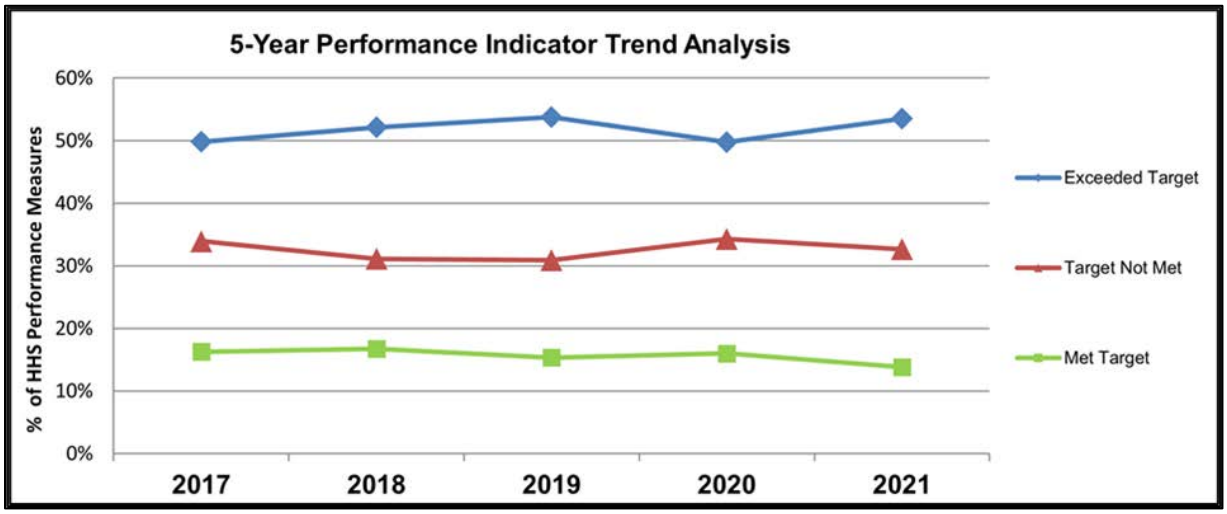
- Processes used to verify and validate measured values;
- Sources for the data;
- Confirmation that the data meets the level of accuracy required for its intended use;
- Any limitations to the data at the required level of accuracy; and
- How the agency will compensate for such limitations, if needed, to reach the required level of accuracy.

Each agency within HHS is responsible for certifying that this data undergoes a thorough quality assurance process and provides a signed letter of attestation to the Performance Improvement Officer. Data quality information for the APG-related measures mentioned below can be found online at Performance.gov. Data source and validation information on other data analyses, such as improper payment measures discussed in the "Other Information" section, can be found at HHS Budget and Performance.

Performance Results

In FY 2022, HHS monitored over 900 performance measures to improve the efficiency and effectiveness of departmental programs and activities. **Figure 1** is a summary chart of performance trends for the bulk of these measures:

Figure 1: 5-Year Performance Indicator Trend Analysis



HHS's Schedule of Spending in the "Financial Section" highlights the total spending by each material program. Funding represents one of many factors that may influence performance results. More detailed information on HHS program performance and funding can be found in the Congressional Budget Justifications at HHS Budget and Performance. For select performance information aligned to the Department's Strategic Plan, see the Annual Performance Plan and Report. To remain consistent with the FY 2024 President's Budget,

updates will be made in February 2023. In addition, HHS leads and contributes to Cross-APGs as part of the President's Management Agenda. For this report, HHS will highlight achievements and plans for the five APGs. For additional information on HHS's APG accomplishments, refer to the HHS page on Performance.gov.

Behavioral Health

There is a significant treatment gap between need and receiving behavioral health services. The 2020 National Survey on Drug Use and Health showed:

- Out of every 40 people identified as needing substance use treatment, 39 did not feel they needed treatment; and
- Among those with co-occurring substance use disorder (SUD) and any mental illness, about half received either substance use treatment or mental health services; even more discouraging, about one in 20 received both.

By September 30, 2023, HHS will:

- Increase dispensed prescriptions for buprenorphine from retail pharmacies in the U.S. by 15 percent over a baseline of 1,015,386 unique patients and 15 percent over a baseline of 324,126 prescriptions dispensed for naloxone in U.S. outpatient retail and mail-order pharmacies (see **Figure 2**); and
- Increase by 20 percent the number of individuals referred for behavioral health services by SAMHSA grantees engaged in screening and assessment (see **Figure 4**).

To achieve this goal HHS is enhancing the capacity of physical health providers to assess, screen, and treat behavioral health conditions by increasing access to treatments for SUDs and other disorders, as well as assisting behavioral health providers to coordinate with individuals, families, and communities.

Many SAMHSA grant programs work with grant recipient organizations to increase access to the services the organizations provide or facilitate. As part of these efforts, many grant recipient organizations work to identify and refer individuals to needed behavioral healthcare and supports. SAMHSA supports technical assistance and ongoing monitoring of grant progress to help increase and monitor referrals. In addition, HHS employs evidence-based strategies for preventing opioid overdoses such as targeted naloxone distribution and medication-assisted treatment and medication for opioid use disorder.

Figures 2, 3, and 4 illustrate this goal's most recent key indicator results from FY 2022 Quarter 3:

Figure 2: Unique Patients Receiving Buprenorphine

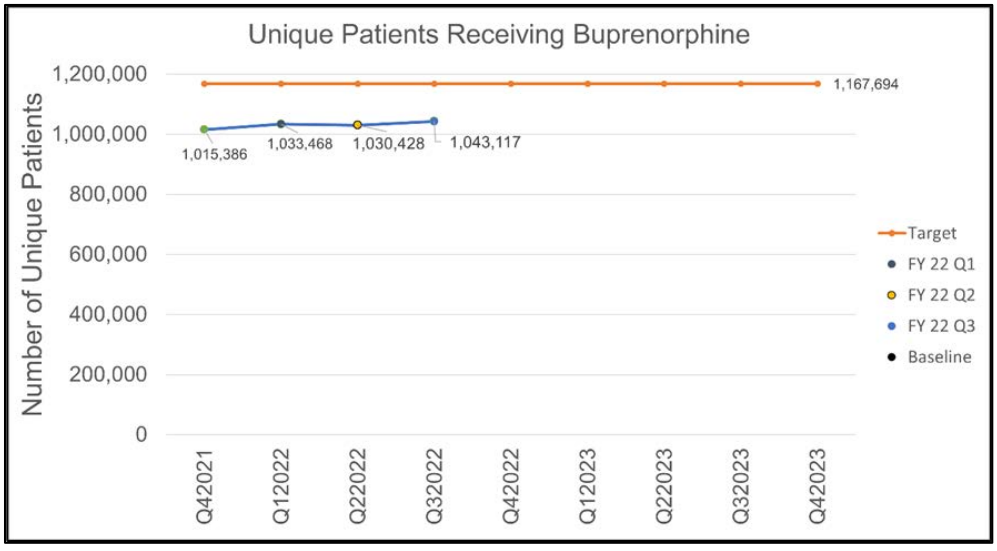


Figure 3: Naloxone Prescriptions Dispensed

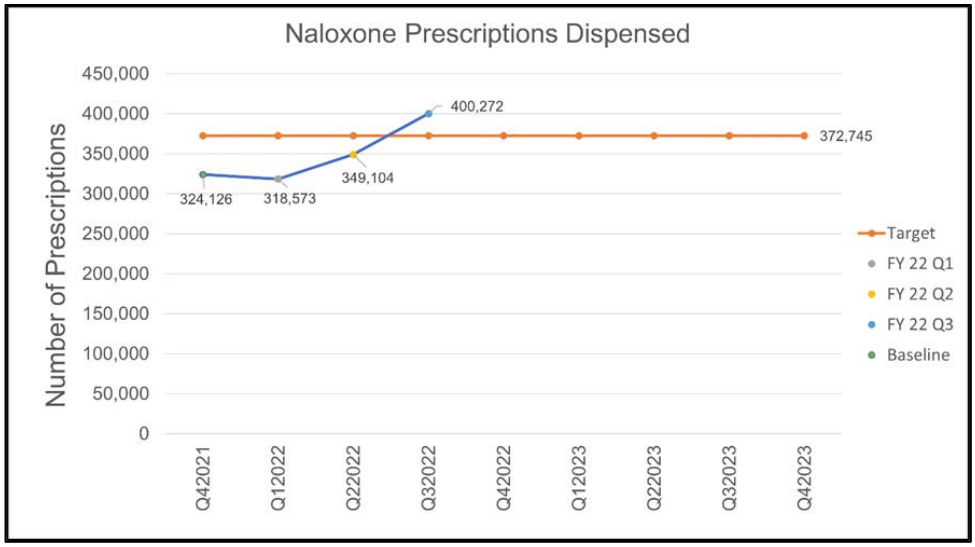
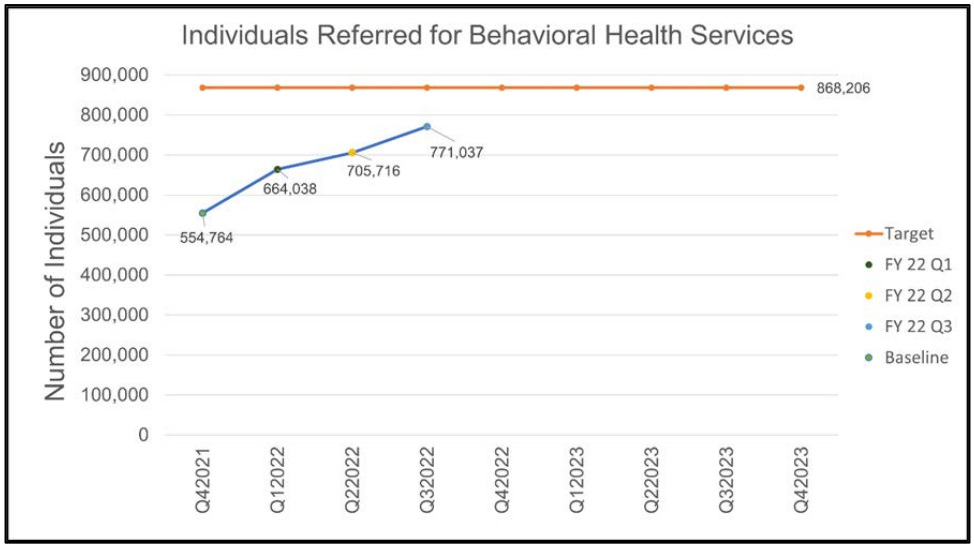


Figure 4: Individuals Referred for Behavioral Health Services



Child Well-Being

HHS strives to improve child well-being, especially in underserved or marginalized populations and communities. Low subsidy payment rates to childcare providers limit children's access to high-quality childcare experiences and perpetuate low pay and high turnover for childcare staff. Child welfare received an estimated 3.9 million referrals alleging maltreatment for approximately 7.1 million children, and 618,000 children were deemed to be victims of child abuse and neglect in FY 2020. During the COVID-19 PHE, primary, preventive, and mental health services use declined among children. Compared to the same period a year earlier, between February through May 2020 there were 18 percent fewer vaccinations for children up to age 19; 26 percent fewer child screening services; 46 percent fewer dental services; and 41 percent fewer outpatient mental health services.

Advancements in this space would mean strengthening early childhood development and expanding opportunities to help children and youth thrive equitably within their families and communities; increasing safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have

experienced trauma or violence; and improving the physical and behavioral health of children and families through increased access to healthcare services in Medicaid and CHIP.

HHS is employing the following strategies to achieve this goal:

Childcare: Provide policy guidance, training, and technical assistance to support states as they increase childcare provider payments and move toward setting payment rates using a cost estimation model.

Head Start and Early Head Start: The Office of Head Start will collaborate with a consortium of partners with expertise in health and behavioral health to promote child and family well-being in programs through Training and Technical Assistance, which will include screenings and preventive healthcare services.

Child Welfare: Provide policy guidance, training, and technical assistance to increase knowledge and capacity of states to effectively implement evidence-based and evidence-informed child abuse prevention programs and practices to increase the total Title IV-E funding that supports evidence-based and evidence-informed child abuse prevention programs and practices.

Healthcare: Provide outreach to states, providers, schools, community-based organizations, and other key stakeholders to share updated data on foregone care during the COVID-19 PHE, and to emphasize the importance of catching up on missed services to improve child well-being.

The most recent results for one of the key indicators supporting this goal from the FY 2022 Quarter 3 updates are shown in **Figure 5, 6, and 7** below.

Figure 5: Vaccination Rate Among Beneficiaries Under Age 19 During the COVID-19 PHE Compared to Prior Years

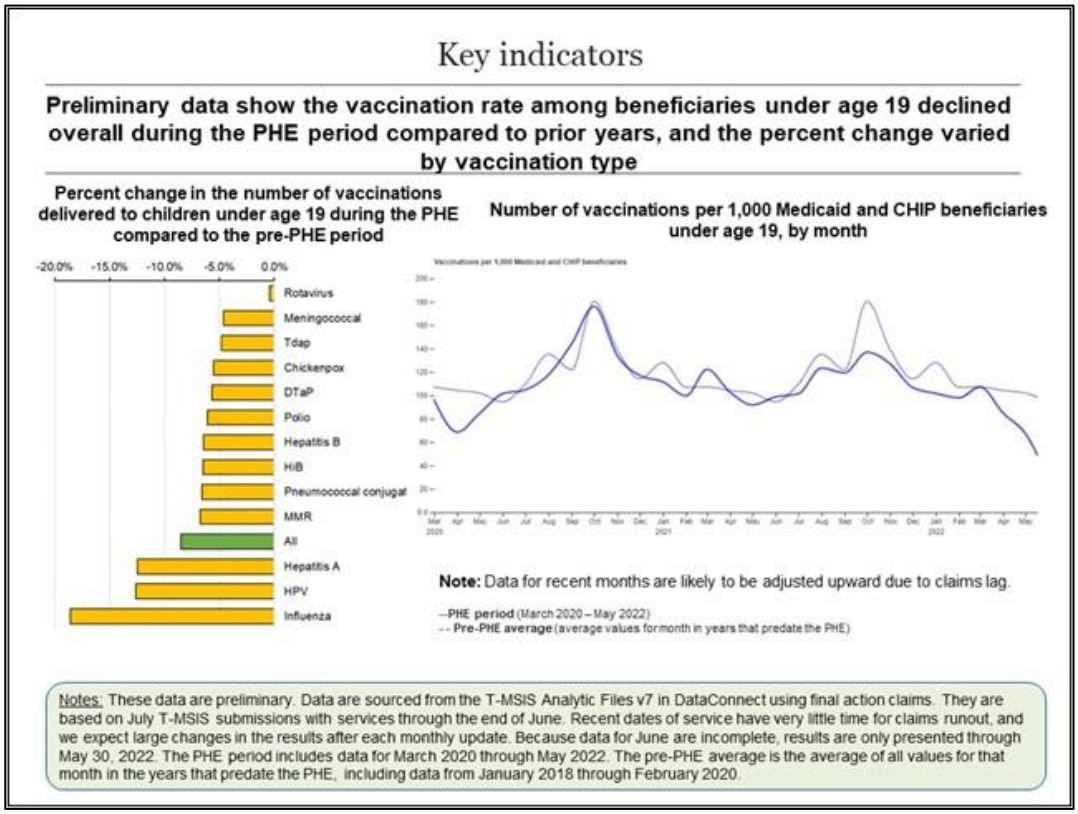


Figure 6: Rate of Child Screen Services During the COVID-19 PHE

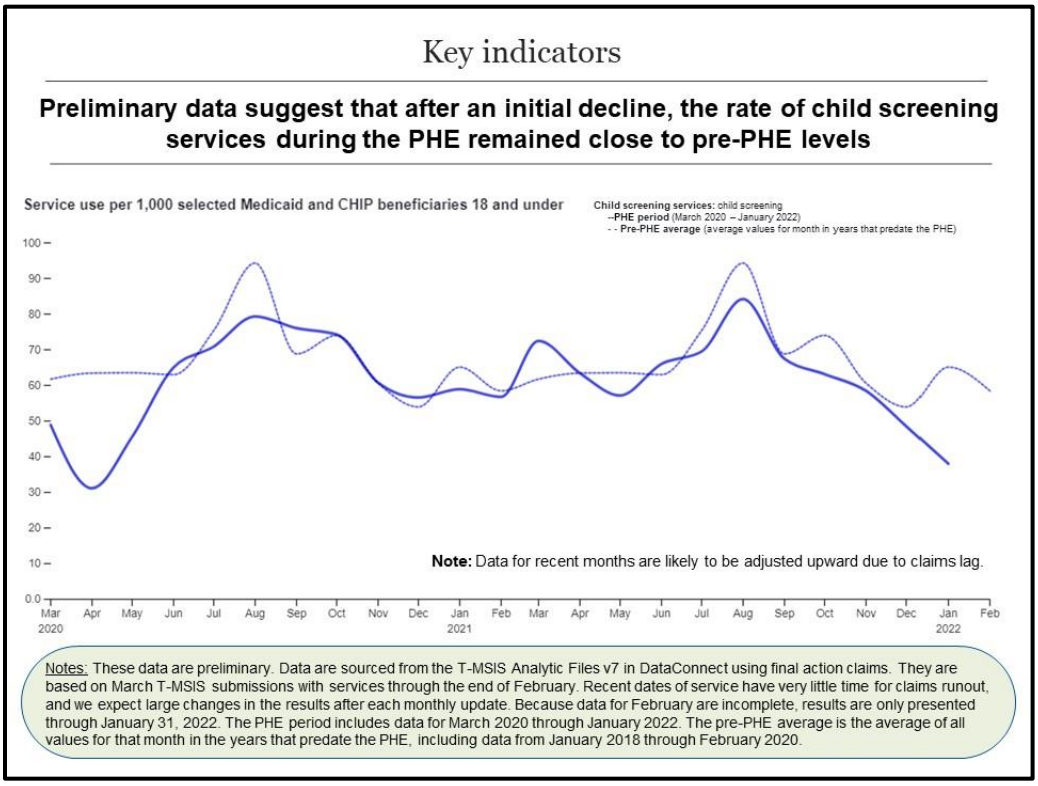
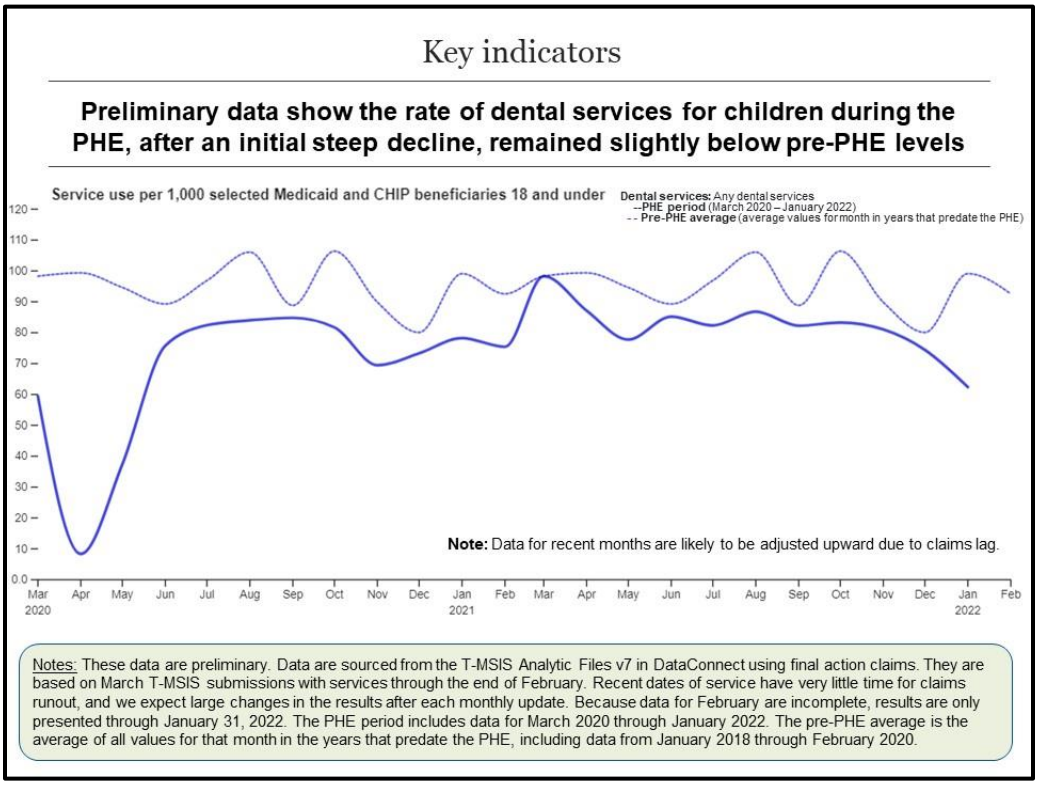


Figure 7: Rate of Dental Services for Children During the COVID-19 PHE



Emergency Preparedness

The domestic and global health, human services, public health, and health security systems face challenges in protecting the well-being of the nation and the global community during disasters and PHEs. HHS is strengthening systems while promoting equitable access. By September 30, 2023, HHS will complete four projects, including to establish a new ASPR office, and increase by at least 10 percent key deliverables that increase resources that develop and improve the national capacity of public health, human services, and global health disaster management entities to respond equitably to emerging threats and emergency incidents above FY 2020 results. These efforts are increasing resources that develop and improve the national capacity of public health, human services, and global health disaster management entities to respond equitably to emerging threats and emergency incidents. Success is demonstrating improved capability of domestic public health and human services organizations and global health disaster management entities.

HHS OpDivs and StaffDivs are employing the following strategies to accomplish objectives of this goal:

- ACF will develop a playbook for training and technical assistance to state, tribal, local, and territorial (STLT) human service departments to improve emergency preparedness and response capabilities. In partnership with ASPE, ACF issued a disaster human services playbook for federal programs in 2021; the STLT playbook will focus on jurisdictional planning and readiness activities for social and human service providers in managing disaster incidents; and
- CDC-ATSDR will develop resources for STLT jurisdictions to strengthen their environmental health emergency capabilities for concurrent disaster and chemical emergencies.
- ASPR's Office of Industrial Base Management and Supply Chain is building a diverse, agile public health supply chain to contribute to long-term U.S. manufacturing capability. Strategic positions are being filled to provide technical and programmatic support; this is enabling ASPR to effectively respond to increased volume during PHEs.
- The OGA will:
    - Increase international engagements to build capacity and promote equity of global public health measures in pandemic preparedness and response, including expanding and/or extending Global Health Security Agenda, Global Health Security Initiative, and other multilateral global health security initiatives;
    - Identify priority gaps and empower partners to engage on closing those gaps; and
    - Drive national priorities through global advocacy, action, and collaboration to mobilize domestic and global resources.

Performance Goals, Objectives, and Results

Table 1: FY 2022 Quarter 3 Emergency Preparedness Key Indicator Results

HHS will…	Name of indicator	Target value	Starting value	Current value
Develop a playbook for training and technical assistance to STLT human service departments to improve emergency preparedness and response capabilities.	Emergency Preparedness STLT Playbook	1-completed	0-not completed	0 (Estimated 15 percent complete)
Develop and pilot a new resource toolkit for STLT health departments to enhance preparedness for concurrent disasters.	Concurrent Disaster Resources	1-completed	0-not completed	0 (Estimated 43 percent complete)
Add website content on chemical emergencies tailored for a public audience, adapted from the Chemical Emergencies for Professionals website, to increase community education on scientific resources for chemical emergencies.	Chemical Emergencies Resources	1-completed	0-not completed	0 (Estimated 33 percent complete)
Increase by at least 10 percent over FY 2020 the number of key deliverables resulting from strategic engagements and cross-sectoral collaborations with domestic and international partners to strengthen the global health security architecture, address financing and legal preparedness gaps, and promote equity in emergency preparedness.	Enhanced Global Health Security Collaboration	72 deliverables	56 deliverables	59 deliverables
Establishing the ASPR Office of Industrial Base Management and Supply Chain Office as an operational office and aligning the office activities with the National Strategy for a Resilient Public Health Supply Chain.	Office establishment and alignment	1-completed	1-under completion	0 (Estimated 90 percent complete)

September 30, 2023

Did You Know?

In response to Hurricane Ian, HHS coordinated several cross-divisional efforts. ASPR's National Disaster Medical System deployed more than 350 medical, public health, and disaster response personnel, and seven Disaster Medical Assistance Team sites to provide top-quality patient care to 3,800 patients while waiting for the healthcare infrastructure to return.

SAMHSA made the Disaster Distress Helpline available 24/7 to connect people in impacted areas with a trained crisis counselor. CDC worked with state authorities to push out information and resources specific to at-risk populations, including older adults, those with chronic conditions, and people with other functional and access needs.

For more information, visit ASPR's website.

Equity

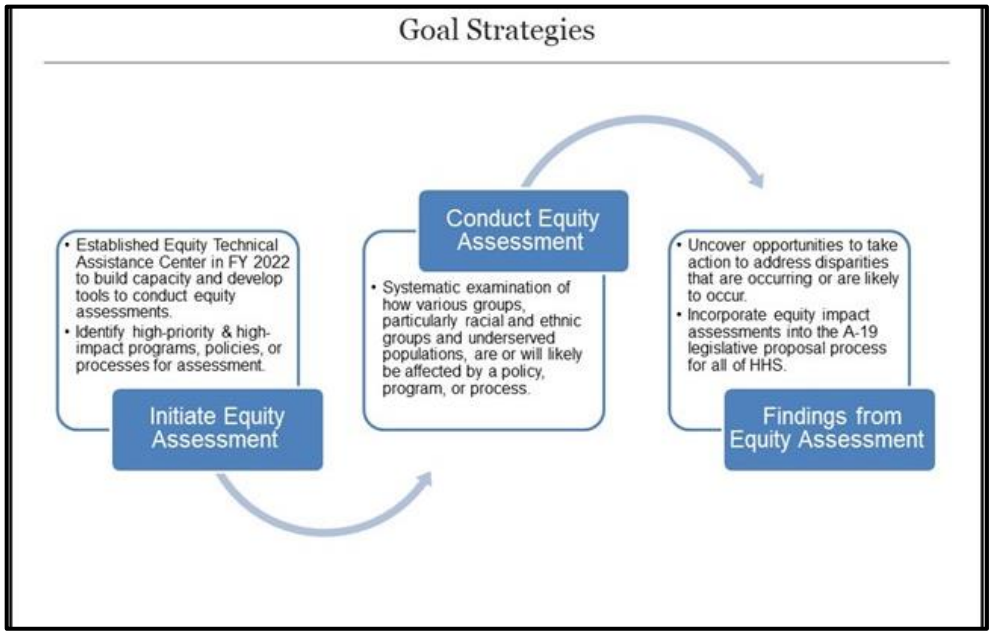
Through this priority goal, HHS seeks to identify historical and current structural conditions under its influence that currently hinder equitable health and social outcomes, as well as identify aspects of HHS processes and policies that affect equity in health and social outcomes.

In coming years, HHS will share the knowledge to advance progress toward equity in health and human services by optimizing opportunities and access for underserved and marginalized populations and by addressing drivers of inequities throughout the life course in order to remove barriers, reduce disparities, and improve outcomes. By September 30, 2023, HHS will initiate at least 10 equity assessments, via the Equity Technical Assistance Center, on HHS policies and activities and identify potential actions for improvement.

The goal of this effort is to promote equity in policy and programmatic decisions, contracting and procurement, data collection, analysis and availability, and the HHS workforce, as well as improve the data available to HHS to assess the reduction of disparities.

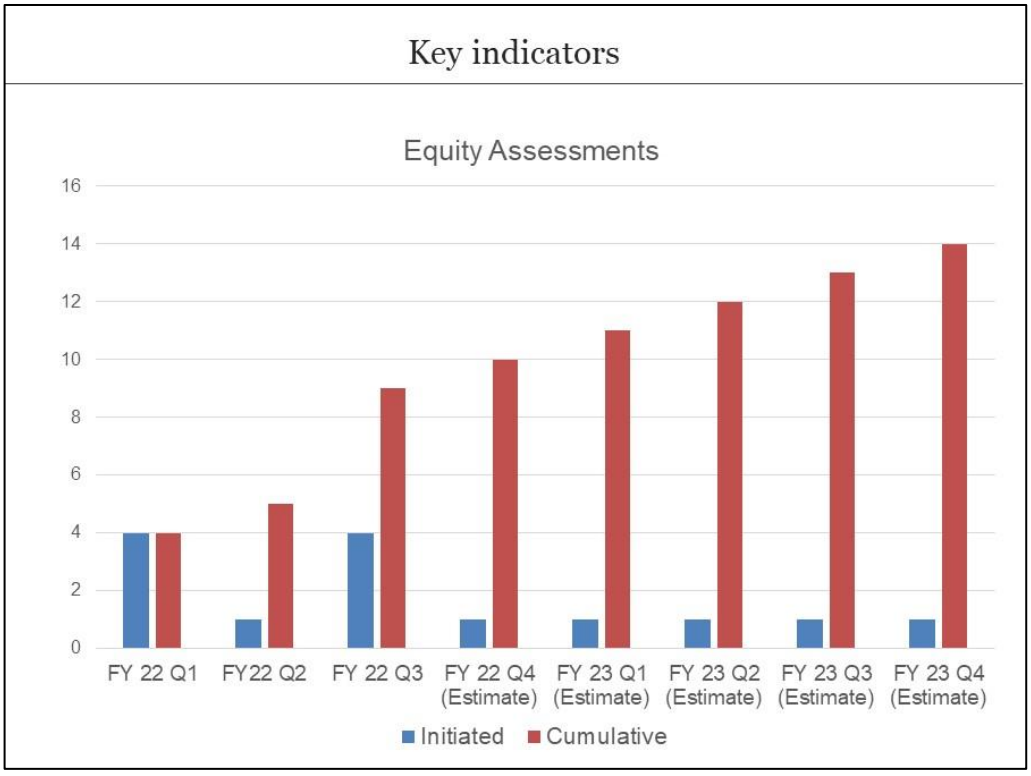
The strategies for this goal are illustrated in **Figure 8**.

Figure 8: Equity Goal Strategies



The most recent key indicator results for this goal from FY 2022 Quarter 3 are illustrated in **Figure 9** below.

Figure 9: Quarter 3 Key Indicators in Equity Assessments



Maternal Health

The U.S. maternal mortality rate is more than double that of comparable countries and the rate has not improved. There are also stark disparities in maternal health outcomes for Black and American Indian and Alaska Native people. These outcomes are driven by variation in access to care and healthcare delivery, systemic and implicit biases in the treatment of certain racial/ethnic groups, and socioeconomic factors that create unequal opportunities to achieve optimal maternal health outcomes.

HHS will improve maternal health and advance health equity across the life course by assuring the equitable provision of evidence-based high-quality care and by addressing racism, discrimination, and other biases. By September 30, 2023, HHS will increase the number of:

- Hospitals participating in Perinatal Quality Collaboratives engaged in data-informed quality improvement efforts to address the drivers of maternal mortality and achieve equity by 10 percent;
- Birthing facilities that are participating in the Alliance for Innovation on Maternal Health by 10 percent; and Birthing facilities that are participating in the Alliance for Innovation on Maternal Health (AIM) by 10 percent; and
- Pregnant and postpartum people, their support networks, and providers reached by HHS messages about urgent maternal warning signs by 20 percent.

In pursuing these goals, HHS strives to improve equity in maternal health, reduce maternal mortality and morbidity rates for all women, and increase engagement at all levels (e.g., federal government, state and local governments, tribal governments, providers, and community-based organizations) to support quality improvement activities and implement evidence-based practices.

HHS will work to achieve these goals by pursuing the following strategies:

- Improve postpartum health and reduce maternal morbidity/mortality through implementing the *American Rescue Plan Act of 2021 (ARP)* Medicaid 12-month postpartum coverage option;
- Increase participation in and measurement of perinatal quality improvement activities;
- Address important drivers of poor maternal health outcomes including cardiovascular and behavioral health issues; and
- Strengthen the maternal health workforce to achieve health equity.

Performance Goals, Objectives, and Results

Figures 10, 11, and 12 illustrate the most recent key indicator results for this goal from FY 2022 Quarter 3.

Figure 10: Hospitals Participating in Perinatal Quality Collaboratives

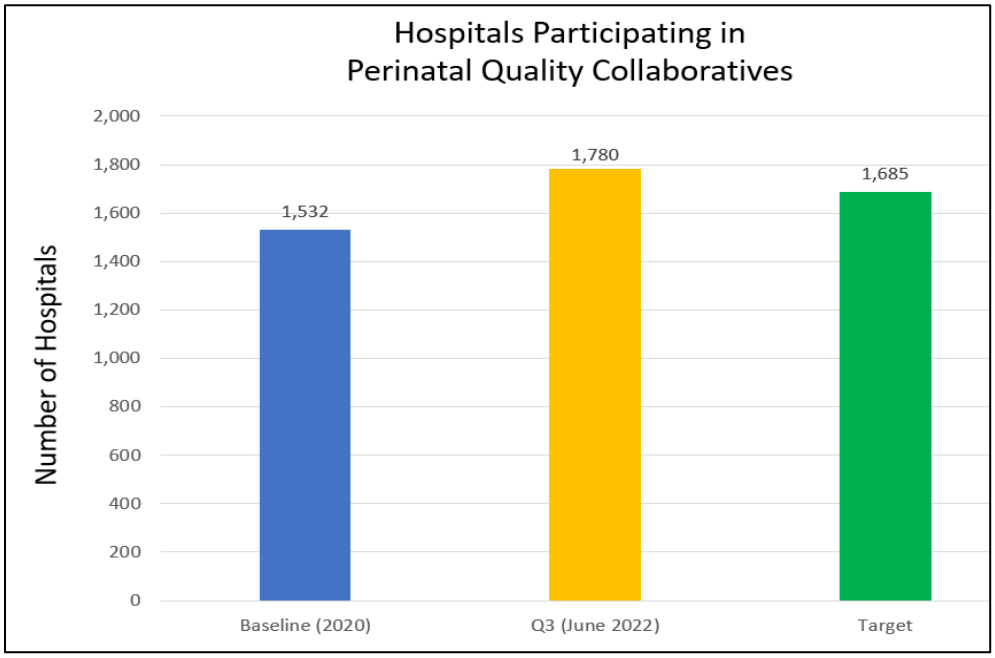


Figure 11: Birthing Facilities Participating in AIM

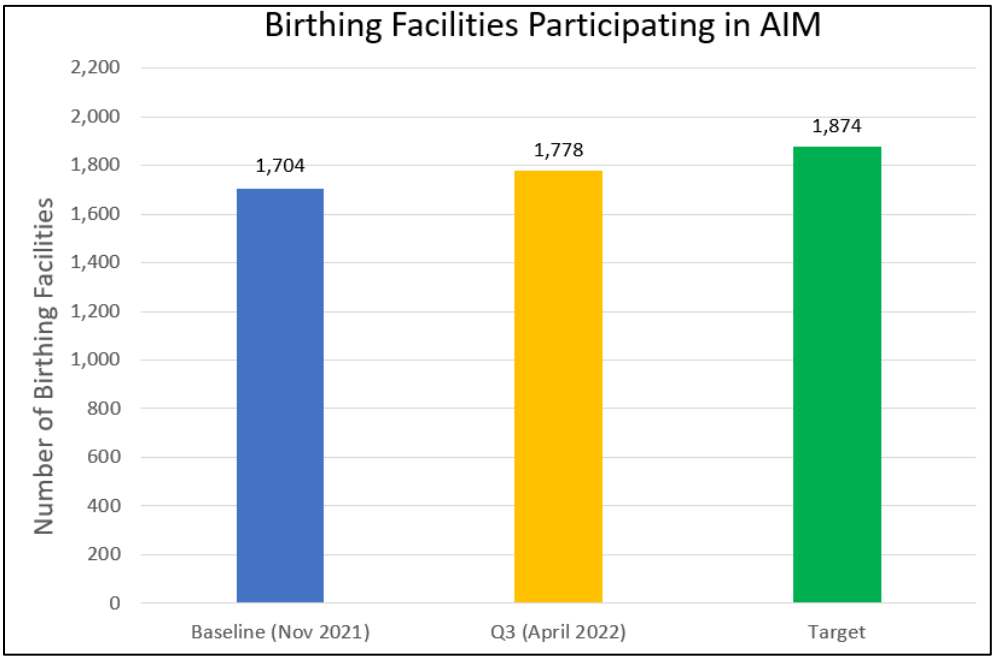
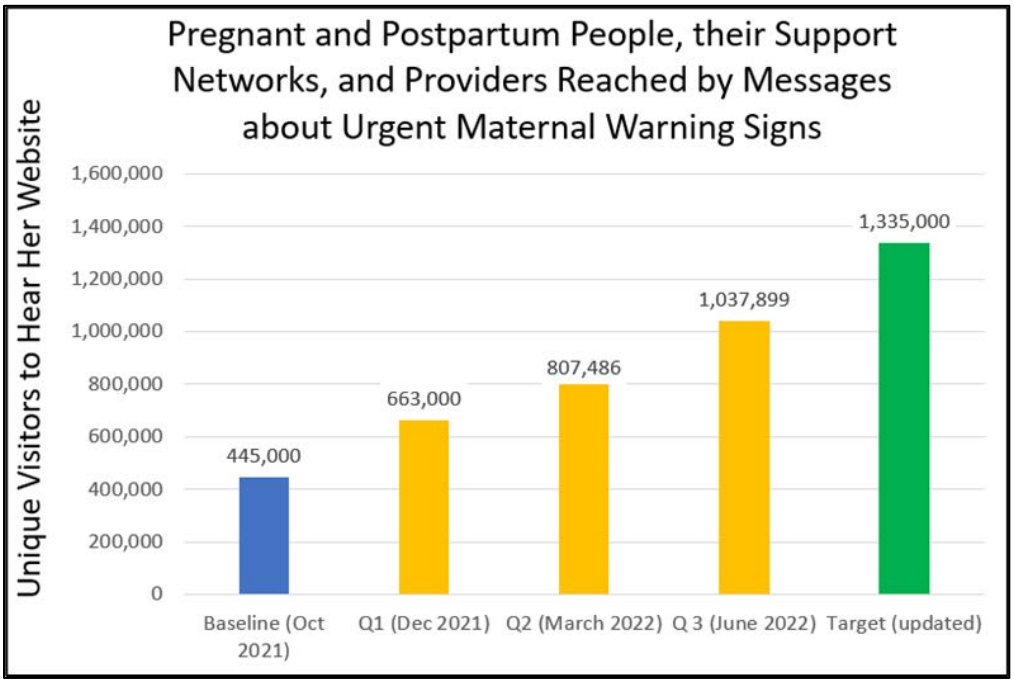


Figure 12: Pregnant and Postpartum People, Their Support Networks, and Providers Reached by Messages About Urgent Maternal Warning Signs



Climate Change

HHS prevents, detects, investigates, forecasts, monitors, responds to, and aids in recovery from environmental and hazardous public health threats and their health effects through the work of a variety of supporting divisions. The Office of Climate Change and Health Equity (OCCHE) was established in 2021 by the President's Executive Order on *Tackling the Climate Crisis at Home and Abroad* to protect the health of people throughout the U.S. in the face of climate change, especially those experiencing a higher share of exposures and impacts. In addition to the work described below, OCCHE leads the HHS Climate Change and Health Equity Working Group, which coordinates HHS efforts to mitigate the impacts of climate change on health outcomes alongside other HHS divisions to develop a set of strategies to address the health threats associated with climate change.

By joining the United Nations Conference of the Parties 26 Health Program, a global decision-making body dedicated to the development of policy to address climate change prevention and preparedness, HHS made commitments to ensuring resiliency in our communities and decarbonization of our health systems. OCCHE coordinates across the federal government to prepare federal health systems for the effects of climate change and ultimately achieve net zero emissions by 2050.

HHS climate change-related programs include:

- **White House/HHS Health Sector Climate Pledge**: On Earth Day, the White House and OCCHE launched the Health Sector Climate Pledge, a voluntary commitment for healthcare organizations to invest in resilience and decarbonization. Two months after the launch, 61 organizations representing over 650 hospitals had signed on, and leadership from across the administration met signees at a White House event to celebrate and plan for their shared work;
- **Interagency Working Group on Extreme Heat**: OCCHE, the Environmental Protection Agency, and the National Oceanic and Atmospheric Administration co-lead the working group formed by the White House Climate Policy Office. OCCHE has coordinated HHS participation in the interagency heat-awareness campaigns and contributes to Heat.gov, the premier source of information regarding heat and health for the nation;

- **NIH Climate Change and Health Initiative**: An urgent, cross-cutting NIH effort to reduce health threats from climate change across the lifespan and build health resilience in individuals, communities, and nations around the world;
- **NIH Climate and Health Scholars Program**: A program that seeks to partner climate and health-focused scientists from outside the U.S. federal government with NIH staff to build climate and health capacity;
- **CDC Climate and Health Program**: A program that supports STLT public health agencies to prepare for the health impacts of a changing climate. CDC's Climate-Ready States and Cities Initiative assists 11 grant recipients around the nation using the five-step, Building Resilience Against Climate Effects framework to identify likely climate impacts in their communities, potential health effects associated with these impacts, and their most at-risk populations and locations;
- **Climate and Health Outlook**: A collaborative effort led by OCCHE involving agencies from across the government. The Outlook informs health professionals and the public on how health may be affected in the coming months by climate events and provides resources to take proactive action;
- **National Academy of Medicine Action Collaborative on Decarbonizing the U.S. Health Sector**: A public-private partnership of leaders from across the health system committed to addressing the sector's environmental impact while strengthening its sustainability and resilience. OCCHE supports the Assistant Secretary for Health in co-chairing the Action Collaborative;
- **Office of Environmental Justice**: In May 2022, OCCHE launched the Office of Environmental Justice in response to the President's Executive Order, *Tackling the Climate Crisis at Home and Abroad*. The Office's mission is to protect the health of disadvantaged communities and vulnerable populations on the frontlines of pollution and other environmental hazards that affect health;
- **Environmental Justice Index Tool**: A collaborative effort with CDC to identify and map communities at highest risk for health impacts of environmental exposures;
- **ASPR Technical Resources, Assistance Center, and Information Exchange (TRACIE)**: The TRACIE program provides a compilation of climate change and health-related resources, including the 2022 publication of Climate Change Resilience and Healthcare System Considerations;
- **AHRQs primer on Reducing Healthcare Carbon Emissions**: An action guide to reduce greenhouse gas emissions, with prioritized measures to monitor progress and guide strategic management; and,
- **The Program Support Center's Climate-Resilient Operations at HHS Facilities**: A continuous effort to update existing policy and guidance to meet newly developed environmental sustainability and climate resilience requirements set by Congress and the Administration:
    - **21st Century Workplace Space Planning Policy**: Promotes the efficient use of HHS space based on the increased teleworking environment (e.g., shared workstations and offices);
    - **Wildfire Vulnerability Assessment Tool**: Identifies and assesses HHS facilities most vulnerable to wildfires, helps reduce direct damage to facilities and property, strengthens transportation and supply-chain routes, and prevents harm to the HHS workforce; and
    - **HHS Building Facility Program Manual**: Outlines Departmental policy and guidance to HHS personnel responsible for directing and managing HHS facility activities and promotes excellence in the management and stewardship of HHS facilities (e.g., HHS facility budget formulation, remediation, and disposal).

Refer to HHS's 2021 Climate Action Plan and the Sustainability Report and Implementation Plan 2020 for more information. The FY 2022 Sustainability Report is currently being developed.

Grants Quality Service Management

The Grants Quality Service Management Office (Grants QSMO) is continuing its work across all federal awarding agencies to assess business needs and viable solutions; modernize, automate, and standardize grants management processes and systems; and facilitate execution of key administration priorities. The Grants QSMO's work is supported in (OMB) Memoranda M-21-20, *Promoting Public Trust in the Federal Government through Effective Implementation of the ARP* and M-22-12, *Stewardship of the Taxpayer Resources and Outcomes in the Implementation of the Infrastructure Investment and Jobs Act,* and further clarified in OMB Memorandum M-22-02, *New Financial Assistance Transparency Reporting Requirements*, and the ARP.

Pursuant to OMB Memorandum M-19-16, *Centralized Mission Support Capabilities for the Federal Government*, and OMB's designation of the Grants QSMO at HHS, the Grants QSMO is authorized and responsible for establishing a marketplace of quality shared solutions/services and governing the long-term sustainability of the solutions/services. In September 2022, the Grants QSMO launched its public-facing Grants QSMO Marketplace of validated Federal Shared Solutions/Services for use by all Federal Awarding Agencies that award grants and/or cooperative agreements. This Grants QSMO Marketplace provides Federal Awarding Agency customers with information to support and inform decisions regarding adoption of shared solutions/services across the entire grants lifecycle. Federal Awarding Agencies that have identified a requirement for grants IT for any part of the grants lifecycle will consult this Marketplace, the Grants QSMO team, and the respective Shared Service Providers to determine if Marketplace offerings can meet their grants IT requirements.

Through strong partnership and coordination with Federal Awarding Agencies on grants IT investment development, the Grants QSMO first seeks to increase the utilization of grants shared service offerings via the Grants QSMO Marketplace to improve mission delivery and help reduce duplicative government IT investments. If an agency cannot meet its grants IT requirements with a Marketplace offering, the Grants QSMO will review investments in grants systems to make recommendations to OMB. OMB Memoranda M-19-16, M-21-20, and M-22-12 require agencies to coordinate with the Grants QSMO on investments made in Grants IT. The Grants QSMO's Grants IT Investment Review process, finalized in September 2022, aims to:

- Modernize, automate, and standardize grants management processes and systems;
- Drive adoption of Grants QSMO's Marketplace of shared solutions/services, where feasible;
- Ensure grants IT investments adhere to the Federal Integrated Business Framework Standard Data Elements for Grants Management; and
- Gradually achieve IT consolidation within agencies to reduce the overall grants IT footprint.

This investment review process also ensures that agencies investing in grants IT align to the Grants QSMO's Seven Guiding Principles for Grants Technology Modernization, leverage the Grants QSMO's existing market research, shared resources, and best practices (e.g., General Services Administration's M3 Playbook) and, avoid duplicative investments government-wide.

Stakeholder conversations with Federal Shared Service Providers and Federal Awarding Agency stakeholders determined that the Grants QSMO Marketplace should expand outside the current federal offerings. This need is driven by significant demand for award management shared services, limited capacity of current validated shared service providers, and customers' needs for more affordable solutions. In March 2022, the Grants QSMO released a Request for Information to better understand the commercial grants IT solution ecosystem and to learn from industry on how best to operationalize the commercial side of the Grants QSMO Marketplace. A government-wide team of over 20 reviewers from 10 federal agencies reviewed the 62 Request for Information responses and participated in a Market Research Week hosted by the Grants QSMO, where one-on-one sessions were held with specified vendors with existing end-to-end solutions. The Grants QSMO partnered with three Federal Awarding Agencies and are currently piloting with them to develop an ordering guide and InfoHub on General Services Administration's Acquisition Gateway.

Performance Goals, Objectives, and Results

By leveraging Grants QSMO market research, which includes vendor cost estimates, current capabilities, Request for Information results, this partnership supports agencies' initial acquisition planning efforts and streamline the acquisition process saving hundreds of hours of market research. In the coming years, the Grants QSMO intends to operationalize and mature the Marketplace by assessing multiple approaches to offer and support the acquisition of commercial solutions/services on the Marketplace.

The Grants QSMO's efforts continue to affirm the long-standing role of HHS as the largest grant-making agency and leader in improving grants management and recognizes HHS's ongoing commitment to improving Grants Management across the Federal government.

Did You Know?

CHIP was established 25 years ago on August 5, 1997. CHIP has provided millions of children and pregnant women with critical health insurance and peace of mind in knowing that they can get the healthcare they need. Prior to CHIP being enacted, 15 percent of all children were uninsured, today, that number is less than 4 percent. In 2022, the largest investment ever made through the Connecting Kids to Coverage program assisted in the efforts to increase outreach and enrollment efforts. CHIP has provided access to critical healthcare, including vaccines, well-childcare, and essential mental health services.

For more information, visit CMS's website.

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Looking Ahead to 2023

In 2023, HHS will address important healthcare, public health, human services, and research challenges that impact all Americans through the strategic direction set forth in the HHS Strategic Plan FY 2022 – FY 2026.

HHS Strategic Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare

Behavioral Health Transformation: HHS recognizes that integrating care is an essential strategy for advancing the national strategy to prevent and treat mental and substance use disorder. We will work in support of the strategy's three pillars to strengthen system capacity, connect people to care, and support people through upstream investments in prevention. HHS will continue efforts to close the gap between mental and SUD care and access to treatment. We will focus on solutions that address integrating the full spectrum of behavioral healthcare into healthcare, social service, and early childhood systems to ensure all people have equitable access to evidence-based, culturally appropriate, person-centered care.

Health Coverage and Access: HHS will continue its efforts to increase choice, affordability, and enrollment in high-quality healthcare coverage through all available channels, including Medicare, Medicaid, and Marketplace coverage. We will continue to reach out to communities eligible for health insurance coverage to encourage them to enroll in coverage. HHS will also continue efforts to expand equitable access to comprehensive, community-based, culturally competent healthcare services while addressing social determinants of health.

Value-Based Purchasing: HHS will continue to conduct research and evaluation of promising models of care that reduce healthcare spending while improving quality and outcomes. In addition, through public engagement, we will continue to solicit feedback from stakeholders concerning best practices to support and incentivize high value models of care for the future.

Drug Pricing: HHS will continue its efforts to improve the affordability and equitable access to prescription drugs for all consumers and throughout the healthcare system. We will implement the *Inflation Reduction Act of 2022* (IRA) to support drug price negotiation with manufacturers in Medicare, stop unreasonable price increases, and reduce out-of-pocket drug costs to Medicare beneficiaries. HHS will continue to improve competition throughout the prescription drug industry. We will also conduct research and evaluations to assess drug pricing, utilization, and access for all patients and to inform policies to reduce consumer out-of-pocket spending.

Healthcare Workforce: HHS will continue to identify opportunities to enhance and improve the capacity of the existing healthcare workforce and to strengthen the primary care workforce. We will evaluate promising policies, programs, and innovations to increase delivery of culturally appropriate care to advance health equity, increase diversity in the healthcare workforce, and to center care on the expressed needs and well-being of all patients.

Supply Chains: HHS will continue efforts to bolster the resilience and security of the supply chains for critical products impacting the health of Americans. We will continue to ensure availability of medical products and incentivize innovation to expand access to safe and high-quality medical devices and drugs.

HHS Strategic Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes

PHE Preparedness and Response: HHS will continue its ongoing efforts to support public health preparedness for, response to, and recovery from disasters and PHEs, including COVID-19 and monkeypox. As the responses to COVID-19 and monkeypox evolve, we will continue to monitor outbreaks, provide information to impacted communities, and facilitate access to safe and effective vaccines and therapeutics. Equity will remain a priority in all HHS response efforts, including ensuring equitable access to tests, vaccines, and treatments, and addressing the needs of those who may be disproportionately impacted by PHEs. In addition to ongoing response

efforts, we are building upon the lessons learned from the COVID-19 response to enhance preparedness for the next PHE and improve our data infrastructure for such emergencies.

Overdose Prevention: HHS will continue to empower states and local communities on the frontlines of the overdose crisis by implementing the HHS Overdose Prevention Strategy, which expands beyond the opioid-specific crisis response and includes other substances that are often involved in overdoses, such as methamphetamine and cocaine. The strategy focuses on four key priority areas—primary prevention, harm reduction, evidence-based treatment, and recovery support—and reflects four key principles: maximizing health equity for underserved populations, using the best available data and evidence to inform policy and actions, integrating SUD services into other healthcare and social services, and reducing stigma. The strategy promotes research and evidence-informed methods to improve the health and safety of our communities.

Combating Antibiotic-Resistant Bacteria: HHS will continue leading the U.S. Government's coordinated approach to slowing the spread and reducing the impact of antibiotic-resistant infections; detecting and containing outbreaks; innovating products to prevent, diagnose, and treat infections; and collaborating across the globe. The COVID-19 pandemic generated many challenges, including seriously ill patients and staffing shortages, which were linked to increased inappropriate antibiotics use. We are committed to overcome these setbacks by building more resilience into our healthcare and public health systems and addressing the need for new strategies to prevent and treat infections.

Climate Change/Environmental Health and Justice: HHS will continue to address the impact of climate change on the health of the American people by identifying vulnerable communities and populations at risk from climate impacts, addressing environmental health disparities, and fostering climate adaptation and resilience for disadvantaged people and communities. HHS will continue to summarize information from each OpDiv to create a coherent HHS Climate Change and Health Equity Strategic Plan with the intention of forming the foundation of a national adaptation plan for health, as agreed to under the United Nations Conference of the Parties 26 Health Programme. We will continue efforts to reduce greenhouse gas emissions and other pollution sources within the healthcare sector and promote training opportunities to build the climate and health workforce. HHS will provide expertise and coordination to federal, state, tribal and territorial authorities to address environmental concerns and health inequities and fulfill international commitments to mitigate climate change.

HHS Strategic Goal 3: Strengthen Social Well-Being, Equity, and Economic Resilience

Child Welfare: HHS will continue efforts to transform the child welfare system, emphasizing equity, prevention, and family support so that children may remain safely with their families whenever possible, particularly in neglect cases in which material needs related to poverty are primary concerns. Priority activities are planned in the areas of prevention, kinship care, and workforce training and support. We will also explore ways to improve supports for youth who age out of foster care and will continue efforts to ensure that congregate care is used only when necessary to meet the child's therapeutic needs, as required by the *Family First Prevention Services Act*.

Early Childhood Development: HHS will continue to strengthen early childhood development by promoting safe and supportive environments that foster child development across multiple developmental domains and increasing the availability, accessibility, and affordability of high-quality early care and education (ECE) for young children and their families. We will achieve these goals by leveraging federal ECE funding and programs; partnering across federal agencies and with state, territory, tribal and local ECE programs and grantees; and strengthening the ECE workforce. The ECE sector is currently facing a workforce crisis, with programs around the country experiencing difficulties hiring qualified staff and/or retaining staff to ensure consistent, high-quality care and education. HHS will use federal levers and tools, such as grant funding, program guidance, technical assistance, research analyses, and program coordination, to promote efforts to increase compensation and improve retention and career advancement for the ECE workforce while maintaining the rich diversity of this workforce.

Looking Ahead to 2023

Economic Mobility: HHS will use federal levers and tools, such as program flexibilities, technical assistance, research analyses, and program coordination, to promote equity for all Americans, and economic resilience and mobility for low-income Americans. The U.S. Interagency Council on Economic Mobility will continue to streamline and coordinate federal programs and policies, creating more equitable, effective, and efficient delivery of benefits.

Health-Related Social Needs: HHS envisions a future in which all individuals, regardless of their social circumstances, have access to equitably delivered, comprehensive, and well-coordinated health and social care that supports their overall well-being. We encourage healthcare providers to screen their patients for social needs, including those that have implications for health outcomes such as housing and food insecurity. HHS will also look for opportunities to help support local efforts to develop sustainable partnerships between healthcare providers, the public health system, and community-based organizations and to advance the infrastructure needed to increase closed-loop referrals to social care providers to address these needs.

Promote Healthy Aging and Reduce Risk for Late-Life Disability: HHS will expand efforts to promote healthy aging, identify and manage chronic conditions, and reduce the risk of developing physical and cognitive impairments in late life. This will require both primary prevention by health risk factors such as exercise, high-quality sleep, and good nutrition, as well as secondary prevention through early identification and management of chronic conditions. We recognize these approaches require both public health and community-based providers, as well as healthcare systems and medical professionals, to work together toward this goal. HHS's efforts will recognize and address racial and ethnic disparities in health risk factors and chronic conditions to reduce disparities in disability services.

Strengthen Supports for Family Caregivers: HHS will implement the National Caregiving Strategy, which sets ambitious goals to galvanize action by HHS, federal, state, and local partners to better support the millions of Americans that care for people with disabilities and older adults daily. Central steps to supporting family caregivers and supporting people with disabilities in their homes and the community include: enhancing the quality of formal long-term services and supports; ensuring the paid workforce of direct care and direct support providers are fairly compensated; and ensuring caregivers have the training and tools they need to provide care to this population.

HHS Strategic Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All

Clinical Trial Diversity: Clinical trials are a crucial component of identifying promising new therapies, but participants often do not reflect the diversity of the nation. HHS efforts to diversify trials through outreach, engagement, and policy change have led to significant successes, exemplified by the highly diverse COVID-19 vaccine trials. We are committed to continuing these efforts and expanding clinical trial participation to communities throughout the country through engagement and outreach, leveraging novel trial approaches, and collaborating with stakeholders including the private sector and non-profits.

Cancer Moonshot: HHS will play a key role in the Cancer Moonshot initiative's ambitious goals of reducing cancer death rates by 50 percent over the next 25 years and improving the experience of people and their families living with and surviving cancer. By leveraging our expertise in research, regulation, and public health, as well as the scientific advances and public health lessons of the COVID-19 pandemic, HHS will improve prevention and diagnosis, learn from patients and caregivers, address lingering inequities, and continue to build on the substantial progress in developing new cancer cures.

Scientific Integrity: The development and use of scientific information are essential to the success of the HHS mission. HHS is taking a coordinated approach to enhance a culture of scientific integrity so that science is conducted, managed, communicated, and used free of political interference. We are actively working to implement the Presidential Memorandum on Restoring Trust in Government through Scientific Integrity and Evidence-based Policymaking by updating HHS's policies and procedures to support the free flow of information, protection from inappropriate interference, and ensuring accountability.

Looking Ahead to 2023

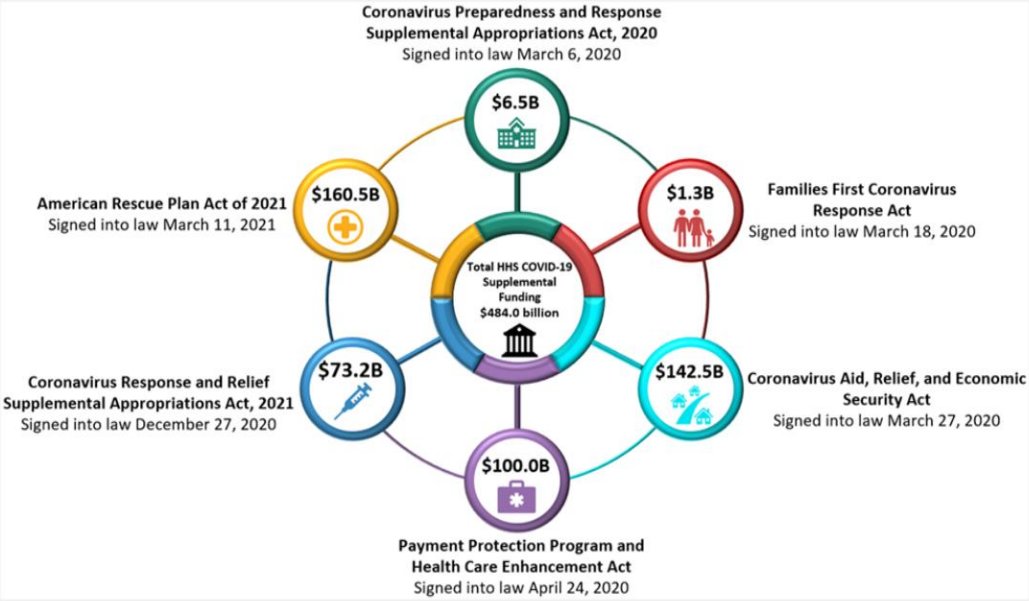
Equity Research Agenda: HHS is developing an Equity Research Agenda to ensure the research that we use to build evidence for programmatic, policy, guidance, and regulatory decisions is conducted in a manner that promotes equity, reflects the experiences of all interested parties, and does not compound harm. HHS will focus on identifying methods for disparities and equity research that are appropriately community-centered; are strengths-based; do not pathologize populations that are marginalized; and establish ways to appropriately generate new evidence to identify and reduce disparities and understand the impact of HHS programs on underserved communities.

Building Data Capacity for Research: HHS will build data capacity for research on health outcomes through a series of coordinated investments in data infrastructure. This coordination will involve partnerships with scientists, research programs, and data stewards to develop and implement a series of projects that expand data capacity for research. These investments will increase the capacity of HHS agencies to collect, link, and analyze data for studying health outcomes and for generating objective, scientific evidence to inform decision-making. Research resulting from these data infrastructure investments will provide evidence about the outcomes and effectiveness of treatments, services, and other healthcare interventions.

Evidence-Building Capacity: HHS will continue to implement the *Foundations for Evidence-based Policymaking Act of 2018* based on information from its capacity assessment of HHS evaluation and evidence-building capacity and functions. We will build the skills and competencies of staff to meaningfully support evidence-building and use. The training plan includes sessions for HHS evaluation and non-evaluation staff on topics such as planning evaluations and other evidence-building activities; evaluation design; building evidence with diverse and impacted communities; insights into how evidence can be translated and used to inform decision-making; and building agency evidence capacity and culture.

Did You Know?

HHS received COVID-19 response and relief funding from six emergency supplemental bills. For more information on the COVID-19 covered funds, visit HHS's website.



HHS Strategic Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability

Workforce Accountability and Innovation: HHS supports strategies to uphold effective and innovative human capital resource management. HHS leads efforts to improve the different aspects of the workplace conditions that lead to engagement, by focusing on three key strategies for its employees: intrinsic work experience, opportunities for professional development and growth, and engagement. These strategies align with HHS organization priorities and the government-wide Diversity, Equity, Inclusion, and Accessibility Strategic Plan.

Minority Leaders Development Program: HHS initiative to develop and implement a two-year fellowship program that provides training in health equity issues and leadership to early career individuals to improve the health of racial and ethnic minority and other disadvantaged populations. This program will seek to enhance skills and competencies necessary for federal leadership service among participants through a curriculum focused on healthcare policy, leadership skill-building, and cultural competence.

HHS Modernization: HHS seeks to leverage modernization as a gateway to strengthened cybersecurity and enhanced risk management. Aligning information security risk management and IT modernization efforts with ERM by sharing opportunities and risks among information security and privacy, IT, and other management disciplines will ensure information security and IT modernization initiatives directly support mission priorities and HHS stakeholders, and consistently meet mandated requirements.

Mitigating Future Climate Change Risks: HHS has developed an overall strategy for addressing the climate and sustainability goals of Executive Orders 14008 and 14057, *Tackling the Climate Crisis at Home and Abroad* and *Catalyzing Clean Energy Industries and Jobs Through Federal Sustainability*. First, OCCHE will launch the Interagency Working Group to Decrease Risk of Climate Change to Children, the Elderly, People with Disabilities, and the Vulnerable in 2023 in addition to updating the Sustainable and Climate Resilient Healthcare Facilities Toolkit. Second, The Program Support Center is collaborating with ASFR to develop a Sustainable Procurement Directive to meet net-zero procurement targets and environmental preferred product purchasing goals. Other office activities, including grant-making and technical assistance, are contingent upon appropriations from Congress.

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Systems, Legal Compliance, and Internal Control

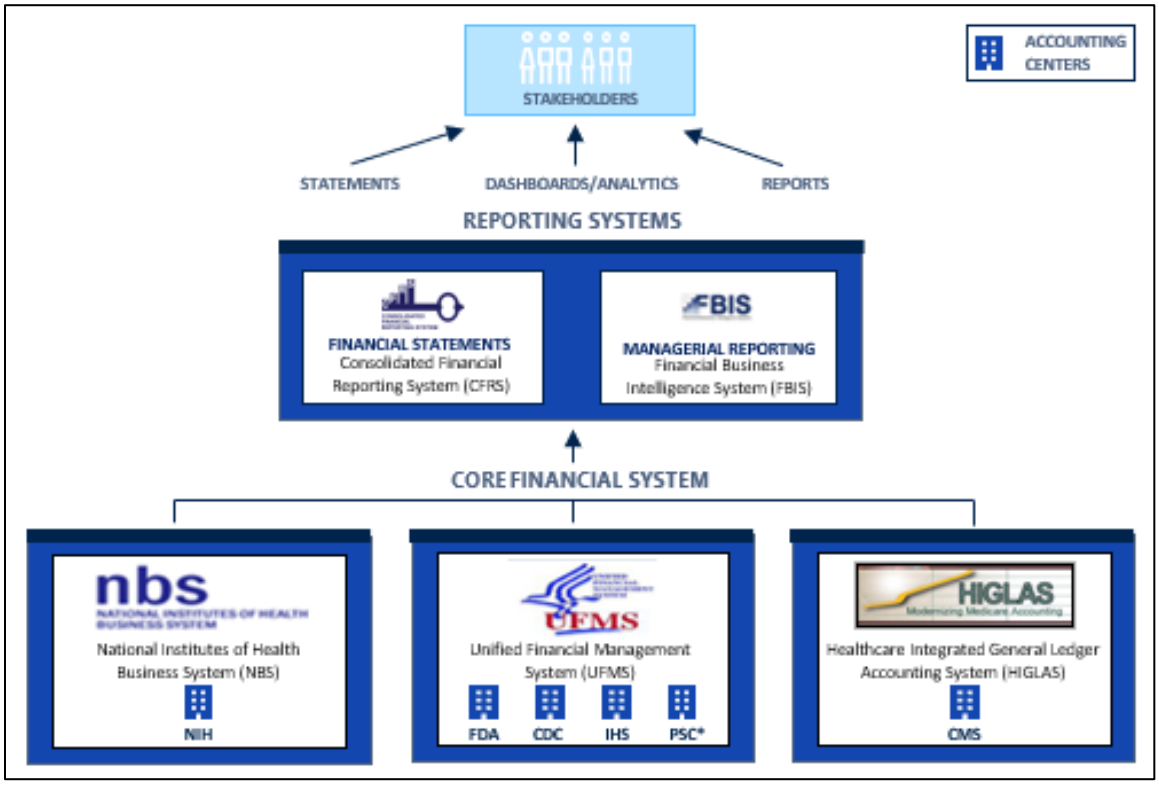
Systems

HHS's Chief Financial Officer community continuously strives to enhance the financial management systems environment to sustain HHS's diverse portfolio of mission-oriented programs and business operations. The primary objectives of the financial management systems environment are to: (1) efficiently process financial transactions in support of program activities and HHS's mission; (2) provide complete and accurate financial information for decision-making; (3) improve data integrity; (4) strengthen internal controls; and (5) mitigate risk.

The HHS financial systems framework provides the foundation to manage approximately $2.7 trillion in budgetary resources entrusted to the Department in FY 2022. These resources include the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act), ARP, and other supplemental funding vital to assisting citizens with the public health and economic impacts of COVID-19. HHS's financial management systems environment supports and ensures the efficient and timely disbursement of funds, which is a critical factor in advancing HHS's COVID-19 relief efforts. Additionally, HHS's robust financial management systems environment provides federal contract, grant, loan, and other financial assistance data to USASpending.gov, which presents clear, accurate, and timely award information while providing transparency and accountability to the American public.

The HHS financial management systems environment, detailed in **Figure 13** and **Figure 14**, consists of a core financial system with three instances and two Department-wide reporting systems. The core financial system's three instances operate on the same commercial off-the-shelf platform to promote Department-wide data standardization. The reporting systems within the HHS financial management systems environment facilitate financial statement compilation, data analysis, and financial and managerial reporting. Together, these systems fulfill HHS's financial accounting and reporting needs.

Figure 13: HHS Financial Management Systems Environment



* PSC-supported OpDivs include ACF, ACL, AHRQ, ASPR, HRSA, SAMHSA, and OS.

Systems, Legal Compliance, and Internal Control

Figure 14: HHS Financial Management Systems

Relevant Legislative Guidance

The HHS financial management systems environment must comply with all applicable federal laws, regulations, and authoritative guidance included in **Figure 15**.

Figure 15: Relevant Legislation and Guidance

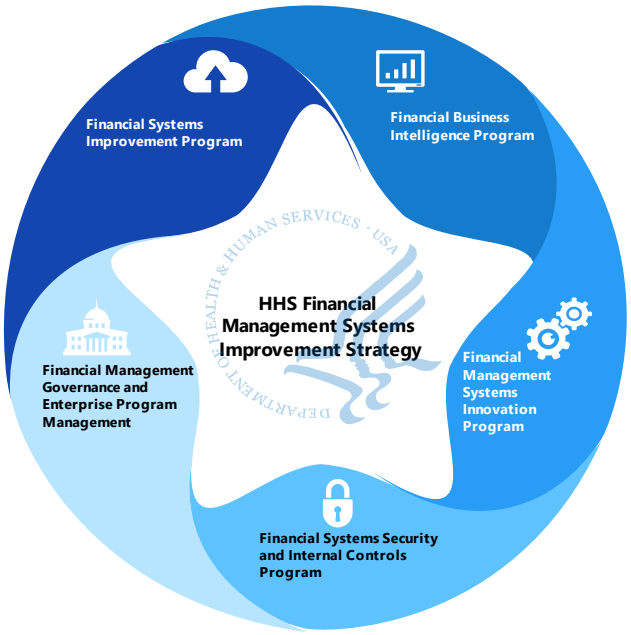
- *Federal Managers' Financial Integrity Act of 1982*
- *Chief Financial Officers Act of 1990*
- *Government Management Reform Act of 1994*
- *Federal Financial Management Improvement Act of 1996*
- *Clinger-Cohen Act of 1996*
- *Federal Information Security Management Act of 2002, as amended by the Federal Information Security Modernization Act of 2014*
- *Digital Accountability and Transparency Act of 2014*
- *Federal Information Technology Acquisition Reform Act of 2014*
- *Fraud Reduction and Data Analytics Act of 2015*
- *Coronavirus Aid, Relief, and Economic Security Act of 2020*
- *American Rescue Plan Act of 2021*
- Office of Management and Budget directives and U.S. Department of the Treasury guidance related to these laws

Financial Management Systems Improvement Strategy

HHS made substantial progress in maturing the financial management systems environment over the years. Financial managers continue to face a rapidly changing financial management landscape with increasing demands for accountability and transparency, evolving federal mandates, increasing security threats, and the need to maximize the value of system investments.

To combat these challenges, HHS developed a Department-wide financial systems improvement strategy with five programs and objectives, as illustrated in **Figure 16**.

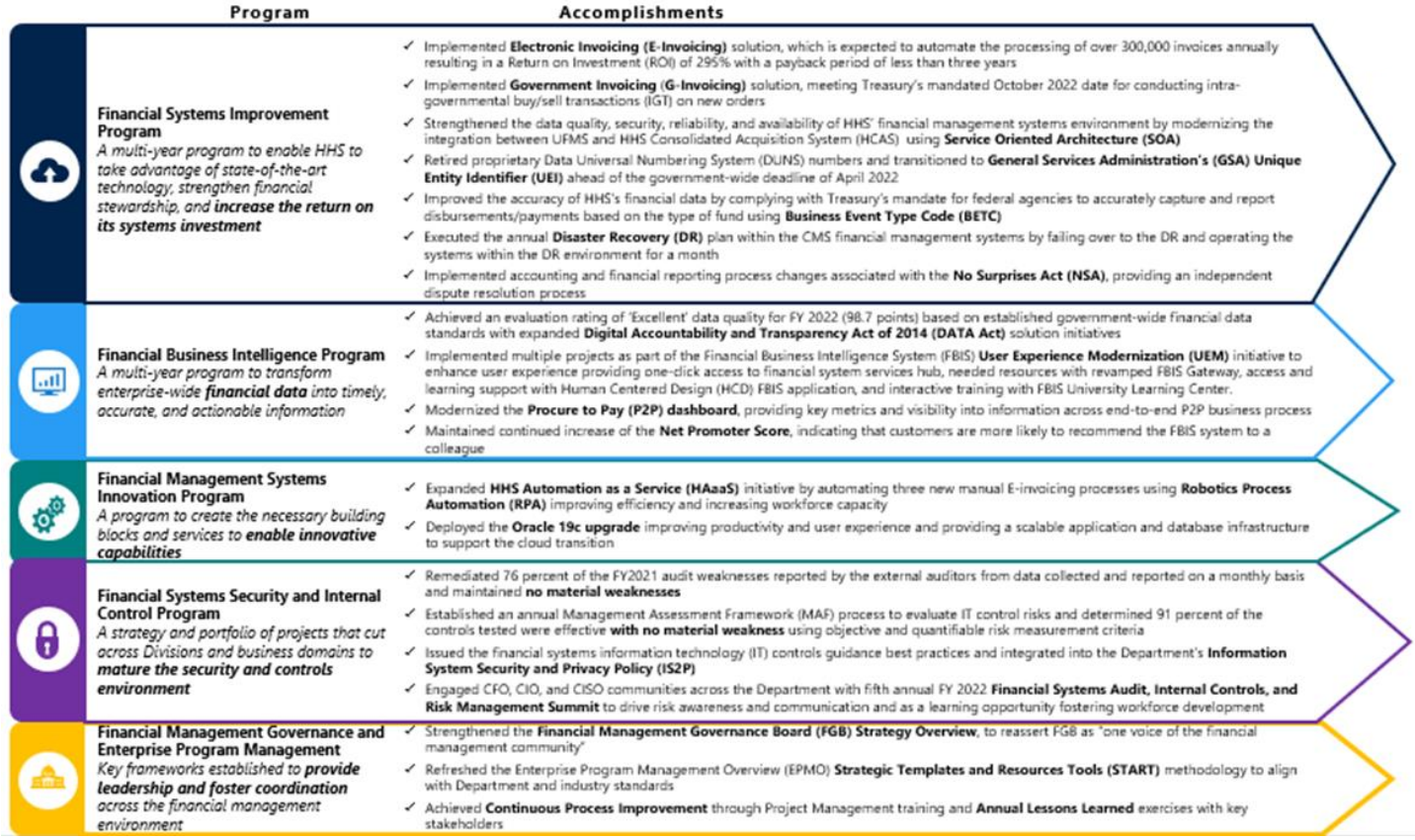
Figure 16: Financial Management Systems Improvement Strategy



In addition, HHS remains focused on the customer experience, ensuring each mission-critical project provides value to the end-user through improved capabilities of the enterprise-wide financial management systems. HHS continues to drive forward the five strategic programs summarized in **Figure 17**.

Systems, Legal Compliance, and Internal Control

Figure 17: Financial Systems Improvement Strategy Programs and Accomplishments



1. Financial Systems Improvement Program

Through the Financial Systems Improvement Program, HHS is actively pursuing multiple initiatives to generate efficiencies and improve the effectiveness of the financial management systems. In FY 2022, HHS successfully implemented U.S. Department of the Treasury's (Treasury) Electronic Invoicing solution. This solution modernized the commercial invoicing process by automating the entry, approval, and processing of commercial invoices; reduced the time between invoice receipt and payment; and improved data quality and access to payment information. HHS expects to automate the processing of over 300,000 invoices annually and provide a 295 percent return on investment with a payback period of less than three years.

HHS successfully strengthened its financial management systems' data quality, security, reliability, and availability by modernizing the integration between Unified Financial Management System and HHS Consolidated Acquisition System using Service Oriented Architecture. This integration streamlines acquisition and financial systems communications and data sharing, improving the overall quality and consistency of the data, and sets the stage for future modernization between Unified Financial Management System and other systems.

HHS successfully implemented the Department-wide Government Invoicing (G-Invoicing) solution, meeting Treasury's mandated October 2022 date for conducting intra-governmental buy/sell transactions (IGT) on new orders. The G-Invoicing implementation will improve quality and reliability of intra-governmental buy/sell transactions, provide transparency among federal agencies, drive more accurate accounting and reporting, and address a long-standing Government-wide material weakness. Implementation of the G-Invoicing solution represents a major accomplishment for a large and complex organization like HHS because of the initiative's technical complexities, required strategic thinking, extensive business process changes, and coordination with both external and internal stakeholders.

In addition, HHS retired proprietary Data Universal Numbering System numbers and transitioned to General Services Administration's Unique Entity Identifier (UEI) for all financial management systems across HHS, ahead of the government-wide deadline of April 2022.

Furthermore, HHS improved the accuracy of its financial data by complying with Treasury's mandate for federal agencies to accurately capture and report disbursements/payments based on the type of fund (General Fund vs. Non-General Fund) using Business Event Type Code.

HHS successfully executed the annual Disaster Recovery (DR) plan within the CMS financial management systems by failing over to the alternate DR location IT environment and operating the systems within the DR environment for a month with zero failures. This demonstrates the resiliency of the CMS financial system program to seamlessly failover and successfully operate in the DR environment while supporting 100 percent remote staff.

Additionally, the team implemented accounting and financial reporting process changes associated with the *No Surprises Act*. The *No Surprises Act*, established to ensure consumer protection against surprise medical bills, required CMS to provide an independent dispute resolution process effective January 1, 2022. The implementation in Healthcare Integrated General Ledger Accounting System will allow CMS to collect fees from Independent Dispute Resolution Entities, generate demand letters for payments of fees to CMS and generate operational reports for the *No Surprises Act*.

2. Financial Business Intelligence Program

The Financial Business Intelligence Program provides operational and business intelligence capabilities to 1,900 users within the HHS financial management community through its business intelligence system, Financial Business Intelligence System (FBIS). HHS has made progress on its commitment to facilitate improved stewardship and decision-making in FY 2022, and HHS made a dedicated effort to bolster FBIS' capabilities and adoption.

HHS continued its compliance with *Digital Accountability and Transparency Act of 2014* (DATA Act) reporting on a monthly basis in accordance with the CARES Act, OMB Memorandum M-20-21, *Implementation Guidance for Supplemental Funding Provided in Response to the* COVID-19, and Treasury implementation guidance. The Department met the government-wide deadline to start reporting all the outlays for COVID-19 and Non-COVID-19 related Treasury Account Symbols (TAS) by expanding HHS's DATA Act Solution. This solution is easy to maintain and upgrade, significantly improves the quality of HHS's financial data, and provides additional analytic capabilities to HHS's users. HHS achieved an evaluation rating of excellent data quality for FY 2022 (98.7 points) based on established government-wide financial data standards.

Additionally, HHS continues to enhance the Segregation of Duties Control Monitoring Dashboard, closing its longstanding Segregation of Duties findings and contributing to a clean audit. As a result, the financial management community has access to new insights, along with tools to execute financial management responsibilities effectively and efficiently.

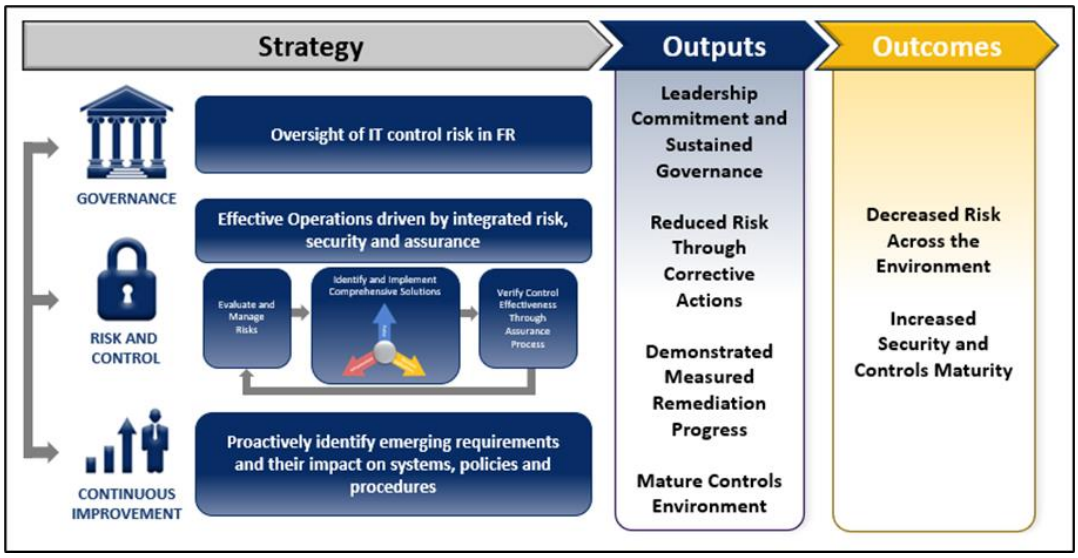
HHS successfully implemented multiple projects as part of the FBIS User Experience Modernization Project to increase ease of access to FBIS, strengthen navigation capabilities, provide on-demand trainings, and create new dashboards – all to enhance the user experience. In FY 2022, as part of this effort, FBIS modernized the Procure to Pay dashboard which provides increased visibility into OpDivs' business processes; rationalizes and globalizes relevant OpDiv-specific reports; and reduces system complexity, enabling the retirement of obsolete reports and making it easier for stakeholders across the Department to access Procure to Pay information. In addition, HHS took a Human Centered Design (HCD) approach to provide streamlined and quick access to useful information, a personalized landing page, and embedded support for learning and discovery. Finally, HHS launched the FBIS University Learning Center featuring over 50 new training resources, including

interactive trainings, job aids, and tutorials, highlighting the OpDiv business functions supported by FBIS. With these enhancements, HHS improved self-service capabilities across the Department to use business analytics for decision-making and maintaining a continual increase in the Net Promoter Score indicating that customers are even more likely to recommend this system to a colleague. Furthermore, 86 percent of survey respondents reported positive satisfaction with FBIS.

3. Financial Management Systems Innovation Program

HHS continues to undertake various initiatives to capitalize on technological advances and enable innovative capabilities to streamline business processes and reduce manual burden.

Figure 18: Financial Systems Control Environment Maturity Strategy



In FY 2022, HHS successfully expanded the HHS Automation-as-a-Service initiative through Robotic Process Automation by automating manual processes across its financial management systems, which include three new manual Electronic Invoicing processes and one G-Invoicing process. The expansion ultimately eliminated the need for HHS to assign human resources to perform new business processes. This resulted in over 5,000 manual hours saved, improved productivity, lower costs, and overall enhanced business value while simultaneously maintaining compliance with security controls.

With a migration to the new generation of Oracle Cloud on the horizon, HHS completed a program-wide approach to upgrade systems and tools from Oracle 12c onto the newest version of Oracle's Database Technology 19c. The upgrades coupled with the Governance, Risk and Compliance deployment, resulting in improved productivity and user experience and providing a scalable application and database infrastructure to support the cloud transition. In addition, HHS performed financial reporting upgrades that will also improve productivity and user experience, create a scalable infrastructure to support a cloud transition, and reduce the financial data consolidation completion time by 30 percent.

HHS reduced the timeframe for processing grants throughout the Department by completing a Grant Interface Improvement project on its financial systems. After the deployment, processing times for grants within the financial systems decreased by 99 percent, providing stakeholders with a significant improvement in customer service.

4. Financial Systems Security and Internal Control Program

The reliability, availability, and security of HHS's financial systems are paramount. HHS continues to execute its comprehensive strategy, established Department-wide to achieve the vision of a mature financial systems control environment to effectively mitigate risk. This Department-wide strategy, shown in **Figure 18**, provides the framework for governance and oversight; guides Department-wide actions to address systemic deficiencies and

mitigate risk(s); and coordinates proactive efforts to continuously improve and mature the overall financial systems environment. These strategic initiatives chart the path to successful achievement of the desired strategic outputs and outcomes.

HHS made significant improvements toward its strategic vision by remediating 76 percent of the prior years' *Federal Information System Controls Audit Manual* audit weaknesses. Most notably, HHS continues to sustain its financial management systems control environment with no material weakness and is focused on downgrading the significant deficiency identified by the external auditors.

HHS's internal control governance focuses on strengthening oversight, standardizing policy and control implementation, and providing timely communications to HHS stakeholders at all levels. For example, HHS issued the financial systems IT controls guidance best practices and integrated as part of the Department's Information System Security and Privacy Policy. In addition, HHS continued the standardization of IT control testing across the financial systems control environment and enhanced communications with HHS stakeholders to promote risk understanding and awareness. The Department has been leading the Financial Systems Risk and Controls Working Group to promote the collaboration among the Chief Financial Officer, Chief Information Officer and Chief Information Security Officer communities. In addition to regular reporting and monthly meetings, the Department hosted its fifth annual IT Audit, Internal Control, and Risk Management Summit in 2022, which serves as a vital platform for driving risk awareness and communication, and provides an opportunity for workforce development.

Risk management and control activities are the foundation of the Department-wide financial systems control environment maturity strategy. These activities steward effective operations by integrating risk, security, and assurance processes. This integration is accomplished through tactical risk evaluations; comprehensive corrective action planning; and risk mitigation monitoring and verification processes. In addition, HHS continues to improve its security posture by modernizing financial systems, implementing innovative solutions, and monitoring emerging technology. For example, HHS established an annual Management Assessment Framework process to evaluate IT control risks within the financial systems control environment using objective and quantifiable risk measurement criteria. The Management Assessment Framework enables management to assess the Department's progress toward achieving its vision of a mature financial systems control environment that effectively mitigates risk. The FY 2022 Management Assessment Framework assessment determined that 91 percent of the controls tested were effective with no material weakness.

HHS has had great success with its "Tiger Team," which was implemented last year to foster collaboration among subject matter experts across the OpDivs, and includes representatives from key financial and mixed systems, identity management systems, and the Office of the Chief Information Officer. The "Tiger Team" aims to address cross-cutting issues identified internally and reported by external auditors. In FY 2022, the "Tiger Team" worked with members of NIH, CMS, and OS to finalize the design of short and long-term solutions to optimize system access security controls.

Systems, Legal Compliance, and Internal Control

5. Financial Management Governance and Enterprise Program Management

HHS institutionalized key frameworks to increase stakeholder engagement at all levels in the decision-making process to help establish a common direction and drive enterprise-wide priorities. To guide Department-wide initiatives that have a financial management impact, HHS continues to employ the Financial Management Governance Board (FGB), an executive-level forum to address enterprise-wide concerns related to financial management policies and procedures, financial data, financial systems, and technology impacting the Department, OpDivs, and StaffDivs. The FGB's goals complement the Department's strategic goals, as illustrated in **Figure 19**.

Figure 19: Financial Management Governance and Enterprise Program Management Overview

In FY 2022, the FGB and its working groups strengthened the FGB Strategy Overview. This strategy will reassert FGB as the "one voice of the financial management community" by increasing member collaboration and engagement, enhancing live meeting engagement, and modernizing FGB Executive tools.

Enterprise Program Management provides a sustaining framework for the HHS financial management community stakeholders, while strengthening coordination, collaboration, and shared responsibilities related to programs and projects across the Department. In FY 2022, the Enterprise Program Management Office (EPMO) continued its efforts to transform project implementation and execution by refreshing its Strategic Templates and Resource Tools and delivering training sessions for Integrated Baseline Review, and Risk Management process areas to align with Department and industry standards. In addition, the EPMO conducted project management training sessions to further enhance project execution, improve consistency, and standardize reporting. The EPMO also conducted its Annual Lessons Learned exercise with key stakeholders to gain insight into successes and challenges for continual process improvement. As the Department's business needs evolve, the EPMO continues to mature and support ongoing collaboration and coordination across the financial systems environment and modernization initiatives.

Legal Compliance

Antideficiency Act

The *Antideficiency Act* (ADA) prohibits federal employees from obligating in excess of an appropriation, obligating before funds are available, and from accepting unauthorized voluntary services. As required by the ADA, HHS notifies all appropriate authorities of any ADA violations. ADA reports can be found on U.S. Government Accountability Office (GAO) - ADA Resources.

HHS management is taking necessary steps to prevent ADA violations. The Director of OMB approved HHS's updated Administrative Control of Funds policy, as required by U.S. Code, Title 31, *Money and Finance*, Section 1514, "Administrative Division of Apportionments." This policy provides HHS's guidelines for budget execution that specify basic fund control principles and concepts, including the administrative control of all funds for HHS and its OpDivs, StaffDivs, and Accounting Centers. HHS is currently reviewing three potential issues and remains fully committed to resolving these matters appropriately in compliance with all aspects of the law.

Bipartisan Infrastructure Law

The Bipartisan Infrastructure Law (*Infrastructure Investment and Jobs Act*), signed on November 15, 2021, will rebuild America's roads, bridges, and rails; expand access to clean drinking water; ensure every American has access to high-speed internet; tackle the climate crisis; advance environmental justice; and invest in communities. HHS has received $4 billion to invest in the IHS Water and Sewer program to support crucial sanitation projects, and the ACF Low-Income Home Energy Assistance Program to support low-income households with costly energy bills. Ultimately, investments in these infrastructure programs will create an influx of union jobs and grow the economy sustainably and equitably in subsequent years. *The Bipartisan Infrastructure Law* has invested in our nation by integrating a safer and healthier framework into all communities.

ACF received $500 million in additional funding for the ACF Low-Income Home Energy Assistance Program to be distributed in five installment payments through fiscal years 2022 - 2026. Established in 1981, ACF Low-Income Home Energy Assistance Program helps keep families safe and healthy through initiatives that assist eligible low-income households with heating and cooling energy costs, bill payments, energy crises, weatherization, and minor energy-related home repairs. The funding will provide eligible households with continuous, affordable, and safe home heating and cooling services.

The legislation has invested $3.5 billion ($700 million each year for the next 5 years) into the IHS Sanitation Facilities' Construction Program, which provides technical and financial assistance to American Indian tribes and Alaskan Native villages for the cooperative development and construction of safe drinking water supply, sewage, and solid waste disposal facilities, and related support facilities. This funding supports crucial sanitation facilities construction projects to improve water supply and waste disposal systems in American Indian and Alaska Native communities across the country to help avoid conditions related to respiratory, skin, soft tissue, and gastroenteric disease.

Coronavirus Aid, Relief, and Economic Security Act

The CARES Act, signed on March 27, 2020, provides emergency assistance and healthcare response for individuals, families, and businesses affected by the COVID-19 pandemic. The CARES Act was the first COVID-19 supplemental appropriation to both authorize emergency funds and mandate significant legal requirements. The CARES Act requirements and subsequent guidance, outlined in Section 15010(a)(6)(D), apply to all prior and future COVID-19 covered funds, including the *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020*, the *Families First Coronavirus Response Act*, the *Paycheck Protection Program and Health Care Enhancement Act*, the *Coronavirus Response and Relief Supplemental Appropriations Act, 2021*, and the *ARP*. An additional set of significant legal requirements was included in ARP (detailed in the following section) and OMB-issued memorandums to help agencies meet the intent of the CARES Act and ARP's non-financial directives, as summarized in **Figure 20**.

Figure 20: Summary of CARES Act and ARP's Compliance Requirements

OIG collaborates with the CARES Act-formed Pandemic Response Accountability Committee (PRAC) and serves as the HHS-equivalent oversight function; HHS's Principal Deputy IG serves as the PRAC Healthcare Subgroup lead. The PRAC leveraged the HHS OIG's mature data analytic operations to assist in building the Pandemic Analytics Center of Excellence providing analytic, audit, and investigation support to the oversight community. By collaborating on the oversight of covered funds, OIG can share lessons learned and avoid duplication of effort.

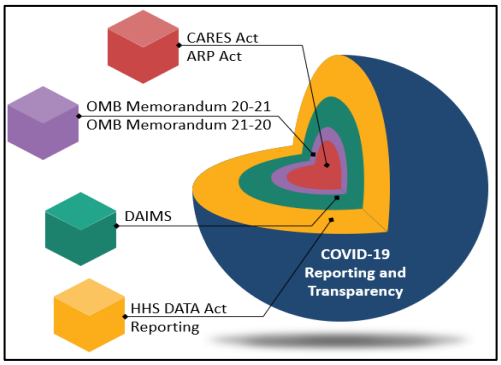
The HHS OIG also met with program stakeholders, OMB, the White House Implementation Coordinator, and the PRAC during the process of standing up new COVID-19 programs to proactively incorporate lessons learned. In December of 2021, OMB praised the success of agencies' partnerships with the PRAC, particularly referencing the "Gold Standard Meeting" process when it issued OMB Memorandum M-22-04, *Promoting Accountability through Cooperation among Agencies and Inspectors General*.

As directed under OMB Memorandum M-20-21, *Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019* (COVID-19), HHS has reported COVID-19 funds by federal account, object class, program activity, and more at the obligation and outlay level on a monthly basis since the third quarter of FY 2020 for all disaster emergency fund codes associated with COVID-19 by Treasury and OMB. In the final mandatory DATA Act audit of FY 2021, no significant errors were identified in testing the COVID-19 attributes reported by HHS. Submissions to USASpending.gov under the DATA Act are described further below and meet the transparency objectives of providing timely and complete spending data to the American public for all operational activities at HHS, including COVID-19-covered funds.

Digital Accountability and Transparency Act of 2014

The DATA Act expanded the *Federal Funding Accountability and Transparency Act of 2006* to increase accountability and transparency in federal spending, making federal expenditure information more accessible to the public. The DATA Act directed the federal government to use government-wide data standards for developing and publishing reports, and to make more information, including award-related data, available on USAspending.gov. Among other goals, the DATA Act aimed to improve the quality of the information on USAspending.gov, as verified through regular reviews of posted data, and to streamline and simplify reporting requirements through clear data standards.

The DATA Act requires agencies to generate data from their financial accounting systems using common fields, formats, and definitions for financial and award data in accordance with the DATA Act Information Model Schema. Treasury collects procurement, financial assistance, and recipient award data from government-wide databases reported under other *Federal Funding Accountability and Transparency Act of 2006* requirements and merges it with the financial data produced from the HHS financial system. On a quarterly basis, agencies must certify the accuracy, completeness, and timeliness of the data considered reportable under these standards. HHS is responsible for meeting these requirements and has successfully ensured the alignment between the sets of internally maintained and externally managed data is valid and reliable in all submissions since May 2017.



Since May 2017, HHS has successfully submitted financial and award-level data for quarterly certification to Treasury's DATA Act Broker. In FY 2022, DATA Act award-level obligations increased to $1,729.2 billion compared to $1,676.7 billion in FY 2021. HHS completely reconciled to an average of 96 percent of award-level obligations for FY 2022. HHS has undergone both GAO and OIG audits of its DATA Act submissions since May 2017, yielding a 'high/excellent quality' data rating in FY 2019 through FY 2022.

The diagram above represents how multiple COVID-19 legislative publications each built on the prior one to create the holistic reporting and transparency approach, beginning with Section 15011 of the CARES Act at the core. OMB clarified that the DATA Act would be used as the reporting vehicle for COVID-19 spending data in OMB Memorandum M-20-21 and furthered the effort in OMB Memorandum M-21-20 to implement ARP. Treasury built on these requirements by issuing the revised DATA Act Information Model Schema, which presented the methodology for agencies to provide public transparency of COVID-19 spending monthly.

Federal Information Technology Acquisition Reform Act

The *Federal Information Technology Acquisition Reform Act* (FITARA), was enacted on December 19, 2014. The act established an enterprise-wide approach to federal IT investments and provided the CIO of *Chief Financial Officers Act of 1990* agencies with greater authority over IT investments, including authoritative oversight of IT budgets, budget execution, and IT-related personnel practices and decisions. The Act established an enterprise-wide approach to federal IT investments and provided the Chief Information Officer (CIO) of *Chief Financial Officers Act of 1990* agencies with greater authority over IT investments, including authoritative oversight of IT budgets, budget execution, and IT-related personnel practices and decisions.

Over the last year, HHS strengthened its implementation of FITARA by focusing on cost savings derived from IT investments through continued consolidation and closure of data centers, and through continued implementation of the Enterprise Infrastructure Solutions transition. Additionally, HHS continued its efforts related to CIO authorities, delegation of authority, and responsibilities under the law. As a result of these efforts, HHS received a grade letter "B" on the House Committee on Oversight and Reform's FITARA Scorecard version 14.0, which was released on July 28, 2022. Since December 2020, HHS has maintained a "B" on the FITARA Scorecard and, in the 14.0 iteration, performed better than 16 other federal agencies.

The HHS CIO engaged with the HHS ASFR and OpDiv CIOs to perform the annual IT Portfolio Review, to ensure proper oversight of IT investments. As a result of HHS's efforts, the agency achieved an "A" on the Scorecard's Portfolio Review Savings (PortfolioStat) metric.

With that strong foundation, HHS can continue to focus on the larger FITARA related initiatives, such as Cybersecurity/*Federal Information Security Management Act*. Going forward, the House Committee has communicated a renewed focus on Cybersecurity/*Federal Information Security Management Act*, citing specifically OMB's need to provide agencies with the cybersecurity Cross Agency Priorities goals. Agencies should look forward to updated guidance around cybersecurity during the next fiscal year.

American Rescue Plan Act of 2021

The American Rescue Plan Act of 2021 (ARP) was enacted on March 11, 2021, as a cornerstone of the Administration's response to the ongoing COVID-19 pandemic. ARP offers funds for economic relief to individuals, families, and businesses; developing COVID-19 treatments and vaccines for mitigating the spread of the virus; and/or procuring supplies such as personal protective equipment. ARP strengthens our pandemic recovery by emphasizing oversight, transparency, equity-oriented results, and meeting the needs of under-served communities.

HHS established itself as a proactive leader with the development of the ARP award description assessment process in accordance with OMB Memorandum M-21-20, *Promoting Public Trust in the Federal Government through Effective Implementation of the ARP and Stewardship of the Taxpayer Resources*. Emphasizing how award descriptions are the public's primary means of transparency over the purpose of federally funded awards, OMB mandated quarterly assessments of the quality of ARP award descriptions to encourage agencies to improve those descriptions. HHS developed a process to review a quarterly sample of ARP awards and provided the results to OMB on a dashboard, highlighting key strengths and weaknesses across the ARP portfolio. HHS was invited to demonstrate the successful process at an OMB forum. After the *Infrastructure Investment and Jobs Act* passed, OMB issued guidance to expand this assessment beyond ARP awards, as detailed in the subsequent section.

Immediately after enactment of the ARP, government-wide coordination teams were stood up to help agencies understand the guidance, implement the requirements, and leverage best practices across agencies. In addition, OMB Memorandum M-21-20 authorized agencies to grant exceptions to recipients affected by the pandemic to help agencies expedite ARP funds for any qualifying financial assistance, including delaying System for Award Management registration, allowing pre-award costs, permitting no-cost extensions, and more. These waivers supplement other flexibilities used by HHS as granted through the PHE declaration and in the six related emergency supplemental bills. GAO-22-105047 cites a notable exercising of these flexibilities where CMS issued waivers to expand access to telehealth services. ACL demonstrated successful COVID-19 relief conducted through program flexibilities for nutrition assistance, home and community-based supportive services, and family caregiver support carried out under the *Older Americans Act of 1965* in using over $1.4 billion in ARP funds. ARP strengthened the partnership between HHS and the Department of Defense by providing $10 billion to prioritize COVID-19 medical supply contracts under the *Defense Production Act of 1950*.

Federal Managers' Financial Integrity Act of 1982 and Federal Financial Management Improvement Act of 1996

The Federal Managers' Financial Integrity Act of 1982 (FMFIA) requires federal agencies to annually evaluate and assert the effectiveness and efficiency of their internal control and financial management systems. Annually, agency heads must provide a statement of reasonable assurance that the agency's internal controls are achieving their intended objectives and the agency's financial management systems conform to government-wide requirements. Section 2 of the FMFIA outlines compliance with internal control requirements, while Section 4 dictates conformance with systems requirements. Additionally, agencies must report any identified material weaknesses and provide a plan and schedule for correcting the weaknesses.

In September 2014, GAO released an updated edition of its *Standards for Internal Control in the Federal Government*, effective FY 2016. The document takes a principles-based approach to internal control, with a balanced focus on operations, reporting, and compliance. In July 2016, OMB released revised Circular A-123, *Management's Responsibility for ERM and Internal Control*. The revised Circular complements GAO's Standards and implements requirements of the FMFIA with the intent to improve accountability in federal programs and increase federal agencies' consideration of ERM. The Department, with its OpDiv and StaffDiv stakeholders, are working together to implement these requirements.

The Federal Financial Management Improvement Act of 1996 (FFMIA) requires federal agency heads to assess the conformance of their financial management information systems to mandated requirements. FFMIA expanded upon FMFIA by requiring agencies to implement and maintain financial management systems that substantially comply with federal financial management systems' requirements, applicable federal accounting standards, and the U.S. Standard General Ledger at the transaction level. Guidance for determining compliance with FFMIA is provided in OMB Circular A-123, Appendix D, Compliance with the FFMIA.

HHS is fully focused on the requirements of FMFIA and FFMIA through its internal control program and a Department-wide approach to ERM. Based on internal assessments and FY 2022 audit findings, HHS provides reasonable assurance that controls are operating effectively. HHS is actively engaged with OpDivs to correct identified material weaknesses and non-compliances through a corrective action process focused on addressing the true root cause of deficiencies and is supported by active management oversight. Refer to the "Internal Control" section and the "Management Assurance" sections below for more information.

Inflation Reduction Act

The IRA, signed on August 16, 2022, aims to provide additional support for American families by lowering the cost of prescription drugs for Medicare recipients, and targets changes to Medicaid, the State CHIP, and private health insurance.

The IRA protects Medicare recipients from high drug prices through the establishment of the Drug Price Negotiation Program. This program requires the Secretary of HHS to negotiate the maximum fair prices with drug manufacturers for physician administered drugs covered under Medicare Part B and retail prescription drugs covered under Medicare Part D. Starting in 2023, manufacturers that sell drugs through Medicare Part B and D must pay rebates to Medicare if they increase drug prices faster than consumer inflation. Medicare Parts B and D recipients can expect a $35 per-month limit for insulin costs, and Medicare Part D enrollees can expect a $2,000 per-year limit for out-of-pocket drug related costs starting in 2025.

Additionally, the IRA identifies changes to vaccine costs for Medicare Part D, Medicaid, and CHIP recipients. Starting January 2023, Medicare Part D plans may not apply a deductible, coinsurance, or other enrollee cost-sharing requirement for adult vaccines recommended by the Advisory Committee on Immunization Practices. Beginning in October 2023, the IRA will expand coverage of Advisory Committee on Immunization Practices-recommended adult vaccines without enrollee cost sharing under Medicaid and CHIP.

The IRA extends better health initiatives to Americans by extending for three additional years the enhanced premium tax credits, originally enacted under ARP, lowering healthcare premiums for working families. Through the enactment of the ARP, the U.S. reached the lowest uninsured rate in history; however, these improvements were set to expire at the end of 2022. The IRA will continue these critical improvements by extending the enhanced subsidies through 2025 with the objective of reducing health insurance premiums by $800 per year for the 13 million people covered under the *Patient Protection and Affordable Care Act*.

Patient Protection and Affordable Care Act

The *Patient Protection and Affordable Care Act* established Health Insurance Marketplaces through which qualified individuals and qualified employers can purchase health insurance coverage. Many individuals who enroll in Qualified Health Plans through individual market Health Insurance Marketplaces are eligible to receive a premium tax credit to reduce their costs for health insurance premiums. Premium tax credits can be paid in advance directly to the consumer's Qualified Health Plan insurer. Consumers then claim the premium tax credit on their federal tax returns, reconciling the credit allowed with any advance payments made throughout the tax year. HHS coordinates closely with the Internal Revenue Service on this process.

The *Patient Protection and Affordable Care Act* also included provisions that address fraud and abuse in healthcare by toughening the sentences for perpetrators of fraud, employing enhanced screening procedures, and enhancing the monitoring of providers. These authorities have facilitated the federal government's efforts to reduce improper payments. For detailed information on improper payment efforts, see the "Other Information" section of this AFR, under "Payment Integrity Report."

Payment Integrity Information Act of 2019

Improper payments occur when a payment is made in an incorrect amount under statutory or other legally applicable requirements. This includes any payment to an ineligible recipient; any payment for an ineligible good or service; or any duplicate payment. For some payments, agencies may be unable to determine a payment is proper or improper due to missing or insufficient documentation; in that case, the payment is deemed to be "unknown." *The Payment Integrity Information Act of 2019* (PIIA) requires federal agencies to review their programs and activities to identify programs that may be susceptible to significant improper payments (also called risk-susceptible programs). Programs identified as risk-susceptible must calculate improper payment estimates, establish reduction targets, and develop and implement corrective actions. HHS works to prevent, detect, and reduce improper payments through close review of our programs and activities using sound risk models, statistical estimates, and internal controls.

HHS has shown tremendous leadership in the improper payments arena. HHS has a robust improper payments estimation and reporting process that has been in place for many years and has taken many corrective actions to prevent, detect, and reduce improper payments in our programs. In accordance with the PIIA, HHS completed 43 improper payment risk assessments in FY 2022 and did not identify any additional risk-susceptible programs. In addition, HHS is publishing improper payment estimates and associated information for nine of the 13 risk susceptible programs in the FY 2022 AFR. Lastly, HHS uses the Do Not Pay portal to check payments and awardees to identify potential improper payments or ineligible recipients. In FY 2022, HHS screened more than $740.8 billion in Treasury-disbursed payments through the Do Not Pay portal. A detailed report of HHS's improper payment and fraud reduction activities and performance is presented in the "Other Information" section of this AFR, under "Payment Integrity Report."

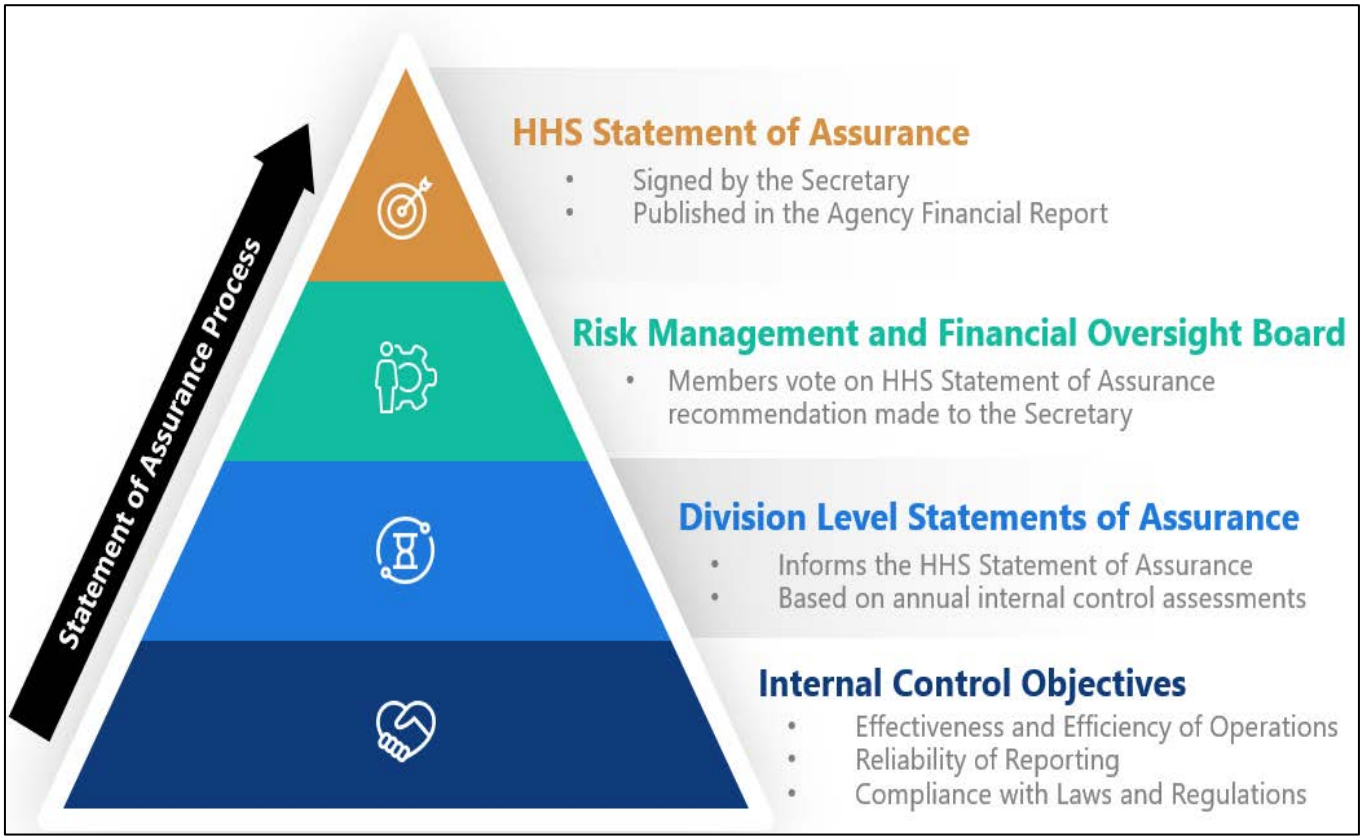
Internal Control

FMFIA requires agency heads to annually evaluate and report on internal control and financial systems that protect the integrity of federal programs. This evaluation aims to provide reasonable assurance that internal controls are achieving the objectives of effective and efficient operations, reliable reporting, and compliance with applicable laws and regulation. The safeguarding of assets is a subset of these objectives. HHS performs rigorous, risk-based evaluations of its internal controls in accordance with OMB Circular A-123, *Management's Responsibility for ERM and Internal Control*. HHS continues to make progress in maturing ERM activities and integrating internal controls.

OMB Circular A-123 provides implementation guidance on improving accountability and effectiveness of programs and operations by identifying and managing risks, and by establishing requirements to assess, update, and report on the effectiveness of internal controls. HHS aims to strengthen its internal control assessment and reporting process to better identify key risks, develop effective risk responses, and implement timely corrective actions. HHS's continuous communication and engagement with OpDivs and StaffDivs facilitates the assessment of existing internal control plans (including disaster-related internal control plans), and enhances current processes to provide reasonable assurance internal controls achieve management's objectives.

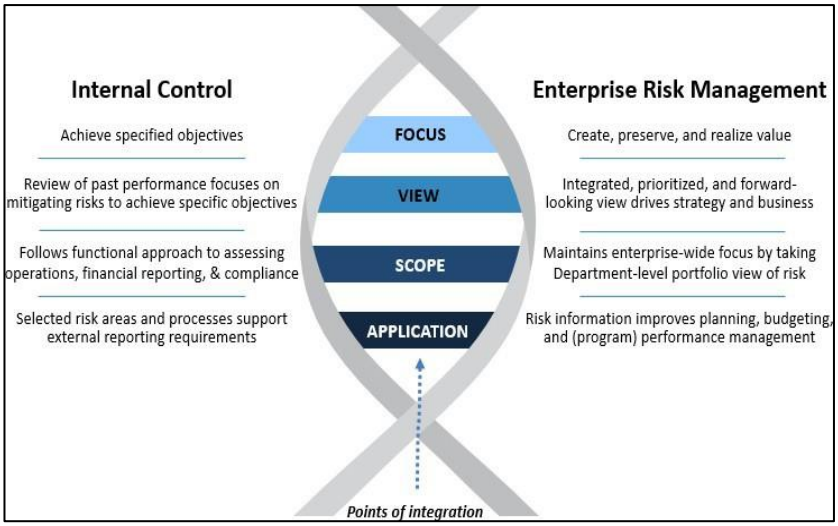
HHS management is directly responsible for establishing and maintaining effective internal controls. As part of this responsibility, management regularly assesses internal controls and executive leadership provides an annual assurance statement reporting on the effectiveness of those internal controls. The HHS Risk Management and Financial Oversight Board reviews assurances provided by OpDiv and StaffDiv management to form a Department-wide assurance recommendation for the Secretary's consideration, resulting in the Secretary's annual Statement of Assurance included in this Agency Financial Report, as illustrated in **Figure 21**.

Figure 21: Secretary's Annual Statement of Assurance Process



Enterprise Risk Management

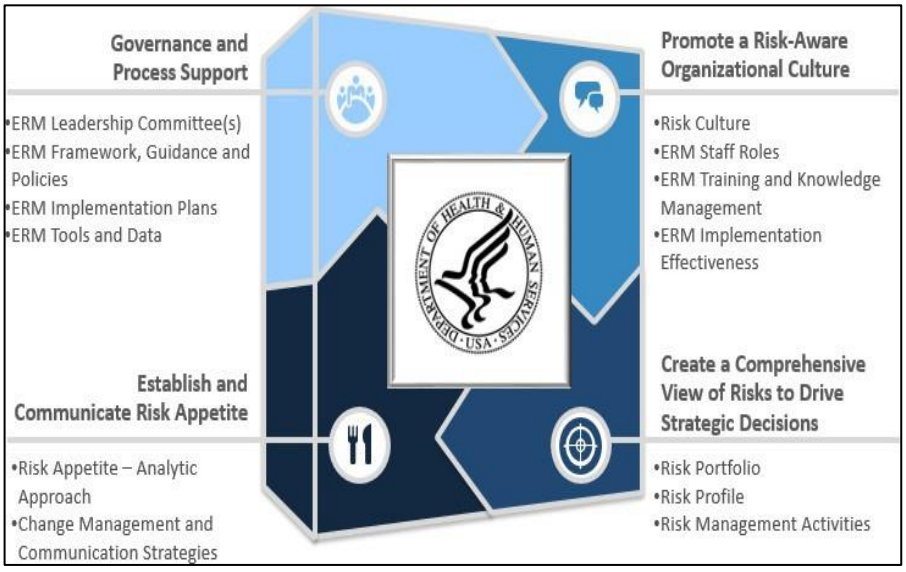
Figure 22: ERM and Internal Control are Integrated in HHS's Financial Management DNA



As required by the 2016 update to OMB Circular A-123, federal agencies must implement ERM to improve accountability and effectiveness of federal programs and mission support operations by identifying and managing risks to reduce or eliminate the potential for disruptive events. ERM is a strategic discipline that enables agencies to address the full spectrum of organizational risks. As illustrated in **Figure 22**, integrating ERM into Department, OpDiv, and StaffDiv operations improves HHS's ability to deliver on its mission of enhancing and protecting the health and well-being of all Americans. By incorporating ERM practices into daily operations, HHS enhanced its speed and agility in adapting to uncertainties that might otherwise impact its ability to execute the mission, achieve goals, and meet objectives.

HHS ASFR supports Department-wide ERM implementation through the HHS ERM Council, which consists of senior career executives across HHS's OpDivs and StaffDivs. The ERM Council was originally established in 2010 as the HHS Program Integrity Coordinating Council, to focus on program integrity risk management concerns. The Council expanded its focus in 2014 by adopting ERM to improve risk management efforts throughout the Department and formally updated its charter and name in 2016 to the ERM Council. The ERM Council provides an internal forum for sharing and coordinating Department-wide risk management efforts. HHS facilitates ERM implementation by: translating the Department-level ERM Framework displayed in **Figure 23** into operational steps; serving as an ERM resource and liaison for OpDivs and StaffDivs; developing and advising on ERM guidance, tools, and techniques that can be tailored by OpDivs and StaffDivs; and approaches to support Division-level ERM implementation. Working closely with OpDiv and StaffDiv ERM leads and subject matter experts, HHS supports implementation of a robust ERM culture and capabilities throughout the Department.

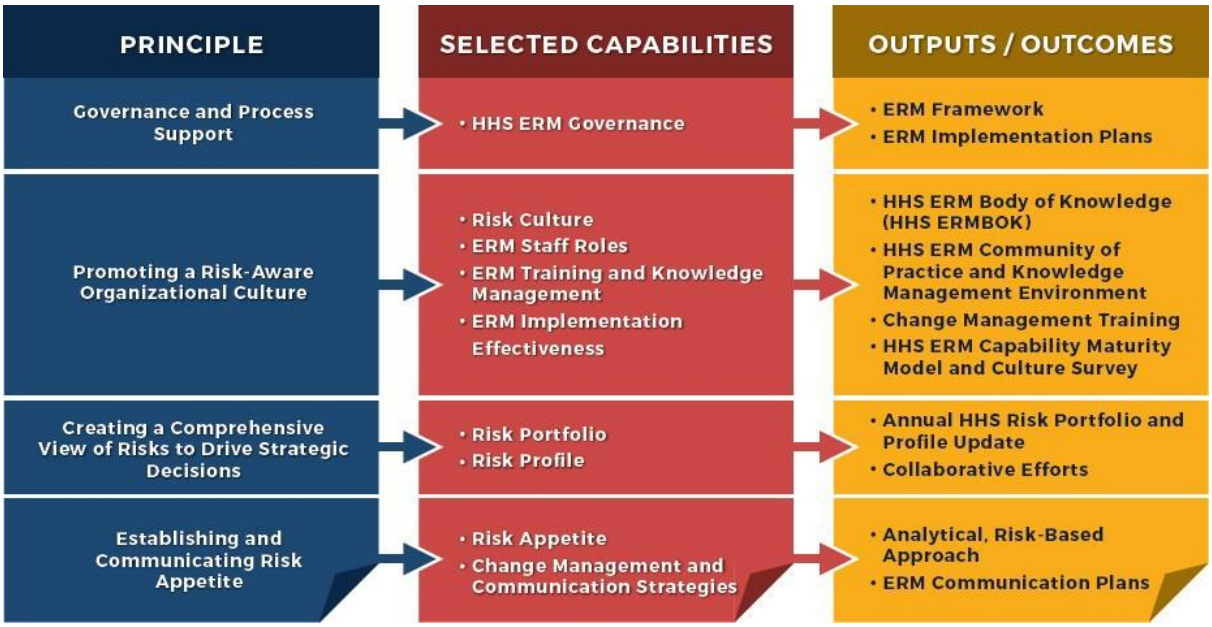
Figure 23: Principles-Based HHS ERM Framework and Capabilities



Systems, Legal Compliance, and Internal Control

The HHS ERM Framework in **Figure 23** outlines the principles-based approach and capabilities that HHS uses to implement and mature ERM. By focusing on principles and capabilities rather than an annual risk profile, HHS's ERM Framework offers flexibility for OpDivs and StaffDivs to manage the pace of change. OpDivs and StaffDivs are encouraged to tailor the ERM Framework to align with their diverse operating cultures and missions. This includes tailoring the portfolio of risks considered and applicable governance to oversee risk management activities. HHS ERM Principles-Based Framework translates selected capabilities into outputs and outcomes, as shown in **Figure 24.**

Figure 24: HHS ERM Principles-Based Framework Translates Capabilities into Outputs and Outcome



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Management Assurances

Statement of Assurance

THE SECRETARY OF HEALTH AND HUMAN SERVICES

WASHINGTON, D.C. 20201

The Department of Health and Human Services (HHS or the Department) management is responsible for managing risks and maintaining effective internal control to meet the objectives of the Federal Managers' Financial Integrity Act of 1982 (FMFIA). The FMFIA objectives are to ensure (1) effective and efficient operations; (2) reliable reporting; and (3) compliance with applicable laws and regulations. The safeguarding of assets is a subset of these objectives.

HHS 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, the Department provides reasonable assurance that internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2022, with the exception of material noncompliances with the *Payment Integrity Information Act of 2019 (PIIA)* and with the *Social Security Act*. HHS is taking corrective actions to address the noncompliances as described in the "Summary."

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 system requirements, federal accounting standards, and the United States Standard General Ledger at the transaction level. HHS conducted its evaluation of financial management systems compliance in accordance with OMB Circular A-123. Based on the results of this assessment, HHS provides reasonable assurance that its financial management systems substantially comply with the FFMIA and conform to the objectives of FMFIA.

HHS will continue to ensure accountability and transparency over the management of taxpayer dollars and to strengthen its system of internal control and financial management systems.

/Xavier Becerra/

Xavier Becerra
Secretary
November 14, 2022

Management Assurances

Summary

1. PIIA

HHS identified material noncompliances with PIIA resulting from the Department (a) not reporting improper payment estimates for the Temporary Assistance for Needy Families (TANF) and Foster Care programs; and (b) reporting improper payment estimates above the PIIA statutory threshold of 10 percent for Medicaid and the CHIP.

The PIIA noncompliances, status of corrective actions, and timelines for resolution are highlighted below and discussed in greater detail, along with other PIIA programs, in the "Payment Integrity Report".

TANF

The TANF program did not report an improper payment estimate due to statutory limitations precluding HHS from requiring states to provide the data needed to develop and report estimates. HHS identified the statutory limitations related to the state-administered TANF program in prior years and they continue to exist.

In the absence of state participation, HHS takes alternative actions and continues to explore options for developing an approach to measure and report improper payment estimates in the TANF program. In FY 2022, HHS completed a risk assessment of the TANF program and will use the results of the assessment to identify areas for risk mitigation.

Foster Care

The Foster Care program did not report improper payment estimates due to the COVID-19 pandemic. Beginning in FY 2020, HHS postponed onsite Foster Care reviews to protect the health and safety of state and federal reviewers. The continued postponement of the onsite reviews results in the Department having no new data to develop improper payment estimates. The Department anticipates resuming onsite reviews in calendar year 2023, enabling future reporting of Foster Care improper payment estimates.

Medicaid and CHIP

The Medicaid program and CHIP reported improper payment estimates above the PIIA statutory threshold of 10 percent.

HHS publishes quarterly scorecards for Medicaid and CHIP on PaymentAccuracy.gov that provide valuable insight into these programs' root causes of monetary losses, anticipated impacts, and related mitigation strategies. CMS and the Department consistently monitor these programs and the progress of corrective actions, key milestones, and recent accomplishments. Corrective actions to address improper payments in the Medicaid and CHIP programs include:

- Providing training, technical assistance, and support for Medicaid and CHIP programs to state program integrity officials via the Medicaid Integrity Institute. These efforts will help reduce common errors that lead to improper payments, especially for insufficient or inaccurate documentation.
- Working with states to implement robust state-specific corrective action plans to reduce future payment errors. This effort includes providing enhanced technical assistance and guidance to states.
- Expanding states and territories access to provider screening and enrollment data to ensure payments meet Medicaid provider screening and enrollment requirements.

2. Social Security Act

The *Social Security Act* establishes five levels to the Medicare appeals process: redetermination, reconsideration, Administrative Law Judge hearing, Medicare Appeals Council review, and judicial review in the U.S. District Court. Sections 1869(d)(1)(A) and 1869(d)(2)(A) of the *Social Security Act* contemplate that an Administrative Law Judge conducts a hearing and renders a decision within 90 days beginning on the date the request for hearing is filed. The Department identified material noncompliance at the Medicare Appeals Council review level with not meeting the statutory decisional timeframes for Medicare appeals.

The volume of pending appeals will prolong the Department's inability to meet the statutory 90-day decisional timeframes at the Medicare Appeal Council review phase of the Medicare appeals process. With current resources and ongoing administrative actions, it will take approximately 4 years to process the respective backlog and steadily meet decisional timeframes directed by statute. Corrective actions to remediate the current backlog at the Medicare Appeals Council include:

- Investing new resources to increase adjudication capacity;
- Taking administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process; and
- Proposing legislative reforms that provide additional funding and new authorities to address the appeals volume.

HHS has undertaken, and continues to explore, new administrative actions that are expected to have a favorable impact on the Medicare appeals backlog. With the new administrative actions and continued support in the FY 2023 President's Budget, HHS anticipates reducing the backlog and meeting the statutory decisional timeframes in approximately 4 years.

Financial Summary and Highlights

For the 24th consecutive year, HHS received an unmodified or "clean" audit opinion on the Consolidated Balance Sheets, Statements of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources, and related notes for the year ended September 30, 2022. HHS received a disclaimer on the Statement of Social Insurance, Statement of Changes in Social Insurance Amounts, and related notes, due to the uncertainty of the long-range assumptions. HHS takes pride in the preparation of the financial statements, yet it can sometimes be difficult to draw the relationships between the information in the statements and the overall performance of an agency. This section is presented as an interpretation of the principal financial statements, as well as selected notes to the principal financial statements. HHS presents these in the "Financial Section" of this report. Included in this analysis is a year-over-year summary of key financial balances, nature of significant changes, and highlights of key financial events to assist readers in establishing the relevance of the financial statements to the operations of HHS.

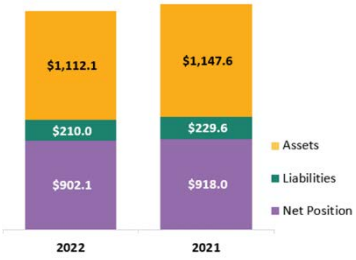
As a federal entity, HHS's financial position and activities are significant to the government-wide statements. Based on the *FY 2021 Financial Report of the U.S. Government*, HHS's net operating cost was larger than any single agency across the entire federal government[1]. A similar relationship exists within HHS, where the Department is significantly represented by one OpDiv, CMS. CMS alone consistently stewards the largest share of HHS's resources. Therefore, noteworthy changes in HHS balances are primarily related to fluctuations in CMS program activity.

Balance Sheets

To communicate performance for HHS at fiscal year-end, the Consolidated Balance Sheets show the resources available to HHS (Assets) and claims against those assets (Liabilities). The remainder represents the equity retained by HHS (Net Position). The table below summarizes the major components of the FY 2022 and FY 2021 year-end balances of HHS's assets available for use, the liabilities owed by HHS, and the equity retained by HHS.

Financial Conditions Summary
(In Billions)

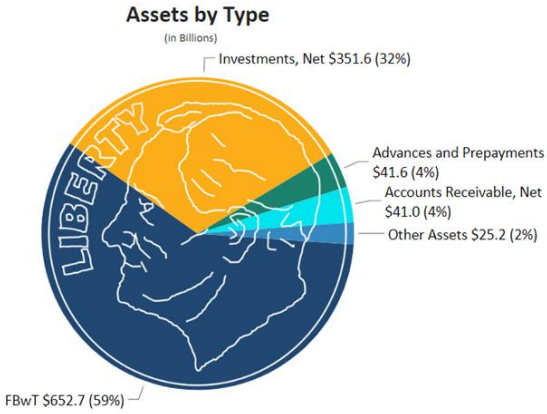
	2022	2021	$ Change (2022-2021)	% Change (2022-2021)
Fund Balance with Treasury	$ 652.7	$ 710.5	$ (57.8)	(8%)
Investments, Net	351.6	312.3	39.3	13%
Accounts Receivable, Net	41.0	29.4	11.6	39%
Advances and Prepayments	41.6	71.1	(29.5)	(41%)
Other Assets	25.2	24.3	0.9	4%
Total Assets	**$ 1,112.1**	**$ 1,147.6**	**$ (35.5)**	**(3%)**
Accounts Payable	$ 4.0	$ 4.7	$ (0.7)	(15%)
Debt	8.2	36.8	(28.6)	(78%)
Entitlement Benefits Due and Payable	141.2	133.8	7.4	6%
Accrued Liabilities	16.3	18.5	(2.2)	(12%)
Federal Employee and Veterans Benefits Payable	19.4	17.2	2.2	13%
Contingencies & Commitments	15.8	12.1	3.7	31%
Other Liabilities	5.1	6.5	(1.4)	(22%)
Total Liabilities	**$ 210.0**	**$ 229.6**	**$ (19.6)**	**(9%)**
Net Position	**$ 902.1**	**$ 918.0**	**$ (15.9)**	**(2%)**
Total Liabilities and Net Position	**$ 1,112.1**	**$ 1,147.6**	**$ (35.5)**	**(3%)**



[1] HHS's net cost is 21 percent of the federal government's total costs, Social Security Administration's net cost is 16 percent, Department of Defense's net cost is 12 percent, Treasury's net cost is 11 percent, and Department of Veterans Affairs' net cost is 9 percent. All remaining agencies combined only represent 30 percent. Source: *FY 2021 Financial Report of the U.S. Government*.

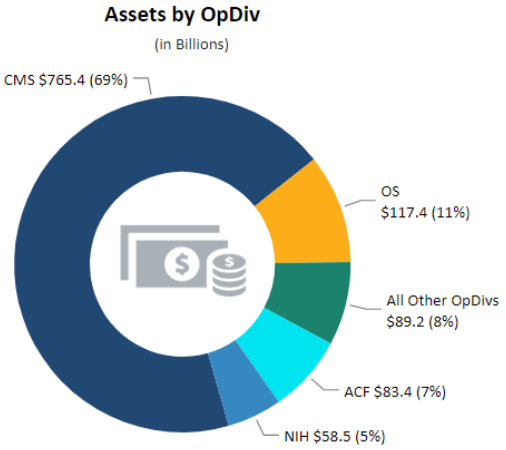
Financial Summary and Highlights

Assets The total assets for HHS were $1,112.1 billion at year-end, representing the value of what HHS owns and manages. This is a decrease of approximately $35.5 billion or 3 percent under September 30, 2021. Fund Balance with Treasury and Investments comprise $1,004.3 billion or 90 percent of HHS's total assets, and collectively decreased $18.5 billion or 2 percent.



Fund Balance with Treasury had a decrease of $57.8 billion or 8 percent under FY 2021, which is primarily due to the Public Health and Social Services Emergency Fund for COVID-19 relief and no additional supplemental funding received in FY 2022. These decreases are offset by increases in Supplementary Medical Insurance (SMI) due to the Payments to the Trust Funds allocations and CHIP due to grants not yet drawn by the states.

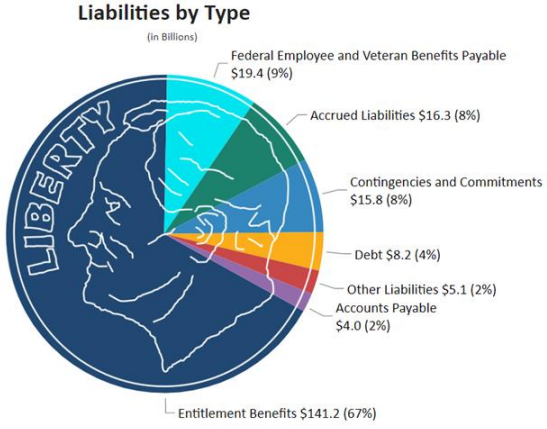
Advances and Prepayments had a decrease of $29.5 billion or 41 percent under FY 2021, which is primarily due to the collections of $61.8 billion and $4.0 billion reclass of COVID-19 Accelerated & Advance Payment (CAAP) advances to demanded receivables. These decreases are offset by the October 2022 Prescription Drug and Medicare Advantage benefit payments of $37.8 billion which occurred on September 30 instead of October 1.



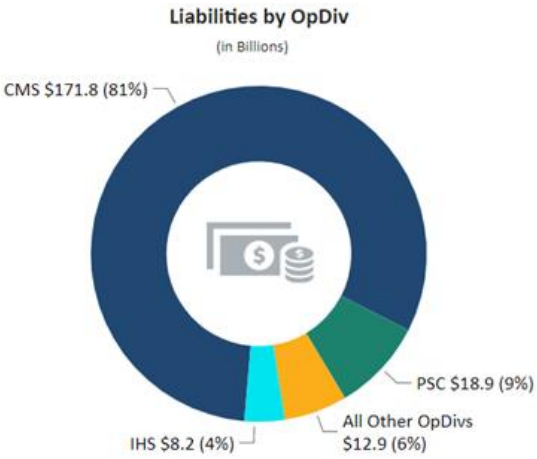
Investments had an increase of $39.3 billion or 13 percent over FY 2021, which is primarily due to higher tax collections for HI.

The HHS "Assets by OpDiv" chart shows asset distribution within HHS, excluding eliminations. The OpDiv asset balances ranged from $353 million at AHRQ (shown in All Other OpDivs) to $765.4 billion at CMS. CMS had the largest dollar increase of $74.6 billion or 11 percent primarily due to increases in Fund Balance with Treasury and Investments for HI, SMI, and CHIP offset by a decrease in Advances and Prepayments. OS had the largest percentage decrease of $88.2 billion or 43 percent primarily due to no FY 2022 COVID-19 funding.

Liabilities The total liabilities for HHS were $210.0 billion at year-end, representing the amounts HHS owes from past transactions or events. Liabilities had a decrease of approximately $19.6 billion or 9 percent under September 30, 2021.



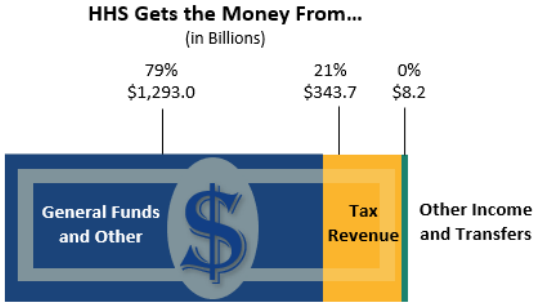
This is mainly attributed to decrease in Debt. Debt had a decrease of $28.6 billion or 78 percent under FY 2021, which is due to the repayment of FY 2021 SMI repayable advances to the Payments to the Trust Fund. This decrease is offset by increases in Entitlement Benefits Due and Payable and Contingencies and Commitments. Entitlement Benefits Due and Payable had an increase of $7.4 billion or 6 percent over FY 2021, which is due to an increase in medical services and claims incurred but not reported reflecting the impact of COVID-19. Contingencies and Commitments had an increase $3.7 billion or 31 percent over FY 2021, which is due to the Medicaid State Plan Amendment accrual.



The HHS "Liabilities by OpDiv" chart shows liability distribution within HHS, excluding eliminations. The OpDivs with the largest and smallest asset balances are also the OpDivs with the largest and smallest liabilities. With the majority share, CMS reports $171.8 billion or 81 percent of the HHS liabilities, while AHRQ (shown in All Other OpDivs) has liabilities of $16 million. CMS had the largest OpDiv dollar value decrease in liabilities under FY 2021 of $14.6 billion due to the decreases in Debt, offset by increases in Entitlement Benefits Due and Payable and Contingencies and Commitments as mentioned previously.

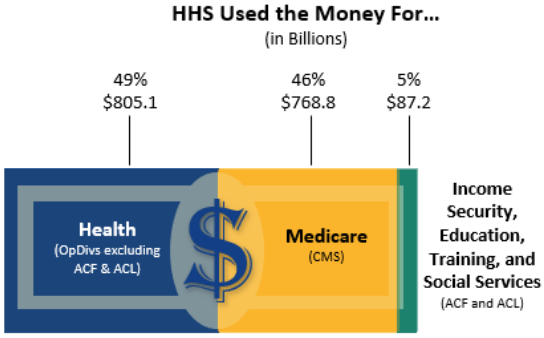
Statement of Changes in Net Position

The Statement of Changes in Net Position displays the activities affecting the difference between the beginning net position and ending net position, as shown on the HHS Consolidated Balance Sheets. This is also represented as the difference between assets and liabilities. Changes in assets are shown by identifying where HHS gets the money from, known as financing sources.



HHS receives the majority of the funding through Congressional appropriations and reimbursement for the provision of goods or services to other federal agencies. HHS's largest financing source, General Funds and Other, decreased $108.3 billion or 8 percent under FY 2021 and is primarily due to decreased COVID-19 funding in FY 2022. The fluctuations in tax revenue of $44.6 billion or 15 percent is related to higher *Federal Insurance Contribution Act* tax revenue due to the rise in wages as a result of employees returning to work post COVID-19 pandemic.

Statements of Net Cost



The Consolidated Statements of Net Cost represents how HHS spent the money. This can also be stated as the difference between the costs incurred by HHS's programs less associated revenues. The Net Cost of Operations for the year ended September 30, 2022, totaled approximately $1,660.8 billion. The "HHS Used the Money For …" chart shows consolidating costs by major budget function[2], which are the categories displayed in the Federal Budget. Most agencies have one or two budget functions, where HHS has many. HHS classifies costs by major budget functions such as Medicare, Health, Income Security, and Education, Training, and Social Services. This is shown on the Consolidating Statement of Net Cost by Budget Function in the "Other Information" section of this report. In FY 2022, total net costs for Health of $805.1 billion and Medicare of $768.8 billion account for 95 percent of HHS's annual net costs.

[2] Totals in the chart are exclusive of intra-HHS eliminations from the Consolidating Statement of Net Cost by Budget Function. This statement can be found in Section III, Other Information.

Financial Summary and Highlights

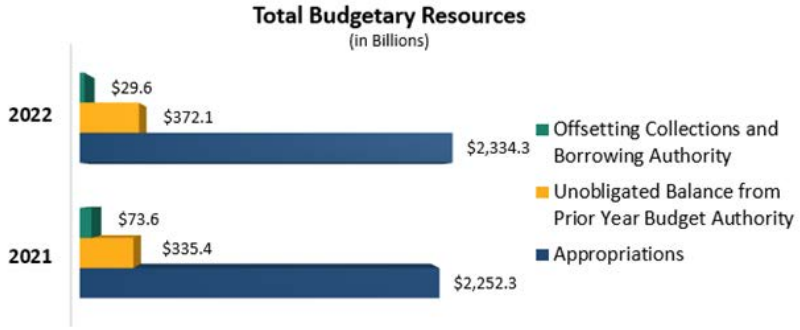
The table below presents FY 2022 Consolidated Net Cost of Operations, which breaks costs into Responsibility Segments between CMS and the remaining OpDivs in Other Segments. Net cost for CMS increased by $111.1 billion or 9 percent over FY 2021, which included increases in Medicaid and Medicare Hospital Insurance (HI) and SMI. Medicaid benefit expense increase of $66.4 billion from higher grant awards to the States due to the continuation of the COVID-19 relief and increase of $3.0 billion for contingent liability expenses for the State Plan Amendments and audit and program disallowances. SMI benefit expenses increased by $46.0 billion offset by $11.5 billion primarily for offsetting receipts from CAAP repayments. SMI revenue increased by $14.0 billion due to premiums for the aged and disabled. Medicare HI benefit expenses increased by $43.0 billion which is offset by $22.0 billion from CAAP repayments and $4.0 billion from the reclass of CAAP advances to demanded receivables. The increase in total Net Cost of Operations for the remaining HHS segments of $41.1 billion or 17 percent over FY 2021 is primarily due to the usage of the ARP appropriations.

Net Cost of Operations
(in Billions)

	2022	2021	$ Change (2022-2021)	% Change (2022-2021)
Responsibility Segments:				
CMS Gross Cost	$ 1,531.3	$ 1,404.9	$ 126.4	9%
CMS Earned Revenue	(148.2)	(132.9)	(15.3)	12%
CMS Net Cost of Operations	$ 1,383.1	$ 1,272.0	$ 111.1	9%
Other Segments:				
Other Segments Gross Cost	$ 284.7	$ 242.3	$ 42.4	17%
Other Segments Earned Revenue	(7.0)	(5.7)	(1.3)	23%
Other Segments Net Cost of Operations	$ 277.7	$ 236.6	$ 41.1	17%
Net Cost of Operations	**$ 1,660.8**	**$ 1,508.6**	**$ 152.2**	**10%**

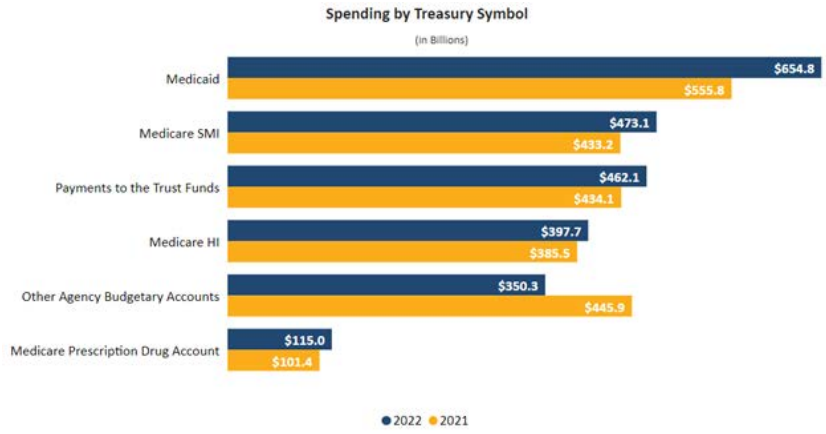
Statement of Budgetary Resources

The Combined Statement of Budgetary Resources displays the budgetary resources available to HHS throughout FY 2022 and FY 2021, and the status of those resources at the fiscal year-end. The primary components of HHS's resources, totaling approximately $2.7 trillion for FY 2022, are appropriations from Congress, resources not yet used from previous years (unobligated balances from prior year budget authority), and spending authority from offsetting collections and borrowing authority. FY 2022 Budgetary Resources has remained consistent with FY 2021. The following graph highlights trends in these balances over the past two fiscal years.



Schedule of Spending

HHS has elected to present the trends in spending in the audited notes to the principal financial statements titled, Combined Schedule of Spending. The chart illustrates spending as of September 30, 2022 and 2021 for the top five TAS. The remaining TAS are presented in Other Agency Budgetary Accounts.



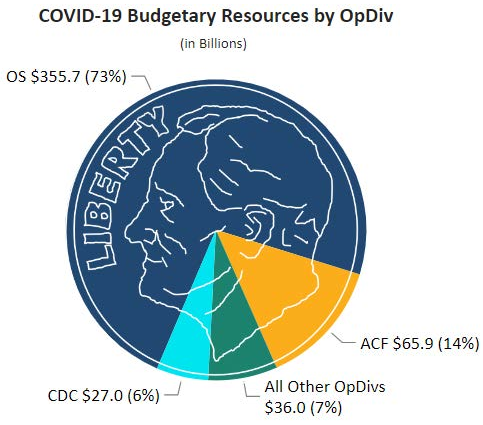
The New Obligations and Upward Adjustments line on the Combined Statement of Budgetary Resources is the same as Total Amounts Agreed to be Spent line on the Combined Schedule of Spending. Total obligations for FY 2022 were approximately $2.5 trillion or 4 percent increase over FY 2021.

The HHS's total spending is once again significantly represented by five of CMS's TAS (Medicaid, Medicare SMI, Payments to the Trust Funds, Medicare HI, and Medicare Prescription Drug Account) at 86 percent of HHS total obligations.

As the American public will see more clearly on the USAspending.gov website, the majority of HHS spending was made through Grants, Subsidies, and Contributions at $1.2 trillion or 49 percent. HHS is the largest grant-making agency in the federal government. Additionally, HHS has incurred obligations for Insurance Claims and Indemnities totaling $985.4 billion or 40 percent. HHS classifies obligations by items or services provided into categories known as object classes. For more information refer to Note 23, Combined Schedule of Spending in the "Financial Section" of this report.

COVID-19 Activities

In FY 2020, the CARES Act and three additional supplemental appropriations provided HHS with COVID-19 budgetary resources of $250.6 billion for response and recovery. Of this amount, $0.3 billion was transferred to the Department of Homeland Security. In FY 2021, *Coronavirus Response and Relief Supplemental Appropriations Act, 2021* and the ARP provided HHS $233.7 billion. In addition, ACF received additional funding through the *Coronavirus Response and Relief Supplemental Appropriations Act, 2021* to support the Low-Income Household Drinking Water and Wastewater Emergency Assistance Program of $0.6 billion. These resulted in net budgetary resources of $484.6 billion. The "COVID -19 Budgetary Resources by OpDiv" chart shows the amount of funding received by OpDiv. OS received $355.7 billion or 73 percent with the majority supporting the Provider Relief Fund, Strategic National Stockpile, and Biomedical Advanced Research and Development Authority.



As of September 30, 2022, HHS has obligated $450.5 billion to support efforts of which $333.3 billion has been outlayed. $34.2 billion remains available for future fiscal years in order to continue providing relief, testing, research, and other COVID-19 related activities. For more information refer to Note 24, COVID-19 Activities in the "Financial Section" of this report.

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 *2022 Annual Report of the Boards of Trustees of the Federal HI and Federal SMI 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-19 care declined significantly (compared to both actual 2019 spending and pre-pandemic expectations for 2020). Overall, the projections are based primarily on actual experience through 2019. However, program costs in 2020 and 2021 were used to help inform the development of adjustment factors by type of service, which account for the impact of COVID-19 through 2028. In spite of these substantial impacts on the Medicare program in 2020, the pandemic was not factored into the SOSI projections until 2021 because of the uncertainty of the impacts at the time the 2020 Trustees Report was released.

Spending for services other than COVID-19 was significantly lower than expected in 2020 and 2021. This decline was more pronounced for elective services. In addition, Medicare beneficiaries whose deaths were identified as related to COVID-19 had costs that were much higher than the average Medicare beneficiary prior to the onset of the pandemic. As a result, compared to the pre-pandemic Medicare population, the surviving Medicare population had lower morbidity, on average, reducing costs by an estimated 1.5 percent in 2020 and 2.9 percent in 2021. This morbidity effect is expected to continue over the next few years but is assumed to decrease over time before ending in 2028.

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 2028. 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 Program was significantly expanded during the COVID-19 public health emergency period. Total payments of approximately $107.2 billion were made from March 2020 through June 2021: roughly $67.1 billion from the HI trust fund and $40.1 billion from the SMI Part B trust fund account. The Trustees assumed that the accelerated and advance payments would be fully repaid by September of 2022, resulting in no net changes to trust fund expenditures. As discussed in Note 8, the majority of these accelerated and advance payments have been repaid as of September 30, 2022.

It should be noted that there is an unusually large degree of uncertainty with these COVID-19 related impacts and that future projections could change significantly as more information becomes available. Moreover, as a result of developments that have occurred since the assumptions for this year's Trustees Report were selected in mid-February 2022, uncertainty has increased regarding the path of the COVID-19 pandemic and the economy. The estimates do not reflect the potential impact of the IRA (Public Law 117-169), which was enacted on August 16, 2022. As of the date of the financial statements, there is still a considerable amount of uncertainty surrounding

these impacts and the projections have not been adjusted. The Trustees will continue to monitor developments and modify the projections in later reports as appropriate. The pandemic is an example of the inherent uncertainty in projecting healthcare 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 $(5.057) trillion, determined as of January 1, 2021, to $(5.094) trillion, determined as of January 1, 2022.

When the combined HI and SMI trust fund assets are included, the present value increases. As of January 1, 2022, the future cash flow for all current and future participants is $(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 $(14.2) 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 FY to the expenditures for the year. This ratio steadily dropped from 66 percent at the beginning of FY 2018 to 38 percent at the beginning of FY 2022.

Trust Fund Ratio Beginning of Fiscal Year[3]	
FY	HI
2022	38%
2021	40%
2020	50%
2019	63%
2018	66%

[3] 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 2022 Trustees Report indicate that the HI trust fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2022 Trustees Report, the HI trust fund ratio is estimated to remain at about the same level for a few years before decreasing for the rest of the projection period until the fund is depleted in calendar year 2028. Assets at the end of calendar year 2021 were $142.7 billion and after 2022 are expected to decrease steadily until depleted in 2028.

Long-Term Financing

The short-range outlook for the HI trust fund is slightly more favorable than what was projected last year. The trust fund ratio declines until the fund is depleted in 2028, two years later than projected in 2021. 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 90 percent in 2028 to 80 percent in 2046, and then to increase to about 93 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 2021 to about 2.2 by 2096. In addition, healthcare costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $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 (RSI): 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 $(47.5) 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 2021, SMI incurred expenditures were 2.4 percent of GDP. By 2096, SMI expenditures are projected to grow to 4.5 percent of the GDP.

Financial Challenges

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

The following table presents key amounts from CMS's basic financial statements for FY 2020 through 2022.

Table of Key Measures[4]
(in Billions)

	2022	2021	2020
Net Position (end of fiscal year)			
Assets	$ 765.4	$ 690.8	$ 590.1
Less Total Liabilities	171.9	186.4	133.4
Net Position (assets net of liabilities)	**$ 593.5**	**$ 504.4**	**$ 456.7**
Costs (end of fiscal year)			
Net Costs	$ 1,383.6	$ 1,272.4	$ 1,157.0
Total Financing Sources	1,430.4	1,285.0	1,189.5
Net Change in Cumulative Results of Operations	**$ 46.8**	**$ 12.7**	**$ 32.5**
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	$ (5,094)	$ (5,057)	$ (4,800)
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	$ (5,057)	$ (4,800)	$ (5,484)
Change in Present Value	**$ (37)**	**$ (257)**	**$ 683**

[4] 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, 2022, decreased by $98 billion due to advancing the valuation date by 1 year and including the additional year 2096, and decreased by $1,958 billion due to changes in economic and healthcare assumptions. However, changes in the projection base, demographic assumptions, and law increased the present value by $1,996, $18, and $5 billion, respectively. The net overall impact of these changes is a decrease in the present value of $37 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*), HHS 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 *2022 Annual Report of the Boards of Trustees of the Federal HI and Federal SMI Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

Limitation of the Principal Financial Statements

The principal financial statements in the "Financial Section" have been prepared to report HHS's financial position and results of operations, pursuant to the requirements of 31 U.S. Code §3515(b). Although the statements have been prepared from HHS's books and records in accordance with generally accepted accounting principles for federal entities and the formats prescribed by the OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records.

The statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing HHS with resources and budget authority.

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SECTION 2:
Financial Section

- Message from the Chief Financial Officer
- Report of the Independent Auditors
- Department's Response to the Report of the Independent Auditors
- Principal Financial Statements
- Notes to the Principal Financial Statements
- Required Supplementary Information

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Message from the Chief Financial Officer

I am honored to join Secretary Becerra in presenting the Department of Health and Human Services (HHS) Fiscal Year (FY) 2022 Agency Financial Report (AFR). HHS oversees one of the largest budgets in the world, managing one of every four dollars spent by the federal government.

This AFR presents our accountability in reporting and stewardship over taxpayer dollars for FY 2022. The Department's FY 2021 AFR was recently recognized for demonstrating excellence in all aspects of accountability and transparency by the AGA (formerly known as the Association of Government Accountants), receiving its ninth consecutive Certificate of Excellence in Accountability Reporting award.

During FY 2022, our HHS Chief Financial Officer (CFO) community took on new initiatives and achieved many key milestones in support of the HHS FY 2022-2026 Strategic Plan Goal 5 to "Advance Strategic Management to Build Trust, Transparency, and Accountability." We are dedicated to collaborating to improve Department-wide financial operations, reporting, and systems, with the overall goal of consistently strengthening internal controls, maintaining program integrity, and increasing data transparency. We are guided by the HHS CFO Community Strategic Plan for FY 2023-2027 that provides a framework for preparing for future challenges, managing risks, improving outcomes, and enabling mission delivery with three overarching goals:

- Promoting a workforce and financial management culture that readily adapts to
- a continuously changing environment;
- Using governance structures for effective strategic planning and decision making; and
- Providing superior financial management products and services.

For the 24th consecutive year, HHS obtained an unmodified, or "clean," opinion on our consolidated balance sheets, related consolidated statements of net costs and changes in net position and combined statement of budgetary resources. The auditors disclaimed providing an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts.

I want to thank our employees and our partners for their efforts and collaboration throughout the fiscal year. The achievements in this report reflect their tireless dedication to our mission and the American people. Together, we are striving to strengthen the Department's financial management capabilities and our stewardship of the resources entrusted to us.

/Robert Gordon/

Robert Gordon
Assistant Secretary for Financial Resources and Chief Financial Officer
November 14, 2022

Report of the Independent Auditors

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

November 14, 2022

TO: The Secretary

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

Digitally signed by AMY FRONTZ
Date: 2022.11.14 16:46:52 -05'00'

SUBJECT: *Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2022*, A-17-22-00001

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2022 financial statements, internal control over financial reporting, 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 HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP, to audit the HHS: (1) consolidated balance sheets as of September 30, 2022 and 2021, and the related consolidated statements of net cost and changes in net position; (2) the combined statements of budgetary resources for the years then ended; and (3) the sustainability statements that comprise the statement of social insurance as of January 1, 2022, and the 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 22-01, *Audit Requirements for Federal Financial Statements.*

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2022 HHS consolidated balance sheets and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. Ernst & Young was unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2022, 2021, 2020, 2019, and 2018, and the related statements of changes in social insurance amounts for the periods ended January 1, 2022 and 2021. As a result, Ernst & Young was not able to, and did not, express an opinion on the sustainability statements for the specified periods.

Ernst & Young also noted two matters involving internal controls with respect to financial reporting. Under the standards established by the American Institute of Certified Public Accountants and *Government Auditing Standards*, issued by the Comptroller General of the United States, Ernst & Young did not identify any deficiencies in internal control that it considered a material weakness. Ernst & Young noted improvements over internal controls but continued to identify two significant deficiencies related to HHS's Financial Reporting Systems, Analyses, and Oversight, and HHS's Financial Information Systems as described below:

- *Financial Reporting Systems, Analysis and Oversight*—During the FY 2022 audit, Ernst & Young noted that HHS made progress in addressing certain issues. However, the FY 2022 audit still identified a series of deficiencies in financial systems and processes for producing financial statements. Ernst & Young specifically described concerns about the number and dollar amount of non-standard journal entries, HHS procurement processes, improper payments, Entitlement Benefits Due and Payable (EBDP), Budgetary Accounting for the COVID-19 Advanced and Accelerated Payment Program, and the Statement of Social Insurance. Ernst & Young noted that a significant number of non-standard journal vouchers are needed to record entries that cannot be recorded through routine processing in HHS Financial Systems. These entries are needed to ensure accurate account balances, but Ernst & Young noted that their volume and dollar values comprise a significant portion of HHS's overall financial activity.

  Ernst & Young noted that HHS management and HHS OIG, over the past several years, have identified a series of: (1) concerns related to internal control and (2) violations of laws and regulations related to the procurement processes at both the HHS Department and Operating Division levels. Consistent with FY 2021, Ernst & Young identified concerns related to accounting and reporting of procurement activity within financial systems, noting for example that the National Institutes of Health (NIH) maintains two separate acquisition systems. These two acquisition systems are: (1) the NIH Business System (NBS) Purchase Request Information System (PRISM), which supports 26 NIH Institutes and Centers, and (2) the Contract Award & Management System (CAMS), which is a standalone system within the National Heart, Lung, and Blood Institute (NHLBI). NBS PRISM is fully integrated with NBS and provides stringent controls across acquisition and financial management. CAMS is not integrated and requires alternative methods and tools to transfer acquisitions data into NBS PRISM to interface with the NBS financial system. Ernst & Young noted that the use of two systems poses significant financial management risks and additional costs that would not exist if NHLBI operated within the NBS PRISM system. Ernst & Young also noted there appears to be no functional, operational, or cost benefits to maintaining a separate acquisition system that supports only one Institute.

  The nature and volume of HHS expenditures present a substantial challenge in the quantification, evaluation, and remediation of improper payments. During FY 2022, although progress was noted, HHS continued to identify challenges that prevented HHS from meeting certain monitoring requirements of its programs for improper payments. Ernst & Young noted HHS developed, executed, and reported improper payments estimates for nine of its 13 risk-susceptible programs. For the other four programs, HHS

indicated an estimate could not be achieved due to either statute limitations, COVID-19 precautions precluding conducting onsite reviews, or time and resource restraints. Management indicated that it is continuing its efforts to produce and report an estimate for each program deemed risk-susceptible in FY 2023. The Payment Integrity Information Act of 2019 (P.L. No. 116-117) requires each agency to perform a risk assessment not less frequently than once every three fiscal years for each program and activity that exceeds $10 million of all reported program or activity payments made during that fiscal year. HHS performed 43 program-specific risk assessments from the over 200 programs within the agency whose outlays exceeded $10 million. HHS indicated to Ernst & Young that it had limited resources to execute a full rotation of risk assessments in FY 2022 but would expand its assessment process to cover all programs whose outlays exceed $10 million within the next three years.

At the Centers for Medicare and Medicaid Services (CMS), health insurance claims represent the vast majority of the payments. CMS has developed sophisticated sampling processes for estimating improper payment rates for its risk-susceptible programs. The CMS risk-susceptible programs are: Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), Medicare Prescription Drugs (Part D), Medicaid, Advance Premium Tax Credit (APTC) and the Children Health Insurance Program (CHIP). CMS remains committed to achieving reductions in all improper payment rates through various corrective actions. CMS has specific initiatives underway to improve results for Medicaid and CHIP, programs that continue to report improper payment rates above the statutory threshold of 10 percent. While management continued to implement corrective actions to reduce the Medicare FFS improper payment rate, the rate increased from the prior year.

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 the Transformed Medicaid Statistical Information System 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 Medicaid EBDP accrual, which would determine the reasonableness of the various State calculations of the incurred but not reported liability, should be further developed. The Medicaid EBDP is a significant liability on the FY 2022 financial statements and is subject to volatility based on the complexity and judgment required in establishing this estimate. Also, the EBDP Accrual for the Medicare Program experienced unusual or large fluctuations within its estimates of cost report settlements that were not properly investigated and required an adjustment after they were further analyzed by management.

CMS established the COVID-19 Advanced and Accelerated Payment Program to help providers and suppliers experiencing cash flow concerns during the Public Health Emergency. Advances under this program were issued in FY 2020 and recoupment of these advances began in FY 2021. OMB previously granted CMS a waiver from requirements to report recoveries and refunds of prior year obligations as new budgetary

resources for the Medicare Program. Ernst & Young reported that CMS did not follow the budgetary accounting set forth in the OMB waiver for the recoupment of these funds.

Ernst & Young 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. Ernst & Young concluded that the control over the formula was not functioning as designed. These deficiencies collectively constitute a significant deficiency in internal control.

- *Financial Information Systems*—Ernst & Young noted that HHS had continued to make improvements over information technology (IT) controls within its financial systems. HHS has established a governance body over the systems that support financial reporting activities. This governance body has been providing the consistent guidance and remediation strategies for core and mixed financial systems. Progress has been made in remediating prior year issues associated with core financial systems for the Department, while consistent controls implementation for mixed systems is still in progress.

  Even with these improvements, Ernst & Young identified deficiencies related to controls over system access and information security that could affect HHS' financial reporting. Examples of these deficiencies include: (1) HHS did not consistently follow procedures for removing users who no longer require access; (2) HHS did not monitor or recertify access for key applications and underlying IT infrastructure or did not retain evidence of monitoring and recertification; and (3) there were insufficient controls over the segregation of duties, including documentation of all possible conflicts, identification of business justifications for conflicts, implementation of the necessary monitoring controls to mitigate known risks, and implementation of user access review controls to document waivers as appropriate.

  Ernst & Young also noted that deficiencies continue to be identified in implementing and monitoring controls, including controls over privileged access to CMS's information systems. The distributed nature of CMS's governance of third parties has resulted in the inconsistent application of oversight procedures for contractors with significant security responsibilities. These deficiencies collectively constitute a significant deficiency in internal control.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2022, HHS was not in full compliance with PIIA. As indicated previously, HHS has developed and reported improper payment rates for 9 of its 13 risk-susceptible programs. For the remaining four programs—the Temporary Assistance for Needy Families program, Foster Care, Head Start, and the COVID-19 Claims Reimbursement for the Uninsured Programs—HHS is working to address various challenges to enable it to develop and report an improper payment estimate for each program. Additionally, although HHS has calculated and reported an improper payment estimate for the federally-facilitated Exchange of the APTC program, it has not calculated and reported an improper payment estimate for the State-based Exchanges, which have been deemed susceptible to significant improper payments. Also, as stated previously, HHS reported two Medicaid and CHIP with error rates in excess of the statutorily required

maximum of 10 percent. CMS did not comply with PIIA, as recovery activities of the identified improper payments for the Part C and Medicare Part D programs were delayed. We will report further on agency compliance with improper payment reporting, as required by the PIIA, later in FY 2023.

HHS's management also determined that it may have potential violations of the Antideficiency Act (31 U.S.C. chapters 13 and 15) related to: (1) an obligation of funds for conference spending at the Food and Drug Administration as well as certain contract obligations at CMS that occurred in FYs 2014 and 2015 and at HHS's Program Support Center that occurred between FYs 2006 and 2011. HHS's management also determined that the agency's Medicare appeals process did not adjudicate appeals within the statutory timeframes required by the Social Security Act (P.L. No. 74-271). As discussed above, HHS identified potential violations with laws and regulations related to its acquisition processes. In FY 2020, CMS management was also notified that it may have potential violations of the Federal Acquisition Regulation related to contracting matters.

Evaluation and Monitoring of Audit Performance

We reviewed Ernst & Young's audit of the HHS 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 HHS 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 the HHS *FY 2022 Agency Financial Report*.

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

Page 6—The Secretary

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Carla J. Lewis, Assistant Inspector General for Audit Services, at (202) 834-5992 or Carla.Lewis@oig.hhs.gov. Please refer to report number A-17-22-00001.

Attachment

cc:
Robert Gordon
Assistant Secretary for Financial Resources

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

Building a better working world

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Report of Independent Auditors

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of the U.S. Department of Health and Human Services (HHS), which comprise the consolidated balance sheets as of September 30, 2022 and 2021, and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources for the years then ended, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of HHS at September 30, 2022 and 2021 and the results of its net cost of operations, its changes in net position and its budgetary resources for the years then ended in accordance with accounting principles generally accepted in the United States of America.

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

We were also engaged to audit the sustainability financial statements of HHS, which comprise the statement of social insurance as of January 1, 2022, 2021, 2020, 2019 and 2018, and the related statement of changes in social insurance amounts for the periods ended January 1, 2022 and 2021, and the related notes (collectively referred to as the "sustainability financial statements").

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

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS), in accordance with the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States (*Government Auditing Standards*), and in accordance with the provisions of Office of Management and Budget (OMB) Bulletin No. 22-01, *Audit Requirements for Federal Financial Statements*. Our responsibilities under those standards and the provisions of OMB Bulletin No. 22-01 are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of HHS and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2022 and 2021, and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources for the years then ended.

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

As discussed in Note 26 to the financial statements, the statement of social insurance presents the actuarial present value of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from, or on behalf of, the participants and estimated future expenditures to be paid to, or on behalf of, participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. The sustainability financial statements are intended to aid users in assessing whether future resources will likely be sufficient to sustain public services and to meet obligations as they come due. The statement of social insurance and the related statement of changes in social insurance amounts are based on income and benefit formulas in current law and assume that scheduled benefits will continue after any related trust funds are exhausted. The sustainability financial statements are not forecasts or predictions. The sustainability financial statements are not intended to imply that current policy or law is sustainable. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

As further described in Note 27 to the financial statements, with respect to the estimates for the social insurance program presented as of January 1, 2022, 2021, 2020, 2019 and 2018, the current-law expenditure projections reflect the physicians' payment levels expected under the MACRA payment rules and the ACA-mandated reductions in other Medicare payment rates. Management has developed an illustrative alternative scenario and projections, using certain alternative payment provisions, intended to quantify the potential understatement of projected Medicare costs in future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 27, certain features of current law may result in some challenges for the Medicare program. Should payment rates prove to be inadequate for any service, beneficiaries' access to, and the quality of, Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law in this report. 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 matters, we were unable to obtain sufficient audit evidence for the amounts presented in the statement of social insurance as of January 1, 2022, 2021, 2020, 2019 and 2018 and the related statement of changes in social insurance amounts for the periods ended January 1, 2022 and 2021.

Responsibilities of Management for the Financial Statements

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

Auditor's Responsibilities for the Audit of the Financial Statements

Except as described in the Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts section of our report, our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* and the provisions of OMB Bulletin No. 22-01 will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards* and the provisions of OMB Bulletin No. 22-01, we:

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

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

Required Supplementary Information

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

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

Other Financial Information

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

Other Information

Management is responsible for the other information included in the agency financial report. The other information comprises the Message from the Secretary, About the Agency Financial Report, Message from the Chief Financial Officer, Summary of Financial Statement Audit and Management Assurances, Civil Monetary Penalty Adjustment for Inflation, Grants Closeout Reporting, Payment Integrity Report, FY 2022 Top Management and Performance Challenges Identified by the Office of Inspector General, Department's Response to the Office of Inspector General, and Section 4: Appendices, as identified on HHS's Agency Financial Report's Table of Contents, but does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information, and we do not express an opinion or any form of assurance thereon.

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

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Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our reports dated November 14, 2022, on our consideration of HHS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, and other matters. The purpose of 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 HHS's 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 HHS's internal control over financial reporting and compliance.

Ernst & Young LLP

November 14, 2022

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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 Secretary and the Inspector General of
the U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*) and the provisions of Office of Management and Budget (OMB) Bulletin No. 22-01, *Audit Requirements for Federal Financial Statements*, the financial statements of the U.S. Department of Health and Human Services (HHS), which comprise the consolidated balance sheet as of September 30, 2022, and the related consolidated statements of net cost and changes in net position and the combined statement of budgetary resources for the fiscal year then ended, and the related notes (collectively referred to as the "financial statements"), and we were engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2022, and the related statement of changes in social insurance amounts for the period ended January 1, 2022, and the related notes (collectively referred to as the "sustainability financial statements"), and have issued our report thereon dated November 14, 2022. Our report disclaims an opinion on the sustainability financial statements because of the significance of the matters described in the Basis for Disclaimer of Opinion section of our Report of Independent Auditors, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on these statements.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered HHS's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of HHS's internal control. Accordingly, we do not express an opinion on the effectiveness of HHS's 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 deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

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

Significant Deficiencies

Financial Reporting Systems, Analysis and Oversight

Although progress in certain areas has been identified, our review of internal control disclosed a series of deficiencies in financial systems and processes for producing financial statements, including the need for a number of non-standard journal entries to significantly adjust financial and budgetary amounts, and/or insufficient analysis and oversight of certain significant accounts, balances, or programs. We identified the following items in the current year's audit that indicate additional improvements in the financial reporting systems and processes are required.

Non-standard Journal Voucher Processes

HHS posts a significant number of non-standard journal vouchers to record entries that are unable to be recorded through routine systematic processing. During FY 2022, HHS was required to process 9,695 non-standard journal vouchers to its NIH Business System (NBS) or Unified Financial Management Systems (UFMS), compared to 7,294 recorded in FY 2021. Additionally, although the National Institutes of Health (NIH) reduced the amount of non-standard journal vouchers from $229 billion in FY 2021 to $24 billion in FY 2022, we noted individual increases at the four remaining HHS accounting centers between FY 2021 and FY 2022. These entries consist of non-standard postings to record both the proprietary and budgetary effects of certain financial activities for which either the financial system is not configured properly to post automatically or to post differences identified during the various reconciliations or analyses performed by HHS personnel. Although necessary to ensure that balances are accurate, the volume and dollar value of manual entries is significant compared with the HHS's overall activity.

HHS Procurement Processes

Over the past several years, HHS and our audit have identified several concerns related to internal control and potential violations of laws and regulations related to its procurement processes at both HHS and Operating Division Levels. We have reported that HHS identified a series of potential violations to the *Antideficiency Act* within our accompanying Report on Compliance and Other Matters.

Consistent with FY 2021, HHS and our audit identified certain concerns related to accounting and reporting of procurement activities within its financial systems. For example: the NIH currently leverages two separate Purchase Request Information Systems Management (PRISM) for their acquisition information management, including one that is not integrated with the NIH's NBS. While the NIH NBS PRISM supports 26 NIH Institutes and Centers (IC), the Contract Award Management System (CAMS) is a stand-alone PRISM within the National Heart, Lung, and Blood Institute (NHLBI). The NBS PRISM is fully integrated with the NBS financial system and provides stringent controls across acquisition and financial management. The CAMS is not integrated and requires alternative methods and tools to transfer acquisitions data into NBS PRISM to interface with the NBS financial system. The dependency on non-integrated third-party applications to transfer acquisitions data poses significant financial management and information security risks and increases the level of effort required to reconcile data between the two acquisition systems. There are also significant costs associated with procuring and maintaining two PRISMs. These increased risks and additional costs would be non-existent if NHLBI operated within the NBS PRISM. Additionally, there appear to be no functional, operational, or cost benefits to maintaining a separate PRISM that supports only one institute.

Payment Integrity

The nature and volume of its expenditures present a substantial challenge to HHS in the quantification, evaluation, and remediation of improper payments. To address the challenge, HHS has developed a series of processes throughout the agency to monitor, investigate, estimate, and report on improper payments. These processes include: (1) identifying risk-susceptible programs through an annual risk assessment process, (2) estimating and reporting on improper payment rates for those programs which are deemed risk-susceptible, (3) developing corrective actions to remediate causes which result in improper payments, and (4) executing recovery activities where improper payments are significant. During FY 2022, although continued progress was noted, HHS continued to identify challenges that prevented HHS from meeting certain monitoring requirements of its programs for improper payments. For example:

- HHS developed, executed, and reported improper payments estimates for nine of its 13 risk-susceptible programs. HHS noted that for four programs, an estimate could not be achieved due to either statutory limitations, COVID-19 precautions precluding conducting on-site reviews, or time and resource restraints. Management indicated that it is continuing its efforts to produce and report an estimate for each program deemed risk-susceptible in FY 2023.

- During FY 2022, HHS performed 43 program-specific risk assessments from the over 200 programs within the agency whose outlays exceeded $10 million. A properly executed risk assessment process with appropriate criteria will assist management in focusing limited resources on those programs that are at a higher risk of having significant improper payments. As only 43 programs were assessed, knowledge about potential susceptibility to

significant improper payments may not be fully realized. The *Payment Integrity Information Act of 2019* requires each agency to perform a risk assessment not less frequently than once every three fiscal years for each program and activity that exceeds $10 million of all reported program or activity payments made during that fiscal year. HHS indicated that it had limited resources to execute a full rotation of risk assessments in FY 2022 but would expand its assessment process to cover all programs whose outlays exceed $10 million within the next three years.

For the Centers for Medicare & Medicaid Services (CMS), 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 risk-susceptible programs of Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), Medicare Prescription Drugs (Part D), Medicaid, CHIP and the Advance Premium Tax Credit (APTC).

CMS remains committed to achieving reductions in all improper payment rates through various corrective actions. CMS has specific initiatives underway to improve results for Medicaid and CHIP, the programs that continue to report improper payment rates above the statutory threshold of 10 percent. While management continued to implement corrective actions to reduce the Medicare FFS improper payment rate, the rate increased from the prior year.

CMS Oversight Processes

We performed a separate audit of the financial statements of CMS and reported on the results of our audit, including a report on its internal controls, dated November 7, 2022. In that report, we outlined details of deficiencies noted and made recommendations for improvement in its financial management controls. Consistent with our findings in the previous year, we concluded that the aggregation of these deficiencies to be a significant deficiency for the CMS internal control over financial reporting.

The most significant of those deficiencies fell within the oversight of the CMS's Medicaid and Medicare Entitlement Benefits Due and Payable, Budgetary Accounting for Recovery and Receipts, and the Statements of Social Insurance.

Entitlement Benefits Due and Payable (EBDP)

Medicaid Entitlement Benefits Due and Payable (EBDP)

The Medicaid program is the primary source of medical assistance for low-income Americans. Medicaid operates as a partnership between the states and the Federal government. The Federal government establishes the minimum requirements and provides oversight for the program and the

states design, implement, administer, and oversee their own Medicaid programs within the Federal parameters.

CMS previously completed implementation of the Transformed-Medicaid Statistical Information System (T-MSIS). The 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 the 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 that 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 2022 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 the CMS's analysis will not be reflected in the CMS's financial statements in a timely manner.

Medicare Entitlement Benefits Due and Payable (EBDP)

The estimate of retroactive settlements of cost reports is a portion of the EBDP liability for the Medicare program. This estimate includes amounts which may be due from or owed to providers for previous years' cost report for disproportionate share hospitals and teaching hospitals, as well as amounts which may be due/owed to hospitals for adjusted prospective payments. During our procedures, we identified fluctuations in the cost report accrual which were not properly investigated by management. Upon further investigation, adjustments to the accrual were necessary to properly state the accurate EBDP for these cost reports. When unusual changes are identified in the resulting data used for the estimate or a large fluctuation is identified in the output of the actuarial calculation, for which the actuaries do not have a thorough understanding, further investigation should be performed and documented prior to finalizing the EBDP estimate.

Budgetary Accounting for the Recoveries and Refunds for COVID-19 Advanced and Accelerated Payment Program

During fiscal year 2020, CMS established the COVID-19 Advanced and Accelerated Payment (CAAP) program to help providers and suppliers experiencing cash flow concerns during the Public Health Emergency. Most of these advances were issued during fiscal year 2020, and recoupment began in fiscal year 2021. OMB had previously granted CMS a waiver from the OMB Circular No. A-11, *Preparation, Submission and Execution of the Budget,* requirement to report

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the recoveries and refunds of prior year obligations as new budgetary resources for the Medicare program. While accounting for these recoupments within the proprietary financial statements (balance sheets) was handled appropriately, it was discovered in the current year that CMS did not follow the proper budgetary accounting treatment within the statement of budgetary resources set forth by this waiver for the recoupment of these advances. The related control to review the accounting for the significant activity of recoupments was not designed or operated effectively to prevent or detect this error in a timely manner.

Statements of Social Insurance

The Statements of Social Insurance (SOSI) for CMS present 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 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 the CMS's policies and procedures. As part of this review, the input into the spreadsheet is checked against the original data sources to ensure that no input errors have been made. In addition, output data, including those that are generated from updating and running any macro in the spreadsheet, are checked by the reviewer. These checks include a comparison to the results from the year before and testing of the formulas that are part of the spreadsheet or macro, to ensure that the projection output from the program is as expected and reasonable. During our procedures, formula errors and input errors of source information 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.

Recommendations

We recommend that HHS continue to develop, refine, and adhere to its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. This will require focused efforts and continued prioritization of issues related to controls within and surrounding its financial information management systems. Specifically, we recommend the following:

- For non-standard journal processes, we recommend that HHS continue to focus on automating and reducing the number of non-standard journal vouchers by determining the cause and the ability to upgrade systems to allow for automated posting of high-volume routine transactions and to ensure financial data is accurate. Additionally, we recommend that HHS strengthen its controls around its manual journal entry process or reinforce its controls through training of personnel to ensure that control processes are operating effectively.

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- HHS should continue to strengthen its processes and accounting related to acquisition activities. As potential internal control and law and regulation concerns are identified, we recommend that policies and procedures are updated with training provided to the acquisition personnel to provide assurances that processes are executed properly. Further, we recommend that the ongoing monitoring process be enhanced to provide stronger internal controls so that anomalies can be prevented or identified in a timely manner. Finally, we recommend that NIH consider transitioning to a single PRISM instance. Operating a stand-alone, non-integrated PRISM system poses significant risks and does not provide any cost benefit. In addition, maintaining a fully integrated acquisition system for 26 NIH ICs, and then procuring and maintaining a second acquisition system for only one component of NIH, raises questions about responsible stewardship of resources to administer acquisition activities at NIH.

- HHS should continue to enhance its monitoring of its programs for improper payments according to the required thresholds and consistent with the organization's objectives of improving payment accuracy levels. This will entail expanding risk assessments to additional programs above the $10 million threshold, developing estimation models for those programs where improper payment rates have not been developed and reported, and further identifying actions to reduce improper payments in programs for which rates exceed 10%.

- 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. This would include having CMS:

    - 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 this liability.

    - Re-evaluate the procedures performed around the completeness and accuracy used in the cost report accrual supporting the Medicare EBDP calculation. When unusual changes are identified in the data used for the estimate or a large fluctuation is identified in the output of the calculation, for which management does not have a thorough understanding, further investigation should be performed and documented prior to finalizing the estimate.

    - Enhance the design of control attributes around the accounting for unique accounting transactions. This may include maintaining a centralized listing of guidance and waivers relevant to the recording of accounting transactions and the

preparation of financial statements. Additional training of personnel should also be conducted.

- 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.

Financial Information Systems

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 the HHS's operations, usage of core and mixed systems for financial reporting, and leveraging multiple platforms for hosting significant financial applications, including public clouds, private clouds, on-premise data centers and contractor co-located data centers, present a multitude of risks that need to be addressed and managed in a consistent manner from the top down.

HHS has taken the steps necessary to implement a governance body over the systems that support financial reporting activities. This governance body has been providing the guidance and risk management oversight for internal controls over financial systems, including remediation strategies for core and mixed financial systems. As a result, progress has been made in remediating prior year issues associated with core financial systems for HHS, while consistent controls implementation for mixed systems is still in progress.

In addition to the financial statement audit for non-CMS systems, we have performed a separate financial statement audit of the CMS for FY 2022 and in conjunction with our reports on that audit have provided recommendations specific to the CMS on our information technology (IT) internal control findings. Those findings and recommendations were considered in our overall HHS conclusions and are summarized below.

As HHS 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 Configuration Controls

HHS has a large number of users requiring access to HHS systems in order to process and record financial transactions. Accordingly, properly implemented system access controls, including user and system account management, segregation of duties and monitoring of system access, are critical to preventing and detecting unauthorized usage of information resources and program and data files. Additionally, information systems security configuration controls are vital to safeguard the confidentiality, integrity, and availability of data.

Deficiencies continued to be identified in the implementation and monitoring of controls, including controls over privileged access reviews. Examples identified for individual systems include:

- Procedures for the removal of users who no longer required logical access were not consistently followed.
- Monitoring and/or recertification of access for key applications and underlying IT infrastructure was not performed, or evidence of such monitoring or recertification activity was not retained.
- Insufficient controls over segregation of duties were identified at the various areas for different systems, including the documentation of all possible Segregation of Duties (SOD) conflicts on an approved matrix, identifying business justifications for all existing conflicts, implementing the necessary monitoring controls to mitigate known SOD risks, or implementing user access review controls to documenting waivers as appropriate.

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 CMS systems and monitoring of information systems security configuration controls, the risk of errors, fraud or other illegal acts is increased.

Governance over CMS Implementation of Third-Party Information Security Controls

As a part of our procedures for the FY 2022 CMS financial statement audit, we noted the distributed nature of the CMS's governance of third parties has resulted in the inconsistent application of oversight procedures for contractors with significant security responsibilities in the CMS Information Security Program. This has resulted in the identification of control deficiencies stemming from inadequate implementation of controls related to logical and physical access, and system configuration. Deficiencies related to the performance of these controls by third parties were also consistently noted in the results of management's internal assessment/OMB A-123 and various HHS OIG audit reports. Commonality in the 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 controls. Specifically:

- The CMS's security configuration management policy was not fully implemented and has resulted in several vulnerabilities related to system configurations with 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.

- Logical and physical access control procedures related to the timely removal of access for terminated personnel supporting CMS were not followed at contractor operated systems and facilities.

Deficiencies related to the performance of these controls by third parties were also consistently noted in the results of the CMS management's internal assessment (OMB A-123) and various HHS OIG audit reports. Commonality in the control deficiencies across the business units indicates monitoring and oversight is an enterprise level risk for which standardized processes should be developed in order for common controls to be implemented in the varying IT environments. Without sufficient and consistent third-party oversight and monitoring for compliance with its established information security control 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

HHS should continue to improve the operating effectiveness of information security controls including access controls and configuration management, to validate that:

- HHS and CMS policies are followed for the removal of users to all systems/facilities and security configurations.

- Privileged access for key CMS applications and the underlying IT infrastructure is in accordance with the principle of least privileged and monitored to detect and correct unauthorized access or activities. Additionally, evidence of such monitoring activities should be retained.

- User access reviews are being performed by HHS system teams timely and by appropriate personnel with the requisite knowledge and experience of the employee access requirements and necessary system functionality.

- System segregation of duty controls are implemented fully as defined by system specific implementation plans.

- Full implementation of the baseline configuration management monitoring process to include formal risk acceptance of vulnerabilities that cannot be remediated within CMS management's expected time frame.

Specific to the governance over implementation of information systems controls standards and processes at the CMS, we recommend that the CMS continually assess the governance and oversight across its organizational units charged with responsibility for the information security of its systems and data at both its Headquarters and the CMS FFS Medicare Administrative Contractor contractors. As such, an approach will require continued and active communication and

integration of efforts by the Office of Financial Management (OFM), Office of Information Technology (OIT) and the Center for Medicare (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 the CMS information systems. Examples of such processes that should be improved include:

- Enhanced risk management procedures and practices 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 timely remediation of deficiencies identified as a part of OIG and HHS's assessments and OMB A-123 audits, including tests performed on the CMS and its Medicare contractors' IT operations, is performed timely.

HHS's Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on the HHS's response to the findings identified in our audit and described in the accompanying letter dated November 14, 2022. HHS's response was not subjected to the other auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and 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.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 14, 2022, on our tests of HHS's compliance with certain provisions of laws, regulations, contracts and grant agreements, and other matters. The purpose of that report is solely to describe the scope of our testing of compliance and the results of that testing, and not to provide an opinion on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's compliance.

Ernst & Young LLP

November 14, 2022

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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 Secretary and Inspector General of
the U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*) and the provisions of Office of Management and Budget (OMB) Bulletin No. 22-01, *Audit Requirements for Federal Financial Statements*, the financial statements of the U.S. Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2022, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal year then ended, and the related notes (collectively referred to as the "financial statements"), and we were engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2022, and the related statement of changes in social insurance amounts for the period ended January 1, 2022, and the related notes (collectively referred to as the "sustainability financial statements"), and have issued our report thereon dated November 14, 2022. Our report disclaims an opinion on the sustainability financial statements because of the significance of the matters described in the Basis for Disclaimer of Opinion section of our Report of Independent Auditors, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on these statements.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether HHS's 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). However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and the provisions of OMB Bulletin No. 22-01, as described below:

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During prior fiscal years, HHS's management determined that it may have potential violations of the *Antideficiency Act* (31 U.S.C. chapters 13 and 15) related to (1) an obligation of funds for conference spending at the Food and Drug Administration and (2) certain contract obligations serviced by the Program Support Center (PSC) between FY 2006 and FY 2011 and the Centers for Medicare & Medicaid Services (CMS) occurring between FY 2014 and FY 2015. Additionally, CMS and PSC management were notified that it may have potential violations of the Federal Acquisition Regulation related to contracting matters. These potential violations are still being evaluated. Finally, HHS management determined that its Medicare appeals process did not adjudicate appeals within the statutory decisional time frames required by the *Social Security Act*.

The *Payment Integrity Information Act of 2019 (P.L. 116-117)* (hereinafter, the "Act") (1) requires federal agencies to identify programs and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments for risk-susceptible programs, and (2) establish certain reporting requirements surrounding such programs and their related estimates. While the Department continues to make progress, HHS is not in full compliance with the requirements of the Act. For example: HHS has not performed risk assessments for all programs that exceed $10 million in annual outlays during the past three years, as defined within the Act.

Additionally, HHS has developed and reported improper payments for nine of its 13 risk-susceptible programs. For the remaining four programs, including its Temporary Assistance for Needy Families (TANF) program, Foster Care program, Head Start program, and the COVID-19 Uninsured Program, HHS is working to address various challenges to enable it to develop and report an improper payment estimate for each of its risk-susceptible programs. Additionally, although HHS has calculated and reported an improper payment estimate for the Federally facilitated exchange of the Advance Premium Tax Credit (APTC) program, it has not calculated and reported an improper payment estimate for the state-based exchanges. HHS indicated that it will continue to develop the improper payment measurement methodology for the state-based exchanges. Further, although HHS reported improper payment rates for Medicaid and CHIP, the two programs' improper payment rates exceeded the statutorily required maximum of 10 percent. Finally, HHS is not in full compliance with the Act as recovery activities of the identified improper payments for Medicare Part C and Medicare Part D program are delayed.

Under FFMIA, we are required to report whether HHS's financial management systems substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA Section 803 (a) requirements. The results of our tests disclosed no instances in which HHS's financial management systems did not substantially comply with requirements as discussed above.

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HHS's Response to Findings

Government Auditing Standards require the auditor to perform limited procedures on HHS's response to the findings identified in our audit and described in the accompanying letter dated November 14, 2022. HHS's response was not subjected to the other auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of 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.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated November 14, 2022 on our consideration of HHS's internal control over financial reporting. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and the results of that testing, and not to provide an opinion on the effectiveness of HHS's internal control over financial reporting. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's internal control over financial reporting.

Ernst & Young LLP

November 14, 2022

Department's Response to the Report of the Independent Auditors

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Office of the Assistant Secretary for
Financial Resources
Washington, D.C. 20201

To: Christi A. Grimm, Inspector General

From: Robert Gordon, Assistant Secretary for Financial Resources and Chief Financial Officer

Subject: Fiscal Year (FY) 2022 Independent Auditors' Financial Statement Audit Reports

Thank you for the opportunity to comment on the FY 2022 Independent Auditors' Reports. We appreciate the continuous commitment and diligence displayed by the Office of Inspector General (OIG) and its independent auditors, Ernst & Young LLP (EY) throughout the audit of the Department of Health and Human Services' financial statements.

We are pleased to receive confirmation of the Department's financial health through the auditors' issuance of an unmodified opinion on our principal financial statements. We acknowledge that the auditors disclaimed providing an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. In response to their Report on Internal Control and Compliance, we generally concur with their findings and are prepared to develop corrective action plans to address those findings. The Department consistently faces unique challenges given the scale and complexity of our mission and operations. We will continue to actively identify root causes of identified deficiencies, implement corrective actions, and monitor active remediation efforts.

We would like to thank the OIG and EY for your efforts on our behalf. We appreciate the continued collaboration of the OIG to improve our stewardship and transparency of taxpayer funds.

/Robert Gordon/

Robert Gordon
Assistant Secretary for Financial Resources and
Chief Financial Officer
November 14, 2022

Principal Financial Statements

U.S. Department of Health and Human Services

Consolidated Balance Sheets

As of September 30, 2022 and 2021

(in Millions)

	2022	2021
Assets (Note 2)		
Intragovernmental		
Fund Balance with Treasury (Note 3)	$ 652,672	$ 710,558
Investments, Net (Note 4)	351,569	312,291
Accounts Receivable, Net (Note 5)	831	705
Advances and Prepayments (Note 8)	2,412	1,000
Total Intragovernmental	**1,007,484**	**1,024,554**
Other than Intragovernmental		
Accounts Receivable, Net (Note 5)	40,128	28,676
Inventory and Related Property, Net (Note 6)	16,560	16,251
General Property, Plant and Equipment, Net (Note 7)	8,276	7,531
Advances and Prepayments (Note 8)	39,188	70,081
Other Assets:		
Loans Receivable, Net	479	487
Other	10	10
Total Other than Intragovernmental	**104,641**	**123,036**
Total Assets	**$ 1,112,125**	**$ 1,147,590**
Stewardship Land (Note 21)		
Liabilities (Note 9)		
Intragovernmental		
Accounts Payable	$ 2,300	$ 3,303
Debt (Note 10)	8,256	36,781
Advances from Other and Deferred Revenue	363	332
Other Liabilities (Note 14)	1,492	1,619
Total Intragovernmental	**12,411**	**42,035**
Other than Intragovernmental		
Accounts Payable	1,727	1,452
Entitlement Benefits Due and Payable (Note 11)	141,177	133,777
Federal Employee and Veteran Benefits Payable (Note 12)	19,409	17,265
Environmental and Disposal Liabilities	312	326
Advances from Others and Deferred Revenue	1,714	2,449
Other Liabilities:		
Accrued Liabilities (Note 13)	16,257	18,472
Contingencies and Commitments (Note 15)	15,776	12,080
Other Liabilities (Note 14)	1,237	1,772
Total Other than Intragovernmental	**197,609**	**187,593**
Total Liabilities	**210,020**	**229,628**
Net Position		
Unexpended Appropriations – Funds from Dedicated Collections (Note 20)	178,704	134,943
Unexpended Appropriations – Funds from Other Than Dedicated Collections	374,265	480,253
Total Unexpended Appropriations	**552,969**	**615,196**
Cumulative Results of Operations – Funds from Dedicated Collections (Note 20)	346,199	296,328
Cumulative Results of Operations – Funds from Other Than Dedicated Collections	2,937	6,438
Total Cumulative Results of Operations	**349,136**	**302,766**
Total Net Position	**902,105**	**917,962**
Total Liabilities and Net Position	**$ 1,112,125**	**$ 1,147,590**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Consolidated Statements of Net Cost
For the Years Ended September 30, 2022 and 2021
(in Millions)

	2022	2021
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Costs	$ 1,531,319	$ 1,404,879
Earned Revenue	(148,181)	(132,908)
CMS Net Cost of Operations	1,383,138	1,271,971
Other Segments:		
Administration for Children and Families (ACF)	85,134	71,185
Administration for Community Living (ACL)	2,752	2,669
Agency for Healthcare Research and Quality (AHRQ)	335	337
Centers for Disease Control and Prevention (CDC)	21,600	16,160
Food and Drug Administration (FDA)	6,246	6,094
Health Resources and Services Administration (HRSA)	15,398	14,572
Indian Health Service (IHS)	9,063	12,029
National Institutes of Health (NIH)	41,180	40,569
Office of the Secretary (OS)	91,771	69,984
Program Support Center (PSC)	2,330	1,897
Substance Abuse and Mental Health Services Administration (SAMHSA)	7,482	6,110
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	$ 283,291	$ 241,606
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan Assumption Changes (Note 12)	1,440	665
Other Segments Gross Costs of Operations after Actuarial Gains and Losses	$ 284,731	$ 242,271
Earned Revenue	(7,076)	(5,686)
Other Segments Net Cost of Operations	277,655	236,585
Net Cost of Operations (Note 22)	**$ 1,660,793**	**$ 1,508,556**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2022

(in Millions)

	Funds from Dedicated Collections (Note 20)	All Other Funds	Eliminations	Consolidated Total
Unexpended Appropriations:				
Beginning Balance	$ 134,943	$ 480,253	$ -	$ 615,196
Appropriations Received	534,019	854,924	-	1,388,943
Appropriations Transferred in/out	-	9	-	9
Other Adjustments	(17,254)	(78,693)	-	(95,947)
Appropriations Used	(473,004)	(882,228)	-	(1,355,232)
Net Change in Unexpended Appropriations	43,761	(105,988)	-	(62,227)
Total Unexpended Appropriations	**$ 178,704**	**$ 374,265**	**$ -**	**$ 552,969**
Cumulative Results of Operations:				
Beginning Balances	$ 296,328	$ 6,438	$ -	$ 302,766
Other Adjustments	-	(40)	-	(40)
Appropriations Used	473,004	882,228	-	1,355,232
Nonexchange Revenue:				
Nonexchange Revenue – Tax Revenue	343,729	-	-	343,729
Nonexchange Revenue – Investment Revenue	6,929	155	-	7,084
Nonexchange Revenue – Other	3,260	332	-	3,592
Donations and Forfeitures of Cash and Cash Equivalents	76	-	-	76
Transfers-in/out without Reimbursement	(4,889)	2,371	-	(2,518)
Donations and Forfeitures of Property	-	33	-	33
Imputed Financing	89	919	(333)	675
Other	21	(721)	-	(700)
Net Cost of Operations	772,348	888,778	(333)	1,660,793
Net Change in Cumulative Results of Operations	49,871	(3,501)	-	46,370
Total Cumulative Results of Operations	**$ 346,199**	**$ 2,937**	**$ -**	**$ 349,136**
Net Position	**$ 524,903**	**$ 377,202**	**$ -**	**$ 902,105**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2021
(in Millions)

	Funds from Dedicated Collections (Note 20)	All Other Funds	Eliminations	Consolidated Total
Unexpended Appropriations:				
Beginning Balance	$ 98,117	$ 333,140	$ -	$ 431,257
Appropriations Received	502,345	1,010,927	-	1,513,272
Appropriations Transferred in/out	-	26	-	26
Other Adjustments	(23,955)	(88,084)	-	(112,039)
Appropriations Used	(441,564)	(775,756)	-	(1,217,320)
Net Change in Unexpended Appropriations	36,826	147,113	-	183,939
Total Unexpended Appropriations	**$ 134,943**	**$ 480,253**	**$ -**	**$ 615,196**
Cumulative Results of Operations:				
Beginning Balances	$ 285,692	$ 2,813	$ -	$ 288,505
Other Adjustments	(1)	(347)	-	(348)
Appropriations Used	441,564	775,756	-	1,217,320
Nonexchange Revenue:				
Nonexchange Revenue – Tax Revenue	299,147	-	-	299,147
Nonexchange Revenue – Investment Revenue	4,904	65	-	4,969
Nonexchange Revenue – Other	3,230	313	-	3,543
Donations and Forfeitures of Cash and Cash Equivalents	71	-	-	71
Transfers-in/out without Reimbursement	(4,802)	2,359	-	(2,443)
Donations and Forfeitures of Property	-	8	-	8
Imputed Financing	106	834	(327)	613
Other	22	(85)	-	(63)
Net Cost of Operations	733,605	775,278	(327)	1,508,556
Net Change in Cumulative Results of Operations	10,636	3,625	-	14,261
Total Cumulative Results of Operations	**$ 296,328**	**$ 6,438**	**$ -**	**$ 302,766**
Net Position	**$ 431,271**	**$ 486,691**	**$ -**	**$ 917,962**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Combined Statement of Budgetary Resources
For the Years Ended September 30, 2022 and 2021
(in Millions)

	2022	2021
Budgetary Resources		
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory)	$ 372,094	$ 335,459
Appropriations (Discretionary and Mandatory)	2,334,321	2,252,266
Borrowing Authority (Discretionary and Mandatory)	40	46,028
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	29,547	27,592
Total Budgetary Resources (Note 23)	**$ 2,736,002**	**$ 2,661,345**
Status of Budgetary Resources		
New Obligations and Upward Adjustments (Note 23)	$ 2,453,016	$ 2,355,877
Unobligated Balance, End of Year:		
Apportioned, Unexpired Accounts	113,903	135,838
Exempt from Apportionment, Unexpired Accounts	220	204
Unapportioned, Unexpired Accounts	21,307	54,980
Unexpired Unobligated Balance, End of Year	135,430	191,022
Expired Unobligated Balance, End of Year	147,556	114,446
Unobligated Balance, End of Year	282,986	305,468
Total Budgetary Resources (Note 23)	**$ 2,736,002**	**$ 2,661,345**
Outlays, Net		
Outlays, Net (Discretionary and Mandatory)	$ 2,342,422	$ 2,088,600
Distributed Offsetting Receipts	(699,432)	(621,612)
Agency Outlays, Net (Discretionary and Mandatory) (Note 22)	**$ 1,642,990**	**$ 1,466,988**
Disbursements, Net	**$ 25**	**$ 278**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Social Insurance (Unaudited)

75-Year Projection as of January 1, 2022 and Prior Base Years
(in Billions)

	2022	Estimates from Prior Years 2021	2020	2019	2018
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 26 and 27)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 14,767	$ 13,029	$ 12,454	$ 11,805	$ 11,323
SMI Part B	39,039	34,467	32,165	27,556	24,143
SMI Part D	7,372	6,881	6,975	7,181	7,176
Have attained eligibility age (age 65 or over)					
HI	793	664	637	559	525
SMI Part B	7,447	6,536	5,864	5,232	4,725
SMI Part D	1,164	1,061	1,016	1,052	1,015
Those expected to become participants					
HI	14,603	13,017	12,464	11,995	10,959
SMI Part B	10,131	9,010	8,567	6,864	5,586
SMI Part D	3,094	2,921	3,043	3,000	2,932
All current and future participants					
HI	$ 30,163	$ 26,710	$ 25,554	$ 24,359	$ 22,807
SMI Part B	56,618	50,013	46,596	39,652	34,453
SMI Part D	11,630	10,863	11,035	11,232	11,124
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 26 and 27)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 23,211	$ 20,940	$ 20,103	$ 20,028	$ 18,604
SMI Part B	38,605	34,075	31,819	27,270	23,832
SMI Part D	7,372	6,881	6,975	7,181	7,176
Have attained eligibility age (age 65 and over)					
HI	7,010	6,230	6,073	5,348	5,027
SMI Part B	7,825	6,892	6,194	5,741	5,180
SMI Part D	1,164	1,061	1,016	1,052	1,015
Those expected to become participants					
HI	5,036	4,597	4,179	4,467	3,884
SMI Part B	10,188	9,046	8,583	6,641	5,442
SMI Part D	3,094	2,921	3,043	3,000	2,932
All current and future participants:					
HI	$ 35,257	$ 31,767	$ 30,355	$ 29,843	$ 27,515
SMI Part B	56,618	50,013	46,596	39,652	34,453
SMI Part D	11,630	10,863	11,035	11,232	11,124
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 26 and 27)					
HI	$ (5,094)	$ (5,057)	$ (4,800)	$ (5,484)	$ (4,708)
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 26 and 27)					
HI	$ (5,094)	$ (5,057)	$ (4,800)	$ (5,484)	$ (4,708)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	177	198	195	200	202
SMI Part B	163	133	100	96	80
SMI Part D	20	10	9	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 26 and 27)					
HI	$ (4,917)	$ (4,859)	$ (4,606)	$ (5,283)	$ (4,506)
SMI Part B	163	133	100	96	80
SMI Part D	20	10	9	8	8

Please note for the entirety of the Statement of Social Insurance:
Totals do not necessarily equal the sum of the rounded components.
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.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Social Insurance (Continued) (Unaudited)

75-Year Projection as of January 1, 2022 and Prior Base Years
(in Billions)

	2022	Estimates from Prior Years 2021	2020	2019	2018
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)	$ 9,404	$ 8,261	$ 7,517	$ 6,843	$ 6,266
Expenditures	15,998	14,184	13,284	12,140	11,222
Income less expenditures	(6,595)	(5,922)	(5,766)	(5,297)	(4,957)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	61,178	54,377	51,594	46,542	42,643
Expenditures	69,188	61,895	58,897	54,479	49,612
Income less expenditures	(8,010)	(7,519)	(7,303)	(7,937)	(6,970)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(14,605)	(13,441)	(13,069)	(13,234)	(11,926)
Combined Medicare Trust Fund assets at start of period	360	341	303	305	290
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (14,244)	$ (13,100)	$ (12,766)	$ (12,929)	$ (11,637)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	$ 27,828	$ 24,948	$ 24,074	$ 21,858	$ 19,477
Expenditures	18,318	16,564	15,805	14,108	12,258
Income less expenditures	9,510	8,384	8,269	7,750	7,219
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(5,094)	(5,057)	(4,800)	(5,484)	(4,708)
Combined Medicare Trust Fund assets at start of period	360	341	303	305	290
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (4,734)	$ (4,716)	$ (4,497)	$ (5,179)	$ (4,418)

Please note for the entirety of the Statement of Social Insurance:
Totals do not necessarily equal the sum of the rounded components.
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.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (Unaudited)

January 1, 2021 to January 1, 2022

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
Total Medicare (Note 28)					
As of January 1, 2021	$ 87,586	$ 92,643	$ (5,057)	$ 341	$ (4,716)
Reasons for change					
Change in the valuation period	1,843	1,942	(98)	(25)	(123)
Change in projection base	(173)	(2,169)	1,996	44	2,040
Changes in the demographic assumptions	748	730	18	-	18
Changes in economic and health care assumptions	8,451	10,409	(1,958)	-	(1,958)
Changes in law	(45)	(50)	5	-	5
Net changes	10,824	10,861	(37)	19	(18)
As of January 1, 2022	$ 98,410	$ 103,504	$ (5,094)	$ 360	$ (4,734)
HI - Part A (Note 28)					
As of January 1, 2021	$ 26,710	$ 31,767	$ (5,057)	$ 198	$ (4,859)
Reasons for change					
Change in the valuation period	473	572	(98)	(40)	(138)
Change in projection base	602	(1,394)	1,996	19	2,015
Changes in the demographic assumptions	(53)	(71)	18	-	18
Changes in economic and health care assumptions	2,431	4,389	(1,958)	-	(1,958)
Changes in law	-	(5)	5	-	5
Net changes	3,453	3,490	(37)	(21)	(58)
As of January 1, 2022	$ 30,163	$ 35,257	$ (5,094)	$ 177	$ (4,917)
SMI - Part B (Note 28)					
As of January 1, 2021	$ 50,013	$ 50,013	$ -	$ 133	$ 133
Reasons for change					
Change in the valuation period	1,121	1,121	-	16	16
Change in projection base	(1,101)	(1,101)	-	14	14
Changes in the demographic assumptions	561	561	-	-	-
Changes in economic and health care assumptions	6,070	6,070	-	-	-
Changes in law	(45)	(45)	-	-	-
Net changes	6,605	6,605	-	30	30
As of January 1, 2022	$ 56,618	$ 56,618	$ -	$ 163	$ 163
SMI - Part D (Note 28)					
As of January 1, 2021	$ 10,863	$ 10,863	$ -	$ 10	$ 10
Reasons for change					
Change in the valuation period	249	249	-	(2)	(2)
Change in projection base	326	326	-	11	11
Changes in the demographic assumptions	240	240	-	-	-
Changes in economic and health care assumptions	(49)	(49)	-	-	-
Changes in law	-	-	-	-	-
Net changes	766	766	-	10	10
As of January 1, 2022	$ 11,630	$ 11,630	$ -	$ 20	$ 20

Totals do not necessarily equal the sum of the rounded components.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (Continued) (Unaudited)

January 1, 2020 to January 1, 2021

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
Total Medicare (Note 28)					
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 healthcare assumptions	5,512	6,471	(959)	-	(959)
Changes in law	140	178	(38)	-	(38)
Net changes	4,401	4,657	(257)	38	(219)
As of January 1, 2021	$ 87,586	$ 92,643	$ (5,057)	$ 341	$ (4,716)
HI - Part A (Note 28)					
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 healthcare 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 28)					
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 healthcare 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 28)					
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 healthcare 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 to the Principal Financial Statements" are an integral part of these statements.

Notes to the Principal Financial Statements

Note 1. Summary of Significant Accounting Policies

A. Reporting Entity

The United States (U.S.) Department of Health and Human Services (HHS or the Department) is a Cabinet-level agency within the executive branch of the federal government. Its predecessor, the Department of Health, Education and Welfare (HEW), was officially established on April 11, 1953. In 1979, the *Department of Education Organization Act* was signed into law. The law established a new federal entity, the Department of Education. The HEW officially became HHS on May 4, 1980. HHS is responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The accompanying financial statements include activities and operations of the HHS. In accordance with Statement of Federal Financial Accounting Standards (SFFAS) 47, *Reporting Entity*, HHS has included all consolidation entities for which it is accountable in this general purpose federal financial report. The Office of the Secretary (OS) and 12 Operating Divisions (OpDivs) listed below are consolidated in the HHS financial statements. HHS conducted a systematic and thorough review of all organizations and determined HHS does not have any disclosure entities.

Organization and Structure of HHS

Each HHS OpDiv is responsible for carrying out a mission, conducting a major line of activity, or producing one or a group of related products and/or services. Although organizationally located within OS, the Program Support Center (PSC) is a responsibility segment and reports separately due to the business activities conducted on behalf of other federal agencies and HHS OpDivs. The Agency for Toxic Substances and Disease Registry (ATSDR) is combined with the Centers for Disease Control and Prevention (CDC) for financial reporting purposes. Therefore, references to the CDC responsibility segment include ATSDR. On July 22, 2022, the Office of the Assistant Secretary for Preparedness and Response was elevated from a Staff Division to an OpDiv, creating the Administration for Strategic Preparedness and Response (ASPR). ASPR is included with OS for fiscal year (FY) 2022 financial reporting purposes. Responsibility segment management report directly to the Department's top management, and the resources and results of operations can be clearly distinguished from those of other responsibility segments. The 13 responsibility segments are:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Administration for Strategic Preparedness and Response (ASPR)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Office of the Secretary (OS)
- Program Support Center (PSC)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

CMS, the largest HHS OpDiv, administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and other health-related programs. CMS is also a separate reporting entity. The CMS annual financial report can be found at CMS.gov.

B. Basis of Accounting and Presentation

HHS financial statements have been prepared to report the financial position and results of operations of the Department, pursuant to the requirements of 31 U.S. Code (U.S.C.) §3515(b), the *Chief Financial Officers Act of 1990* (CFO Act), as amended by the *Government Management Reform Act of 1994*, and presented in accordance with the requirements in the Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements* (OMB Circular A-136). These financial statements have been prepared from HHS's financial records in conformity with accounting principles generally accepted in the U.S. The generally accepted accounting principles (GAAP) for federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB) and recognized by the American Institute of Certified Public Accountants as federal GAAP. Therefore, these statements are different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control the use of budgetary resources.

Transactions are recorded on accrual and budgetary basis of accounting. Under the accrual method of accounting, revenues are recognized when earned, and expenses are recognized when resources are consumed without regard to the payment of cash. Budgetary accounting principles are designed to recognize the obligation of funds according to legal requirements, which, in many cases, is prior to the occurrence of an accrual-based transaction. The recognition of budgetary accounting transactions is essential for compliance with legal constraints and controls over the use of federal funds.

The financial statements consolidate the balances of approximately 218 appropriation accounts. These accounts are used for general government functions, collection of receipts, and suspense. Transactions and balances within HHS have been eliminated in the presentation of the Consolidated Balance Sheets, Statements of Net Cost, and Statement of Changes in Net Position. The Statement of Budgetary Resources is represented on a combined basis. Therefore, transactions and balances within HHS have not been eliminated from that statement. Supplemental information is accumulated from the OpDivs, regulatory reports, and other sources within HHS. These statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing resources and budget authority for HHS.

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.

C. Budgetary Terms

The purpose of Federal budgetary accounting is to control, monitor, and report on funds made available to Federal agencies by law and help ensure compliance with the law. The following budget terms are commonly used.

Appropriations

Appropriations are a provision of law, not necessarily in an appropriations act, authorizing the expenditure of funds for a given purpose. Usually, but not always, an appropriation provides budget authority.

Budgetary Resources

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

Offsetting Collections

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

Offsetting Receipts

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

Obligations

An obligation is an action that creates a legal liability to disburse funds, immediately or in the future. Budgetary resources must be available before obligating actions can be taken legally. In entitlement programs, obligations may arise under operation of law.

Outlays

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

D. Use of Estimates in Preparing Financial Statements

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 the reader in understanding the effect of changes in assumptions on the related information.

E. *Patient Protection and Affordable Care Act*

In FY 2010, the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* were signed and are collectively referred to as the PPACA. Further information is available at Healthcare.gov.

The PPACA contains the most significant changes to healthcare coverage since the *Social Security Act*.

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.

Marketplace Risk Adjustment Program

The Risk Adjustment program 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.

F. COVID-19 Activities

The *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act), was signed on March 27, 2020 to provide emergency assistance and healthcare response for individuals, families, and businesses affected by the COVID-19 pandemic. In addition to the CARES Act, during FY 2020, HHS received additional supplemental appropriations through the *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020*, the *Families First Coronavirus Response Act*, and the *Paycheck Protection Program and Health Care Enhancement Act*.

HHS received funding to support the Provider Relief Fund which was created to prevent, prepare for, and respond to COVID-19, both domestically and internationally. The Provider Relief Fund provides necessary expense reimbursements to assist eligible healthcare providers for healthcare related expenses or lost revenues attributed to COVID-19. HHS also received funding to support Biomedical Advanced Research and Development Authority (BARDA) efforts to advance research, development, manufacturing, production, and purchase of COVID-19 vaccines, therapeutics, and testing and related supplies; rebuild the Strategic National Stockpile (SNS); and support other COVID-19 related activities.

The *Coronavirus Response and Relief Supplemental Appropriations Act, 2021* supplements existing initiatives under the Provider Relief Fund, as well as support for the expansion of COVID-19 vaccination activities across jurisdictions. In addition, the Child Care and Development Fund provided additional financial support to childcare providers during the COVID-19 public health crisis.

The *American Rescue Plan Act of 2021* provides relief funding to workers and families for nationwide testing sites and community vaccination sites as well as addressing disparities in obtaining quality healthcare. In addition, HHS received funding to support testing, contact tracing, and mitigation activities. The Child Care Development Fund received funding – both for childcare stabilization grants and other supplemental funds – to help working parents by providing childcare subsidies, stabilizing the childcare sector, and increasing childcare options.

G. Parent/Child Reporting

Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. HHS has allocation transfers with other federal entities as both a transferring (parent) entity and a receiving (child) entity. All financial activity related to these allocation transfers is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations, and budget apportionments are derived.

HHS received an exception to the parent/child reporting requirements of OMB Circular A-136, as it pertains to the allocation transfer from the Department of Homeland Security to HHS for the Biodefense Countermeasures Fund for FY 2008 and beyond. Under this exception, HHS, as the child, assumed the financial statement reporting responsibilities of this fund.

Under the PPACA, HHS has established a child relationship with the Internal Revenue Service (IRS) of the U.S. Department of the Treasury (Treasury) for the payment of the advance premium tax credits to insurance providers. No financial activity is included in HHS's financial statements.

HHS also receives allocation transfers, as the child, from the Departments of Agriculture, Justice, and State. HHS allocates funds, as the parent, to the Bureau of Indian Affairs of the Department of the Interior (DOI), Department of Labor (DOL), Treasury, and Social Security Administration (SSA).

H. Changes, Reclassifications and Adjustments

Reclassifications

Effective FY 2022, the principal Balance Sheets, supplementary Balance Sheets, Statement of Changes in Net Position, and Statement of Social Insurance (SOSI), as well as some footnotes have changed to be in compliance with the OMB Circular A-136 and United States Standard General Ledger (USSGL) financial statement crosswalks. Thus, certain FY 2021 balances have been reclassified for comparability. For example, USSGLs previously mapped to Accounts Payable are currently mapped to Other Liabilities which resulted in adjustments to prior year balances.

I. Funds from Dedicated Collections

Funds from dedicated collections are generally financed by specifically identified revenues and provided to the government by non-federal sources. The sources are often supplemented by other financing sources, which remain available over time. Dedicated collections must meet the following criteria:

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

HHS's major funds from dedicated collections are described in the sections below.

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 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 the *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 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. In addition, the Low Income Subsidy helps those with limited income and resources.

The 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.

J. Revenue and Financing Sources

HHS receives the majority of funding needed to support its discretionary programs through Congressional appropriations and user fees. The U.S. Constitution prescribes that no money may be expended by an agency unless the funds have been made available by Congressional appropriation. Appropriations are recognized as financing sources when related expenses are incurred, or assets are purchased. Revenues from reimbursable agreements are recognized when the goods or services are provided by HHS. Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the Consolidated Statement of Changes in Net Position.

Appropriations

HHS receives annual, multi-year, and no-year appropriations that may be used within statutory limits. For example, funds for general operations are normally made available for one fiscal year. Funds for long-term projects such as major construction will be available for the expected life of the project, and funds used to establish revolving fund operations are generally available indefinitely (i.e., no-year funds).

Permanent Indefinite Appropriations

HHS permanent indefinite appropriations are open-ended; the dollar amount is unknown at the time the authority is granted. These appropriations are available for specific purposes without current year action by Congress.

Earned Revenue

Earned revenue results when HHS provides goods or services to another entity for a price and is recognized when earned (i.e., when goods have been delivered or services have been rendered). These revenues reduce the cost of operations.

HHS pricing policy for reimbursable agreements is to recover full cost and should result in no profit or loss for HHS. In addition to revenues related to reimbursable agreements, HHS collects various user fees to offset the cost of its services. Certain fees charged by HHS are based on an amount set by law or regulation and may not represent full cost.

With minor exceptions, all revenue receipts by federal agencies are processed through the Treasury Central Accounting Reporting System. Regardless of if they are derived from exchange or non-exchange transactions, all receipts not earmarked by Congressional appropriation for immediate HHS use are deposited in the General Fund or HHS designated Special Funds. Amounts not retained for use by HHS are reported as Transfers-in/out without Reimbursement to other government agencies on the HHS Consolidated Statement of Changes in Net Position.

Non-Exchange Revenue

Non-exchange revenue results from donations to the government and from the government's sovereign right to demand payment, including taxes. Non-exchange revenues are recognized when a specifically identifiable, legally enforceable claim to resources arises, but only to the extent that collection is probable, and the amount is reasonably estimable.

Non-exchange revenue is not considered to reduce the cost of the Department's operations and is separately reported on the Consolidated Statement of Changes in Net Position. Employment tax revenue collected under FICA and SECA is considered non-exchange revenue.

Imputed Financing Sources

In certain instances, HHS's operating costs are paid out of funds appropriated to other federal entities. For example, by law, certain costs of retirement programs are paid by the Office of Personnel Management (OPM), and certain legal judgments against HHS are paid from the Judgment Fund maintained by Bureau of Fiscal Service (Fiscal Service), Treasury. When costs are identifiable to HHS, directly attributable to HHS's operations, and paid by other agencies, HHS 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.

K. Intragovernmental Transactions and Relationships

Intragovernmental transactions are business activities conducted between two different federal entities. Transactions other than intragovernmental are transactions in which either the buyer or seller of the goods or services is a non-federal entity.

If a federal entity purchases goods or services from another federal entity and sells them to the public, the earned revenue is classified as other than intragovernmental, but the related costs would be classified as intragovernmental. The purpose of the classifications is to enable the federal government to provide consolidated financial statements and not to match public and intragovernmental revenue with costs incurred to produce public and intragovernmental revenue.

In the course of operations, HHS has relationships and financial transactions with numerous federal agencies, including SSA and Treasury. SSA determines eligibility for Medicare programs and also deducts Medicare Part B premiums from Social Security benefit payments for beneficiaries who elect to enroll in the Medicare Part B program

and elect to deduct their premiums from their benefit checks. SSA then transfers those funds to the Medicare Part B trust fund. Treasury receives the cumulative excess of Medicare receipts and other financing over outlays and issues interest-bearing securities in exchange for the use of those monies. Medicare Part D is primarily financed by the General Fund as well as beneficiary premiums and payments from states.

L. Entity and Non-Entity Assets

Entity assets are assets the reporting entity has authority to use in its operations (i.e., management has the authority to decide how the funds are used), or management is legally obligated to use the funds to meet entity obligations.

Non-entity assets are assets held by the reporting entity, but not available for use. HHS non-entity assets are related to delinquent child support payments withheld from federal tax refunds for the Child Support Enforcement program, interest accrued on over-payments, and cost settlements reported by the Medicare contractors.

M. Fund Balance with Treasury (FBwT)

The FBwT is the aggregate amount of funds in the Department's accounts with Treasury. FBwT is available to pay current liabilities and finance authorized purchases. Treasury processes cash receipts and disbursements for the Department's operations. HHS reconciles FBwT accounts with Treasury on a regular basis.

N. Custodial Activity

HHS reports custodial activities on its Consolidated Balance Sheets in accordance with OMB Circular A-136. However, HHS does not prepare a separate Statement of Custodial Activity since custodial activities are incidental to its operations and the amounts collected are immaterial.

ACF receives funding from the IRS for outlay to the states for child support. This funding represents delinquent child support payments withheld from federal tax refunds. FDA custodial activity involves collections of Civil Monetary Penalties that are assessed by the Department of Justice on behalf of the FDA. FDA is charged with assessing penalties for violations in areas such as illegally manufactured, marketed, and distributed animal food and drug products. CDC's custodial activity consists of the collection of interest on outstanding receivables and funds received from debts in collection status.

O. Investments, Net

HHS invests entity Medicare trust fund balances in excess of current needs in U.S. securities. The Treasury acts as the fiscal agent for the U.S. Government's investments in securities. Sections 1817 and 1841 of the *Social Security Act* require that funds in the HI and SMI trust funds not needed to meet current expenditures be invested in interest-bearing obligations or in obligations guaranteed as to both principal and interest by the U.S. Government. The cash receipts, collected from the public as dedicated collections, are deposited with the Treasury, which uses the cash for general governmental purposes. Treasury securities are issued by the Fiscal Service to the HI and SMI trust funds as evidence of their receipt and are reported as an asset of the trust funds and a corresponding liability of the Treasury. The federal government does not set aside assets to pay future benefits or other expenditures associated with the HI or SMI trust funds.

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

The Treasury securities issued and redeemed to the HI and SMI trust funds are Non-marketable (Par Value) securities. These investments are carried at face value as determined by the Fiscal Service. Interest income is compounded semi-annually (i.e., June and December) by the Fiscal Service, and at fiscal year-end, interest income is adjusted to include an accrual for interest earned from July 1 to September 30.

The Vaccine Injury Compensation trust fund, a dedicated collections fund similar to the HI and SMI trust funds, invests in Non-Marketable, Market-Based securities issued by the Fiscal Service in the form of One Day Certificates and Market-Based Bills, Notes, and Bonds.

The NIH Gift Funds are invested in Non-Marketable, Market-Based Securities issued by the Fiscal Service. Funds are invested for either a 90 or 180-day period based on the need for funds. No provision is made for unrealized gains or losses on these securities since it is HHS's intent to hold investments to maturity.

P. Accounts Receivable, Net

Accounts Receivable, Net consists of the amounts owed to HHS by other federal agencies and the public for the provision of goods and services, less an allowance for uncollectible accounts. Intragovernmental accounts receivable consists of the amounts owed to HHS by other federal agencies for reimbursable work. Accounts Receivable, Net from the public is primarily composed of provider and beneficiary over-payments: Medicare Prescription Drug over-payments, Medicare premiums, civil monetary penalties, criminal restitution, state phased-down contributions, Medicaid/CHIP overpayments, audit disallowances, and Medicare Secondary Payer accounts receivable.

Accounts Receivable, Net from the public is net of an allowance for uncollectible accounts. 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 5 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 is comprised mostly of amounts due to HHS related to collections for Marketplace activities.

Q. Advances and Prepayments and Accrued Liabilities

Starting in March 2022, HHS began to recognize grant expenses at the time of payment to the grant recipients. As part of the implementation of the new process, HHS liquidated most of the balances related to grants. Historically, the expenditure would not be recognized until the grant recipient reported on the Quarterly Federal Cash Transaction Report (FCTR). The new process creates the advance and expenditure transaction at the time of payment. This change is reflected in the reduction in the accrual, which now only includes the incurred but not reported (IBNR) amount.

Formula grants and block grants are funded when grantees provide services or payments to individuals and local agencies from a fixed amount of money. These grants are funded based on allocations determined by budgets and agreements approved by the sponsoring OpDiv. The expenses are recorded as the grantees draw funds; no year-end accrual is required.

The standard Accelerated and Advance Payment (AAP) program was established to help providers and suppliers who are experiencing disruptions in cash flow due to system issues or claims processing delays. Standard AAPs are most commonly used during local emergencies, such as hurricanes or wildfires, which impact a provider or supplier's ability to submit or receive claims payments.

On March 30, 2020, the COVID-19 AAP (CAAP) program was established, under the CARES Act, to address the significant disruption to the healthcare industry caused by delays in non-essential surgeries and procedures and disruptions to billing, among other challenges related to the pandemic. On October 1, 2020 under the terms of the *Continuing Appropriations Act, 2021 and Other Extensions Act*, CMS further delayed repayment for one year from the date each provider or supplier's CAAP was issued. Then repayment occurs through an automatic recoupment by offset of 25 percent of Medicare claims payments for the next 11 months. After the 11-month period, recoupment increases to 50 percent of Medicare claims payments for an additional 6 months. If the provider or supplier is unable to repay the total amount of the CAAP within 29 months, CMS will issue a demand letter requiring repayment of any outstanding balance, subject to an interest rate of 4 percent, consistent with the terms of the *Continuing Appropriations Act, 2021 and Other Extensions Act*. As of September 2022, certain CAAP advances have been demanded and are reflected in the Medicare FFS accounts receivable balance.

R. Inventory and Related Property, Net

Inventory and Related Property, Net primarily consists of Inventory Held for Sale or Use and Stockpile Materials Held for Emergency and Contingency.

Inventory Held for Sale or Use includes Inventories Held for Sale and Operating Material and Supplies. Inventories Held for Sale consists of small equipment and supplies held by the Service and Supply Funds (SSF) for sale to HHS components and other federal entities. These inventories are valued at historical cost using the weighted average valuation method for the PSC's SSF inventories and using the moving average valuation method for the NIH's SSF inventories. Operating Materials and Supplies include pharmaceuticals, biological products, and other medical supplies used to provide medical services and conduct medical research. They are recorded as assets when purchased and are expensed when consumed. Operating Materials and Supplies are valued at historical cost using the first-in/first-out (FIFO) cost flow assumption.

Stockpile Materials are Held in Reserve to respond to local and national emergencies. HHS maintains several stockpiles for emergency response purposes, which include the SNS and Vaccines for Children (VFC). The stockpile contains several million doses of vaccine in bulk, which are stored and maintained for possible use.

Project BioShield has increased the preparedness of the nation by procuring medical countermeasures that include anthrax vaccine, anthrax antitoxins, botulin antitoxins, and blocking and decorporation agents for a radiological event. All stockpiles are valued at historical cost, using various cost flow assumptions, including the FIFO for SNS and specific identification for VFC.

S. General Property, Plant and Equipment, Net

General Property, Plant and Equipment (PP&E), Net consists of buildings, structures, and facilities used for general operations, land acquired for general operating purposes, equipment, assets under capital lease, leasehold improvements, construction-in-progress, and internal-use software. The basis for recording purchased PP&E is full cost, including all costs incurred to bring the PP&E to a form and location suitable for its intended use and is presented net of accumulated depreciation.

The cost of General PP&E acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception. When property is acquired through a donation, the cost recognized is the estimated fair market value on the date of acquisition. The cost of General PP&E transferred from other federal entities is the transferring entity's net book value. Except for internal-use software, HHS capitalizes all General PP&E with an initial acquisition cost of $100,000 or more and an estimated useful life of 2 years or more. HHS increased the General PP&E

capitalization threshold from $25,000 to $100,000 HHS-wide (except for Internal Use Software). This asset capitalization threshold increase was implemented on October 1, 2021.

HHS has commitments under various operating leases with private entities as well as the General Services Administration (GSA) for offices, laboratory space, and land. Leases with private entities have initial or remaining noncancelable lease terms from 1 to 50 years; however, some GSA leases are cancelable with 120-days notice. Under an operating lease, the cost of the lease is expensed as incurred.

General PP&E is depreciated using the straight-line method over the estimated useful life of the asset. Land and land rights, including permanent improvements, are not depreciated. Normal maintenance and repair costs are expensed as incurred.

In accordance with SFFAS 10, *Accounting for Internal Use Software*, capitalization of internally developed, contractor-developed/commercial off-the-shelf software begins in the software development phase. HHS's capitalization threshold for internal-use software costs for appropriated fund accounts is $1 million, and the threshold for revolving fund accounts is $500,000. Costs below the threshold levels are expensed. Software is amortized using the straight-line method over a period of 5 to 10 years consistent with the estimated life used for planning and acquisition purposes. Capitalized costs include all direct and indirect costs.

T. Stewardship Land

HHS Stewardship Land (i.e., land not acquired for or in connection with General PP&E) is Indian Trust land used to support the IHS day-to-day operations of providing healthcare to American Indians and Alaska Natives in remote areas of the country where no other facilities exist. In accordance with SFFAS 29*, Heritage Assets and Stewardship Land,* HHS does not report a related amount on the Consolidated Balance Sheets.

HHS asset accountability reports differentiate Indian Trust land parcels from General PP&E situated thereon.

U. Liabilities

Liabilities are recognized for amounts of probable and measurable future outflows or other sacrifices of resources as a result of past transactions or events. Since HHS is a component of the U.S. Government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. Payments of all liabilities other than contracts can be abrogated by the sovereign entity. In accordance with public law and existing federal accounting standards, no liability is recognized for future payments to be made on behalf of current workers contributing to the Medicare HI trust fund, since liabilities are only those items that are present obligations of the government. HHS's liabilities are classified as covered by budgetary resources, not covered by budgetary resources, or not requiring budgetary resources.

Liabilities Covered by Budgetary Resources

Available budgetary resources include new budget authority, spending authority from offsetting collections, recoveries of expired budget authority, unobligated balances of budgetary resources at the beginning of the year, permanent indefinite appropriation, and borrowing authority.

Liabilities Not Covered by Budgetary Resources

Sometimes funding has not yet been made available through Congressional appropriation or current earnings. The major liabilities in this category include contingencies, employee annual leave earned, but not taken, and amounts billed by the DOL for disability payments. The actuarial *Federal Employee Compensation Act* (FECA) liability determined by the DOL but not yet billed is also included in this category. In addition, HHS has debt related to amounts borrowed to cover the accelerated and advance payments made for the CAAP program.

Liabilities Not Requiring Budgetary Resources

Clearing accounts, non-fiduciary deposit funds, custodial collections, and unearned revenue and liabilities that have not in the past required and will not in the future require use of budgetary resources.

V. Accounts Payable

Accounts Payable primarily consist of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

W. Accrued Payroll and Benefits

Accrued Payroll and Benefits consist of salaries, wages, leave, and benefits earned by employees but not disbursed at the end of the reporting period. A liability for annual and other vested compensatory leave is accrued as earned and reduced when taken. At the end of each fiscal year, the balance in the accrued annual leave liability account is adjusted to reflect current pay rates. Annual leave earned but not taken is considered an unfunded liability, since it will be funded from future appropriations when it is actually taken by employees. Sick leave and other types of leave are not accrued and are expensed when taken. Intragovernmental Accrued Payroll and Benefits consist primarily of HHS's current FECA liability to DOL.

X. Debt

HHS's debt to the Treasury is related to amounts borrowed to cover the accelerated and advance payments made for the CAAP program. The *Continuing Appropriations Act, 2021 and Other Extensions Act* requires debt to Treasury for the AAP program to be repaid from collections (described in the Advances and Prepayments and Accrued Liabilities section of this note) on a periodic basis. In addition, HHS has debt for amounts borrowed to cover Medicare Part B premium shortfalls. The *Bipartisan Budget Act of 2015* (Section 601) authorized a transfer from the General Fund to SMI, to temporarily replace the reduction in Medicare Part B premiums for calendar years 2016 and 2017. Section 601 created an additional premium charged alongside the normal Medicare 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* made similar changes for 2021. These repayments are transferred quarterly.

Y. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represents a liability for Medicare fee-for-service, Medicare Advantage and the Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims IBNR as of the end of the reporting period.

Z. Federal Employee and Veteran Benefits Payable

HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System (authorized by the *Public Health Service Act*), a defined non-contributory benefit plan, for its active-duty officers, retiree annuitants, and survivors. The plan does not have accumulated assets, and funding is provided entirely on a pay-as-you-go basis by Congressional appropriation. HHS records the present value of the Commissioned Corps pension and post-retirement health benefits on the Consolidated Balance Sheets. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end on the Statements of Net Cost.

The liability for Federal Employee and Veteran Benefits also includes an actuarial liability for estimated future payments for workers' compensation pursuant to the FECA. FECA provides income and medical cost protection to federal employees who are injured on the job or who sustained a work-related occupational disease. It also covers beneficiaries of employees whose deaths are attributable to job-related injury or occupational disease. The FECA program is administered by DOL, which pays valid claims and subsequently bills the employing federal agency. The FECA liability consists of two components: (1) actual claims billed by the DOL to agencies but not yet paid; and (2) an

estimated liability for future benefit payments as a result of past events such as death, disability, and medical costs. The claims that have been billed by DOL are included in Accrued Payroll and Benefits.

Most HHS employees participate in the Civil Service Retirement System (CSRS), a defined benefit plan, or the Federal Employees Retirement System (FERS), a defined benefit and contribution plan. For employees covered under CSRS, the Department contributes a fixed percentage of pay. Most employees hired after December 31, 1983, are automatically covered by the FERS. The FERS plan has three parts: a defined benefit payment, Social Security benefits, and the Thrift Savings Plan. For employees covered under FERS, HHS contributes a fixed percentage of pay for the defined benefit portion and the employer's matching share for Social Security and Medicare Insurance. HHS automatically contributes one percent of each employee's pay to the Thrift Savings Plan and matches the first three percent of employee contributions dollar for dollar. Each additional dollar of the employee's next 2 percent of basic pay is matched at 50 cents on the dollar.

OPM is the administering agency for both of these benefit plans and, thus, reports CSRS and FERS assets, accumulated plan benefits, and unfunded liabilities applicable to federal employees. Therefore, HHS does not recognize any liability on its Consolidated Balance Sheets for pensions, other retirement benefits, or other post-employment benefits of its federal employees with the exception of the PHS Commissioned Corps. However, HHS does recognize an expense in the Consolidated Statements of Net Cost and an imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statement of Changes in Net Position. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end.

AA. Contingencies

A loss contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to HHS. The uncertainty ultimately should be resolved when one or more future events occur or fail to occur. The likelihood that the future event or events will confirm the loss or the incurrence of a liability can range from probable to remote. SFFAS 5, *Accounting for Liabilities of the Federal Government*, as amended by SFFAS 12, *Recognition of Contingent Liabilities from Litigation*, contains the criteria for recognition and disclosure of contingent liabilities.

HHS and its components could be parties to various administrative proceedings, legal actions, and claims brought by or against it. With the exception of pending, threatened or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is more likely than not to occur, and the related future outflow or sacrifice of resources is measurable. For pending, threatened, or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is likely to occur and the related future outflow or sacrifice of resources is measurable.

Treaties and other international agreements are written agreements between the U.S. and other sovereign states, or between the U.S. and international organizations, governed by international law. The Department of State developed and continues to manage the Circular 175 procedure, which outlines the approval process for the negotiation and conclusion of international agreements which HHS will become a party. For reporting purposes HHS has no present or contingency obligation related to treaties and international agreements when entered into force.

HHS has no material obligations related to cancelled appropriations for which there is a contractual commitment for payment or for contractual arrangements which may require future financial obligations.

AB. Statement of Social Insurance (unaudited)

The SOSI presents, for the 75-year projection period, the present values of the income and expenditures of the HI and 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 *2022 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.

Note 2. Entity and Non-Entity Assets (in Millions)

	2022	2021
Non-Entity Intragovernmental Assets	$ 25	$ 60
Non-Entity Other than Intragovernmental Assets	58	80
Total Non-Entity Assets	83	140
Total Entity Assets	1,112,042	1,147,450
Total Assets	**$ 1,112,125**	**$ 1,147,590**

HHS reported a decrease of $35.5 billion in Total Entity Assets primarily due to changes in FBwT, Investments, Accounts Receivable, and Advances and Prepayments. Refer to the respective footnotes below for additional information.

Note 3. Fund Balance with Treasury (in Millions)

	2022	2021
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 114,123	$ 136,042
Unavailable	168,863	169,426
Obligated Balance not yet Disbursed	438,808	470,977
Non-Budgetary Fund Balance with Treasury	(69,122)	(65,887)
Total Fund Balance with Treasury	**$ 652,672**	**$ 710,558**

The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of $29.1 billion as of September 30, 2022 ($28.6 billion as of September 30, 2021). The restricted amount is primarily for CHIP, CMS Program Management, Center for Medicare and Medicaid Innovation, and State Grants and Demonstrations.

The Unobligated Balance, Available decrease of $21.9 billion is mostly due to decreased apportionments in the PHSSEF for COVID-19, offset by an increase to Payments to the Trust Fund, reflecting the transfer to SMI to cover the FY 2021 Repayable Advance for CAAP Program and the FY 2021 SMI Premium Repayment Advance Loan during FY 2021.

The Obligated Balance not yet Disbursed decrease of $32.2 billion is mostly due to the reduction of undelivered orders which are unpaid since COVID-19 related obligations are continually being delivered and paid.

Note 4. Investments, Net (in Millions)

	2022				
	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 345,361	$ -	$ 1,903	$ 347,264	$ 347,264
Non-Marketable: Market-Based	4,336	(41)	10	4,305	4,305
Total Intragovernmental	**$ 349,697**	**$ (41)**	**$ 1,913**	**$ 351,569**	**$ 351,569**

	2021				
	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 306,845	$ -	$ 1,288	$ 308,133	$ 308,133
Non-Marketable: Market-Based	4,186	(38)	10	4,158	4,158
Total Intragovernmental	**$ 311,031**	**$ (38)**	**$ 1,298**	**$ 312,291**	**$ 312,291**

HHS investments consist primarily of Medicare Trust Fund investments. Medicare Non-Marketable: Par Value Bonds are carried at face value and have maturity dates ranging from June 30, 2024, through June 30, 2037, with interest rates ranging from 1.500 percent to 3.000 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2023, with an interest rate of 3.375 percent.

Securities held by the Vaccine Injury Compensation Trust Fund will mature in FY 2023 through FY 2025. The Market-Based Notes paid rates ranging from 0.375 percent to 2.375 percent during October 1, 2021, to September 30, 2022. The Market-Based Bonds pay 6.875 percent through FY 2025.

The Market-Based Securities held in the NIH gift funds yielded rates ranging from 0.0450 percent to 2.9071 percent from October 1, 2021 through September 30, 2022 depending on date purchased and length of time to maturity.

Note 5. Accounts Receivable, Net (in Millions)

	2022				
	Accounts Receivable, Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivable, Net
Intragovernmental					
Entity	$ 831	$ -	$ 831	$ -	$ 831
Total Intragovernmental	**$ 831**	**$ -**	**$ 831**	**$ -**	**$ 831**
Other than Intragovernmental					
Entity					
Medicare	$ 29,858	$ -	$ 29,858	$ (4,162)	$ 25,696
Medicaid	7,802	-	7,802	(786)	7,016
Other	7,940	368	8,308	(950)	7,358
Non-Entity	42	76	118	(60)	58
Total Other than Intragovernmental	**$ 45,642**	**$ 444**	**$ 46,086**	**$ (5,958)**	**$ 40,128**

	2021				
	Accounts Receivable, Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivables, Net
Intragovernmental					
Entity	$ 705	$ -	$ 705	$ -	$ 705
Total Intragovernmental	**$ 705**	**$ -**	**$ 705**	**$ -**	**$ 705**
Other than Intragovernmental					
Entity					
Medicare	$ 19,356	$ -	$ 19,356	$ (3,709)	$ 15,647
Medicaid	7,349	-	7,349	(1,027)	6,322
Other	7,254	363	7,617	(990)	6,627
Non-Entity	57	71	128	(48)	80
Total Other than Intragovernmental	**$ 34,016**	**$ 434**	**$ 34,450**	**$ (5,774)**	**$ 28,676**

As of September 30, 2022, the Accounts Receivable, Net increase of $11.5 billion is primarily due to an increase in Medicare receivables, of which $6.0 billion is due to program growth in Part D IBNR and a $4.0 billion increase in HI for CAAP program advances that were demanded receivables.

Note 6. Inventory and Related Property, Net (in Millions)

	2022	2021
Inventory Held for Sale or Use	$ 563	$ 422
Stockpile Materials Held for Emergency or Contingency	15,997	15,829
Inventory and Related Property, Net	**$ 16,560**	**$ 16,251**

The Inventory and Related Property, Net increase of $0.3 billion is mostly due to an increase in the PHSSEF for SNS inventory and COVID-19 personal protective equipment.

Note 7. General Property, Plant and Equipment, Net (in Millions)

			2022		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	N/A	N/A	$ 64	$ (4)	$ 60
Construction in Progress	N/A	N/A	1,626	-	1,626
Buildings, Facilities & Other Structures	Straight-Line	5-50 Yrs	6,807	(4,056)	2,751
Equipment	Straight-Line	3-20 Yrs	1,773	(912)	861
Internal Use Software	Straight-Line	5-10 Yrs	6,178	(3,232)	2,946
Assets Under Capital Lease	Straight-Line	1-30 Yrs	72	(57)	15
Leasehold Improvements	Straight-Line	*Life of Lease	31	(14)	17
Totals			**$ 16,551**	**$ (8,275)**	**$ 8,276**

			2021		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	N/A	N/A	$ 64	$ (2)	$ 62
Construction in Progress	N/A	N/A	1,284	-	1,284
Buildings, Facilities & Other Structures	Straight-Line	5-50 Yrs	6,619	(3,790)	2,829
Equipment	Straight-Line	3-20 Yrs	2,420	(1,427)	993
Internal Use Software	Straight-Line	5-10 Yrs	5,828	(3,519)	2,309
Assets Under Capital Lease	Straight-Line	1-30 Yrs	119	(84)	35
Leasehold Improvements	Straight-Line	*Life of Lease	74	(55)	19
Totals			**$ 16,408**	**$ (8,877)**	**$ 7,531**

*7 to 15 years or the life of the lease, whichever is shorter.

	2022			2021		
	Acquisition Cost	Accumulated Depreciation	PP&E, Net	Acquisition Cost	Accumulated Depreciation	PP&E, Net
Balance Beginning of Year	$ 16,408	$ (8,877)	$ 7,531	$ 14,897	$ (7,993)	$ 6,904
Capitalized Acquisitions	1,512	468	1,980	1,643	(23)	1,620
Dispositions	(1,390)	1,377	(13)	(132)	130	(2)
Depreciation Expense	-	(1,250)	(1,250)	-	(991)	(991)
Other	21	7	28	-	-	-
Balance End of Year	**$ 16,551**	**$ (8,275)**	**$ 8,276**	**$ 16,408**	**$ (8,877)**	**$ 7,531**

Note 8. Advances and Prepayments (in Millions)

	2022	2021
Intragovernmental		
Advances to Other Federal Entities	$ 2,412	$ 1,000
Total Intragovernmental	**$ 2,412**	**$ 1,000**
Other than Intragovernmental		
Prescription Drug and Medicare Advantage	$ 37,751	$ -
COVID-19 Accelerated and Advance Payment Program	1,255	67,011
Grant Advances	152	3,033
Other	30	37
Total Other than Intragovernmental	**$ 39,188**	**$ 70,081**

As of September 30, 2022, Advances and Prepayments Other than Intragovernmental primarily represent payment of the Prescription Drug and Medicare Advantage benefit payments for October 2022 that occurred on September 30 instead of October 1.

CAAP program advances had a decrease of $65.8 billion primarily due to collections of $61.8 billion. Additionally, in September 2022, CAAP program advances have been demanded and are reflected in the Medicare fee-for-service accounts receivable balance. This reclassification resulted in a decrease of $4.0 billion in CAAP program advances.

Grant advances had a decrease of $2.9 billion as a result of HHS recognizing grant expenses at the time of payment to the grant recipients.

Note 9. Liabilities Not Covered by Budgetary Resources (in Millions)

	2022	2021
Intragovernmental		
Accrued Payroll and Benefits	$ 47	$ 49
Debt (Note 10)	7,747	36,312
Other	1,349	1,419
Total Intragovernmental	**$ 9,143**	**$ 37,780**
Federal Employee and Veteran Benefits Payable (Note 12)	$ 19,394	$ 17,260
Contingencies and Commitments (Note 15)	15,776	12,080
Accrued Liabilities	7,270	6,221
Other	321	333
Total Liabilities Not Covered by Budgetary Resources	$ 51,904	$ 73,674
Total Liabilities Covered by Budgetary Resources	155,568	152,652
Total Liabilities Not Requiring Budgetary Resources	2,548	3,302
Total Liabilities	**$ 210,020**	**$ 229,628**

Liabilities Not Covered by Budgetary Resources had a decrease of $21.8 billion, mostly due to Debt decrease of $28.6 billion primarily for the CAAP program. This is offset by increases in Contingencies of $3.7 billion and Federal Employee and Veteran Benefits Payable of $2.1 billion.

Note 10. Debt (in Millions)

	2021 Beginning Balance	2021 Net Borrowing	2021 Ending Balance	2022 Net Borrowing	2022 Ending Balance
Debt to the Treasury					
COVID-19 Accelerated and Advance Payment Program	$ -	$ 29,352	$ 29,352	$ (26,468)	$ 2,884
Transitional SMI Contribution	1,154	5,806	6,960	(2,097)	4,863
Other	207	262	469	40	509
Total Debt to the Treasury	**$ 1,361**	**$ 35,420**	**$ 36,781**	**$ (28,525)**	**$ 8,256**

HHS has $8.3 billion ($36.8 billion as of September 30, 2021) in total debt due to Treasury. Debt of $2.9 billion ($29.4 billion as of September 30, 2021) is related to amounts borrowed to cover the accelerated and advance payments made for the CAAP program. CAAP program repayments are based on collections. The decrease is due to CAAP repayments of $26.5 billion.

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. Debt of $4.9 billion ($7.0 billion as of September 30, 2021) is for amounts borrowed to cover the premium shortfalls. The decrease is due to the FY 2021 Transitional SMI advance repayments to Payments to the Trust Funds of $2.1 billion.

Note 11. Entitlement Benefits Due and Payable (in Millions)

	2022	2021
Medicare Fee-For-Service	$ 65,883	$ 57,765
Medicare Advantage/Prescription Drug Program	19,190	22,013
Medicaid	54,835	52,757
CHIP	1,269	1,242
Totals	**$ 141,177**	**$ 133,777**

Entitlement Benefits Due and Payable represents a liability for Medicare fee-for-service, Medicare Advantage and Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims IBNR as of the end of the reporting period.

The Medicare fee-for-service liability is primarily an actuarial liability which represents: (1) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment; (2) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued; (3) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees; (4) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year; and (5) an estimate of retroactive settlements of cost reports. The September 30, 2022 and 2021 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 the calendar year 2022. 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, 2022.

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, 2022 and 2021.

Note 12. Federal Employee and Veteran Benefits Payable (in Millions)

	2022	2021
Other than Intragovernmental		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 17,478	$ 15,272
PHS Commissioned Corp Post-Retirement Health Benefits	724	752
Workers' Compensation Benefits (Actuarial FECA Liability)	242	269
Unfunded Leave	950	967
Liabilities Covered by Budgetary Resources		
Other	15	5
Total Federal Employee and Veteran Benefits Payable	**$ 19,409**	**$ 17,265**

Public Health Service Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 5,819 active-duty officers and individual ready reserve members and 7,807 retiree annuitants and survivors. As of September 30, 2022, the actuarial accrued liability for the retirement benefit plan was $17.5 billion and $0.7 billion for non-Medicare coverage of the Post-Retirement Medical Plan.

The Commissioned Corps Retirement System and the Post-Retirement Medical Plan are not funded. Therefore, in accordance with SFFAS 33, *Pensions, Other Retirement Benefits and Other Postemployment Benefits: Reporting the Gains and Losses from Changes in Assumptions and Selecting Discount Rates and Valuation Dates*, the discount rate is based on long-term assumptions, for marketable securities (i.e., Treasury marketable securities) of similar maturity to the period over which the payments are to be made. The discount rates are matched with the expected timing of the associated expected cash flow. A single discount rate may be used for all the projected cash flow, as long as the resulting present value is not materially different than the resulting present value using multiple rates.

The significant assumptions used in the calculation of the pension and medical program liability, as of September 30, 2022 and September 30, 2021, were:

	2022	2021
Discount Rate	3.22 percent	3.37 percent
Annual Basic Pay Scale Increase	2.31 percent	2.28 percent
Annual Inflation	2.44 percent	1.98 percent

The table on the next page shows key valuation results as of September 30, 2022 and 2021, in conformance with the actuarial reporting standards set forth in the SFFAS 5, *Accounting for Liabilities of The Federal Government* and SFFAS 33. The valuation is based upon the current plan provisions, membership data collected as of September 30, 2022 and actuarial assumptions. The September 30, 2022 valuation includes an increase in liabilities of $2.2 billion resulting from changes in the assumed annual inflation rate, in the assumed salary scale, and in the assumed discount rate. These changes in combination with the actual plan experience over the past year (based upon new census data), resulted in an overall net increase in the actuarial accrued liability as compared to the prior valuation. The annual expense for the Retirement Benefit Plan for FY 2022 has increased relative to the prior year expense.

	2022	2021
Beginning Liability Balance	$ 16,024	$ 15,036
Expense		
Normal Cost	441	417
Interest on the Liability Balance	529	524
Actuarial (Gain)/Loss		
From Experience	409	(27)
From Assumption Changes		
Change in Discount Rate Assumption	442	414
Change in Inflation/Salary Increase Assumption	1,071	259
Change in New Medical Trends Assumption	(44)	18
Change in Others	(29)	(26)
Total From Assumption Changes	$ 1,440	$ 665
Net Actuarial (Gain)/Loss	1,849	638
Total Expense	$ 2,819	$ 1,579
Less Amounts Paid	(641)	(591)
Ending Liability Balance	**$ 18,202**	**$ 16,024**

Workers' Compensation Benefits

The actuarial liability for future workers' compensation benefits includes the expected liability for death, disability, medical and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims. The liability utilizes historical benefit payment patterns to predict the ultimate payment related to that period. For FYs 2022 and 2021, discount rates were based on averaging the Treasury's Yield Curve for Treasury Nominal Coupon Issues for the current and prior 4 years. Interest rate assumptions utilized for discounting as of September 30, 2022 and September 30, 2021, were:

	2022	2021
Wage Benefits	2.119% in Year 1 and years thereafter	2.231% in Year 1 and years thereafter
Medical Benefits	1.973% in Year 1 and years thereafter	2.060% in Year 1 and years thereafter

To provide specifically for the effects of inflation on the liability for future workers' compensation benefits, wage inflation factors (i.e., cost of living adjustments [COLA]) and medical inflation factors (i.e., consumer price index-medical [CPI-M]) are applied to the calculations of projected future benefits. The actual rates for these factors are also used to adjust the methodology's historical payments to current year constant dollars. The compensation COLAs and CPI-Ms used in the projections are:

FY	COLA	CPI-M
2022	N/A	N/A
2023	3.37%	3.13%
2024	3.97%	3.62%
2025	4.10%	3.55%
2026	4.16%	3.84%
2027	3.91%	4.20%

Note 13. Accrued Liabilities (in Millions)

	2022	2021
Grant Liability	$ 4,597	$ 9,861
Other Accrued Liabilities	11,660	8,611
Accrued Liabilities	**$ 16,257**	**$ 18,472**

Note 14. Other Liabilities (in Millions)

	2022	2021
Intragovernmental		
Legal Liabilities	$ 1,217	$ 1,216
Benefit Program Contribution Payable	150	210
Custodial Liabilities	114	149
Other	11	44
Total Intragovernmental	**$ 1,492**	**$ 1,619**
Other than Intragovernmental		
Accrued Payroll and Benefits	$ 382	$ 638
Custodial Liabilities	50	99
Other	805	1,035
Total Other than Intragovernmental	**$ 1,237**	**$ 1,772**

Legal Liabilities of $1.2 billion as of September 30, 2022 ($1.2 billion as of September 30, 2021) consists of reimbursable claims due to the Judgment Fund, which is administered by Fiscal Service.

Note 15. Contingencies and Commitments

HHS 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. HHS has accrued contingent liabilities where a loss is determined to be probable and the amount can be estimated. The liabilities are primarily related to the Medicaid audit and program disallowances. 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. Selected contingencies and commitments are described below.

Medicaid Audit and Program Disallowances

The Medicaid amount of $7.0 billion as of September 30, 2022 ($3.7 billion as of September 30, 2021) consists of Medicaid audit and program disallowances and reimbursement of State Plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the states. The funds could have been returned or HHS can decrease the state's authority. HHS will be required to pay these amounts if the appeals are decided in favor of the states. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a state. There are also outstanding reviews of the state expenditures in which a final determination has not been made.

Other Accrued Contingent Liabilities

The U.S. Supreme Court decision in *Salazar v Ramah Navajo Chapter*, dated June 18, 2012, and subsequent cases related to contract support costs have resulted in increased claims against IHS. As a result of this decision, many tribes have filed claims. Some claims have been paid and others have been asserted but not yet settled. It is expected that some tribes will file additional claims for prior years. The estimated amount recorded for contract support costs is $6.1 billion as of September 30, 2022 ($5.8 billion as of September 30, 2021).

Other contingent liabilities against HHS have been accrued in the financial statements for the Vaccine Injury Compensation Program and the Health Center Program malpractice claims through the *Federal Tort Claims Act*.

Note 16. Net Adjustments to Unobligated Balance, Brought Forward, October 1 (in Millions)

	2022	2021
Unobligated Balance, End of Year (from Prior Year)	$ 305,468	$ 240,861
Adjustments to Unobligated Balance Brought Forward:		
Recoveries of Prior Year Unpaid Obligations	95,245	52,646
Recoveries of Prior Year Paid Obligations	19,023	55,610
Appropriation Withdrawn	(36,762)	-
Appropriations Temporarily Precluded from Obligation - Prior-Year	(13)	(4,922)
Cancelled Authority	(11,125)	(9,229)
Prior Year Adjustments	214	1,245
Other	44	(752)
Total Unobligated Balance Brought Forward, October 1	**$ 372,094**	**$ 335,459**

Net adjustments to the Unobligated Balance, Brought Forward, October 1 primarily includes activity related to recoveries of prior year unpaid and paid obligations, appropriation withdrawn, appropriations which were temporarily precluded from obligation in the prior year, cancelled authority, and prior year adjustments.

HHS had $36.8 billion in Appropriation Withdrawn which represents the return of prior year indefinite authority related to Medicaid premium matching for repayment of repayable advance.

In FY 2022, HHS reported $0.2 billion in prior year adjustments. These adjustments were made to account for backdated authority issued by Treasury for Payments for Foster Care and Adoption Assistance and to adjust trust fund receivables. In FY 2021, HHS reported $1.2 billion in prior year adjustments. These adjustments were made to account for backdated authority issued by Treasury for Payments for Foster Care and Permanency and to adjust the carry forward amount for the Recovery Audit Contractor program.

Note 17. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances on the Combined Statement of Budgetary Resources consist of trust funds, appropriated funds, revolving funds, management funds, gift funds, cooperative research and development agreement funds, and royalty funds. Annual appropriations are available for new obligations in the year of appropriation and for adjustments to valid obligations for 5 subsequent years. Other appropriations are available for obligation for multiple years or until expended based on Congressional authority.

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources. 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 Combined Statement of Budgetary Resources; therefore, it is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and become available for obligation, as needed. The entire trust fund balances in the amount of $261.5 billion, as of September 30, 2022 ($224.1 billion as of September 30, 2021) are included in Investments on the Consolidated Balance Sheets.

Note 18. Explanation of Differences between the Combined Statement of Budgetary Resources and the Budget of the United States Government (in Millions)

	2021			
	Budgetary Resources	New Obligations and Upward Adjustments	Distributed Offsetting Receipts	Outlays, net (discretionary and mandatory)
Combined Statement of Budgetary Resources	$ 2,661,345	$ 2,355,877	$ 621,612	$ 2,088,600
Expired Accounts	(115,570)	-	-	-
Other	(11)	(1)	39	1
Budget of the U.S. Government	**$ 2,545,764**	**$ 2,355,876**	**$ 621,651**	**$ 2,088,601**

The *Budget of the United States Government* (also known as the *President's Budget*), with the actual amounts for FY 2022, has not been published; therefore, no comparisons can be made between FY 2022 amounts presented in the Combined Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The *FY 2024 President's Budget* is expected to be released in February 2023 and may be obtained from OMB or from the Government Publishing Office.

HHS reconciled the amounts of the FY 2021 column on the Combined Statement of Budgetary Resources to the actual amounts for FY 2021 from the Appendix in the *FY 2023 President's Budget* for budgetary resources, new obligations and upward adjustments, distributed offsetting receipts, and net outlays.

For the budgetary resources reconciliation, the amount used from the *President's Budget* was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the Combined Statement of Budgetary Resources and not in the *President's Budget* is the budgetary resources that were not available. The Expired Accounts line in the above schedule includes expired authority, recoveries, and other amounts included in the Combined Statement of Budgetary Resources that are not included in the *President's Budget*.

Note 19. Undelivered Orders (in Millions)

	2022			2021		
	Federal	Non-Federal	Total	Federal	Non-Federal	Total
Undelivered Orders, Paid	$ 3,033	$ 39,522	$ 42,555	$ 1,565	$ 70,223	$ 71,788
Undelivered Orders, Unpaid	33,199	254,578	287,777	34,844	288,841	323,685
Total Undelivered Orders	**$ 36,232**	**$ 294,100**	**$ 330,332**	**$ 36,409**	**$ 359,064**	**$ 395,473**

Undelivered Orders include obligations that have been issued but not yet drawn down, as well as goods and services ordered that have not been received. HHS reported $330.3 billion of budgetary resources obligated for undelivered orders as of September 30, 2022 ($395.5 billion as of September 30, 2021). The Undelivered Orders, Paid decrease of $29.2 billion is primarily due to the CAAP advances that have been collected. The Undelivered Orders, Unpaid decrease of $35.9 billion is primarily due to the COVID-19 related obligations being delivered and paid.

Note 20. Funds from Dedicated Collections (in Millions)

Medicare is the largest dedicated collections program managed by HHS and is presented in a separate column in the table. The Medicare program includes the HI Trust Fund; the SMI Trust Fund which includes both Part B medical insurance, and the Medicare Prescription Drug Benefit – Part D; and the Medicare and Medicaid Integrity Programs. See Note 1 for a description of each fund's purpose and how HHS accounts for and reports the funds.

Balance Sheet	2022 Medicare	Other	Combined Funds from Dedicated Collections	Eliminations	Consolidated Funds from Dedicated Collections
Fund Balance with Treasury	$ 191,070	$ 17,887	$ 208,957	$ -	$ 208,957
Investments, Net	347,264	3,965	351,229	-	351,229
Accounts Receivable, Net	91,025	7,127	98,152	(97,598)	554
Advances and Prepayments	-	74	74	(70)	4
Other Assets	-	-	-	70	70
Total Intragovernmental Assets	**629,359**	**29,053**	**658,412**	**(97,598)**	**560,814**
Accounts Receivable, Net	25,696	6,853	32,549	-	32,549
General Property, Plant and Equipment, Net	456	2,003	2,459	-	2,459
Advances and Prepayments	39,006	1	39,007	-	39,007
Other Assets	-	10	10	-	10
Total Assets Other than Intragovernmental	**65,158**	**8,867**	**74,025**	**-**	**74,025**
Total Assets	**$ 694,517**	**$ 37,920**	**$ 732,437**	**$ (97,598)**	**$ 634,839**
Accounts Payable	$ 100,906	$ 56	$ 100,962	$ (97,683)	$ 3,279
Debt	7,747	-	7,747	-	7,747
Other Liabilities	-	13	13	85	98
Total Intragovernmental Liabilities	**108,653**	**69**	**108,722**	**(97,598)**	**11,124**
Accounts Payable	145	195	340	-	340
Entitlement Benefits Due and Payable	85,073	-	85,073	-	85,073
Federal Employee and Veteran Benefits Payable	7	88	95	-	95
Advances from Others and Deferred Revenue	1,295	280	1,575	-	1,575
Other Liabilities	1	11,728	11,729	-	11,729
Total Liabilities Other than Intragovernmental	**86,521**	**12,291**	**98,812**	**-**	**98,812**
Total Liabilities	**$ 195,174**	**$ 12,360**	**$ 207,534**	**$ (97,598)**	**$ 109,936**
Unexpended Appropriations	174,874	3,830	178,704	-	178,704
Cumulative Results of Operations	324,469	21,730	346,199	-	346,199
Total Liabilities and Net Position	**$ 694,517**	**$ 37,920**	**$ 732,437**	**$ (97,598)**	**$ 634,839**
Statement of Net Cost					
Gross Program Costs	$ 905,691	$ 19,113	$ 924,804	$ (647)	$ 924,157
Less: Earned Revenues	(136,896)	(15,560)	(152,456)	632	(151,824)
Net Cost of Operations	**$ 768,795**	**$ 3,553**	**$ 772,348**	**$ (15)**	**$ 772,333**
Statement of Changes in Net Position					
Unexpended Appropriations:					
Beginning Balance	$ 134,077	$ 866	$ 134,943	$ -	$ 134,943
Appropriations Received	530,954	3,065	534,019	-	534,019
Other Adjustments	(17,249)	(5)	(17,254)	-	(17,254)
Appropriation Used	(472,908)	(96)	(473,004)	-	(473,004)
Total Unexpended Appropriations	**174,874**	**3,830**	**178,704**	**-**	**178,704**
Cumulative Results of Operations:					
Beginning Balance	275,788	20,540	296,328	-	296,328
Appropriations Used	472,908	96	473,004	-	473,004
Other than Intragovernmental Nonexchange Revenue:					
Nonexchange Revenue – Other	(758)	10	(748)	-	(748)
Intragovernmental Nonexchange Revenue	354,666	-	354,666	-	354,666
Donations and Forfeitures of Cash and Cash Equivalents	-	76	76	-	76
Transfers-in/out without Reimbursement	(9,344)	4,455	(4,889)	-	(4,889)
Imputed Financing	4	85	89	(15)	74
Other	-	21	21	-	21
Net Cost of Operations	768,795	3,553	772,348	(15)	772,333
Net Change and Cumulative Results of Operations	48,681	1,190	49,871	-	49,871
Total Cumulative Results of Operations	**324,469**	**21,730**	**346,199**	**-**	**346,199**
Net Position, End of Period	**$ 499,343**	**$ 25,560**	**$ 524,903**	**$ -**	**$ 524,903**

Balance Sheet	2021 Medicare	Other	Combined Funds from Dedicated Collections	Eliminations	Consolidated Funds from Dedicated Collections
Fund Balance with Treasury	$ 145,714	$ 13,213	$ 158,927	$ -	$ 158,927
Investments, Net	308,133	3,965	312,098	-	312,098
Accounts Receivable, Net	86,056	7,308	93,364	(92,821)	543
Advances and Prepayments	-	36	36	(30)	6
Other Assets	-	-	-	30	30
Total Intragovernmental Assets	**539,903**	**24,522**	**564,425**	**(92,821)**	**471,604**
Accounts Receivable, Net	15,647	6,148	21,795	-	21,795
General Property, Plant and Equipment, Net	286	1,496	1,782	-	1,782
Advances and Prepayments	67,012	80	67,092	-	67,092
Other Assets	-	7	7	-	7
Total Assets Other than Intragovernmental	**82,945**	**7,731**	**90,676**	**-**	**90,676**
Total Assets	**$ 622,848**	**$ 32,253**	**$ 655,101**	**$ (92,821)**	**$ 562,280**
Accounts Payable	$ 95,920	$ 45	$ 95,965	$ (92,875)	$ 3,090
Debt	36,312	-	36,312	-	36,312
Other Liabilities	1	29	30	54	84
Total Intragovernmental Liabilities	**132,233**	**74**	**132,307**	**(92,821)**	**39,486**
Accounts Payable	143	186	329	-	329
Entitlement Benefits Due and Payable	79,778	-	79,778	-	79,778
Federal Employee and Veteran Benefits Payable	5	90	95	-	95
Advances from Others and Deferred Revenue	815	1,513	2,328	-	2,328
Other Liabilities	9	8,984	8,993	-	8,993
Total Liabilities Other than Intragovernmental	**80,750**	**10,773**	**91,523**	**-**	**91,523**
Total Liabilities	**$ 212,983**	**$ 10,847**	**$ 223,830**	**$ (92,821)**	**$ 131,009**
Unexpended Appropriations	134,077	866	134,943	-	134,943
Cumulative Results of Operations	275,788	20,540	296,328	-	296,328
Total Liabilities and Net Position	**$ 622,848**	**$ 32,253**	**$ 655,101**	**$ (92,821)**	**$ 562,280**
Statement of Net Cost					
Gross Program Costs	$ 853,407	$ 17,332	$ 870,739	$ (1,244)	$ 869,495
Less: Earned Revenues	(122,634)	(14,500)	(137,134)	1,227	(135,907)
Net Cost of Operations	**$ 730,773**	**$ 2,832**	**$ 733,605**	**$ (17)**	**$ 733,588**
Statement of Changes in Net Position					
Unexpended Appropriations:					
Beginning Balance	$ 97,863	$ 254	$ 98,117	$ -	$ 98,117
Appropriations Received	501,642	703	502,345	-	502,345
Other Adjustments	(23,947)	(8)	(23,955)	-	(23,955)
Appropriation Used	(441,481)	(83)	(441,564)	-	(441,564)
Total Unexpended Appropriations	**134,077**	**866**	**134,943**	**-**	**134,943**
Cumulative Results of Operations:					
Beginning Balance	266,988	18,704	285,692	-	285,692
Other Adjustments	-	(1)	(1)	-	(1)
Appropriations Used	441,481	83	441,564	-	441,564
Other than Intragovernmental Nonexchange Revenue:					
Nonexchange Revenue – Other	(793)	4	(789)	-	(789)
Intragovernmental Nonexchange Revenue	308,070	-	308,070	-	308,070
Donations and Forfeitures of Cash and Cash Equivalents	-	71	71	-	71
Transfers-in/out without Reimbursement	(9,185)	4,383	(4,802)	-	(4,802)
Imputed Financing	-	106	106	(17)	89
Other	-	22	22	-	22
Net Cost of Operations	730,773	2,832	733,605	(17)	733,588
Net Change and Cumulative Results of Operations	8,800	1,836	10,636	-	10,636
Total Cumulative Results of Operations	**275,788**	**20,540**	**296,328**	**-**	**296,328**
Net Position, End of Period	**$ 409,865**	**$ 21,406**	**$ 431,271**	**$ -**	**$ 431,271**

Note 21. Stewardship Land

IHS provides federal health services to American Indians and Alaska Natives to help raise their health status to the highest possible level. IHS provides healthcare to approximately 2.6 million American Indians and Alaska Natives who belong to 574 federally recognized tribes in 37 states. Health services are provided on tribal/reservation trust land that DOI transferred to IHS for this purpose. Although the structures on this land are operational in nature, the land on which these structures reside is managed in a stewardship manner. All trust land, when no longer needed by IHS, must be returned to the DOI's Bureau of Indian Affairs for continuing trust responsibilities and oversight.

The table below presents stewardship land held by HHS:

Indian Trust Land by Locations and Number of Sites

IHS Area	2022	2021
Albuquerque	6	4
Bemidji	2	2
Billings	7	7
Great Plains	9	9
Navajo	36	36
Oklahoma City	1	1
Phoenix	10	10
Portland	3	3
Tucson	5	5
Total	**79**	**77**

Note 22. Reconciliation of Net Cost to Net Outlays (in Millions)

The Reconciliation of Net Cost of Operations to Net Outlays reconciles proprietary basis of accounting Net Cost of Operations to budgetary basis of accounting Outlays, Net. Reconciling items include activity impacting Net Cost of Operations but are not included in Outlays, Net and activity impacting Outlays, Net but are not included in Net Cost of Operations. The miscellaneous items account for activities to be added or removed based on HHS activities that are not reflected in the reconciliation crosswalk.

	2022		
	Intragovernmental	Other than Intragovernmental	Total
Net Cost of Operations	**$ 42,599**	**$ 1,618,194**	**$ 1,660,793**
Components of Net Cost Not Part of the Budget Outlays			
Property, Plant, and Equipment Depreciation Expense	-	(1,262)	(1,262)
Cost of Goods Sold	-	(25)	(25)
Applied Overhead/Cost Capitalization Offset	-	1,738	1,738
Gain/Losses on All Other Investments	-	(11)	(11)
	-	**440**	**440**
Increase/(Decrease) in Assets:			
Accounts Receivables	126	11,455	11,581
Securities and Investments	601	-	601
Advances and Prepayments	1,412	(30,893)	(29,481)
Other Assets	-	(8)	(8)
	2,139	**(19,446)**	**(17,307)**
(Increase)/Decrease in Liabilities:			
Accounts Payable	1,003	(271)	732
Debt	28,525	-	28,525
Benefits Due and Payable	-	(7,400)	(7,400)
Federal Employee and Veteran Benefits Payable	-	(2,144)	(2,144)
Accrued Liabilities	-	2,215	2,215
Contingencies and Commitments	-	(3,696)	(3,696)
Environmental and Disposal Liabilities	-	14	14
Other Liabilities	27	1,429	1,456
	29,555	**(9,853)**	**19,702**
Other Financing Sources:			
Imputed Cost	(675)	-	(675)
Total Components of Net Cost of Operating Costs Not Part of the Budgetary Outlays	**31,019**	**(28,859)**	**2,160**

	2022		
	Intragovernmental	Other than Intragovernmental	Total
Components of Budget Outlays Not Part of Net Cost:			
Acquisition of Capital Assets	7	438	445
Acquisition of Inventory	1	1,040	1,041
Acquisition of Other Assets	1	-	1
Other Financing Sources:			
Donated Revenue	-	(76)	(76)
Transfers out(in) without Reimbursement	2,519	-	2,519
Total Components of Budget Outlays Not Part of Net Cost	**2,528**	**1,402**	**3,930**
Miscellaneous Items:	:		
Custodial/Non-Exchange Revenue	(6,418)	61	(6,357)
Non-entity activity	780	-	780
Other Temporary Timing Differences	-	246	246
Appropriated Receipts for Trust/Special Funds	-	8,117	8,117
Reconciling Items:			
Debt	(28,526)	-	(28,526)
Custodial/Non-Exchange Revenue	6,419	(62)	6,357
Miscellaneous Receipts	-	(1,661)	(1,661)
Federal Share of Child Support Collections	(684)	-	(684)
Total Miscellaneous Items	**(28,429)**	**6,701**	**(21,728)**
Net Outlays	**$ 47,717**	**$ 1,597,438**	**$ 1,645,155**
Other Reconciling Items			(2,165)
Agency Outlays, Net			**$ 1,642,990**

	2021		
	Intragovernmental	Other than Intragovernmental	Total
Net Cost of Operations	**$ 28,376**	**$ 1,480,180**	**$ 1,508,556**
Components of Net Cost Not Part of the Budget Outlays			
Property, Plant, and Equipment Depreciation Expense	-	(995)	(995)
Cost of Goods Sold	-	(28)	(28)
Applied Overhead/Cost Capitalization Offset	-	1,110	1,110
Gain/Losses on All Other Investments	-	(6)	(6)
	-	**81**	**81**
Increase/(Decrease) in Assets:			
Accounts Receivables	(10)	7,026	7,016
Securities and Investments	358	-	358
Advances and Prepayments	(993)	(36,001)	(36,994)
Other Assets	-	(36)	(36)
	(645)	**(29,011)**	**(29,656)**
(Increase)/Decrease in Liabilities:			
Accounts Payable	(906)	1,131	225
Debt	(35,420)	(1)	(35,421)
Benefits Due and Payable	-	(16,842)	(16,842)
Federal Employee and Veteran Benefits Payable	-	(1,040)	(1,040)
Accrued Liabilities	-	(2,934)	(2,934)
Contingencies and Commitments	-	(813)	(813)
Environmental and Disposal Liabilities	-	(113)	(113)
Other Liabilities	(62)	(1,035)	(1,097)
	(36,388)	**(21,647)**	**(58,035)**
Other Financing Sources:			
Imputed Cost	(613)	-	(613)
Total Components of Net Cost of Operating Costs Not Part of the Budgetary Outlays	**(37,646)**	**(50,577)**	**(88,223)**

	2021		
	Intragovernmental	Other than Intragovernmental	Total
Components of Budget Outlays Not Part of Net Cost:			
Acquisition of Capital Assets	4	494	498
Acquisition of Inventory	5	2,918	2,923
Acquisition of Other Assets	5	1	6
Other Financing Sources:			
Donated Revenue	-	(71)	(71)
Transfers out(in) without Reimbursement	2,442	-	2,442
Total Components of Budget Outlays Not Part of Net Cost	**2,456**	**3,342**	**5,798**
Miscellaneous Items:	:		
Custodial/Non-Exchange Revenue	(4,081)	(120)	(4,201)
Non-entity activity	717	-	717
Appropriated Receipts for Trust/Special Funds	-	6,888	6,888
Reconciling Items:			
Debt	35,420	1	35,421
Custodial/Non-Exchange Revenue	4,081	120	4,201
Federal Share of Child Support Collections	(887)	-	(887)
Total Miscellaneous Items	**35,250**	**6,889**	**42,139**
Net Outlay	**$ 28,436**	**$ 1,439,834**	**$ 1,468,270**
Other Reconciling Items			(1,282)
Agency Outlays, Net			**$ 1,466,988**

Note 23. Combined Schedule of Spending (in Millions)

The Combined Schedule of Spending presents an overview of how departments or agencies spend (i.e., obligate) money. The data used to populate this schedule are the same underlying data used to populate the Combined Statement of Budgetary Resources. Simplified terms are used to improve the public's understanding of the budgetary accounting terminology used in the Combined Statement of Budgetary Resources.

Additional efforts to improve the transparency of spending activity in the federal government have recently come to fruition in the implementation of the *Digital Accountability and Transparency Act of 2014* (DATA Act). This legislation makes available to the public, at no cost, a searchable website that provides award and financial information on contracts and financial assistance awards (including grants). While the underlying obligation data used to generate both the Combined Schedule of Spending and the DATA Act submission are the same, there is a fundamentally different purpose behind each, which should be considered when comparing the two. The Combined Schedule of Spending presents total budgetary resources, total new obligations, and upward adjustments for the reporting entity. The website displaying the DATA Act submission, USAspending.gov,[5] collects the same data as well as recoveries. Additional differences include the definition of key attributes in each. Programs for the Combined Schedule of Spending are defined by the Treasury Account Symbol, whereas the DATA Act uses the Program and Financing lines from the *President's Budget*. The Combined Schedule of Spending and DATA Act both report spending activity by object class. However, the DATA Act requires granular-level object class assignments, while the Combined Schedule of Spending groups object classes at a higher level for presentation purposes. Additionally, the DATA Act submission at the award-level data does not include certain obligations, such as personnel compensation, travel, utilities, leases, intra-departmental and interagency spending, and various other categories of financial awards. The Combined Schedule of Spending has no such exclusions and is similar to the program activity reporting file for DATA Act. Lastly, the DATA Act reporting responsibility for award-level activity in allocation accounts is always assigned to the child entity. This is not entirely consistent with allocation account reporting for the financial statements for which either the parent or child will report.

What Money is Available to Spend? This section presents resources that were available to spend, as reported in the Combined Statement of Budgetary Resources. Total Resources refers to Total Budgetary Resources as described in the Combined Statement of Budgetary Resources and represents amounts approved for spending by law. Amount Available but Not Agreed to be Spent represents amounts that HHS was allowed to spend but did not take action to spend by the end of the fiscal year. Amount Not Available to be Spent represents amounts that HHS was not approved to spend during the current fiscal year. Total Amounts Agreed to be Spent represents spending actions taken by HHS – including contracts, purchase orders, grants, or other legally binding agreements of the federal government – to pay for goods or services. This line total agrees to the New Obligations and Upward Adjustments line in the Combined Statement of Budgetary Resources.

Who did the Money Go To? This section identifies the recipient of the money by federal and non-federal entities. Amounts in this section reflect amounts agreed to be spent and agree to the New Obligations and Upward Adjustments line on the Statement of Budgetary Resources.

How was the Money Spent/Issued? This section presents services or items that were purchased and categorized by program with spending greater than $2.0 billion. Grants, Subsidies, & Contributions, Insurance Claims and Indemnities, Other Contractual Services and Personnel Compensation & Benefits are the object classes that have a

[5] The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

material impact on HHS reporting. HHS Medicare payments are reported under Insurance Claims and Indemnities based on the OMB Circular A-11, *Preparation, Submission, and Execution of the Budget*, object class definition.

Combined Schedule of Spending

For the Years Ended September 30, 2022 and 2021
(in Millions)

What Money is Available to Spend	2022	2021
Total Resources	$ 2,736,002	$ 2,661,345
Less Amount Available but Not Agreed to be Spent	114,123	136,042
Less Amount Not Available to be Spent	168,863	169,426
Total Amounts Agreed to be Spent	**$ 2,453,016**	**$ 2,355,877**

Who Did the Money Go To	2022	2021
Federal	$ 48,647	$ 49,062
Non-Federal	2,404,369	2,306,815
Total Amounts Agreed to be Spent	**$ 2,453,016**	**$ 2,355,877**

Total Amounts Agreed to be Spent increased by $97.1 billion, mostly due to increases in Medicaid, primarily related to Medicaid grant awards to the states, SMI, PTF, HI and Part D. This is offset by decreases in COVID-19 funding for the CARES Act, *Consolidated Appropriations Act, 2021* and the *American Rescue Plan Act of 2021.*

Combined Schedule of Spending By Object Class

For the Year Ended September 30, 2022

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Insurance Claims & Indemnities	Other Contractual Services	Personnel Compensation & Benefits	Other	Total
Medicaid	$ 654,795	$ 1	$ -	$ -	$ -	$ 654,796
Federal Supplementary Medical Insurance Trust Fund	-	467,116	137	-	5,883	473,136
Payments to Trust Funds	349,632	-	-	-	112,465	462,097
Federal Hospital Insurance Trust Fund	-	394,309	9	-	3,387	397,705
Medicare Prescription Drug Account	-	114,766	-	1	248	115,015
Public Health and Social Services Emergency Fund	4,130	-	75,549	328	893	80,900
Taxation on OASDI Benefits, HI	32,775	-	-	-	-	32,775
State Children's Health Insurance Fund	19,346	-	7	-	-	19,353
Temporary Assistance for Needy Families	16,624	-	81	16	2	16,723
Children and Families Services Programs	13,202	-	324	176	13	13,715
Refugee and Entrant Assistance	5,500	-	5,109	60	5	10,674
Payments for Foster Care and Permanency	9,482	-	49	1	1	9,533
Risk Adjustment Program Payments	-	8,378	-	-	-	8,378
Indian Health Services	3,141	2	1,456	1,739	1,364	7,702
Defense Production Act Medical Supplies Enhancement	-	-	5,932	1	1,461	7,394
CMS Program Management	616	-	5,624	767	112	7,119
National Cancer Institute	4,284	-	1,926	695	132	7,037
National Institute of Allergy and Infectious Diseases	4,015	-	2,171	431	131	6,748
FDA Salaries and Expenses	327	1	2,513	3,235	503	6,579
Payment to States for the Child Care and Development Block Grant*	6,030	-	171	6	1	6,208
Primary Health Care	5,310	-	291	104	8	5,713
Vaccines for Children Program	126	-	79	25	5,311	5,541
CDC-Wide Activities and Program Support	1,333	-	3,065	225	90	4,713
Payments to States for Child Support Enforcement and Family Support Programs	3,885	-	705	-	-	4,590
National Institute on Aging	3,798	-	374	108	35	4,315
Substance Abuse Treatment	3,822	-	115	20	3	3,960
National Heart, Lung, and Blood Institute	3,126	-	576	187	32	3,921
Low Income Home Energy Assistance	3,896	-	4	-	-	3,900
Child Care Entitlement to States*	3,612	-	48	-	1	3,661
National Institute of General Medical Sciences	2,974	-	108	39	1	3,122
NIH Service and Supply Fund	-	-	2,229	371	374	2,974
NIH Office of the Director	1,913	-	619	207	13	2,752
National Institute of Neurological Disorders and Stroke	2,138	-	359	130	29	2,656
Aging and Disability Services Programs	2,488	-	61	34	4	2,587
Ryan White HIV/AIDS Program	2,352	-	109	33	6	2,500
Health Care Fraud and Abuse Control Program	-	-	1,566	103	747	2,416
National Institute of Diabetes and Digestive and Kidney Diseases	1,906	-	272	148	21	2,347
Mental Health	2,158	-	145	24	2	2,329
National Institute of Mental Health	1,814	-	301	127	14	2,256
Other Agency Budgetary Accounts	23,073	804	10,551	5,889	2,859	43,176
Total Amounts Agreed to be Spent	**$ 1,193,623**	**$ 985,377**	**$ 122,635**	**$ 15,230**	**$ 136,151**	**$ 2,453,016**

*Funding from the Child Care and Development Fund

Combined Schedule of Spending By Object Class

For the Year Ended September 30, 2021

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Insurance Claims & Indemnities	Other Contractual Services	Personnel Compensation & Benefits	Other	Total
Medicaid	$ 555,791	$ -	$ 2	$ -	$ -	$ 555,793
Payments to Trust Funds	336,728	-	-	-	97,404	434,132
Federal Supplementary Medical Insurance Trust Fund	-	428,315	118	1	4,737	433,171
Federal Hospital Insurance Trust Fund	-	381,772	2	-	3,703	385,477
Public Health and Social Services Emergency Fund	37,847	1	77,911	281	1,899	117,939
Medicare Prescription Drug Account	-	100,589	-	1	859	101,449
Payment to States for the Child Care and Development Block Grant*	54,281	-	552	4	1	54,838
Taxation on OASDI Benefits, HI	24,975	-	-	-	-	24,975
State Children's Health Insurance Fund	18,144	-	7	-	-	18,151
Temporary Assistance for Needy Families	17,619	-	81	15	1	17,716
Children and Families Services Programs	16,047	-	374	173	11	16,605
CDC-Wide Activities and Program Support	9,043	-	6,348	207	75	15,673
Primary Health Care	12,378	-	462	100	11	12,951
Indian Health Services	6,215	1	1,403	1,715	1,147	10,481
Payments for Foster Care and Permanency	10,258	-	54	1	1	10,314
Low Income Home Energy Assistance	8,212	-	3	-	-	8,215
Refugee and Entrant Assistance	2,672	1	4,824	38	17	7,552
National Cancer Institute	4,046	-	1,967	653	109	6,775
National Institute of Allergy and Infectious Diseases	4,092	-	1,895	412	127	6,526
FDA Salaries and Expenses	321	1	2,409	3,083	665	6,479
Risk Adjustment Program Payments	-	6,341	-	-	-	6,341
CMS Program Management	98	-	5,351	763	102	6,314
Substance Abuse Treatment	5,172	-	99	5	1	5,277
Payments to States for Child Support Enforcement and Family Support Programs	3,715	-	910	-	-	4,625
Health Surveillance and Program Support	4,265	-	74	73	7	4,419
Aging and Disability Services Programs	4,040	-	58	32	4	4,134
National Institute on Aging	3,442	-	358	97	40	3,937
Vaccines for Children Program	133	-	87	24	3,562	3,806
National Heart, Lung, and Blood Institute	2,921	-	595	175	24	3,715
Child Care Entitlement to States*	3,505	-	48	-	-	3,553
Mental Health	3,411	-	89	3	2	3,505
National Institute of General Medical Sciences	2,857	-	105	36	2	3,000
NIH Office of the Director	2,000	-	623	182	17	2,822
NIH Service and Supply Fund	-	-	1,941	337	362	2,640
National Institute of Neurological Disorders and Stroke	2,080	-	325	121	24	2,550
Ryan White HIV/AIDS Program	2,297	-	108	31	6	2,442
Health Care Fraud and Abuse Control Program	-	-	1,591	87	712	2,390
National Institute of Diabetes and Digestive and Kidney Diseases	1,841	-	264	140	22	2,267
National Institute of Mental Health	1,705	-	287	119	17	2,128
Other Agency Budgetary Accounts	21,366	780	10,332	5,525	2,797	40,800
Total Amounts Agreed to be Spent	**$ 1,183,517**	**$ 917,801**	**$ 121,657**	**$ 14,434**	**$ 118,468**	**$ 2,355,877**

*Funding from the Child Care and Development Fund

Note 24. COVID-19 Activities (in Millions)

Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020	FY 2022	FY 2021	FY 2020
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 663	$ 1,253	$ -
New Budget Authority	-	-	6,497
Budgetary Resources Obligated	(117)	(590)	(5,244)
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	546	663	1,253
Outlays, Net	$ 1,070	$ 2,439	$ 1,392

Families First Coronavirus Response Act	FY 2022	FY 2021	FY 2020
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 6	$ 511	$ -
New Budget Authority	-	-	1,314
Budgetary Resources Obligated	(5)	(505)	(803)
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	1	6	511
Outlays, Net	$ 34	$ 544	$ 719

Coronavirus Aid, Relief, and Economic Security Act	FY 2022	FY 2021	FY 2020
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 5,486	$ 80,621	$ -
New Budget Authority	-	-	142,544*
Budgetary Resources Obligated	(2,552)	(75,135)	(61,923)
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	2,934	5,486	80,621
Outlays, Net	$ 11,045	$ 86,985	$ 33,813

Paycheck Protection Program and Health Care Enhancement Act	FY 2022	FY 2021	FY 2020
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 35,416	$ 9,837	$ -
New Budget Authority	-	-	100,000
Budgetary Resources Obligated	(26,928)	25,579	(90,163)
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	8,488	35,416	9,837
Outlays, Net	$ 35,880	$ (25,897)	$ 77,533

Coronavirus Response and Relief Supplemental Appropriations Act, 2021	FY 2022	FY 2021	FY 2020
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 13,487	$ -	$ -
New Budget Authority	-	73,175	-
Budgetary Resources Obligated	(12,132)	(59,688)	-
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	1,355	13,487	-
Outlays, Net	$ 23,066	$ 13,965	$ -

American Rescue Plan Act of 2021	FY 2022	FY 2021	FY 2020
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 64,828	$ -	$ -
New Budget Authority	-	160,494	-
Budgetary Resources Obligated	(43,954)	(95,666)	-
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	20,874	64,828	-
Outlays, Net	$ 58,854	$ 11,682	$ -

Low-Income Household Drinking Water and Wastewater Emergency Assistance Program	FY 2022	FY 2021	FY 2020
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ -	$ -	$ -
New Budget Authority	-	638	-
Budgetary Resources Obligated	-	(638)	-
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	-	-	-
Outlays, Net	$ 184	$ 1	$ -

Total COVID-19	FY 2022	FY 2021	FY 2020
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 119,886	$ 92,222	$ -
New Budget Authority	-	234,307	250,355*
Budgetary Resources Obligated	(85,688)	(206,643)	(158,133)
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	34,198	119,886	92,222
Outlays, Net	$ 130,133	$ 89,719	$ 113,457

*The HHS Budget Authority is reduced by $289 million in *Coronavirus Aid, Relief, and Economic Security Act* funds transferred to the Department of Homeland Security.

The *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020* provides funding for HHS to reimburse costs incurred for COVID-19 preparedness and response activities. Funds could be used for contract support services to support the prevention of, preparation for, or response to COVID-19. HHS received $6.5 billion to support programs including: BARDA; SNS; grants for state, local, and tribal governments; Institute of Allergy and Infectious Diseases; and Institute of Environmental Health Sciences.

The *Families First Coronavirus Response Act* provides funding for paid leave, free COVID-19 testing, unemployment benefits, food assistance for vulnerable children and families, and states for economic consequences due to the pandemic. HHS received $1.3 billion primarily for the PHSSEF, with $1.0 billion for provider reimbursement.

The CARES Act provides emergency assistance and healthcare for individuals, families, and businesses impacted by COVID-19. HHS received $142.5 billion primarily for the PHSSEF, which received $126.7 billion. Through the PHSSEF, the Provider Relief Fund received $100.0 billion to prevent, prepare for, and respond to COVID-19 domestically and internationally. The Provider Relief Fund provides payments to assist eligible healthcare providers for healthcare related expenses or lost revenues attributed to the COVID-19 pandemic. Additionally, BARDA received funding to advance research, development, manufacturing, production, purchases, and other activities related to COVID-19 testing.

The *Paycheck Protection Program and Health Care Enhancement Act* provides additional funding to key programs under the CARES Act, including the Paycheck Protection Program, loans and grants to small businesses, healthcare providers and hospitals, and COVID-19 testing. HHS received $100.0 billion for the PHSSEF, including $75.0 billion for the Provider Relief Fund, and the remaining $25.0 billion to provide relief to state, local, and tribal governments and other COVID-19 response activities.

The *Coronavirus Response and Relief Supplemental Appropriations Act, 2021* provides funding to support a three-month extension of sequester relief from existing provider relief funds, reduce anticipated cuts to physician payments, and improve rural facility reimbursements. HHS received $73.2 billion which includes $63.2 billion ($46.7 billion for the PHSSEF) to carry out these activities and $10.0 billion for the Child Care and Development Fund to provide families and childcare providers additional financial support during the COVID-19 public health crisis.

The *American Rescue Plan Act of 2021* provides relief funding to workers and families for nationwide testing sites and community vaccination sites as well as addressing disparities in obtaining quality healthcare. HHS received $160.5 billion, of which $80.1 billion was for PHSSEF ($47.8 billion was for testing, contact tracing, and mitigation activities). In addition, the Child Care and Development Fund received $38.9 billion — for childcare stabilization grants and additional supplemental funds — to help working parents by providing childcare subsidies, stabilizing the childcare sector, and increasing childcare options.

The Low-Income Household Drinking Water and Wastewater Emergency Assistance Program (LIHWAP) is an emergency program introduced in the Coronavirus Response and Relief Supplemental Appropriations Act, 2021, providing HHS with $638 million to assist households with paying for drinking water and wastewater services in

response to needs created by the COVID-19 pandemic. Preliminary data shows that in the first two quarters of FY-2022, 41 states and over 56 tribes began accepting LIHWAP applications, over 150,000 households received LIHWAP assistance, and over 91,000 households had services restored or disconnection prevented through LIHWAP benefits assistance. This program funding is available for use through September 30, 2023.

The Medicare Payment for Over-the-Counter COVID-19 Testing Demonstration Program was launched on April 4, 2022. This program provides direct payment to participating eligible pharmacies and healthcare providers for up to eight free over-the-counter COVID-19 tests per calendar month per beneficiary when provided to people with Medicare Part B, including those enrolled in Medicare Advantage plans, for the duration of the COVID-19 public health emergency. HHS received $8.7 billion to support this program with any remaining to be returned. During FY 2022, $284 million was used to provide COVID-19 tests.

Refer to the following notes for additional information on COVID-19 activities: Summary of Significant Accounting Policies (Note 1), Entity and Non-Entity Assets (Note 2), Fund Balance with Treasury (Note 3), Inventory and Related Property, Net (Note 6), Advances (Note 8), Liabilities Not Covered by Budgetary Resources (Note 9), Debt (Note 10), Undelivered Orders (Note 19), and Combined Schedule of Spending (Note 23).

Note 25. Reclassification of Statement of Net Cost for FR Compilation Process

Reclassification of Statement of Net Cost to Line Items Used for the Government-wide Statement of Net Cost For the Year Ended September 30, 2022 (in Millions)							
FY 2022 HHS Statement of Net Cost		Line Items Used to Prepare FY 2022 Government-wide Statement of Net Cost					
Financial Statement Line	Amounts	Dedicated Collections Combined	Dedicated Collections Eliminations	All Other Amounts (with Eliminations)	Eliminations Between Dedicated and All Other	Total	Reclassified Financial Statement Line
		$ 922,149	**$ -**	**$ 848,749**	**$ -**	**$ 1,770,898**	***Non-Federal Costs***
							Intragovernmental Costs
		424	-	1,965	-	2,389	*Benefit Program Costs*
		89	(15)	601	-	675	*Imputed Costs*
		1,999	(633)	38,567	-	39,933	*Buy/Sell Costs*
		-	-	10	-	10	*Purchase of Assets*
		-	-	11	-	11	*Borrowing and Other Interest Expense*
		130	-	573	-	703	*Other Expenses (w/o Reciprocals)*
		$ 2,642	**$ (648)**	**$ 41,727**	**$ -**	**$ 43,721**	**Total Intragovernmental Costs**
CMS: Gross Cost	$ 1,531,319						
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	283,291						
Total Gross Costs	**$ 1,814,610**	**$ 924,791**	**$ (648)**	**$ 890,476**	**$ -**	**$ 1,814,619**	***Total Reclassified Gross Costs***
		$ (151,816)	**$ -**	**$ (2,328)**	**$ -**	**$ (154,144)**	**Non-Federal Earned Revenue**
							Intragovernmental Earned Revenue
		(639)	633	(1,106)	-	(1,112)	*Buy/Sell Revenue*
		-	-	(10)	-	(10)	*Borrowing and Other Interest Revenue*
		-	-	(1)	-	(1)	*Purchase of Assets Offset*
		$ (639)	**$ 633**	**$ (1,116)**	**$ -**	**$ (1,122)**	**Total Intragovernmental Earned Revenue**
CMS: Earned Revenue	$ (148,181)						
Other Segments: Earned Revenue	(7,076)						
Total Earned Revenue	**$ (155,257)**	**$ (152,455)**	**$ 633**	**$ (3,444)**	**$ -**	**$ (155,266)**	***Total Reclassified Earned Revenue***
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan Assumption Changes	1,440	-	-	1,440	-	1,440	Gain/Loss on Changes in Actuarial Assumptions (Non-Federal)
Net Cost	**$ 1,660,793**	**$ 772,336**	**$ (15)**	**$ 888,472**	**$ -**	**$ 1,660,793**	**Net Cost**

*Subtotals and totals may not equal due to rounding.

To prepare the Financial Report of the U.S. Government (FR), Treasury requires agencies to submit an adjusted trial balance, which is a listing of amounts by USSGL account that appears in the financial statements. Treasury uses the trial balance information reported in Governmentwide Treasury Account Symbol Adjusted Trial Balance System (GTAS) to develop a Reclassified Balance Sheet, Reclassified Statement of Net Cost, and a Reclassified Statement of Changes in Net Position for each agency, which are accessed using GTAS. Treasury eliminates all intragovernmental balances from the reclassified statements and aggregates lines with the same title to develop the FR statements. This note shows the HHS financial statements and the HHS reclassified statements prior to elimination of intragovernmental balances and prior to aggregation of repeated FR line items. A copy of the 2021 FR can be found at Fiscal Service's website and the 2022 FR will be posted to the site as soon as it is released.

Note 26. 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 *2022 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. 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 pre-pandemic expectations for 2020). Overall, the projections are based primarily on actual experience through 2019. However, program costs in 2020 and 2021 were used to help inform the development of adjustment factors by type of service, which account for the impact of COVID-19 through 2028. In spite of these substantial impacts on the Medicare program in 2020, the pandemic was not factored into the SOSI projections until 2021 because of the uncertainty of the impacts at the time the 2020 Trustees Report was released.

Spending for services other than COVID-19 was significantly lower than expected in 2020 and 2021. This decline was more pronounced for elective services. In addition, Medicare beneficiaries whose deaths were identified as related to COVID had costs that were much higher than the average Medicare beneficiary prior to the onset of the pandemic. As a result, compared to the pre-pandemic Medicare population, the surviving Medicare population had lower morbidity, on average, reducing costs by an estimated 1.5 percent in 2020 and 2.9 percent in 2021. This morbidity effect is expected to continue over the next few years but is assumed to decrease over time before ending in 2028.

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 2028. 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 Program was significantly expanded during the COVID-19 public health emergency period. Total payments of approximately $107.2 billion were made from March 2020 through June 2021: roughly $67.1 billion from the HI trust fund and $40.1 billion from the SMI Part B trust fund account. The Trustees assumed that the accelerated and advance payments would be fully repaid by September of 2022, resulting

in no net changes to trust fund expenditures. As discussed in Note 8, the majority of these accelerated and advance payments have been repaid as of September 30, 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. Moreover, as a result of developments that have occurred since the assumptions for this year's Trustees Report were selected in mid-February 2022, uncertainty has increased regarding the path of the COVID-19 pandemic and the economy. The Trustees will continue to monitor developments and modify the projections in later reports as appropriate. The pandemic is an example of the inherent uncertainty in projecting healthcare financing and spending over any duration.

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 healthcare cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar deficits because each account is automatically in financial balance every year due to its statutory financing mechanism.

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

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in medical care, demographic factors

affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these inherently uncertain factors and by the application of future payment updates. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program.

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 June 2, 2022, except that the projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. In addition, the estimates do not reflect the potential impact of the *Inflation Reduction Act* (Public Law 117-169), which was enacted on August 16, 2022. As of the date of the financial statements, there is still a considerable amount of uncertainty surrounding these impacts and the projections have not been adjusted.

In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary healthcare 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 healthcare costs vary throughout the projection period.

The following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2022 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2022. 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.[6]

[6] 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 2022

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[11]
2022	1.68	1,440,000	824.8	1.98	6.52	4.54	3.9	6.7[9]	6.8[9]	-0.2[10]	-3.0
2030	1.87	1,341,000	738.4	1.25	3.65	2.40	2.0	3.7	5.3	4.3	2.1
2040	1.98	1,288,000	679.8	1.17	3.57	2.40	1.9	4.2	4.7	4.2	2.3
2050	2.00	1,256,000	627.2	1.11	3.51	2.40	2.0	3.4	3.8	4.3	2.3
2060	2.00	1,240,000	580.6	1.16	3.56	2.40	2.0	3.4	3.8	4.2	2.3
2070	2.00	1,228,000	539.3	1.16	3.56	2.40	1.9	3.4	3.6	4.0	2.3
2080	2.00	1,221,000	502.6	1.13	3.53	2.40	2.0	3.5	3.7	4.1	2.3
2090	2.00	1,217,000	469.9	1.14	3.54	2.40	2.1	3.5	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 healthcare 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 2022 mainly due to slower growth in overall drug prices and 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 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 2022-2018

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2022	2.0	1,217,000	469.9	1.14	3.54	2.40	2.1	3.5	3.7	4.2	2.3
2021	2.0	1,218,000	472.7	1.14	3.54	2.40	2.1	3.4	3.7	4.2	2.3
2020	1.95	1,218,000	460.5	1.13	3.53	2.40	2.0	3.3	3.6	4.1	2.3
2019	2.0	1,218,000	453.5	1.16	3.76	2.60	2.0	3.5	3.6	4.3	2.5
2018	2.0	1,218,000	444.7	1.15	3.75	2.60	2.1	3.4	3.5	4.3	2.7

[1]Average number of children per woman. The continued use of a cohort-based projection approach that was first implemented in the 2021 Trustees Report results in a much longer transition to ultimate birth rates from the current low birth rates. The ultimate fertility rate is assumed to be reached in 2056.

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

[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated 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 27. Alternative Statement of Social Insurance 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. For physician services, not only are updates below the rate of inflation in all future years, but there are more immediate concerns because updates for these services are projected to be −2.9 percent in 2023 and 0.0 percent for 2024 and 2025 and certain bonuses paid to physicians are scheduled to expire in 2025. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business total factor

productivity[7] although these health providers have historically achieved lower levels of productivity growth. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law in this report.

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.[8] 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.

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

[8] 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.

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	$ 30,163	$ 30,217
Part B	56,618	63,733
Part D	11,630	11,621
Expenditures		
Part A	35,257	41,560
Part B	56,618	63,733
Part D	11,630	11,621
Income less expenditures		
Part A	(5,094)	(11,343)
Part B	-	-
Part D	-	-

[1]These amounts are not presented in the 2022 Trustees Report.

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

The difference between the current-law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly 40 percent of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.0-percent reduction in annual cost growth each year for these providers. If the payment updates that are affected by the productivity adjustments were to gradually transition from current law to the payment updates assumed for private health plans, the physician updates transitioned to the Medicare Economic Index, and the 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 18 percent and Part B expenditures would be higher than the current-law projections by roughly 13 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 13 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

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

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

Note 28. 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, 2021 to the period beginning on January 1, 2022, and the reconciliation from the period beginning on January 1, 2020 to the period beginning on January 1, 2021. The reconciliation identifies several significant components of the change and provides reasons for the change.

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

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

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

All estimates in the SCSIA represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions, represent the additional effect 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 26 summarizes these assumptions for the current year.

Period beginning on January 1, 2021 and ending January 1, 2022

Present values as of January 1, 2021 are calculated using interest rates from the intermediate assumptions of the 2021 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2022. 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 2021 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and healthcare assumptions are calculated using the interest rates under the intermediate assumptions of the 2022 Trustees Report.

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 healthcare assumptions are calculated using the interest rates under the intermediate assumptions of the 2021 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2021 to the period beginning on January 1, 2022

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2021-95) to the current valuation period (2022-96) 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 2021, replaces it with a much larger negative net cash flow for 2096, and measures the present values as of January 1, 2022, 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 2021-95 to 2022-96. 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 2021 are realized. The change in valuation period resulted in a small decrease in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $123 billion.

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.

Change in Projection Base

From the period beginning on January 1, 2021 to the period beginning on January 1, 2022

Actual income and expenditures in 2021 were different from what was anticipated when the 2021 Trustees Report projections were prepared. For Part A, income was higher and expenditures were lower than anticipated in 2021 based on actual experience. Part B income and expenditures were lower than estimated based on actual experience. For Part D 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 $2,040 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, 2021 and January 1, 2022 is incorporated in the current valuation and is more than projected in the prior valuation. In Section III.B3 of the 2022 Trustees Report, the base change represented the impact of the change in the 2019 experience rather than the 2021 experience. This was done to accurately quantify the full impact of the COVID-19 pandemic by attributing much of the reduction in 2020 and 2021 income and expenditures to it. For purposes of the SCSIA, we have reflected the impact of the change in the 2021 experience to the projection base change in order to be consistent with prior reporting.

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.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2021 to the period beginning on January 1, 2022

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).

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2022) are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Final birth rate data for calendar year 2020 indicated slightly lower birth rates than were assumed in the prior valuation.
- Near-term lawful permanent resident (LPR) immigration data were updated since the prior valuation; near-term LPR immigration assumptions were also updated to better reflect the expected effects of the recovery from the pandemic.
- Historical population data and other-than-LPR immigration data were updated since the prior valuation.

There was one notable change in demographic methodology. An improvement was made to put more emphasis on recent mortality data by increasing the weights for the most recent years in the regressions used to calculate the starting rates of improvement and starting death rates.

These changes resulted in an increase in the estimated future net cash flow. The present values of estimated income and expenditures are lower for Part A and higher for Parts B and D. Overall, these changes increased the present value of the estimated future net cash flow by $18 billion.

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 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 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.

Changes in Economic and Healthcare Assumptions

For the period beginning on January 1, 2021 to the period beginning on January 1, 2022

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

The ultimate economic assumptions for the current valuation (beginning on January 1, 2022) are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed. The most significant are identified below.

- Near-term real interest rates are assumed to be slightly higher on average than those for the prior valuation.
- Economic starting values and near-term growth assumptions were updated to reflect the stronger-than-expected recovery from the pandemic-induced recession.
- The level of potential GDP for years 2021 and later is assumed to be about 1.1 percent higher than the level in the prior valuation, reflecting the strong recovery and the expectation of a permanent level shift in total economy labor productivity.

There were no additional notable changes in economic methodology.

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

- High projected spending growth for outpatient hospital services and for physician-administered drugs.
- Slower price growth and higher direct and indirect remuneration (DIR).

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 $1,958 billion.

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 healthcare assumptions are specific to the Medicare projections. The following healthcare 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.

Changes in Law

For the period beginning on January 1, 2021 to the period beginning on January 1, 2022

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

- *The Infrastructure Investment and Jobs Act* (Public Law 117-58, enacted on November 15, 2021) included provisions that affect the HI and SMI programs.
  - The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by 1 year, through fiscal year 2031 (which, for sequestration purposes, covers April 1, 2031 through March 31, 2032). The benefit payment reductions for fiscal year 2030 (covering April 1, 2030 through March 31, 2031) are changed to a uniform 2 percent (instead of 2 percent for the first 5.5 months, 4 percent for the next 6 months, and 0 percent for the final 0.5 months), and the benefit payment reductions for fiscal year 2031 (covering April 1, 2031 through March 31, 2032) are 4 percent for first 6 months and 0 percent for the final 6 months.
- *The Protecting Medicare and American Farmers from Sequester Cuts Act* (Public Law 117-71, enacted on December 10, 2021) included provisions that affect the HI and SMI programs.
  - The temporary exemption from sequestration for the Medicare program from May 1, 2020 through December 31, 2021 (as described in last year's report) is extended through March 31, 2022, and the benefit payment reduction for April 1, 2022 through June 30, 2022 is changed to 1 percent (from 2 percent). In addition, the benefit payment reductions for fiscal year 2030 (covering April 1, 2030 through March 31, 2031) are changed to 2.25 percent for the first 6 months and 3 percent for the second 6 months (from a uniform 2 percent for the entire period). (The benefit payment reductions for fiscal year 2031, covering April 1, 2031 through March 31, 2032, remain the same as described under Public Law 117-58.)
  - In the formula used for determining Medicare physician payment rates under the physician fee schedule for services furnished during calendar year 2022, the conversion factor is increased by 3 percent over the amount that it would have been in the absence of this provision's enactment. (This increase is not subject to the budget neutrality requirements that typically apply.)
  - Implementation of the Medicare Radiation Oncology Model is delayed until January 1, 2023 at the earliest (from January 1, 2022 at the earliest).
  - For the market-based system used to update the Medicare clinical laboratory fee schedule, laboratories are exempted for another year from the requirement that they report private payer rates. The next data reporting period is now the first quarter of 2023 (instead of the first quarter of 2022). Also, during the phase-in period for this system, the caps in place to limit reductions in fee schedule payments from year to year are changed to 0 percent for 2021–2022 and 15 percent for 2023–2025 (as opposed to the previous statutory parameters of 0 percent for 2021 and 15 percent for 2022–2024). That is, tests furnished under the fee schedule during 2021–2022 are to be paid at the same rates as under the 2020 fee schedule, and payments may not be reduced by more than 15 percent for services provided during 2023–2025.

The net impact of all legislative changes was a small increase in the estimated future net cash flow for total Medicare. For Part A the present value of estimated expenditures is slightly lower. The present values of estimated income and expenditures are lower for Part B. Overall, these changes increased the present value of the estimated future net cash flow by $5 billion.

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.

Required Supplementary Information

Combining Statement of Budgetary Resources

For the Year Ended September 30, 2022
(in Millions)

	CMS					
	Medicare HI	Medicare SMI	Payments to Trust Funds	Medicaid	Other Agency Accounts	Agency Combined Totals
Budgetary Resources						
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory)	$ 83	$ 80	$ 130,320	$ 50,431	$ 191,180	$ 372,094
Appropriations (Discretionary and Mandatory)	397,622	473,056	530,954	603,130	329,559	2,334,321
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	40	40
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	-	-	-	1,596	27,951	29,547
Total Budgetary Resources	**$ 397,705**	**$ 473,136**	**$ 661,274**	**$ 655,157**	**$ 548,730**	**$ 2,736,002**
Status of Budgetary Resources						
New Obligations and Upward Adjustments	$ 397,705	$ 473,136	$ 495,036	$ 654,796	$ 432,343	$ 2,453,016
Unobligated Balance, End of Year:						
Apportioned, Unexpired Accounts	-	-	35,918	50	77,935	113,903
Exempt from Apportionment, Unexpired Accounts	-	-	-	-	220	220
Unapportioned, Unexpired Accounts	-	-	-	311	20,996	21,307
Unexpired Unobligated Balance, End of Year	-	-	35,918	361	99,151	135,430
Expired Unobligated Balance, End of Year	-	-	130,320	-	17,236	147,556
Unobligated Balance, End of Year	-	-	166,238	361	116,387	282,986
Total Status of Budgetary Resources	**$ 397,705**	**$ 473,136**	**$ 661,274**	**$ 655,157**	**$ 548,730**	**$ 2,736,002**
Outlays, Net						
Outlays, Net (Discretionary and Mandatory)	$ 392,055	$ 470,292	$ 469,024	$ 586,909	$ 424,142	$ 2,342,422
Distributed Offsetting Receipts	(88,522)	(607,967)	-	-	(2,943)	(699,432)
Agency Outlays, Net (Discretionary and Mandatory)	**$ 303,533**	**$ (137,675)**	**$ 469,024**	**$ 586,909**	**$ 421,199**	**$ 1,642,990**
Disbursements, Net	**$ -**	**$ -**	**$ -**	**$ -**	**$ 25**	**$ 25**

Summary of Other Agency Accounts

	Budgetary Resources	Outlays, Net
ACF	$ 78,371	$ 85,007
ACL	2,647	2,719
AHRQ	399	339
CDC	26,561	21,560
CMS	212,380	142,388
FDA	8,763	4,518
HRSA	15,878	16,122
IHS	16,794	6,489
NIH	55,653	40,063
OS	120,848	93,754
PSC	2,138	855
SAMHSA	8,298	7,385
Totals	**$ 548,730**	**$ 421,199**

Deferred Maintenance and Repairs

The FASAB issued SFFAS 42, *Deferred Maintenance and Repairs*: *Amending Statement of Federal Financial Accounting Standards 6, 14, 29, and 32,* effective for periods after September 30, 2014. This standard clarifies that repair activities should be included to better reflect asset management practices and improve reporting on deferred maintenance and repairs. Deferred maintenance and repairs are maintenance and repair activities not performed when they should have been or were scheduled to be, and then put off or delayed for a future period. Maintenance and repairs are the activities directed toward keeping fixed capital assets in acceptable condition, including preventive maintenance, normal repairs, replacement of parts and structural components, and other activities needed to preserve the asset so that it continues to provide acceptable service. Other factors under consideration are whether the asset meets applicable building codes and achieves its expected life. Maintenance and repairs do not include activities aimed at expanding the capacity of an asset or otherwise upgrading it to serve needs different from, or significantly greater than, those originally intended. Maintenance and repair expenses are recognized as incurred.

CDC, NIH, and FDA use the condition assessment survey for all classes of property. IHS uses two methods to assess installations – annual general inspections and facility condition surveys. The landholding OpDivs prioritize their maintenance activities based on urgency and the best use of their limited resources, with life safety the top priority. Deferred maintenance and repairs have been reported for all active and inactive assets; excess buildings and structures that are slated for disposal or demolition are not included. For buildings, equipment, and other structures, acceptable condition is defined in accordance with standards comparable to those used in private industry. For example, factors can include Property, Plant and Equipment location, age, design etc. Equipment affixed to real property should be appropriately reflected in building and other structures.

Estimated Cost to Return to Acceptable Condition

(in Millions)

Category of Asset	2022	2021
General PP&E		
Buildings	$ 4,664	$ 3,692
Other Structures	30	25
Total	**$ 4,694**	**$ 3,717**

In a condition assessment survey, asset condition is assessed on a scale of 1-5 as follows: Excellent-1; Good-2; Fair-3; Poor-4; Very Poor-5. A "fair" or 3 rating is considered acceptable operating condition. Although Property, Plant and Equipment categories may be rated as acceptable, individual assets within a category may require maintenance work to return them to acceptable operating condition. Therefore, asset categories with an overall rating of "fair" or above may still report necessary costs to return them to acceptable condition.

Land

HHS land is categorized as General PP&E and Operational per SFFAS 59, *Accounting and Reporting of Government Land*. IHS land hosts hospitals and public-facing health centers across the country and NIH land hosts its five major research campuses. The table below provides the detail by OpDiv and total estimated acreage as of September 30, 2022.

Estimated Acreage by Predominant* Use

	Operational				
	CDC	FDA	IHS	NIH	Total Estimated Acreage
End of Prior Year/Start of Current Year	506	729	3,305	1,346	5,886
End of Current Year	506	729	3,296	1,346	5,877
Held for Disposal or Exchange					
End of Current Year	-	-	(9)	-	(9)

Note*: "Predominant use" is defined by SFFAS 59, *Accounting and Reporting of Government Land*, and does not affect provisions governing land use.

Estimated Acreage for Stewardship Land

IHS Area	2022
Albuquerque	16
Bemidji	23
Billings	118
Great Plains	184
Navajo	700
Oklahoma City	6
Phoenix	29
Portland	3
Tucson	29
Total	**1,108**

Social Insurance

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

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

RSI material is generally drawn from the *2022 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. 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 pre-pandemic expectations for 2020). Overall, the projections are based primarily on actual experience through 2019. However, program costs in 2020 and 2021 were used to help inform the development of adjustment factors by type of service, which account for the impact of COVID-19 through 2028. In spite of these substantial impacts on the Medicare program in 2020, the pandemic was not factored into the Statement of Social Insurance projections until 2021 because of the uncertainty of the impacts at the time the 2020 Trustees Report was released.

Spending for services other than COVID-19 was significantly lower than expected in 2020 and 2021. This decline was more pronounced for elective services. In addition, Medicare beneficiaries whose deaths were identified as related to COVID had costs that were much higher than the average Medicare beneficiary prior to the onset of the pandemic. As a result, compared to the pre-pandemic Medicare population, the surviving Medicare population had lower morbidity, on average, reducing costs by an estimated 1.5 percent in 2020 and 2.9 percent in 2021. This morbidity effect is expected to continue over the next few years but is assumed to decrease over time before ending in 2028.

Overall, the projections are based primarily on actual experience through 2019. However, program costs in 2020 and 2021 were used to help inform the development of adjustment factors by type of service, which account for the impact of COVID-19 through 2028. 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, are not materially affected by the pandemic.

Because of the large wave of COVID-19 cases in late 2021 through early 2022, the Trustees estimate that non-COVID-related spending will be lower than previously expected for the beginning of 2022. For the latter part of 2022 and 2023, the return of deferred care that is assumed to be more intensive, and thus more costly, results in spending

that increases to a level that is closer to the pre-pandemic expectations. The Trustees assume that healthcare spending patterns will return to pre-pandemic levels in 2024 but that the lingering morbidity effects will continue through 2028.

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. Moreover, as a result of developments that have occurred since the assumptions for this report were selected in mid-February 2022, uncertainty has increased regarding the path of the COVID-19 pandemic and the economy. The estimates do not reflect the potential impact of the *Inflation Reduction Act* (Public Law 117-169), which was enacted on August 16, 2022. There is still a considerable amount of uncertainty surrounding these impacts and the projections have not been adjusted. The Trustees will continue to monitor developments and modify the projections in later reports as appropriate.

The Medicare Accelerated and Advance Payments Program was significantly expanded during the COVID-19 public health emergency period, by both legislative provisions and administrative actions taken by CMS early on during the emergency. Total payments of approximately $107.2 billion were made from March 2020 through June 2021: roughly $67.1 billion from the HI trust fund and $40.1 billion from the SMI Part B trust fund account. The Trustees assumed that the accelerated and advance payments would be fully repaid by September of 2022, resulting in no net changes to trust fund expenditures. As discussed in Note 8, the majority of these accelerated and advance payments have been repaid as of September 30, 2022.

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 2028. 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 healthcare 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. For physician services, not only are updates below the rate of inflation in all future years, but there are more immediate concerns because updates for these services are projected to be −2.9 percent in 2023 and 0.0 percent for 2024 and 2025 and certain bonuses paid to physicians are scheduled to expire in 2025. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business total factor productivity[9] although these health providers have historically achieved lower levels of productivity growth. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law in this report.

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

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); an *Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes* (Public Law 117-7, enacted on April 14, 2021); the *Infrastructure Investment and Jobs Act* (Public Law 117-58, enacted on November 15, 2021); and the *Protecting Medicare and American Farmers from Sequester Cuts Act* (Public Law 117-71, enacted on December 10, 2021).

The sequestration reduces benefit payments by the percentages listed below:

- 2 percent from April 1, 2013 through April 30, 2020;
- 1 percent from April 1, 2022 through June 30, 2022;
- 2 percent from July 1, 2022 through March 31, 2030;
- 2.25 percent from April 1, 2030 through September 30, 2030;
- 3 percent from October 1, 2030 through March 31, 2031; and
- 4 percent from April 1, 2031 through September 30, 2031.

Because of sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013 through September 30, 2031, excluding May 1, 2020 through March 31, 2022 when it was suspended.

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

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent challenges in projecting healthcare cost growth over time. The expenditure projections reflect the cost-reduction provisions required under current law. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes that (i) there would be a transition from current-law[10] payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for healthcare productivity; (ii) the average physician payment updates would transition from current law[11] 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 than expire in 2025. The difference between the illustrative alternative and the current-law projections continues to demonstrate

[10] 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).

[11] 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.

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 27 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 (410786-6386) 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.[12] 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.[13]

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 healthcare services for the total health sector and for Medicare. Therefore, the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions.

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

(i) ***All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.***

HI services are inpatient hospital, skilled nursing facility, home health, 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 2046, or GDP plus 0 percent, declining gradually to 3.4 percent in 2096, or GDP minus 0.3 percent.

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

[13] 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).

(ii) ***Physician services***

Payment rate updates are 0.75 percent per year for those qualified physicians assumed to be participating in advanced APMs and 0.25 percent for those assumed to be participating in MIPS. The year-by-year cost growth rates for physician payments are assumed to decline from 3.2 percent in 2046, or GDP minus 0.4 percent, to 2.8 percent in 2096, 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,[14] 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 2046, or GDP minus 0.8 percent, to 2.6 percent in 2096, or GDP minus 1.1 percent.

(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 36 percent of total Part B expenditures in 2031 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.[15] 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 2046, or GDP plus 0.7 percent, to 4.1 percent by 2096, or GDP plus 0.4 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. Beginning with the 2020 Trustees Report, these impacts reflect the changing distribution of Medicare enrollment by age, sex, and the beneficiary's proximity to death, which is referred to as a time-to-death (TTD) adjustment. The TTD adjustment reflects the fact that the closer an individual is to death, the higher his or her healthcare spending is. Thus, as mortality rates improve and a smaller portion of the Medicare population is likely to die at any given age, the effect of individuals getting older and spending more on healthcare is offset somewhat.[16] 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 2046, or GDP plus 0.2 percent, declining to 3.7 percent by 2096, 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 2046, declining to 3.7 percent, or GDP plus 0 percent by 2096.

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,

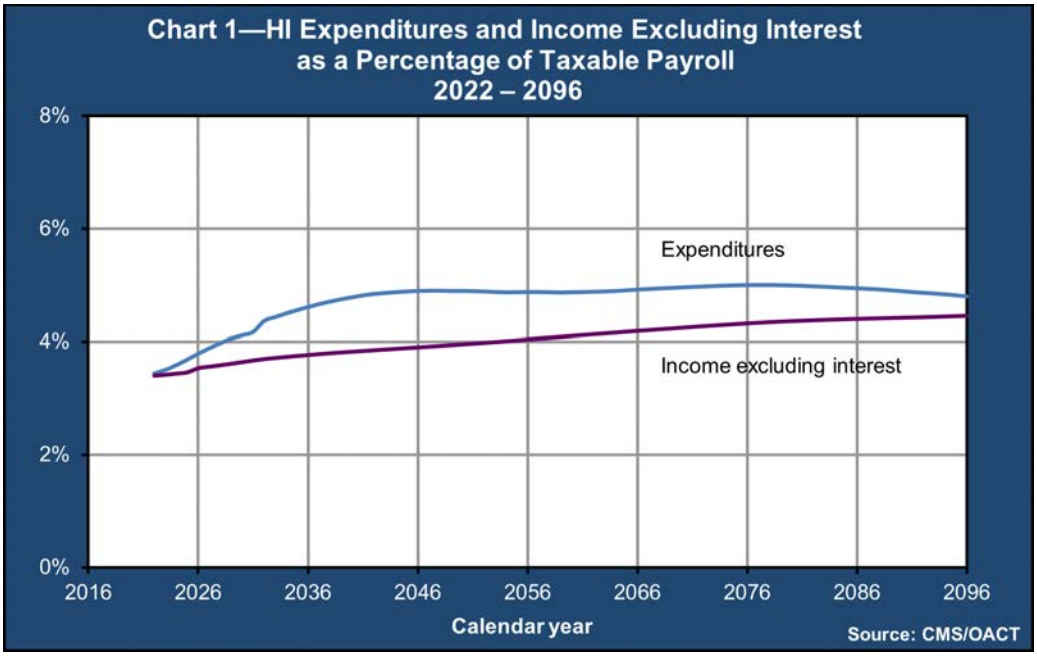
[14] The portion of durable medical equipment that is subject to competitive bidding is included with all other Medicare services since the price is determined by a competitive bidding process. For more information on the bidding process, see section IV.B of the 2022 Medicare Trustees Report.

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

[16] More information on the TTD adjustment is available on the CMS website.

income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as taxable payroll).

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI cost rates are lower than those from last year for all years because of (i) lower healthcare utilization through 2028 due to the pandemic and (ii) higher taxable payroll in all years resulting from the changing economic and demographic assumptions.



Since the standard HI payroll tax rates are not scheduled to change in the future under current law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. In addition, starting in 2013, high-income workers pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns). Because income thresholds for determining eligibility for the additional HI tax are not indexed, over time an increasing proportion of workers will become subject to a higher HI tax rate, and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation; this outcome will occur because the income thresholds determining taxable benefits are not indexed for price inflation and because the income tax brackets are indexed to the chained CPI (CCPI-U), which increases at a slower rate than average wages. After the 10th year of the projection period, income tax brackets are assumed to rise with average wages, rather than with the CCPI-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.[17] Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

In 2022 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.

[17] See section V.C7 of the *2022 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.

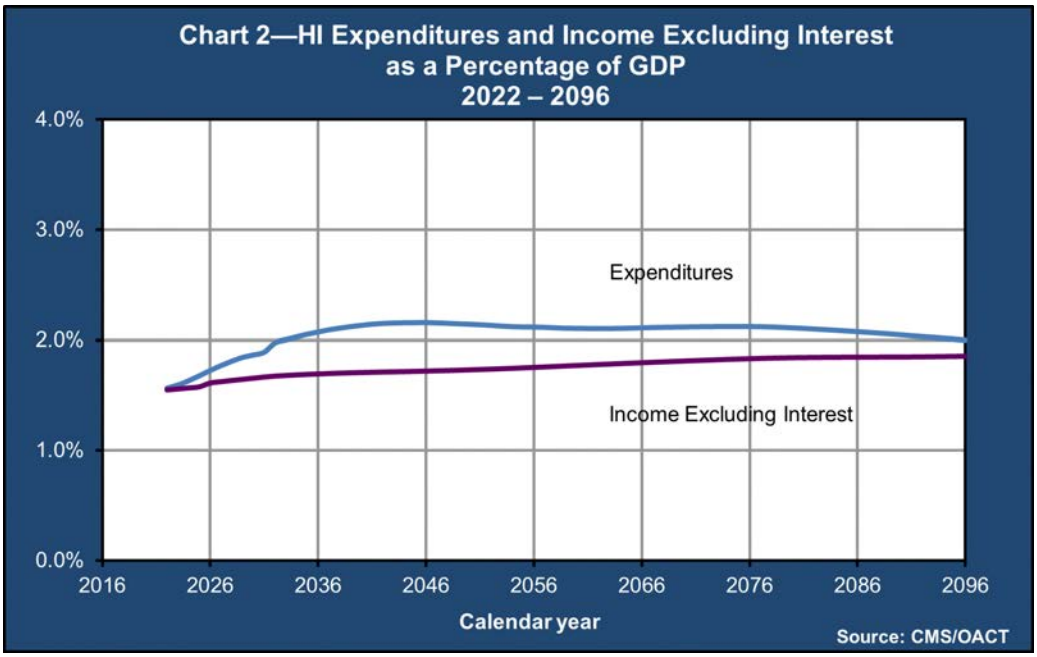
This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.7 percent through 2031 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 5.3 percent in 2047 and 7.2 percent in 2096.

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 2021, the expenditures were $328.9 billion, which was 1.4 percent of GDP. As Chart 2 illustrates, this percentage is projected to increase steadily until about 2045 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 2096.

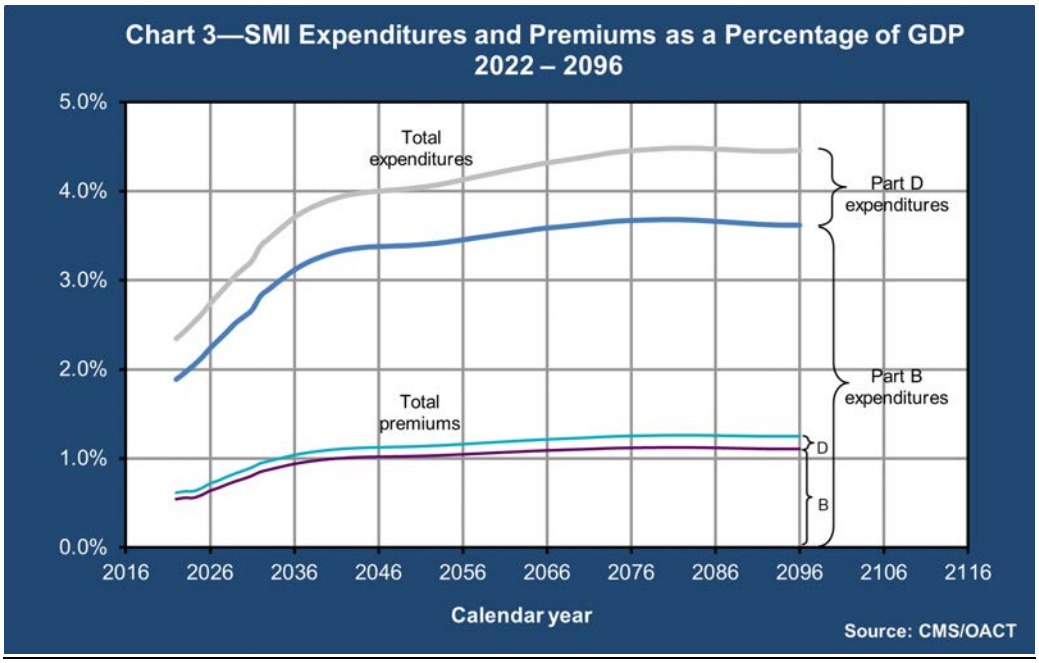


SMI

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.



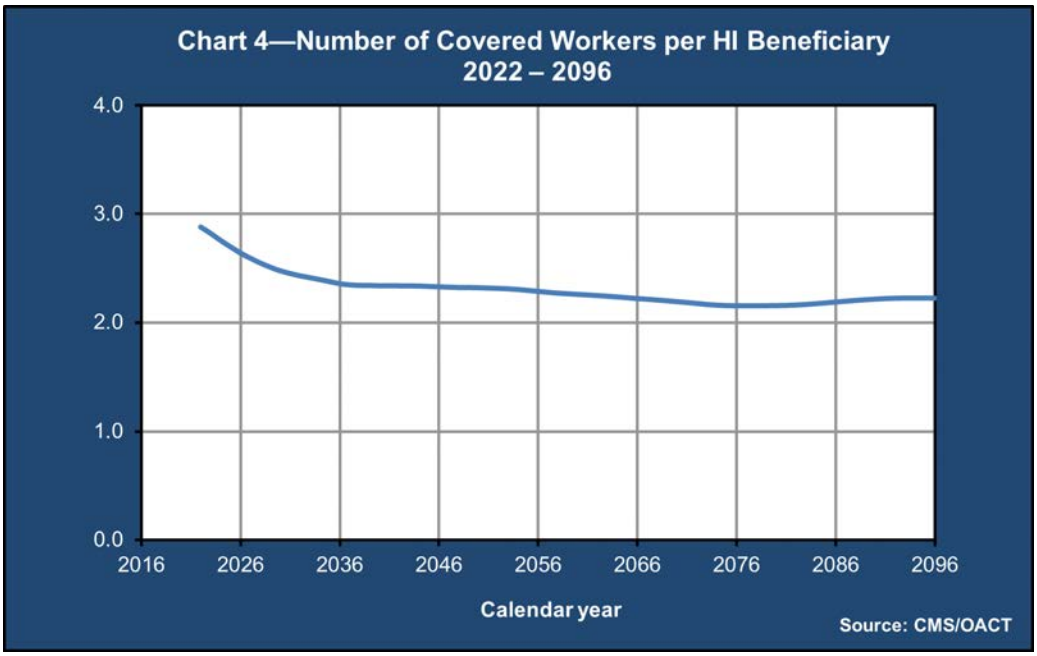
In 2021, SMI expenditures were $510.4 billion, or about 2.2 percent of GDP. Under current law, they would grow to about 4.0 percent of GDP within 25 years and to 4.5 percent by the end of the projection period, as demonstrated in Chart 3. Under the illustrative alternative, total SMI expenditures in 2096 would be 5.5 percent of GDP.

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 2021 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. State payments have decreased faster than GDP for almost every year since 2015 and are projected to do so for the entire long-range period.

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 2021, 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 2096.

Sensitivity Analysis

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

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[18] The assumptions varied are the healthcare cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.[19]

For this analysis, the intermediate economic and demographic assumptions in the 2022 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, 2022 and are based on estimates of income and expenditures during the 75-year projection period.

[18] 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.
[19] 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.

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.

Healthcare Cost Factors

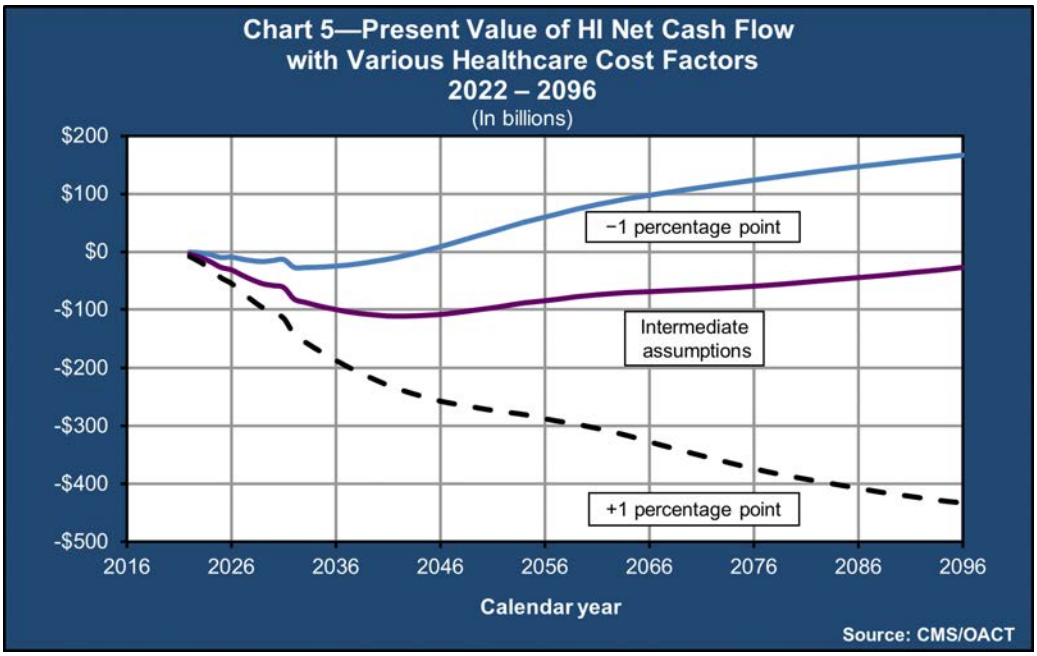
Table 1 shows the net present value of cash flow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered healthcare services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs,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

Table 1—Present Value of Estimated HI Income Less Expenditures under Various Healthcare Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$4,969	-$5,094	-$21,235

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $10,063 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 $16,141 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 healthcare service costs.

Real-Wage Differential

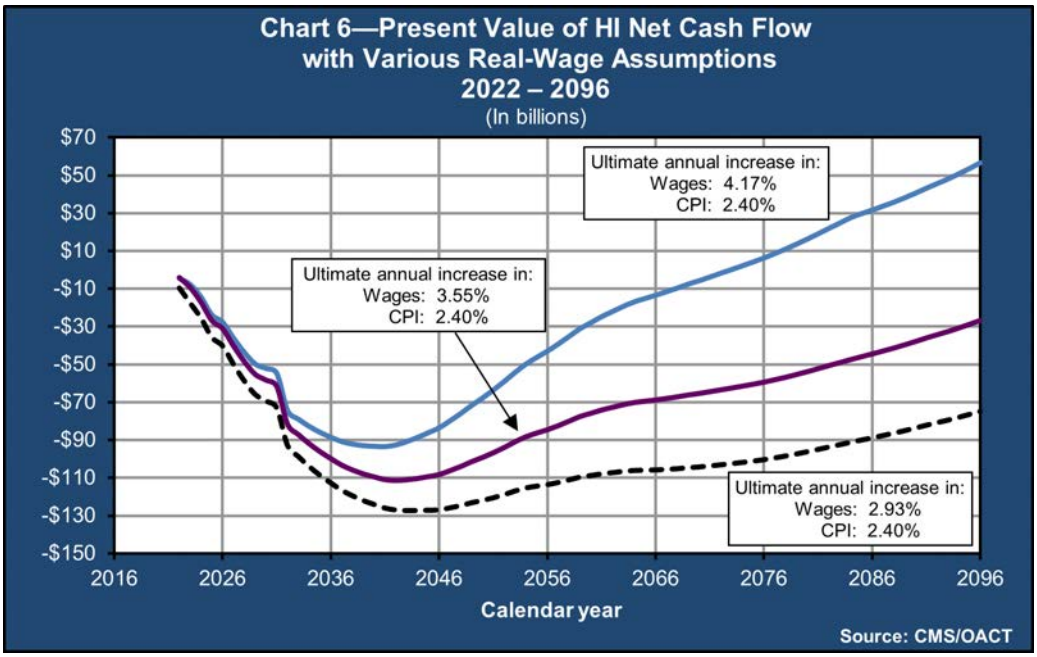
Table 2 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.53, 1.15, and 1.77 percentage points.[20] In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, yielding ultimate 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)	−$7,269	−$5,094	−$1,871

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 $2,599 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $1,754 billion.

[20] 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.



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

Consumer Price Index

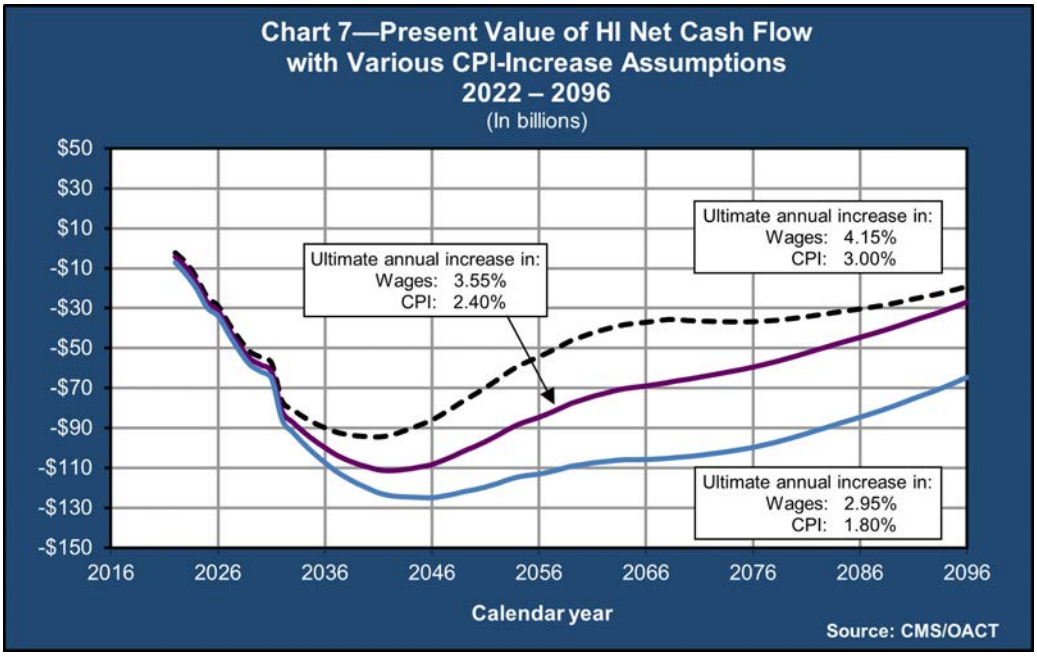
Table 3 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.0, 2.4, and 1.8 percent. In each case, the assumed ultimate real-wage differential is 1.15 percent, which yields ultimate percentage increases 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)	−$3,715	−$5,094	−$7,033

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.0 percent, the deficit decreases by $1,379 billion. On the other hand, if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $1,939 billion.

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



This assumption has a small impact when the cash flow is expressed as present values, as Chart 7 indicates. The projected present values of HI cash flow are relatively insensitive to the assumed level of general price inflation because price inflation has about the same proportionate effect on income as it does on costs. In present value terms, a smaller deficit is the result under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios; under high-inflation conditions, however, the present value of HI income increases as more people become subject to the additional 0.9percent 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

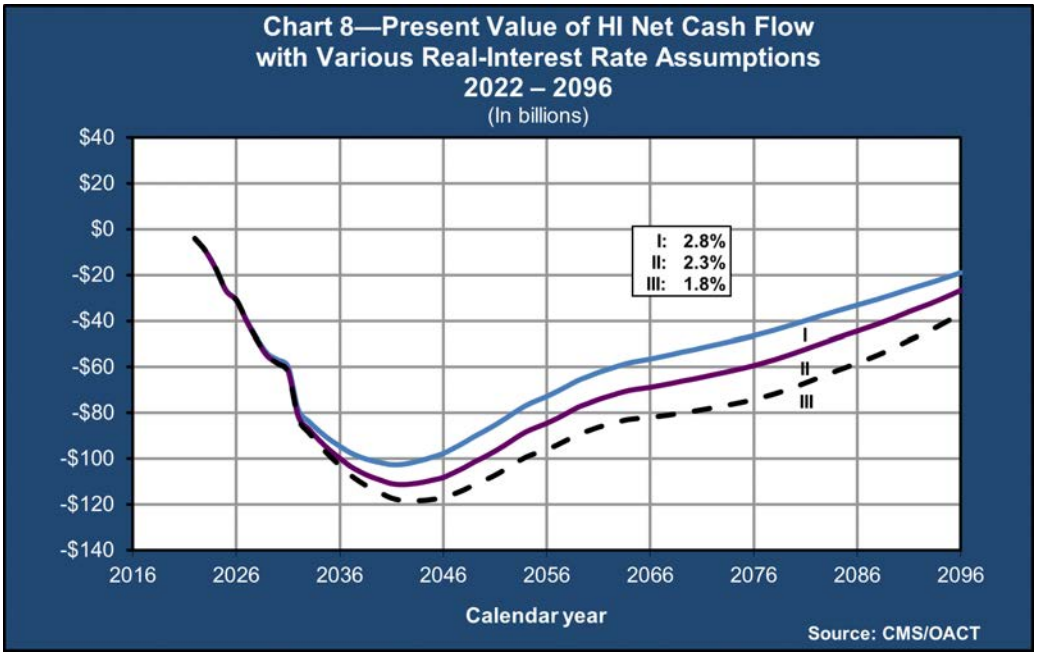
Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 1.8, 2.3, and 2.8 percent. In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, which results in ultimate annual yields of 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)	-$5,813	-$5,094	-$4,412

As demonstrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $140 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 2028. 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.

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.

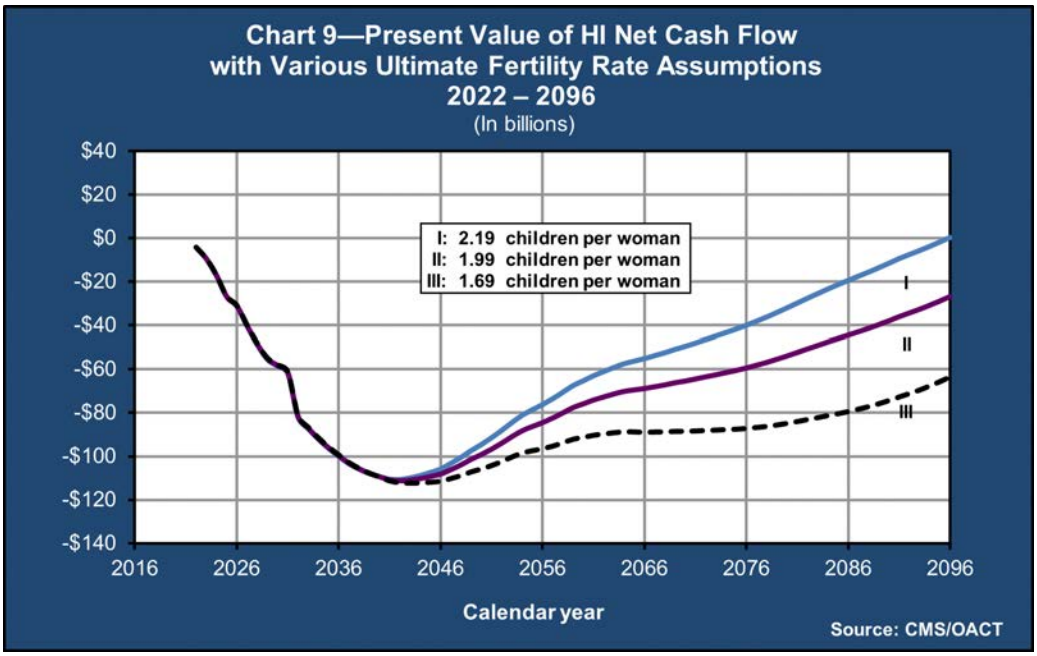
Table 5—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.69	1.99	2.19
Income minus expenditures (in billions)	−$6,265	−$5,094	−$4,263

[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 $405 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 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

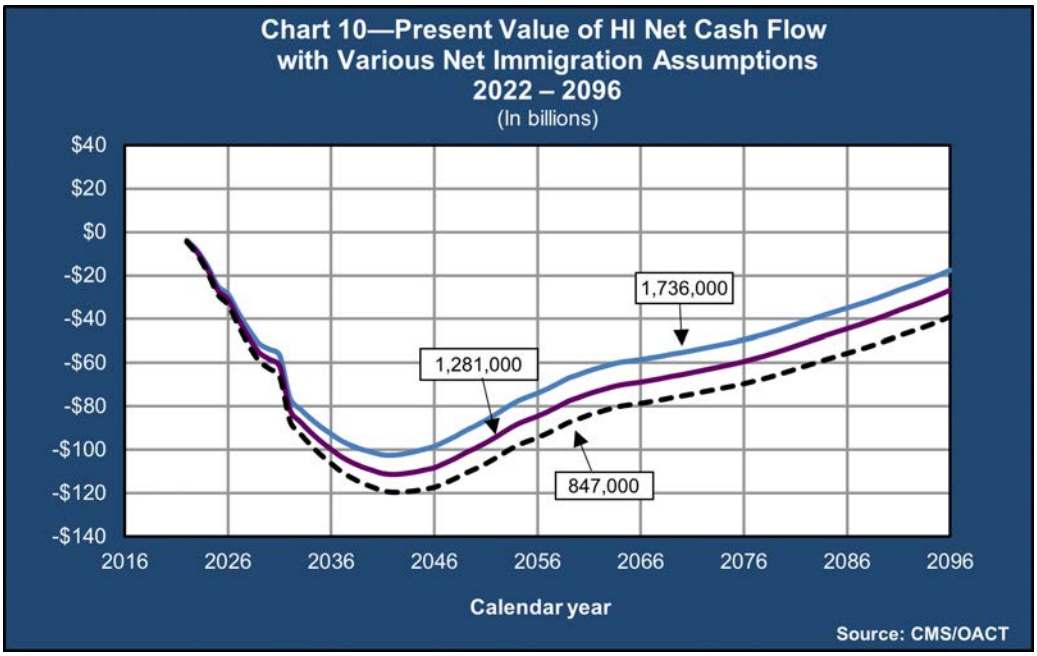
Table 6 illustrates the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 847,000 persons, 1,281,000 persons, and 1,736,000 persons per year.

Table 6—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	847,000	1,281,000	1,736,000
Income minus expenditures (in billions)	−$5,754	−$5,094	−$4,451

As indicated in Table 6, if the average annual net immigration assumption is 847,000 persons, the deficit—expressed in present-value dollars—increases by $660 billion. Conversely, if the assumption is 1,736,000 persons, the deficit decreases by $643 billion.

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



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

Trust Fund Finances and Sustainability

HI

The short-range financial outlook for the HI trust fund is slightly more favorable than the projections in last year's Medicare Trustees Report. The estimated depletion date for the HI trust fund is 2028, 2 years later than projected in last year's report. 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 higher than last year's estimates because both the number of covered workers and average wages are projected to be higher. HI expenditures are projected to be lower than last year's estimates in the beginning of the short-range period mainly due to the pandemic but are projected to become larger after 2023 due to higher projected provider payment updates.

HI expenditures exceeded income each year from 2008 through 2015. In 2016 and 2017, however, there were fund surpluses amounting to $5.4 billion and $2.8 billion, respectively. In 2018, 2019, and 2020, expenditures again exceeded income, with trust fund deficits of $1.6 billion, $5.8 billion, and $60.4 billion, respectively. The large deficit in 2020 was mostly due to accelerated and advance payments to providers from the trust fund. In 2021, there was a small surplus of $8.5 billion as these payments began to be repaid to the trust fund, and this continued repayment will result in a larger surplus in 2022. After that, the Trustees project deficits in all future years until the trust fund becomes depleted in 2028. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to healthcare services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

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

SMI

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

The nature of the financing for both parts of SMI is similar in that the law establishes a mechanism by which income from the Part B premium and the Part D premium, and the corresponding general 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[21] will exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2022–2028). For the 2022 Medicare Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2025, 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 2024 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 2021 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 2022 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policymakers to "work closely together with a sense of urgency to address these challenges."

[21] 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.

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SECTION 3:
Other Information

- Other Financial Information
- Summary of Financial Statement Audit and Management Assurances
- Civil Monetary Penalty Adjustment for Inflation
- Grants Closeout Reporting
- Payment Integrity Report
- FY 2022 Top Management and Performance Challenges Identified By the Office of Inspector General Facing HHS
- Department's Response to the Office of Inspector General

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Other Financial Information

Consolidating Balance Sheet by Budget Function

As of September 30, 2022

(in Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)							
Intragovernmental							
Fund Balance with Treasury (Note 3)	$ 20,651	$ 375,820	$ 191,070	$ 65,131	$ 652,672	$ -	$ 652,672
Investments, Net (Note 4)	-	4,305	347,264	-	351,569	-	351,569
Accounts Receivable, Net (Note 5)	330	9,563	91,025	-	100,918	(100,087)	831
Advances and Prepayments (Note 8)	232	2,516	-	620	3,368	(956)	2,412
Total Intragovernmental	**21,213**	**392,204**	**629,359**	**65,751**	**1,108,527**	**(101,043)**	**1,007,484**
Other than Intragovernmental							
Accounts Receivable, Net (Note 5)	-	14,383	25,696	49	40,128	-	40,128
Inventory and Related Property, Net (Note 6)	-	16,560	-	-	16,560	-	16,560
General Property, Plant and Equipment, Net (Note 7)	-	7,820	456	-	8,276	-	8,276
Advances and Prepayments (Note 8)	1	44	39,006	137	39,188	-	39,188
Other Assets	-	489	-	-	489	-	489
Total Other than Intragovernmental	**1**	**39,296**	**65,158**	**186**	**104,641**	**-**	**104,641**
Total Assets	**$ 21,214**	**$ 431,500**	**$ 694,517**	**$ 65,937**	**$ 1,213,168**	**$ (101,043)**	**$ 1,112,125**
Stewardship Land (Note 21)							
Liabilities (Note 9)							
Intragovernmental							
Accounts Payable	$ 12	$ 1,453	$ 100,906	$ 14	$ 102,385	$ (100,085)	$ 2,300
Debt (Note 10)	-	509	7,747	-	8,256	-	8,256
Advances from Others and Deferred Revenue	20	1,298	-	-	1,318	(955)	363
Other Liabilities (Note 14)	2	1,473	-	20	1,495	(3)	1,492
Total Intragovernmental	**34**	**4,733**	**108,653**	**34**	**113,454**	**(101,043)**	**12,411**
Other than Intragovernmental							
Accounts Payable	23	1,547	145	12	1,727	-	1,727
Entitlement Benefits Due and Payable (Note 11)	-	56,104	85,073	-	141,177	-	141,177
Federal Employee and Veteran Benefits (Note 12)	20	19,377	7	5	19,409	-	19,409
Environmental and Disposal Liabilities	-	312	-	-	312	-	312
Advances from Others and Deferred Revenue	-	419	1,295	-	1,714	-	1,714
Other Liabilities:							
Accrued Liabilities (Note 13)	620	14,639	-	998	16,257	-	16,257
Contingencies and Commitments (Note 15)	-	15,776	-	-	15,776	-	15,776
Other Liabilities (Note 14)	3	1,180	1	53	1,237	-	1,237
Total Other than Intragovernmental	**666**	**109,354**	**86,521**	**1,068**	**197,609**	**-**	**197,609**
Total Liabilities	**700**	**114,087**	**195,174**	**1,102**	**311,063**	**(101,043)**	**210,020**
Net Position							
Unexpended Appropriations – Funds from Dedicated Collections (Note 20)	-	3,830	174,874	-	178,704	-	178,704
Unexpended Appropriations – Funds from Other Than Dedicated Collections	20,388	289,096	-	64,781	374,265	-	374,265
Total Unexpended Appropriations	**20,388**	**292,926**	**174,874**	**64,781**	**552,969**	**-**	**552,969**
Cumulative Results of Operations – Funds from Dedicated Collections (Note 20)	-	21,730	324,469	-	346,199	-	346,199
Cumulative Results of Operations – Funds from Other Than Dedicated Collections	126	2,757	-	54	2,937	-	2,937
Total Cumulative Results of Operations	**126**	**24,487**	**324,469**	**54**	**349,136**	**-**	**349,136**
Total Net Position	**20,514**	**317,413**	**499,343**	**64,835**	**902,105**	**-**	**902,105**
Total Liabilities and Net Position	**$ 21,214**	**$ 431,500**	**$ 694,517**	**$ 65,937**	**$ 1,213,168**	**$ (101,043)**	**$ 1,112,125**

Other Financial Information

Consolidating Statement of Net Cost by Budget Function

For the Year Ended September 30, 2022
(in Millions)

Responsibility Segments	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra HHS Eliminations		Consolidated Totals
						Cost (-)	Revenue	
ACF	$ 15,620	$ -	$ -	$ 68,850	$ 84,470	$ (169)	$ 777	$ 85,078
ACL	2,764	-	-	-	2,764	(15)	3	2,752
AHRQ	-	337	-	-	337	(21)	16	332
CDC	-	21,892	-	-	21,892	(678)	197	21,411
CMS	-	614,781	768,795	-	1,383,576	(458)	20	1,383,138
FDA	-	3,673	-	-	3,673	(337)	20	3,356
HRSA	-	16,010	-	-	16,010	(708)	12	15,314
IHS	-	6,815	-	-	6,815	(206)	281	6,890
NIH	-	39,282	-	-	39,282	(227)	1,218	40,273
OS	-	92,168	-	-	92,168	(1,284)	631	91,515
PSC	-	2,895	-	-	2,895	(81)	717	3,531
SAMHSA	-	7,244	-	-	7,244	(44)	3	7,203
Totals	**$ 18,384**	**$ 805,097**	**$ 768,795**	**$ 68,850**	**$ 1,661,126**	**$ (4,228)**	**$ 3,895**	**$ 1,660,793**

Gross Cost and Earned Revenue

For the Year Ended September 30, 2022
(in Millions)

Responsibility Segments	Intragovernmental						Other than Intragovernmental		Consolidated Net Cost of Operations
	Gross Cost			Less: Earned Revenue			Gross Cost	Less: Earned Revenue	
	Combined	Eliminations	Consolidated	Combined	Eliminations	Consolidated			
ACF	$ 911	$ (169)	$ 742	$ (820)	$ 777	$ (43)	$ 84,392	$ (13)	$ 85,078
ACL	29	(15)	14	(3)	3	-	2,738	-	2,752
AHRQ	50	(21)	29	(17)	16	(1)	306	(2)	332
CDC	5,142	(678)	4,464	(316)	197	(119)	17,136	(70)	21,411
CMS	1,232	(458)	774	(27)	20	(7)	1,530,545	(148,174)	1,383,138
FDA	1,737	(337)	1,400	(32)	20	(12)	4,846	(2,878)	3,356
HRSA	841	(708)	133	(12)	12	-	15,265	(84)	15,314
IHS	844	(206)	638	(329)	281	(48)	8,425	(2,125)	6,890
NIH	1,765	(227)	1,538	(1,340)	1,218	(122)	39,642	(785)	40,273
OS	34,945	(1,284)	33,661	(872)	631	(241)	58,110	(15)	91,515
PSC	360	(81)	279	(953)	717	(236)	3,491	(3)	3,531
SAMHSA	84	(44)	40	(287)	3	(284)	7,442	5	7,203
Totals	**$ 47,940**	**$ (4,228)**	**$ 43,712**	**$ (5,008)**	**$ 3,895**	**$ (1,113)**	**$ 1,772,338**	**$ (154,144)**	**$ 1,660,793**

Summary of Financial Statement Audit and Management Assurances

As described in the "Management's Discussion and Analysis" section, management annually presents an assurance statement on the effectiveness of internal control. The following two tables present summary information related to any material weakness identified during the audit, as well as conformance with the *Federal Managers' Financial Integrity Act of 1982* (FMFIA) and compliance with the *Federal Financial Management Improvement Act of 1996* (FFMIA).

Table 1: Summary of Financial Statement Audit

Audit Opinion			Unmodified for Six Financial Statements Disclaimed Opinion on Statement of Social Insurance and Statement of Changes in Social Insurance Amounts		
Restatement			**No**		
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Ending Balance**
No Material Weaknesses Noted	0	-	-	-	0
Total Material Weaknesses	***0***	***-***	***-***	***-***	***0***

Definition of Terms – Tables 1 And 2

(Reference: Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements*, June 3, 2022, pages 110)

Beginning Balance: The beginning balance must agree with the ending balance from the prior year.

New: The total number of material weaknesses/non-conformances identified during the current year.

Resolved: The total number of material weaknesses/non-conformances that dropped below the level of materiality in the current year.

Consolidated: The combining of two or more findings.

Reassessed: The removal of any finding not attributable to corrective actions (e.g., management has re-evaluated and determined a finding does not meet the criteria for materiality or is redefined as more correctly classified under another heading).

Ending Balance: The year-end balance that will be the beginning balance next year.

Table 2: Summary of Management Assurances

Effectiveness of Internal Control over Reporting (FMFIA Section 2)

Statement of Assurance	Unmodified					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
No Material Weaknesses Noted	0	-	-	-	-	0
Total Material Weaknesses	***0***	***-***	***-***	***-***	***-***	***0***

Effectiveness of Internal Control over Operations and Compliance with Laws and Regulations (FMFIA Section 2)

Statement of Assurance	Modified					
Material Weaknesses/ Noncompliances	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Payment Integrity Information Act of 2019 (PIIA)*	4	-	1	1	-	2
*Social Security Act***	1	-	-	-	-	1
Total Material Weaknesses/ Noncompliances	***5***	***-***	***1***	***1***	***-***	***3***

*The Department of Health and Human Services (HHS) identified material noncompliances with PIIA resulting in (a) not reporting improper payment estimates for the Temporary Assistance for Needy Families (TANF) and Foster Care programs; and (b) reporting improper payment estimates above the PIIA statutory threshold of 10 percent for Medicaid and Children's Health Insurance Program (CHIP).

**HHS identified a material noncompliance with *Social Security Act* (the Act) related to not meeting the 90 statutory decision timeframes for the Medicare Appeals Process.

Conformance with Federal Financial Management System Requirements (FMFIA Section 4)

Statement of Assurance	Federal Systems conform to financial management system requirements					
Noncompliance	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
No Noncompliance Noted	0	-	-	-	-	0
Total Noncompliance	***0***	***-***	***-***	***-***	***-***	***0***

Compliance with Section 803(a) of the FFMIA

	Agency	Auditor
1. Federal Financial Management System Requirements	No lack of compliance noted	No lack of compliance noted
2. Applicable Federal Accounting Standards	No lack of compliance noted	No lack of compliance noted
3. U.S. Standard General Ledger at Transaction Level	No lack of compliance noted	No lack of compliance noted

Civil Monetary Penalty Adjustment for Inflation

The *Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015* (the 2015 Act), as amended, requires agencies to make regular and consistent inflationary adjustments of civil monetary penalties to maintain their deterrent effect. To improve compliance with the 2015 Act, agencies are required to publish annual inflation adjustments in the Federal Register and should report annually in their Agency Financial Report.

The 2015 Act applies to eight Operating Divisions (OpDivs) and Staff Divisions (StaffDivs): Administration for Children and Families; Agency for Healthcare Research and Quality; Health Resources and Service Administration; Food and Drug Administration; Centers for Medicare & Medicaid Services; Office for Civil Rights; Office of the General Counsel; and Office of Inspector General. The tables below illustrate HHS's Civil Monetary Penalties by OpDivs and StaffDivs. Refer to the Federal Register for the Annual Civil Monetary Penalties Inflation Adjustment.

Administration for Children and Families

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for Misuse of Information in the National Directory of New Hires.	42 U.S.C. 653(l)(2)	2021	2022	$ 1,687

Agency for Healthcare Research and Quality

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for using or disclosing identifiable information obtained in the course of activities undertaken pursuant to Title IX of the *Public Health Service Act*, for a purpose other than that for which the information was supplied, without consent to do so.	42 U.S.C. 299c-3(d)	2021	2022	$ 16,443

Health Resources and Services Administration

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for each instance of overcharging a 340B covered entity.	42 U.S.C. 256b(d)(1)(B)(vi)	2021	2022	$ 6,323

Civil Monetary Penalty Adjustment for Inflation

Office for Civil Rights

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for violation of confidentiality provision of the *Patient Safety and Quality Improvement Act*.	42 U.S.C. 299b-22(f)(1)	2021	2022	$ 13,885
Penalty for each pre-February 18, 2009, violation of the *Health Insurance Portability and Accountability Act* (HIPAA) administrative simplification provisions.	42 U.S.C. 299b-22(f)(1)	2021	2022	174
Calendar Year Cap	42 U.S.C. 299b-22(f)(1)	2021	2022	43,678
Penalty for each February 18, 2009, or later violation of a HIPAA administrative simplification provision in which it is established that the covered entity or business associate did not know and by exercising reasonable diligence, would not have known that the covered entity or business associate violated such a provision:	42 United States Code (U.S.C.) 1320(d)-5(a)			
Minimum	42 U.S.C. 1320(d)-5(a)	2021	2022	127
Maximum	42 U.S.C. 1320(d)-5(a)	2021	2022	63,973
Calendar Year Cap	42 U.S.C. 1320(d)-5(a)	2021	2022	1,919,173
Penalty for each February 18, 2009, or later violation of a HIPAA administrative simplification provision in which it is established that the violation was due to reasonable cause and not to willful neglect:	42 U.S.C. 1320(d)-5(a)			
Minimum	42 U.S.C. 1320(d)-5(a)	2021	2022	1,280
Maximum	42 U.S.C. 1320(d)-5(a)	2021	2022	63,973
Calendar Year Cap	42 U.S.C. 1320(d)-5(a)	2021	2022	1,919,173
Penalty for each February 18, 2009, or later violation of a HIPAA administrative simplification provision in which it is established that the violation was due to willful neglect and was corrected during the 30-day period beginning on the first date the covered entity or business associate knew, or, by exercising reasonable diligence, would have known that the violation occurred:	42 U.S.C. 1320(d)-5(a)			
Minimum	42 U.S.C. 1320(d)-5(a)	2021	2022	12,794
Maximum	42 U.S.C. 1320(d)-5(a)	2021	2022	63,973
Calendar Year Cap	42 U.S.C. 1320(d)-5(a)	2021	2022	1,919,173
Penalty for each February 18, 2009, or later violation of a HIPAA administrative simplification provision in which it is established that the violation was due to willful neglect and was not corrected during the 30-day period beginning on the first date the covered entity or business associate knew, or by exercising reasonable diligence, would have known that the violation occurred:	42 U.S.C. 1320(d)-5(a)			
Minimum	42 U.S.C. 1320(d)-5(a)	2021	2022	63,973
Maximum	42 U.S.C. 1320(d)-5(a)	2021	2022	1,919,173
Calendar Year Cap	42 U.S.C. 1320(d)-5(a)	2021	2022	1,919,173

Civil Monetary Penalty Adjustment for Inflation

Office of the General Counsel

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for the first time an individual makes an expenditure prohibited by regulations regarding lobbying disclosure, absent aggravating circumstances.	31 U.S.C. 1352	2021	2022	$ 22,021
Penalty for second and subsequent offenses by individuals who make an expenditure prohibited by regulations regarding lobbying disclosure:	31 U.S.C. 1352			
Minimum	31 U.S.C. 1352	2021	2022	22,021
Maximum	31 U.S.C. 1352	2021	2022	220,213
Penalty for the first time an individual fails to file or amend a lobbying disclosure form, absent aggravating circumstances.	31 U.S.C. 1352	2021	2022	22,021
Penalty for second and subsequent offenses by individuals who fail to file or amend a lobbying disclosure form, absent aggravating circumstances:	31 U.S.C. 1352			
Minimum	31 U.S.C. 1352	2021	2022	22,021
Maximum	31 U.S.C. 1352	2021	2022	220,213
Penalty for failure to provide certification regarding lobbying in the award documents for all sub-awards of all tiers:	31 U.S.C. 1352			
Minimum	31 U.S.C. 1352	2021	2022	22,021
Maximum	31 U.S.C. 1352	2021	2022	220,213
Penalty for failure to provide statement regarding lobbying for loan guarantee and loan insurance transactions:	31 U.S.C. 1352			
Minimum	31 U.S.C. 1352	2021	2022	22,021
Maximum	31 U.S.C. 1352	2021	2022	220,213
Penalty against any individual who - with knowledge or reason to know - makes, presents or submits a false, fictitious or fraudulent claim to the Department.	31 U.S.C. 3801-3812	2021	2022	11,507
Penalty against any individual who - with knowledge or reason to know - makes, presents or submits a false, fictitious or fraudulent claim to the Department.	31 U.S.C. 3801-3812	2021	2022	11,507

Office of Inspector General

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for each individual who violates safety and security procedures related to handling dangerous biological agents and toxins.	42 U.S.C. 262a(i)(1)	2021	2022	$ 381,393
Penalty for any other person who violates safety and security procedures related to handling dangerous biological agents and toxins.	42 U.S.C. 262a(i)(1)	2021	2022	762,790
Penalty per violation for committing information blocking.	42 U.S.C. 300jj-51	2021	2022	1,162,924
Penalty for knowingly presenting or causing to be presented to an officer, employee, or agent of the United States (U.S.) a false claim.	42 U.S.C. 1320a-7a(a)	2021	2022	22,427
Penalty for knowingly presenting or causing to be presented a request for payment which violates the terms of an assignment, agreement, or Prospective Payment System agreement.	42 U.S.C. 1320a-7a(a)	2021	2022	22,427
Penalty for knowingly giving or causing to be presented to a participating provider or supplier false or misleading information that could reasonably be expected to influence a discharge decision.	42 U.S.C. 1320a-7a(a)	2021	2022	33,641

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for an excluded party retaining ownership or control interest in a participating entity.	42 U.S.C. 1320a-7a(a)	2021	2022	22,427
Penalty for remuneration offered to induce program beneficiaries to use particular providers, practitioners, or suppliers.	42 U.S.C. 1320a-7a(a)	2021	2022	22,427
Penalty for employing or contracting with an excluded individual.	42 U.S.C. 1320a-7a(a)	2021	2022	22,427
Penalty for knowing and willful solicitation, receipt, offer, or payment of remuneration for referring an individual for a service or for purchasing, leasing, or ordering an item to be paid for by a Federal health care program.	42 U.S.C. 1320a-7a(a)	2021	2022	112,131
Penalty for ordering or prescribing medical or other item or service during a period in which the person was excluded.	42 U.S.C. 1320a-7a(a)	2021	2022	22,427
Penalty for knowingly making or causing to be made a false statement, omission or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider or supplier.	42 U.S.C. 1320a-7a(a)	2021	2022	112,131
Penalty for knowing of an overpayment and failing to report and return.	42 U.S.C. 1320a-7a(a)	2021	2022	22,427
Penalty for making or using a false record or statement that is material to a false or fraudulent claim	42 U.S.C. 1320a-7a(a)	2021	2022	63,231
Penalty for failure to grant timely access to HHS OIG for audits, investigations, evaluations, and other statutory functions of HHS OIG.	42 U.S.C. 1320a-7a(a)	2021	2022	33,641
Penalty for payments by a hospital or critical access hospital to induce a physician to reduce or limit services to individuals under direct care of physician or who are entitled to certain medical assistance benefits.	42 U.S.C. 1320a-7a(b)	2021	2022	5,606
Penalty for physicians who knowingly receive payments from a hospital or critical access hospital to induce such physician to reduce or limit services to individuals under direct care of physician or who are entitled to certain medical assistance benefits.	42 U.S.C. 1320a-7a(b)	2021	2022	5,606
Penalty for a physician who executes a document that falsely certifies home health needs for Medicare beneficiaries.	42 U.S.C. 1320a-7a(b)	2021	2022	11,213
Penalty for knowingly presenting or causing to be presented a false or fraudulent specified claim under a grant, contract, or other agreement for which the Secretary provides funding.	42 U.S.C. 1320a-7a(o)	2021	2022	10,937
Penalty for knowingly making, using, or causing to be made or used any false statement, omission, or misrepresentation of a material fact in any application, proposal, bid, progress report, or other document required to directly or indirectly receive or retain funds provided pursuant to grant, contract, or other agreement.	42 U.S.C. 1320a-7a(o)	2021	2022	54,686
Penalty for knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent specified claim under grant, contract, or other agreement.	42 U.S.C. 1320a-7a(o)	2021	2022	54,686
Penalty for knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit funds or property with respect to grant, contract, or other agreement, or knowingly conceals or improperly avoids or decreases any such obligation.	42 U.S.C. 1320a-7a(o)			
Maximum for each false record statement	42 U.S.C. 1320a-7a(o)	2021	2022	53,772
Maximum per day	42 U.S.C. 1320a-7a(o)	2021	2022	10,754
Penalty for failure to grant timely access, upon reasonable request, to the I.G. for purposes of audits, investigations, evaluations, or other statutory functions of I.G. in matters involving grants, contracts, or other agreements.	42 U.S.C. 1320a-7a(o)	2021	2022	16,406
Penalty for failure to report any final adverse action taken against a health care provider, supplier, or practitioner.	42 U.S.C. 1320a-7e(b)(6)(A)	2021	2022	42,788
Penalty for the misuse of words, symbols, or emblems in communications in a manner in which a person could falsely construe that such item is approved, endorsed, or authorized by HHS.	42 U.S.C. 1320b-10(b)(1)	2021	2022	11,506

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for the misuse of words, symbols, or emblems in a broadcast or telecast in a manner in which a person could falsely construe that such item is approved, endorsed, or authorized by HHS.	42 U.S.C. 1320b-10(b)(2)	2021	2022	57,527
Penalty for certification of a false statement in assessment of functional capacity of a skilled nursing facility (SNF) resident assessment.	42 U.S.C. 1395i-3(b)(3)(B)(ii)(1)	2021	2022	2,400
Penalty for causing another to certify or make a false statement in assessment of functional capacity of a SNF resident assessment.	42 U.S.C. 1395i-3(b)(3)(B)(ii)(2)	2021	2022	11,995
Penalty for any individual who notifies or causes to be notified a SNF of the time or date on which a survey is to be conducted.	42 U.S.C. 1395i-3(g)(2)(A)	2021	2022	4,799
Penalty for a Medicare Advantage (MA) organization that substantially fails to provide medically necessary, required items and services.	42 U.S.C. 1395w-27(g)(2)(A)	2021	2022	43,678
Penalty for a MA organization that charges excessive premiums.	42 U.S.C. 1395w-27(g)(2)(A)	2021	2022	42,788
Penalty for a MA organization that improperly expels or refuses to reenroll a beneficiary.	42 U.S.C. 1395w-27(g)(2)(A)	2021	2022	42,788
Penalty for a MA organization that engages in practice that would reasonably be expected to have the effect of denying or discouraging enrollment.	42 U.S.C. 1395w-27(g)(2)(A)	2021	2022	171,156
Penalty per individual who does not enroll as a result of a MA organization's practice that would reasonably be expected to have the effect of denying or discouraging enrollment.	42 U.S.C. 1395w-27(g)(2)(A)	2021	2022	25,673
Penalty for a MA organization misrepresenting or falsifying information to Secretary.	42 U.S.C. 1395w-27(g)(2)(A)	2021	2022	171,156
Penalty for a MA organization misrepresenting or falsifying information to individual or other entity.	42 U.S.C. 1395w-27(g)(2)(A)	2021	2022	42,788
Penalty for MA organization interfering with provider's advice to enrollee and non- Medicaid Managed Care Organization (MCO) affiliated providers that balance bill enrollees.	42 U.S.C. 1395w-27(g)(2)(A)	2021	2022	42,788
Penalty for a MA organization that employs or contracts with excluded individual or entity.	42 U.S.C. 1395w-27(g)(2)(A)	2021	2022	42,788
Penalty for a MA organization enrolling an individual in without prior written consent.	42 U.S.C. 1395w-27(g)(2)(A)	2021	2022	42,788
Penalty for a MA organization transferring an enrollee to another plan without consent or solely for the purpose of earning a commission.	42 U.S.C. 1395w-27(g)(2)(A)	2021	2022	42,788
Penalty for a MA organization failing to comply with marketing restrictions or applicable implementing regulations or guidance.	42 U.S.C. 1395w-27(g)(2)(A)	2021	2022	42,788
Penalty for a MA organization employing or contracting with an individual or entity who violates 1395w-27(g)(1)(A)-(J).	42 U.S.C. 1395w-27(g)(2)(A)	2021	2022	42,788
Penalty for a prescription drug card sponsor that falsifies or misrepresents marketing materials, overcharges program enrollees, or misuse transitional assistance funds.	42 U.S.C. 1395w-141(i)(3)	2021	2022	14,950
Penalty for improper billing by Hospitals, Critical Access Hospitals, or Skilled Nursing Facilities.	42 U.S.C. 1395cc(g)	2021	2022	5,816
Penalty for a hospital with 100 beds or more or responsible physician dumping patients needing emergency medical care.	42 U.S.C. 1395dd(d)(1)	2021	2022	119,942
Penalty for a hospital with less than 100 beds dumping patients needing emergency medical care.	42 U.S.C. 1395dd(d)(1)	2021	2022	59,973
Penalty for an HMO or competitive medical plan is such plan substantially fails to provide medically necessary, required items or services.	42 U.S.C. 1395mm(i)(6)(B)(i)	2021	2022	59,973
Penalty for HMOs/competitive medical plans that charge premiums in excess of permitted amounts.	42 U.S.C. 1395mm(i)(6)(B)(i)	2021	2022	59,973
Penalty for an HMO or competitive medical plan that expels or refuses to reenroll an individual per prescribed conditions.	42 U.S.C. 1395mm(i)(6)(B)(i)	2021	2022	59,973
Penalty for an HMO or competitive medical plan that implements practices to discourage enrollment of individuals needing services in future.	42 U.S.C. 1395mm(i)(6)(B)(i)	2021	2022	239,885

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty per individual not enrolled in a plan as a result of a HMO or competitive medical plan that implements practices to discourage enrollment of individuals needing services in the future.	42 U.S.C. 1395mm(i)(6)(B)(i)	2021	2022	34,517
Penalty for a HMO or competitive medical plan that misrepresents or falsifies information to the Secretary.	42 U.S.C. 1395mm(i)(6)(B)(i)	2021	2022	239,885
Penalty for a HMO or competitive medical plan that misrepresents or falsifies information to an individual or any other entity.	42 U.S.C. 1395mm(i)(6)(B)(i)	2021	2022	59,973
Penalty for failure by HMO or competitive medical plan to assure prompt payment of Medicare risk sharing contracts or incentive plan provisions.	42 U.S.C. 1395mm(i)(6)(B)(i)	2021	2022	59,973
Penalty for HMO that employs or contracts with excluded individual or entity.	42 U.S.C. 1395mm(i)(6)(B)(i)	2021	2022	55,052
Penalty for submitting or causing to be submitted claims in violation of the Stark Law's restrictions on physician self-referrals.	42 U.S.C. 1395nn(g)(3)	2021	2022	27,750
Penalty for circumventing Stark Law's restrictions on physician self-referrals.	42 U.S.C. 1395nn(g)(4)	2021	2022	185,009
Penalty for a material misrepresentation regarding Medigap compliance policies.	42 U.S.C. 1395ss(d)(1)	2021	2022	11,506
Penalty for selling Medigap policy under false pretense.	42 U.S.C. 1395ss(d)(2)	2021	2022	11,506
Penalty for an issuer that sells health insurance policy that duplicates benefits.	42 U.S.C. 1395ss(d)(3)(A)(ii)	2021	2022	51,796
Penalty for someone other than issuer that sells health insurance that duplicates benefits.	42 U.S.C. 1395ss(d)(3)(A)(ii)	2021	2022	31,076
Penalty for using mail to sell a non-approved Medigap insurance policy.	42 U.S.C. 1395ss(d)(4)(A)	2021	2022	11,506
Penalty for a Medicaid MCO that substantially fails to provide medically necessary, required items or services.	42 U.S.C. 1396b(m)(5)(B)(i)	2021	2022	57,527
Penalty for a Medicaid MCO that charges excessive premiums.	42 U.S.C. 1396b(m)(5)(B)(i)	2021	2022	57,527
Penalty for a Medicaid MCO that improperly expels or refuses to reenroll a beneficiary.	42 U.S.C. 1396b(m)(5)(B)(i)	2021	2022	230,107
Penalty per individual who does not enroll as a result of a Medicaid MCO's practice that would reasonably be expected to have the effect of denying or discouraging enrollment.	42 U.S.C. 1396b(m)(5)(B)(i)	2021	2022	34,517
Penalty for a Medicaid MCO misrepresenting or falsifying information to the Secretary.	42 U.S.C. 1396b(m)(5)(B)(i)	2021	2022	230,107
Penalty for a Medicaid MCO misrepresenting or falsifying information to an individual or another entity.	42 U.S.C. 1396b(m)(5)(B)(i)	2021	2022	57,757
Penalty for a Medicaid MCO that fails to comply with contract requirements with respect to physician incentive plans.	42 U.S.C. 1396b(m)(5)(B)(i)	2021	2022	51,796
Penalty for willfully and knowingly certifying a material and false statement in a SNF resident assessment.	42 U.S.C. 1396r(b)(3)(B)(ii)(I)	2021	2022	2,400
Penalty for willfully and knowingly causing another individual to certify a material and false statement in a SNF resident assessment.	42 U.S.C. 1396r(b)(3)(B)(ii)(II)	2021	2022	11,995
Penalty for notifying or causing to be notified a SNF of the time or date on which a survey is to be conducted.	42 U.S.C. 1396r(g)(2)(A)(i)	2021	2022	4,799
Penalty for the knowing provision of false information or refusing to provide information about charges or prices of a covered outpatient drug.	42 U.S.C. 1396r-8(b)(3)(B)	2021	2022	207,183
Penalty per day for failure to timely provide information by drug manufacturer with rebate agreement.	42 U.S.C. 1396r-8(b)(3)(C)(i)	2021	2022	20,719
Penalty for knowing provision of false information by drug manufacturer with rebate agreement.	42 U.S.C. 1396r-8(b)(3)(C)(ii)	2021	2022	207,183
Penalty for notifying home and community-based providers or settings of survey.	42 U.S.C. 1396t(i)(3)(A)	2021	2022	4,144
Penalty for failing to report a medical malpractice claim to National Practitioner Data Bank.	42 U.S.C. 11131(c)	2021	2022	25,076
Penalty for breaching confidentiality of information reported to National Practitioner Data Bank.	42 U.S.C. 11137(b)(2)	2021	2022	25,076

Civil Monetary Penalty Adjustment for Inflation

Food and Drug Administration

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for violations related to drug samples resulting in a conviction of any representative of manufacturer or distributor in any 10-year period.	21 U.S.C. 333(b)(2)(A)	2021	2022	$ 115,054
Penalty for violation related to drug samples resulting in a conviction of any representative of manufacturer or distributor after the second conviction in any 10-year period.	21 U.S.C. 333(b)(2)(B)	2021	2022	2,301,065
Penalty for failure to make a report required by 21 U.S.C. 353(d)(3)(E) relating to drug samples.	21 U.S.C. 333(b)(3)	2021	2022	230,107
Penalty for any person who violates a requirement related to devices for each such violation.	21 U.S.C. 333(f)(1)(A)	2021	2022	31,076
Penalty for aggregate of all violations related to devices in a single proceeding.	21 U.S.C. 333(f)(1)(A)	2021	2022	2,071,819
Penalty for any individual who introduces or delivers for introduction into interstate commerce food that is adulterated per 21 U.S.C. 342(a)(2)(B) or any individual who does not comply with a recall order under 21 U.S.C. 350l.	21 U.S.C. 333(f)(2)(A)	2021	2022	87,362
Penalty in the case of any other person (other than an individual) for such introduction or delivery of adulterated food.	21 U.S.C. 333(f)(2)(A)	2021	2022	436,809
Penalty for aggregate of all such violations related to adulterated food adjudicated in a single proceeding.	21 U.S.C. 333(f)(2)(A)	2021	2022	873,618
Penalty for all violations adjudicated in a single proceeding for any person who violates 21 U.S.C. 331(jj) by failing to submit the certification required by 42 U.S.C. 282(j)(5)(B) or knowingly submitting a false certification; by failing to submit clinical trial information under 42 U.S.C. 282(j); or by submitting clinical trial information under 42 U.S.C. 282(j) that is false or misleading in any particular under 42 U.S.C. 282(j)(5)(D).	21 U.S.C. 333(f)(3)(A)	2021	2022	13,237
Penalty for each day any above violation is not corrected after a 30-day period following notification until the violation is corrected.	21 U.S.C. 333(f)(3)(B)	2021	2022	13,237
Penalty for any responsible person that violates a requirement of 21 U.S.C. 355(o) (post-marketing studies, clinical trials, labeling), 21 U.S.C. 355(p) (risk evaluation and mitigation [REMS]), or 21 U.S.C. 355–1 (REMS).	21 U.S.C. 333(f)(4)(A)(i)	2021	2022	330,948
Penalty for aggregate of all such above violations in a single proceeding.	21 U.S.C. 333(f)(4)(A)(i)	2021	2022	1,323,791
Penalty for REMS violation that continues after written notice to the responsible person for the first 30-day period (or any portion thereof) the responsible person continues to be in violation.	21 U.S.C. 333(f)(4)(A)(ii)	2021	2022	330,948
Penalty for REMS violation that continues after written notice to responsible person doubles for every 30-day period thereafter the violation continues, but may not exceed penalty amount for any 30-day period.	21 U.S.C. 333(f)(4)(A)(ii)	2021	2022	1,323,791
Penalty for aggregate of all such above violations adjudicated in a single proceeding.	21 U.S.C. 333(f)(4)(A)(ii)	2021	2022	13,237,910
Penalty for any person who violates a requirement which relates to tobacco products for each such violation.	21 U.S.C. 333(f)(9)(A)	2021	2022	19,192
Penalty for aggregate of all such violations of tobacco product requirement adjudicated in a single proceeding.	21 U.S.C. 333(f)(9)(A)	2021	2022	1,279,448
Penalty per violation related to violations of tobacco requirements.	21 U.S.C. 333(f)(9)(B)(i)(I)	2021	2022	319,863
Penalty for aggregate of all such violations of tobacco product requirements adjudicated in a single proceeding.	21 U.S.C. 333(f)(9)(B)(i)(I)	2021	2022	1,279,448
Penalty in the case of a violation of tobacco product requirements that continues after written notice to such person, for the first 30-day period (or any portion thereof) the person continues to be in violation.	21 U.S.C. 333(f)(9)(B)(i)(II)	2021	2022	319,863
Penalty for violation of tobacco product requirements that continues after written notice to such person shall double for every 30-day period thereafter the violation continues, but may not exceed penalty amount for any 30-day period.	21 U.S.C. 333(f)(9)(B)(i)(II)	2021	2022	1,279,448

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for aggregate of all such violations related to tobacco product requirements adjudicated in a single proceeding.	21 U.S.C. 333(f)(9)(B)(i)(II)	2021	2022	12,794,487
Penalty for any person who either does not conduct post-market surveillance and studies to determine impact of a modified risk tobacco product for which the HHS Secretary has provided them an order to sell, or who does not submit a protocol to the HHS Secretary after being notified of a requirement to conduct post-market surveillance of such tobacco products.	21 U.S.C. 333(f)(9)(B)(ii)(I)	2021	2022	319,863
Penalty for aggregate of for all such above violations adjudicated in a single proceeding.	21 U.S.C. 333(f)(9)(B)(ii)(I)	2021	2022	1,279,448
Penalty for violation of modified risk tobacco product post-market surveillance that continues after written notice to such person for the first 30-day period (or any portion thereof) that the person continues to be in violation.	21 U.S.C. 333(f)(9)(B)(ii)(II)	2021	2022	319,863
Penalty for post-notice violation of modified risk tobacco product post-market surveillance shall double for every 30-day period thereafter that the tobacco product requirement violation continues for any 30-day period, but may not exceed penalty amount for any 30-day period.	21 U.S.C. 333(f)(9)(B)(ii)(II)	2021	2022	1,279,448
Penalty for aggregate above tobacco product requirement violations adjudicated in a single proceeding.	21 U.S.C. 333(f)(9)(B)(ii)(II)	2021	2022	12,794,487
Penalty for any person who disseminates or causes another party to disseminate a direct-to-consumer advertisement that is false or misleading for the first such violation in any 3-year period.	21 U.S.C. 333(g)(1)	2021	2022	330,948
Penalty for each subsequent above violation in any 3-year period.	21 U.S.C. 333(g)(1)	2021	2022	661,896
Penalty to be applied for violations of 21 U.S.C. 387f(d)(5) or of violations of restrictions on the sale or distribution of tobacco products promulgated under 21 U.S.C. 387f(d) (e.g., violations of regulations in 21 CFR part 1140) with respect to a retailer with an approved training program in the case of a second regulation violation within a 12-month period.	21 U.S.C. 333 note	2021	2022	320
Penalty in the case of a third violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 24-month period.	21 U.S.C. 333 note	2021	2022	638
Penalty in the case of a fourth violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 24-month period.	21 U.S.C. 333 note	2021	2022	2,559
Penalty in the case of a fifth violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 36-month period.	21 U.S.C. 333 note	2021	2022	6,397
Penalty in the case of a sixth or subsequent violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 48-month period as determined on a case-by-case basis.	21 U.S.C. 333 note	2021	2022	12,794
Penalty to be applied for violations of 21 U.S.C. 387f(d)(5) or of violations of restrictions on the sale or distribution of tobacco products promulgated under 21 U.S.C. 387f(d) (e.g., violations of regulations in 21 CFR part 1140) with respect to a retailer that does not have an approved training program in the case of the first regulation violation.	21 U.S.C. 333 note	2021	2022	320
Penalty in the case of a second violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 12-month period.	21 U.S.C. 333 note	2021	2022	638
Penalty in the case of a third violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 24-month period.	21 U.S.C. 333 note	2021	2022	1,280
Penalty in the case of a fourth violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 24-month period.	21 U.S.C. 333 note	2021	2022	2,559
Penalty in the case of a fifth violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 36-month period.	21 U.S.C. 333 note	2021	2022	6,397
Penalty in the case of a sixth or subsequent violation of 21 U.S.C. 387f(d)(5) tobacco product regulations within a 48-month period as determined on a case-by-case basis.	21 U.S.C. 333 note	2021	2022	12,794

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for each violation for any individual who made a false statement or misrepresentation of a material fact, bribed, destroyed, altered, removed, or secreted, or procured the destruction, alteration, removal, or secretion of, any material document, failed to disclose a material fact, obstructed an investigation, employed a consultant who was debarred, debarred individual provided consultant services.	21 U.S.C. 335b(a)	2021	2022	487,638
Penalty in the case of any other person (other than an individual) per above violation.	21 U.S.C. 335b(a)	2021	2022	1,950,548
Penalty for any person who violates any such requirements for electronic products, with each unlawful act or omission constituting a separate violation.	21 U.S.C. 360pp(b)(1)	2021	2022	3,198
Penalty imposed for any related series of violations of requirements relating to electronic products.	21 U.S.C. 360pp(b)(1)	2021	2022	1,090,241
Penalty per day for violation of order of recall of biological product presenting imminent or substantial hazard.	42 U.S.C. 262(d)	2021	2022	250,759
Penalty for failure to obtain a mammography certificate as required.	42 U.S.C. 263b(h)(3)	2021	2022	19,507
Penalty per occurrence for any vaccine manufacturer that intentionally destroys, alters, falsifies, or conceals any record or report required.	42 U.S.C. 300aa-28(b)(1)	2021	2022	250,759

Centers for Medicare & Medicaid Services

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for a hospital's non-compliance with making public standard charges for hospital items and services.	42 U.S.C. 300gg-18, 1302	2021	2022	$ 300 per day
Per Day (Maximum)	42 U.S.C. 300gg-18, 1302	2021	2022	5,500 per day
Penalty for a provider's non-compliance with price transparency requirements regarding diagnostic tests for COVID–19	CARES Act, Pub. L. 116-136, Section 3202(b)(2)			-
Per Day (Maximum)	CARES Act, Pub. L. 116-136, Section 3202(b)(2)	2021	2022	300 per day
Penalty for a clinical laboratory's failure to meet participation and certification requirements and poses immediate jeopardy:	42 U.S.C. 263a(h)(2)(B) & 1395w-2(b)(2)(A)(ii)			
Minimum	42 U.S.C. 263a(h)(2)(B) & 1395w-2(b)(2)(A)(ii)	2021	2022	7,018
Maximum	42 U.S.C. 263a(h)(2)(B) & 1395w-2(b)(2)(A)(ii)	2021	2022	23,011
Penalty for a clinical laboratory's failure to meet participation and certification requirements and the failure does not pose immediate jeopardy:	42 U.S.C. 263a(h)(2)(B) & 1395w-2(b)(2)(A)(ii)			
Minimum	42 U.S.C. 263a(h)(2)(B) & 1395w-2(b)(2)(A)(ii)	2021	2022	116
Maximum	42 U.S.C. 263a(h)(2)(B) & 1395w-2(b)(2)(A)(ii)	2021	2022	6,902
Penalty for a clinical laboratory's failure to meet SARS-CoV-2 test reporting requirements:	42 U.S.C. 263a(h)(2)(B) & 1395w-2(b)(2)(A)(ii)			
First day of noncompliance	42 U.S.C. 263a(h)(2)(B) & 1395w-2(b)(2)(A)(ii)	2021	2022	-

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Each additional day of noncompliance	42 U.S.C. 263a(h)(2)(B) & 1395w-2(b)(2)(A)(ii)	2021	2022	-
Failure to provide the Summary of Benefits and Coverage.	45 U.S.C. 300gg-15(f)	2021	2022	1,264
Penalty for violations of regulations related to the medical loss ratio reporting and rebating.	45 U.S.C. 300gg-18	2021	2022	126
Price against hospital identified by CMS as noncompliant according to 45 CFR 182.50 with respect to price transparency requirements regarding diagnostic tests for COVID-19.	45 U.S.C. 300gg-18			
Penalties for failure to comply with *No Surprises Act* requirements on providers, facilities, providers of air ambulance services	42 U.S.C. 300gg-18 note 300gg-134	2021	2022	10,622
Penalty for manufacturer or group purchasing organization failing to report information required under 42 U.S.C. 1320a-7h(a), relating to physician ownership or investment interests:	42 U.S.C. 1320a-7h(b)(1)			
Minimum	42 U.S.C. 1320a-7h(b)(1)	2021	2022	1,264
Maximum	42 U.S.C. 1320a-7h(b)(1)	2021	2022	12,646
Calendar Year Cap	42 U.S.C. 1320a-7h(b)(1)	2021	2022	189,692
Penalty for manufacturer or group purchasing organization knowingly failing to report information required under 42 U.S.C. 1320a-7h(a), relating to physician ownership or investment interests:	42 U.S.C. 1320a-7h(b)(2)			
Minimum	42 U.S.C. 1320a-7h(b)(2)	2021	2022	12,646
Maximum	42 U.S.C. 1320a-7h(b)(2)	2021	2022	126,463
Calendar Year Cap	42 U.S.C. 1320a-7h(b)(2)	2021	2022	1,264,622
Penalty for an administrator of a facility that fails to comply with notice requirements for the closure of a facility.	42 U.S.C. 1320a-7h(b)(2)	2021	2022	126,463
Minimum penalty for the first offense of an administrator who fails to provide notice of facility closure.	42 U.S.C. 1320a-7j(h)(3)(A)	2021	2022	632
Minimum penalty for the second offense of an administrator who fails to provide notice of facility closure.	42 U.S.C. 1320a-7j(h)(3)(A)	2021	2022	1,898
Minimum penalty for the third and subsequent offenses of an administrator who fails to provide notice of facility closure.	42 U.S.C. 1320a-7j(h)(3)(A)	2021	2022	3,793

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for an entity knowingly making a false statement or representation of material fact in the determination of the amount of benefits or payments related to old-age, survivors, and disability insurance benefits, special benefits for certain World War II veterans, or supplemental security income for the aged, blind, and disabled.	42 U.S.C. 1320a-8(a)(1)	2021	2022	9,250
Penalty for the violation of 42 U.S.C. 1320a-8a(1) if the violator is a person who receives a fee or other income for services performed in connection with determination of the benefit amount or the person is a physician or other health care provider who submits evidence in connection with such a determination.	42 U.S.C. 1320a-8(a)(1)	2021	2022	8,723
Penalty for a representative payee (under 42 U.S.C. 405(j), 1007, or 1383(a)(2)) converting any part of a received payment from the benefit programs described in the previous civil monetary penalty to a use other than for the benefit of the beneficiary.	42 U.S.C. 1320a-8(a)(3)	2021	2022	7,244
Penalty for failure of covered individuals to report to the Secretary and 1 or more law enforcement officials any reasonable suspicion of a crime against a resident, or individual receiving care, from a long-term care facility.	42 U.S.C. 1320b-25(c)(1)(A)	2021	2022	252,925
Penalty for failure of covered individuals to report to the Secretary and 1 or more law enforcement officials any reasonable suspicion of a crime against a resident, or individual receiving care, from a long-term care facility if such failure exacerbates the harm to the victim of the crime or results in the harm to another individual.	42 U.S.C. 1320b-25(c)(2)(A)	2021	2022	379,386
Penalty for a long-term care facility that retaliates against any employee because of lawful acts done by the employee, or files a complaint or report with the State professional disciplinary agency against an employee or nurse for lawful acts done by the employee or nurse.	42 U.S.C. 1320b-25(d)(2)	2021	2022	252,925
Penalty for any person who knowingly and willfully fails to furnish a beneficiary with an itemized statement of items or services within 30 days of the beneficiary's request.	42 U.S.C. 1395b-7(b)(2)(B)	2021	2022	171
Penalty per day for a SNF that has a Category 2 violation of certification requirements:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	120
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	7,195
Penalty per instance of Category 2 noncompliance by a SNF:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	2,400
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	23,989
Penalty per day for a SNF that has a Category 3 violation of certification requirements:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	7,317
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	23,989

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty per instance of Category 3 noncompliance by a SNF:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	2,400
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	23,989
Penalty per day and per instance for a SNF that has Category 3 noncompliance with Immediate Jeopardy:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Per Day (Minimum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	7,317
Per Day (Maximum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	23,989
Per Instance (Minimum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	2,400
Per Instance (Maximum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	23,989
Penalty per day of a SNF that fails to meet certification requirements. These amounts represent the upper range per day:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	7,317
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	23,989
Penalty per day of a SNF that fails to meet certification requirements. These amounts represent the lower range per day:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	120
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	7,195
Penalty per instance of a SNF that fails to meet certification requirements:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	2,400
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	23,989
Penalty imposed for failure to comply with infection control weekly reporting requirements at 42 CFR 483.80(g)(1) and (2):	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
First Occurrence	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	1,075
Incremental increases for each subsequent occurrence	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2022	537

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for knowingly, willfully, and repeatedly billing for a clinical diagnostic laboratory test other than on an assignment-related basis. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 320a-7a(a).)	42 U.S.C. 1395(h)(5)(D)	2021	2022	17,472
Penalty for knowingly and willfully presenting or causing to be presented a bill or request for payment for an intraocular lens inserted during or after cataract surgery for which the Medicare payment rate includes the cost of acquiring the class of lens involved.	42 U.S.C. 1395(i)(6)	2021	2022	4,603
Penalty for knowingly and willfully failing to provide information about a referring physician when seeking payment on an unassigned basis.	42 U.S.C. 1395l(q)(2)(B)(i)	2021	2022	4,404
Penalty for any durable medical equipment supplier that knowingly and willfully charges for a covered service that is furnished on a rental basis after the rental payments may no longer be made. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 42U.S.C. 1320a-7a(a)).	42 U.S.C. 1395m(a)(11)(A)	2021	2022	17,472
Penalty for any nonparticipating durable medical equipment supplier that knowingly and willfully fails to make a refund to Medicare beneficiaries for a covered service for which payment is precluded due to an unsolicited telephone contact from the supplier. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(a)(18)(B)	2021	2022	17,472
Penalty for any nonparticipating physician or supplier that knowingly and willfully charges a Medicare beneficiary more than the limiting charge for radiologist services. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(b)(5)(C)	2021	2022	17,472
Penalty for any supplier of prosthetic devices, orthotics, and prosthetics that knowing and willfully charges for a covered prosthetic device, orthotic, or prosthetic that is furnished on a rental basis after the rental payment may no longer be made. (Penalties are assessed in the same manner as 42 U.S.C. 1395m(a)(11)(A), that is in the same manner as 42 U.S.C. 395u(j)(2)(B), which is assessed according to 42 U.S.C. 1320a-7a(a).)	42 U.S.C. 1395m(h)(3)	2021	2022	17,472
Penalty for any supplier of durable medical equipment including a supplier of prosthetic devices, prosthetics, orthotics, or supplies that knowingly and willfully distributes a certificate of medical necessity in violation of section 1834(j)(2)(A)(i) of the Act or fails to provide the information required under section 1834(j)(2)(A)(ii) of the Act.	42 U.S.C. 1395m(j)(2)(A)(iii)	2021	2022	1,850
Penalty for any supplier of durable medical equipment, including a supplier of prosthetic devices, prosthetics, orthotics, or supplies that knowingly and willfully fails to make refunds in a timely manner to Medicare beneficiaries for series billed other than on as assignment-related basis under certain conditions. (Penalties are assessed in the same manner as 42 U.S.C. 1395m(j)(4) and 1395u(j)(2)(B), which is assessed according to 42 U.S.C. 1320a-7a(a).)	42 U.S.C. 1395m(j)(4)	2021	2022	17,472
Penalty for an applicable entity that has failed to report or made a misrepresentation or omission in reporting applicable information with respect to a clinical diagnostic laboratory test.	42 U.S.C. 1395m-1(a)	2021	2022	11,649
Penalty for any person or entity who knowingly and willfully bills or collects for any outpatient therapy services or comprehensive outpatient rehabilitation services on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 U.S.C. 1395m(k)(6) and 1395u(j)(2)(B), which is assessed according to 42 U.S.C. 1320a-7a(a).)	42 U.S.C. 1395m-1(a)	2021	2022	17,472

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for any supplier of ambulance services who knowingly and willfully fills or collects for any services on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(b)(18)(B), which is assessed according to 1320a-7a(a).)	42 U.S.C. 1395m(l)(6)	2021	2022	17,742
Penalty for any practitioner specified in Section 1842(b)(18)(C) of the Act or other person that knowingly and willfully bills or collects for any services by the practitioners on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 42 U.S.C. 1320a-7a(a).)	42 U.S.C. 1395u(b)(18)(B)	2021	2022	17,742
Penalty for any physician who charges more than 125% for a non-participating referral. (Penalties are assessed in the same manner as 42 U.S.C. 1320a-7a(a).)	42 U.S.C. 1395u(j)(2)(B)	2021	2022	17,742
Penalty for any physician who knowingly and willfully presents or causes to be presented a claim for bill for an assistant at a cataract surgery performed on or after March 1, 1987, for which payment may not be made because of section 1862(a)(15) of the Act. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 42 U.S.C. 1320a-7a(a).)	42 U.S.C. 1395u(k)	2021	2022	17,742
Penalty for any nonparticipating physician who does not accept payment on an assignment-related basis and who knowingly and willfully fails to refund on a timely basis any amounts collected for services that are not reasonable or medically necessary or are of poor quality under 1842(l)(1)(A). (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 42 U.S.C. 1320a-7a(a.)).	42 U.S.C. 1395u(l)(3)	2021	2022	17,742
Penalty for any nonparticipating physician charging more than $500 who does not accept payment for an elective surgical procedure on an assignment related basis and who knowingly and willfully fails to disclose the required information regarding charges and coinsurance amounts and fails to refund on a timely basis any amount collected for the procedure in excess of the charges recognized and approved by the Medicare program. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 42 U.S.C. 1320a-7a(a).)	42 U.S.C. 1395u(m)(3)	2021	2022	17,742
Penalty for any physician who knowingly, willfully, and repeatedly bills one or more beneficiaries for purchased diagnostic tests any amount other than the payment amount specified by the Act. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(n)(3)	2021	2022	17,742
Penalty for any practitioner specified in Section 1842(b)(18)(C) of the Act or other person that knowingly and willfully bills or collects for any services pertaining to drugs or biologics by the practitioners on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(b)(18)(B) and 1395u(j)(2)(B), which is assessed according to 42 U.S.C. 1320a-7a(a).)	42 U.S.C. 1395u(o)(3)(B)	2021	2022	17,472
Penalty for any physician or practitioner who knowingly and willfully fails promptly to provide the appropriate diagnosis codes upon CMS or Medicare administrative contractor request for payment or bill not submitted on an assignment-related basis.	42 U.S.C. 1395u(p)(3)(A)	2021	2022	4,603
Penalty for a pharmaceutical manufacturer's misrepresentation of average sales price of a drug, or biologic.	42 U.S.C. 1395w-3a(d)(4)(A)	2021	2022	14,950

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for any nonparticipating physician, supplier, or other person that furnishes physician services not on an assignment-related basis who either knowingly and willfully bills or collects in excess of the statutorily-defined limiting charge or fails to make a timely refund or adjustment. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 42 U.S.C. 1320a-7a(a).)	42 U.S.C. 1395w-4(g)(1)(B)	2021	2022	17,472
Penalty for any person that knowingly and willfully bills for statutorily defined State-plan approved physicians' services on any other basis than an assignment-related basis for a Medicare/Medicaid dual eligible beneficiary. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 42 U.S.C. 1320a-7a(a).)	42 U.S.C. 1395w-4(g)(3)(B)	2021	2022	17,472
Penalty for each termination determination the Secretary makes that is the result of actions by a MA organization or Part D sponsor that has adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.	42 U.S.C. 1395w-27(g)(3)(A); 1857(g)(3); 1860D-12(b)(3)(E)	2021	2022	42,788
Penalty for each week beginning after the initiation of civil money penalty procedures by the Secretary because a MA organization or Part D sponsor has failed to carry out a contract, or has carried out a contract inconsistently with regulations.	42 U.S.C. 1395w-27(g)(3)(B); 1857(g)(3); 1860D-12(b)(3)(E)	2021	2022	17,116
Penalty for a MA organization's or Part D sponsor's early termination of its contract.	42 U.S.C. 1395w-27(g)(3)(D); 1857(g)(3): 1860D-12(b)(3)(E)	2021	2022	158,947
Penalty for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits not to enroll under a group health plan or large group health plan which would be a primary plan.	42 U.S.C. 1395y(b)(3)(C)	2021	2022	10,360
Penalty for any non-governmental employer that, before October 1, 1998, willfully or repeatedly failed to provide timely and accurate information requested relating to an employee's group health insurance coverage.	42 U.S.C. 1395y(b)(5)(C)(ii)	2021	2022	1,687
Penalty for any entity that knowingly, willfully, and repeatedly fails to complete a claim form relating to the availability of other health benefits in accordance with statute or provides inaccurate information relating to such on the claim form.	42 U.S.C. 1395y(b)(6)(B)	2021	2022	3,701
Penalty for any entity serving as insurer, third party administrator, or fiduciary for a group health plan that fails to provide information that identifies situations where the group health plan is or was a primary plan to Medicare to the HHS Secretary.	42 U.S.C. 1395y(b)(7)(B)(i)	2021	2022	1,325
Penalty for any non-group health plan that fails to identify claimants who are Medicare beneficiaries and provide information to the HHS Secretary to coordinate benefits and pursue any applicable recovery claim.	42 U.S.C. 1395y(b)(8)(E)	2021	2022	1,325
Penalty for any person that fails to report information required by HHS under section 1877(f) of the Act concerning ownership, investment, and compensation arrangements.	42 U.S.C. 1395nn(g)(5)	2021	2022	22,021
Penalty for any durable medical equipment supplier, including a supplier of prosthetic devices, prosthetics, orthotics, or supplies, that knowingly and willfully fails to make refunds in a timely manner to Medicare beneficiaries under certain conditions. (42 U.S.C. 1395(m)(18) sanctions apply here in the same manner, which is under 1395u(j)(2) and 1320a–7a(a)).	42 U.S.C. 1395pp(h)	2021	2022	17,472
Penalty for any person that issues a Medicare supplemental policy that has not been approved by the State regulatory program or does not meet Federal standards after a statutorily defined effective date.	42 U.S.C. 1395ss(a)(2)	2021	2022	59,972

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for someone other than issuer that sells or issues a Medicare supplemental policy to beneficiary without a disclosure statement.	42 U.S.C. 1395ss(d)(3)(A)(vi)(II)	2021	2022	31,076
Penalty for an issuer that sells or issues a Medicare supplemental policy without disclosure statement.	42 U.S.C. 1395ss(d)(3)(A)(vi)(II)	2021	2022	51,796
Penalty for someone other than issuer that sells or issues a Medicare supplemental policy without acknowledgement form.	42 U.S.C. 1395ss(d)(3)(B)(iv)	2021	2022	31,076
Penalty for issuer that sells or issues a Medicare supplemental policy without an acknowledgement form.	42 U.S.C. 1395ss(d)(3)(B)(iv)	2021	2022	51,796
Penalty for someone other than issuer that sells or issues Medicare supplemental polices after a given date that fail to conform to the NAIC or Federal standards established by statute.	42 U.S.C. 1395ss(p)(8)	2021	2022	31,076
Penalty for an issuer that sells or issues Medicare supplemental polices after a given date that fail to conform to the NAIC or Federal standards established by statute.	42 U.S.C. 1395ss(p)(8)	2021	2022	51,796
Penalty for someone other than issuer that sells a Medicare supplemental policy and fails to make available for sale the core group of basic benefits when selling other Medicare supplemental policies with additional benefits or fails to provide the individual, before selling the policy, an outline of coverage describing benefits.	42 U.S.C. 1395ss(p)(9)(C)	2021	2022	31,076
Penalty for an issuer that sells a Medicare supplemental policy and fails to make available for sale the core group of basic benefits when selling other Medicare supplemental policies with additional benefits or fails to provide the individual, before selling the policy, an outline of coverage describing benefits.	42 U.S.C. 1395ss(p)(9)(C)	2021	2022	51,796
Penalty for any person that fails to suspend the policy of a policyholder made eligible for medical assistance or automatically reinstates the policy of a policyholder who has lost eligibility for medical assistance, under certain circumstances.	42 U.S.C. 1395ss(q)(5)(C)	2021	2022	51,796
Penalty for any person that fails to provide refunds or credits as required by section 1882(r)(1)(B) of the Act.	42 U.S.C. 1395ss(r)(6)(A)	2021	2022	51,796
Penalty for any issuer of a Medicare supplemental policy that does not waive listed time periods if they were already satisfied under a proceeding Medicare supplemental policy, or denies a policy, or conditions the issuances or effectiveness of the policy, or discriminates in the pricing of the policy base on health status or other specified criteria.	42 U.S.C. 1395ss(s)(4)	2021	2022	21,989
Penalty for any issuer of a Medicare supplemental policy that fails to fulfill listed responsibilities.	42 U.S.C. 1395ss(t)(2)	2021	2022	51,796
Penalty someone other than issuer who sells, issues, or renews a Medigap Rx policy to an individual who is a Part D enrollee.	42 U.S.C. 1395ss(v)(4)(A)	2021	2022	22,426
Penalty for an issuer who sells, issues, or renews a Medigap Rx policy who is a Part D enrollee.	42 U.S.C. 1395ss(v)(4)(A)	2021	2022	37,377
Penalty for any individual who notifies or causes to be notified a home health agency of the time or date on which a survey of such agency is to be conducted.	42 U.S.C. 1395bbb(c)(1)	2021	2022	4,799
Maximum daily penalty amount for each day a home health agency is not in compliance with statutory requirements.	42 U.S.C. 1395bbb(f)(2)(A)(i)	2021	2022	23,011
Penalty per day for home health agency's noncompliance (Upper Range):	42 U.S.C. 1395bbb(f)(2)(A)(i)	2021	2022	-
Minimum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2021	2022	19,559
Maximum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2021	2022	23,011
Penalty for a home health agency's deficiency or deficiencies that cause immediate jeopardy and result in actual harm.	42 U.S.C. 1395bbb(f)(2)(A)(i)	2021	2022	23,011
Penalty for a home health agency's deficiency or deficiencies that cause immediate jeopardy and result in potential for harm.	42 U.S.C. 1395bbb(f)(2)(A)(i)	2021	2022	20,709

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for an isolated incident of noncompliance in violation of established Home Health Agency policy.	42 U.S.C. 1395bbb(f)(2)(A)(i)	2021	2022	19,559
Penalty for a repeat and/or condition-level deficiency that does not constitute immediate jeopardy, but is directly related to poor quality patient care outcomes (Lower Range):	42 U.S.C. 1395bbb(f)(2)(A)(i)			
Minimum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2021	2022	3,453
Maximum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2021	2022	19,559
Penalty for a repeat and/or condition-level deficiency that does not constitute immediate jeopardy and that is related predominately to structure or process-oriented conditions (Lower Range):	42 U.S.C. 1395bbb(f)(2)(A)(i)			
Minimum	42 U.S.C. 1395bbb(f)(2)(A)(i))	2021	2022	1,151
Maximum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2021	2022	2,301
Penalty imposed for instance of noncompliance that may be assessed for one or more singular events of condition-level noncompliance that are identified and where the noncompliance was corrected during the onsite survey:	42 U.S.C. 1395bbb(f)(2)(A)(i)			
Minimum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2021	2022	2,301
Maximum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2021	2022	23,011
Penalty for each day of noncompliance (Maximum)	42 U.S.C. 1395bbb(f)(2)(A)(i)	2021	2022	23,011
Penalty for PACE organization that discriminates in enrollment or disenrollment, or engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment, on the basis of health status or the need for services.	42 U.S.C. 1395eee(e)(6)(B); 1396u-4(e)(6)(B)	2021	2022	42,788
For each individual not enrolled as a result of the PACE organization's discrimination in enrollment or disenrollment or practice that would deny or discourage enrollment:	42 U.S.C. 1395eee(e)(6)(B); 1396u-4(e)(6)(B)			
Minimum	42 U.S.C. 1395eee(e)(6)(B); 1396u-4(e)(6)(B)	2021	2022	16,121
Maximum	42 U.S.C. 1395eee(e)(6)(B); 1396u-4(e)(6)(B)	2021	2022	107,478
Penalty for a PACE organization that charges excessive premiums.	42 U.S.C. 1395eee(e)(6)(B); 1396u-4(e)(6)(B)	2021	2022	42,788
Penalty for a PACE organization misrepresenting or falsifying information to CMS or the State.	42 U.S.C. 1395eee(e)(6)(B); 1396u-4(e)(6)(B)	2021	2022	171,156
Penalty for any other violation specified in 42 CFR 460.40.	42 U.S.C. 1395eee(e)(6)(B); 1396u-4(e)(6)(B)	2021	2022	42,788
Penalty per day for a nursing facility's failure to meet a Category 2 certification:	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	120
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	7,195
Penalty per instance for a nursing facility's failure to meet Category 2 certification:	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	2,400

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	23,989
Penalty per day for a nursing facility's failure to meet Category 3 certification:	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	7,317
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	23,989
Penalty per instance for a nursing facility's failure to meet Category 3 certification:	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	2,400
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	23,989
Penalty per instance for a nursing facility's failure to meet Category 3 certification, which results in immediate jeopardy:	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	2,400
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	23,989
Penalty per day for nursing facility's failure to meet certification (Upper Range):	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	7,317
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	23,989
Penalty per day for nursing facility's failure to meet certification (Lower Range):	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	120
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	7,195
Penalty per instance for nursing facility's failure to meet certification:	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	2,400
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	23,989
Penalty imposed for failure to comply with infection control weekly reporting requirements at 42 CFR 483.80(g)(1) and (2):	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
First occurrence (Minimum)	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	1,075
Incremental increases for each subsequent occurrence	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	537
Grounds to prohibit approval of Nurse Aide Training Program—if assessed a penalty in 1819(h)(2)(B)(i) or 1919(h)(2)(A)(ii) of "not less than $5,000" [Not CMP authority, but a specific CMP amount (CMP at this level) that is the triggering condition for disapproval].	42 U.S.C. 1396r(f)(2)(B)(iii)(I)(c)	2021	2022	11,995
Grounds to waive disapproval of nurse aide training program—reference to disapproval based on imposition of CMP "not less than $5,000" [Not CMP authority but CMP imposition at this level determines eligibility to seek waiver of disapproval of nurse aide training program].	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2021	2022	11,995

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for each day of noncompliance for a home or community care provider that no longer meets the minimum requirements for home and community care:	42 U.S.C. 1396t(j)(2)(C)			
Minimum	42 U.S.C. 1396t(j)(2)(C)	2021	2022	2
Maximum	42 U.S.C. 1396t(j)(2)(C)	2021	2022	20,719
Penalty for a Medicaid managed care organization that fails substantially to provide medically necessary items and services.	42 U.S.C. 1396u-2(e)(2)(A)(i)	2021	2022	42,788
Penalty for Medicaid managed care organization that imposes premiums or charges on enrollees in excess of the premiums or charges permitted.	42 U.S.C. 1396u-2(e)(2)(A)(i)	2021	2022	42,788
Penalty for a Medicaid managed care organization that misrepresents or falsifies information to another individual or entity.	42 U.S.C. 1396u-2(e)(2)(A)(i)	2021	2022	40,788
Penalty for a Medicaid managed care organization that fails to comply with the applicable statutory requirements for such organizations.	42 U.S.C. 1396u-2(e)(2)(A)(i)	2021	2022	40,788
Penalty for a Medicaid managed care organization that misrepresents or falsifies information to the HHS Secretary.	42 U.S.C. 1396u-2(e)(2)(A)(ii)	2021	2022	171,156
Penalty for Medicaid managed care organization that acts to discriminate among enrollees on the basis of their health status.	42 U.S.C. 1396u-2(e)(2)(A)(ii)	2021	2022	171,156
Penalty for each individual that does not enroll as a result of a Medicaid managed care organization that acts to discriminate among enrollees on the basis of their health status.	42 U.S.C. 1396u-2(e)(2)(A)(iv)	2021	2022	25,673
Penalty for a provider not meeting one of the requirements relating to the protection of the health, safety, and welfare of individuals receiving community supported living arrangements services.	42 U.S.C. 1396u(h)(2)	2021	2022	23,989
Penalty for disclosing information related to eligibility determinations for medical assistance programs.	42 U.S.C. 1396w-2(c)(1)	2021	2022	12,794
Failure to comply with ACA requirements related to risk adjustment, reinsurance, risk corridors, Exchanges (including Qualified Health Plan standards) and other ACA Subtitle D standards; Penalty for violations of rules or standards of behavior associated with issuer compliance with risk adjustment, reinsurance, risk corridors, Exchanges (including Qualified Health Plan standards) and other ACA Subtitle D standards.	42 U.S.C. 18041(c)(2)	2021	2022	174
Penalty for providing false information on Exchange application.	42 U.S.C. 18081(h)(1)(A)(i)(II)	2021	2022	31,616
Penalty for knowingly or willfully providing false information on Exchange application.	42 U.S.C. 18081(h)(1)(B)	2021	2022	316,155
Penalty for knowingly or willfully disclosing protected information from Exchange:	42 U.S.C. 18081(h)(2)			
Minimum	42 U.S.C. 18081(h)(2)	2021	2022	31,616
Maximum	42 U.S.C. 18081(h)(2)	2021	2022	323
Penalties for violation of applicable Exchange standards by consumer assistance entities in Federally-facilitated Exchanges:	42 U.S.C. 18041(c)(2)	2021	2022	38,771
Maximum (Per Day)	42 U.S.C. 18041(c)(2)	2021	2022	107

Grants Closeout Reporting

The *Grants Oversight and New Efficiency Act* (Public Law 114-117) reporting requirements have expired. Nevertheless, to promote the efficient administration of HHS grants programs, all reporting entities must submit a brief high-level summary of expired, but not closed, Federal grants and cooperative agreements (awards).

Table 1: HHS Expired-but-not-Closed Awards with a Period of Performance (POP) End Date Exceeding 2 Years

Category	2-3 Years FYs 2019 - 2020	3-5 Years FYs 2018 - 2019	More than 5 Years Before FY 2017
Number of Grants/Cooperative Agreements with Zero Dollar Balances	323	473	775
Number of Grants/Cooperative Agreements with Undisbursed Balances	2,921	3,453	1,302
Total Amount of Undisbursed Balances	**$1,626,470,645**	**$736,154,197**	**$625,366,769**

HHS continues to make grants closeout a priority by re-engineering business process improvements and enhancing grant systems to prevent the future growth of backlogs. When the number of grants and cooperative agreements reported in Table 1 above are totaled, HHS has 9,247 grant awards with POP end dates of September 30, 2020, or earlier that are expired but not yet closed. Table 1 above is not comparable to previous HHS AFR *Grants Oversight and New Efficiency Act* reporting as the OMB Circular A-136, *Financial Reporting Requirements*, parameters were modified from before September 30, 2019, to the current requirement of September 30, 2020.

HHS remains committed to addressing and remediating the complexities that prevent the closeouts of open but expired accounts. During fiscal year (FY) 2022, an HHS project team continued its focus on open grant documents with POP end dates prior to September 30, 2017. The table above reflects nearly a 66% decrease (from 6,053 to 2,077) in these grant documents. Much of the remaining backlog is due to expired amounts permitted under appropriations law and statutory authority. This project team will continue its work into FY 2023. Additionally, HHS continues to work on the challenges related to change management and operational priorities that delay the timely closeout of eligible grant awards by utilizing further business process improvements, policy enhancements, and training initiatives identified in the FY 2021 AFR.

Payment Integrity Report

OVERVIEW

An improper payment occurs when a payment is made in an incorrect amount under statutory or other legally applicable requirements. This includes any payment to an ineligible recipient, any payment for an ineligible good or service, or any duplicate payment. HHS is committed to reducing improper payments in all programs to better serve recipients and protect taxpayer resources. The Department continues to find innovative solutions to address the root causes of improper payments, while protecting beneficiaries' access to health and human services.

HHS publishes detailed payment integrity information to PaymentAccuracy.gov. In addition, in accordance with the *Payment Integrity Information Act of 2019* (PIIA); OMB Circular A-136, *Financial Reporting Requirements*; and Appendix C of OMB Circular A-123, *Requirements for Payment Integrity* Improvement (M-21-19), HHS's Fiscal Year (FY) 2022 Payment Integrity Report includes:

Payment Integrity Topics	
1.0	**Program Descriptions**
2.0	**Payment Categories**
3.0	**Phases of Assessments:**
3.1	**• Phase 1: Risk Assessments**
3.2	**• Phase 2: Improper Payment Estimation & Reporting**
4.0	**Identifying Payment Errors**
5.0	**Mitigation Strategies & Corrective Actions:**
5.1	**• Payment Integrity Efforts**
6.0	**Proper, Improper, and Unknown Payments for HHS's Risk-Susceptible Programs:**
6.1	**• Improper and Unknown Payment Performance**
7.0	**Improper and Unknown Payment Error Types**
8.0	**Program-Specific Reporting Information:**
8.1	**• Medicare Fee-for-Service (FFS) (Parts A and B)**
8.2	**• Medicare Advantage (Part C)**
8.3	**• Medicare Prescription Drug Benefit (Part D)**
8.4	**• Medicaid**
8.5	**• Children's Health Insurance Program (CHIP)**
8.6	**• Advance Premium Tax Credit (APTC)**
8.7	**• Provider Relief Fund (PRF) Payments**
8.8	**• Temporary Assistance for Needy Families (TANF)**
8.9	**• Foster Care**
8.10	**• Child Care and Development Fund (CCDF)**
8.11	**• Head Start Disaster Relief**
9.0	**Recovery Auditing Reporting**

1.0 PROGRAM DESCRIPTIONS

HHS conducts risk assessments annually to identify programs that are susceptible to significant improper payments. These programs are required to estimate and report improper payments, reduction targets, and corrective actions.

Figure 1 provides a brief description of the programs that HHS or OMB identified as risk-susceptible and are discussed in this report.

Figure 1: Risk-Susceptible Programs

Medicare FFS	A federal health insurance program for people aged 65 or older, people younger than 65 with certain disabilities, and people of all ages with End-Stage Renal Disease.
Medicare Part C	A federal health insurance program that allows beneficiaries to receive their Medicare benefits through a private health plan.
Medicare Part D	A federal prescription drug benefit program for Medicare beneficiaries.
Medicaid	A joint federal/state program, administered by the states, that provides health insurance to qualifying low-income individuals.
CHIP	A joint federal/state program, administered by the states, that provides health insurance for qualifying children.
APTC	A federal insurance affordability program, administered by HHS and/or the states, to support enrollees in purchasing Qualified Health Plan coverage from state and federal Health Insurance Exchanges (Exchanges).
PRF	A federal program that provides payments to eligible healthcare providers for healthcare related expenses or lost revenues attributable to COVID-19.
COVID-19 Uninsured Program (UIP)	A federal program that provides claims reimbursement to healthcare providers for COVID-19 testing, treatment, and vaccine administration for uninsured individuals.
TANF	A joint federal/state program, administered by the states, that provides time-limited cash assistance as well as job preparation, work support, and other services to needy families with children to promote work, responsibility, and self-sufficiency.
Foster Care	A joint federal/state program, administered by the states, for children who are deemed to need placement outside their homes in a foster family home or a childcare facility.
CCDF	A joint federal/state program, administered by the states, that provides childcare financial assistance to low-income working families.
Head Start	A federal program that provides comprehensive developmental services for America's low-income, preschool children ages three to five and their families.
Head Start Disaster Relief	Supplemental appropriation for a federal program that provides comprehensive developmental services for America's low-income, preschool children ages three to five and their families.

Program-specific information on each risk-susceptible program is located throughout the Payment Integrity Report. In addition, under the *Bipartisan Budget Act of 2018* (Public Law 115-123) and the *Additional Supplemental Appropriations for Disaster Relief Requirements Act, 2017* (Public Law 115-72) (for this report, these two laws are referred to as the "Disaster Relief Act"), HHS received approximately $1 billion to respond to and recover from hurricanes, wildfires, and other disasters. Department programs that received funding and expended more than $10 million during an annual reporting period are required to report improper payment estimates. In FY 2022, Head Start Disaster Relief reported improper payment estimates for disaster funding. Section 8.11: *Head Start Disaster Relief* provides detail on the disaster relief program.

OMB also deems risk-susceptible programs to be "high-priority" programs if the monetary loss estimates are greater than $100 million in a fiscal year. High-priority programs must fulfill additional requirements, including quarterly reporting on activities to prevent and reduce improper payments. OMB designated the following six programs as high-priority for FY 2022: CCDF, Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, and CHIP.

2.0 PAYMENT CATEGORIES

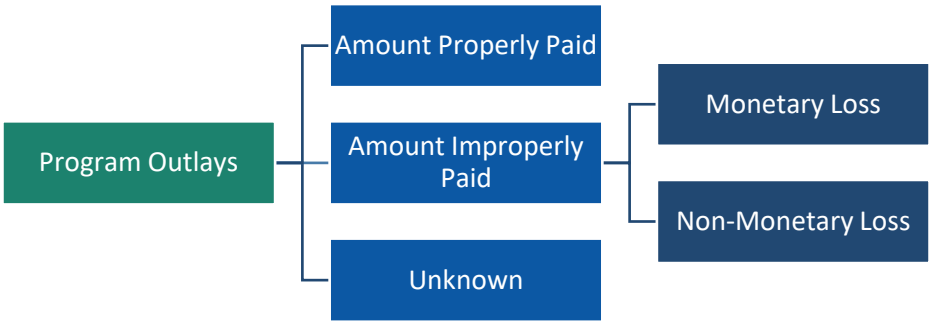
HHS uses sampling and statistical methods to estimate proper payments, improper payments, and unknown payments among its programs. See **Figure 2** for an illustration of the payment categories and improper payment types. Under Appendix C of OMB Circular A-123, there are two types of improper payments:

1) **Monetary Loss:** Payments to the wrong recipient, or to the correct recipient in a higher amount than what should have been disbursed, are monetary losses to the government.
2) **Non-monetary Loss:** Payments to the correct recipient in a lesser amount than what should have been disbursed are non-monetary losses to the government.

While fraud, waste, and abuse are improper payments, it is important to note that not all improper payments are the result of fraud; and improper payment estimates are not fraud estimates.

Unknown payments are instances in which a program cannot determine whether a payment is proper or improper due to insufficient payment documentation. Further, OMB guidance states that payments should be categorized as unknown if the agency is still conducting research or reviews to determine the appropriateness of the payment at the time the agency must finalize and report its estimates.

Figure 2: Payment Categories



3.0 PHASES OF ASSESSMENT

Under Appendix C of OMB Circular A-123, all programs with annual outlays greater than $10 million fall into either phase 1 (subject to periodic risk assessments) or phase 2 (subject to statistical testing and reporting requirements), which require the varying degrees of oversight and effort described in the following subsections. Based on improper payment risk assessments, programs that are likely to have an annual amount of improper and unknown payments below the statutory threshold are categorized as phase 1 and are required to complete a risk assessment once every 3 years. Programs likely to be above the statutory threshold are categorized as phase 2 and are required to report an improper payment estimate.

3.1 Phase 1: Risk Assessments

HHS reviews its programs using the Department's Risk Assessment Portal—an automated platform for collecting and processing risk assessments—to determine susceptibility to significant improper payments. The portal provides a comprehensive review and analysis of selected program operations, across a broad range of risk factors, to determine potential payment risks and risk severity. HHS made minor updates to the risk assessment questionnaire and risk factor calculation as well as enhancements to the portal. HHS will continue to develop policies, procedures, and supporting tools throughout FY 2023, particularly to facilitate coverage of all programs over $10 million per PIIA.

HHS conducted 43 program-specific improper payment risk assessments, regardless of outlay amounts, and did not identify any additional programs that are susceptible to significant improper payments. For additional information on HHS programs assessed for risk of improper payments during the FY 2022 risk assessment cycle, refer to PaymentAccuracy.gov.

3.2 Phase 2: Improper Payment Estimation & Reporting

All programs that reported improper payment estimates (e.g., Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, APTC, PRF, CCDF, and Head Start Disaster Relief) complied with OMB guidance on sampling and estimation plans to produce a statistically valid methodology. In addition, four other risk-susceptible programs (COVID-19 UIP, Foster Care, Head Start, and TANF) are not reporting estimates for FY 2022.

Estimates for Medicaid, CHIP, and CCDF are based on a system of reviews wherein each state is reviewed triennially, and each year's improper payment estimate incorporates new review data for approximately one-third of states. As a result, the estimate is not based on the full population of payments for any one year, but rather on a combination of statistical samples drawn from several different years.

HHS updated the sampling and estimation methodology plans for Medicare Part C and Medicare Part D and established new plans for APTC, PRF, and COVID-19 UIP.

The statistical sampling and estimation processes are detailed in Section 8.0: *Program-Specific Reporting Information*.

4.0 IDENTIFYING PAYMENT ERRORS

A key component of the sampling, estimation, and reporting process is identifying types of payment errors. Once a risk-susceptible program identifies payment error types, program personnel work with stakeholders to implement corrective actions to address them.

5.0 MITIGATION STRATEGIES & CORRECTIVE ACTIONS

HHS strives to improve payment integrity and prevent, reduce, and recover improper payments. HHS monitors existing corrective actions and explores innovative approaches to reduce improper and unknown payments.

Each program develops mitigation strategies and corrective actions to address payment integrity risks. Mitigation strategies and corrective actions progress through various stages—development, pilot, implementation, refinement (if needed), and completion. For programs that established a baseline measurement, these planned actions help HHS set targets for reducing improper payments with a timetable to achieve scheduled targets. The Department reviews strategies and actions annually to ensure plans address the root causes of the improper payments and increase the likelihood that programs meet targets, reduce improper payment estimates, or perform other activities

to strengthen program integrity. If targets are not met, HHS develops new strategies, adjusts staffing and other resources, or revises targets. Because actions vary and are implemented on a concurrent or continuous basis, it can be difficult to establish key milestones and target completion dates for individual activities. Despite these challenges, HHS continues to evaluate the impact of mitigation strategies and corrective actions to refine program integrity activities.

See Section 8.0: *Program-Specific Reporting Information* for each program's key mitigation strategies and corrective actions for reducing the estimated rate of improper payments. HHS organizes each program's information by common improper and unknown payment mitigation strategies and corrective actions, as defined in Appendix C of OMB Circular A-123.

5.1 Payment Integrity Efforts

HHS strengthened payment integrity through collaboration with stakeholders on detection, enforcement, and investigations to prevent improper payments. Results of these cross-cutting efforts are outlined below. More detailed information on program performance and corrective actions can be found in Section 8.0: *Program-Specific Reporting Information*.

Fraud Reduction

HHS continues to take steps to implement fraud risk management requirements under PIIA and to adopt leading practices in fraud risk management presented in GAO's *A Framework for Managing Fraud Risks in Federal Programs* (GAO-15-593SP, Fraud Risk Management Framework). These fraud reduction efforts comply with Principle 8 ("Assess Fraud Risk") of the revised *Standards for Internal Control in the Federal Government* and OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*.

The Department continued applying its Fraud Risk Management Implementation Plan that outlines HHS's phased approach to establish a formal fraud risk management program that is coordinated by the Office of the Assistant Secretary for Financial Resources. Select activities carried out by the Department included:

- Completing a survey of fraud risk management activities occurring at the Division level to identify opportunities to provide additional Departmental support;
- Preparing a data-driven fraud exposure analysis of HHS programs to assist the Department in targeting its highest risk programs; and
- Developing a tool that supports a structured, repeatable fraud risk assessment process that will assist Divisions to evaluate the vulnerability of their programs to specific types of fraud schemes in line with GAO's Fraud Risk Management Framework.

HHS continues to manage fraud risk within other scopes of responsibility—such as annual internal control reviews and audits; reviews of allegations involving misuse of grant or contractor funds, conflicts of interest, misconduct, or misuse; continuous monitoring of grant recipients via audit resolution, special conditions/drawdown restrictions, site visits, performance reports, etc.; the use of SAM.gov (e.g., Suspension and Debarment) to review potential recipients; and other activities. The Department will continue working with OMB and other agencies to implement PIIA requirements and progress toward applying the Fraud Risk Management Implementation Plan.

Healthcare Fraud Prevention Partnership

The Healthcare Fraud Prevention Partnership (the Partnership) is a voluntary public-private partnership among the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations. The purpose of the Partnership is to exchange data and information between

the partners to help improve capabilities to fight fraud, waste, and abuse in the healthcare industry. The number of participants has increased to 267 public, private, and state partner organizations at the end of FY 2022.

The Partnership commenced and/or completed studies by which a trusted third-party contractor uses shared data from partners that actively submit claim level data (now numbering 74 partners) to analyze fraud, waste, and abuse, provides those partners with detailed results pertaining to their organizations that they may use to undertake corrective actions. Efforts to foster collaboration among partners continued by hosting virtual information-sharing sessions and holding quarterly Executive Board meetings. These meetings are used to share fraud schemes and provider alerts, provide non-privileged updates on law enforcement activities, and strategize on how to broaden the Partnership's impact in the private and public sectors. In addition, the Partnership organized focus groups to help formulate the initiative's strategic direction.

Major Case Coordination

Since FY 2018, the Major Case Coordination initiative, which includes representation from the HHS Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), and CMS has provided an opportunity for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and fraud investigators to collaborate before, during, and after developing fraud leads. Since creation, there have been over 4,000 cases reviewed and law enforcement partners have made over 2,600 requests for CMS to refer reviewed cases. In FY 2022, CMS reviewed 1,109 cases at Major Case Coordination meetings, and law enforcement partners made 512 requests for CMS to refer reviewed cases.

In FY 2020, HHS established the Medicaid Major Case Coordination process, which brings together the HHS OIG, DOJ, state Medicaid Fraud Control Units, state program integrity units, and CMS to discuss Medicaid-related law enforcement referrals. Since implementation, HHS has participated in 28 Medicaid Major Case Coordination meetings, and from those meetings, law enforcement partners made 64 requests for CMS to refer reviewed cases. The information gained from this process can also be used to identify Medicaid and CHIP vulnerabilities that can lead to improper payments. In addition, this stakeholder collaboration contributed to several successful coordinated law enforcement actions and helped HHS to better identify national trends and program vulnerabilities that can lead to fraud and other improper payments. For additional information on the Major Case Coordination initiative, please refer to the Health Care Fraud and Abuse Control Program Annual Report for FY 2021.

Medicaid Integrity Program

Under Section 1936 of the *Social Security Act*, as amended by the *Deficit Reduction Act of 2005* (DRA), HHS's Medicaid Integrity Program is responsible for:

- Reviewing Medicaid provider activities, auditing claims, identifying overpayments, and educating providers and others on Medicaid program integrity issues; and
- Supporting and assisting state efforts to combat Medicaid provider fraud, waste, and abuse.

The Medicaid Integrity Program includes federal personnel specialized in program integrity as well as contractor support to states to bolster program integrity activities and collections. Increased Medicaid recoveries demonstrate HHS's continued commitment to Medicaid program integrity. Since enactment of the DRA, total state Medicaid program integrity collections (federal and state shares) have grown from $265 million in FY 2006 to $435.90 million in FY 2022.[22] In addition, HHS uses DRA funding to support critical Medicaid financial management oversight activities, including reviewing quarterly state expenditure requests to ensure appropriate use of federal funds,

[22] This amount may differ from that which is reported in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the Agency Financial Report is prepared prior to finalizing state reporting.

conducting targeted state financial management reviews based on questionable claims identified through claims review processes, and working with states to recover the federal share of unallowable Medicaid expenditures.

The DRA also requires HHS to establish a 5-year Comprehensive Medicaid Integrity Plan that sets forth HHS's strategy to safeguard the integrity of the Medicaid program. The current 5-year plan covers FYs 2019 through 2023 and focuses on protecting taxpayer dollars in the Medicaid program and CHIP by combatting fraud, waste, and abuse. Examples of initiatives in the current plan include conducting oversight of states' corrective action plans and audits of Medicaid managed care plans' Medical Loss Ratio calculations.

Medicaid Provider Enrollment

HHS provides ongoing guidance, education, and outreach to states on federal requirements for Medicaid provider screening and enrollment. In addition, HHS updated the Medicaid Provider Enrollment Compendium in July 2018 and March 2021 to provide additional sub-regulatory guidance to assist states in applying the regulatory requirements. HHS also continued to assess provider screening and enrollment compliance, provide technical assistance, and offer states the opportunity to leverage Medicare screening and enrollment activities. Due to COVID-19, many states utilized Section 1135 waiver authority[23] granted by HHS to temporarily relax or waive certain screening and enrollment requirements (e.g., revalidation, fingerprint-based criminal background checks, application fees, site visits). HHS is working with states to mitigate the impact of these waivers on compliance efforts by continuing to develop compliance plans with the states. Additionally, HHS provided the states training on how to mitigate risks associated with these waivers.

HHS shares Medicare data to assist states and territories with meeting Medicaid screening and enrollment requirements. Since May 2016, HHS has offered a data compare service allowing states and territories to rely on Medicare's screening in lieu of conducting a state screening, particularly during revalidation. This allows states and territories to remove dually enrolled providers from the revalidation workload. HHS also returns information on providers who have deactivated National Provider Identifiers, are deceased, are excluded by the HHS OIG, or who are revoked by Medicare or terminated for cause by a State Medicaid Agency (thus allowing the state or territory to take deactivation or termination action against the provider when applicable). Using the data compare service, a state or territory provides a Medicaid provider enrollment data extract to HHS, and then HHS returns information indicating which providers have undergone a Medicare screening on which the state can rely (thus reducing the state's or territory's workload).

Medicare Drug Integrity Contractors

As part of HHS's ongoing efforts to ensure effective oversight of the Medicare Part C and Part D programs, HHS contracts with two Medicare Drug Integrity Contractors (MEDIC): 1) the Plan Program Integrity (PPI) MEDIC and 2) the Investigations MEDIC (I-MEDIC). The PPI MEDIC primarily assists HHS with outreach and education support, audits of plan sponsors, and data analysis. The I-MEDIC conducts investigations of prescribers and pharmacies, recommends administrative actions, and submits case referrals to law enforcement.

Provider and Supplier Screening for New and Existing Medicare Providers and Suppliers

HHS uses three levels of provider and supplier enrollment risk-based screening: limited, moderate, and high. Providers and suppliers in the "limited" risk category undergo verification of licensure and a wide range of database checks to confirm compliance with all provider- or supplier-specific requirements. Providers and suppliers in the

[23] Section 1135 of the Act grants the Secretary the authority to temporarily waive or modify certain specified requirements of Titles XVIII, XIX, or XXI during certain Presidential and Secretarially-declared natural emergencies to ensure that healthcare items and services are available to meet the needs of individuals in such areas enrolled in the programs and healthcare providers that furnish items and services in good faith, but that are unable to comply with one or more requirements, may be reimbursed.

"moderate" risk category are subject to unannounced site visits in addition to all the requirements in the "limited" screening level. Providers and suppliers in the "high" risk category are subject to fingerprint-based criminal background checks in addition to all requirements in the "limited" and "moderate" screening levels.

HHS revalidates all existing Medicare providers and suppliers on an ongoing basis to verify that only qualified providers and suppliers deliver healthcare items and services to Medicare beneficiaries. HHS's provider screening and enrollment initiatives have had a significant impact on removing ineligible providers and suppliers from the Medicare program. HHS manages close to 2.7 million distinct Medicare enrollments through the Provider Enrollment, Chain, and Ownership System.

Public Assistance Reporting Information System

The Public Assistance Reporting Information System provides state public assistance agencies in all 50 states, the District of Columbia, and Puerto Rico with matching data to verify program eligibility and to detect and deter improper payments in TANF, Medicaid, Workers' Compensation, childcare related programs, and the Supplemental Nutrition Assistance Program (SNAP). Provided to states at no cost, the system helps states strengthen program administration by allowing states to compare public assistance data between non-interoperable systems. Over the course of four quarterly matches (August 2021 to May 2022), states submitted over 312 million records for matching and received average match records of over 2.5 million unique social security numbers each quarter.

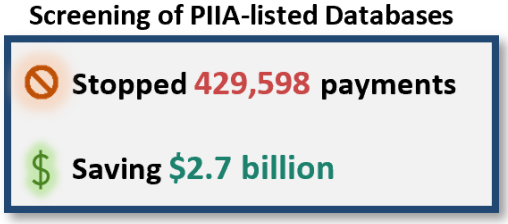
State public assistance agencies realize cost savings in a variety of manners using this data. For example:

- The Michigan Department of Health and Human Services reports its usage of the interstate match resulted in $8.7 million in annualized cost avoidance in FY 2021;
- New York's Office of Temporary and Disability Assistance closed or removed active clients from 8,328 public assistance cases for projected cost savings of $58.6 million between August 2021 and March 2022;
- Washington State Health Care Authority's Veterans Program had approximately $26.83 million in Medicaid cost savings from cessation of managed care premium payments and reduction in fee-for-service claims due to Third Party Liability discovery from data matches between July 2021 and June 2022; and
- The Washington State Economic Service Administration, which serves 1.7 million individuals, accounted for nearly $2.3 million in cost avoidance and $1.4 million in overpayments in the SNAP and TANF benefits program between October 2021 and August 2022.

For more information, refer to the Public Assistance Reporting Information System.

Results of the Do Not Pay Initiative in Preventing Improper Payments

In June 2010, the President issued a Memorandum on Enhancing Payment Accuracy Through a "Do Not Pay (DNP) List" where agencies can access and analyze relevant information before determining eligibility for funding. Several Divisions are using DNP to check for recipients' or potential recipients' eligibility for payment and to prevent improper payments. Further, U.S. Department of the Treasury (Treasury)-disbursed payments are matched against the Social Security Administration's Death Master File (DMF); Department of Defense Death Records; Department of State Death Records; and American InfoSource Death Data (a commercial data source that gathers information from funeral homes, newspapers, and county probate records) in the DNP portal daily to identify improper payments. The Department screened over 1 million payments against these death record databases, representing $740.8



billion. While the Department identified 10 potential improper payments over the past year through these daily matches, upon further investigation, HHS confirmed zero payments as improper. Lastly, CMS also checks certain payments against PIIA-listed databases[24] outside of the DNP portal. CMS screened 1.1 billion payments against PIIA-listed databases, representing $401.9 billion in payments. Through these checks, CMS stopped 429,598 payments, representing a savings of $2.7 billion.

Did You Know?

HHS was one of the first agencies to establish a Computer Matching Agreement with Treasury in FY 2014 and has utilized these data sources successfully since then to verify eligibility and identify potential improper payments.

Single Audit Resolution

Federal grant recipients that receive more than $750,000 per year are required to have a periodic and independent audit conducted on programs (known as a Single Audit). Many HHS risk-susceptible programs (e.g., Medicaid, CHIP, CCDF, and Foster Care) are grant programs where states are required to conduct Single Audits. HHS works with states to analyze Single Audit material non-compliance findings related to programs and to implement corrective actions to address these findings.

Vulnerability Collaboration Council

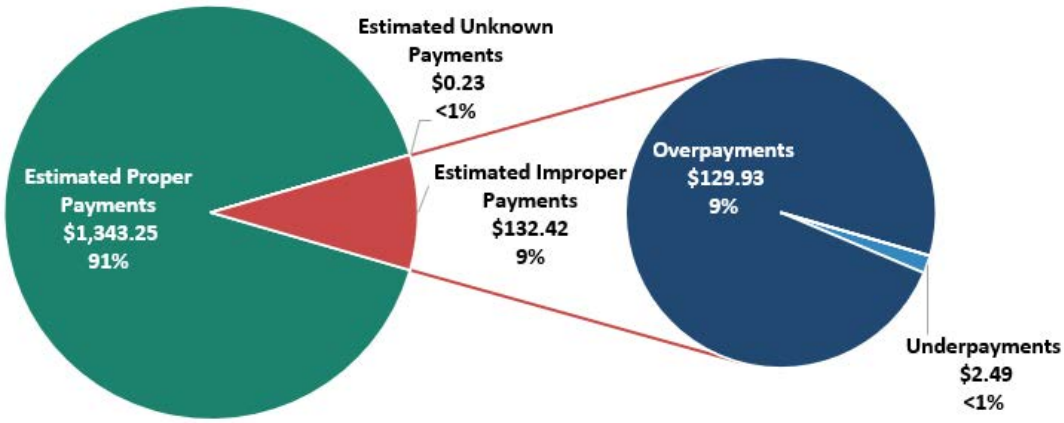
CMS utilizes a centralized vulnerability management process to identify, prioritize, track, and mitigate vulnerabilities that affect the integrity of federal health programs. The centralized component of this process, known as the Vulnerability Collaboration Council (the Council), is comprised of CMS leadership and subject matter experts that work collaboratively to identify and mitigate vulnerabilities in payment and coverage policies. CMS aligned the Council's risk-based approach with GAO's Fraud Risk Management Framework. CMS conducted three program integrity risk assessments focused on durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); home health; and Medicaid managed care. Additionally, CMS continued its work on potential vulnerabilities arising from COVID-19 waivers and flexibilities.

6.0 PROPER, IMPROPER, AND UNKNOWN PAYMENTS FOR HHS'S RISK-SUSCEPTIBLE PROGRAMS

Overall, most of the Department's payments are proper, going to the right recipient for the right amount. Prior to FY 2021, improper payment estimates included payments from three categories: overpayments, underpayments, and unknown payments. Under the latest OMB guidance, unknown payments are defined and reported as a category separate from improper payments (see Section 2.0: *Payment Categories* for a description of unknown payments). **Figure 3** illustrates the overpayment, underpayment, and unknown payment estimates for all of HHS's risk-susceptible programs.

[24] For example, CMS receives the Social Security Administration's DMF on a daily basis. CMS uses the DMF to confirm Medicare eligibility.

Figure 3: RY 2022 Estimated Proper, Improper, and Unknown Payments[1] (Dollar Amounts in Billions)



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

6.1 Improper and Unknown Payment Performance

Each year, HHS reports percentage estimates of payment categories and payment error types in the Payment Integrity Report. **Table 1** displays the following data, as applicable, for each risk-susceptible program:

- For the current reporting year (RY):
  - Outlays (Total Payments Actually Made During the Sampling Timeframe);
  - Estimated rate (%) and dollar amount ($) of:
    - Proper Payments (PP);
    - Improper Payments (IP);
    - Unknown Payments (UP); and
    - Improper Payments + Unknown Payments (IP + UP).
- For outyear reporting (RY+1):
  - Estimated outlays; and
  - Target rate (%) and amount ($) of Reduction Target.

HHS uses statistical sampling to calculate each program's estimated improper and unknown payment rates and a projected dollar amount of improper and unknown payments. **Figure 4** provides the equation for calculating the improper plus unknown payment rate.

Figure 4: Improper Plus Unknown Payment Rate Equation

The improper plus unknown payment rate is the official program rate for payments that are not verifiably proper and is included in **Table 1**.

Table 1: HHS's Risk-Susceptible and High-Priority Programs' Improper Payment Results and Outlook

RY 2022 (in Millions)[1]

Program or Activity	RY Outlays $	RY PP %	RY PP $	RY IP + UP % [2]	RY IP + UP $	RY IP %	RY IP $	RY UP %	RY UP $	RY+1 Est. Outlays $	RY+1 Reduction Target %	RY+1 Reduction Target $
Medicare FFS	$421,914.44 [a]	92.54%	$390,457.72	7.46%	$31,456.72	7.46% [b]	$31,456.72	0.00%	$0.00	$455,755.81 [c]	7.36%	$33,543.63
Medicare Part C	$257,174.12 [d]	94.58%	$243,233.30	5.42%	$13,940.82	5.42%	$13,940.82	0.00%	$0.00	$460,020.00 [e]	5.77%	$26,543.15
Medicare Part D	$88,415.62 [f]	98.46%	$87,054.51	1.54%	$1,361.11	1.54%	$1,361.11	0.00%	$0.00	$113,525.00 [g]	1.64%	$1,866.68
Medicaid	$515,813.52 [h]	84.38%	$435,240.49	15.62%	$80,573.03	15.62% [i]	$80,573.03	0.00%	$0.00	$556,284.44 [h]	12.68%	$70,545.09
CHIP	$16,093.00 [j]	73.25%	$11,788.45	26.75%	$4,304.55	26.75% [k]	$4,304.55	0.00%	$0.00	$16,613.00 [j]	21.04%	$3,495.73
APTC	$41,255.81 [l]	99.38%	$41,000.05	0.62%	$255.76	0.62% [m]	$255.76	0.00%	$0.00	$46,497.89 [l]	N/A [m]	N/A [m]
PRF	$126,460.50 [n]	99.68%	$126,051.02	0.32%	$409.48	0.32%	$409.48	0.00%	$0.00	$21,414.37 [n]	0.32%	$68.52
COVID-19 UIP [o]	$5,356.74 [o]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$18,569.84 [o]	N/A	N/A
TANF	$15,897.37 [p]	N/A	N/A	N/A	N/A	N/A [q]	N/A	N/A	N/A	$16,077.27 [p]	N/A	N/A
Foster Care	$2,311.00 [r]	N/A	N/A	N/A	N/A	N/A [s]	N/A	N/A	N/A	$2,017.00 [r]	N/A	N/A
CCDF	$8,699.10 [t]	96.04%	$8,354.40	3.96% [u]	$344.70	1.31%	$114.17	2.65%	$230.53	$11,635.50 [t]	N/A [u]	N/A [u]
Head Start [v]	$10,844.10 [w]	N/A	N/A	N/A	N/A	N/A	$N/A	N/A	$N/A	$11,301.00 [w]	N/A	N/A
Head Start Disaster Relief	$69.61 [x]	99.78%	$69.46	0.22%	$0.15	0.22%	$0.15	0.00%	$0.00	$0.05 [x]	N/A [y]	N/A [y]

[1] Totals do not necessarily equal the sum of the rounded components.

[2] Beginning in FY 2021, the term "improper plus unknown payment rate" replaced "improper payment rate" used in previous years. The "improper payment rate" now only includes payments that are determined to be improper, whereas the historical "improper payment rate," reported in prior fiscal years, included what are now termed "unknown payments."

Accompanying Notes for Table 1: Estimated Proper, Improper, and Unknown Payments for HHS's Risk-Susceptible Programs

a) Medicare FFS RY outlays are from the FY 2022 Medicare FFS Improper Payments Report (based on claims submitted from July 2020 – June 2021).

b) HHS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services provided should have been outpatient services. This adjustment factor reflects the difference between the inpatient hospital claims paid under Medicare Part A and what the payment would have been had the hospital claim been properly submitted as a Medicare Part B outpatient claim. Application of the adjustment factor decreased the overall improper payment rate by 0.17 percentage points to 7.46 percent or $31.46 billion. Additional adjustment factor information is on pages 166-167 of HHS's FY 2012 AFR.

c) Medicare FFS RY+1 outlays are based on the *FY 2023 President's Budget*.

d) Medicare Part C RY outlays reflect 2020 Part C payments, as reported in the FY 2022 Medicare Part C Payment Error Final Report.

e) Medicare Part C RY+1 outlays are based on the *FY 2023 President's Budget*.

f) Medicare Part D RY outlays reflect 2020 Part D payments, as reported in the FY 2022 Medicare Part D Payment Error Final Report.

g) Medicare Part D RY+1 outlays are based on the *FY 2023 President's Budget*.

h) Medicaid RY outlays are based on FY 2021 expenditures, and RY+1 outlays (Medicaid – Outlays current law exclude Centers for Disease Control and Prevention (CDC) Vaccine for Children program funding) are based on the *FY 2023 President's Budget*.

i) HHS calculated and is reporting the national Medicaid estimates based on measurements conducted in FYs 2020, 2021, and 2022. The national Medicaid component improper payment estimates are: Medicaid FFS: 10.42 percent, Medicaid managed care: 0.03 percent, and Medicaid eligibility: 11.89 percent.

j) CHIP RY outlays are based on FY 2021 expenditures, and RY+1 outlays are based on the *FY 2023 President's Budget*.

k) HHS calculated and is reporting the national CHIP estimates based on measurements conducted in FYs 2020, 2021, and 2022. The national CHIP component improper estimates are: CHIP FFS: 11.23 percent, CHIP managed care: 0.62 percent, and CHIP eligibility: 24.01 percent.

l) APTC RY outlays are for the Federally-facilitated Exchange only and are based on internal financial reporting.

m) The APTC improper payment results represents improper payments for the Federally-facilitated Exchange. HHS 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. The APTC program is not reporting a RY+1 improper payment target. The publication of a reduction target will occur once the State-based Exchanges are included in the measurement to establish and reports a full baseline. See Section 8.6: *APTC* for more information.

n) PRF RY outlays are based upon PRF payments made during the sampling timeframe between March 27, 2020 and March 26, 2021, and RY+1 outlays between March 27, 2021 and March 26, 2022.

o) The COVID-19 UIP outlays are based upon adjusted claims payments during the period March 27, 2020 through March 26, 2021. COVID-19 UIP outlays are based on the *Families First Coronavirus Response Act*, *Paycheck Protection Program and Health Care Enhancement Act*, *Coronavirus Aid, Relief, and Economic Security Act*, and the *Coronavirus Response and Relief Supplemental Appropriations Act*, and are based on claims reimbursement to healthcare providers for testing uninsured individuals for COVID-19, for treating uninsured individuals with COVID-19 primary diagnosis, and for COVID-19 vaccine administration to the uninsured. Due to the timing constraints of testing claims, HHS was unable to complete the statistical sampling methodology and subsequent extrapolation procedures to identify and report improper and unknown payments in FY 2022. HHS expects to complete testing and report an improper payment estimate for this program in FY 2023.

p) TANF RY and RY+1 outlays are based on the *FY 2023 President's Budget* baseline (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs and excluding the TANF Contingency Fund).

q) The TANF program is not reporting estimates for FY 2022. As discussed in Section 8.9: *TANF*, statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement.

r) Foster Care RY and RY+1 outlays are based on the *FY 2023 President's Budget* baseline and reflect the federal share of maintenance payments.

s) Foster Care is not reporting an error rate for FY 2022 or a RY+1 improper payment plus unknown payment target for FY 2023. HHS is planning to resume conducting onsite Title IV-E Reviews in 2023, however they will not be completed in time for the FY 2023 improper payment reporting cycle. In addition, once reviews resume, the reported error rate will be based only on the results of the newly completed reviews. HHS will not set a target for improvement until all states have been newly reviewed and the program reestablishes a baseline.

t) CCDF RY and RY+1 outlays are based on the *FY 2023 President's Budget* baseline.

u) CCDF is not reporting a RY+1 improper payment plus unknown payment reduction target for FY 2023. The *Child Care and Development Block Grant Act of 2014* (CCDBG) and CCDF regulations (2016) required states to create and adopt new policies and procedures. State grantees have been implementing large-scale changes to child care programs and HHS anticipated that the improper

payment rate could be affected as states work to meet the new requirements. HHS anticipated reestablishing the baseline and setting a reduction target in FY 2022, however, limitations and restrictions due to COVID-19 impacted states' abilities to complete planned actions as states were granted needed flexibility. The effects of COVID-19 will continue to impact the improper payment rate in the FY 2023 measurement and beyond, making it challenging to determine a target rate. For these reasons, HHS delayed establishment of a baseline until all cohorts have substantially completed planned actions.

v) HHS determined Head Start to be risk-susceptible in FY 2021. As with other programs, developing and implementing a new improper payment estimation methodology and process can be a time-intensive process. HHS is developing an improper payment measurement and expects to report an error rate for this program in FY 2023.

w) Head Start RY and RY+1 outlays are based on the *FY 2023 President's Budget* baseline.

x) Head Start Disaster Relief RY outlays are from the *Bipartisan Budget Act of 2018* (Public Law 115-123) and are based on award recipient expenditures related to Hurricanes Harvey, Irma, and Maria during FY 2021, and RY+1 outlays are based on an estimated expenditure rate: (Total Appropriation, less reserve for Federal Administration, less grantee drawdowns through the period under review) divided by four expenditure years remaining through September 30, 2026.

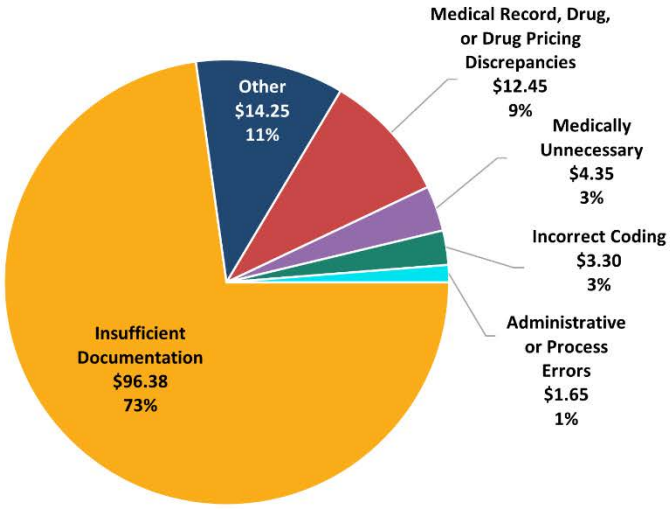
y) The Head Start Disaster Relief program is not reporting a RY+1 improper payment plus unknown payment reduction target for FY 2023 because the program is below the statutory threshold for reporting an estimate.

7.0 IMPROPER AND UNKNOWN PAYMENT ERROR TYPES

Figure 5 below displays HHS's main payment error types for all risk-susceptible programs. Most error types are more detailed than OMB root cause categories to help generate useful information regarding HHS improper payments. Refer to the HHS risk-susceptible programs' submissions for FY 2022 on PaymentAccuracy.gov for information that aligns with OMB's root cause categories.

Section 8.0: *Program-Specific Reporting Information* provides additional programmatic information on error types, and mitigation strategies and corrective actions.

Figure 5: RY 2022 Improper and Unknown Payment Error Types for HHS's Risk-Susceptible Programs[1] (Dollar Amounts in Billions)



[1] Input Errors and Incorrect Calculation each accounted for less than 1 percent of HHS's improper and unknown payments ($0.15 billion and $0.11 billion, respectively) and, thus, were not included in Figure 5. In addition, due to rounding, amounts in this figure may not add up precisely to other tables in this document.

HHS's estimated improper payments (in both dollar amounts and percentages) are distributed between overpayments (monetary loss) and underpayments (non-monetary loss) for each program, as displayed in **Table 2** below. The total amount of overpayments also includes improper payments due to missing or insufficient documentation that do not necessarily represent monetary loss.

Table 2: Estimated Improper Payments by Program

RY 2022 (in Millions)

	Overpayments		Underpayments	
Program or Activity	Amount	Percent of Total Payments	Amount	Percent of Total Payments
Medicare FFS	$30,677.99	**7.27%**	$778.72	**0.18%**
Medicare Part C	$12,686.06	**4.93%**	$1,254.76	**0.49%**
Medicare Part D	$1,323.24	**1.50%**	$37.87	**0.04%**
Medicaid	$80,203.69	**15.55%**	$369.34	**0.07%**
CHIP	$4,303.02	**26.74%**	$1.52	**0.01%**
APTC	$236.07	**0.57%**	$19.69	**0.05%**
PRF	$409.48	**0.32%**	$0.00	**0.00%**
CCDF	$91.04	**1.05%**	$23.13	**0.27%**
Head Start Disaster Relief	$0.15	**0.22%**	$0.00	**0.00%**
Total [1]	**$129,930.74**	**8.80%**	**$2,485.03**	**0.17%**

[1] Totals do not necessarily equal the sum of the rounded components.

8.0 PROGRAM-SPECIFIC REPORTING INFORMATION

In addition to descriptions in this section, please refer to PaymentAccuracy.gov for additional information on HHS's payment integrity efforts.

8.1 MEDICARE FFS (PARTS A AND B)

Medicare FFS Statistical Sampling Process

HHS reviews a stratified random sample of Medicare FFS claims to determine if HHS properly paid claims under Medicare's policies on coverage, coding, and billing. **Figure 6** below depicts the sampling process.

Figure 6: Sampling Process

The sampling process ensures statistically valid random sampling across four claim types:

- Part A claims excluding hospital Inpatient Prospective Payment System (including but not limited to home health, Inpatient Rehabilitation Facility [IRF], SNF, and hospice);
- Part A hospital Inpatient Prospective Payment System claims;
- Part B claims (e.g., physician, laboratory, and ambulance services); and
- DMEPOS.

In August 2020, HHS resumed program activities that had been paused due to COVID-19, thus impacting the RY 2022 reporting period. As a result, the improper payment rate reflects processes that had a 2-month delay in contacting providers and suppliers for documentation and an adjusted sample size. In addition, the waivers and flexibilities provided by HHS for providers and suppliers during COVID-19 apply to all claims in the reporting period.

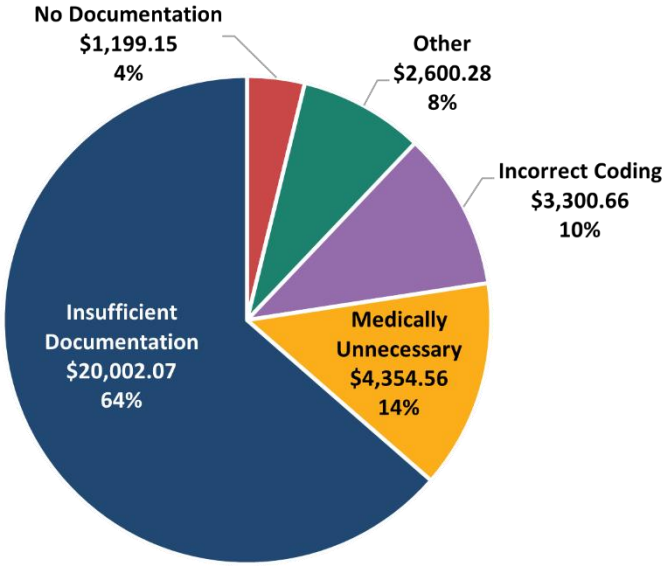
HHS sampled approximately 42,000 claims. The rate estimated from this sample reflects all claims processed by the Medicare FFS program during the report period. Additional information on the Medicare FFS improper payment methodology is on pages 166-167 of HHS's FY 2012 AFR.

Calculations and Findings

Medicare FFS properly paid an estimated 92.54 percent of total outlays or $390.46 billion. The improper payment estimate is 7.46 percent of total outlays or $31.46 billion. The improper payment estimate due to missing or insufficient documentation is 5.03 percent or $21.20 billion, representing 67.40 percent of total improper payments.

Figure 7 shows the estimated percentage and amount of improper payments associated with each error type.

Figure 7: RY 2022 Medicare FFS Estimated Payment Error Types[1] (Dollar Amounts in Millions)



[1] Figure may not equal 100 percent or add up precisely to other tables in this document due to rounding.

Improper payments for SNF, hospital outpatient, hospice, and home health claims were major contributing factors to the Medicare FFS estimate, comprising 47.34 percent of the overall estimate. While the factors contributing to improper payments are complex and vary by year, the primary causes continue to be insufficient documentation and medically unnecessary errors as described in the following four driver service areas: [25]

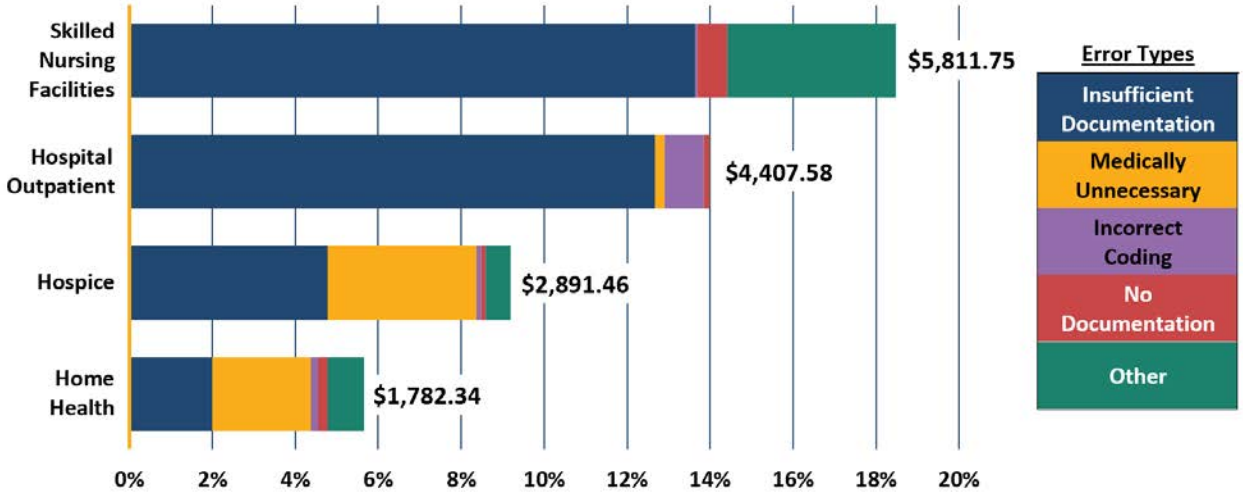
- **SNF:** Insufficient documentation continues to be the major error reason for SNF claims. The improper payment estimate for SNF claims increased from 7.79 percent in RY 2021 to 15.10 percent in RY 2022. The primary reasons for these errors are missing documentation to support the level of care requirements and missing documentation to support the required components for the billed code.

[25] Although increases and decreases are identified, some are not statistically significant. An increase or decrease estimated from a statistical sample is said to be "not statistically significant" if the estimate's margin of error is too wide to conclude that the improper payment rate is different from the previous year.

- **Hospital Outpatient:** Insufficient documentation continues to be the major error reason for hospital outpatient claims. The improper payment estimate for hospital outpatient claims increased from 4.57 percent in RY 2021 to 5.43 percent in RY 2022; however, this change is not statistically significant. The primary reason for these errors is missing documentation to support the order, or the intent to order for certain services.
- **Hospice:** Both insufficient documentation and medically unnecessary were the major error reasons for hospice claims. The improper payment estimate for hospice claims increased from 7.77 percent in RY 2021 to 12.04 percent in RY 2022. The primary reasons for these errors are missing or insufficient documentation to support the certification or recertification and the hospice coverage criteria for medical necessity was not met.
- **Home Health:** Medically unnecessary was the major error reason for home health claims. The improper payment estimate for home health claims decreased from 10.24 percent in FY 2021 to 10.15 percent in FY 2022; however, this change is not statistically significant. The primary reason for these errors is that the home health coverage criteria for medical necessity was not met.

Figure 8 shows the RY 2022 Medicare FFS drivers for SNF, hospital outpatient, hospice, and home health claims by error type.

Figure 8: RY 2022 Medicare FFS Service Areas with the Largest Estimated Improper Payment Dollar Amounts: Percentage Share of Medicare FFS Improper Payments by Error Type (Dollar Amounts in Millions)



Medicare FFS Mitigation Strategies and Corrective Actions

HHS addresses improper payments in Medicare FFS through various mitigation strategies and corrective actions. Through commitment and steadfast efforts to identify the root causes, HHS implements action plans to reduce and prevent improper payments, and extend our capacity to address emerging areas of risk through workgroups and interagency collaborations.

HHS has developed preventive measures for specific service areas with high improper payment estimates, such as SNF, hospital outpatient, hospice, and home health. HHS believes targeted actions will prevent and reduce improper payments in these areas.

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Automation	• **Automated Edits:** Due to the high volume of Medicare claims processed by HHS daily and the significant cost associated with conducting medical reviews of an individual claim, HHS relies on automated edits to identify inappropriate claims. HHS designed its systems to detect anomalies and prevent payment for many erroneous claims through these efforts. HHS also uses the National Correct Coding Initiative to prevent improper payments of Medicare Part B claims and Medicaid claims. HHS will report FY 2022 savings from these edits in the forthcoming Annual Report to Congress on the Medicare and Medicaid Integrity Programs.
Training	• **DMEPOS Supplier Education:** HHS educated providers and DMEPOS suppliers through Medicare Learning Network articles called Provider Compliance Tips. HHS posted 29 articles to the CMS website, each on a different DMEPOS-related service area. These Provider Compliance Tips are updated regularly because of improper payment findings, as well as regulatory and other policy changes, including the Calendar Year 2021 End-stage Renal Disease and DMEPOS Final Rule (CMS-1713-F).
Internal Process or Policy Change	• **Hospital Outpatient Prior Authorization:** HHS continued the nationwide prior authorization of Blepharoplasty, Botulinum Toxin Injections, Panniculectomy, Rhinoplasty, Vein Ablation, Implanted Spinal Neurostimulators, and Cervical Fusion with Disc Removal. HHS provisionally affirmed (approved) 104,144 services through this process. On July 26, 2022, HHS proposed the addition of Facet Joint Interventions to the nationwide prior authorization process for hospital outpatient department services in the Calendar Year 2023 Outpatient Prospective Payment System/Ambulatory Surgical Center Proposed Rule. • **DMEPOS Prior Authorization:** HHS announced in the Federal Register on January 13, 2022, that the following items had been added to the Required Prior Authorization List beginning April 13, 2022: five lower limb orthoses[26] (*L0648, L0650, L1832, L1833, and L1851*) and six additional power mobility devices (*K0800, K0801, K0802, K0806, K0807, and K0808*). HHS continued the prior authorization of 40 Power Mobility Devices, five Pressure Reducing Support Surface codes, and six Lower Limb Prosthetic codes nationwide. HHS provisionally affirmed (approved) 65,131 DMEPOS items through the prior authorization process. • **Ambulance Transport Prior Authorization:** HHS successfully expanded the Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model nationwide to all remaining U.S. states and territories, as the model has met all expansion criteria under Section 1834(l)(16) of the Act (as added by Section 515(b) of the *Medicare Access and CHIP Reauthorization Act of 2015* [Public Law 114-10]). HHS provisionally affirmed (approved) 19,662 ambulance prior authorization requests through this process.[27] • **Provider and Supplier Screening for Existing Medicare Providers and Suppliers:** HHS performed 235,288 initial enrollment screenings, deactivated 165,772 enrollments, and revoked 2,833 enrollments. • **Provider and Supplier Screening for New Medicare Providers and Suppliers:** HHS conducted 53,352 site visits for non-durable medical equipment (DME) Medicare FFS

[26] Implementation of this requirement will be completed in three phases. Phase 1 began on April 13, 2022 in New York, Illinois, Florida, and California. Phase 2 began on July 12, 2022 in Maryland, Pennsylvania, New Jersey, Michigan, Ohio, Kentucky, Texas, North Carolina, Georgia, Missouri, Arizona, and Washington. Phase 3 will occur in FY 2023 for all remaining states and territories not included in phase 1 or phase 2.

[27] A single prior authorization decision may affirm up to 40 round trips for up to a 60-day period. Beneficiaries with a chronic medical condition are eligible to receive an extended affirmation period. For these beneficiaries, a single prior authorization decision may affirm up to 120 round trips for up to a 180-day period.

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
	providers and suppliers, and 13,166 site visits for Medicare DME suppliers. This work resulted in 278 revocations due to non-operational site visit determinations for all providers and suppliers. • **Medical Review Strategies:** HHS and its contractors develop medical review strategies using improper payment data to target the areas of highest risk and exposure. HHS requires its Medicare review contractors to identify and prevent improper payments due to documentation errors in certain error-prone claim types, such as SNF, hospital outpatient claims, IRF, hospice, and home health. • **Medical Review Accuracy Award Fee Metric:** HHS includes the Medical Review Accuracy Award Fee Metric in the Award Fee Plan for Medicare Administrative Contractors (MACs) that process Part A, Part B, and DME claims. This metric measures the accuracy of the MAC's complex medical review decisions. The metric project assists with consistent medical review decisions across MACs, leading to uniform education to providers on all improper payments, including medical necessity and the impact of insufficient documentation errors. Additional project goals include identifying unclear and/or burdensome policy requirements that can be clarified or simplified to prevent unnecessary denials. • **Overpayment Recoveries Related to Regulatory Provisions:** In the Medicare Reporting and Returning of Self-Identified Overpayments (CMS-6037-F) Final Rule, HHS required providers and suppliers to identify, report, and return self-identified Medicare Part A or Part B overpayments. This rule incentivizes providers and suppliers to maintain documentation and submit accurate claims, reducing potential improper payments. • **Review Choice Demonstration for Home Health Services:** The Review Choice Demonstration for Home Health Services gives Jurisdiction M (Palmetto) providers operating in Illinois, Ohio, North Carolina, Florida, and Texas an initial choice of three options (i.e., pre-claim review, post-payment review, or minimal post-payment review with a 25 percent payment reduction for all home health services). A provider's compliance with Medicare billing, coding, and coverage requirements would determine the provider's next steps under the demonstration. HHS provisionally affirmed (approved) 1,824,526 billing periods for home health services. • **Provider Billing Review Evaluation:** HHS issued 10 Comparative Billing Reports for 8 unique topics that included: Critical Care; Orthoses (Referring Providers); Chiropractic Manipulative Treatment of the Spine; Podiatry; Nail Debridement and Evaluation and Management Services; Lipid Panel Testing with a Focus on Direct Measurement; Ambulance Ground Transport; Allergy and Immunotherapy Services; and Cataract Surgery.
Audits	• **Targeted Probe and Educate:** MACs continued the Target Probe and Educate process and continued to offer extensions as needed due to the continued impacts of COVID-19.[28] This process consists of up to three rounds of review of 20-40 claims per round, with one-on-one education provided at the end of each round. HHS uses medical review in the hospital outpatient, IRF, SNF, home health, hospice, and DMEPOS service areas. MACs reviewed approximately 3,280 hospital outpatient providers, 1,909 home health agency providers, 1,150 hospice providers, 205 IRF providers, and 5,333 DME suppliers.

[28] See the CMS website for additional information on Targeted Probe and Educate.

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
	• **Supplemental Medical Review Contractor (SMRC) Reviews:** SMRC conducted Medicare FFS reviews on a post-payment basis for hospital outpatient, IRF, SNF, hospice, and DMEPOS claims. SMRC shares medical review results with the MACs for claim adjustments upon review completion. The providers receive detailed SMRC review result letters and MAC demand letters for overpayment recovery, which include educational information regarding what was incorrect in the original billing of the claim. SMRC performed medical reviews on a post-payment basis for 26,777 hospital outpatient claims; 4,236 SNF claims; 31,744 hospice claims; 59,369 DME claims, and other areas. • **Recovery Audit Contractor (RAC) Reviews:** Medicare FFS RACs identified and collected improper payments related to IRF, SNF, professional services, home health, and DMEPOS claims. The largest share of Medicare FFS RAC collections (37.4 percent) were from hospital outpatient overpayments and an additional 5.8 percent were from SNF overpayments. • **RAC DME Reviews:** The national Medicare FFS DME RAC conducted complex DME reviews for medical necessity of DME items billed, insufficient documentation to support DME items billed, missing valid orders for DME items billed, and if items/services billed were rendered. The DME RAC also conducted automated DME reviews for inappropriate unbundling, excessive units billed, and if the DME items billed were medically necessary.
Predictive Analytics	• **Fraud Prevention System Models:** The Fraud Prevention System analyzes Medicare FFS claims using sophisticated algorithms to target investigative resources; generate alerts for suspect claims or providers and suppliers; and facilitate and support investigations of the most egregious, suspect, or aberrant activity. The Fraud Prevention System generated alerts that resulted in 960 new leads for program integrity contractors and augmented information for 759 existing leads or investigations. Contractors reported initiating attributable actions against 786 providers.

8.2 Medicare Advantage (Part C)

Medicare Advantage Statistical Sampling Process

The Part C improper payment measurement methodology estimates improper payments resulting from errors in beneficiary risk scores. The primary component of most beneficiary risk scores is clinical diagnoses (the CMS Hierarchical Condition Category [CMS-HCC]) submitted by the Medicare Advantage Organization (MAO). To calculate the projected error rate, HHS selects a random sample of enrollees with one or more CMS-HCCs and requests medical records to support each condition. If medical records do not support the diagnoses submitted to HHS the risk scores may be inaccurate and result in payment errors.

HHS selected a stratified random sample of beneficiaries with a risk adjusted payment in Calendar Year 2020 and reviewed medical records of the diagnoses submitted by plans for the sample beneficiaries. As one of the last key steps in the process (see **Figure 9** below), HHS calculates the beneficiary risk score error and extrapolates that beneficiary-level error to the population subject to risk adjustment, resulting in a Part C gross payment error amount.

HHS finalized a policy regarding treatment of spontaneous "additionals" in the improper payment rate calculation.[29] Diagnoses that were not submitted to HHS for payment have been excluded from the payment error calculation to get a true measure of payment error. In previous years, these potential payments were reflected in the underpayment rate and overall payment error calculation; however, including the spontaneous "additionals" in the gross underpayment portion resulted in an overstatement of the overall improper payment rate. The implemented policy contributed to a decrease in the projected Part C improper payment rate, representing a new baseline improper payment rate for Part C and is not directly comparable with prior reporting years. Moreover, FY 2021 also represented a new baseline due to various methodology changes,[30] most significantly, a refined denominator calculation.

Figure 9: Part C Improper Payment Measurement Process

Calculations and Findings

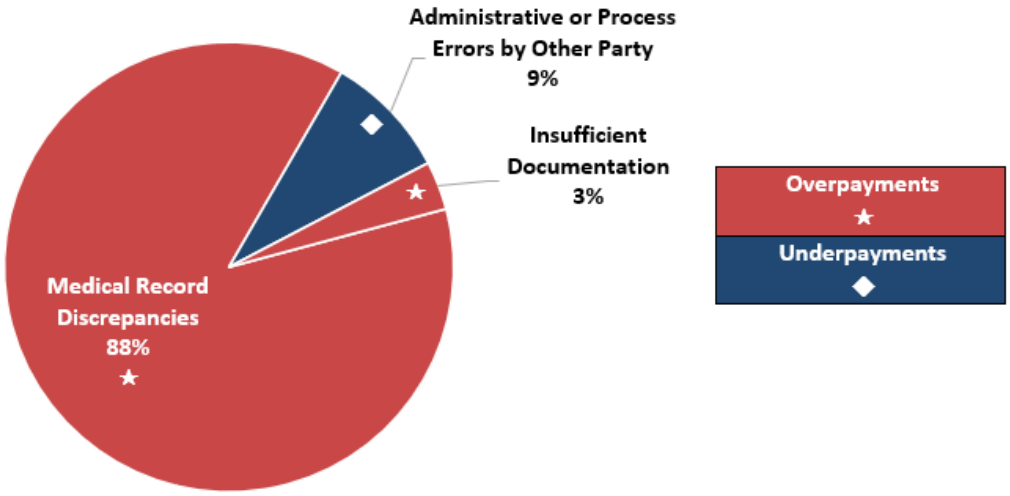
Medicare Part C properly paid an estimated 94.58 percent of total outlays or $243.23 billion. The improper payment estimate is 5.42 percent of total outlays or $13.94 billion. The improper payment estimate due to missing or insufficient documentation is 0.19 percent or $0.49 billion, representing 3.49 percent of total improper payments.

The primary error type of Medicare Part C improper payments consists of medical record discrepancies (4.74 percent in overpayments and 0.49 percent in underpayments), with a smaller portion of improper payments resulting from insufficient documentation to determine whether proper or improper (0.19 percent). Improper payments due to medical record discrepancies occur when medical record documentation submitted by the MAO does not substantiate the CMS-HCC for which it received payment. The underpayment component is comprised of risk scores identified during the medical review process that the MAO did not submit for payment. The breakdown of Medicare Part C improper payments is displayed in **Figure 10** below.

[29] There are two major categories of "additionals": (1) new, or spontaneous, "additionals" identified as an artifact of CMS's improper payment measurement review and were not originally submitted by the MAO for payment purposes and (2) "additionals" within the same hierarchy as the audited CMS-HCCs. "Additionals" occur during the medical review process where the medical record submitted by the MAO supports an HCC that was never submitted for payment, or the medical record supports a diagnosis more severe within the same hierarchy as the HCC submitted for payment. Spontaneous "additionals" do not meet the definition of improper payment and are excluded under HHS's FY 2022 methodology. "Additionals" within the same hierarchy as the audited CMS-HCCs are included under HHS's FY 2022 methodology.

[30] FY 2021 methodology changes are described on pages 219-220 of HHS's FY 2021 AFR.

Figure 10: RY 2022 Medicare Part C Estimated Payment Categories and Error Types[1]



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

Medicare Advantage Mitigation Strategies and Corrective Actions

HHS addresses improper payments in Medicare Part C through the following mitigation strategies and corrective actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Webinars:** HHS held Opioid Education Mission webinars in October 2021 and May 2022; an updated COVID-19 fraud, waste, and abuse webinar in February 2022; and a MAO and Prescription Drug Plan fraud, waste, and abuse training webinar in September 2022.
Audits	• **Risk Adjustment Data Validation (RADV) Audits:** Contract-level RADV audits are HHS's primary mitigation strategy to recoup Part C overpayments. RADV uses medical record review to verify the accuracy of enrollee diagnoses submitted by MAOs for risk adjusted payment. HHS expects payment recovery will have a sentinel effect on risk adjustment data quality submitted by MAOs for payment because contract-level RADV audits increase the incentive for MAOs to submit valid and accurate diagnosis information. Contract-level RADV audits also encourage MAOs to self-identify, report, and return overpayments. HHS conducted preliminary analyses of medical record review results for the payment year 2014 RADV audits and continued medical record reviews for payment year 2015 RADV audits. • **Program Integrity Audits:** HHS conducts audits of Part C plan sponsors to reduce improper payments and identify areas of non-compliance with program integrity requirements. HHS conducted three Program Integrity Audits, with the goal of educating Part C plan sponsors on issues of fraud, waste, and abuse. • **I-MEDIC Investigations:** I-MEDIC initiated 651 investigations; submitted 77 recommendations for provider revocations; submitted 162 referrals to law enforcement, including 31 immediate advisements; and submitted 167 referrals to

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
	other entities, such as state pharmacy and medical boards, Medicare quality improvement organizations, and other Medicare contractors.[31]

8.3 Medicare Prescription Drug Benefit (Part D)

Medicare Prescription Drug Benefit Statistical Sampling Process

The Part D improper payment measurement methodology estimates the payment error related to prescription drug event (PDE) data.[32] HHS measures inconsistencies between information reported on PDEs and supporting documentation submitted by Part D sponsors: prescription record hardcopies (or medication orders as appropriate) and detailed claims information. Based on these reviews, each sampled PDE is assigned a gross drug cost error. A representative sample of beneficiaries undergoes a simulation to determine the Part D improper payment estimate. HHS then extrapolates these improper payments to the entire Part D population to produce the final Part D estimate.

HHS simplified the standard error calculation to adhere to statistical best practice, resulting in a lower margin of error and more accurate estimate. In the new calculation, HHS uses the standard deviation of the simulations to determine the standard error of the improper payment estimate. Further, HHS updated the data sources used to calculate the denominator, resulting in a more accurate, precise, and transparent calculation. The denominator calculation only considers Part D expenditures that may be identified through clinical validation of PDE cost and payment amounts. The Part D improper payment measurement refinements improved the overall accuracy of the Part D improper payment rate; however, the RY 2022 improper payment rate is statistically similar to the RY 2021 rate and does not represent a new baseline.

Calculations and Findings

Medicare Part D properly paid an estimated 98.46 percent of total outlays or $87.05 billion. The improper payment estimate is 1.54 percent of total outlays or $1.36 billion. The improper payment estimate due to missing or insufficient documentation is 1.21 percent or $1.07 billion, representing 78.49 percent of total improper payments. The increase from the prior year's estimate of 1.33[33] percent is due to year-over-year variability and is not statistically different from the prior year. As the rate is already low, variation in sampled error types and amounts can cause minor shifts in the total estimated error rate.

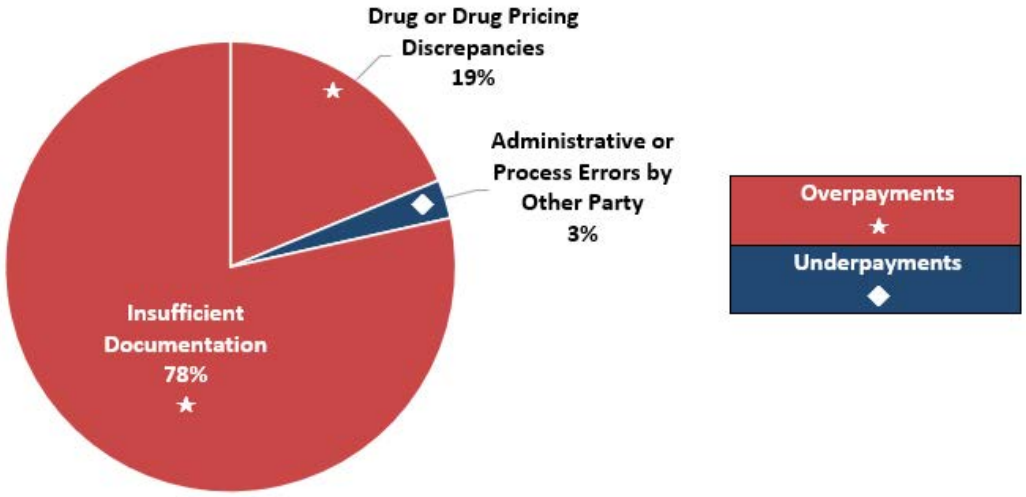
The Medicare Part D improper payment error categories are drug or drug pricing discrepancies (0.29 percent in Overpayments and 0.04 percent in Underpayments) and insufficient documentation to determine whether proper or improper (1.21 percent). Improper payments due to drug or drug pricing discrepancies occur when the prescription documentation submitted indicates that an overpayment occurred. Underpayments result when prescription record hard copies (or medication orders) indicates that CMS should have paid more. The breakdown of Medicare Part D improper payments is displayed in **Figure 11** below.

[31] The I-MEDIC's investigative efforts and ensuing recommendations may involve providers/suppliers participating in Medicare FFS, Medicare Part C, and/or Medicare Part D.

[32] PDE data represents the summary record of each time a beneficiary fills a prescription under Medicare Part D.

[33] The reported improper underpayments were overrepresented in the initial reporting for FY 2021. The corrected Part D calculations led to an overall decrease in estimated improper payment rate for FY 2021. The Part D estimate was originally reported as 1.58% (or $1.37 billion), instead of 1.33% (or $1.15 billion).

Figure 11: RY 2022 Medicare Part D Estimated Payment Categories and Error Types[1]



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

Medicare Prescription Drug Benefit Mitigation Strategies and Corrective Actions

HHS addresses improper payments in Medicare Part D through the following mitigation strategies and corrective actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Webinars:** HHS held Opioid Education Mission webinars in October 2021 and May 2022; an updated COVID-19 fraud, waste, and abuse webinar in February 2022; and a MAO and Prescription Drug Plan fraud, waste, and abuse training webinar in September 2022. • **Outreach:** HHS continued formal outreach to plan sponsors for invalid or incomplete documentation. HHS distributed Final Findings Reports to all Part D sponsors participating in the PDE review process. This report provided feedback on the plan sponsor's submission and validation results against an aggregate of all participating plan sponsors.
Audits	• **Part D Audits:** HHS conducts audits of Part D plan sponsors, focusing on drugs that are at high risk of improper payments. Each type of audit is different in scope but has the same goal of educating Part D plan sponsors on issues of fraud, waste, and abuse, as well as identifying, reducing, and recovering inappropriate payments under Part D. HHS conducted 13 Part D audits. • **I-MEDIC Investigations:** The I-MEDIC initiated 651 investigations; submitted 77 recommendations for provider revocations; submitted 162 referrals to law enforcement, including 31 immediate advisements; and submitted 167 referrals to other entities, such as state pharmacy and medical boards, Medicare quality improvement organizations, and other Medicare contractors.[34] • **Program Integrity Audits:** HHS conducts audits of Part D plan sponsors to reduce improper payments and identify areas of non-compliance with program integrity requirements. HHS conducted three Program Integrity Audits, with the goal of

[34] The I-MEDIC's investigative efforts and ensuing recommendations may involve providers/suppliers participating in Medicare FFS, Medicare Part C, and/or Medicare Part D.

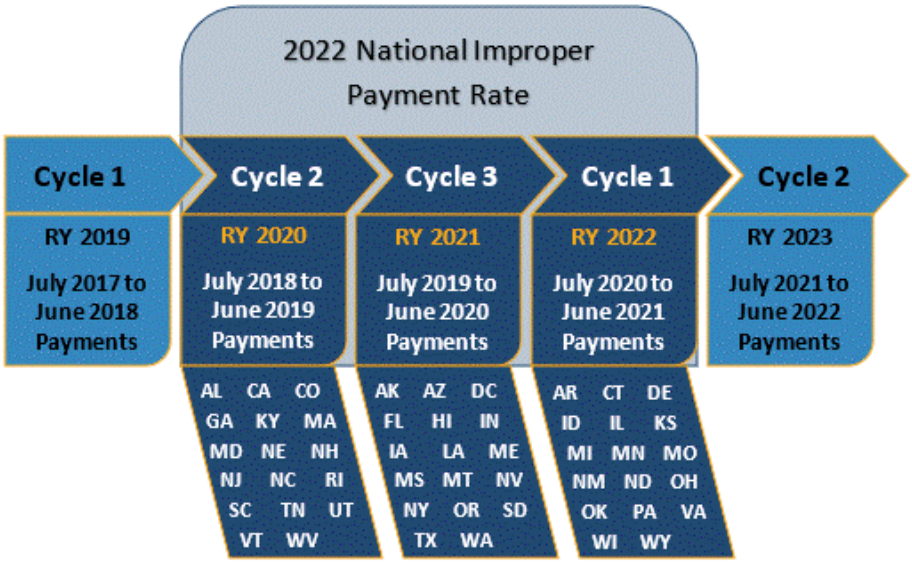
Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
	educating Part D plan sponsors on issues of fraud, waste, and abuse. • **PPI MEDIC:** Based on data analysis projects and Part D plan sponsor self-audits, HHS recovered $640,832.83.[35]

8.4 MEDICAID

Medicaid Statistical Sampling Process

HHS estimates Medicaid improper payments on an annual basis through the Payment Error Rate Measurement program, using federal contractors to measure three components: FFS claims, managed care payments, and eligibility determinations. HHS uses a 17-states-per-year, 3-year rotation. Each time a group of 17 states is measured, HHS removes that group's previous findings from the calculation and includes its newest findings. The national Medicaid rate is based on measurements from RYs 2020, 2021, and 2022 (see **Figure 12**).

Figure 12: RY 2022 Medicaid Cycle Measurements



To learn how HHS grouped states into three cycles, refer to pages 177-179 of HHS's FY 2012 AFR.

FFS and Managed Care Components

FFS includes the traditional method of paying for medical services under which a state pays providers for each service rendered to individual beneficiaries. Managed care is a delivery system where a state makes a monthly payment to a managed care organization, which is responsible for managing beneficiary care and rendering payments to providers. States submit adjudicated claims data quarterly and HHS randomly selects a sample of FFS claims and managed care payments. Each FFS claim selected undergoes a medical and data processing review, while managed care payments are subjected to only a data processing review. Reviewing medical records associated with historical provider payments or provider payments that occurred during the month sampled does not have a direct link to the

[35] HHS will report the full fiscal year recoveries from the PPI MEDIC's data analysis projects and Part D plan sponsor self-audits in the forthcoming Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

established capitated payment sampled and, thus, is not included in the managed care component of the improper payment review.

Additionally, HHS selects a combination of FFS claims and managed care payments for eligibility review. Based on each state's expenditures, historical FFS, and managed care payment data, the FFS sample size was between 49 and 1,717 claims per state, the managed care sample size was between 38 and 197 payments per state, the eligibility FFS sample size was between 51 and 477 per state, and the eligibility managed care sample size was between 52 and 578 per state. When a state's FFS or managed care component accounted for less than two percent of the state's total Medicaid expenditures, HHS combined the state's FFS and managed care claims into one component for sampling and measurement purposes.

Eligibility Component

Through the eligibility component, a federal contractor assesses states' application of federal rules and the state's documented policies and procedures related to beneficiary eligibility. States must produce records and documentation to support the eligibility determination. Examples of noncompliance with eligibility requirements include a state: enrolling an ineligible beneficiary; determining a beneficiary to be eligible for the incorrect eligibility category, resulting in an ineligible service or incorrect federal reimbursement amount being provided; not conducting beneficiary redeterminations timely or at all; or not performing, completing, or providing sufficient documentation to support a required element of the eligibility determination process, such as income verification. See additional information regarding the eligibility component and establishment of a baseline measurement on pages 225-226 of HHS's FY 2021 AFR.

Calculations and Findings

The national Medicaid program's improper payment estimate combines each state's Medicaid FFS, managed care, and eligibility estimates. In addition, HHS combines individual state component improper payment estimates to calculate the national component improper payment estimates. National component rates and the Medicaid program rate are weighted by state size, such that a state with a $10 billion program is appropriately weighted more in the national rate than a state with a $1 billion program. A correction factor in the methodology ensures that each Medicaid improper payment is counted only once in the combined national rate.

Medicaid properly paid an estimated 84.38 percent of total outlays or $435.24 billion. The national Medicaid improper payment estimate is 15.62 percent or $80.57 billion. The improper payment estimate due to missing or insufficient documentation is 13.56 percent or $69.95 billion, representing 86.82 percent of total improper payments.

The national Medicaid improper payment estimate for each component is:

- *Medicaid FFS*: 10.42 percent;
- *Medicaid managed care*: 0.03 percent; and
- *Medicaid eligibility*: 11.89 percent.

The national Medicaid improper payment estimate reflects reviews that accounted for certain flexibilities afforded to states during COVID-19, such as postponed eligibility determinations and reduced requirements around provider enrollment or revalidations. HHS will publish supplemental information related to the Medicaid results on the CMS website following AFR publication.

The areas driving the Medicaid improper payment estimate are:

- **Insufficient Documentation:** Represents situations where the required verification of eligibility data, such as income, was not done at all and where there is an indication that eligibility verification was initiated but the

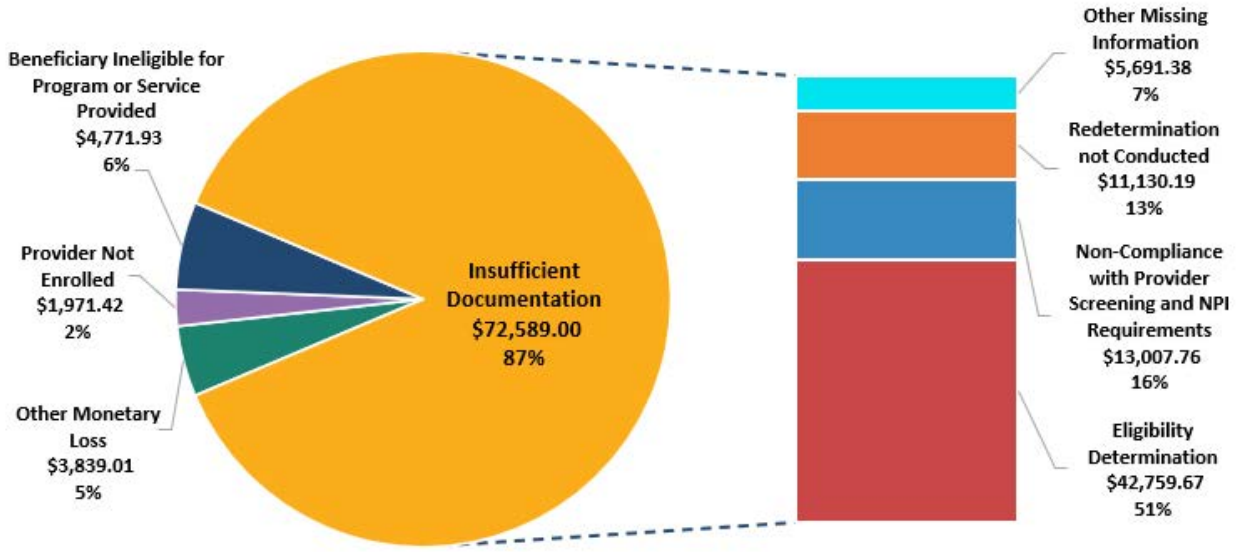
state provided no documentation to validate that the verification process was completed. This includes situations where medical records were either not submitted or were missing required documentation to support the medical necessity of the claim.

- **State Non-Compliance:** Represents noncompliance with federal eligibility redetermination requirements; enrolled providers not appropriately screened by the state; providers not appropriately rescreened at revalidation; providers not enrolled; and/or providers without the required National Provider Identifier on the claim. State compliance with provider enrollment or screening requirements has improved as the Medicaid FFS component improper payment estimate decreased from 13.90 percent in RY 2021 to 10.42 percent in RY 2022. COVID-19 review flexibilities afforded to states should also be considered in the identified decrease in the Medicaid FFS and eligibility components between RY 2021 and RY 2022.

A majority of Medicaid improper payments were due to instances where information required for payment was missing, an eligibility determination was missing from the state system, states did not follow the appropriate process for enrolling providers, and/or states did not follow the appropriate process for determining beneficiary eligibility. However, these improper payments do not necessarily represent payments to illegitimate providers or on behalf of ineligible beneficiaries. If the missing information had been on the claim and/or the state had complied with the enrollment or redetermination requirements, then the claims may have been payable. Conversely, if the missing documentation had been available, it could have affirmatively indicated whether a provider or beneficiary was ineligible for Medicaid reimbursement and, therefore, the payment was improper.

Figure 13 below provides a breakdown of Medicaid's payment error types, including: provider not enrolled, beneficiary ineligible for program or service, incorrect coding, and other errors like claims processing errors, duplicate claims, or pricing mistakes. The insufficient documentation errors include claims where information was missing, or states did not follow appropriate processes to determine if a payment was proper or improper.

Figure 13: RY 2022 Medicaid Estimated Improper Payments by Error Types[1] (Dollar Amounts in Millions)



[1] The total Medicaid improper payments in Figure 13 are greater than the improper payment totals displayed in Table 1 because improper payments in this figure can be categorized in more than one payment error type. In addition, figure may not equal or add up precisely to other tables in this document due to rounding.

Medicaid Mitigation Strategies and Corrective Actions

Because the Medicaid program is a federal-state partnership, HHS works closely with all states to develop mitigation strategies and corrective actions that focus on major causes of improper payments. All states are responsible for implementing, monitoring, and evaluating the effectiveness of mitigation strategies and corrective actions. State mitigation strategies and corrective actions focus on system or process changes to reduce these errors, including implementing new claims processing edits, converting to a more sophisticated claims processing system, implementing provider enrollment process improvements, implementing beneficiary enrollment and redetermination process improvements, and conducting provider communication and education to reduce errors related to documentation requirements.

HHS addresses improper payments in Medicaid through the following mitigation strategies and corrective actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Medicaid Integrity Institute:** HHS offers training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute. Offerings included a Medicaid Risk Assessment Webinar, a Corrective Action Symposium, a Managed Care Symposium, eligibility requirements and policies, and a Provider Enrollment and Terminations Webinar, among others. In response to COVID-19, HHS continued to offer virtual courses to provide educational offerings to states, territories, and other stakeholders. Despite this change, state interest and participation were strong, consistent with previous years. More information is located at the Medicaid Integrity Institute website.
Internal Process or Policy Change	• **Enhanced State Corrective Action Plan Process:** HHS continued working with states to implement a robust state-specific Corrective Action Plan process that provides enhanced technical assistance and guidance to states. HHS works with states to coordinate state development of corrective action plans to address each error and deficiency identified during the measurement cycle. After each state submits the corrective action plan, HHS monitors the state's progress in implementing effective corrective actions. Throughout the process, HHS also provided training opportunities to ensure compliance with federal policies. For example, in September 2022, HHS conducted a 3-day Corrective Action Symposium with all states and offers quarterly training on various topics. HHS continues to use lessons learned to develop future guidance and education for states.
Cross Enterprise Sharing	• **State Medicaid Provider Screening and Enrollment:** Kentucky and Rhode Island participated in the data compare service. HHS is working to expand the data compare service to additional states. In addition to the data compare service, HHS piloted a process to screen Medicaid-only providers on behalf of states beginning in FY 2019. In FY 2020, HHS screened two states' Medicaid-only providers (Iowa and Missouri) and produced a report of providers with licensure issues, criminal activity, or Do Not Pay activity. HHS evaluated the pilot impact and results and expanded the service to additional states in FY 2021 and FY 2022. Colorado, North Dakota, Oklahoma, Oregon, and Rhode Island are also participating in the pilot and HHS continues engage with other states on their possible participation. • **DMF**: To help alleviate state concerns with the cost of completing the Social Security Administration's DMF check as part of provider screening, HHS worked with the Social Security Administration to provide states the DMF. HHS later

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
	updated access to DMF data to states via the Data Exchange, which is a system for sharing data among HHS and each state's Medicaid program. All 50 states, the District of Columbia, and Puerto Rico have access to DMF data through the Data Exchange. • **Transformed Medicaid Statistical Information System:** HHS developed the Transformed Medicaid Statistical Information System to facilitate state submission of timely claims data to HHS, expand the dataset, and allow HHS to review the completeness and quality of state submissions in real-time. Using this information system, HHS is acquiring higher quality data and reduce data requests to the states. HHS closely monitors monthly data submissions, with a focus on assessing and improving the data quality.
Audits	• **Medicaid Eligibility Quality Control (MEQC) Program:** Under the MEQC program, states design and conduct pilots to evaluate the processes that determine an individual's eligibility for Medicaid and CHIP benefits. The MEQC program also reviews eligibility determinations that are not reviewed under the Payment Error Rate Measurement program, such as denials and terminations. States have flexibility in designing pilots to focus on vulnerable or error-prone areas identified. MEQC pilots are conducted during the 2-year intervals ("off-years") that occur between states' triennial review years, allowing states to implement prospective improvements in eligibility determination processes prior to their next review. HHS worked with the Cycle 1 states to design their MEQC pilots and start their case reviews in January 2022; the Cycle 2 states to submit their MEQC summary reports and corrective action plans in November 2021; and the Cycle 3 states to complete their MEQC reviews and prepare their summary-level reports and corrective action plans for submission in November 2022. Starting with the Cycle 1 state pilots that began in January 2022, the COVID-related streamlined and reduced reporting requirements have ended. • **Beneficiary Eligibility Audits:** As part of HHS's Comprehensive Medicaid Integrity Plan for FYs 2019-2023, HHS continued conducting audits of beneficiary eligibility determinations in high-risk states based on a risk assessment that reviewed states with higher eligibility improper payment rates, eligibility errors based on GAO or OIG reports, issues identified by states through the MEQC program, and issues identified through HHS's various corrective action plan oversight processes. HHS continued audits in Connecticut, Kansas, Missouri, and Pennsylvania. • **Unified Program Integrity Contractors (UPIC):** UPICs are CMS's program integrity contractors that conduct audits and investigations to reduce fraud, waste, and abuse in Medicare and Medicaid. The UPICs operate in geographic areas or jurisdictions defined by individual task orders. The UPICs perform numerous functions to detect, prevent, and deter specific risks and broader vulnerabilities to Medicaid integrity. The most common provider type audits and investigations initiated were hospitals, clinics, pharmacies and pharmacists, hospices, DME suppliers, and labs. Managed care network providers made up over 50 percent of those audits and investigations.

8.5 CHIP

CHIP Statistical Sampling Process

HHS estimates CHIP improper payments on an annual basis through the Payment Error Rate Measurement program, utilizing federal contractors to measure three components: FFS claims, managed care payments, and eligibility determinations.

HHS uses the same state sampling process as with Medicaid to measure CHIP improper payments. HHS determined that the states selected for Medicaid review each year can also be measured in CHIP. For information on how HHS grouped states into three cycles for CHIP, refer to pages 183-185 of HHS's FY 2012 AFR. The national RY 2022 CHIP rate is based on measurements from RYs 2020, 2021, and 2022.

FFS and Managed Care Components

For Payment Error Rate Measurement purposes, claims processing for FFS and managed care components in CHIP are measured in the same way as Medicaid. See Section 8.4: *Medicaid* for general information related to FFS and managed care components.

Based on each state's expenditures, historical FFS, and managed care improper payment data, the FFS sample size was between 32 and 968 claims per state, the managed care sample size was between 27 and 78 payments per state, the eligibility FFS sample size was between 42 and 309 per state, and the eligibility managed care sample size was between 36 and 454 per state. When a state's FFS or managed care component for a state accounted for less than two percent of the state's total CHIP expenditures, HHS combined the state's FFS and managed care claims into one component for sampling and measurement purposes.

Eligibility Component

Through the eligibility component, a federal contractor assesses the state's application of federal rules and the state's documented policies and procedures related to beneficiary eligibility. States must produce records and documentation to support the eligibility determination. Examples of noncompliance with eligibility requirements include a state: inappropriately claiming a beneficiary under Title XXI (CHIP) rather than Title XIX (Medicaid); enrolling an ineligible beneficiary; determining a beneficiary to be eligible for the incorrect eligibility category, resulting in an ineligible service or incorrect federal reimbursement amount being provided; not conducting beneficiary redeterminations timely or at all; or not performing, completing, or providing sufficient documentation to support a required element of the eligibility determination process, such as income verification. See additional information regarding the eligibility component and establishment of a baseline measurement on pages 230-231 of HHS's FY 2021 AFR.

Calculations and Findings

The national CHIP improper payment estimate combines each state's FFS, managed care, and eligibility estimates. In addition, HHS combines individual state component improper payment estimates to calculate the national improper payment estimate. National component rates and the CHIP rate are weighted by state size, such that a state with a $1 billion program is appropriately weighted more in the national rate than a state with a $200 million program. A correction factor in the methodology ensures that each CHIP improper payment is counted only once in the combined national rate.

CHIP properly paid an estimated 73.25 percent of total outlays or $11.79 billion. The national CHIP improper payment estimate is 26.75 percent or $4.30 billion. The improper payment estimate due to missing or insufficient documentation is 20.34 percent or $3.27 billion, representing 76.05 percent of total improper payments.

The national CHIP improper payment estimate for each component is:

- *CHIP FFS:* 11.23 percent;
- *CHIP managed care:* 0.62 percent; and
- *CHIP eligibility*: 24.01 percent.

The national CHIP improper payment estimate reflects reviews that accounted for certain flexibilities afforded to states during COVID-19, such as postponed eligibility determinations and reduced requirements around provider enrollment or revalidations. HHS will publish supplemental information related to the CHIP results on the Payment Error Rate Measurement page of the CMS website following AFR publication.

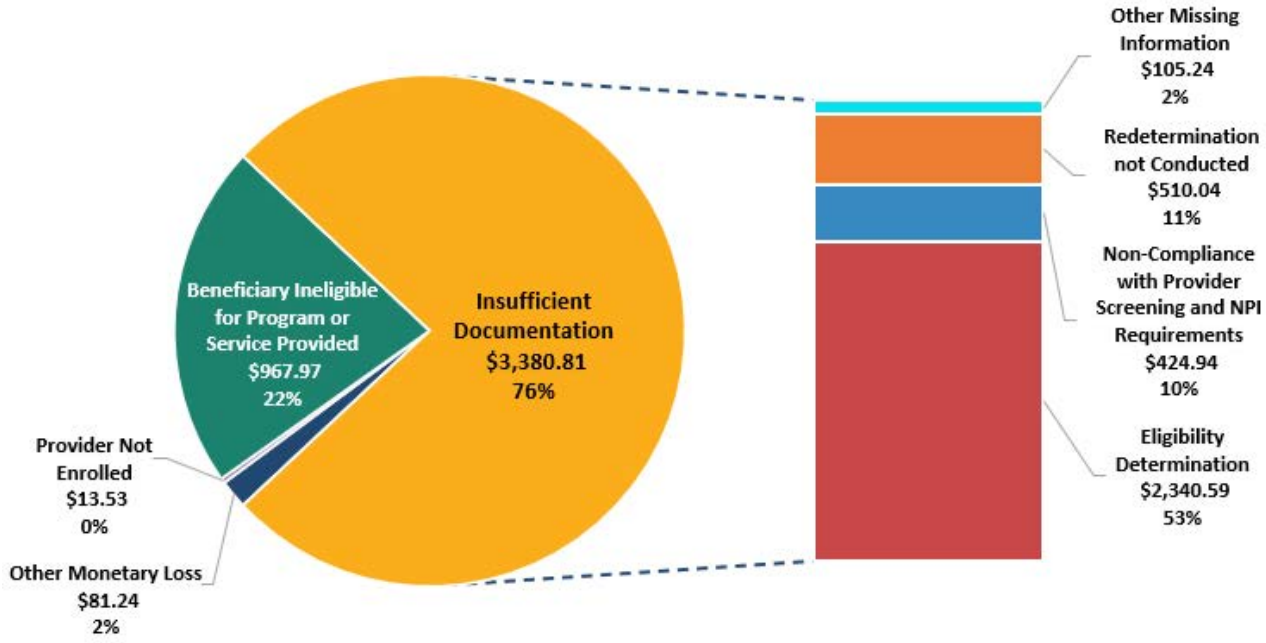
The areas driving the CHIP improper payment estimate are as follows:

- **Insufficient Documentation:** Represents situations where the required verification of eligibility data, such as income, was not done at all and where there is an indication that eligibility verification was initiated but the state provided no documentation to validate that the verification process was completed. This includes situations where medical records were either not submitted or were missing required documentation to support the medical necessity of the claim.
- **Improper Determinations:** Represents situations where the beneficiary was inappropriately claimed under Title XXI (CHIP) rather than Title XIX (Medicaid), mostly related to incorrect state calculations based on beneficiary income, the presence of third-party insurance, household composition, or tax filer status. Improper Determinations accounted for 14.68 percent or $0.63 billion of total errors cited in CHIP FFS, CHIP managed care and CHIP eligibility.
- **State Non-Compliance:** Represents noncompliance with federal eligibility redetermination requirements; enrolled providers not appropriately screened by the state; providers not appropriately rescreened at revalidation; providers not enrolled; and/or providers without the required National Provider Identifier on the claim. State compliance with provider enrollment or screening requirements has improved as the CHIP FFS component improper payment estimate decreased from 13.67 percent in RY 2021 to 11.23 percent in RY 2022. COVID-19 review flexibilities afforded to states should also be considered in the identified decrease in the CHIP FFS and eligibility components between RY 2021 and RY 2022.

A majority of CHIP improper payments were due to instances where information required for payment was missing, an eligibility determination was missing from the state system, states did not follow the appropriate process for enrolling providers, and/or states did not follow the appropriate process for determining beneficiary eligibility. However, these payments do not necessarily represent payments to illegitimate providers or on behalf of ineligible beneficiaries. If the missing information had been on the claim and/or the state had complied with the enrollment or redetermination requirements, then the claims may have been payable. Conversely, if the missing documentation had been available, it could have affirmatively indicated whether a provider or beneficiary was ineligible for CHIP reimbursement and, therefore, the payment was improper.

Figure 14 below provides a breakdown of CHIP's payment error types. The improper payments include those with provider not enrolled, beneficiary ineligible for program or service, incorrect coding, and other errors like claims processing errors, duplicate claims, or pricing mistakes. The insufficient documentation errors include claims where information was missing, or states did not follow appropriate processes to determine if a payment was proper or improper.

Figure 14: RY 2022 CHIP Estimated Improper Payments by Error Types[1] (Dollar Amounts in Millions)



[1] The total CHIP improper payments in Figure 14 are greater than the improper payment totals displayed in Table 1 because improper payments in this figure can be categorized in more than one payment error type. In addition, figure may not equal or add up precisely to other tables in this document due to rounding.

CHIP Mitigation Strategies and Corrective Actions

Since CHIP is a federal-state partnership, HHS works closely with all states to develop mitigation strategies and corrective actions that focus on major causes of improper payments in CHIP. Many of the actions that states implement to address Medicaid improper payments, as described in Section 8.4: *Medicaid*, also apply to CHIP.

8.6 APTC

APTC Statistical Sampling Process

Federally-facilitated Exchange: HHS reviews a statistically valid random sample of health insurance applications to determine if the Federally-facilitated Exchange properly paid APTC benefits under the statutory and regulatory requirements relating to eligibility and payment determinations.[36] **Figure 15** below depicts the sampling process.

Figure 15: APTC Sampling Process

HHS used a statistically valid random sample of 2,000 health insurance applications. The improper payment rate and amounts estimated from this sample reflect all health insurance applications with APTC payments processed by the Federally-facilitated Exchange for Calendar Year 2020. A federal contractor conducts a detailed review of health insurance applications, which obtains consumer application information and Exchange data, and forms an independent expectation of an application's outcomes based on applicable regulatory requirements. The federal

[36] Relevant regulatory requirements are generally contained within 45 Code of Federal Regulations (CFR) 155.

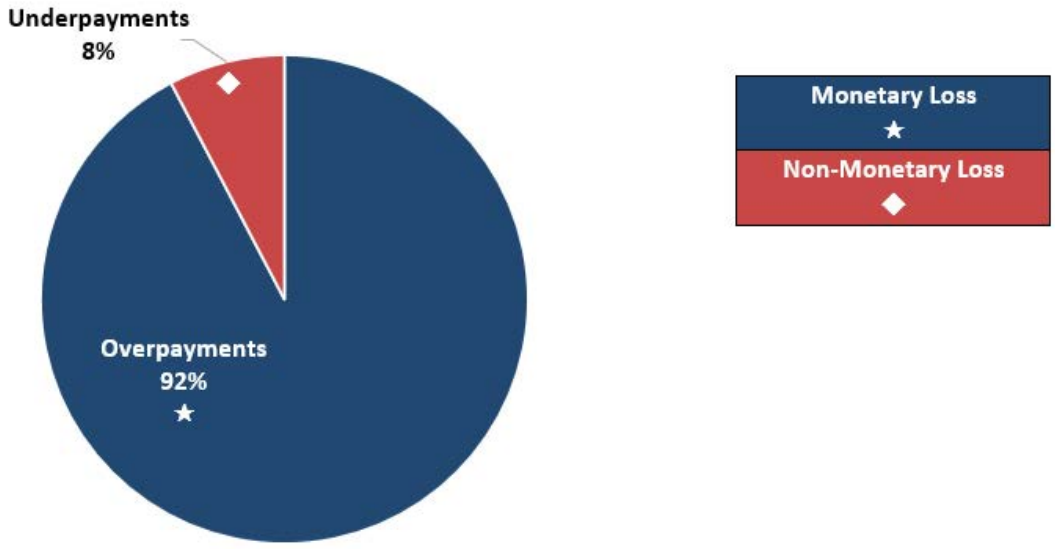
contractor then compares its expectation of the application outcomes, for example eligibility determinations and determinations of payment amounts, to the actual outcomes reached by the Federally-facilitated Exchange to determine the extent to which discrepancies represent improper payments.

State-based Exchanges: Certain states do not use the Federally-facilitated Exchange to administer the APTC program, and instead have elected to operate independent State-based Exchanges.[37] For Calendar Year 2020, State-based Exchanges made payments totaling approximately $11.52 billion, or 21.84 percent of total APTC payments made. The improper payment rate and amounts estimated herein do not reflect APTC payments made by State-based Exchanges. HHS 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 HHS 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.

Calculations and Findings

The Federally-facilitated Exchange properly paid an estimated 99.38 percent of total outlays or $41.00 billion. The improper payment estimate is 0.62 percent of total outlays or $255.76 million. The improper payment estimate due to missing or insufficient documentation is 0.04 percent or $16.82 million, representing 6.58 percent of total improper payments. The improper payments estimate is made up of 92.30 percent of overpayments ($236.07 million) and 7.70 percent of underpayments ($19.69 million). **Figure 16** below provides a breakdown of the APTC improper payment estimate by payment categories.

Figure 16: RY 2022 APTC Estimated Improper Payments by Payment Categories[1]



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

[37] For 2020, states not using the Federally-facilitated Exchange include California, Colorado, Connecticut, Idaho, Massachusetts, Maryland, Minnesota, Nevada, New York, Rhode Island, Vermont, and Washington. Additionally, Washington D.C. did not use the Federally-facilitated Exchange.

The APTC payment error type is as follows:

- **Administrative and Process Errors:** The primary cause of overpayments is manual errors associated with determining consumer eligibility for APTC payments (94.30 percent of overpayments, or $222.63 million and 100 percent of underpayments, or $19.69 million). Most health insurance applications have consumer eligibility verified using automated processes. Automated processes refer to those functions which are executed using computer programming, and do not involve manual intervention. Certain eligibility verifications consist of electronically comparing information provided by a consumer to that of third-party databases and inconsistencies exist that may affect a consumer's eligibility. For certain applications, manual eligibility verifications are necessary because of the circumstances of a consumer's application (for example, an application submitted past the open enrollment period due to certain qualifying life events), or because the automated verification process identified a need for additional information to be provided by the consumer to verify their eligibility. Manual verifications involve complex rules and a large variety of documentation types and formats, and therefore have a heightened risk of error. Specifically, the estimated underpayments are associated with manual verifications improperly finding consumers to be ineligible for APTC payments, resulting in less APTC being paid than what would have been paid in the absence of such manual errors.

Combined Improper Payment Information

The APTC program represents the first of two potential[38] payment streams for the overall Premium Tax Credit program. The second payment stream relates to additional Premium Tax Credit amounts claimed by taxpayers at the time of their tax filings, referred to as "Net Premium Tax Credits" (hereafter, "Net PTC"). That is, total Premium Tax Credit outlays / credits are equal to APTC payments plus Net PTC claims. The Internal Revenue Service (IRS) measures improper payments associated with Net PTC claims, and for Calendar Year 2020 reported[39] Net PTC claims of $1.25 billion, improper payments of $342.14 million, and an improper payment rate of 27.43 percent. The combined APTC and Net PTC improper payment estimate is $597.90 million out of $42.50 billion total Premium Tax Credit outlays / claims, or 1.41 percent. Note that similarly to the APTC improper payment information provided above, this combined APTC and Net PTC improper payment information does not reflect payments made by State-based Exchanges.

APTC Mitigation Strategies and Corrective Actions

HHS addresses improper payments in APTC through the following mitigation strategies and corrective actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Automation	• **Systems Automation:** Some errors relate to the actual generation of APTC payments and others relate to the application of policies or procedures to the automated processes associated with APTC. HHS's corrective actions include identifying and remediating system defects within the Exchanges that may impact APTC payments. These defects become known through various mechanisms, including internal quality control activities and external reviews of APTC eligibility determinations made by the Exchanges. HHS continually evaluates the policies and procedures that underlie the automated processes associated with APTC to identify and address weaknesses that may surface as they become operationalized. HHS implemented process automation to reduce human error introduced during

[38] Taxpayers may elect not to benefit from APTC payments, and instead may claim the entirety of the Premium Tax Credit at the time of tax filing.
[39] Please also see the Fiscal Year 2022 U.S. Department of the Treasury's Agency Financial Report for more information.

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
	adjudication and processing of supporting documentation. HHS will continue to encourage and require that additional tasks be automated to further reduce manual errors and improve the accuracy and quality of required adjudication tasks.
Training	• **Eligibility Support Contractor Education:** All personnel undergo a rigorous training when onboarded to the workforce. They also receive annual refreshers and quick training lessons when program policy or operations are updated. Ad hoc training is added as additional training needs are identified. HHS conducted additional training sessions related to Data Matching Issues verifications, casework, and outreach.
Audits	• **Internal and External Controls:** Both the automated and the manual processes of the Exchanges are subject to rigorous annual testing of key internal controls as required by Appendix C of OMB Circular A-123. External audits by OIG and GAO are another common mechanism that help to identify potential payment integrity risks within the Exchanges, specifically by evaluating APTC eligibility determinations made by the Exchanges within the context of federal statute and regulations.
Predictive Analytics	• **Agent/Broker Risk Model:** The Marketplace Program Integrity Contractor has implemented a risk model, which incorporates many risk factors that may be indicative of potential fraud or misconduct by agents or brokers. The result is a risk profile and weighted risk score for each agent or broker. Those that pose the highest risk, based on weighted risk score, are prioritized for investigations. The risk profile is also leveraged as part of a prioritized investigation and significant discoveries may be used to inform interview questions or as supporting evidence in overall case findings.

8.7 PRF

PRF Statistical Sampling Process

In FY 2021, HHS conducted an improper payment risk assessment and identified PRF as susceptible to significant improper payments. HHS developed a Sampling and Estimation Methodology Plan for PRF in accordance with Appendix C of OMB Circular A-123, the PRF Program Audit Strategy Manual, which outlines the audit evaluation criteria and associated detailed protocols, and the PRF Distribution Program Terms and Conditions. Procedures performed include developing definitions, identifying root causes, and corresponding payment cycle risk points and assessing controls, policies, and procedures.

HHS used a stratified random sampling methodology to select a statistically valid and rigorous sample from the disbursement population for PRF paid within the 12-month period of March 27, 2020 through March 26, 2021. HHS stratified the population by a combination of risk score wave and payment amount HHS first assigned a risk score wave to each disbursement in the population in terms of likelihood of containing payment errors. Waves were defined in the population by low, medium, and high risk.

HHS then stratified all payments within each wave by payment amount and defined a census stratum within each wave, containing large payment amounts. HHS selected a random sample of PRF disbursements from each stratum for testing and extrapolated the improper and unknown payment results.

Calculations and Findings

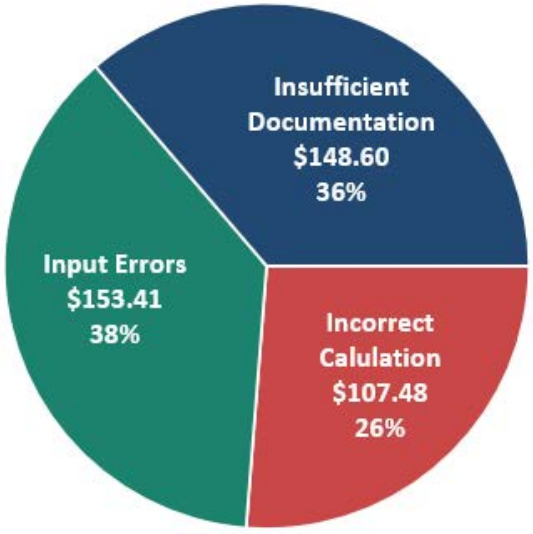
HHS properly paid an estimated 99.68 percent of total outlays or $126.01 billion. HHS's improper payment estimate is 0.32 percent of total outlays or $0.41 billion.

The PRF payment error types are as follows:

- **Input Errors:** The improper payment estimate due to input errors (an incorrect payment calculation was used due to an input error) is 0.12 percent or $153.41 million, representing 37 percent of total improper payments.
- **Insufficient Documentation:** The improper payment estimate due insufficient documentation (the revenue listed on the application was not supported by documentation provided) is 0.12 percent or $148.60 million, representing 36 percent of total improper payments.
- **Incorrect Calculation:** The improper payment estimate due to incorrect calculation (an incorrect ratio or variable was used when calculating payments) is 0.08 percent or $107.48 million, representing 26 percent of total improper payments).

Figure 17 below provides a breakdown of the PRF estimated payment error types.

Figure 17: RY 2022 PRF Estimated Payment Error Types[1] (Dollar Amounts in Millions)



[1] Figure may not equal 100 percent or add up precisely to other tables in this document due to rounding.

PRF Mitigation Strategies and Corrective Actions

HHS addresses improper payments in PRF through the following mitigation strategies and corrective actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Automation	• **Robotic Process Automation:** HHS leverages robotic process automation to strengthen program integrity in the post-payment review of PRF applications by significantly reducing the data set of PRF recipients manually reviewed; improving efficiency, accuracy, and quality by reducing human errors; identifying improper payments through continued systematic internal controls.

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Payment Disbursement Training:** HHS provides training to personnel on conducting audits and other reviews as part of the payment disbursement process. Trainings include reviewing federal laws and internal policies.
Internal Process or Policy Change	• **Process Improvement:** HHS developed standardized practices for calculating payments and deductions, including leveraging pay files, systems, validating recipients for application-based payments, and exploratory analysis for determining and authenticating recipients' payment history. • **Pre-Payment Controls:** HHS implemented a pre-payment control, such as manually validating high-dollar payments and additional peer reviewers, to aid in identifying and correcting errors before payment disbursement.
Cross Enterprise Sharing	• **Post-Pay Review:** HHS improved records management to account for changes in methodology for future payments and address issues identified in post-pay review process.
Audits	• **Provider Reporting and Audits:** Recipients, as part of their agreement to the terms and conditions specific to receipt of funds, agree to fully cooperate in all audits that HHS, HHS OIG, or the Pandemic Response Accountability Committee conduct. In addition, PRF recipients are required to adhere to the audit requirements in 45 CFR 75 Subpart F.
Predictive Analytics	• **Anomaly Detection:** HHS uses a system that flags anomalies for further analytical review and investigation to correct potential error, such as payment denial, or modify documentation to explain why the anomaly is not an error.

8.8 TANF

TANF Statistical Sampling Process

Statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement. As a result, the TANF program is not reporting an estimate.

TANF Mitigation Strategies and Corrective Actions

Since TANF is a state-administered program, mitigation strategies and corrective actions to reduce improper payments are implemented at the state level. HHS does not have the authority to require states participation in a TANF measurement and is unable to collect the required information to implement and report on mitigation strategies and corrective actions. Despite limitations, HHS used a multi-faceted approach to improving TANF program integrity and reducing the likelihood of improper payments through the following actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Comprehensive Needs Assessment:** In FY 2019, HHS conducted a comprehensive needs assessment of all TANF states, territories, and the District of Columbia, including information about payment integrity efforts. The assessment showed that over 90 percent of state respondents are using at least one of the HHS-recommended strategies to minimize initial errors and at least one of the HHS-

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
	recommended strategies to identify and correct existing errors. These strategies included: ○ Training staff to solicit accurate and complete information; ○ Using integrated databases from multiple assistance programs; and ○ Performing quality control checks.
Internal Process or Policy Change	• **Risk Assessment:** HHS completed a TANF improper payment risk assessment to identify additional areas for risk mitigation.
Cross Enterprise Sharing	• **Data Sources:** The Public Assistance Reporting Information System, the National Directory of New Hires, and the Income and Eligibility Verification System are databases States may access to minimize improper payments.

8.9 FOSTER CARE

Foster Care Statistical Sampling Process

In response to COVID-19, HHS postponed Title IV-E reviews to protect the health and safety of state and federal reviewers and to ensure that state child welfare officials remain focused on mission-critical activities serving children and families. Because Title IV-E reviews (which occur onsite) provide the data normally used to calculate improper payment estimates, the postponement of reviews resulted in HHS having no new data. Therefore, HHS is not reporting an improper payment estimate. HHS has determined that when reviews resume, the program will use the same methodology. Given the passage of time, the program expects to re-establish the baseline for Foster Care's improper payment measurement once reviews resume and all states are included in the new cycle. To prepare for the resumption of reviews, HHS worked to modify the Title IV-E review instrument and instructions to reflect the changes to the aspects of eligibility by the *Family First Prevention Services Act*,[40] primarily relating to placements of children in child care institutions or congregate care.

Foster Care Mitigation Strategies and Corrective Actions

Since Foster Care is a state-administered program, mitigation strategies and corrective actions to reduce improper payments are implemented at the state level. HHS designs mitigation strategies and corrective actions to help states address errors that contribute most to Title IV-E improper payments. All improper payments are due to incorrect case classification and payment processing by state agencies. Information on the most recent root causes and leading payment error types can be found in the FY 2020 AFR. Despite pausing the Title IV-E reviews, HHS continued other program integrity efforts and relied on previous data and experiences to update the following mitigation strategies and corrective actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Program Improvement Support:** HHS assisted states in developing and implementing program improvements. This assistance helps states expand organizational capacity and promote more effective program operations.

[40] The *Family First Prevention Services Act*, enacted as *Title VII of the Bipartisan Budget Act of 2018*, changed the federal statutory requirements for staff safety checks at childcare institutions. All states become subject to all new restrictions effective October 1, 2021.

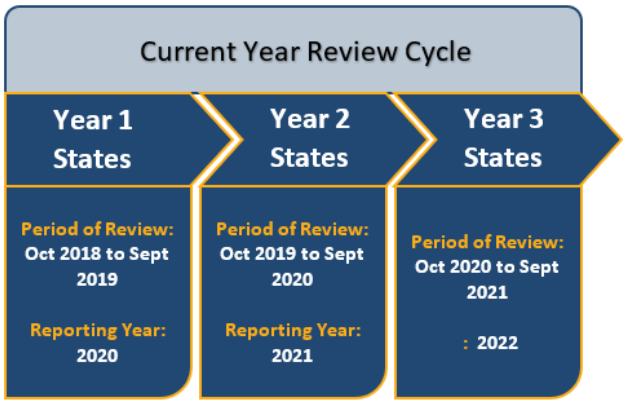
Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
	• **Tribal Technical Assistance:** HHS provided technical assistance on Title IV-E eligibility issues to tribes operating or planning to operate the Title IV-E foster care program, many of whom have limited previous experience in matters relating to Title IV-E eligibility determinations.
Internal Process or Policy Change	• **Outreach Regarding Changes in Federal Requirements:** HHS reviewed state policy documentation and responded to questions relating to program eligibility. These exchanges with states allowed HHS to explain Title IV-E requirements, clarify documentation requirements, and assist states' understanding of complex policy` concepts and eligibility determination for foster care maintenance payments.
Cross Enterprise Sharing	• **Emphasize Quality Improvement:** HHS engaged state Title IV-E Foster Care agencies to enhance understanding of program compliance requirements and to share successful strategies among states. • States have the option to receive federal financial participation to develop and implement a Comprehensive Child Welfare Information System in accordance with federal regulations at 45 CFR 1355.50 through 1355.59.
Audits	• **Claims Reviews:** HHS's Office of Grants Management (OGM) and the Children's Bureau reviewed Title IV-E quarterly claims submitted by states and addressed claiming errors and anomalies on an ongoing basis.

8.10 CCDF

CCDF Statistical Sampling Process

The CCDF improper payments methodology uses case-record review to determine if childcare subsidies were paid properly for services provided to eligible families. All states, the District of Columbia, and Puerto Rico (hereafter referred to as "states") are split into three cohorts and conduct the improper payment rate review once every 3 years (as shown in **Figure 18**).

Figure 18: CCDF Improper Payment Rate Review Cycle and Reporting Year



In addition to federal rules, states have varying requirements for establishing and verifying eligibility. The methodology enables states to determine error types and their sources to reflect policies and procedures unique to each state. For CCDF's improper payments methodology, see Improper Payments Error Rate Review Process.

The current methodology incorporates the following: (1) drawing a statistical sample from a universe of paid cases; (2) measuring improper payments; and (3) requiring states with improper payment estimates exceeding 10 percent to submit a corrective action plan.

While COVID-19 continued to impact state improper payment reviews, and many Year Three states experienced challenges such as staffing shortages, limited access to files, and a need to conduct reviews remotely, all Year Three states completed the full sample of 276 case reviews.

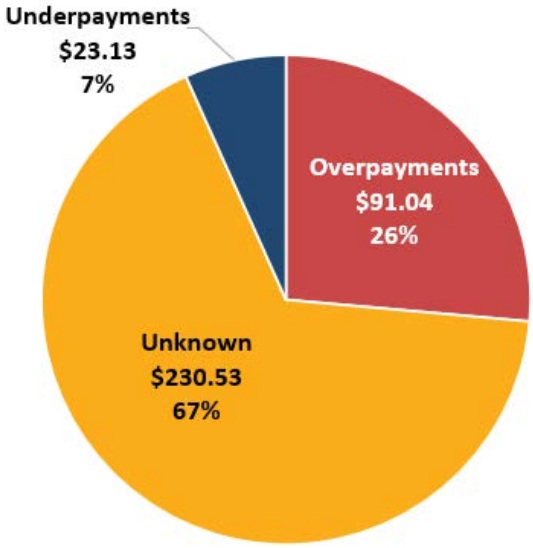
Calculations and Findings

The CCDF improper plus unknown payment estimate is 3.96 percent or $344.70 million. HHS attributes the decrease, from 4.36 percent in RY 2021 to 3.96 percent in RY 2022, to HHS's successful multi-pronged approach to supporting states as they continue to comply with the CCDF reauthorization and related regulations. For example, HHS provided technical assistance while also allowing needed flexibility due to the unprecedented circumstances of COVID-19.

The HHS Payment Integrity Report data reflects only what CCDF refers to as payment errors—that is, errors that create a monetary discrepancy between the subsidy amount as determined by the reviewer and the sample month payment amount. A payment error example may include a missing paystub if non-receipt of a paystub results in a monetary discrepancy. CCDF further classifies its payment errors as (1) administrative errors, corresponding to what this report terms "improper payments," and (2) errors caused by missing or insufficient documentation, corresponding to what this report terms "unknown payments."

Figure 19 shows that unknown payments were considerably larger (at about 66.88 percent of total improper plus unknown payments or $230.53 million) than improper payments (the sum of overpayments, at about 26.41 percent or $91.04 million, and underpayments, at about 6.71 percent or $23.13 million).

Figure 19: RY 2022 CCDF Payment Categories[1] (Dollar Amounts in Millions)

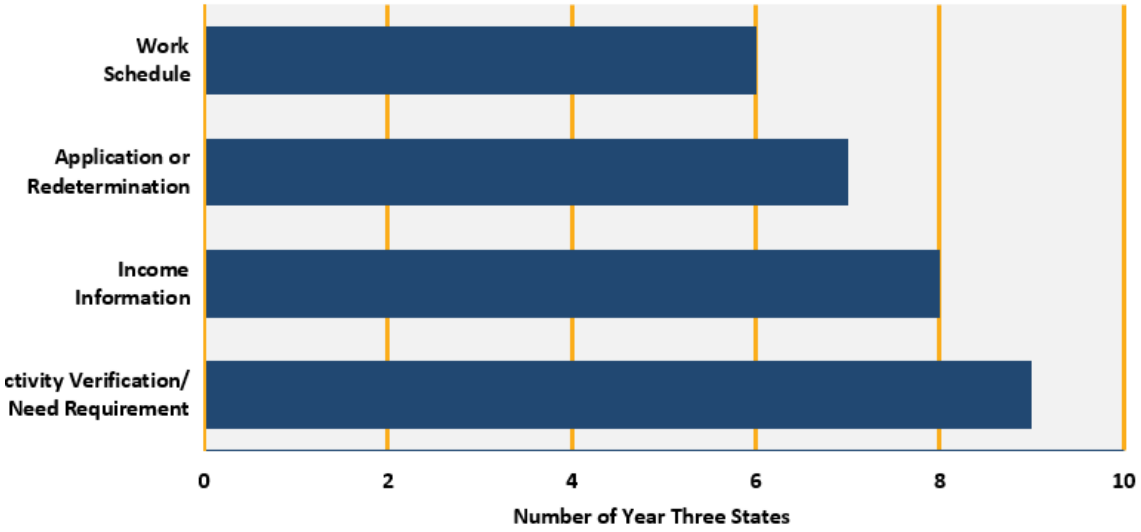


[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

Missing or insufficient documentation (66.88 percent or $230.53 million) and administrative errors made by a state or local agency (33.12 percent or $114.17 million; $91.04 million overpayments and $23.13 million underpayments) drive CCDF improper and unknown payments.

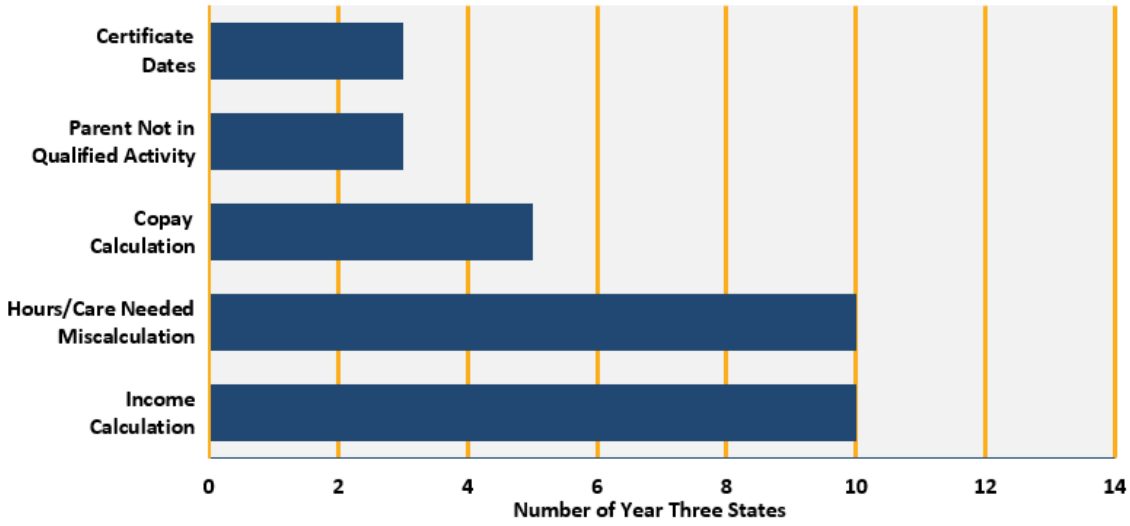
Missing or insufficient documentation errors accounted for an estimated 41.83 percent of number of payment errors identified in the CCDF review process. Errors were primarily due to missing or insufficient documentation in the case record. **Figure 20** presents the most frequently cited errors.

Figure 20: Most Frequently Cited Errors Due to Missing or Insufficient Documentation for CCDF



Administrative errors represent approximately 58.17 percent of number of errors noted in the Year Three reviews. These errors consist of the failure to apply policy correctly, as shown in **Figure 21**.

Figure 21: Most Frequently Cited Errors Due to Administrative Errors for CCDF



CCDF Mitigation Strategies and Corrective Actions

Since CCDF is a state-administered program, mitigation strategies and corrective actions to reduce improper payments are implemented at the state level. HHS supports states in establishing mitigation strategies and corrective actions. States must report on the causes of errors identified in the prior and current review cycle and actions that will be taken to correct those causes. Year Three states plan to implement new information systems and automation to enhance data quality and fix system errors; conduct reviews and audits to monitor for compliance

with CCDF regulations; create new tools or eligibility processes; update policies and procedures; implement eligibility worker performance evaluations; meet with eligibility agencies to discuss errors; and provide guidance, training, and technical assistance to eligibility staff.

HHS addresses improper payments in CCDF through the following mitigation strategies and corrective actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• Conducted site visits with states needing assistance to address root causes. • Provided states with technical assistance on policy and procedure changes to meet new CCDBG requirements. • Funded the Office of Child Care's National Center on Subsidy Innovation and Accountability to provide technical assistance to states and territories on program integrity and accountability, including targeting technical assistance to states to support reauthorization requirements. • Delivered technical assistance to states updating or developing IT systems that will improve practices and reduce errors. • Provided improper payments methodology training on how to conduct error rate reviews, which also allow states to share best practices with each other on conducting the reviews. • Conducted Joint Case Reviews with all reporting states and included state and federal staff. Through these efforts, HHS gained insight into the error measurement methodology implementation and provided technical assistance to states to ensure consistent reviews.

8.11 HEAD START DISASTER RELIEF

Head Start Disaster Relief Statistical Sampling Process

HHS received $650 million in Disaster Relief Act funds to assist Head Start and Early Head Start grantees to support program response, recovery, and other activities directly related to Hurricanes Harvey, Irma, and Maria. Of the $650 million provided to Head Start, $12.5 million was available for federal administrative expenses. Head Start and Early Head Start grantees can use the remaining $637.5 million in the following six categories: 1) Facilities (repairs, renovations, purchase, and construction); 2) Materials, Supplies, and Equipment; 3) Program Operations; 4) Additional Health, Mental Health, Dental, and Nutrition Services; 5) Training and Technical Assistance; and 6) Disaster Recovery Expenses Incurred Prior to Availability of Funds under the Disaster Relief Act.

HHS required all Disaster Relief Act funds recipients to submit reconciliations of payments made by grantees. HHS then used these reconciliations for statistical sampling and estimation of improper payments. HHS designed a stratified sampling plan; the stratification reflects HHS disaster recovery funds recent oversight experience (e.g., from Superstorm Sandy) and breaks the population into subgroups to allow higher likelihood of sampling high-dollar transactions where larger improper payments may reside and therefore have a higher priority for detection:

- The High Stratum (Stratum 3) consists of the largest dollar transactions, accounting for approximately one-third of all outlays for the FY being monitored. Because this stratum contains the largest payments and represents approximately the same level of aggregate outlays as the other strata, it consists of the fewest number of transactions.
- The Middle Stratum (Stratum 2) consists of the mid-tier transactions, between those in the High and Low Strata: these payments also represent approximately one-third of outlays.

- The Low Stratum (Stratum 1) consists of the lowest dollar transactions, also accounting for approximately one-third of all outlays for the FY being monitored. Because this stratum contains the smallest payments yet represents the same level of outlays as the other strata, it has the highest number of transactions.

HHS reviewed the sampled payments from all strata to determine whether the items were supported by adequate documentation, and then HHS used a statistically valid formula to calculate an improper payment estimate for total disaster relief funding.

Calculations and Findings

The Head Start Disaster Relief improper payment plus unknown payment estimate is 0.22 percent or $0.15 million.

The one payment error in the Head Start Disaster Relief program sample was due to administrative errors made by a third party (grant recipient). Specifically, the cause of the one improper payment was a grantee purchased an item that was never received.

Head Start Disaster Relief Mitigation Strategies and Corrective Actions

HHS addresses improper payments in Head Start Disaster Relief through the following mitigation strategies and corrective actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• HHS provided training in areas needed such as procurement, source documentation, cost allocation, and any other areas identified by subject matter experts as common areas of fiscal challenge in the program.

9.0 RECOVERY AUDITING REPORTING

HHS has a risk-based strategy to implement PIIA's recovery auditing provisions. Specifically, HHS focuses on implementing recovery audit programs in Medicare and providing a framework for states to implement recovery audit programs in Medicaid, which together account for most of HHS's outlays. HHS is progressing in recovering overpayments in Medicare and Medicaid and, most importantly, implementing corrective actions to prevent improper payments, as described in Section 8.0*: Program-Specific Reporting Information* and the following subsections. HHS considers lessons learned from these experiences as it implements this requirement.

Medicare FFS RACs

Section 1893(h) of the Act requires the establishment of a nationwide Medicare FFS Recovery Audit Program conducted by Recovery Audit Contractors. The mission of the Medicare FFS Recovery Audit Program is to identify and correct overpayments made on claims for healthcare items and services provided to beneficiaries, to identify and correct underpayments to providers, and to provide information that allows HHS to implement corrective actions that will prevent future improper payments. HHS has multiple RACs that review post-payment Medicare FFS claims in defined geographic regions.[41] As required by Section 1893(h), RACs are paid on a contingency fee basis.

The Medicare FFS RAC program identified approximately $583.06 million in overpayments and recovered $464.74 million. Outpatient claims represented the majority of Medicare FFS RAC collections. Medicare FFS RACs made

[41] One Medicare FFS RAC reviews national DME, home health, and hospice claims, and four Medicare FFS RACs review other types of claims in four geographic regions.

recommendations to HHS to improve program operations and prevent improper payments. These recommendations resulted in proposed RAC topics for review.

HHS also uses Medicare FFS RAC findings to prevent future improper payments. For example, HHS released Provider Compliance Newsletters with detailed information on one finding identified by the Medicare FFS RACs. HHS used these findings to implement local and/or national system edits to prevent improper payments. More information can be found at the Medicare FFS RAC program website.

Medicare Secondary Payer (MSP) RACs

The MSP RAC, also known as the MSP Commercial Repayment Center (CRC), is a single contractor with national jurisdiction. The CRC reviews HHS collected information regarding beneficiaries that had or have primary coverage through an employer-sponsored Group Health Plan (GHP) and situations where a Non-Group Health Plan (e.g., Workers' Compensation entity or No-Fault insurer) has or had primary payment responsibility. When GHP information is incomplete, Medicare FFS may mistakenly pay for services as the primary payer. The CRC recovers these payments from the entity that had primary payment responsibility (typically the employer or other plan sponsor, insurer, or claims processing administrator). At the end of FY 2016, the CRC began recovering certain conditional payments made by Medicare FFS until HHS identifies a Non-Group Health Plan with primary payment responsibility.

CRC identified approximately $441.71 million and collected $298.94 million in mistaken payments. The MSP RAC recommended HHS improve program operations by:

- Implementing a new electronic payment process that allows debtors to make direct payment using the Automated Clearing House network, thereby supporting faster recovery and reducing efforts associated with paper checks;
- Improving the MSP GHP recovery portal to allow users to electronically defend GHP cases at the line level instead of submitting paper documentation to the CRC via U.S. Mail and Fax; and
- Improving the MSP recovery portals and case management system to allow users to have access to real-time updates on account receivables.

Medicare Part C and Part D RACs

Section 1893(h) of the Act expanded the RAC program to Medicare Part C and Part D. HHS has taken many actions over the years to implement the Medicare Part C and Part D RAC requirement. These steps are discussed on page 243 of HHS's FY 2021 AFR.

Despite their success in Medicare FFS, RACs have found Medicare Part C to not represent an appealing business case for them because of differing payment structures, a narrow scope of payment error, and unlimited appeal timeframes. Because HHS did not procure a Part C RAC, HHS's primary corrective action on Part C payment error is the contract-level RADV audits. The RADV program is operational with the support of contractors. Given the purpose of RADV audits, HHS believes that the RADV audit program performs Part C RAC functions.

Similar to the Part C RAC, HHS believes that the PPI-MEDIC performs the Part D RAC functions. The PPI-MEDIC's workload is substantially like that of a Part D RAC and has a robust program to identify improper payments. The PPI-MEDIC continued audits that identified potential improper payments and conducted education and outreach for Part D plan sponsors. As stated in Section 5.1: *Payment Integrity Efforts*, based on the PPI MEDIC's data analysis projects and Part D plan sponsor self-audits, HHS recovered $640,833 from Part D sponsors.

State Medicaid RACs

Section 1902(a)(42)(B) of the Act required states to implement Medicaid RAC programs. However, federal law allows states to request an exemption from the Medicaid RAC requirements, and many states operated under an approved exemption (for example, because of the high proportion of beneficiaries enrolled in Medicaid managed care compared to FFS). State Medicaid RAC federal-share recoveries totaled $83.72 million and reflect overpayments collected, adjusted, or refunded to HHS, as reported by states on the Form CMS-64, Medicaid Statement of Expenditures.[42]

Recovery Auditing Reporting Table

Table 3 provides information on HHS's recovery auditing programs and other efforts to recover improper payments.

[42] This amount may differ from the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the AFR is prepared prior to the finalization of state reporting.

Table 3: Overpayments Recovered through and Outside of Recovery Audits

FY 2022 (in Millions)

Program or Activity	Overpayments Recovered through Recovery Audits			Overpayments Recovered Outside of Recovery Audits	
	Amount Identified	Amount Recovered [1]	Recovery Rate	Amount Identified	Amount Recovered [1]
CMS Error Rate Measurements [2]				$25.19	$16.98
Medicare FFS Recovery Auditors	$583.06	$464.74	80%		
Medicare Secondary Payer Recovery Auditor	$441.71	$298.94	68%		
Medicare Contractors [3]				$17,734.17	$12,141.44
Medicaid Integrity Contractors - Federal Share [4]				$37.73	$12.73
State Medicaid Recovery Auditors - Federal Share [5]	N/A	$83.72	N/A		
ACF IP Rate Measurements and Eligibility Reviews [6]				$0.26	$0.14
ACF OIG Reviews [7]				$12.68	$0.31
ACF Single Audits [8]				$6.54	$10.82
Single Audits [9]				$361.80	$41.57
HRSA National Health Service Corps				$9.04	$6.09
TOTAL [10]	**$1,024.77**	**$847.40**	**83%**	**$18,187.41**	**$12,230.08**

Notes:

1. The amount reported in the Amount Recovered column is the amount recovered in FY 2022, regardless of the year HHS identified the overpayment.
2. The CMS Error Rate Measurements row includes recoveries from Medicare FFS (via the Comprehensive Error Rate Testing program), as well as Medicaid and CHIP (via the Payment Error Rate Measurement program). The actual overpayments identified by the Comprehensive Error Rate Testing program during the FY 2022 report period were $24,004,089.28. The MACs recovered the identified overpayments via standard payment recovery methods. As of the report publication date, MACs reported collecting $15,552,853.67 or 64.79 percent of the actual overpayment dollars. For Medicaid and CHIP, HHS works closely with states to recover overpayments identified from the FFS and managed care claims sampled and reviewed. The Act and related regulations govern the recoveries of Medicaid and CHIP improper payments. States reimburse HHS for the federal share of overpayments. Section 1903(d) of the Act allows states up to 1 year from the date of discovery of an overpayment for Medicaid and CHIP services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the federal share of the overpayment. The actual overpayments identified by the Payment Error Rate Measurement program during the FY 2022 report period were $946,460.62 for Medicaid and $242,650.28 for CHIP. HHS recovered $1,012,033 for Medicaid and $411,163 for CHIP. The amounts recovered were for overpayments identified in prior report periods and, therefore, do not represent a proportion recovered from the identified overpayment amount for this report period. This row does not include sample overpayments identified or recovered via the measurement of the Medicare Part C, Medicare Part D, or Federally-facilitated Exchange of the APTC program.
3. Total reflects amounts reported by Medicare FFS Contractors excluding amounts reported for the Medicare FFS Recovery Auditors program and Medicare FFS Error Rate Measurement program, which HHS reports separately in this table.
4. Medicaid Integrity Contractors identified total overpayments that include both federal and state shares. However, HHS reports only the federal share across audits. The amount recovered may differ from that which is reported in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the Agency Financial Report is prepared prior to the finalization of state reporting.
5. For the State Medicaid Recovery Auditors - Federal Share row, only the amount recovered is available. The amount recovered may differ from that which is reported in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the Agency Financial Report is prepared prior to the finalization of state reporting.
6. The ACF Improper Payment Rate Measurements and Eligibility Reviews row contains Amount Identified information for the Foster Care, CCDF, and Head Start Disaster Relief programs for which the amounts were identified during the current reporting year. Since HHS postponed Foster Care reviews in FY 2022, no new reviews have taken place and consequently no overpayments have been recovered. For CCDF, states must recover childcare payments resulting from fraud and have discretion as to whether to recover misspent funds that were not the result of fraud, such as in cases of administrative error identified in the improper payments review. For the CCDF portion of the Amount Identified and Amount Recovered information, data reported in FY 2022 represent improper payments recovered in FYs 2019 through 2021 by the Year Three states based on improper payments identified in FY 2019. States reported identifying $135,557 and recovering $20,903. For the Head Start Disaster Relief portion, HHS identified and recovered $123,000 in improper payments during the FY 2022 report period.
7. The ACF OIG Reviews row, column Amount Identified includes information for all ACF programs for which the amounts from an HHS OIG Report were sustained from August 2021 to July 2022.
8. The ACF Single Audits row represents results from August 1, 2021 to July 31, 2022.
9. The Single Audits row includes information for all Divisions except ACF and represents results for the full FY 2022.
10. Totals do not necessarily equal the sum of the rounded components.

FY 2022 Top Management and Performance Challenges Identified By the Office of Inspector General

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

DATE: November 1, 2022

TO: Xavier Becerra, Secretary

THROUGH: Elizabeth J. Gramling, Executive Secretary

FROM: Christi A. Grimm, Inspector General

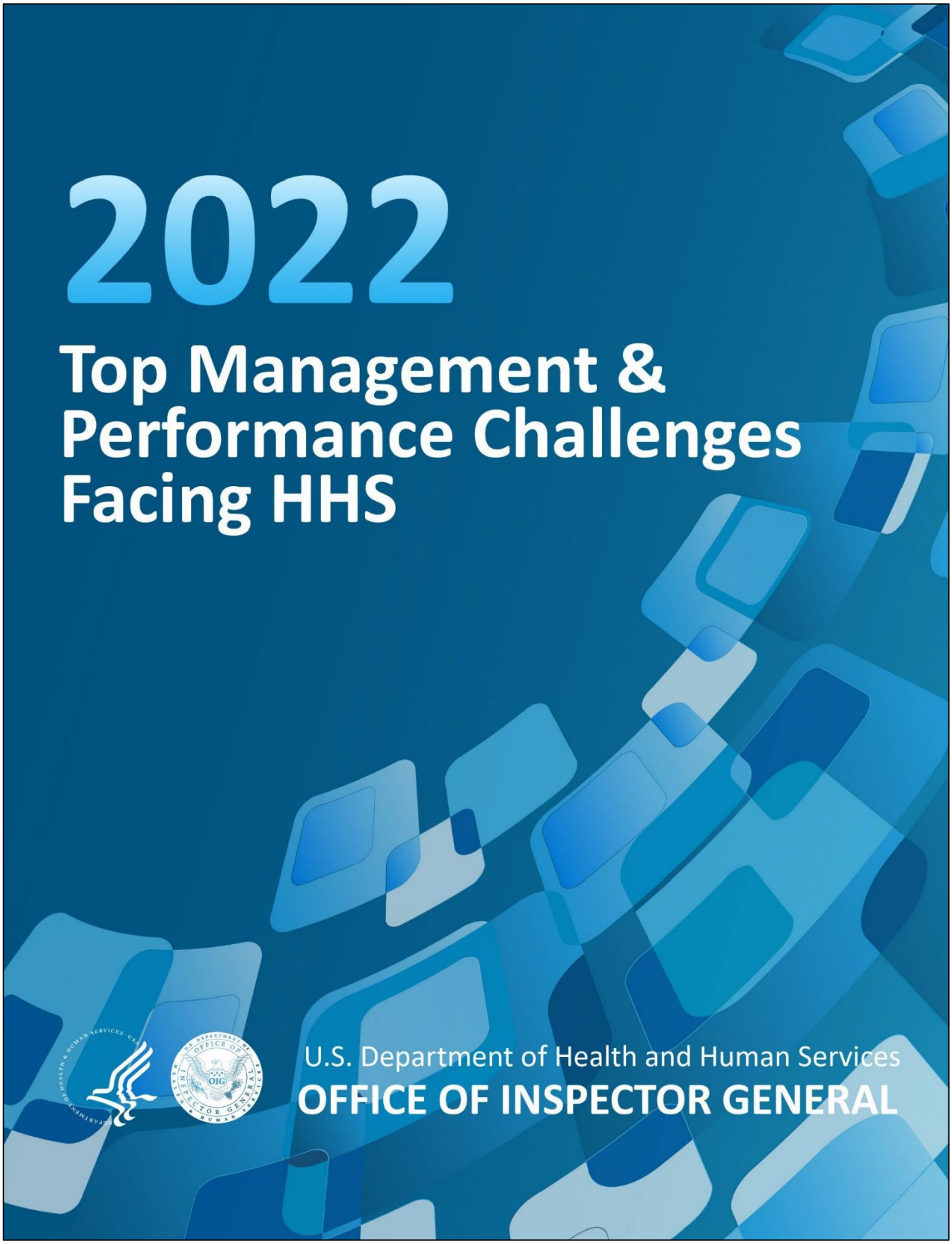
SUBJECT: Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2022

This memorandum transmits the Office of Inspector General's (OIG's) list of top management and performance challenges facing the Department of Health and Human Services (HHS or the Department). The Reports Consolidation Act of 2000, P.L. No. 106-531, requires OIG to identify these management challenges, assess the Department's progress in addressing each challenge, and submit this statement to the Department annually.

HHS's top management and performance challenges for fiscal year 2022 are:

1. Safeguarding Public Health
2. Ensuring the Financial Integrity of HHS Programs
3. Delivering Value, Quality, and Improved Outcomes in CMS Programs
4. Safeguarding the Well-Being of HHS Beneficiaries
5. Harnessing and Protecting Data and Technology to Improve the Health and Well-Being of Individuals
6. Strengthening Coordination for Better Programs and Services

OIG looks forward to continuing to work with the Department to identify and implement strategies to protect the integrity of the Department's programs and the well-being of the people enrolled in these programs. If you have any questions or comments, please contact me, or your staff may contact Juliet Hodgkins, Acting Chief of Staff, at (202) 708-9797 or Juliet.Hodgkins@oig.hhs.gov.


2022
Top Management & Performance Challenges Facing HHS
U.S. Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

Introduction

The *Top Management and Performance Challenges Facing HHS* is an annual publication of the Department of Health and Human Services (HHS or the Department), Office of Inspector General (OIG). In this edition, OIG has identified six top management and performance challenges (TMCs) that the Department faces as it strives to fulfill its mission to enhance the health and well-being of all Americans.

In selecting these TMCs, OIG considered our oversight, enforcement, data analytics, and risk analysis work, as well as Department information and developments in law and HHS's responsibilities.

The Department continues to face challenges in responding to Public Health Emergencies (PHEs), such as the COVID-19 pandemic and the monkeypox PHE. Challenges related to the Department's COVID-19 and monkeypox responses are primarily addressed in TMCs 1 and 6 on public health. However, responses to PHEs affect nearly every aspect of Department operations, and related challenges are addressed in other TMCs.

Management and performance challenges are inherently crosscutting. Multiple HHS Staff Divisions (StaffDivs) and Operating Divisions (OpDivs) must address these pressing issues. Furthermore, the challenges themselves intersect. For example, the challenge of safeguarding the well-being of people served by HHS programs highlighted in TMC 4 intersects with the challenge of delivering value, quality, and improved outcomes in Medicare and Medicaid, which is the subject of TMC 3. Some priority issues, such as improving nursing home care, raise multiple challenges. Improving nursing home care is primarily addressed in TMC 4 because of serious, persistent quality-of-care vulnerabilities, but elements of this issue appear in other TMCs. Given that challenges cross internal HHS boundaries and externally with Federal and State agencies, coordination among HHS divisions, with Tribal governments, and across the Government sector at all levels is integral to addressing these challenges, as set out in TMC 6.

HIGHLIGHT: Challenge Implementing New Legislation

The Department must efficiently and effectively implement the provisions of new legislation, including most recently the *Bipartisan Safer Communities Act* and the *Inflation Reduction Act of 2022*. This includes ensuring HHS has appropriate resources, data, technologies, and expertise. The Department should consider program integrity when implementing and operating new requirements and expanded programs.

The six TMCs are not the only challenges that confront HHS. OIG reports are a key resource that highlight additional opportunities to improve HHS programs and operations. OIG also maintains a list of significant and unimplemented OIG recommendations, including legislative recommendations, that address vulnerabilities. If implemented, these recommendations would, in OIG's view, positively affect HHS programs in terms of cost savings, program effectiveness and efficiency, and public health and safety.

More information on OIG's work, including the reports mentioned in this publication, appears on our website at https://oig.hhs.gov.


2022
Top Management & Performance Challenges Facing HHS
1
Safeguarding Public Health
2
Ensuring the Financial Integrity of HHS Programs
3
Delivering Value, Quality, and Improved Outcomes in CMS Programs
4
Safeguarding the Well-Being of HHS Beneficiaries
5
Harnessing and Protecting Data and Technology To Improve the Health and Well-Being of Individuals
6
Strengthening Coordination for Better Programs and Services

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Acronyms

ACF	Administration for Children and Families
ADHD	Attention Deficit/Hyperactivity Disorder
AI/AN	American Indian/Alaska Native
AMP	Average Manufacturer Price
API	Application Programming Interface
APTC	Advance Premium Tax Credit
ASP	Average Sales Price
ASPR	Administration for Strategic Preparedness and Response
CCDF	Child Care and Development Fund
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CIO	Chief Information Officer
CMS	Centers for Medicare & Medicaid Services
DHS	Department of Homeland Security
DME	Durable Medical Equipment
EIS	Emergency Intake Sites
EO	Executive Order
EUA	Emergency Use Authorization
FAR	Federal Acquisition Regulation
FDA	Food and Drug Administration
FFE	Federally Facilitated Exchange
FFS	Fee-for-Service
FY	Fiscal Year
GAO	Government Accountability Office
HAC	Hospital Acquired Condition
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IIJA	Infrastructure Investment and Jobs Act
IRA	Inflation Reduction Act
IT	Information Technology
MA	Medicare Advantage
MAO	Medicare Advantage Organization
NIH	National Institutes of Health
OIG	Office of Inspector General
OMB	Office of Management and Budget
OpDiv	Operating Division
ORR	Office of Refugee Resettlement
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PERM	Payment Error Rate Measurement
PHE	Public Health Emergency
PMTA	Premarket Tobacco Product Application
PRF	Provider Relief Fund
REMS	Risk Evaluation and Mitigation Strategy
SAMHSA	Substance Abuse and Mental Health Services Administration
SFC	Sanitation Facilities Construction
SNF	Skilled Nursing Facility
StaffDiv	Staff Division
TANF	Temporary Assistance for Needy Families
TEFCA	Trusted Exchange Framework and Common Agreement
TMC	Top Management and Performance Challenge
T-MSIS	Transformed Medicaid Statistical Information System
UC	Unaccompanied Children
UIP	Uninsured Program

1: Safeguarding Public Health

Key Takeaways

Relevant Agencies

- All HHS

Elements of the Challenge

- Strengthening emergency preparedness and response capabilities
- Providing adequate oversight of FDA-regulated products
- Addressing the mental health and drug overdose crises

Outbreaks of COVID-19 and monkeypox in 2020–22 tested the Department's capacity to safeguard public health. As of October 4, 2022, the United States had reported more than 96.25 million cases of COVID-19, losing more than 1.05 million people to the disease,[1] and had confirmed more than 26,194 cases of monkeypox.[2] In addition to infectious diseases, the United States continues to experience a variety of emergencies that require Federal assistance due to hurricanes, extreme heat, flooding, and wildfires. HHS must be able to foresee and combat major outbreaks and provide public health and medical emergency assistance while effectively operating a range of programs and services that are essential to protecting individuals and communities. This work includes effectively preparing for future emergencies while advancing response capabilities, ensuring that products regulated by the Food and Drug Administration (FDA) are safe and effective, and combating the mental health and drug overdose crises. To operate effective public health programs, the Department must ensure that its OpDivs and StaffDivs coordinate efforts internally as well as with partners at all levels of Government and with other stakeholders. (See TMC 6 for more information on the challenge the Department faces in coordinating with internal and external partners.)

Strengthening emergency preparedness and response capabilities

Public health emergencies can severely strain public health and medical infrastructure as well as lead to serious illness and loss of life. According to the Centers for Disease Control and Prevention (CDC), from 2020 to 2021 life expectancy in the United States declined from 77.0 to 76.1 years—its lowest level since 1996. Declines in life expectancy since 2019 were driven largely by the COVID-19 pandemic.[3] Pandemics such as COVID-19 are so extensive that they impact every aspect of every American's life and alter the fabric of our society, with greater harm inflicted on vulnerable populations, such as those who are marginalized at a pandemic's outset, have been historically disadvantaged, have less access to health care, or are dependent on health and social services, including those who reside in congregate care settings such as nursing homes. There have been pronounced racial and ethnic disparities in COVID-19 infections, hospitalizations, death rates, and vaccination rates.[4] HHS programs must address racial, socioeconomic, geographic, and other types of disparities, and the effects that such disparities have on public health. (See TMCs 3 and 4 for additional information related to equity and health disparities, including in nursing homes.)

HHS has a leading role in preparing for, responding to, and recovering from the adverse health effects of PHEs including those related to infectious disease outbreaks, natural disasters, and chemical, biological, radiological, and nuclear events. HHS is uniquely positioned to provide technical assistance, guidance, funding, and coordination to assist State, Tribal, local, and Territorial leaders to effectively and equitably plan for and respond to emergencies, as well as support sustained recovery and resilience-building efforts. As we look to the future, disasters are becoming more frequent and intense because of climate change, and occurrences of disease outbreaks are projected to increase.[5] Recent experiences—including the spread of COVID-19 and monkeypox, and weather events

such as wildfires, winter storms, and hurricanes—underscore that HHS must be prepared to address multiple emergencies simultaneously with different response needs and challenges.

A key challenge for HHS is having adequate planning and mechanisms in place prior to an emergency so that assets and relief can be deployed efficiently and rapidly to those in need of HHS resources and assistance. This includes planning for controls and strategies to mitigate disaster preparedness and response risk.[6] For instance, a 2021 OIG report looking at CMS's emergency preparedness guidance for hospitals found that CMS's controls were well-designed and implemented, but CMS's authority was insufficient for it to fulfill its responsibility to ensure that accredited hospitals would maintain quality and safety during an emerging infectious disease emergency.[7] OIG is also assessing hospital compliance with CMS's emergency preparedness requirements including preventive measures hospitals are taking to minimize the spread of COVID-19 and monkeypox.[8] Furthermore, OIG continues to conduct multiple reviews of nursing homes' infection prevention and emergency preparedness. Nursing homes have been acutely challenged in the face of both infectious disease and natural disaster emergencies. OIG recently excluded seven Louisiana nursing homes and their owner from participating in Federal health care programs; the homes evacuated residents to a warehouse where they suffered inhumane and squalid conditions, and seven residents died.[9] (See TMC 4 for more information related to nursing homes.)

In addition, an effective emergency response requires a prepared public health workforce. The *American Rescue Plan Act of 2021* provided HHS with additional funds including $7.6 billion to establish, expand, and sustain the public health workforce.[10] HHS must use these resources effectively to support the public health workforce and build the capacity for addressing current and future emergencies.

For infectious disease emergencies, multiple HHS divisions play critical roles in identifying, acquiring, developing, distributing, and administering medical countermeasures including vaccines, therapeutics, and diagnostics. Playing particularly critical roles among HHS's divisions are the CDC, Administration for Strategic Preparedness and Response (ASPR),[11] National Institutes of Health (NIH), Office of Global Affairs, and FDA. For example, CDC is responsible for understanding outbreaks and implementing appropriate, equitable, and immediate early interventions and prevention strategies. FDA may use its Emergency Use Authorization (EUA) authority and accelerated approval pathways to facilitate the availability of medical countermeasures during PHEs, as it did for COVID-19 diagnostics, vaccines, and therapeutics.

HHS and its divisions have been subjected to public criticism for their handling of recent emergencies. In January 2022, the Government Accountability Office (GAO) identified HHS's leadership and coordination of PHEs as at high risk due to persistent deficiencies in HHS's leadership role in preparing for and responding to PHEs.[12] (See TMC 6 for more information on the challenge of coordination when preparing for and responding to PHEs.) Subsequently, CDC acknowledged that it had made mistakes over the past few years, lost public trust, and needed to transform while refocusing on public health needs.[13]

OIG work on prior outbreaks of communicable disease illustrates the importance of ongoing HHS readiness to detect, assess, and respond to new disease outbreaks and other emergencies. For instance, an OIG report about HHS's response to the 2014 Ebola outbreak recommended that HHS develop departmentwide objectives and a strategic framework for responding to international PHEs.[14] HHS concurred with the recommendations in the report but has not yet taken the actions necessary to implement them.

In addition to coordinating emergency planning and response efforts with its program offices, HHS works with States, localities, and Tribes to facilitate planning and preparedness to address a wide range of health and human service needs, including the management and distribution of medical supplies, establishment of alternative care sites, and distribution of vaccines and antiviral drugs. In an OIG survey of hospitals conducted in March 2021, hospitals reported that operating in "survival mode" for an extended period had created challenges with health care delivery, staffing, vaccinations, supplies, and finances. Hospitals reported that the emergency exacerbated longstanding challenges in health care delivery, access, and health outcomes.[15] Prior OIG work identified opportunities for health care facilities to improve emergency preparedness and response planning during infectious disease outbreaks and disasters.[16] HHS should continue to support the development and maturation of health care coalitions as entities in

this diverse group—including hospitals, public health agencies, emergency medical services, nursing facilities, and emergency management entities—work together to plan and coordinate emergency response.[17, 18]

HHS must rely on up-to-date information to sustain and strengthen its emergency response, and provide effective health guidance to the American public while building the public's trust. As the COVID-19 emergency continues to evolve and the spread of monkeypox heightens concerns, new data provides a deeper understanding of topics such as transmission, testing, therapeutics, vaccines, vaccination programs, public health communication, and short- and long-term health effects. HHS faces the challenge of ensuring that as an organization it is continuously learning, charged with gathering data about threats that may be evolving and complex, evaluating the data, and using the data to inform emergency responses and guide the public.

Hospitals reported operating in 'survival mode' for an extended period created challenges with health care delivery, staffing, vaccinations, supplies, and finances, exacerbating longstanding challenges in health care delivery, access, and health outcomes.

Providing adequate oversight of FDA-regulated products

FDA is charged with ensuring the safety, effectiveness, quality, and security of human and animal drugs, biological products, and medical devices; ensuring the safety of the nation's food supply, cosmetics, and products that emit radiation; and regulating tobacco products. These functions are critical to ensuring that Americans can trust the expansive array of products within FDA's purview.[19] FDA has the added challenge of facilitating emergency response efforts related to PHEs including, for example, reviewing scientific evidence and issuing EUAs and approvals for COVID-19 vaccines and other medical products; providing surveillance of medical product safety, effectiveness, and quality; and updating guidance based on emerging science.[20]

Drugs, biologics, and medical devices

FDA helps to ensure the safety, effectiveness, and quality of medical products through a number of activities, which include evaluating manufacturing facilities; reviewing drugs, devices, and biologics for safety, effectiveness, and quality; authorizing the use of investigational medical products; and conducting postmarket surveillance. The public relies on FDA to be expeditious, independent, unbiased, and evidence-based when evaluating products and making decisions regarding approval for marketing in the United States. OIG found more than one-third of drugs approved through the accelerated approval pathway have incomplete confirmatory trials.[21] OIG work also illustrates FDA's challenge of balancing availability and quality in its EUA processes.[22] FDA's task of assessing complex products has become more difficult as science and technology have evolved. The drug, biologic, and medical device supply chain is becoming increasingly complex, and many of the products used in the United States are manufactured overseas or are dependent on raw materials that are produced overseas. For all FDA-regulated drugs, 73 percent of the manufacturing facilities producing active pharmaceutical ingredients and 52 percent of the manufacturing facilities producing finished dosage forms of human drugs were located outside of the United States in 2022. In addition, OIG found that FDA could improve its for-cause drug inspection process and recommended that FDA identify and implement ways to improve the timeliness of these inspections.[23]

The rapid evolution of science and technology presents new oversight challenges for FDA, as does managing cybersecurity risks associated with increasing numbers of networked devices. (See TMC 5 for additional information on the challenge of managing cybersecurity risks.)

Food and infant formula

The 2022 identification of *Cronobacter sakazakii* infections associated with infant formula and the corresponding recall resulted in supply shortages and the ongoing challenge of providing families access to a safe and adequate supply of infant formula. The infant formula outbreak demonstrates the importance of FDA managing a robust food safety program.

Foodborne illness is a largely preventable threat to public health. An estimated 1 in 6 Americans gets sick, 128,000 are hospitalized, and 3,000 die from contaminated foods each year.[24] FDA is responsible for overseeing the Nation's increasingly diverse and complex food system and supply chain. The American public relies on FDA, which works in collaboration with other Federal agencies and State, local, and Territorial partners to help ensure the safety of both human and animal food.[25] FDA's current approach to food safety includes goals to "enhance traceability, improve predictive analytics, respond more rapidly to outbreaks, address new business models, reduce food contamination, and foster the development of stronger food safety cultures."[26] FDA must continue to modernize the food safety system and respond effectively and efficiently when issues are identified. FDA should conduct risk-based inspections of domestic and foreign food facilities within the timeframes required by the *Food Safety Modernization Act*, identify instances of failure to comply with good manufacturing practices, and take necessary steps when health risks are identified, including administrative and enforcement actions when warranted.[27] FDA has made organizational changes to improve incident response through, for example, its Coordinated Outbreak Response and Evaluation Network and should continue to improve the timeliness and effectiveness of its processes, such as food recalls. OIG is assessing whether FDA followed the inspections and recall process for infant formula per Federal requirements.[28]

Tobacco

Tobacco use is the leading cause of preventable death and disease in the United States.[29] FDA regulates the manufacturing, marketing, sale, and distribution of tobacco products to protect public health and has committed to reducing harm from tobacco products, particularly among youth. CDC's 2021 National Youth Tobacco Survey indicates that youth tobacco product use remains a public health threat, with approximately 1 in 4 students (24.1 percent) ever using a tobacco product, and approximately 1 in 10 students (9.3 percent) using a tobacco product during the previous 30 days.[30] In 2021, e-cigarettes were the most-used tobacco product among both middle and high school students.[31] FDA must continue efforts to reduce harm amid increasing concerns surrounding the use and detrimental health effects of electronic nicotine delivery systems, such as e-cigarettes and vape pens, that contain tobacco-derived nicotine and non-tobacco, or synthetic, nicotine. OIG is assessing FDA's Premarket Tobacco Product Application (PMTA) process for electronic nicotine delivery systems.[32] Through the PMTA process, FDA must determine whether a new tobacco product is appropriate for the protection of public health, taking into account the increased or decreased likelihood that existing users of tobacco products will stop using such products, and the increased or decreased likelihood that those who do not use tobacco products will start using such products.

While working with CDC, FDA faces the challenge of better understanding the science of tobacco products and the most effective use of its authorities to regulate their manufacture, marketing, sale, and distribution, including premarket reviews and health warnings on packaging and advertisements. OIG is assessing FDA's Tobacco Retailer Compliance Check Inspection program under which FDA contractors (generally States) carry out undercover-buy inspections of tobacco retailers to ensure compliance with restrictions on sales to minors.[33]

Addressing the mental health and drug overdose crises

Mental health crisis

The United States faces a mental health crisis. In 2020, 21 percent of all adults experienced mental illness.[34] During the pandemic, that number is thought to have trended upward, with more than 30 percent of adults in the United States reporting symptoms of anxiety and/or depressive disorder.[35] Additionally, more than 20 percent of school-aged children have experienced worsened mental or emotional health since the pandemic began.[36] According to CDC, the United States had one death by suicide every 11 minutes in 2020.

Many who experience mental health illness do not obtain treatment, and it is critically important that the crisis care system in America is transformed and people are provided timely access to quality help.[37] HHS has committed resources toward enhancing the mental health workforce and connecting people to treatment, such as through Substance Abuse and

Mental Health Services Administration's (SAMHSA's) launch of 988—the three-digit phone number for the National Suicide Prevention Lifeline. OIG is currently evaluating the availability of behavioral health care in Medicare fee-for-service (FFS), Medicare Advantage (MA), and Medicaid managed care.[38] Under the *Bipartisan Safer Communities Act*, HHS is responsible for administering $800 million in new grant funding to address the mental health care needs of adults and children. As described in TMC 2, sound financial management of these grant funds is important to ensure that the government gets the quality of services and outcomes for which it is paying.[39]

Overdose crisis

In recent years illicit opioids, largely driven by fentanyl and its analogues, have become key contributors to the overdose crisis. Other controlled substances, including benzodiazepines and stimulants (particularly methamphetamine), are also being used in combination with opioids. Since 2017, HHS has declared an ongoing opioid PHE nationwide, and in the past few years our country has experienced heightened concerns about the prevalence and detrimental effects of substance use disorders, including those involving alcohol, tobacco, opioids, and other drugs. Provisional data from CDC show that drug overdose deaths attributable to opioids as well as other categories of drugs have significantly increased since the start of the COVID-19 pandemic.[40] For the 12-month period ending in March 2022, there were 104,671 reported drug overdose deaths, which was a 40-percent increase from the 74,679 reported drug overdose deaths during the 12-month period ending in March 2020.[41] In early fiscal year (FY) 2022, HHS released an overdose prevention strategy.[42] Current Federal priorities for drug policy include expanding access to evidence-based treatment for substance use disorder, advancing racial equity in the approach to drug policy, and reducing the supply of illicit substances.[43]

Opioids prescribed by licensed medical professionals and paid for, in part, with Federal funds have contributed to the opioid crisis. Moreover, OIG has found that opioid-related fraud encompasses a broad range of criminal activity, from prescription drug diversion to substance use disorder treatment schemes. OIG investigations show that opioid drug diversion—the redirection of drugs prescribed for medical use to nonmedical purposes—is on the rise. Diverted opioid drugs present a high risk of inappropriate use and cause significant harm, such as overdoses. Also, potentiator drugs (drugs that exaggerate euphoria and escalate the potential for misuse when combined with opioids) and drugs indicated to treat Opioid Use Disorders (OUDs) (including buprenorphine and methadone) are at high risk for diversion.

More than 43,000 people enrolled in Medicare Part D overdosed on prescription opioids or illicit opioids during 2020. Overall, 1 in 4 Medicare patients enrolled in Part D received opioids during 2020.[44] Unlike recent years, there was no growth in the number of people receiving prescriptions through Part D for the opioid overdose-reversal drug, naloxone. Access to naloxone is important: Naloxone used in response to an overdose can save a life. Additionally, growth in the number of people receiving drugs through Part D to treat OUDs slowed. Ensuring sufficient access to treatment is particularly important as we do not yet know the full extent to which the stressors of the COVID-19 pandemic may have increased both the prevalence of OUDS and the need for these treatments.

The Department should continue to use the tools available across its divisions to address the ongoing overdose crisis while being mindful of patients' needs to access appropriate management for acute and chronic pain, which may include the use of opioid analgesics. FDA has key roles in ensuring the safe use of opioid analgesics including, for example, evaluating proposed new opioid analgesics and approving them for marketing in the United States only if their benefits outweigh risks.[45] FDA also employs tools to mitigate risks associated with opioid analgesics, including requiring product labeling changes and Risk Evaluation and Mitigation Strategies (REMS) as needed.[46] An OIG evaluation found that data quality issues made it challenging for FDA to determine whether two REMS for opioid analgesics had been effective and that REMS may not be well-suited to quickly address the opioid crisis.[47] FDA must work to ensure that strategies it uses to mitigate the misuse and abuse of opioids achieve their intended impacts. CMS and States should continue to follow up with prescribers with questionable prescribing patterns to ensure that Medicare Part D and Medicaid are not paying for unnecessary drugs being diverted for resale or recreational use. In addition, the Department must guard against fraud in OUD treatment programs, including the submission of fraudulent insurance claims for purported OUD treatment and testing services.[48]

Ensuring access to effective substance use disorder treatment, especially in regions with greater risk for opioid misuse and overdose, remains crucial to combating the overdose crisis.[49] Measures to address COVID-19 have further challenged access to treatment. In a survey of 143 opioid treatment programs (OTPs), OIG identified various challenges OTPs encountered during the COVID-19 pandemic including maintaining pre-pandemic service levels, managing impacts on facility operations, and maintaining patient participation in opioid treatment program activities, among others.[50] To ensure access to effective treatment, HHS needs data to continue building its ability to monitor access and unmet needs. An OIG evaluation identified opportunities to enhance information about access and the need for medication to treat OUD through the Buprenorphine Waiver Program, one of the SAMHSA's key initiatives for combating the overdose crisis by expanding treatment services.[51] In spring 2021, HHS released new buprenorphine practice guidelines designed to expand access to evidence-based treatment for OUD.[52]

In addition, HHS must ensure that funding to address the overdose crisis is efficiently and effectively spent for its intended purpose. In a series of OIG audits of Medicaid payments for OTP services, OIG found that Medicaid reimbursements for OTP services in some States did not meet Federal and State requirements.[53, 54] Another OIG audit of a SAMHSA grant to combat OUD found that the recipient did not meet its goal for the number of naloxone kits distributed, nor could the recipient ensure that the naloxone kits were distributed to targeted populations.[55]

2: Ensuring the Financial Integrity of HHS Programs

Key Takeaways

Relevant Agencies

- All HHS

Elements of the Challenge

- Controlling costs by ensuring prudent payments for goods and services
- Preventing, reducing, and recovering improper payments
- Combating fraud, waste, and abuse
- Monitoring and reporting on the integrity of HHS programs

HHS is the largest civilian agency in the Federal government, with $2.9 trillion in budgetary resources.[56,57] Sound stewardship that ensures the transparency and accountability of HHS funds is paramount to making sure people served by HHS and the American public benefit from this substantial financial investment.[58]

HHS's Medicare program is the Nation's largest health insurer by expenditures and handles more than 1 billion claims per year. Medicaid is the largest health insurer in terms of lives covered, with nearly 89 million individuals enrolled in Medicaid and the Children's Health Insurance Program (CHIP) as of May 2022.[59] Spending for the Medicare and Medicaid programs (including State spending) represents 38 cents of every dollar spent on health care annually in the United States.[60] Medicare expenditures totaled $857.1 billion and Medicaid expenditures totaled $521.8 billion in 2021.[61] HHS is the largest grantmaking and second-largest contracting agency in the Federal government. In FY 2021, HHS awarded $236.4 billion in grants (excluding CMS grants) and $38.9 billion in contracts.[62]

The Department must protect the fiscal integrity of HHS funds and ensure that beneficiaries have access to the services they need. This is a growing challenge due to, among other factors, looming financial shortfalls in the Medicare program,[63,64] growth in the number of people enrolled in Medicaid, and massive COVID-19 funds that HHS is responsible for distributing and overseeing via grants and other mechanisms. HHS must manage the efficient and effective use of funds internally and oversee the use of Federal funds by hundreds of thousands of external funding recipients.

Controlling costs by ensuring prudent payments for goods and services

Whether HHS is paying for medical services, prescription drugs, or human service programs, managing what the Department pays and recognizing and remedying problematic payment policies are critical to controlling costs.

Prescription drug programs

The Medicaid, CHIP, and Medicare programs accounted for 42 percent ($147 billion) of total U.S. prescription drug expenditures in 2020.[65] The Medicare Part D program had net costs of $79.8 billion for FY 2021, and 48 million people relied on Part D for prescription drug coverage.[66,67]

A top management challenge for HHS is implementation of the *Inflation Reduction Act* (IRA), which makes several changes to Medicare and provides certain complex new authorities. Under IRA, CMS must negotiate prices on selected Medicare Part B and Part D brand-name drugs that account for the greatest program spending. IRA also mandates rebates for Part B or Part D drugs for which prices increased at a rate exceeding the rate of inflation. The law also changes the structure of the Part D program and caps annual out-of-pocket costs at $2,000 per enrollee. Portions of the statute take effect as soon as January 2023. OIG's prior work looking at drug spending in areas such as biosimilars and hepatitis drugs suggests that the Part D reforms could have a substantial impact. Administering new and complex programs creates challenges and risks for CMS, including those tied to managing technical and regulatory complexity, meeting required timeframes, managing resources efficiently, issuing clear guidance, delivering program outcomes, designing and providing effective oversight, and preventing and detecting fraud and abuse. More specifically with respect to implementing prescription drug provisions, OIG work has identified challenges in calculating inflation-indexed rebates in Part B and ensuring the completeness and accuracy of measures, such as average sales price (ASP) and average manufacturer price (AMP). Furthermore, OIG work suggests that CMS must be attuned to ensuring accurate and complete reporting of manufacturer data, such as ASP and AMP data, required for effective and efficient program operations. CMS must also provide effective oversight and, where appropriate, enforcement of manufacturer compliance with new program requirements.

The way that Medicare and Medicaid pay and reimburse for drugs can impact prescription drug prices and costs for people and programs. For example, in the Part B program OIG found that Medicare would have saved millions of dollars if dispensing fees for several drugs had been aligned with the rates that Part D and State Medicaid programs paid.[68] Also, OIG looked at the impact of the least costly alternative policy in Part B, which based the payment amount for a group of clinically comparable products on that of the least costly product, on costs for certain prostate cancer drugs. OIG found that when the least costly alternative policy was rescinded there was an increase in costs for the studied drugs.

Furthermore, OIG work on the Part D program has raised concerns about whether the program design encourages the use of the highest value drugs. OIG found that although there was a 17 percent decrease in Medicare Part D prescriptions for brand-name drugs between 2011 and 2015, there was a 77 percent increase in total reimbursements for these drugs, leading to greater overall Part D spending and higher enrollee out-of-pocket costs.[69] OIG work looking at the use of lower cost biosimilar drugs that are clinically equivalent to their higher cost reference biological drugs found that the program and its enrollees could realize significant savings if biosimilar use were to increase, but the lack of biosimilar coverage on Part D formularies may limit increased use.[70]

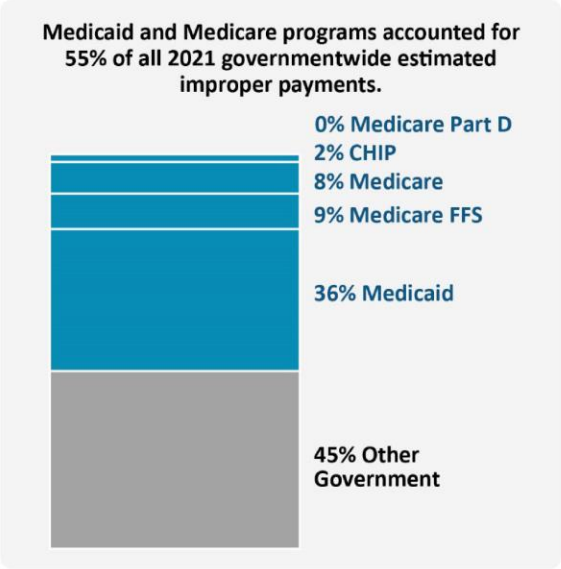
Additionally, manufacturers' uses of reasonable assumptions when calculating AMPs and best prices—a practice OIG's work has established as common—represents a vulnerability in drug pricing for thousands of drugs used in the Medicaid program.[71] HHS must endeavor to limit the impact of high prices on programs and beneficiaries while protecting access to medically necessary drugs. The Department also should be prepared to address the coverage and reimbursement challenges of emerging technologies.

Preventing, reducing, and recovering improper payments

An improper payment is any payment that does not meet statutory, contractual, administrative, or other legally applicable requirements, and that may be an overpayment or underpayment.[72] Reducing improper payments—such as payments to ineligible recipients or duplicate payments—is critical to safeguarding Federal funds. Due in part to their size and in part to some programs having error rates that exceed statutory benchmarks, HHS programs account for some of the largest estimated improper payments in the Federal Government. Medicare, Medicaid, and CHIP together accounted for 55 percent, or $153.7 billion, of all governmentwide estimated improper payments reported in FY 2021.[73] Furthermore, insufficient HHS oversight of grant programs and contracts poses risks of significant improper payments.

Medicare

Original Medicare FFS and Medicare Part D (also known as Medicare Prescription Drug) accounted for $26.4 billion, or 17 percent, of the estimated improper payments that HHS reported in FY 2021.[74] Notably, the Medicare FFS improper payment rate estimate during the past 3 years has decreased from 7.3 percent ($28.9 billion) in FY 2019, to 6.3 percent ($25.0 billion) in FY 2021.[75] The improvements in Medicare FFS estimated improper payments represent positive momentum on which the Department and CMS can build. However, some types of providers and suppliers pose heightened risks to the financial security of Medicare. For instance, OIG and CMS have identified especially high rates of improper payments for home health, hospice, and skilled nursing facility (SNF) care; durable medical equipment (DME); drug testing services; and certain hospital services.[76] CMS has taken corrective actions for Medicare FFS by focusing on specific service areas with high improper payment rates. But more must be done. The reduction in the improper payment rate was driven primarily by reductions in Part B and DME claims. CMS should take further action to reduce improper payments among providers and suppliers.



Graphic adapted from PaymentAccuracy.gov.

CMS must ensure appropriate billing for Medicare services and must monitor for indications that hospitals may be engaging in inappropriate billing practices, such as upcoding.[77] For example, OIG found that hospitals increasingly billed for inpatient stays under Medicare severity diagnosis-related groups at the highest severity—and most expensive—level from FY 2014 through FY 2019. CMS should also ensure that it is prepared to detect and prevent improper payments in areas with growing utilization, such as telehealth and genetic testing. When improper payments are identified, such as through OIG audits, CMS should continue its efforts to recover collectible overpayments. OIG has recommended additional steps CMS could take to improve its ability to recover misspent funds.[78]

MA allows people to receive Medicare benefits through private managed care plans. HHS pays plans in part by adjusting the per-person amount to account for health status differences between enrolled people in order to determine the monthly payment amount, which means that plans receive higher payments for enrollees reported to have a poorer than average health status, and lower payments for enrollees reported to have better than average health status. HHS reported an improper payment rate of 10.28 percent for MA, accounting for $23.2 billion, or 15 percent of the estimated improper payments HHS reported in FY 2021.[79] As it exceeds 10 percent, the FY 2021 rate is not in compliance with the *Payment Integrity Information Act*. As disclosed in the FY 2021 Agency Financial Report (AFR), contributing to the increase in the error rate was the rebasing of the measure to exclude MA payments not related to risk adjustment from the calculation. Nevertheless, the amount of improper payments in MA indicates further scrutiny is needed, especially considering the incentive to receive higher payments by misreporting diagnoses. HHS should evaluate critical and feasible action steps to assist MA organizations with compliance efforts, specifically with organizations that have significant improper payments year-over-year to ensure that medical record documentation is sufficient and substantiates clinical diagnoses.

Medicaid

Medicaid is a Federal-State partnership through which the 50 States, District of Columbia, and 5 Territories each offers its own program, within certain Federal parameters, reflecting State and local needs and preferences. CMS's Payment Error

Rate Measurement (PERM) program measures improper payments in Medicaid and CHIP, and produces a national improper payment rate for each program. The estimated Medicaid improper payment rate increased from 21.4 percent in FY 2020 to 21.7 percent in FY 2021, while CHIP increased from 27.0 percent to 31.8 percent.[80] These increases were largely due to the continued re-introduction of beneficiary eligibility errors into the error rate calculation; inclusion of these errors had previously been paused while CMS updated the PERM eligibility component.[81] Medicaid accounted for approximately $98.7 billion in estimated improper payments in FY 2021. CMS attributes these increases to high levels of eligibility errors, such as those occurring when States maintain insufficient documentation to substantiate that income and other information were appropriately verified, failures in conducting timely and appropriate annual redeterminations, as well as errors when beneficiaries are claimed under incorrect eligibility categories that provide a Federal matching rate higher than appropriate.[82]

OIG has long identified eligibility determinations as a significant risk area. Medicaid expansion under the *Affordable Care Act* and mandated changes to Medicaid eligibility rules led to a significant increase in applications for Medicaid coverage. More recently, the *Families First Coronavirus Response Act* temporarily increased the Federal Government's share of Medicaid costs, with the condition that States accepting the additional funds are prohibited from making their Medicaid eligibility requirements more restrictive and from terminating people's coverage during the COVID-19 PHE. After the COVID-19 PHE ends, States will need to conduct renewals of eligibility for all individuals enrolled in Medicaid and CHIP, which could affect millions of people.

Prior OIG audits found that some States did not always determine Medicaid eligibility for some beneficiaries per Federal and State requirements. We determined that both human and system errors, as well as a lack of policies and procedures, contributed to improper or potentially improper payments. We estimated that 4 States we audited made Federal Medicaid payments totaling almost $1.4 billion for more than 700,000 people whose eligibility could be considered because of the *Affordable Care Act* expansion but who did not meet or may not have met eligibility requirements. Furthermore, States made Federal Medicaid payments totaling more than $5 billion on behalf of 5 million individuals who fit traditional Medicaid coverage groups but who did not meet or may not have met eligibility requirements. As with Medicare, CMS faces other fiscal integrity challenges with Medicaid, such as collecting overpayments from State Medicaid agencies. As of April 2022, CMS had not collected about $1.5 billion in overpayments identified in OIG audit reports.[83]

Advanced Premium Tax Credit

The risk assessment process that HHS uses to estimate improper payments determined that the APTC program is susceptible to significant improper payments. HHS has started the improper payment measurement program for the Federally Facilitated Exchange (FFE) and anticipates reporting an improper payment estimate for the FFE in the FY 2022 AFR. HHS continues to develop the improper payment measurement methodology for State-based exchanges and will continue to update AFR with the measurement program development status.

Grants and contracts

Administering grant programs and contracts requires that HHS implement oversight and guidance to ensure that program goals are met and funds are used appropriately. HHS is responsible for providing guidance and up-to-date policies to grant recipients and helping States and other grantees address financial management and internal control issues. Without proper internal controls at the grantee level, funds may be misspent, duplication of services may occur, and subrecipients may not be adequately monitored. OIG has identified grantee-level concerns in several HHS programs. For example, OIG found that most NIH grantees failed to meet at least one Federal requirement related to investigators' foreign interests and support and lacked oversight practices to ensure that all materials submitted to NIH were accurate. OIG has identified a range of other problems with grants and contracts oversight. For example, some grantees of the Office of Refugee Resettlement (ORR) Unaccompanied Children (UC) Program reported unallowable rental, construction, subcontractor, or other costs,[84] and ORR did not award or sufficiently manage a sole source contract in accordance with Federal requirements.[85] Additionally, it remains the responsibility of individual organizations within HHS to administer the Small Business Innovation

Research (SBIR) program. OIG made two recommendations to address vulnerabilities in the SBIR program: (1) HHS should ensure awardee compliance with SBIR eligibility requirements and (2) HHS should improve procedures to check for duplicative awards.[86]

HHS must track and report improper payment rates for its risk-susceptible grant programs and thus adhere to the *Payment Integrity Information Act of 2019.*[87] However, since the inception of these reporting requirements HHS has not reported an improper payment estimate for the Temporary Assistance for Needy Families (TANF) program. HHS stated in its FY 2021 AFR that it did not report an improper payment estimate for TANF because statutory limitations preclude HHS from requiring States to participate in a TANF improper payment measurement. The Office of Management and Budget (OMB) identified TANF as a risk-susceptible program that must report estimated error rates and amounts. HHS must continue to pursue legislative or other remedies to develop an appropriate methodology for measuring TANF payment accuracy and report an improper payment estimate for TANF.[88]

Although HHS has taken steps to improve the contract management and closeout processes, the Department in terms of its oversight of contracts needs to take additional actions to ensure that it is meeting other Federal requirements. For example, OIG found that, while some Federal Acquisition Regulation (FAR) were met, FDA did not always identify contracts eligible for closeout and did not always follow the FAR requirements for closing contracts in a timely manner.[89] HHS must also improve its use and management of other transaction agreements, which carry a higher risk than traditional awards. OIG found that NIH did not fully comply with Federal requirements for awarding and administering other transactions. NIH implemented the OIG recommendations to strengthen its internal controls.[90]

COVID-19 funding

Congress appropriated $484.0 billion to HHS for the COVID-19 response.[91] This includes the Provider Relief Fund (PRF) to support health care providers affected by the COVID-19 pandemic and the Uninsured Program (UIP) to reimburse health care providers that have conducted COVID-19 testing, administered vaccines, or provided treatment for uninsured individuals with a COVID-19 primary diagnosis.[92, 93] Both programs are administered by the Health Resources and Services Administration (HRSA). PRF and UIP had to be rolled out quickly, which presented challenges and vulnerabilities in administering the programs. A recent OIG audit found that HHS's and HRSA's controls related to selected PRF program requirements could be improved. OIG found that HHS and HRSA did not have certain procedures related to supporting documentation, calculation of nonautomatic payments, and return of rejected payments. Other procedures had weaknesses. OIG recommended, and HRSA concurred, that HRSA seek repayment of overpayments and strengthen efforts as it fully implements postpayment quality control review processes.[94] OIG is currently conducting additional audits and evaluations of PRF and UIP distributions, including PRF distributions made to nursing homes.[95]

Combating fraud, waste, and abuse

Fraud, waste, and abuse divert needed program resources to inappropriate, unauthorized, or illegal purposes. Effectively fighting fraud, waste, and abuse requires vigilance and sustained focus on preventing problems from occurring in the first place, detecting problems promptly when they occur, and rapidly remediating detected problems through investigations, enforcement, and corrective actions. The Department should apply a robust variety of program integrity strategies to protect HHS programs, including implementing systems and processes to detect and prevent fraud, as well as plans for addressing fraud when it occurs. (For an additional discussion on combating fraud, waste, and abuse in CMS programs, see TMC 3.)

Fraud Schemes

- Billing for services not provided
- Identity theft
- Kickbacks
- Improper prescribing
- Deceptive marketing
- Money laundering

COVID-19 funds

OIG has identified serious concerns related to fraud schemes that would divert funds intended for the COVID-19 response and recovery. Law enforcement investigations have included allegations of providers falsely attesting to their eligibility for funds and providers using relief funds for impermissible personal expenses. OIG has identified other serious fraud schemes that threaten programs and people. These include schemes in which fraudsters offer unapproved and illegitimate COVID-19 tests and fake vaccination cards, often in exchange for personal details, including information that can be used to falsely bill Medicare or other payers. HHS must apply effective internal controls and efficiently manage the collection, maintenance, and analysis of relevant data that are key to ensuring COVID-19 funds are used for their intended purposes.

Furthermore, as with all HHS grant programs, it will be critical that the Department provide up-to-date policies to COVID-19-related grant recipients and help States and other grantees address their own financial management and internal control issues. Without proper internal controls, funds may be misspent, duplication of services may occur, and subrecipients may lack adequate monitoring. (See TMC 3 for additional details regarding COVID-19 flexibilities and the challenge of terminating these flexibilities at the end of the PHE.)

Grants and Contracts

Without adequate oversight and internal controls, HHS grants and contracts are vulnerable to fraud schemes including embezzlement and theft.[96] HHS has worked to strengthen some of its program integrity efforts focused on grant programs. For instance, HHS issued guidance and developed tools to help its awarding OpDivs examine prospective grantee risk prior to awarding grants.[97] This information enhanced awarding OpDivs' assessments of prospective grant recipients' integrity and potential performance. Suspension and debarment programs help protect the integrity of Federal grants and contracts. Most suspension and debarment referrals resulted in actions to protect funds. Furthermore, most of the referrals came from HHS non-awarding entities, while many HHS awarding agencies made no referrals during the 5-year period we reviewed. This suggests there were missed opportunities for additional referrals among these awarding agencies. HHS has since made improvements in strengthening program integrity for its suspension and debarment programs. HHS implemented two of OIG's four recommendations to strengthen suspension and debarment programs by issuing the Discretionary Suspension and Debarment Handbook for Contracts and Grants and conducting ongoing training across the Department to encourage the use of suspension and debarment as a viable administrative remedy. [98]

Provider enrollment screening processes

An effective provider enrollment screening process is an important tool for preventing Medicaid and Medicare fraud. Such a process plays a vital role in identifying and preventing unscrupulous providers from enrolling in Medicaid and Medicare. OIG found that Medicaid is vulnerable to being defrauded by high-risk providers that were not properly screened.[99] We also found that unscrupulous providers could exploit loopholes in the provider enrollment process to enroll in State Medicaid programs without undergoing these checks.[100] In addition, OIG found 23 States had not enrolled all providers serving Medicaid beneficiaries in their respective Medicaid programs, exposing enrollees to potentially harmful providers that had not been screened for fraud and abuse.[101] Despite legislative requirements in the *21st Century Cures Act* designed to strengthen Medicaid program integrity, terminated providers continue to serve people enrolled in Medicaid. We recommended that CMS: (1) ensure that all States fully implement fingerprint-based criminal background checks for high-risk Medicaid providers and (2) work with States to ensure that they have the controls required to prevent unenrolled providers from participating in Medicaid.

Monitoring and reporting on the integrity of HHS programs

HHS must ensure the completeness, accuracy, and timeliness of financial and program information provided to other entities both in and external to the Federal Government. Responsible stewardship of HHS programs is vital to operating a financial management and administrative infrastructure that employs appropriate safeguards to minimize risk and provide oversight to protect resources. Although HHS continues to maintain a clean opinion on its basic financial statements and has addressed most severe weaknesses in

financial management systems, OIG recommends that HHS focus on refreshing OpDivs' understanding of departmental guidance and identifying those areas for which OpDiv training would be developed to prevent and detect future accuracy issues related to performance dates, award types, and award descriptions.

In addition, financial management systems help OpDivs and StaffDivs ensure operational effectiveness and efficiency, financial reporting reliability, and compliance with applicable laws and regulations. OIG continues to find deficiencies in internal controls over segregation of duties, configuration management for approved changes to HHS financial systems, and access to HHS financial systems.[102] These deficiencies collectively constitute a significant deficiency in internal controls. HHS must take additional actions to address and resolve these issues, including continuing to work to control user access, ensuring proper approval of and documentation supporting system changes, and ensuring appropriate segregation of duties.[103]

3: Delivering Value, Quality, and Improved Outcomes in CMS Programs

Key Takeaways

Relevant Agency

- CMS

Elements of the Challenge

- Aligning program incentives with quality, equity, and health outcomes
- Strengthening program integrity
- Ensuring smooth transitions when PHE waivers and flexibilities end

CMS is tasked with administering the two largest Federal health care programs, Medicare and Medicaid, as well as CHIP and the Health Insurance Marketplaces. More than 147 million people (43 percent of Americans) rely on Medicare and Medicaid for their health insurance including senior citizens, individuals with disabilities, low-income families and individuals, and individuals with end-stage renal disease.[104]

Effectively and efficiently managing this complex suite of programs is a top HHS challenge. These programs use multiple delivery models (including FFS, managed care, and value-based care); cover a broad array of health conditions, providers, services, settings, and insurance plans; and operate pursuant to intricate statutory directives and regulatory schemes. Spending on these programs is massive, totaling $1.3 trillion in FY 2021.[105] CMS's task is further complicated by the fact that it must administer portions of these programs collaboratively with States and private insurance companies. For example, Medicaid is functionally more than 50 different Federal-State partnerships, with substantial State customization and variation in benefits and payment methodologies. CMS programs rapidly change and evolve. Most recently, for example, IRA enacted major changes including a new requirement to negotiate prescription drug prices for certain expensive Medicare Part B or Part D drugs, and an extension of subsidies available to purchasers of marketplace plans. (For more information about implementing IRA, see TMC 2.)

Administering these programs comes with an array of operational and program integrity risks and challenges, as well as promising opportunities for better care and health outcomes, improved access and health equity, lower costs, more transparency and choices for consumers, and reduced administrative burden.[106] (Additional information regarding challenges related to costs and quality of care can be found in TMCs 2 and 4.) To achieve better care at lower cost, HHS must maintain a steady focus on developing and refining effective, innovative, and evidence-driven payment and delivery models. At the same time, CMS must be proactive in preventing and detecting fraud, waste, and abuse, including abuse and neglect in nursing homes and other care settings. HHS must pay special attention to effectiveness and program integrity in nascent areas such as expanded benefits addressing social determinants of health and new uses of digital technology. This is vitally important given the current and anticipated growth in the costs and numbers of people enrolled in Medicare and Medicaid.

Meeting this challenge will enable the Department to expand the reach of dollars devoted to these programs, thereby abating some of the anticipated increases in program costs in coming decades and improving the lives and health outcomes of the people they serve.

Aligning program incentives with quality, equity, and health outcomes

Developing effective incentives, policies, and safeguards to drive better quality, equity, and health outcomes is a significant challenge given the complexities of health care, the evolving science of quality measurement, the broad range of providers and others who furnish services, and the varying needs and circumstances of the populations served by CMS programs. One of the main ways that CMS tests potential quality incentives is through the CMS Innovation Center. In a report to Congress, CMS estimated that more than 27.8 million people enrolled in Medicare and Medicaid and individuals with private insurance in multipayer model tests had been included in Innovation Center models and initiatives as of September 30, 2020.[107] Estimated payments for model tests and initiatives (excluding reimbursement for covered services) totaled about $13 billion for FY 2010–20.

Reforming health care payment and delivery models gives rise to risk-management challenges in CMS programs. CMS must maintain a steady focus on quality of care and health outcomes. This is particularly true during a PHE if normal guardrails and conditions are adjusted to address exigent public health circumstances and if providers may temporarily be unable to meet optimal care guidelines. (See TMC 4 for further discussion of quality-of-care challenges.)

Quality measurement

The Department is undertaking initiatives to streamline, improve, and target quality measures more precisely and to move from process measures to outcome measures. In March 2021, CMS launched Meaningful Measures 2.0: Moving from Reduction to Modernization to "reduce the number of measures in its programs" and "further shape the entire ecosystem of quality measures that drive value-based care."[108] CMS recently announced its first set of quality measures for Medicaid-funded home and community-based services.[109]

Moving forward, HHS should ensure that its programs use effective, evidence-based measures to monitor quality of care and beneficiary outcomes. CMS must clearly define actionable and meaningful quality and outcomes measures for its programs and ensure their reliability, accuracy, and utility. CMS should continue, where appropriate, to align its efforts with other HHS divisions that use quality measurements to enhance efficiency and strengthen quality measurement. CMS outlined a range of steps it is taking in its 2021 annual report to Congress on Identification of Quality Measurement Priorities.[110]

Aligning payment incentives

In managing its portfolio of FFS, managed care, and value-based payment models, CMS must ensure that payment mechanisms are driving high-quality, efficient care. OIG work has identified many opportunities for better alignment of incentives and outcomes. For example, an OIG report examined inpatient rehabilitation facility (IRF) transfer payment policy for early discharges to home health and found that CMS's transfer payment policy was not aligned with costs, which may have provided IRFs with a financial incentive to admit patients inappropriately.[111] In response, CMS reported to OIG that it is developing an IRF Review Choice Demonstration and collaborating with ASPE to develop a prototype and recommendations for a unified, post-acute care payment system to more closely align Medicare post-acute care payments with the post-acute care needs of Medicare beneficiaries. Some policies result in Medicare and enrollees paying more for care provided in certain settings than for the same care provided in other settings. A 2021 study found that Medicare and enrollees who receive outpatient services and then are admitted for inpatient care for the same condition shortly afterward pay more if the outpatient services provider is affiliated with the admitting hospital than if the outpatient service provider is wholly owned by the admitting hospital.[112] CMS should be attentive to nursing home payments to ensure appropriate incentives to deliver high-quality care. For example, understanding SNF costs is crucial to understanding the factors that contribute to

In managing its portfolio of FFS, managed care, and value-based payment models, CMS must ensure that payment mechanisms are driving high-quality, efficient care.

nursing home performance and how nursing homes deliver care to beneficiaries. OIG is assessing whether SNFs are reporting related-party costs as per Federal regulations and will determine whether SNF allocations of Medicare funds could impact beneficiary care, such as whether overhead costs might have increased while allocations for patient care decreased, potentially reducing care.

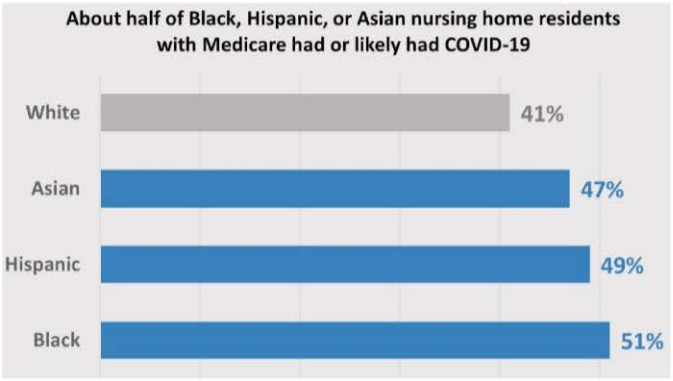
Another recent OIG report, discussed in more detail in TMC 4, revealed continued high rates of patient harm in hospitals and recommended that CMS broaden its lists of hospital-acquired conditions (HACs) to capture common, preventable, and high-cost harm events.[113] This expansion would have the effect of reducing payments for a broader array of HACs, thus more appropriately aligning payment with quality of care. CMS has observed challenges in aligning payment and desired outcomes in some models being tested by the Innovation Center. In a July 2022 analysis of certain acute and specialty care models, CMS noted that generous financial incentive payments spurred robust participation in the models but made it difficult for many models to demonstrate net savings.[114] CMS must continue to monitor the results of its range of models and remain attuned to opportunities to better align payments with quality and efficient care.

Nontraditional services

Value-based models typically pay, in full or part, based on health outcomes achieved for patients and reductions in health care costs. Providers are paid for a set or bundle of services, often provided across a continuum of care settings, with accountability for outcomes and costs expected over an established period. To meet care and cost goals, providers in value-based models (as with managed care) often furnish a range of services not typically paid under volume-based, traditional FFS. These might include social services, care coordination, or health technology. Especially when nontraditional services affect the payment amount, HHS should be attentive to ensuring that such services contribute to achieving quality, equity, and efficiency in outcomes. Because these interventions are not reflected in normal claims data, CMS should ensure it has the available data necessary to understand the services provided and evaluate their effectiveness. This may require that CMS partner with other HHS divisions and Federal agencies that support social services. Operation and oversight of models that integrate traditional health and other services may be hampered by data silos both within HHS and across the Federal Government. (See TMC 5 on data sharing.) There is a heightened program integrity risk if add-on, nontraditional services are offered to patients for marketing purposes (e.g., to induce them to obtain medically unnecessary services), rather than to foster improvements in patient health outcomes, efficiencies, or equity.

Equity

Access to care and health equity are longstanding challenges that have been exacerbated by the COVID-19 pandemic. OIG work has long identified access issues in Medicare and Medicaid. For example, a report examining provider shortages and limited availability of behavioral health services in New Mexico's Medicaid managed care program provides insights into challenges likely shared by other States. Identified challenges included an uneven distribution of licensed providers across the State, staff retention, poor care coordination, and a lack of transportation and broadband services. Promising initiatives to increase availability of behavioral health services included open-access scheduling, a "treat first" clinical model, care integration, and telehealth.[115]



Graphic adapted from OIG report COVID-19 Had A Devastating Impact on Beneficiaries in Nursing Homes During 2020.

Ensuring that programs have accurate demographic and other data is a requisite step in identifying, understanding causes of, and addressing health disparities. An OIG analysis of Medicare claims data showed that in 2020 the COVID-19 pandemic did not affect nursing home residents equally. About half of Black, Hispanic, and Asian nursing home residents had or likely had COVID-19, compared to 41 percent of White residents.[116] OIG also found that dually eligible, Black, Hispanic, and older beneficiaries were disproportionately hospitalized with COVID-19 during surges in six localities. Another OIG report found that inaccuracies in Medicare's race and ethnicity data hinder CMS's ability to assess health disparities and recommended steps CMS should take to improve this data.[117]

Strengthening program integrity

HHS must be attentive across its programs to combating fraud, waste, and abuse. The nature of fraud and abuse risk differs depending on how Medicare and Medicaid pay for services. Traditional FFS risks, arising from volume-sensitive payments, include inappropriate increased utilization, increased program costs, and improper patient steering. In managed care, a capitated payment system could lead to potential risks such as: (1) stinting on care to reduce costs; (2) discriminating against expensive patients; or (3) manipulating or falsifying data used to measure performance, outcomes, acuity, or diagnoses for risk adjustment. In addition, OIG's oversight and enforcement work has revealed opportunities for "downstream" fraud and abuse in managed care by providers paid by plans on an FFS basis. In nontraditional health care models that marry FFS payments with value-based payments, such as shared savings or partial capitation payments, elements of both FFS and managed care risks may be present. In evaluating and managing risks for a specific value-based program or model, CMS must consider the range of incentives in the model.

Managed care

HHS faces a significant challenge in conducting oversight of managed care programs and protecting against fraud, waste, and abuse. Managed care is the primary delivery system for Medicaid, covering at least some services for more than 80 percent of all enrollees.[118] In Medicare, nearly half of beneficiaries are currently enrolled in Medicare Advantage Organizations (MAOs).

The MA program is vulnerable to fraud, waste, and abuse perpetrated by MAOs to inappropriately inflate payments they receive from Medicare or inappropriately deny care they are obligated to provide. For example, OIG has found risk-adjustment data that MAOs submitted to CMS for use in the risk-adjustment program were not always supported by medical records. OIG has recommended that certain MAOs refund overpayments and enhance their policies and procedures to prevent, detect, and correct noncompliance with Federal requirements.[119] OIG also found that billions of dollars in estimated MA risk-adjusted payments supported solely through chart reviews or diagnoses reported only on health risk assessments raise concerns about the completeness of payment data submitted to CMS, the validity of diagnoses on chart reviews and health risk assessments, and the quality of care provided to beneficiaries.[120, 121] OIG has recommended CMS improve its oversight of MAOs so that MAOs will ensure practices drive better care—not just higher profits—as well as enact policies and procedures to improve the integrity and usefulness of payment data. (See TMC 2 for additional information on program integrity related to managed care and Medicaid eligibility determinations.)

Additionally, significant concerns have been raised that the capitated payment model used in MA may provide a potential incentive for MAOs to inappropriately deny access to services and payments to increase their profits. Recent OIG work showed that MAOs sometimes delayed or denied enrollees access to medical services, even though the requested care was medically necessary and met Medicare coverage rules. These denials likely prevented or delayed needed care for beneficiaries.[122] OIG also found that high numbers of overturned denials upon appeal and performance problems identified by CMS audits raise concerns that some beneficiaries and providers may not be getting services and payments that MAOs are required to provide.[123]

Value-based models

In testing and implementing value-based models, CMS must continue to focus on program integrity risks, incorporating safeguards to reduce and strategies to correct these risks. Focusing on program integrity risk is especially important for

models that introduce new payment incentives, which could lead to new fraud schemes, and for models for which customary payment, coverage, or fraud and abuse laws do not apply due to waivers, exceptions, or safe harbors. Additional risks may arise from novel flexibilities granted because of the COVID-19 PHE.

Many value-based models promote care in home and community settings through in-person home visits, remote monitoring, and other technologies. These services are often preferred by patients. OIG work in areas such as hospice care, home health, and personal care services consistently demonstrates that patients may be vulnerable to fraud and abuse in home and community-based settings. Ensuring that home-based services meet quality of care requirements remains important. (See TMC 4 for further information on quality of care.)

Marketplaces

The Department must be attuned to ensuring that payments for advance premium tax credits (APTCs) for consumers enrolled in marketplace insurance are accurate. There was an estimated 20 percent increase in people eligible for subsidized marketplace coverage after passage of the *American Rescue Plan Act of 2021* and an estimated $35.5 billion increase in premium tax credits.[124] With passage of the IRA, a further increase in the volume of APTC is possible. OIG work has found weaknesses in State and Federal marketplace systems for ensuring correct eligibility determinations and accurate APTC payments. For example, a recent OIG audit determined that APTC payments were paid on behalf of enrollees who did not make required premium payments and recommended improvements to processes and data collection and sharing with the Internal Revenue Service.[125]

Additional risks to program integrity across Medicare and Medicaid are covered in more detail in other TMCs.

Ensuring smooth transitions when PHE waivers and flexibilities end

When the President declares a national emergency or major disaster and the Secretary declares a PHE, the Secretary is authorized under section 1135 of the *Social Security Act* to temporarily modify or waive certain Medicare, Medicaid, CHIP, and *Health Insurance Portability and Accountability Act of 1996 (*HIPAA) requirements to ensure sufficient health care items and services are available to meet the needs of beneficiaries and to ensure providers of such items and services in good faith may be reimbursed and exempted from sanctions. In some cases, the Department can issue blanket waivers; in others, providers or States ask for individual waivers. In implementing, administering, and terminating waivers and flexibilities, CMS must strive to ensure timeliness, continuity, and quality of care, as well as to ensure equity for people served by its programs.

CMS implemented hundreds of waivers and flexibilities addressing coverage and payment for items and services in response to the COVID-19 PHE. For example, CMS suspended or reduced the scope of many program integrity safeguards, such as provider enrollment screening, in an effort to ensure access to care in exigent circumstances. However, these waivers and flexibilities also raised the risk of fraud, waste, or abuse. CMS should take steps to ensure that funds are paid only to eligible recipients—in correct amounts—and used per program requirements.

CMS must plan for and manage risks associated with termination of these waivers and flexibilities when the COVID-19 PHE ends. CMS must be attuned to the impacts of unwinding on enrollees, providers, State agencies, and health care delivery, as well as on program payments, effectiveness, and outcomes. The Department has indicated that it will provide at least 60 days notice before terminating the PHE. Even with such notice, as a practical matter States, providers, contractors, and others may be challenged to shift business operations rapidly and effectively. They will need clear, timely guidance from CMS.

As a condition for receiving a temporary increase in Medicaid funding as authorized under the *Families First Coronavirus Response Act* (FFCRA), States must maintain enrollments of most people enrolled in Medicaid as of March 18, 2020, through the end of the month in which the PHE ends. In large part due to this condition, Medicaid and CHIP enrollment increased between February 2020 and May 2022 by 25.9 percent.[126] After the COVID-19 PHE ends, States will be required to redetermine eligibility for millions of people covered through Medicaid and CHIP during the PHE. CMS has issued guidance giving States up to 12 months to initiate and

14 months after the end of the PHE to complete all redeterminations, and OIG is planning oversight of this process. A 50-State survey of State Medicaid and CHIP officials in January 2022 found that many State Medicaid programs had not made key decisions on how to resume eligibility determinations, and only half of the States had a plan for doing so.[127] States reported wide variances among anticipated approaches. In April 2022, CMS published best and promising practices from States based on discussions with every State and Territory related to renewal planning and preparation for unwinding. In June 2022, CMS published *Top 10 Fundamental Actions to Prepare for Unwinding and Resources to Support State Efforts*.[128] The stakes are high for this transition because of the risk of unnecessary disruptions in insurance coverage and patient care. CMS has indicated that it plans to streamline Medicaid and marketplace enrollment to ensure individuals can receive coverage in the program for which they are eligible.[129] At the conclusion of the PHE, it will be important for CMS to ensure that States complete pending eligibility and enrollment actions per CMS requirements. (See TMC 2 for additional discussion of Medicaid eligibility determinations and improper payments.)

Also challenging may be the termination of waivers and flexibilities through which CMS expanded Medicare access to a wide range of services that could be delivered by telehealth. These waivers and flexibilities proved effective in aiding providers and patients in furnishing and obtaining health care beyond the more limited range of telehealth services ordinarily covered by Medicare. To the extent possible, CMS must ensure that new, post-PHE telehealth policies—including any extensions of existing waivers or flexibilities—are designed to improve care and enhance access while also protecting patients and programs from fraud and abuse. A new OIG evaluation found that certain people enrolled in Medicare, such as urban residents and Hispanic people, were more likely than others to use telehealth during the first year of the COVID-19 pandemic.[130] This report concluded that as CMS, HHS, Congress, and other stakeholders consider permanent changes to Medicare telehealth services, it is important to balance concerns about issues such as access, quality of care, health equity, and program integrity. The report recommended CMS take appropriate steps to enable a successful transition from current pandemic-related flexibilities to well-considered long-term policies for the use of telehealth. (See TMC 5 for additional information on telehealth.)

Looking forward, to the extent flexibilities and waivers are needed to address new or existing PHEs, CMS should mitigate risks by incorporating guardrails into their design, monitor implementation of flexibilities for any abuse, and take prompt action to correct problems and hold wrongdoers accountable.

4: Safeguarding the Well-Being of HHS Beneficiaries

Key Takeaways

Relevant Agencies

- ACF, CMS, IHS, HRSA, SAMHSA

Elements of the Challenge

- Promoting health and safety in nursing homes
- Ensuring safety and quality of care for beneficiaries of Federal health care programs
- Protecting the health and safety of children served by HHS programs
- Preventing abuse and neglect

HHS programs provide critical services to diverse populations across a broad range of settings including hospitals, clinics, child care facilities, shelters, nursing homes, and peoples' own homes. Services are directly provided by HHS personnel, delivered via HHS grant programs, delivered by contractors supporting HHS, or rendered by professionals chosen by individuals who then claim reimbursements from Federal programs. Services include health care, education, child care, and in limited circumstances taking legal custody for select populations. Ensuring that intended beneficiaries receive appropriate services that meet standards for quality, are free from abuse or neglect, and are not exposed to infectious agents represents a major challenge for the Department. This imperative is particularly pronounced for nursing home care that serves many Americans whose health is most fragile. As the Department supports the Nation's efforts to respond to and recover from the COVID-19 pandemic, there will be challenges to ensuring safety and quality for beneficiaries receiving all varieties of care and services.

Promoting health and safety in nursing homes

The administration has prioritized improving nursing home care and the Department continues efforts to improve the quality of services and the information available to beneficiaries and their families when selecting a care provider.[131] A longstanding Department effort is CMS's Five-Star Quality Rating System that is intended to facilitate informed comparisons of nursing homes. CMS also issued guidance to improve safety and quality of care for long-term care residents, including measures such as steps to reduce crowding.[132] As the Nation strives to recover from the COVID-19 pandemic, it is important that residents and their families have accurate and timely information about infection rates in nursing homes and the vaccination status of staff.

The COVID-19 pandemic—the first in a century for which a nationwide PHE was declared—posed unprecedented challenges to the Department's and other stakeholders' efforts to protect the health and safety of nursing home residents. Nursing home residents were prioritized for COVID-19 vaccinations, but this vulnerable population sustained an outsized toll from the disease, especially early in the pandemic. In 2020, 42 percent of Medicare nursing home residents were diagnosed with or likely had COVID-19, with rates of disease even higher for Black, Hispanic, and Asian residents.[133] The COVID-19 pandemic also highlighted the importance of good infection control practices for COVID-19 and other infectious diseases. Quality Improvement Organizations have conducted education and outreach to nursing homes in ways such as by providing assistance with COVID-19 infection control and promoting vaccinations for residents and staff. Initiatives to vaccinate nursing home staff against COVID-19 have resulted in a vaccination rate above 90 percent.[134]

As the COVID-19 pandemic has taken a heavy toll on nursing home residents, longstanding staffing and quality-of-care concerns remain pressing. Staffing issues have long complicated nursing homes' ability to provide safe and high-quality care, and CMS now includes additional staffing data in nursing homes inspections. As part of the administration's priority focus on improving quality of nursing home care, CMS launched a new effort to establish minimum staffing requirements which included issuing a Request for Information and conducting a study it plans to issue in spring 2023.[135] Planned revisions to the nursing home survey process aim to improve complaint investigations and facility-reported incidents.[136] Additionally, nursing homes were charged with implementing new infection control imperatives needed to maintain operations during natural disasters, utility service disruptions, and other occurrences that complicate delivery of care. OIG is continuing its series of audits to assess nursing home compliance with health and safety regulations. An 8-State review identified more than 2,200 areas of potential noncompliance with life safety and emergency preparedness requirements after unannounced visits to 150 nursing homes.[137]

An 8-State review identified more than 2,200 areas of noncompliance with life safety and emergency preparedness requirements after unannounced visits to 150 nursing homes.

Ensuring effective front-line oversight of nursing homes by State survey agencies is another longstanding challenge that was exacerbated by the COVID-19 pandemic. In the early months of the COVID-19 PHE, CMS directed State agencies to focus on infection control surveys and serious complaint investigations and halt comprehensive standard surveys. However, these infection control surveys identified few deficiencies despite significant COVID-19 outbreaks at many nursing homes during that timeframe, and backlogs of standard surveys mounted.[138, 139] These rising backlogs put further pressure on an already strained system, as many States were failing to investigate serious complaints in a timely manner even before the pandemic.[140] Furthermore, appropriate surveyor oversight has long been a concern, with just over half of the States failing to meet survey performance measures in 3 or 4 consecutive years from FY 2015 to FY 2018.[141] CMS has expressed its commitment to clearing these backlogs. OIG has recommended CMS safeguard the health and safety of nursing home residents by ensuring facility correction of deficiencies.[142] Government enforcement actions have stopped some poorly performing nursing homes from rendering deficient services. One nursing home chain charged with rendering grossly substandard care to people enrolled in Medicare and Medicaid agreed to repay $18 million and abide by the terms of a corporate integrity agreement to ensure that it delivers appropriate care going forward.[143]

Pressing changes are needed to nursing home care beyond those associated with the COVID-19 pandemic. For example, OIG continues looking at the use of antipsychotic drugs and recommended improved data to better ensure that patients do not receive inappropriate medications.[144] OIG has also evaluated facility-initiated discharges and will continue to urge further attention to ensure adequate safeguards against inappropriately moving residents against their wishes or interests.[145] In June 2022, CMS released updated long-term care surveyor guidance and training related to facility-initiated discharge.[146]

Looking forward, CMS will need to consider the full range of potential contributors to poor nursing home performance including, for example, the potential impacts of private equity and other ownership structures and fragmented reimbursement for nursing home care. Ensuring that nursing homes prioritize quality of care and quality of life for residents remains important. CMS must continue to take steps to ensure that it and the States can detect problems at nursing homes quickly and insist on rapid remediation. Improving nursing home care will require partnerships and sustained commitment from Government and private stakeholders to achieve positive change. OIG is prioritizing improving nursing home care and continuing to conduct a substantial number of audits and evaluations addressing an array of nursing home topics.

Ensuring safety and quality of care for people enrolled in Federal health care programs

Federal health care programs cover specific health care services that may include hospital care, physician services, prescription drugs, immunizations, hospice care, home and community-based care, DME, and skilled nursing care.

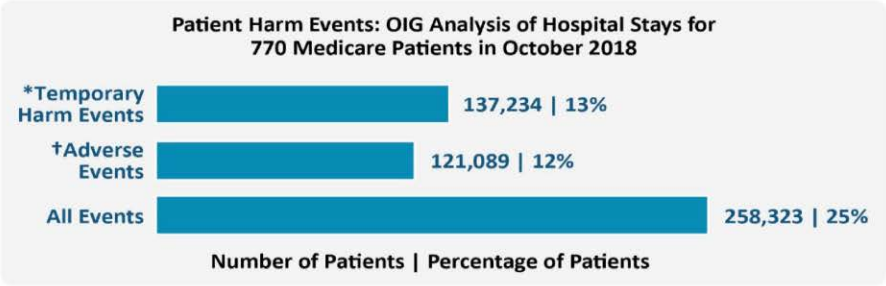
Delivering covered services

Ensuring access to and use of care that meets quality and safety standards remains a challenge. Even when Federal health care programs cover care, many people do not actually receive the care they need. For example, OIG found that more than 500,000 children with attention deficit/hyperactivity disorder (ADHD) who were Medicaid-enrolled did not receive timely followup care, and that more than 50,000 such children did not receive behavioral therapy as recommended by professional guidelines.[147] Moreover, hospice care is a growing health care sector serving people and their families at an extremely vulnerable time near end-of-life. OIG found that more than 80 percent of hospice providers had quality-of-care deficiencies.[148] Additionally, fixed daily payment structures may incentivize hospices to enroll people for longer time periods but provide insufficient care. At times, the greatest barrier to care derives from a person's own behavior and beliefs. The Department is currently working to overcome substantial vaccine hesitancy that has hampered COVID-19 vaccination efforts, despite ample supplies of and an adequate ability to distribute and administer multiple, safe, and effective vaccines.[149]

OIG found more than 500,000 children with ADHD who were Medicaid-enrolled did not receive timely followup care, and more than 50,000 such children did not receive behavioral therapy as recommended by professional guidelines.

Improving quality of care

Although the Department has made progress, more work remains to improve access to and quality of all types of care. Oversight work revealed that patients experience significant rates of adverse events (patient harm as a result of medical care) in health care facilities. Specifically, in a series of studies looking at patient care from 2010 to 2014, OIG found that 25 percent of people enrolled in Medicare were harmed during stays in acute-care hospitals (2010), 33 percent in SNFs (2011), 29 percent in rehabilitation hospitals (2012), and 46 percent in long-term care hospitals (2014).[150] OIG also found that hospitals did not identify when harm occurred in their facilities, in part due to confusion over guidance from HHS and other Government agencies regarding how to define and report adverse events.[151] OIG re-examined the harm rate for Medicare beneficiaries in hospitals in 2018 and found that the rate was similar to that in OIG's prior study for 2010.[152]



Source: OIG analysis of hospital stays for 770 Medicare patients in October 2018.
* The rate and number of patients who experienced temporary harm events involve patients who experienced at least one temporary harm event and no adverse events.
† The rate and number of patients who experienced adverse events involve patients who experienced at least one adverse event. Four percent of patients (41,708) in this group also experienced temporary harm.

Indian Health Service (IHS). To address longstanding quality-of-care concerns in IHS-operated hospitals,[153] IHS created a Quality Framework and Office of Quality to provide better guidance and oversight to its facilities and clinical staff.[154] IHS is also working to establish a nationwide compliance program to address several OIG recommendations and improve care for people receiving benefits. However, some longstanding challenges, such as recruiting and retaining qualified staff, persist. IHS continues efforts to combat the longstanding problem of OUD and can take additional steps to better protect people receiving benefits.[155] There is also a pressing need to protect patients—especially children—from predators who may be within the ranks of health care and service providers. To continue improvements at IHS, OIG has recommended IHS prioritize developing and implementing a staffing program to ensure sufficient qualified staff at facilities, enhance training for staff and hospital leaders, intervene quickly and effectively when quality problems are identified, and establish better procedures, including improved external communications.[156] (See TMC 6 for more information on crosscutting Government efforts to keep patients safe).

Protecting the health and safety of children served by HHS programs

HHS operates or funds many programs that provide child care, education, and residential care in addition to health care for children, including some especially vulnerable children such as children living in foster care and children in the UC Program. The Head Start program—administered by the Administration for Children and Families (ACF)—promotes school readiness for nearly 900,000 children in low-income families,[157] and the Child Care and Development Fund (CCDF) provides child care assistance for about 1.5 million children in low-income families.[158] The importance of properly vetting program staff to ensure child safety is discussed below.

Operating the UC Program

By law, UC who enter the United States without lawful immigration status are referred to the care and custody of ORR. ORR's UC Program merits specific discussion as it is uniquely mandated to assume care and custody of children. Through the UC Program, ORR places children in shelters and other facilities operated by grantees or contractors. These facilities provide food and shelter as well as medical and mental health care and other services. Children remain in these placements until a sponsor (usually a parent or family member) is found to whom the child may be safely released, the child's immigration status is resolved, or the child turns 18 years old and ages out of the program. Since ORR began operating the UC Program in 2002, it has served more than 410,000 children.[159] As of April 20, 2022, more than 9,800 UC were in HHS custody.[160]

During the previous administration, ORR was called upon to care for more children who were separated from parents or guardians by the Department of Homeland Security (DHS) at or after arriving in the United States. OIG's work has shown that neither ORR care provider facilities nor DHS had kept adequate records about separated families, impeding efforts to identify and reunite them. Prior to recent reform efforts, OIG found that ORR and DHS were not able to systemically automate, collect, or reconcile information about separated children across both agencies.[161] Limitations in data about separated children complicate HHS's ability to ensure appropriate placement and may cause children to spend more time in HHS custody. Issues related to identifying and vetting appropriate sponsors may also contribute to the amount of time children spend in HHS care facilities. During a 2018 audit, OIG found two key vulnerabilities with Influx Care Facilities (ICFs): (1) limited staff background checks and (2) insufficient clinical staff to serve children's mental health needs.[162] In prior evaluations of the UC Program, OIG also found: (1) a lack of routine oversight concerning whether facilities' regular use of inspection checklists ensuring required physical security measures were present and working[163] and (2) that ORR's incident reporting system lacked designated fields to capture information to protect the safety of children.[164] OIG also found areas for improvement in HHS intra-agency coordination and communication with ORR about UC.[165] (See TMC 5 for information about the UC portal.)

The number of children entering the United States fluctuates. The Department prepares to serve additional children at times of increased need. In response to approximately 122,000 referrals of UC in FY 2021, compared to 16,000 referrals in FY 2020, ORR opened 1 ICF and 14 Emergency Intake Sites (EISs) to provide services and additional space when the capacity of standard shelters was exceeded. ORR opened these facilities in an effort to avoid having children spend prolonged periods of time in border facilities operated by DHS. ORR established these facilities during a time when ORR's total available bed capacity across its standard care provider network had been reduced by up to 40 percent due to COVID-19 mitigation measures and staffing shortages. At the same time, nearly 6,000 children were in DHS custody awaiting transfer to and placement in an ORR facility, with more than 4,000 of these transfers exceeding the 72-hour limit (for an average of 138 hours). OIG found that operational challenges within ORR and the ORR EIS at Fort Bliss hindered case management for children.[166] Although HHS has closed or transitioned all EIS to ICFs, OIG has recommended ORR take a number of measures to help ensure children receive quality case management services that prioritize their safety and well-being, including during an influx.

The Department must work to ensure that UC Program-funded facilities meet all safety requirements, including infection control priorities related to COVID-19, and provide adequate medical and mental health care. As discussed below, HHS must also enhance efforts to ensure that all staff with unsupervised and direct access to children have passed required background checks.

Preventing abuse and neglect

HHS funds and oversees many types of services for a broad range of people. Thousands of HHS-funded providers hold positions of trust that bring them into close contact with individuals, often behind closed doors and at especially vulnerable times. The vast

majority of providers seek to serve people's best interests. However, some providers may harm people, and HHS must protect people enrolled in its programs from abuse and neglect. For example, a former IHS pediatrician is currently serving a prison sentence for sexually assaulting boys he treated as patients. This disturbing case commanded extensive attention, and the Department committed to collaborating with a Presidential Task Force on Protecting Native American Children in the IHS system established in March 2019.[167] The task force released a report in July 2020 detailing its investigation of institutional and systemic breakdowns that resulted in failure to protect children from abuse.[168] (See TMC 6 regarding protecting IHS patients.) Better attention to protecting vulnerable people of all ages in all HHS care settings is also needed.

Vetting providers and staff

Although even the most thorough vetting may not completely prevent all potential predators from abusing Federal programs to gain access to victims, background checks remain a useful prevention tool. OIG identified a lack of uniformity across UC facilities in conducting all required background checks for staff whose jobs entailed direct access to and supervision of children.[169] OIG is currently reviewing whether the UC Program's ICFs and previously instituted EISs, which are not State-licensed and are established during periods of UC influx, conducted required background checks before hiring employees. This review also seeks to determine whether mitigation strategies have since been implemented to ensure the safety and well-being of children.[170]

Conducting adequate background checks has been a problem in other HHS-funded child care programs as well. In several audits, OIG found that some States have not fully implemented CCDF requirements to conduct comprehensive criminal background checks on current and prospective staff.[171] Additionally, some IHS-funded, Tribe-run health centers failed to conduct required background checks on employees working with American Indian children.[172] Implementing background checks for long-term care providers remains a challenge as well.[173] Along with demonstrating job-specific competency and qualifications, ensuring that staff pass all required background checks is an important safety measure.

The Department should improve efforts to ensure only staff who have passed required background checks have access to patients in various health care settings and to children in the UC Program and CCDF-funded programs. The Department is working to support States implementing the CCDF background check requirements. The Department should continue to work with States to ensure that implementation of the *Child Care and Development Block Grant Act of 2014* background check requirements align with the statutorily required effective dates and allowable timelines described in the CCDF Final Rule.[174]

Identifying and reporting abuse and neglect

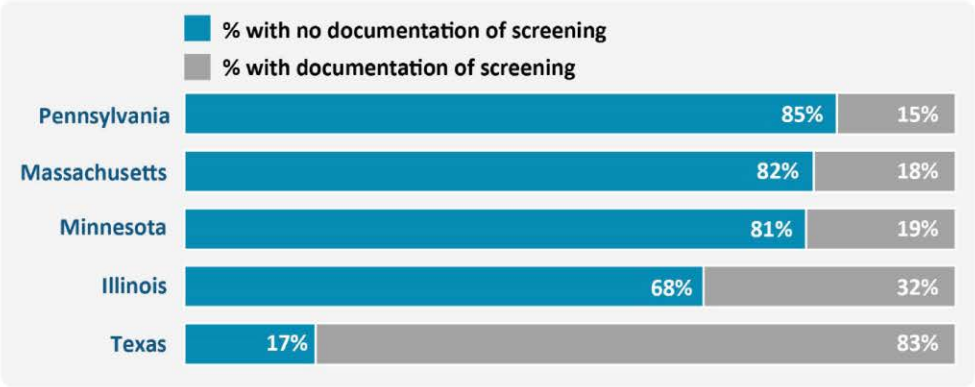
People in all care settings are at risk of abuse and neglect. Home and community-based services allow many Medicaid beneficiaries opportunities to avoid undesired facility care. However, some beneficiaries have been abused or neglected by individuals such as family members who were paid by Federal health care programs to care for the beneficiary at home. Group homes provide care to many especially vulnerable people, including adults with developmental disabilities. OIG's work found extensive failures in the proper handling of critical incidents, including the suspected abuse and neglect of group home residents.[175] The Department, in coordination with OIG, has created several resources to better address the abuse and neglect of residents in group homes. These resources include model practices for: (1) State incident management and investigation, (2) State incident management audits, (3) State mortality reviews, and (4) State quality assurance.[176] CMS has also published additional resources and training materials regarding health and welfare issues in Medicaid home and community-based services.[177]

About 1.8 million people enrolled in Medicare receive care in SNFs each year.[178] OIG has identified cases of substantial failure to report incidents of potential abuse or neglect of Medicare beneficiaries living in SNFs who require treatment in hospital emergency departments.[179] CMS's June 2022 Updated Guidance for Nursing Home Resident Health and Safety clarifies reporting requirements.[180] In addition, OIG work identified cases of potential abuse of people enrolled in Medicare who were in hospice care and for whom hospices failed to act in some instances.[181] These cases revealed vulnerabilities in

beneficiary protections that CMS must address to better ensure that beneficiary harm is identified, reported, addressed, and ultimately prevented.

All States have enacted mandatory reporting laws that require certain individuals, such as schoolteachers or nursing home staff, to report suspected abuse or neglect targeting vulnerable individuals. Despite State and Federal requirements, many instances of abuse and neglect go unreported, making it harder to help victims and hold wrongdoers accountable.[182] Failure to conduct adequate screening, including failure to adequately screen for sex trafficking children who went missing from foster care, may also cause abuse and neglect to go undetected.[183]

The case files of many children in OIG's review had no documentation of a screening to identify whether they were victims of sex trafficking, as required.



Source: OIG analysis of documentation in foster care case files, 2022. Our review included 74 children from Pennsylvania, 91 children from Minnesota, 88 children from Massachusetts, 62 children from Illinois, and 98 children from Texas.

It is important to prevent harm by identifying providers and facilities that are subjecting beneficiaries to abuse or neglect. States and other partners should use claims data to better identify unreported abuse and neglect. OIG created a resource guide to help accomplish this goal.[184] OIG has also explored Medicaid claims data as an additional way to identity potential child abuse and neglect.[185] Additional efforts would help improve reporting. For example, CMS should compile a list of diagnosis codes that indicate potential abuse or neglect, conduct periodic data extracts, and encourage States to better use data to facilitate compliance with mandatory reporting laws.

CMS should work to ensure that its reporting requirements sufficiently protect individuals in all care settings and are adequately enforced. Protecting people from abuse and neglect is a critical responsibility requiring attention and cooperation from all stakeholders.

5: Harnessing and Protecting Data and Technology To Improve the Health and Well-Being of Individuals

Key Takeaways

Relevant Agencies

- All HHS

Elements of the Challenge

- Expanding and improving HHS's capacity to collect, use, and exchange data to support evidence-based policymaking, management, and program improvement
- Securing HHS data and systems to positively impact the cybersecurity posture of HHS and the sectors HHS influences

The Department continues to improve how it collects, manages, shares, and secures its data. In parallel, HHS is refining its approach to influence and shape how other entities use technology. Yet HHS faces significant challenges to both protect data and technology from persistent cybersecurity threats and improve how the Department and related entities share large amounts of critical data from disparate sources, including public health data, on an unprecedented scale. The importance of managing these challenges is highlighted by critical issues such as addressing inequities across health and human service programs, which often requires foundational improvements to data collection and analysis to better understand the effects on disadvantaged individuals and communities. Continued modernization of HHS data and technology capabilities is needed for HHS and its divisions to fulfill their missions, improve situational awareness, and better prepare for future public health threats and emergencies.

HHS's authorities and policies also shape how technology and individuals' data are used and protected by other private and public entities. These authorities are increasingly important in a technology-enabled health and human services delivery system. HHS has made progress; however, the ability to access quality data quickly and easily remains a challenge within the Department and in the health care and public health systems. Data collection challenges also hinder better understanding of racial and geographical population disparities. (See TMC 3 for more information on longstanding access to care and health equity challenges.) Continued progress on these challenges must happen as the Department continues to respond to multiple, simultaneous emergencies and while the quantity, frequency, and sophistication of cybersecurity risks rapidly increase.

Expanding and improving HHS's capacity to collect, use, and share data to support evidence-based policymaking, management, and program improvement

Data are central to every HHS program, and the Department and its programs are continually seeking to improve their ability to collect, use, and exchange data from disparate sources. Collecting large amounts of data does not automatically translate to efficient and effective use, particularly as much of HHS's data is unstructured and not standardized. The Department is finalizing its HHS Data Strategy, which is intended to focus on addressing challenges related to data sharing, security, privacy, and governance.

Improving HHS data governance and standardization is critical for effective program operations

Improving the governance, standardization, and structure of data collected and used by HHS is fundamental to making HHS programs more effective and efficient. However, data governance practices are not consistent across HHS. HHS's need to improve data governance is not unique to the Department and is a requirement for all Federal agencies.[186] Although progress has been made, the Department must effectively operationalize its data governance plans. Hurdles HHS must overcome include the continued effect of data silos and legacy technology that do not easily support modern data governance and standardization.

Most significantly, HHS faces challenges in how it manages and leverages data across its programs. Most HHS divisions primarily collect data to administer their own programs. The ability of OpDivs and StaffDivs to quickly access and use actionable data from other programs remains a challenge because data are often housed within a single HHS division's data silo.[187] Eliminating or reducing data silos within the Department and within HHS programs, ensuring that standardized data sets are developed, and increasing appropriate access across programs are essential to improving program management, evidence-based decision making, and benefiting from new technologies. (See TMC 6 for more information on HHS's coordination challenges.)

The effect of these data silos was seen during the response to the pandemic, limiting how HHS and its partners gained insight about COVID-19. Achieving a mature, public health reporting system that can respond to future public health threats requires extensive collaboration among Federal, State, local, and Tribal entities. It requires interoperability and security across a range of systems to allow for the exchange of data in a timely fashion and data collection that is accurate, timely, and efficient to track and thwart emerging health threats. To address these challenges, CDC is taking steps to modernize its operations, including developing new internal systems, processes, and policies to enhance bidirectional communication.[188]

Some HHS programs rely on decades-old, legacy IT systems with limited data capabilities, which may exacerbate the effect of data silos.[189] Legacy systems can limit operational effectiveness by acting as a significant barrier to modern data analysis and sharing tools. These are often custom software projects that require significant manual work to communicate with other systems. In the ORR UC Program, deficiencies with the UC Portal's search capabilities impeded case managers' ability to reliably determine whether potential sponsors were sponsoring other children, and ORR staff have had to engage in significant efforts to receive and reconcile data from other Federal agencies.[190, 191] (See TMC 4 for more information on challenges associated with the UC Program.) While HHS is making progress in updating its critical legacy systems, these efforts are complex and can take years. However, failure to take on these projects poses a greater long-term risk, and HHS must continue to invest in the long-term modernization of its IT systems.

Improving access to HHS data

Although much of HHS's data are publicly available, some are not easy to use or barriers, such as a lack of standardization, limit access, understanding, or use of the data by stakeholders and the public.[192] These barriers hinder public access to and use of data vital for public health and welfare and data that may lead to innovation and improvement in health and human service systems. HHS external stakeholders rely on effective dissemination of data collected by departmental programs. Currently, in many instances HHS does not use contemporary approaches, such as application programming interfaces (APIs), to provide users access to actionable data from HHS systems. Some OpDivs, in collaboration with the private sector, have deployed the Fast Healthcare Interoperability Resources API, which enables health data to be quickly and efficiently exchanged to support a more seamless flow and integration of data across systems.

HHS must ensure any progress made in improving access and use of its internally generated data also applies to data generated by external entities and received and managed by the Department. CMS has made significant improvements to the national Medicaid data set, the Transformed Medicaid Statistical Information System (T-MSIS).[193] Now that all States report in T-MSIS, CMS is able to leverage T-MSIS for programmatic insights, including insight about COVID-19 treatment and

testing and how the PHE affected Medicaid service utilization.[194] Although CMS has made public some T-MSIS information (mainly metrics on State data quality and some research files), additional work is needed to make T-MSIS an effective data tool for States and other stakeholders.[195]

Encouraging data sharing among health care providers, patients, and payers

The health care system and patients in general have not fully realized and benefited from contemporary approaches to the seamless flow of electronic health information. Two key goals of HHS's Information Technology Strategic Plan aim to improve health information exchange. The goals are to enhance data and interoperability, and to improve IT management and governance.[196] The potential is great for HHS to improve the availability and interoperability of electronic health information by updating regulations that advance certified electronic health record technology. Although there are signs of recent progress in improving interoperability and access, routine and robust health information exchange among providers remains a challenge across the health care system.[197] In May 2020, CMS published the Interoperability and Patient Access final rule that continued to build on and expand the use of health IT standards to emphasize improving health information exchange and facilitating appropriate and necessary patient, provider, and payer access to information in health records. In January 2022, the Office of the National Coordinator for Health Information Technology published the Trusted Exchange Framework and Common Agreement (TEFCA), which outlines a common set of principles, terms, and conditions to facilitate network-to-network electronic health information sharing in a timely and secure manner. HHS is faced with translating TEFCA's authorities and other initiatives into more widespread improvements across the health care industry and public health systems. This will require further engagement and efforts to ensure progress is not limited to those health care entities with resources to implement modern technologies and data practices, which would only serve to broaden the digital divide.

Securing HHS data and systems to positively impact the cybersecurity posture of HHS and the sectors HHS influences

As HHS expands its technological capabilities, increases data sharing among HHS programs and the public, and improves data interoperability in the broader health care and public health systems, it must take crucial steps to modernize its approach to cybersecurity. The importance of improving cybersecurity posture across the Federal Government has been recognized by the President, such as in the May 2021 Executive Order (EO) Improving the Nation's Cybersecurity, which directed Federal agencies to fundamentally and systemically change their approach to cybersecurity. In support, the HHS Office of Information Security is finalizing its Strategic Plan. HHS efforts will require significant investments in resources as well as cultural and organizational change. To operationalize the EO, OMB directed agencies including HHS to meet specific cybersecurity standards and objectives by the end of FY 2024. These include adopting a "zero trust" security architecture approach. This method requires meaningful organizational change in how HHS implements security across its divisions and programs so that the Department protects the enterprise "anytime, anywhere" regardless of where its assets and resources are located.[198]

Persistent and growing cybersecurity threats exacerbate the challenges facing HHS associated with data and technologies used to carry out the vital health and human service missions of HHS divisions. These threats, if not mitigated, can put critical HHS program operations at risk and potentially impact the health and welfare of individuals served by HHS. It is common practice for adversaries to continuously conduct reconnaissance for discovering new systems under development, often to gain understanding of the underlying technologies, data, and potential vulnerabilities that may be exploited.

This challenge is multifaceted and complex because program needs and timeliness often compete with cybersecurity controls and capabilities. To overcome this challenge, HHS will need to ensure that its divisions and programs establish and use a risk-based approach to rapid system development and deployment. This includes understanding the value of protecting technology and data and the risk presented by cybersecurity threats.

Cybersecurity challenges in a federated environment

Although the Department continues to improve its overall cybersecurity posture, OIG and GAO have identified challenges and systemic weaknesses. One persistent challenge is the federated nature of IT and cybersecurity environments across HHS with its vast network of interdependent, increasingly digital health, social, and administrative services. The large scale of HHS's mission and IT environments dictates that the Department must simultaneously address a range of dynamic cybersecurity requirements along with the specific data and technological needs for each division or program. For example, 24 of NIH's 28 entities receive individual funding from Congress and administer their own budgets. Each NIH entity designates its own chief information officer (CIO) who coordinates with the NIH CIO.[199] IHS also has a decentralized environment with a headquarters, area offices, and individual hospitals and clinics that often have additional health care mandates because they provide direct patient care. This type of environment poses challenges to IHS's ability to assess, manage, and respond to cybersecurity threats, as well as modernize cybersecurity approaches in order to become resilient in the face of persistent threats.[200]

The challenges posed by HHS's federated nature are exacerbated by the complexity of ensuring that thousands of HHS contractors, grantees, and other partners have appropriate cybersecurity capabilities and implement the best-of-breed security solutions. For many HHS grant programs, both an OpDiv and a grantee have responsibilities for protecting sensitive data, such as data generated from research that is the intellectual property of the United States. As datasets continue to grow, the ability to prevent bad actors from directly and indirectly inferring personally identifiable information is a challenge. Ownership of data (whether the owner is Federal or a grantee) in some cases is unclear, resulting in some challenges regarding the applicability of specific data protections. However, both HHS and its grantees have faced challenges to consistently adopting controls to address the growing cybersecurity risks facing these programs. HHS and its divisions must make additional progress to ensure grantees, as well as other HHS contractors and partners, have adequate data protections in place and are developing a risk-based approach that can be effectively implemented across a wide range of OpDiv and StaffDiv missions.

Maintaining vigilance is critical to protecting HHS and health system infrastructure security

HHS's cybersecurity defenses continue to be tested as cyberthreats persist and adversaries continue to increase their levels of sophistication and maliciousness. In 2022, HHS OpDivs experienced numerous sophisticated phishing and business email compromise attacks on employees. In response, HHS issued an Advisory Notification to mitigate risk for the entire Department. The Department as well as the health care and public health sectors must maintain vigilance. Future sophisticated and novel methods of social engineering, coupled with technical threats, will present cybersecurity challenges and opportunities for cyberattacks.

In 2021, 45 million people were affected by cyberattacks on health care providers and related entities, up from 34 million in 2020.[201] The average total cost of a breach in the health care industry increased almost 10 percent from $9.2 million in 2021 to $10.1 million in 2022.[202] Threat communication has improved through public-private partnerships spearheaded by the HHS Healthcare Cybersecurity and Coordination Center and the Department of Homeland Security Cybersecurity and Infrastructure Security Agency. These partnerships have increased the health care sector's awareness of the impacts ransomware could have on operations, including having to move patients to other facilities, loss of access to electronic health records, potential fraud, and the compromising of electronic health information and other sensitive information.

This challenge is widely expected to increase as new technologies are developed and introduced into the market. These technologies include the expansion of telehealth and other remote patient monitoring modalities, AI, precision medicine technologies, and future digital treatments and therapies. In particular, FDA and the health care industry must continue to improve cybersecurity for networked medical devices (such as infusion pumps and pacemakers that use internet connectivity).[203] To address cybersecurity threats and reduce patient risks, FDA has issued guidance to help support premarket and postmarket processes related to cybersecurity impacts for devices. Additionally, FDA has sought additional funding and authorities to support its ongoing efforts to help device manufacturers and the ecosystem combat

cybersecurity threats.[204] FDA should continue to take steps to enhance its ability to receive relevant information as well as securely share information with key stakeholders.[205] HHS may have additional options to assess the cybersecurity of devices once in use by health care providers; however, there has been limited progress to assess this issue as part of the existing oversight mechanisms, such as the survey and certification process for Medicare-participating hospitals.[206]

The Department plays a significant role in ensuring the privacy of individual data such as personal health information, genetic information, and other sensitive data. The HIPAA Privacy Rule's requirements, established nearly 20 years ago, may not adequately address current issues related to privacy concerns. Patients and providers continue to have questions about how best to protect data while navigating the requirements and constraints of HIPAA. The Department's challenge is to be responsive to changes in the health care industry, including nontraditional health care delivery approaches that may impact patient privacy. Moving in this direction, the Office for Civil Rights has begun data collection to learn from the health care community which changes are needed to enable HIPAA to support present-day requirements.

6: Strengthening Coordination for Better Programs and Services

Key Takeaways

Relevant Agencies

- All HHS

Elements of the Challenge

- Preparing for and responding to PHEs
- Reducing health disparities in American Indian and Alaska Native communities
- Protecting children
- Keeping patients safe

The importance of HHS's mission and the breadth of its programs and authorities put the Department at the center of some of the largest and most complex problems facing the Nation. To solve these problems—and address issues on the horizon—HHS needs to coordinate, collaborate, and communicate effectively across HHS programs and with other Federal agencies as well as outside the Federal Government with Tribal, State, and local Governments, international entities, industry, and other stakeholders.

Strengthening HHS's coordination, collaboration, and communication can help Americans receive more efficient, higher quality health programs and human services and benefit from greater advances in the sciences underlying them. Interagency efforts led by the Department such as the HHS Task Force to Prevent Human Trafficking and the Behavioral Health Coordinating Council provide opportunities for HHS programs to work more efficiently and in closer alignment.[207, 208] Collaboration among HHS experts also helps the Department bring forward the best evidence to develop multifaceted strategies, such as the HHS Overdose Prevention Strategy.[209] Proactive engagement with integrity partners, such as OIG, can help HHS programs consider practices that mitigate risks of fraud, waste, and abuse when launching new or expand programs.[210, 211]

Effective partnerships with other Federal agencies help ensure that critical initiatives and resources, such as those for emergency preparedness and response or law enforcement investigations, are working in concert. Established networks of information exchange with State, Tribal, and local Governments can better allow HHS programs to reflect community needs and support culturally responsive public health efforts.[212] HHS's capacity to mitigate drug overdose risk through its Opioid Rapid Response Program, for example, relies on timely communication and coordination across OpDivs and StaffDivs and with State public health agencies.[213]

Engagement with HHS's vast array of nongovernmental stakeholders—from health care providers to food and drug manufacturers, health systems, nursing homes, hospices, professional associations, scientists, consumers, and community nonprofits, to name a few—is essential to delivering the best services and care to the American people and supporting HHS programs in achieving their intended outcomes. HHS's initiatives to ensure that the U.S. supply of safe and nutritionally adequate infant formula meets demand, for example, requires new engagements with companies that import, sell, and distribute infant formula, and those seeking to enter the formula market for the first time.[214] HHS's efforts to strengthen and protect the public health supply chain and industrial base cannot be accomplished without an array of industry partners, as well as strategic coordination among Federal, Tribal, State, Territorial, and local entities to prevent the maldistribution of critical resources in an emergency, such as personal

protective equipment, diagnostics, vaccines, and therapeutics.[215] HHS's ability to ensure that callers to 988, the National Suicide Prevention Lifeline, receive appropriate help at times of crisis requires collaboration with local organizations as well as States.[216]

Preparing for and responding to PHEs

In January 2022, GAO identified HHS's leadership and coordination of PHEs as a high-risk area in need of transformation. Although the unprecedented nature of the COVID-19 pandemic presented new coordination challenges—from medical supply shortages to the distribution of funds through new programs and large-scale vaccination programs—GAO's designation stemmed from deficiencies in HHS's emergency preparation and response leadership for more than a decade including during the H1N1 influenza pandemic, Zika, Ebola, and extreme weather emergencies, as well as during the COVID-19 pandemic. The GAO report pointed to HHS's coordination challenges as impediments to its leadership, specifically in establishing roles and responsibilities, communicating effectively with partners and the public at large, and understanding the parameters of its partners' capabilities.[217] In July 2022, HHS elevated leadership for emergency preparedness and response from StaffDiv, ASPR, to OpDiv, ASPR.[218] An early responsibility of the new agency was making vaccines available through the Strategic National Stockpile to mitigate the spread of monkeypox as the Nation confronted the monkeypox PHE.[219] Using lessons learned from COVID-19, CDC announced in August 2022 a reorganization designed to, among other goals, improve collaboration and communication and focus on a customer-centric structure.[220]

Decades of OIG reports have identified challenges to HHS's emergency preparedness and response and have provided recommendations to address these challenges.[221] A June 2022 OIG report found that some of the same challenges related to communication with partners and partner capabilities as identified by GAO heightened the risk of exposure to COVID-19 in facilities providing care to unaccompanied children.[222] Deficiencies in safety procedures occurred, in part, because the ORR was rapidly expanding capacity, setting up new emergency intake facilities, and developing COVID-19 protocols and guidance for their use. However, ORR did not have a process in place for widely disseminating the guidance and frequent updates to appropriate staff.

Information sharing across public health entities can lead to better decisions. Ensuring appropriate data access across HHS stakeholders is especially important in emergencies. Without access to data, public health decisionmakers lack timely information to develop the most effective response and allocate scarce resources. The *Tribal Health Data Improvement Act of 2021* required HHS to establish a strategy for providing access to public health care data to Indian Tribes and Tribal epidemiology centers.[223] During the COVID-19 pandemic, however, Tribal epidemiology centers were unable to readily access critical data maintained by HHS. Both GAO and OIG have recommended that HHS address issues blocking Tribal epidemiology centers from timely access to all public health data to which they are entitled.[224, 225]

Reducing health disparities in American Indian and Alaska Native communities

Ensuring Tribal epidemiology centers have access to data is key not only to an effective pandemic response but also to addressing health disparities affecting American Indian and Alaska Native (AI/AN) communities, which were disproportionally negatively impacted by COVID-19.[226, 227] Health disparities are health status differences across various socioeconomic, ethnic, and racial groups. People of color experience disparities in areas such as access to care and quality of care.[228] Such disparities have profound implications for the health and well-being of these individuals.

Access to safe drinking water and adequate waste disposal facilities are essential for healthy populations as these prevent disease. To address sanitation deficiencies in AI/AN communities, the *Infrastructure Investment and Jobs Act* (IIJA) allocated $3.5 billion to the IHS Sanitation Facilities Construction (SFC) Program.[229] Through effective collaboration and communication with Tribal entities and other stakeholders, HHS has an opportunity to assist AI/AN communities in addressing challenges associated with managing the rapid increase in SFC funding provided under the IIJA, and ultimately to reduce disparities in access for AI/AN communities to adequate sanitation and in health outcomes.

Protecting children

As described in TMC 4, a Top Management Challenge for HHS is safeguarding the well-being of people served by HHS programs, including children. Recent OIG reviews highlight areas in which better collaboration, coordination, and communication could help address program vulnerabilities that put children at risk.

OIG reviews of children missing from foster care demonstrate opportunities for better collaboration between HHS and State agencies to improve outcomes for the thousands of children missing from their placements nationwide and reduce episodes of missing children and associated risk, including the risk of being trafficked.[230, 231, 232] A 2022 OIG evaluation found a lack of communication among HHS divisions regarding unaccompanied children during the development and early implementation of CDC's Title 42 order to suspend the entries of certain persons into the United States due to COVID-19 risks. Based on this finding, as well as prior findings related to the UC Program,[233] OIG recommended that HHS take steps to improve internal coordination and communication about unaccompanied children and ensure that CDC coordinates with ORR when making future decisions that could affect the number of unaccompanied children placed in ORR's care.[234]

Keeping patients safe

OIG reports have identified issues with HHS coordination with, and outreach to, external partners that may leave patients at risk of harm. For example, OIG found that more than half of the States repeatedly failed to meet one or more performance measures—most commonly, timeliness requirements—for conducting nursing home surveys. Nevertheless, CMS rarely reached out to senior State officials, such as Governors or health department directors, to raise concerns about State survey performance. OIG recommended that CMS engage with senior State officials earlier and more frequently when it identifies persistent or egregious performance problems. Earlier and more frequent contact may underscore the importance of requirements for protecting the health and safety of nursing home residents, build a greater understanding of the urgency to resolve performance problems and their implications for nursing home residents, and provide opportunities for State officials or other stakeholders to develop solutions before problems become critical.[235] (See TMC 4 for more information on nursing homes and patient safety.)

HHS coordination internally and with medical organizations is a key recommendation in an OIG review that found children enrolled in Medicaid in five States did not receive important blood lead screening tests on schedule. Specifically, more than one-third of the 1 million children who were required to receive a 12-month and a 24-month blood lead screening test received neither test. The OIG review recommended that CMS coordinate with Federal agencies, such as CDC, and medical organizations, such as the American Academy of Pediatrics, to develop educational materials for State Medicaid agencies that clearly communicate Medicaid's requirements and testing schedule, and highlight the current actionable blood lead reference value.[236]

As described in TMC 1, OIG work raises concerns about people enrolled in Medicare receiving treatment for OUD. OIG has recommended several collaborative approaches to increase the number of people receiving treatment, such as CMS outreach to enrollees, engagement to increase the number of providers and opioid treatment programs, and assisting SAMHSA with data.[237]

Conclusion

To run effective and efficient programs, HHS must consider issues and impacts outside a single program or mission for any one of its agencies. Barriers to coordination include navigating a wide breadth of HHS stakeholders with different goals and authorities and varying logistic, economic, and workforce pressures, as well as the scope and complexity of the problems for which HHS needs partnerships to resolve and the ever-changing landscape of the health and human services sectors. Overcoming these barriers requires HHS to engage in intentional, sustained, and forward-looking efforts toward building strategic partnerships both domestically and internationally, communicating effectively, managing collaborative work, and maintaining accountability.

ENDNOTES

[1] CDC, *COVID Data Tracker*. Available at https://covid.cdc.gov/covid-data-tracker.

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Department's Response to the Office of Inspector General

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Deputy Secretary

To: Christi A. Grimm, Inspector General

From: Andrea Palm, Deputy Secretary

Subject: FY 2022 Top Management and Performance Challenges Facing HHS

Thank you for the Office of Inspector General's (OIG) work in assessing the major management and performance challenges facing the Department of Health and Human Services (HHS). We appreciate the OIG's dedication to the improvement of HHS operations through its audit and investigative work over the years. In FY 2022, the OIG identified six top management and performance challenges affecting the Department's effectiveness in current programs and responsibilities. HHS recognizes the importance of identifying and mitigating risks impeding the successful execution of our mission and sound stewardship of taxpayer dollars.

The OIG highlighted the challenges of numerous public health emergencies, including the emergence of the monkeypox virus and perpetual evolution of mental health solutions. HHS is committed to the vital responsibility of assisting communities through these and other public health emergencies. To do so effectively, we know we must continue to improve how we operate.

The Department acknowledges the management and performance challenges identified by the OIG, and we are devoted to resolving these challenges so we can achieve our overall mission of improving the health and well-being of the American people. We look forward to partnering with you and our stakeholders on the continuous improvement of our activities.

/Andrea Palm/

Andrea Palm
Deputy Secretary
November 14, 2022

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SECTION 4:
Appendices

- Appendix A: Acronyms
- Appendix B: Connect with HHS

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Appendix A: Acronyms

AAP	Accelerated and Advance Payment
ACF	Administration for Children and Families
ACL	Administration for Community Living
ADA	Antideficiency Act
AFR	Agency Financial Report
AHRQ	Agency for Healthcare Research and Quality
AIM	Alliance for Innovation on Maternal Health
APG	Agency Priority Goal
APM	Alternative Payment Model
APTC	Advance Premium Tax Credit
ARP	American Rescue Plan
ASFR	Office of the Assistant Secretary for Financial Resources
ASPE	Office of the Assistant Secretary for Planning and Evaluation
ASPR	Office of the Assistant Secretary for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry
BARDA	Biomedical Advanced Research and Development Authority
CAAP	COVID-19 Accelerated & Advance Payment
CAAP	COVID-19 Accelerated & Advance Payment
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CDC	Centers for Disease Control and Prevention
CFO Act	Chief Financial Officer Act
CFO	Chief Financial Officer
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COLA	Cost of Living Adjustment
COVID-19	Coronavirus Disease
CPI	Consumer Price Index
CRC	Commercial Repayment Center
CSRS	Civil Service Retirement System
DATA Act	Digital Accountability and Transparency Act of 2014
DIR	Direct and Indirect Remuneration
DME	durable medical equipment
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
DMF	Death Master File
DNP	Do Not Pay
DOI	Department of the Interior
DOJ	Department of Justice
DOL	Department of Labor
DR	Disaster Recovery
DRA	Deficit Reduction Act of 2005
ECE	early care and education
EPMO	Enterprise Program Management Office
ERM	Enterprise Risk Management
FASAB	Federal Accounting Standards Advisory Board
FBIS	Financial Business Intelligence System
FBwT	Fund Balance with Treasury
FCTR	Federal Cash Transaction Report
FDA	Food and Drug Administration
FECA	Federal Employees' Compensation Act
FERS	Federal Employees Retirement System
FFMIA	Federal Financial Management Improvement Act of 1996
FFS	Fee-For-Service
FGB	Financial Management Governance Board
FICA	Federal Insurance Contributions Act
FIFO	First-In/First-Out
FITARA	Federal Information Technology Acquisition Reform Act
FMFIA	Federal Managers' Financial Integrity Act of 1982
FR	Financial Report of the United States Government
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	U.S. Government Accountability Office
GDP	Gross Domestic Product
GHP	Group Health Plan
G-Invoicing	Government Invoicing
Grants QSMO	Grants Quality Service Management Office
GSA	General Services Administration
GTAS	Governmentwide Treasury Account Symbol Adjusted Trial Balance System
HEW	Department of Health, Education, and Welfare
HHC	Hierarchical Condition Category
HHS	Department of Health and Human Services
HI	Hospital Insurance
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HRSA	Health Resources and Services Administration
IBNR	Incurred But Not Reported
IHS	Indian Health Service
I-MEDIC	Investigations Medicare Drug Integrity Contractor
IRA	Inflation Reduction Act
IRF	Inpatient Rehabilitation Facility

Acronyms

IRS	Internal Revenue Service
IT	Information Technology
LIHWAP	Low-Income Household Drinking Water and Wastewater Emergency Assistance Program
LPR	Lawful Permanent Resident
MA	Medicare Advantage
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MAO	Medicare Advantage Organization
MARx	Medicare Advantage Prescription Drug
MCO	Medicaid Managed Care Organization
MEDIC	Medicare Drug Integrity Contractor
MEQC	Medicaid Eligibility Quality Control
MIPS	Merit-based Incentive Payment System
MMA	Medicare Modernization Act of 2003
MSP	Medicare Secondary Payer
Net PTC	Net Premium Tax Credits
NIH	National Institutes of Health
OASDI	Old-Age, Survivors, and Disability Insurance
OASH	Office of the Assistant Secretary for Health
OCCHE	Office of Climate Change and Health Equity
OCR	Office for Civil Rights
OGA	Office of Global Affairs
OGM	Office of Grants Management
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OpDiv	Operating Division
OPM	Office of Personnel Management
ORR	Office of Refugee Resettlement
OS	Office of the Secretary
Part A	Hospital Insurance
Part B	Medical Insurance
Part C	Medicare Advantage
Part D	Medicare Prescription Drug Benefit
PDE	Prescription Drug Event
PHE	Public Health Emergency
PHS	Public Health Service
PHSSEF	Public Health and Social Services Emergency Fund
PIIA	Payment Integrity Information Act of 2019
POP	Period of Performance
PP&E	Property, Plant and Equipment
PPACA	Patient Protection and Affordable Care Act
PPI	Plan Program Integrity
PRAC	Pandemic Response Accountability Committee
PRF	Provider Relief Fund
PSC	Program Support Center
PTF	Payments to the Trust Funds
RAC	Recovery Auditor Contractor
RADV	Risk Adjustment Data Validation
REMS	risk evaluation and mitigation
RSI	Required Supplementary Information
RSI	Required Supplementary Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SCSIA	Statement of Changes in Social Insurance Amounts
SECA	Self Employment Contributions Act of 1954
Section 601	Bipartisan Budget Act of 2015
SFFAS	Statement of Federal Financial Accounting Standards
SGR	Sustainable Growth Rate
SMI	Supplementary Medical Insurance
SMRC	Supplemental Medical Review Contractor
SNF	Skilled Nursing Facility
SNS	Strategic National Stockpile
SOSI	Statement of Social Insurance
SSA	Social Security Administration
SSF	Service and Supply Funds
StaffDiv	Staff Division
STLT	state, tribal, local, and territorial
SUD	Substance use disorder
TANF	Temporary Assistance for Needy Families
TAS	Treasury Account Symbol
The Act	Social Security Act
Treasury	U.S. Department of the Treasury
TTD	Time-to-Death
U.S.	United States
U.S.C.	United States Code
UIP	Uninsured Program
UPICS	Unified Program Integrity Contractors
USSGL	United States Standard General Ledger
VFC	Vaccines for Children

Appendix B: Connect with HHS

On behalf of the Department, we would like to sincerely thank and acknowledge all the individuals that provided support, either through content contribution or review feedback, to produce the FY 2022 AFR. We could not have prepared the FY 2022 AFR without the talent, time, and dedication of the employees across the Department of Health and Human Services.

The Hubert H. Humphrey Building, headquarters of the U.S. Department of Health and Human Services, was the first federal building dedicated to a living person.

Thank you for your interest in HHS's FY 2022 AFR. We welcome your comments on how we can make this report more informative for our readers. Please send your comments to:

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