Department of Health and Human Services

Agency Financial Report

FISCAL YEAR 2023

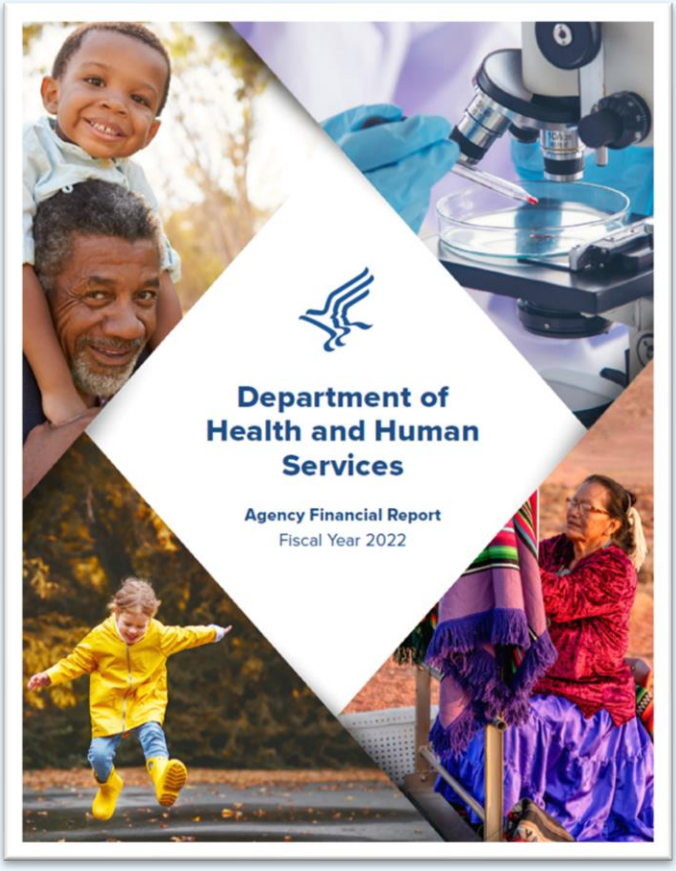
CELEBRATING 70 YEARS OF HHS

70 YEARS

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. The AGA (formerly known as Association of Government Accountants) has recognized HHS's Agency Financial Report (AFR) for 10 consecutive years 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 agency accomplishments during a fiscal year (FY) and to discuss any challenges that remain.

The FY 2022 AFR exemplifies our dedication, spirit, and commitment to the HHS mission. Through another year of pandemic-related challenges, HHS's perseverance and efforts in FY 2022 continue to demonstrate award-winning results.




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

payment integrity report presentation

in the Agency Financial Report for fiscal year 2022


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 2022

HHS's FY 2022 AFR was honored with a Best-in-Class Award for "Payment Integrity Report Presentation."

This is the second time HHS has been recognized in this area for producing a comprehensive report with clear explanations of the improper payment challenges, overview of the risks, and informative analyses and explanation of corrective actions the agency is taking.

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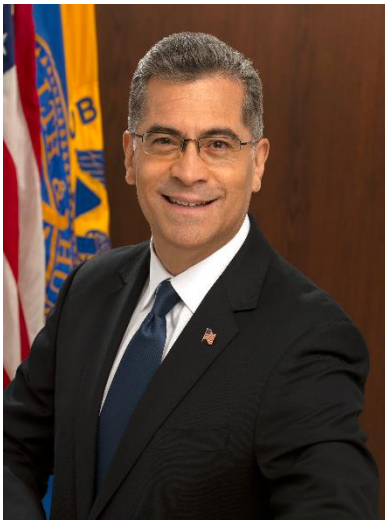
Message from the Secretary



Xavier Becerra

I am proud to present the Fiscal Year (FY) 2023 Agency Financial Report (AFR) for the U.S. Department of Health and Human Services (HHS). This comprehensive report details how we used our resources to accomplish the Department's mission during the last year. In 2023, we moved beyond the COVID public health emergency with a foundation strengthened to address future challenges and an HHS workforce that demonstrated its commitment to improving the health and well-being of children, adults, and seniors.

This year marks the 70th anniversary of HHS's founding, and I am honored to highlight how our vital work promoted innovation in medicine, public health, and social services during the last seven decades. We continue those efforts today by focusing on five priority areas I touch on in this Message.

Top Priorities

The women and men at HHS are committed to eliminating barriers to equitable care and to ensuring we leave no one behind. We are working to lower costs, advance health equity, decrease disparities, and improve health outcomes for all. We are moving our society from an illness-care system to a wellness care system.

We learned many lessons during the last 3 years, and we are better prepared today to address emergent challenges than at any time in our past. We strengthened our preparedness and response capability by creating resiliency in the domestic supply chain, building capacity to ensure adequate stockpiles, and fostering innovation across the health care system.

We may have ended the recent pandemic, but we are advancing innovative vaccines and therapeutics through a $5 billion investment in Project NextGen to protect against evolving COVID threats. For Americans dealing with the effects of Long COVID, we formed the Office of Long COVID Research and Practice to lead the response and coordination across the federal government. We have made updated COVID-19 vaccinations available free of charge to Americans, regardless of their income or health insurance status, thanks to the Centers for Disease Control and Prevention (CDC) Bridge Access Program. We must also make up lost ground on childhood immunizations, routine cancer screenings, and other foundational health actions that were stopped or delayed in recent years.

Pandemics are not the only threats to our collective well-being; climate disasters like droughts, wildfires, tornadoes, and hurricanes are becoming more frequent and intense. HHS is toughening our public health response system to the growing impacts from the climate crisis. This summer we launched the Heat-Related Illness EMS Activation Surveillance Dashboard to help communities and officials keep people cool, safe, and alive through effective heat mitigation strategies. And our investments into infrastructure and emergency equipment ahead of hurricane season helped ensure communities in hurricane-prone areas have continuous access to primary care services.

In only one year, the President's lower cost prescription drug law – the Inflation Reduction Act – helped reduce health care costs and expand access to care for millions of Americans. The law capped the cost of insulin at $35 per month for Medicare beneficiaries and made Shingles and other vaccines available for free. For the first time ever, Medicare is now able to negotiate directly with drug manufacturers on the cost of prescription drugs – ten drugs will be part of the first round of negotiations. The law also helped consumers save over $800 in premiums per year by extension of enhanced financial assistance. I am happy to share that the national uninsured rate reached an all-time low of 7.7 percent in early 2023, with a record number of 16.4 million people signing up or re-enrolling in health insurance coverage through HealthCare.gov during the Open Enrollment Period.

Message from the Secretary

HHS is committed to supporting and growing the health care workforce while ensuring historically underserved and rural communities get the primary care services and other health care they need to thrive. Our heroic health care workforce is stretched to the limit, but HHS is working to recruit, retain, and upskill the workforce so our health sector meets growing care demands. We are investing in the workforce through loan repayments and scholarships and offering grants to organizations that direct professionals to underserved communities. Our efforts help more health professionals work in historically underrepresented communities, including rural and tribal communities.

HHS is focused on strengthening behavioral health care and effectively responding to the drug and opioid crisis by investing in prevention, treatment, harm reduction, and recovery services. Over the past year, we took unprecedented steps to expand access to naloxone and other harm reduction interventions. We are permitting the use of federal funding for state and local public health departments to purchase naloxone, issuing guidance to make it easier to obtain and distribute naloxone to at-risk populations, and we are approving Narcan for direct sale to consumers as the first nonprescription "over-the-counter" naloxone nasal spray. As a result, the CDC overdose data show a decrease or flattening of reported overdoses in 2023.

We are keen on tackling health disparities and helping families stay healthy at home. HHS invested $6.1 billion to help low-income households cover heating and cooling costs for over six million households through the Low Income Home Energy Assistance Program. We have funded the expansion of Certified Community Behavioral Health Clinics (CCBHC) that provide equitable access to behavioral health services for all Americans. These clinics serve anyone who requests care for mental health or substance use, regardless of their ability to pay. And we know these clinics work – data show that CCBHC decrease homelessness, the use of illegal substances, stays in correctional facilities, and time spent in emergency rooms for behavioral health issues and inpatient mental health treatment.

In July, we celebrated the 1-year anniversary of the 988 Suicide & Crisis Lifeline. Since last year's launch, the 988 Lifeline has answered more than five million calls, chats, and texts, including contacts from one million veterans or their family members. We also added Spanish text and chat services and specialized services for LGBTQI^{+} youth and young adults. Since the launch of the 988 Lifeline, text contacts increased by 1135 percent, chats answered increased by 141 percent, and calls answered increased by 46 percent. We continue to build out the 988 Lifeline through $200 million in grants to help communities create new crisis response teams.

And, HHS is supporting grantees who train healthcare providers caring for individuals in need of mental health and substance use services in underserved and rural communities. In July, the Substance Abuse and Mental Health Services Administration announced $47.8 million in awards for five grant programs devoted to combating the nation's overdose epidemic and more than $64 million through the Community Mental Health Services Block Grant program to address the nation's mental health crisis and make our communities safer.

We are also addressing disparities and investing in the health and well-being of children by supporting early child-care, expanding health care access in schools, and ensuring children's access to mental and behavioral health services. HHS continued our investment in states, territories, and tribes through Community Services Block Grant funding to help reduce poverty through community-based programming that alleviates the causes and conditions of poverty. We also expanded primary health care in schools to include mental health services through HHS-funded health centers in 3,400 sites across the country, and we are taking bold actions to strengthen school-based health care services through our Medicaid program so children in every community have the support they need.

We recognize there is a maternal health crisis in our country. The U.S. has the highest maternal mortality rate of any developed nation and more than double the rate of peer countries. This year, we took significant steps to improve maternal health outcomes and reduce disparities for patients at highest risk, including investing in programs that strengthen the maternal health workforce, improve pre-natal, delivery, and post-pregnancy support services, offer new parents mental health support, and increase services in underserved communities.

We supported the Administration of Children and Families' Diaper Distribution Pilot to fund a critical need for low-income families, investing $24.3 million in the pilot since the program's inception in September 2022. In 2023, we dedicated $435 million in grants for programs that research and address care disparities and support pregnant women and parents with young children who live in communities that face greater risks and barriers to achieving positive maternal and child health outcomes.

Cutting-edge research to improve the nation's health is a foundation of our work at HHS. We are committed to investing in programs that use innovative technology and systems to support the life and health of Americans when and where they need it most. Advanced Research Project Agency for Health, which launched last year, initiated its first round of projects in 2023. Our stewardship and oversight of the Organ Procurement and Transplantation Network (OPTN) was a top priority this year as well, and our OPTN Modernization Initiative will strengthen accountability and transparency and make data more accessible. In April, HHS released a National Cancer Plan developed by the National Cancer Institute of the National Institutes of Health. The plan's eight essential goals and accompanying strategies outline a framework to prevent more cancers, reduce deaths from the disease, and improve the lives of everyone after a cancer diagnosis. To help achieve these goals, the plan depicts how the public and private sectors can work together to reduce the cancer death rate by 50 percent within 25 years – the challenge issued by President Biden when he relaunched his Cancer Moonshot. As we have since 1953, HHS will continue providing highly innovative health care services to the American people while wisely using our resources.

Stewardship

HHS has a long history of budgetary and financial excellence. For the 25th consecutive year, we obtained an unmodified (clean) opinion on our FY 2023 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 *Patient Protection and Affordable Care Act* 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 2023 Medicare Trustees Report, as required by standards issued by the Federal Accounting Standards Advisory Board. The "Financial Section" includes more detailed information.

The *Federal Managers' Financial Integrity Act* and the Office of Management and Budget's Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, direct us to closely evaluate our internal controls and financial management systems each year. Accordingly, we have identified a material noncompliance with the *Payment Integrity Information Act of 2019*. The "Management's Discussion and Analysis" section includes details. Based on assessments, I can provide reasonable assurance the financial and performance information contained in this report is complete, reliable, and accurate.

Moving Forward

I take immense pride in the HHS workforce, who have selflessly driven the Department's successes for 70 years with unwavering dedication and commitment. Their passion for our mission and for each other justifies how HHS placed second of all large government agencies in the annual "Best Places to Work in the Federal Government" rankings. And we are committed to our mission in the decades to come, as discussed in the "Looking Ahead" section. To successfully move forward we must also identify ways to improve our processes and results; the Office of Inspector General describes our most significant management and performance challenges in the "Other Information" section.

Conclusion

HHS has a rich history of unwavering service to the nation and unparalleled success in our mission. As you review this report and reflect on the 70-year history and countless accomplishments of HHS, know that we will not rest on those laurels. HHS will continue to show up, embrace challenges, innovate approaches, and carry out our vital call to improve the health and well-being of all Americans far into the future.

/Xavier Becerra/

Xavier Becerra
Secretary
November 14, 2023

Walking Through 70 Years of HHS's Past and Present Accomplishments

The origins of HHS can be traced back to 1798, with the passage of an Act for the Relief of Sick and Disabled Seamen, establishing a federal network of hospitals to care for sick and disabled merchant seamen. The Department has since grown to become one of the largest U.S. federal agencies, serving to enhance the health and well-being of all Americans. HHS honors the past and celebrates 70 years of our accomplishments as we advance our mission into the future. For more information, visit the HHS Historical Highlights page.

1953

Cabinet-level Department of Health, Education, and Welfare created under President Eisenhower, officially coming into existence on April 11, 1953.

1955

Indian Health Service transferred to Department of Health, Education, and Welfare from Department of the Interior. The Salk polio vaccine was licensed.

1965

Medicare and Medicaid programs created, making comprehensive healthcare available to millions of Americans.

1966

Global Smallpox Eradication program established.

1970

National Health Service Corps created, providing scholarships and loan repayments to healthcare providers in exchange for a period of service in health professional shortage areas.

1977

Worldwide eradication of smallpox, led by the U.S. Public Health Service.

1980

Department of Health, Education, and Welfare became the U.S. Department of Health and Human Services on May 4, 1980.

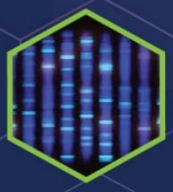
1981

Centers for Disease Control and Prevention identified and recognized Acquired Immunodeficiency Syndrome as a new disease.

1984
National Organ Transplant Act signed into law, addressing organ donation shortage and improving organ matching process.

1988
Job Opportunities and Basic Skills program and federal support for childcare created.

1989
Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality) created.



1990
Human Genome Project established.

1991
Administration for Children and Families created, becoming the U.S.' largest human services administration.

1996
Health Insurance Portability and Accountability Act enacted.

1997
State Children's Health Insurance Program created, enabling states to extend health coverage to more uninsured children.

1999
Ticket to Work and Work Incentives Improvement Act of 1999 signed, enabling millions of Americans with disabilities to join the workforce without fear of losing Medicaid and Medicare coverage. Modernized the employment services system for people with disabilities.

2000
Assembled 85 percent of the human genome sequence, generating and publishing the complete sequence in 2003.

2001
Centers for Medicare & Medicaid Services created, replacing the Health Care Financing Administration.

2002
Office of Public Health Emergency Preparedness (now the Administration for Strategic Preparedness and Response) created to coordinate efforts against bioterrorism and other emergency health threats.

2003
Medicare Prescription Drug Improvement and Modernization Act of 2003 enacted, expanding Medicare to include a prescription drug benefit.

2009
Approval of 100th antiretroviral drug aimed to treat people living with Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome worldwide, in cooperation with the President's Emergency Plan for AIDS Relief.

2010
Patient Protection and Affordable Care Act signed into law, enacting monumental comprehensive U.S. health insurance reforms.

2012
Administration for Community Living created to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers.

2013
Brain Research through Advancing Innovative Neurotechnologies Initiative launched to revolutionize our understanding of the human brain.

INTRODUCTION

2015

Centers for Disease Control and Prevention launched the Global Rapid Response Team to rapidly respond to global public health concerns in the U.S. and around the world.

2016

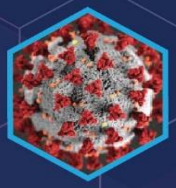
Cancer Moonshot program launched to accelerate progress against cancer.

2018

Food and Drug Administration approved first generic version of EpiPen and EpiPen Jr (epinephrine) auto-injector for the emergency treatment of allergic reactions, including life-threatening anaphylaxis.

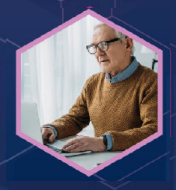
2019

Food and Drug Administration approved first Ebola vaccine.



2020

National Institutes of Health launched the Rapid Acceleration of Diagnostics initiative, speeding innovation in developing, commercializing, and implementing COVID-19 testing technologies – a pivotal component of returning to normal during the global pandemic.



2021

Though virtual visits have occurred since the late 1950s, telemedicine grew exponentially due to the global pandemic, improving patient safety, access to health-care, and accessibility to people with disabilities.

2022

Substance Abuse and Mental Health Services Administration's 988 three-digit dialing code became available nationwide to connect directly to the 988 Suicide & Crisis Lifeline (formerly National Suicide Prevention Lifeline), representing a significant step toward a transformed crisis care system in America. Inflation Reduction Act was signed into law.

2023

U.S. Department of Health and Human Services' Office of Climate Change and Health Equity, in partnership with the National Highway Traffic Safety Administration, launched a first-of-its-kind online information portal called the Heat-Related Illness EMS Activation Surveillance Dashboard, mapping emergency medical services responses to heat-related illness across the country.

About the Agency Financial Report

The HHS FY 2023 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, 2022, through September 30, 2023. This report provides an overview of our programs, accomplishments, challenges, and management's accountability for the resources entrusted to us. We prepared this report 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

- The Management's Discussion and Analysis section provides an overview of HHS's mission, activities, organizational structure, program performance, and forward looking information. 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

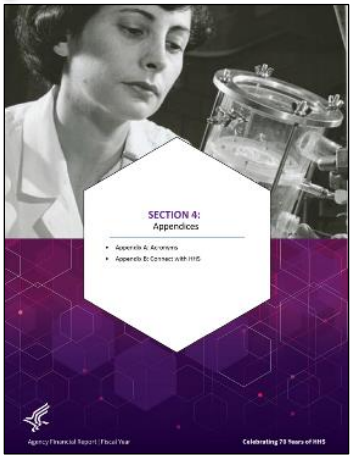
- The Financial section begins with a message from the Chief Financial Officer. Section 2 continues with the independent auditor's report, management's response to the audit report, financial statements with accompanying notes, and required supplementary information, including the Combining Statement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

Section 3: Other Information

- The Other Information 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

- The Appendices 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 2024 including:

- FY 2025 *Annual Performance Plan and Report*
- FY 2025 *Congressional Budget Justification*

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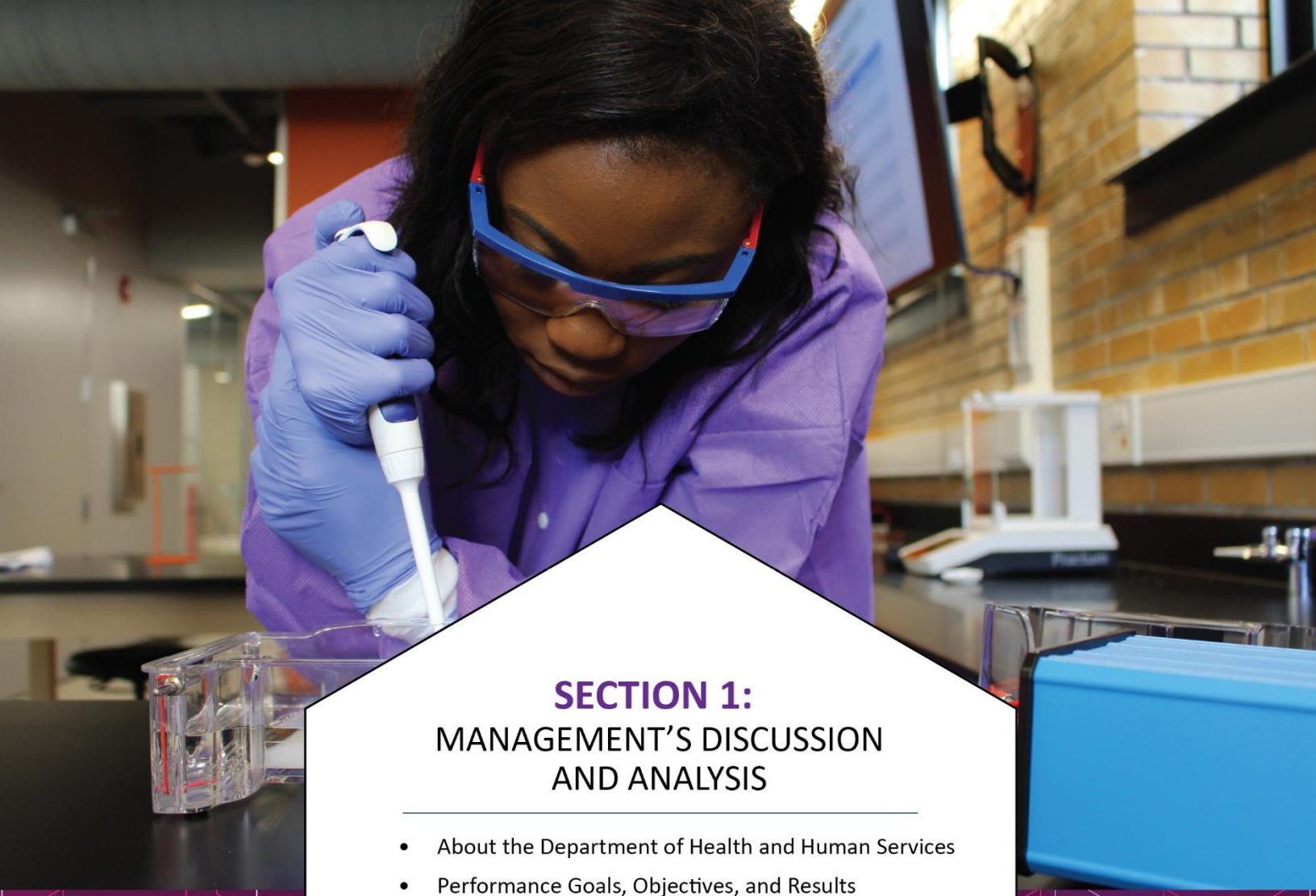

SECTION 1:
MANAGEMENT'S DISCUSSION AND ANALYSIS

- About the Department of Health and Human Services
- Performance Goals, Objectives, and Results
- Looking Ahead to 2024
- 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 health of 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 160 million Americans.

What We Do

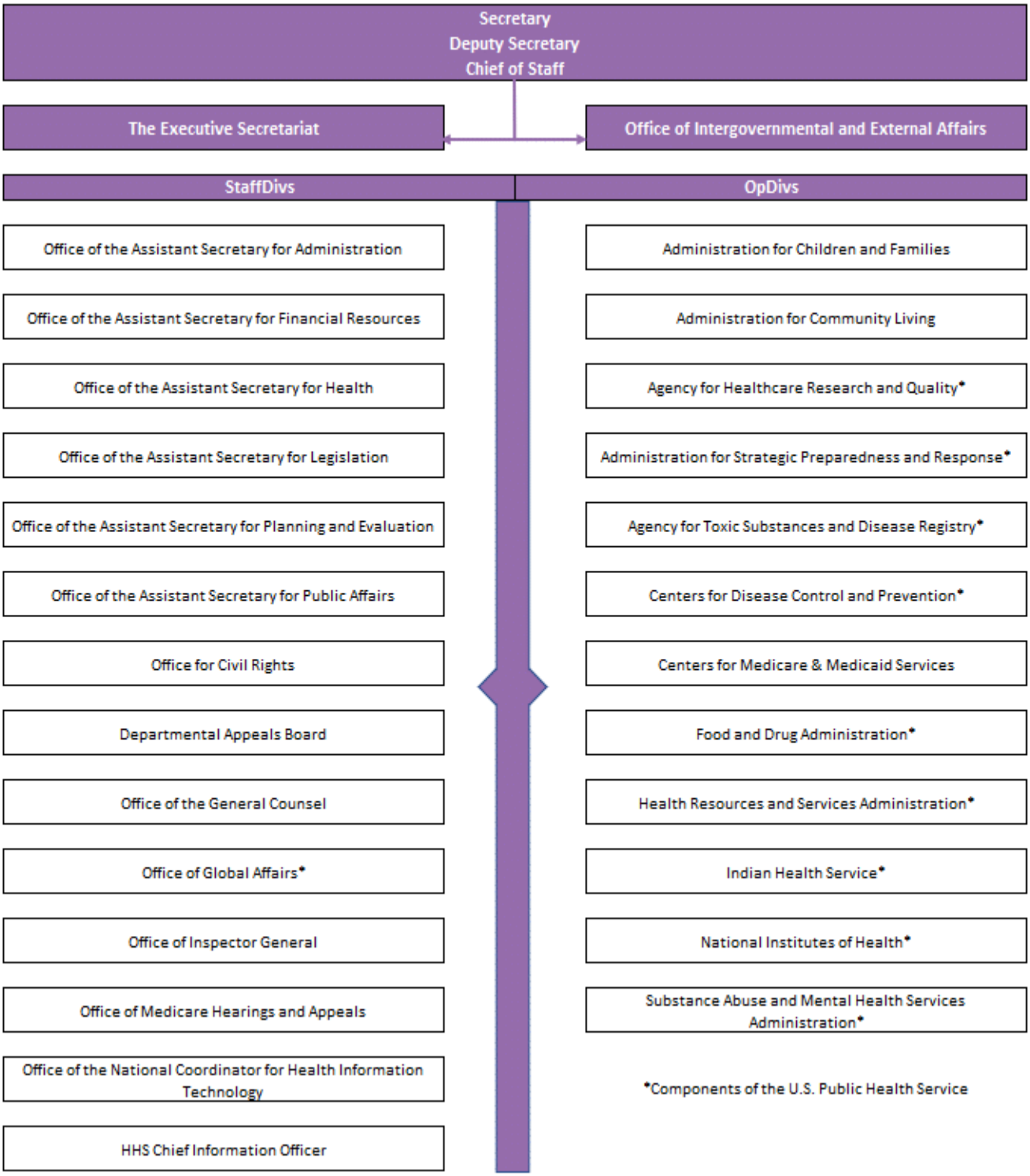
HHS works closely with U.S. state, local, territorial, and tribal governments and agencies; and private sector recipients that provide many HHS-funded services at the local level. While HHS is a domestic agency working to protect and promote the health and well-being of the American people, the interdependence 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 agencies in the U.S. Public Health Service and three providing human services – 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:

- Promotes health and disease prevention by offering resources that help the American people eat smart, exercise regularly, and get routine health screenings and vaccinations;
- Leads the nation's medical and public health in preparing for, responding to, and recovering from disasters and public health emergencies;
- Strengthens early childhood development and expands opportunities to help children and youth thrive equitably within their families and communities;
- Provides education and training opportunities for health professionals and students including loans, scholarships, and training programs;
- Helps families and individuals stay safe and informed about food, drugs, medical devices, violence prevention, and more;
- Protects patients' rights of nondiscrimination and privacy in healthcare delivery through enforcement of federal rights, and through education and guidance of same to healthcare providers and covered entities;
- Invests 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.

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.



About the Department of Health and Human Services

Each OpDiv contributes to the HHS mission as follows:

Administration for Children and Families (ACF)

ACF's mission is to foster health and well-being by providing federal leadership, partnership, and resources for the compassionate and effective delivery of human services. Through its Strategic Plan, 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. ACF also works to improve access to services through planning, reform, and integration, as well as address the needs, strengths, and abilities of vulnerable populations, including refugees and migrants.

Administration for Community Living (ACL)

ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities across their lifespan, and their families and caregivers. ACL was created around the fundamental principle that older adults and people of all ages with disabilities should be able to live where they choose, with the people they choose, and with the ability to participate fully in their communities. ACL helps make this principle a reality for millions of Americans by funding services and supports provided primarily by networks of community-based organizations, and with investments in research, education, and innovation.

Agency for Healthcare Research and Quality (AHRQ)

AHRQ's mission is to produce evidence to make healthcare safer, higher quality, and more accessible, equitable, and affordable. AHRQ works within HHS and with other partners to ensure evidence is understood and used by focusing on three core competencies: (1) Health Systems Research; (2) Practice Improvement; and (3) Data & Analytics.

Administration for Strategic Preparedness and Response (ASPR)

ASPR's mission is to assist the country in preparing for, responding to, and recovering from public health emergencies and disasters. ASPR accomplishes its mission by developing, stockpiling, and distributing response tools against multiple threats; sending clinical response teams to places in times of crisis; and ensuring our healthcare and public health partners have the knowledge and tools they need to navigate today's challenges and confront whatever challenges lay ahead.

Agency for Toxic Substances and Disease Registry (ATSDR)

ATSDR's mission is to protect communities from harmful health effects related to exposure to natural and man-made hazardous substances. ATSDR does this by responding to environmental health emergencies; investigating emerging environmental health threats; conducting research on the health impacts of hazardous waste sites; and building capabilities of and providing actionable guidance to state and local health partners.

About the Department of Health and Human Services

Centers for Disease Control and Prevention (CDC)

CDC's mission is to work around the clock to protect America from health, safety, and security threats, both foreign and domestic. To accomplish its mission, CDC conducts critical science and provides health information that protects our nation against expensive and dangerous health threats and responds when these threats arise. CDC's Strategic Plan leverages five core capabilities: (1) Diverse Public Health Workforce; (2) World-class Data & Analytics; (3) State-of-the-Art Laboratories; (4) Rapid Response to Outbreaks at Their Source; and (5) Strong Global Capacity & Domestic Preparedness that reflects the commitment to equity and diversity and lifting CDC's investments through the pandemic.

Centers for Medicare & Medicaid Services (CMS)

CMS's mission is to lead the advancement and integration of health equity in the development, evaluation, and implementation of CMS's policies, programs, and partnerships. To accomplish its mission, CMS provides health coverage to more than 160 million people through Medicare, Medicaid, CHIP, and the Health Insurance Marketplace, which provides access to private health insurance coverage to individuals and families in more than 30 states. Over the last 50 years, CMS evolved into the largest purchaser of healthcare and now houses the nation's largest collection of healthcare data. CMS works in partnership with the entire healthcare community to improve quality, equity, and outcomes in the healthcare system. CMS's strategic vision focuses on delivering meaningful, person-centered, and equitable care through implementing six strategic pillars: (1) Advance Equity; (2) Expand Access; (3) Engage Partners; (4) Drive Innovation; (5) Protect Programs; and (6) Foster Excellence.

Food and Drug Administration (FDA)

FDA's mission is to protect 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 is responsible for advancing the public health by helping to speed innovations that make medical products safer, more effective, and more affordable, and by helping the public get the accurate, science-based information they need to use medical products and foods to maintain and improve their health. 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.

Did You Know?

Located at the foot of Capitol Hill in Washington D.C., the Hubert H. Humphrey Building is the headquarters building of HHS. The naming of the building in 1977 marked the first time that a federal building had been dedicated to a living person. Hubert Humphrey, who served as U.S. senator from Minnesota and Vice President of the U.S., was born in 1911 and died in 1978.

About the Department of Health and Human Services

Health Resources and Services Administration (HRSA)

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. HRSA is dedicated to providing equitable healthcare to the nation's highest-need communities–serving people who are geographically isolated and economically or medically vulnerable. HRSA programs support people with low incomes, people with human immunodeficiency virus (HIV), pregnant people, children, parents, rural communities, transplant patients, and other communities in need, as well as the health workforce, health systems, and facilities that care for them.

Indian Health Service (IHS)

IHS's mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. IHS creates healthy communities and quality healthcare systems through strong partnerships and culturally responsive practices. 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 provides a comprehensive health service delivery system for approximately 2.8 million American Indians and Alaska Natives who belong to 574 federally recognized tribes in 37 states.

National Institutes of Health (NIH)

NIH's mission is to seek 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 applies its leadership and knowledge to provide direction to programs designed to improve the health of the nation. NIH seeks to foster fundamental creative discoveries, innovative research strategies, and their applications as a basis for ultimately protecting and improving health. The NIH-Wide Strategic Plan outlines its vision for biomedical research direction, capacity, and stewardship.

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA's 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 leads public health efforts to advance the behavioral health of the nation and to improve the lives of individuals living with mental and substance use disorders (SUD), as well as their families. SAMHSA envisions that people with, affected by, or at risk for mental health and substance use conditions receive care, achieve well-being, and thrive. SAMHSA's efforts prioritize equity, trauma-informed approaches, recovery, and a commitment to data and evidence. SAMHSA focuses on five key priority areas of its Strategic Plan: (1) Preventing substance abuse 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.

About the Department of Health and Human Services

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

Immediate Office of the Secretary (IOS)

IOS is responsible for Department operations and coordinates 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, coordinates 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.

Assistant Secretary for Administration (ASA)

ASA provides leadership for HHS departmental administration by overseeing the areas of human resources policy, equal employment opportunity, diversity, facilities management, information technology and the Department's service operations. The Program Support Center, a component of ASA, is a shared services organization dedicated to providing support services to help its customers achieve mission-oriented results.

Office of the Assistant Secretary for Financial Resources (ASFR)

ASFR provides advice and guidance to the HHS Secretary on all aspects of budget, financial management, grants, and acquisition management, and provides direction for implementing these activities across the Department.

Office of the Assistant Secretary for Health (OASH)

OASH oversees the Department's key public health offices and programs, a number of Presidential and Secretarial advisory committees, 10 regional health offices across the nation, Office of the Surgeon General, and the Commissioned Corps of the U.S. Public Health Service.

Office of the Assistant Secretary for Legislation (ASL)

ASL serves as the primary link between the Department and Congress for the HHS Secretary and is responsible for developing and implementing HHS's legislative agenda.

Office of the Assistant Secretary for Planning and Evaluation (ASPE)

ASPE advises the Secretary on policy development in health, disability, human services, data, and science, and provides advice and analysis on economic policy. ASPE leads special initiatives; coordinates the Department's evaluation, research, and demonstration activities; and manages cross-Department planning activities such as strategic planning, legislative planning, and review of regulations. Integral to this role, ASPE conducts research and evaluation studies; develops policy analyses; and estimates the cost and benefits of policy alternatives under consideration by the Department or Congress.

About the Department of Health and Human Services

Office of the Assistant Secretary for Public Affairs (ASPA)

ASPA serves as the principal counsel on public affairs and provides centralized leadership and guidance for HHS's StaffDivs, OpDivs, and regional health offices. ASPA manages the Department's digital communications and administers the Freedom of Information and Privacy Acts. The Division leads in planning, developing, and implementing emergency incident communications strategies and activities for the Department.

Office for Civil Rights (OCR)

As a law enforcement agency, OCR investigates complaints; conducts compliance reviews; develops policy; promulgates regulations; provides technical assistance. OCR also educates the public about federal civil rights and conscience laws that prohibit recipients of HHS federal financial assistance from discriminating on the basis of race, color, national origin, disability, age, sex, religion, and conscience, and the *Health Insurance Portability and Accountability Act* (HIPPA) privacy, security, and breach notification laws that protect the privacy and security of health information. OCR works to promote and protect health information privacy and national security of the nation's healthcare systems, including implementing and regulating the HIPAA Privacy, Security, and Breach Notification Rules, and the *Patient Safety Act* and Rules. OCR also aims to ensure non-discriminatory access to the nation's social service and healthcare systems and provides tools for covered entities and individuals to understand their rights and obligations under the law.

Departmental Appeals Board (DAB)

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

Did You Know?

HHS announced the First-Ever Official U.S. Public Health Service Commissioned Corps Service Mascot. Lt. Commander Abigail is a trained facility dog who will provide therapeutic care to patients and Public Health Service officers. She was named after the former First Lady of the United States, Abigail Adams.

The idea of a service mascot originated during the early days of the COVID-19 pandemic, when Public Health Service officers were deployed to respond to the largest public health emergency in modern times. The goal was to improve mental well-being and enhance camaraderie. Lt. Commander Abigail serves as a symbol of the U.S Public Health Service Commissioned Corps commitment to protecting and advancing the nation's health.

About the Department of Health and Human Services

Office of the General Counsel (OGC)

OGC provides quality representation and legal advice to the Department on a wide range of highly visible national issues. OGC supports developing and implementing the Department's programs through sound legal services to the HHS Secretary and the organization's various agencies and divisions.

Office of Global Affairs (OGA)

OGA acts as the diplomatic voice of the Department by providing leadership and expertise in global health diplomacy and policy. Through relationships with multilateral organizations, foreign governments, ministries of health, civil society groups, and the private sector, OGA creates and maintains the pathways for HHS to apply its expertise globally, learn from its overseas counterparts, and advance policies that protect and promote health at home and worldwide.

Office of Inspector General (OIG)

OIG provides objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS programs, as well as the health and welfare of program participants. OIG aims to drive positive change in HHS programs and in the lives of the people served by these programs.

Office of Medicare Hearings and Appeals (OMHA)

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. OMHA also hears appeals arising from Medicare benefits entitlement claims and Medicare Part B and Part D premium appeals disputes. OMHA operates separately from the other agencies involved in the Medicare claims appeal process.

Office of the National Coordinator for Health Information Technology (ONC)

ONC is at the forefront of the Administration's health information technology (IT) efforts and serves as a resource to the entire health system, supporting the adoption of health IT and promoting nationwide standards-based health information exchange to improve healthcare. ONC focuses on two objectives: advancing the development and use of health IT capabilities and establishing standards for data sharing.

Office of the Chief Information Officer (OCIO)

OCIO establishes and provides assistance and guidance on the use of technology-supported business process reengineering; investment analysis; performance measurement; strategic development and application of information systems and infrastructure; policies to provide improved management of information resources and technology; and better, more efficient service to our clients and employees.

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 *GPRA Modernization Act of 2010* require federal agencies to update their Strategic Plan every 4 years at the beginning of an Administration's new term. The strategic plan presents HHS's vision and identifies the agency's goals and objectives for the next 4 years and describes HHS's actions to manage challenges and achieve those goals.

The HHS Strategic Plan defines its goals and strategies and 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 FY 2022 – 2026 has five strategic goals, representing input from HHS OpDivs and StaffDivs, along with public comments. HHS aligns its focus, strategies, and activities to achieve these strategic goals and objectives. The 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 substance abuse disorder (SUD) treatment and recovery services for individuals and families

1.5 Bolster the health workforce to ensure delivery of quality services and care

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, ASFR, ASPE, ASPR, OASH, OCR, OGA, ONC, and 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 experienced trauma or violence

Supporting Divisions – ACF, ACL, AHRQ, CDC, CMS, FDA, HRSA, IHS, NIH, ASFR, ASPE, OASH, OCR, OGA, and 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 to foster prudent use of resources, accountability, and public trust

5.3 Uphold 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

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. HHS continues to institute significant performance management improvements that include:

- Developing, analyzing, reporting, and managing Agency Priority Goals (APGs), and conducting performance reviews amongst OpDivs, StaffDivs, and HHS leadership to monitor progress toward achieving key performance objectives;
- Conducting strategic reviews to support decision-making and performance improvement across HHS;
- Coordinating performance measurement, budgeting, strategic planning, enterprise risk management (ERM), and evidence building activities within the Department;
- Fostering a network of OpDiv and StaffDiv Performance Officers who support, coordinate, and implement performance management efforts across HHS; and
- Sharing performance management best practices at HHS through webinars and other media.

Data Quality

HHS follows *GPRA Modernization Act of 2010* guidelines for reporting data quality. For all measures that appear in APG reporting or in the HHS Strategic Plan, HHS publicly reports:

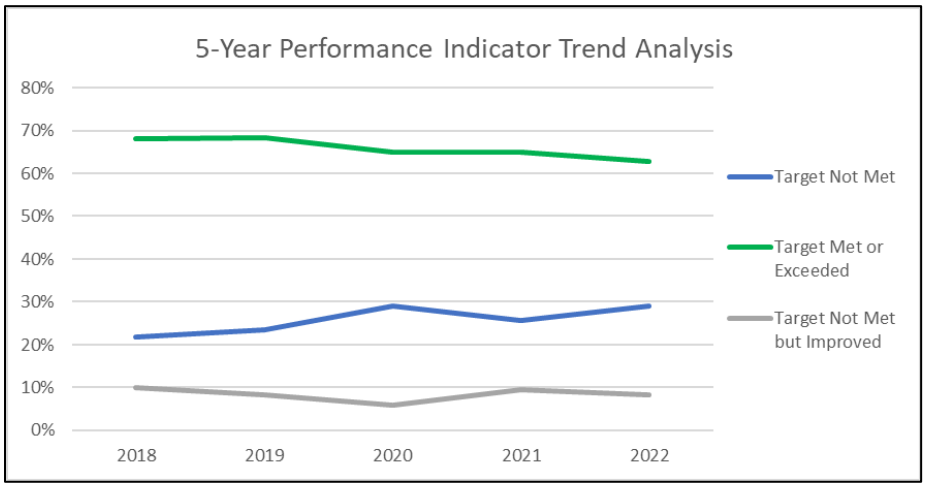
- Processes used to verify and validate measured values;
- Data sources;
- Confirmation that the data meets the level of accuracy required for its intended use;
- Any limitations to the data at the required level of accuracy; and
- How the agency will compensate for such limitations, if needed, to reach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

Each OpDiv/StaffDiv certifies that its data undergoes a thorough quality assurance process and provides a signed letter of attestation to the Performance Improvement Officer. Data quality information for APGs is included in each APG Action Plan, which is published quarterly on 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 2023, HHS monitored over 900 performance measures to improve the efficiency and effectiveness of departmental programs and activities. **Figure 1** is a summary chart for reported performance results through FY 2022, the most recent results available.

Figure 1: 5-Year Performance Indicator Trend Analysis



The HHS 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 on the HHS Budget and Performance webpage. For select performance information aligned to the Department's Strategic Plan, refer to the FY 2024 Annual Performance Plan and Report. To maintain consistency with the FY 2024 President's Budget, final FY 2023 performance results and other updates will be published in February 2024. In addition, HHS leads and contributes to Cross-APG as part of the President's Management Agenda.

For this report, HHS chose to highlight the achievements of its five APGs, detailed below. For additional information on HHS's APG accomplishments, refer to Performance.gov.

Agency Priority Goals

APGs are a set of ambitious but realistic performance objectives 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:

- **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;
- **Child Well-Being**: Improve child well-being, especially in underserved or marginalized populations and communities;
- **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;

- **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
- **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.

Behavioral Health

Agency Priority Goal Statement

Increase equitable access to and utilization of prevention, treatment, and recovery services to improve health outcomes for those affected by behavioral health conditions.

- By September 30, 2023, increase by 15 percent over a baseline of 1,015,386 the number of unique patients dispensed prescriptions for buprenorphine from retail pharmacies in the U.S. and 15 percent over a baseline of 324,126 the number of prescriptions dispensed for naloxone in U.S. outpatient retail and mail-order pharmacies.
- By September 30, 2023, increase by 20 percent the number of individuals referred for behavioral health services by SAMHSA grantees engaged in screening and assessment.

There is a significant treatment gap between need and receiving services. The 2021 National Survey on Drug Use and Health showed:

Among the 40.7 million people aged 12 or older in 2021 with an illicit drug or alcohol use disorder in the past year who did not receive treatment at a specialty facility, 96.8 percent did not feel that they needed treatment; 2.1 percent felt that they needed treatment but did not make an effort to get treatment; and 1.1 percent felt that they needed treatment and made an effort to get treatment.

Among the 17.9 million adults aged 18 or older in 2021 with co-occurring mental illness and an illicit drug or alcohol use disorder in the past year, 52.5 percent received either substance use treatment at a specialty facility or mental health services in the past year. Among adults aged 18 or older with co-occurring mental illness and an illicit drug or alcohol use disorder who received either service in the past year, most (84.0 percent) received only mental health services.

HHS's strategy to achieve this priority goal includes enhancing the capacity of physical health providers to assess, screen, and treat behavioral health conditions by increasing access to treatments for SUD and other disorders; and assisting behavioral health providers to coordinate with individuals, families, and communities.

To increase referrals, many SAMHSA grant programs work to increase access to the services provided or facilitated by grant recipient organizations. As part of these efforts, many grant recipient organizations work to identify and refer individuals to needed behavioral healthcare and support. SAMHSA provides technical assistance and continuously monitors the 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. Buprenorphine is a medication used to treat opioid use disorder. Naloxone is a medication for reversing the effects of opioid overdose.

Performance Goals, Objectives, and Results

Results

Figures 2, 3, and 4 illustrate this goal's most recently reported key indicator results from FY 2023 Quarter 3:

Figure 2: Unique Patients Receiving Buprenorphine

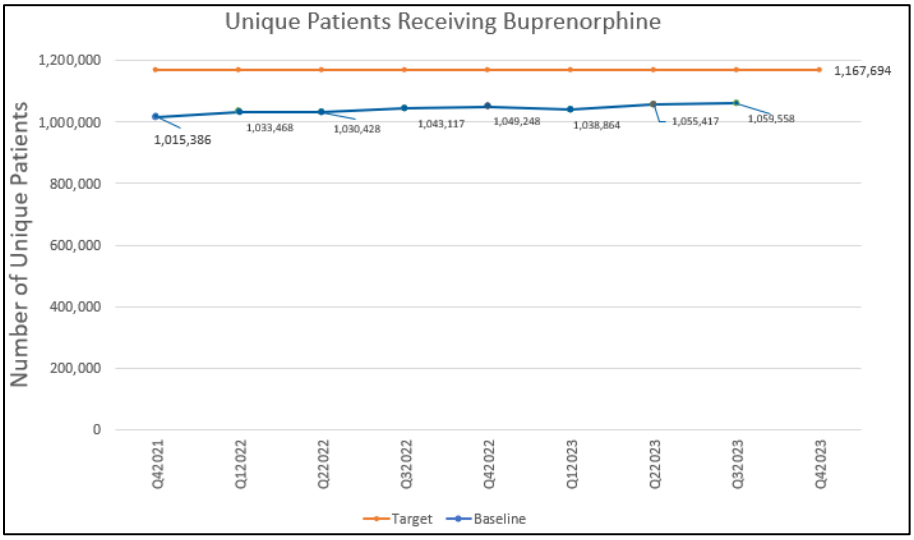
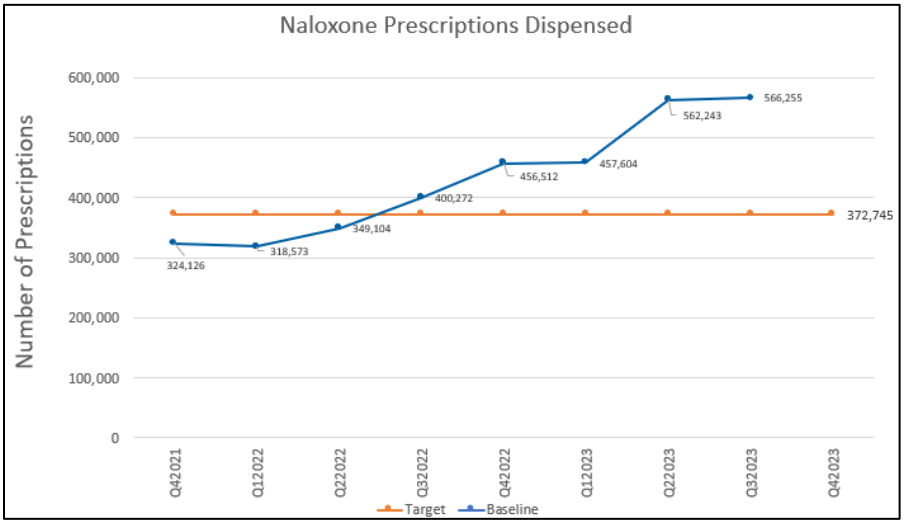


Figure 3: Naloxone Prescriptions Dispensed

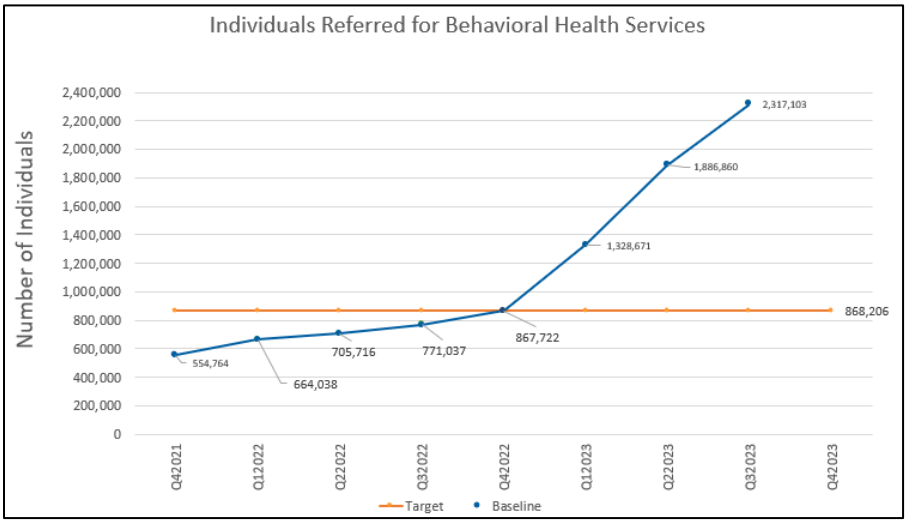


Did You Know?

HRSA's Rural Communities Opioid Response Program Team Won the 2023 Samuel J. Heyman Service to America Medals People's Choice Award. Their work to prevent and respond to the opioid crisis is making a real difference on the ground as rural communities expand treatment sites, grow their prevention strategies, and build and sustain pathways to recovery. To date, the program has invested over $500 million and served more than 4 million rural individuals in over 1,800 rural counties across 47 states and two territories.

Performance Goals, Objectives, and Results

Figure 4: Individuals Referred for Behavioral Health Services



Child Well-Being

Agency Priority Goal Statement

By September 30, 2023, HHS will improve child well-being, especially in underserved or marginalized populations and communities.

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 Public Health Emergency (PHE), the use of primary, preventive, and mental health services declined among children. Compared to the same period a year earlier, 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.

Achieving this priority goal 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 priority goal:

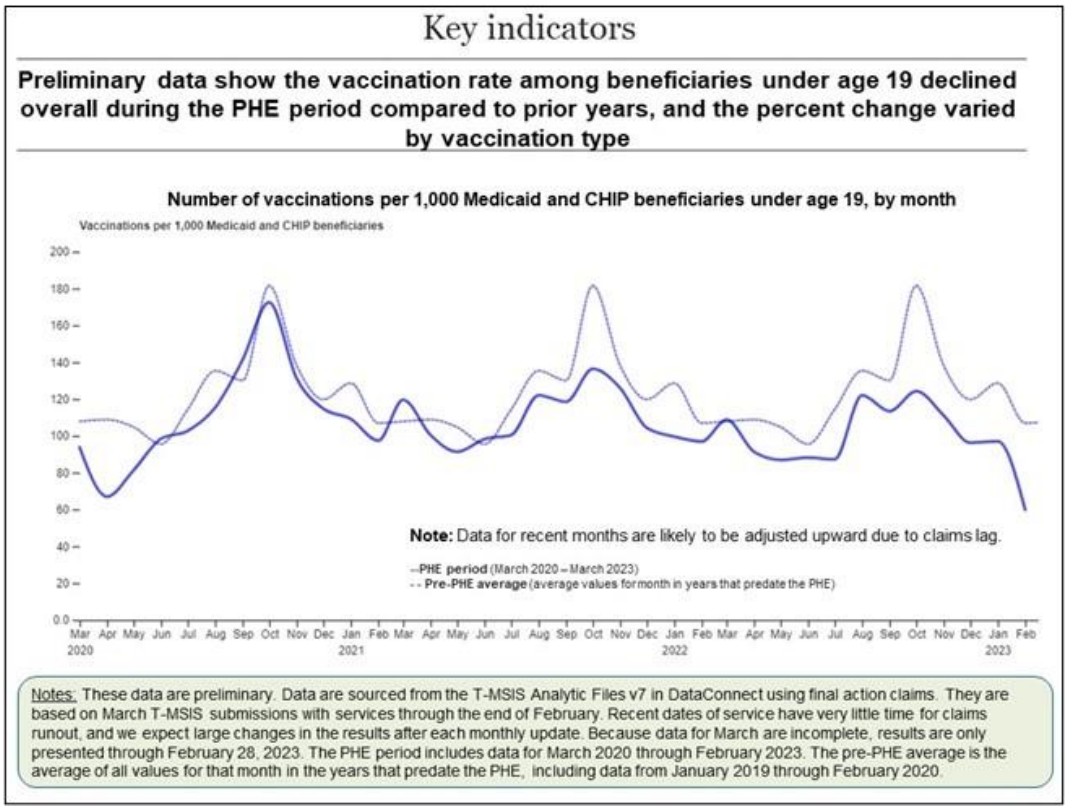
- **Childcare:** Provide policy guidance and training and technical assistance to support states as they increase childcare provider payments and move toward setting payment rates using a cost estimation model.
- **Head Start and Early Head Start:** The Office of Head Start (OHS) will collaborate with 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 training and technical assistance on screenings and preventive healthcare services.
- **Child Welfare:** Provide policy guidance and 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.

Results

The most recent results for one of the key indicators supporting this goal from the FY 2023 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



Performance Goals, Objectives, and Results

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

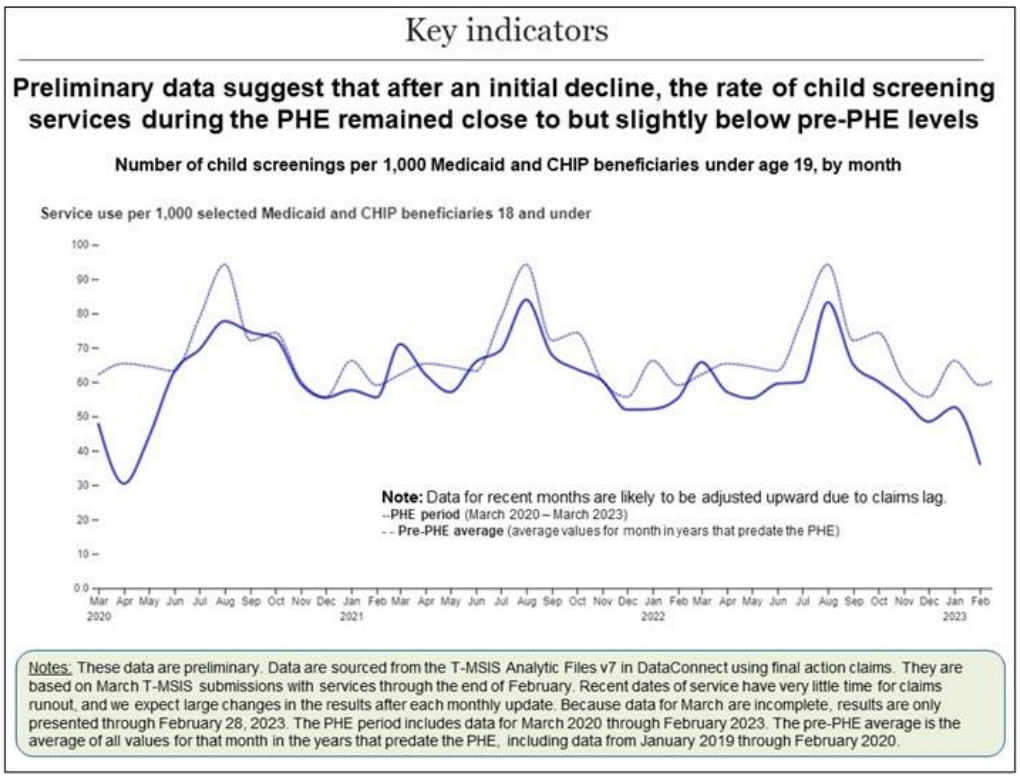
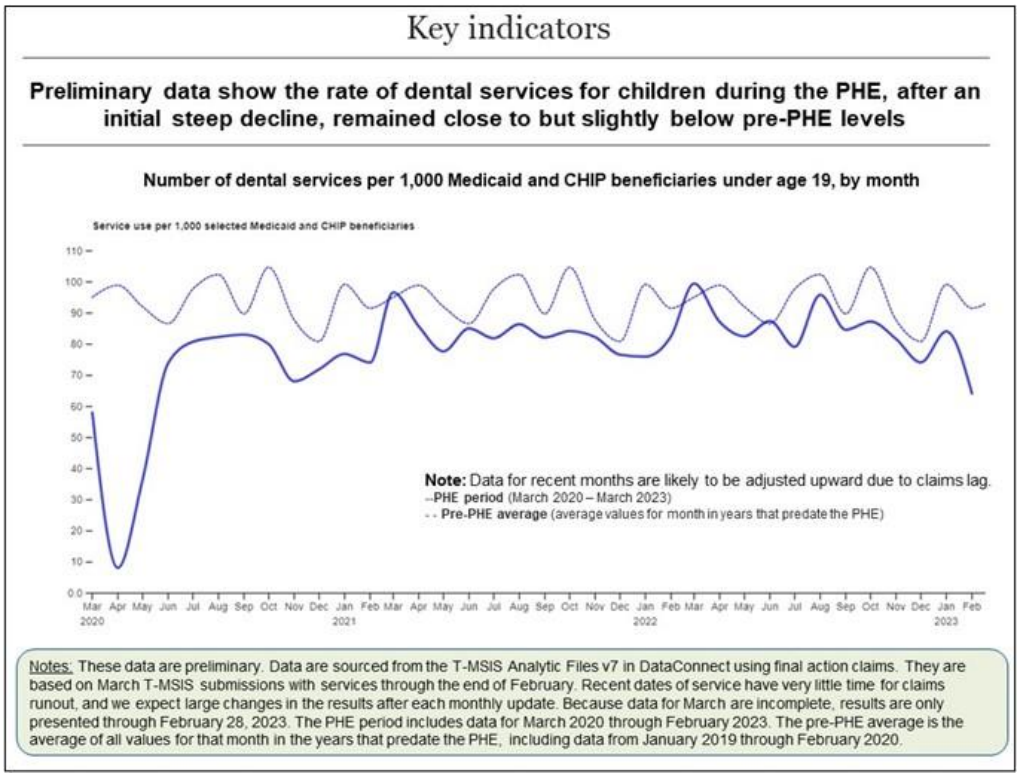


Figure 7: Rate of Dental Services for Children During the COVID-19 PHE



Performance Goals, Objectives, and Results

Emergency Preparedness

Agency Priority Goal Statement

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. By September 30, 2023, HHS will complete four projects, establish a new ASPR office, and increase by at least10 percent key deliverables to 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.

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 developed and issued a disaster human services playbook for federal programs in 2021; the STLT playbook focuses on jurisdictional planning and readiness activities for social and human service providers in managing disaster incidents.
- CDC-ATSDR will develop resources for STLT jurisdictions to strengthen their environmental health emergency capabilities for concurrent disaster and chemical emergencies.
- The ASPR Industrial Base Management and Supply Chain Office will be reorganized to build a diverse, agile public health supply chain and sustain long-term U.S. manufacturing capability. Strategic positions will be filled to provide technical and programmatic support, better enabling ASPR to respond to surges during PHEs.
- OGA will:
    - Increase international engagements to build capacity and promote equitable 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.

Did You Know?

Following the devastation of Hurricane Katrina in 2005, a national public service announcement (PSA) campaign was launched to encourage people who may be experiencing psychological distress following hurricanes to consider seeking mental health services. As a result of a partnership between SAMHSA and the Ad Council, the PSAs were distributed to 12,000 media outlets worldwide.

Two years later, HHS teamed up with the National Football League launching another set of PSAs, this time designed to combat childhood obesity and encourage physcial activity amongst children. The new ads featured popular National Football League players who urged families to "get up and play an hour a day," aiming to reach chldren ages 6-13 and communicate physical activity is fun and easy.

Performance Goals, Objectives, and Results

Table 1: FY 2023 Quarter 3 Emergency Preparedness Key Indicator Results

HHS will…	Indicator Name	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 55 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 93 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 88 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	84 deliverables	76 deliverables	44 deliverables
Establish the ASPR Industrial Base Management and Supply Chain Office as an operational office and align the office activities with the National Strategy for a Resilient Public Health Supply Chain.	Office Establishment and Alignment	1-completed	0-under completion	0 (Estimated 95 percent complete)

September 30, 2023

Performance Goals, Objectives, and Results

Equity

Agency Priority Goal Statement

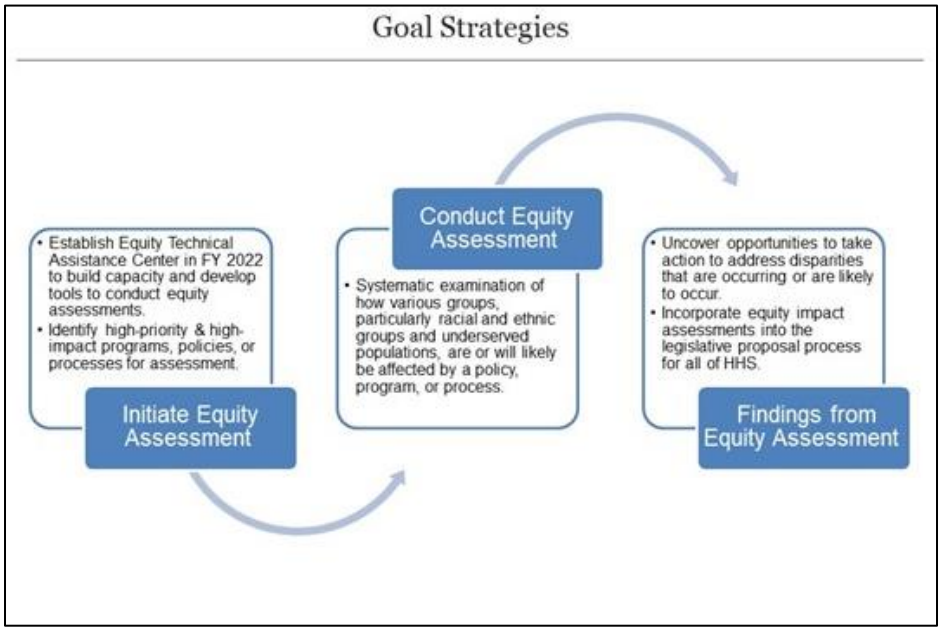
Advance progress toward equity in health and human services by optimizing opportunities and access for underserved and marginalized populations and addressing drivers of inequities throughout the life course in order to remove barriers, reduce disparities, and improve outcomes. By September 30, 2023, initiate at least 10 equity assessments on HHS policies and activities and identify potential actions for improvement.

Through this priority goal, HHS seeks to identify historical and 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 doing so, HHS will create the knowledge to 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.

The goal of this effort is to promote equity in policy and programmatic decisions, contracting and procurement, data collection, analysis and availability of data, 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

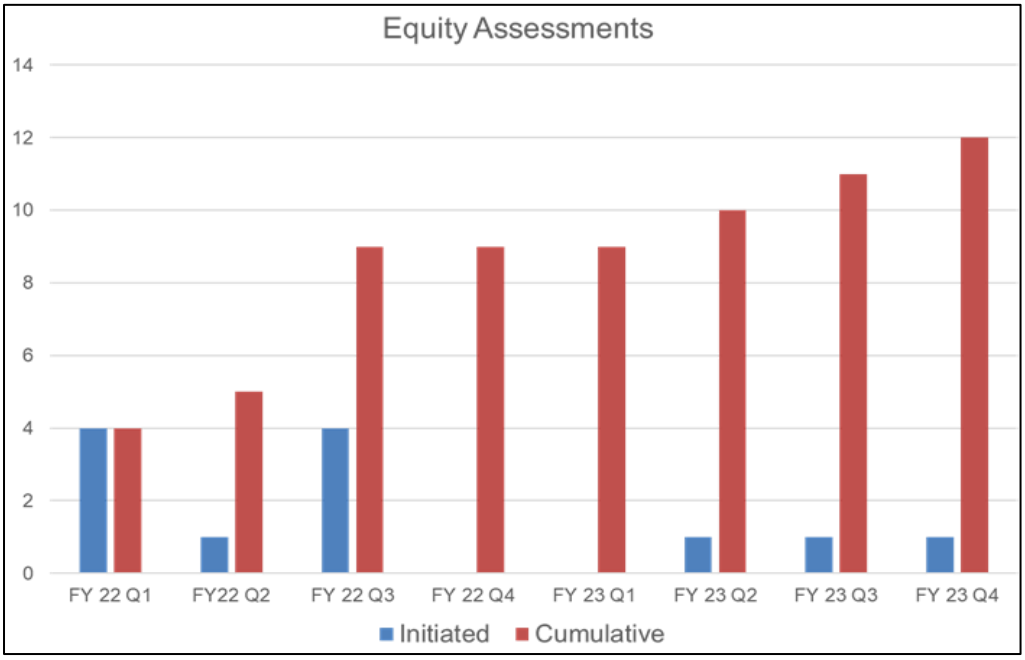


Performance Goals, Objectives, and Results

Results

The most recent key indicator results for this goal from FY 2023 Quarter 3 are illustrated in **Figure 9** below.

Figure 9: Quarter 3 Key Indicators in Equity Assessments



Maternal Health

Agency Priority Goal Statement

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 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;
- Increase the number of birthing facilities that are participating in the Alliance for Innovation on Maternal Health (AIM) by 10 percent; and
- Increase the number of pregnant and postpartum people, their support networks, and providers reached by HHS messages about urgent maternal warning signs by 20 percent.

The U.S. maternal mortality rate is more than double that of comparable countries, and the rate has not been improving. 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 work to achieve these goals by pursuing the following strategies:

- Improve postpartum health and reduce maternal morbidity/mortality through implementing the American Rescue Plan's (ARP) Medicaid 12-month postpartum coverage option;
- Increase participation in and measurement of perinatal quality improvement activities;

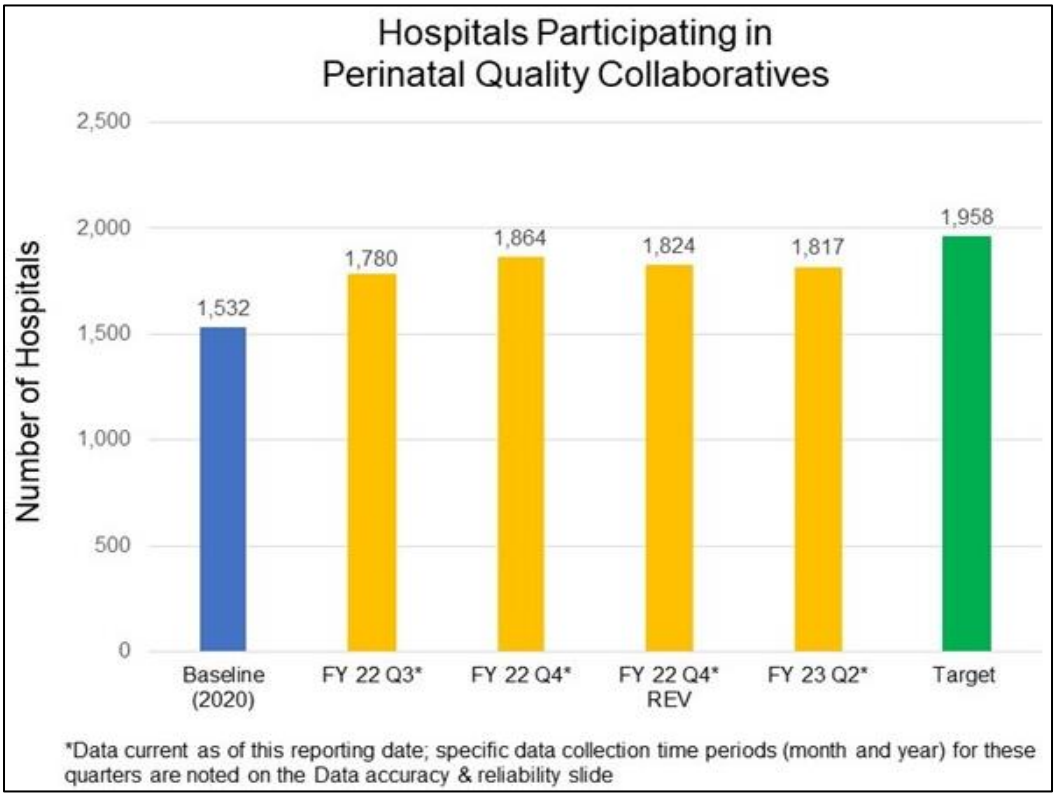
- Address important drivers of poor maternal health outcomes including cardiovascular and behavioral health issues; and
- Strengthen the maternal health workforce to achieve health equity.

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.

Results

Figures 10, 11, and 12 illustrate the most recently reported key indicator results for this goal from FY 2023 Quarter 3.

Figure 10: Hospitals Participating in Perinatal Quality Collaboratives



Performance Goals, Objectives, and Results

Figure 11: Birthing Facilities Participating in AIM

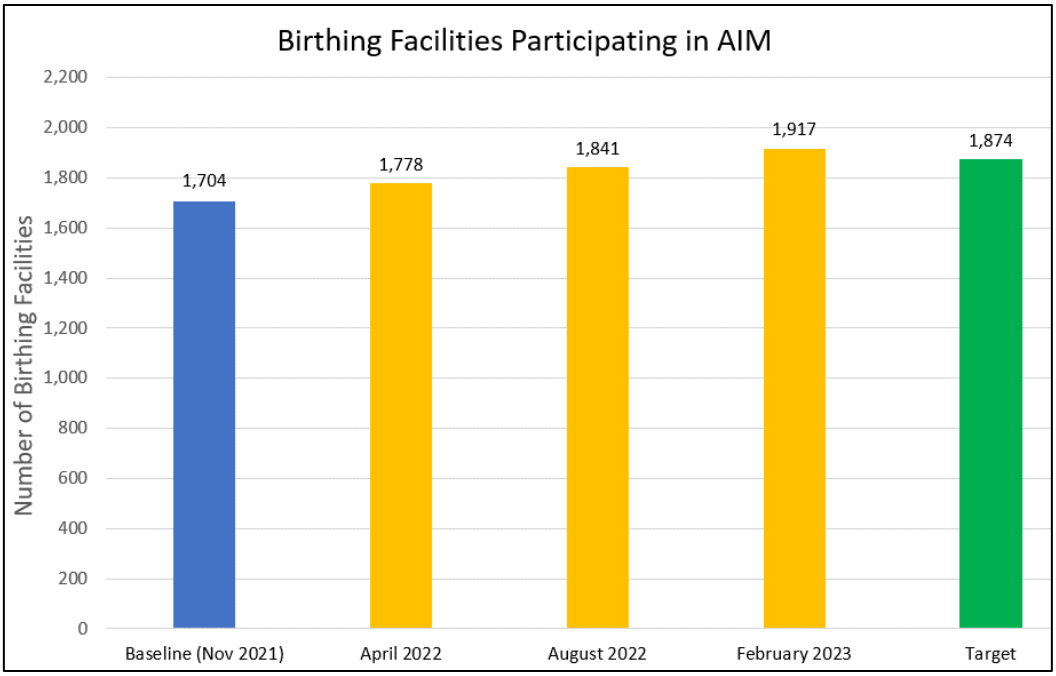
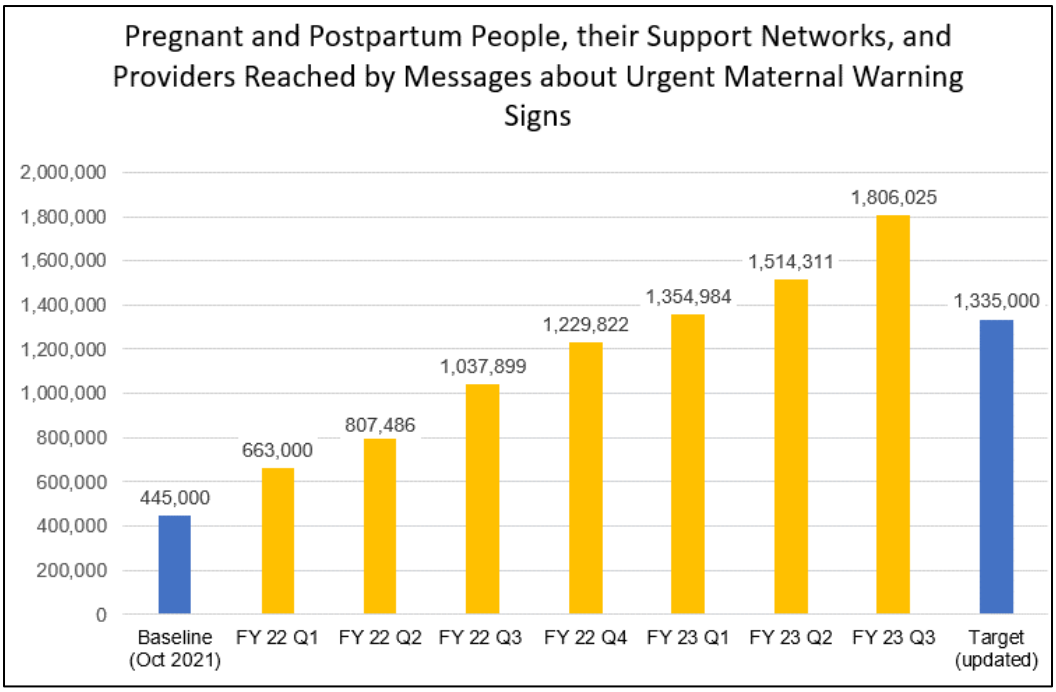


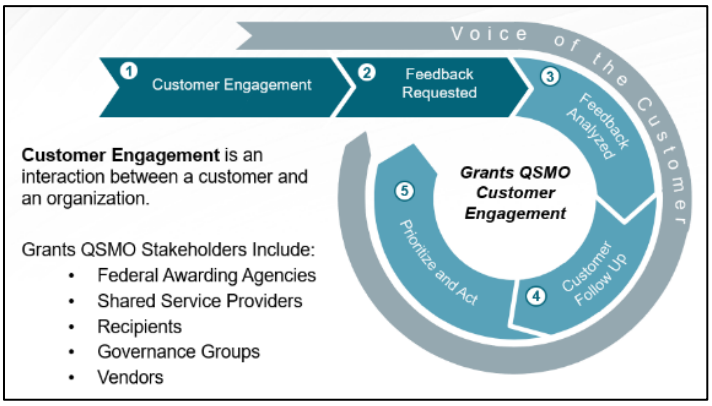
Figure 12: Pregnant and Postpartum People, Their Support Networks, and Providers Reached by Messages About Urgent Maternal Warning Signs



Grants Quality Service Management Office

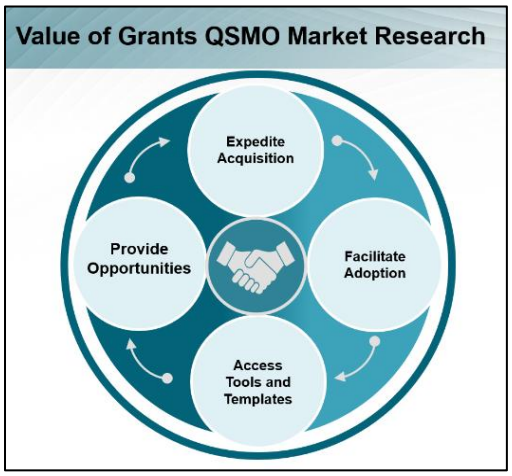
Authorized by Office of Management and Budget (OMB) Memorandum M-19-16, *Centralized Mission Support Capabilities for the Federal Government*, and OMB's designation of the Grants Quality Service Management Office (QSMO) at HHS, the Grants QSMO is responsible for establishing a marketplace of quality shared solutions/services, governing the long-term sustainability of the solutions/services, and driving implementation of grants data standards. The Grants QSMO's vision seeks to 1) ease burden and drive efficiencies through standardization and modernization; 2) leverage data as a strategic asset through standard adoptions; and 3) respond to customer needs through continuous engagement of applicants, recipients, and providers. The Grants QSMO's work continues to be supported in OMB Memoranda M-21-20, M-22-12, and further clarified in M-22-02. In 2023, the Grants QSMO's role within the broader grants community governance structure was highlighted in M-23-19, which created the Council on Federal Financial Assistance (COFFA) as a single governance forum of interagency council members to inform federal financial assistance policy, oversight and technology activities, including strategic direction, policy, recommendations, and priorities for grants-related activities. In FY 2024, the Grants QSMO, in concert with the COFFA, will continue to refine a federal-wide strategy to improve grants mission delivery across the government through a customer experience (CX) lens and provide guidance on grants data standards functions.

Figure 13: Grants QSMO Customer Engagement



The Grants QSMO formalized a CX-focused approach to customer engagement in 2023 to address OMB, President's Management Agenda, and Executive Order (EO) priorities; identify and improve issues that prevent positive customer experience; and create responsive customer feedback loops. Pursuant to these priorities, the Grants QSMO developed journey maps, customer personas, and worked with Shared Service Providers (SSPs) to deploy modern CX tools providing opportunities for enhancement of customer facing program areas.

Figure 14: Value of Grants QSMO Market Research



As mentioned in FY 2022, the Grants QSMO focuses on three main designation criteria initiatives: the Grants QSMO Marketplace, Grants IT Investment Reviews, and driving the adoption of data standards. The Grants QSMO Marketplace provides Federal Awarding Agencies with information to support and inform decisions on adopting shared solutions/services across the entire grants lifecycle. Since its inception, the Grants QSMO has identified a significant demand for a commercial marketplace, providing agencies with options for high quality grants management systems and solutions. Stakeholder conversations with SSPs and agency stakeholders determined that the Grants QSMO Marketplace should expand beyond the current federal offerings. This need was driven by significant agency demand for award management shared services, limited capacity of current validated SSPs, and an underserved market for smaller agencies. In March 2023, the Grants QSMO released a Request for Information to better understand the commercial grants IT solution ecosystem and to learn from industry providers how best to operationalize the commercial side of the Grants QSMO Marketplace. In 2023, the Grants QSMO partnered with three agencies to develop an ordering guide and Catalog of Market Research on General Services Administration's (GSA) Acquisition Gateway. By leveraging Grants QSMO market research, which aligns with the Grants Management Integrated Business Framework government-wide standards

as well as contract details, system capabilities, and system demos, the Grants QSMO streamlined the acquisition process to better support agencies' initial acquisition planning efforts. Agencies identifying requirements 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.

While the Marketplace initially consisted of only federal SSPs, the Grants QSMO is taking an iterative approach to onboard commercial vendors via our Grants QSMO Acquisition Gateway site. Launched in September 2023, the Grants QSMO Acquisition Gateway provides access to quality tools, checklists, and sample acquisition documents to expedite the acquisition process to access quality IT solutions. As a result, this allows the Grants QSMO to provide appropriate solutions for different Federal customers (i.e., small, medium, and large agencies), avoiding a "one size fits all" approach. The Grants QSMO also focused on transparency in 2023, ensuring that federal agencies select appropriate solutions for each agency's specialized needs by expanding the information available on the Grants QSMO Marketplace. The Marketplace now provides federal agency customers with more comprehensive SSP data through an initiative called *Buying Insights* providing information on pricing methodologies, IT accessibility and ratings, grant volume, and GSA Office of Shared Solutions and Performance Improvement Customer Satisfaction ratings.

Through strong partnership and coordination with agencies on Grants IT investment development, the Grants QSMO aims to increase the utilization of grants shared service offerings via the Grants QSMO Marketplace and acquisitions support tools to improve mission delivery and help reduce duplicative government IT investments. 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.

This investment review process also ensures that agencies align with 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., GSA's M3 Playbook); and avoid duplicative investments government-wide. The Grants QSMO completed its first Investment Action Plan in 2023 with a SSP partner, significantly advancing the objectives of this process.

Complying with the *Grant Reporting Efficiency & Agreements Transparency Act of 2019* (GREAT Act) requirements, the Office of Grants hired a grants data standards lead to finalize grants data standards technical requirements, drive implementation of the GREAT Act, and further mature the Grants Management Integrated Business Framework. The Grants QSMO directly partnered with this resource and OMB to coordinate stakeholder feedback for needed implementation guidance and timelines. During FY 2024, the Grants QMSO plans to work with the COFFA to prepare government-wide announcement of grants data standards guidance and stakeholder engagement during FY 2024. Additionally, the Grants QSMO was awarded the 2023 Service to the Citizen Award as recognition for prioritizing CX, responding to customers need, and furthering mission success for grants applicants, recipients, and Federal Awarding Agencies.

Looking Ahead to 2024

In 2024, HHS will address important healthcare, public health, human services, and research issues that impact all Americans through the strategic direction set forth in the HHS Strategic Plan.

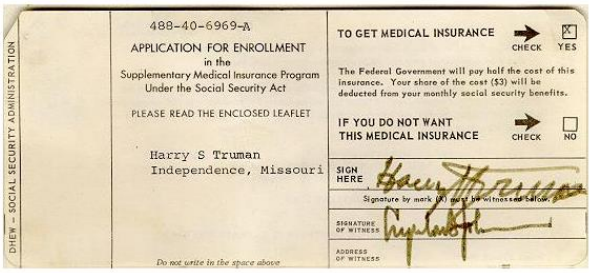
HHS Strategic Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare	
	*HHS works to protect and strengthen equitable access to high-quality and affordable healthcare. Increasing choice, affordability, and enrollment in high quality healthcare coverage is a focus of the Department's efforts in addition to reducing costs, improving quality of healthcare services, and ensuring access to safe medical devices and drugs. HHS also works to expand equitable access to comprehensive, community-based, innovative, and culturally and linguistically appropriate healthcare services while addressing social determinants of health. The Department is driving 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. HHS also bolsters the health workforce to ensure delivery of quality services and care.* Behavioral Health: HHS recognizes that integrating care is an essential component of advancing the White House strategy to prevent and treat mental health and SUDs. HHS will continue to implement the HHS Roadmap for Behavioral Health Integration and will work in support of the three pillars of the Strategy: strengthening system capacity, connecting people to care, and supporting people through upstream investments in prevention. 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. Drug Pricing: HHS will continue to work to make drug prices affordable and equitable for all consumers throughout the healthcare system. HHS will continue implementing the *Inflation Reduction Act of 2022*, which includes provisions to enable HHS to support drug price negotiation with manufacturers and stop unreasonable price increases to ensure access to drugs that can improve health for all Americans. HHS will also continue to improve competition throughout the prescription drug industry and foster scientific innovation to promote better and improved health into the future. Healthcare Workforce: HHS will continue to identify opportunities to enhance and improve the capacity of the existing healthcare 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, center care on the expressed needs and well-being of all patients, and reduce healthcare worker burnout. Maternal and Reproductive Health: HHS will work to maximize access to comprehensive health coverage for pregnant and post-partum people and support quality improvement efforts to enhance care delivery so it is evidence-based, safer, and more responsive and accommodating to the expressed needs of pregnant and postpartum people. HHS will also work toward maintaining access to affordable and comprehensive reproductive healthcare services and methods.

Looking Ahead to 2024

HHS Strategic Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare	
	Nondiscrimination and Enforcement of Civil Rights and Privacy Laws for Patients Accessing Healthcare: HHS will continue work to ensure nondiscrimination and enforcement of civil rights and privacy laws for patients accessing healthcare. OCR vigorously enforces laws and regulations that prohibit discrimination based on race, color, national origin, disability, age, religion, and sex (including pregnancy, sexual orientation, and gender identity) in health care and human services. Through enforcement of the HIPAA Privacy, Security, and Breach Notification Rules, OCR continues to promote and protect health information privacy and national security of our nation's healthcare systems. OCR will continue its Right of Access Initiative focusing on ensuring individuals are able to receive their health records as required by the HIPAA Rules. Nursing Home Quality and Safety: HHS will implement policies to improve nursing home quality and safety. This will include promulgating new regulations related to nursing home staffing requirements, and reporting requirements on staffing spending. In addition, CMS will work to implement existing staffing nursing home standards requiring minimum staffing as well as examine nursing homes that have concerning antipsychotic prescribing practices. Together, these efforts will ensure that all nursing home residents receive high quality services. 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 human medical products and critical foods, including relevant raw material and ancillary equipment, and incentivize innovation to expand access and affordability to safe and high quality medical devices, critical foods, and drugs.

Did You Know?

At the Medicare program bill-signing ceremony in 1965, President Johnson enrolled President Truman as the first Medicare beneficiary and presented him with the first Medicare card. This is President Truman's application for the optional Part B medical care coverage, which President Johnson signed as a witness.



Looking Ahead to 2024

HHS Strategic Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes	
	*HHS is dedicated to safeguarding and improving health conditions and health outcomes for everyone. The Department improves capabilities to predict, prevent, prepare for, respond to, and recover from disasters, public health and medical emergencies, and threats, domestically and abroad. The Department protects individuals, families, and communities from infectious disease and prevents non-communicable disease through the development and equitable delivery of effective, innovative, readily available treatments, therapeutics, medical devices, and vaccines. HHS enhances the promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death. The Department also mitigates the impacts of environmental factors, including climate change, on health outcomes.* 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 incorporate contributions from each OpDiv to develop a coherent HHS Climate Change and Health Equity Strategic Plan and revise the HHS Environmental Justice Strategic Plan to form the foundation of a national adaptation plan for health, as agreed to under the United Nations Conference of the Parties 26 Health Programme. HHS will continue to develop tools to inform and help the American people address climate change, support efforts to reduce climate impacts from the healthcare sector, and promote climate change resiliency within the health industry. 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 will continue to enforce emerging issues involving environmental justice to advance safe and sustainable health conditions, free from discrimination. Combating Antibiotic-Resistant Bacteria: HHS will continue its leadership role in implementing 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, and collaborating across the globe. In addition to continuing to work toward reversing the setbacks generated by the COVID-19 pandemic, HHS is broadening our perspective through better understanding of health disparities in antibiotic resistance and through better integration of One Health efforts including antibiotic resistance in the environment. 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,

Looking Ahead to 2024

HHS Strategic Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes	
	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. Public Health Emergency Preparedness and Response: HHS will continue its ongoing efforts to support public health preparedness for, response to, and recovery from disasters and public health emergencies. As the nation moves forward from the PHE phase of the COVID-19 pandemic, HHS is committed to building upon lessons learned and enhancing preparedness for the next public health threat. HHS will also continue to respond to public health emergencies when they occur, including natural disasters such as hurricanes and wildfires, emerging infectious diseases, and other threats. Equity will remain a key focus in all HHS's preparedness and response activities as we work to mitigate the disproportionate impact public health emergencies can have on underserved populations.

HHS Strategic Goal 3: Strengthen Social Well-Being, Equity, and Economic Resilience	
	*HHS works to strengthen the economic and social well-being of Americans across the lifespan. HHS provides effective and innovative pathways leading to equitable economic success for all individuals and families. The Department strengthens early childhood development and expands opportunities to help children and youth thrive equitably within their families and communities. HHS expands 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. HHS also increases safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence.* 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. HHS will also explore ways to improve support 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*. HHS continues to care for unaccompanied children who are transferred to the custody of HHS from the Department of Homeland Security. The Department follows standards and principles of child welfare, providing for the socioemotional and educational needs for children while in custody, and working to identify and vet sponsors for the children once released. Following release, HHS provides continued follow-up and services to children and their sponsors as needed. Economic Mobility: HHS will use federal levers and tools, such as interagency collaboration, program flexibilities, technical assistance, research analyses,

Looking Ahead to 2024

HHS Strategic Goal 3: Strengthen Social Well-Being, Equity, and Economic Resilience	
	and program coordination, to promote equity for all Americans, and economic resilience and mobility for low-income Americans. Through the new federal Children's Interagency Coordinating Council, HHS will work with other federal departments, agencies, and the National Academies of Sciences, Engineering, and Medicine to identify ways to improve child well-being and decrease child poverty. This effort leverages the ongoing work of the U.S. Interagency Council on Economic Mobility and other interagency groups to improve coordination across federal programs and policies and facilitate more equitable, effective, and efficient delivery of benefits. Additionally, HHS has long collaborated with other federal agencies to break down silos among the housing, homelessness, health, and human services sectors and to provide services that support preventing and ending homelessness. As part of ongoing interagency collaboration, HHS, in partnership with the U.S. Interagency Council on Homelessness and federal departments, works to pair housing with services, scale models of coordinated housing and services, and develop a homelessness prevention strategy outlined in U.S. Interagency Council on Homelessness' *ALL IN: Federal Strategic Plan to Prevent and End Homelessness*. Health-Related Social Needs: HHS envisions a future in which all individuals, regardless of their social circumstances, have access to aligned, high quality, person-centered health and social care systems that can improve health and well-being. Support from all levels of government and cross-sector partnerships among social care service providers, public health departments, healthcare (including behavioral health) providers, faith-based organizations, community members, persons with lived experience, refugee and newcomer-serving agencies, and others will be necessary to transform how we as a nation address health-related social needs and reduce inequities in related health outcomes. Information, Services, or Benefits from HHS Programs and Activities for Individuals with Limited English Proficiency: HHS will work to remove barriers that individuals with limited English proficiency face in obtaining information, services, or benefits from HHS programs and activities that individuals with limited English proficiency face in obtaining information, services, or benefits from HHS programs and activities. HHS will finalize and implement the updated language access plan while assisting HHS OpDivs and StaffDivs to develop and implement their own Language Access Plans. We will continue to make strides toward improving access to in-language content on websites and public outreach materials, telephonic interpreter services, in-language program and benefit information, and federal funding for recipients of HHS funds to provide language access services. Long-Term Care Workforce: A high quality workforce is essential for supporting older adults and people with disabilities in both nursing homes and in their homes and communities. HHS is committed to growing and supporting the long-term services and support workforce by sharing resources for states and employers, highlighting best practices for recruiting and retaining these workers, and facilitating collaboration between state Medicaid, aging, disability, and workforce agencies. HHS will also develop the data infrastructure to study the supply of, and demand for, this workforce so that policymakers can be prepared for changing demographics.

Looking Ahead to 2024

HHS Strategic Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All	
	*HHS is dedicated to restoring trust and accelerating advancements in science and research. The Department is prioritizing science, evidence, and inclusion to improve the design, delivery, and outcomes of HHS programs. It is investing 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. Strengthening surveillance, epidemiology, and laboratory capacity is another major focus to better understand and equitably address diseases and conditions. HHS is also increasing evidence-based knowledge through improved data collection, use, and evaluation efforts to achieve better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience.* Cancer Moonshot: On February 2, 2022, the President reignited the Cancer Moonshot to capitalize on recent progress in cancer treatment and care, as well as the scientific advances and public health lessons of the COVID-19 pandemic. HHS will play a key role in the new 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. The National Cancer Plan, released in April 2023, lays out specific goals and strategies for how HHS will leverage its expertise in research, regulation, and public health to 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. Clinical Research Diversity: Clinical research forms the foundation for understanding and developing treatments for all types of medical conditions, but participants often do not reflect the diversity of the nation. HHS's efforts to diversify clinical research through outreach, engagement, and policy change have led to significant successes, exemplified by the highly diverse COVID-19 vaccine trials and NIH's *All of Us* research program. HHS is committed to continuing these efforts and expanding clinical research participation to communities throughout the country through engagement and outreach, leveraging technology and novel trial approaches, and collaborating with stakeholders including the private sector and nonprofits. Data Capacity for Patient-Centered Outcomes Research: HHS will continue to support intradepartmental collaborative projects that expand data capacity for researchers to study the outcomes and effectiveness of healthcare interventions and services. These data projects will build data capacity for researchers to study the health outcomes associated with pregnancy, HIV disease, intellectual and developmental disabilities, and cancer. In addition, HHS will develop initiatives that expand data for researchers to scientifically investigate social needs, economic outcomes, and the ways to generate evidence to advance equity in healthcare. Developing Evidence-Building Capacity: HHS continues to increase evidence-based knowledge through implementing the four-year capacity-building training schedule. Training topics were selected based on the HHS-wide Capacity Assessment conducted in FY 2021 and focus on a range of evidence-building areas and are geared for a variety of HHS staff (e.g., performance officers, evaluation staff, programmatic

Looking Ahead to 2024

HHS Strategic Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All	
	and policy staff). Work is ongoing to develop new tools and approaches for improving data at each stage of the data lifecycle. This includes updating the CDC Evaluation Framework. Guidance to Improve Data Usability: The HHS Data Council is the principal internal advisory body to the Secretary on HHS data policy that coordinates data policy activities. Current projects include showcasing the benefits of forming new linkages with HHS data and data linkage strategies as well as the different considerations for maintaining respondent privacy when linking data; mapping out major steps and considerations in determining when and how programs should revise their data collections and related processes; and providing guidance for analysis of data from variables that allow respondents to select multiple discrete categories (e.g., race, chronic conditions, service needs), surveying the ways different HHS programs and the literature suggest modeling this kind of data, reviewing the assumptions these models require, and finally illustrating these different strategies using the same dataset. These projects will improve HHS's data governance and the usability of HHS data. Increase Data Capacity, Improve Processes and Governance, Focus Efforts and Resources, and Grow Shared Data Infrastructure: The 2023 HHS Data Strategy outlines the Department's priorities and initiatives to harness data to enhance the health and well-being of all Americans. This strategy is based on the research and recommendations of a cross-agency task force of data leaders and subject matter experts convened by the Deputy Secretary of HHS in Fall 2022. The strategy will help HHS realize its vision for data that are available, accessible, timely, equitable, meaningfully usable, and protected and actively used by HHS, our partners, and the public to realize HHS's mission. Scientific Integrity: Developing and using scientific information is 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. HHS is actively working to implement the January 27, 2021, *Presidential Memorandum on Restoring Trust in Government through Scientific Integrity and Evidence-based Policymaking*, by developing an HHS-wide Scientific Integrity Policy to support free flow of information, protect science from inappropriate interference, and ensure accountability. The final policy will be published in early 2024.

Looking Ahead to 2024

HHS Strategic Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability	
	*HHS is dedicated to advancing strategic management across the Department to build trust, transparency, and accountability. A major focus of the Department is promoting effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices. HHS sustains strong financial stewardship of resources to foster prudent use of resources, accountability, and public trust. HHS works to uphold effective and innovative human capital resource management resulting in an engaged, diverse workforce with the skills and competencies to accomplish the HHS mission. The Department also ensures the security of HHS facilities, technology, data, and information, while advancing environment-friendly practices.* Administrative Data to Understand the Effects of Public Health Emergencies on HHS Staffing: The extant research on COVID-19's effect on the public health and human services workforce focused on one position at a time, rather than taking a time-series, system-level approach. HHS is developing a collaborative study that will serve as an initial investigation of the effects of the pandemic on agency staffing by tracking weekly human resources data on applications and separations by agency and job series across medical, administrative, and public policy milestones over the course of the COVID-19 pandemic. This information will produce valuable COVID-19 lessons learned and help HHS identify opportunities to bolster staff retention and applications during future public health emergencies. Mitigate Future Climate Change Risks: HHS developed an overall strategy for addressing the climate and sustainability goals of EO 14008 and 14057, *Tackling the Climate Crisis at Home and Abroad* and *Catalyzing Clean Energy Industries and Jobs Through Federal Sustainability*. First, the Office of Climate Change and Health Equity has developed a Health Sector Resource Hub and the Climate Resilient Healthcare Facilities Toolkit to support health sector sustainability and climate preparedness and has been an active participant in the Extreme Heat Interagency Working Group to communicate, coordinate, and improve the federal response to extreme heat. Other office activities, including grant-making and technical assistance, are contingent upon appropriations from Congress. The Program Support Center is collaborating with the ASFR to develop a Sustainable Procurement Directive to meet net-zero procurement targets and environmental preferred product purchasing goals.

Systems, Legal Compliance, and Internal Control

Systems

HHS's Chief Financial Officer (CFO) 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:

- Efficiently process financial transactions in support of program activities and HHS's mission;
- Provide complete and accurate financial information for decision making;
- Improve data integrity;
- Strengthen internal controls; and
- Mitigate risk.

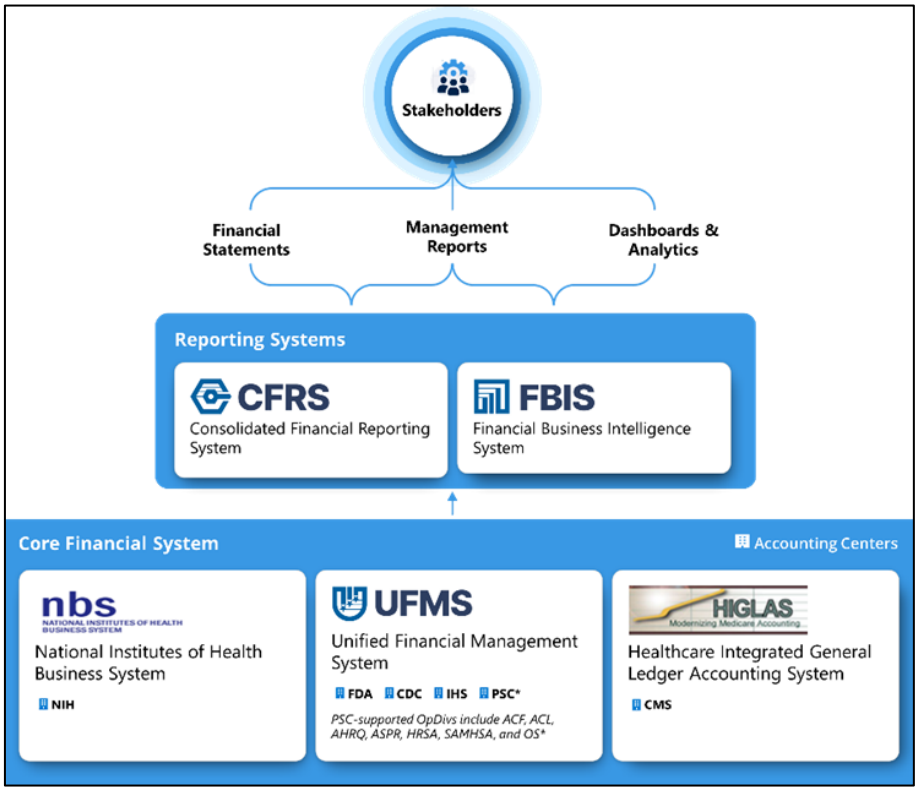
The HHS financial systems framework provides the foundation to manage approximately $2.8 trillion in budgetary resources entrusted to the Department in FY 2023. These resources include the *Coronavirus Aid, Relief, and Economic Security Act* (CARES), ARP, and other supplemental funding vital to assisting 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 providing effective health and human services to all Americans. 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 awards information while providing transparency and accountability to the American public.

The HHS financial management systems environment, detailed in **Figure 15**, consists of two Department-wide systems and a core financial system. 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 driven business decisions, and financial and managerial reporting. Together, these systems fulfill HHS's financial accounting and reporting needs.

Systems, Legal Compliance, and Internal Control

Figure 15: HHS Financial Management Systems Environment



CFRS systematically consolidates information from the core financial system's three instances to generate Departmental quarterly and year-end consolidated financial statements on a consistent and timely basis while supporting HHS in meeting regulatory reporting requirements.

FBIS retrieves, combines, consolidates, and reports data from the core financial system. Additionally, it provides end-users with the functionality to analyze data and present actionable information, including metrics and key performance indicator dashboards with graphical displays, interactive reports, and ad-hoc reporting.

NBS supports NIH's diverse biomedical research program, and business, financial, acquisition, and logistics requirements for 27 NIH Institutes and Centers. NBS also supports grant funding for more than 300,000 researchers at over 2,500 universities, medical schools, and other research institutions in every state and around the world.

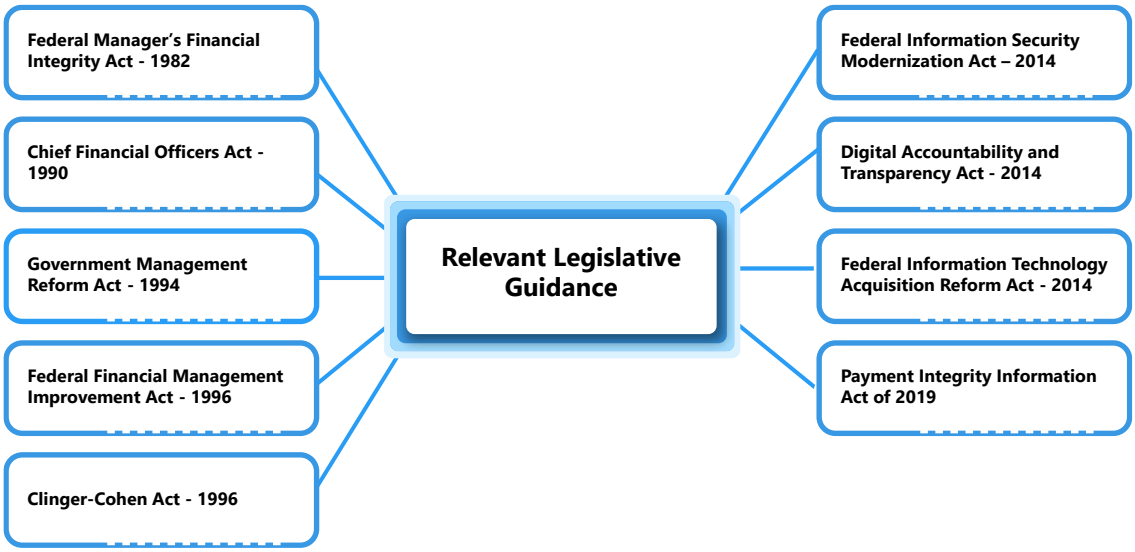
UFMS integrates with over 50 program, business, and administrative systems to provide a secure, reliable, and highly available shared services financial management environment supporting the CDC, FDA, IHS, and PSC. PSC provides shared-service accounting support for ACF, ACL, AHRQ, ASPR, HRSA, SAMHSA, and 14 StaffDivs within OS.

HIGLAS processes an average of five million transactions daily and supports four lines of CMS business: Medicare Fee-for-Service (FFS), Medicare Secondary Payer, Federal Facilitated Marketplace, and Administrative Program Accounting activities.

Relevant Legislative Guidance

The HHS financial management systems environment must comply with all applicable federal laws, regulations, and authoritative guidance included in **Figure 16**.

Figure 16: Relevant Legislation



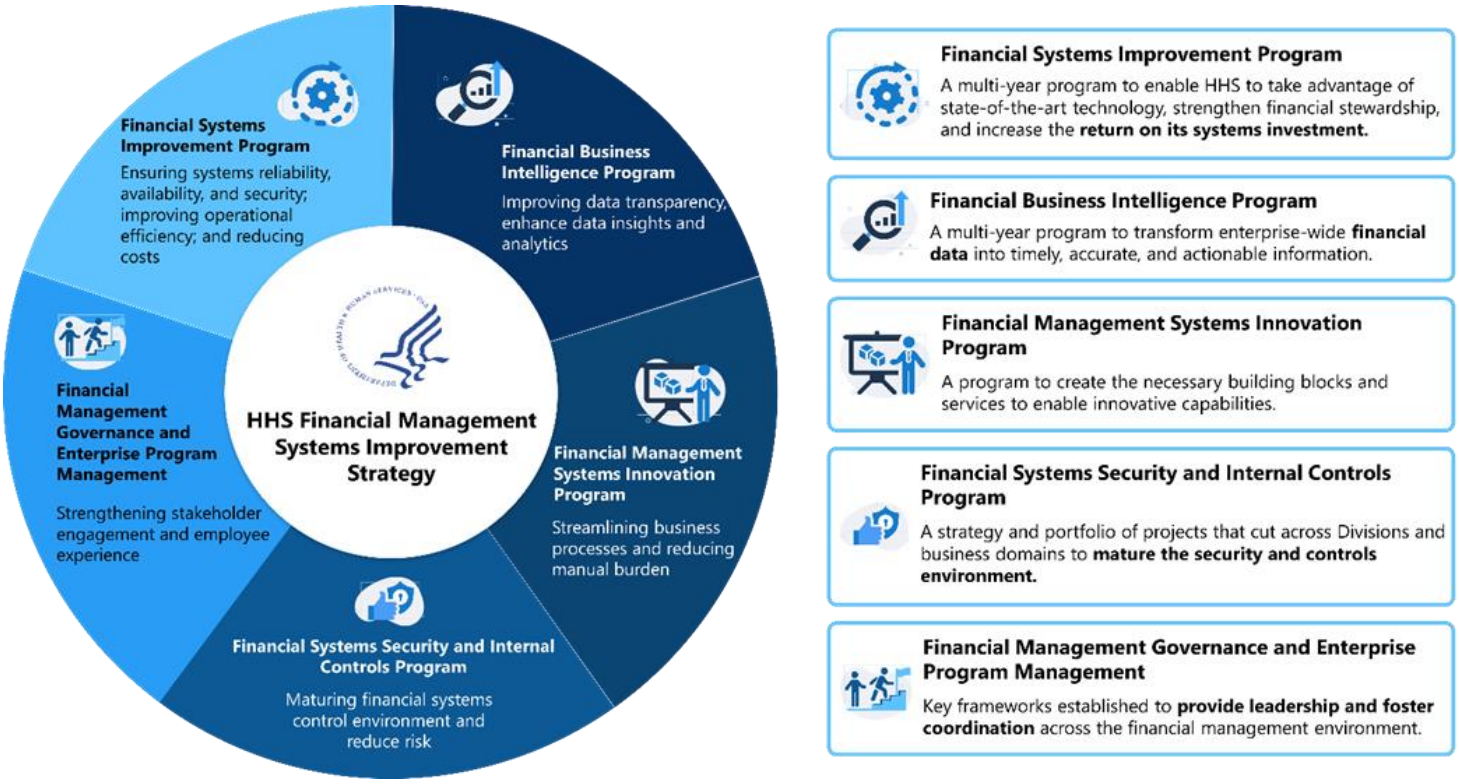
Financial Management Systems Improvement Strategy

Financial managers continue to face a rapidly changing financial management landscape with increasing demands for accountability and transparency, evolving federal mandates, emerging technologies, increasing security threats, and maximizing the value of systems investments. HHS has made substantial progress in maturing the financial management systems environment to anticipate and address these challenges. To address these challenges, HHS developed a Department-wide holistic financial management systems improvement strategy by creating five programs that work together to provide a secure, reliable, and high-performing financial management systems environment. This environment is constantly innovating and evolving, quickly incorporating federal mandates while also providing operational efficiency and reducing costs. The five critical programs balance each other to take advantage of state-of-the-art technology; strengthen financial stewardship; improve data analytics; implement intelligent automation to bring efficiencies, streamline business processes; strengthen stakeholder engagement; and mature the security and internal controls.

At the same time, HHS remains focused on the customer experience, ensuring that 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 Management Systems Improvement Strategy



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.

- HHS successfully implemented the U.S. Department of the Treasury's (Treasury) Government Invoicing (G-Invoicing) solution for conducting intra-governmental (IGT) buy/sell transactions in October 2022. The business need is driven by the government-wide high volume of IGTs totaling approximately $1.38 trillion in FY 2021, with unreconciled differences totaling $13.6 billion (per Treasury's Bureau of the Fiscal Service IGT buy/sell facts). In addition to fulfilling the government-wide mandate, the G-Invoicing implementation enhances data quality and reliability of IGTs, provides transparency among federal agencies, improves accounting and reporting accuracy, and effectively addresses a long-standing government-wide material weakness.
- HHS matured Treasury's commercial Electronic Invoicing (E-Invoicing) process, leading to increased user adoption. In FY 2023, over 93 percent of Purchase Order (PO) invoices were processed through the E-Invoicing solution. This is a 15 percent increase over FY 2022. The E-Invoicing initiative modernized the invoicing process by automating the entry, routing, and processing of invoices to reduce the time between invoice submission to payment. In addition to aligning with a government-wide federal mandate (OMB M-15-19), HHS expects a return on investment of 295 percent and a payback period of less than 3 years.
- HHS launched the Development, Security, and Operations initiative that will accelerate the implementation of changes for customers to meet their business needs, improve quality of the products delivered, and integrate security throughout the system development life cycle and maintenance.

2. Financial Business Intelligence Program

The Financial Business Intelligence Program provides approximately 1,900 users within the HHS financial management community with the ability to analyze financial information and transform data into actionable insights for strategic and tactical decision making through the FBIS. HHS has made progress on its commitment to facilitate improved stewardship and decision-making in FY 2023 through a dedicated effort to bolster FBIS's capabilities and adoption.

- HHS launched the FBIS University Learning Center in 2022, which offers over 50 new training resources, including interactive trainings, job aids, bite-sized videos, and tutorials, empowering users to learn at their own pace and make informed decisions based on financial data.
- Based on insights from the Customer Listening Tours and subsequent Human-Centric Design workshops, HHS modernized the user experience to enable a more intuitive and user-friendly experience. The improvements have not only increased user adoption and reduced support costs but have also elevated application performance. As a result, the annual customer experience survey found an overall positive satisfaction rate of 95 percent, marking a 9 percent increase over FY 2022. Furthermore, a Net Promoter Score of 82 indicates that customers are more likely to recommend the system to a colleague.
- HHS provided new, insight-driven reports and dashboards by enhancing managerial reporting capabilities and facilitating improved stewardship and decision-making. These include new G-Invoicing, Acquisition, and Grants dashboards and enhanced Procure-to-Pay, E-Invoicing, Undelivered Order, and Year-End Close dashboards. As a result, the financial management community has access to insights they never had before, along with tools to execute financial management responsibilities effectively and efficiently.

3. Financial Management Systems Innovation Program

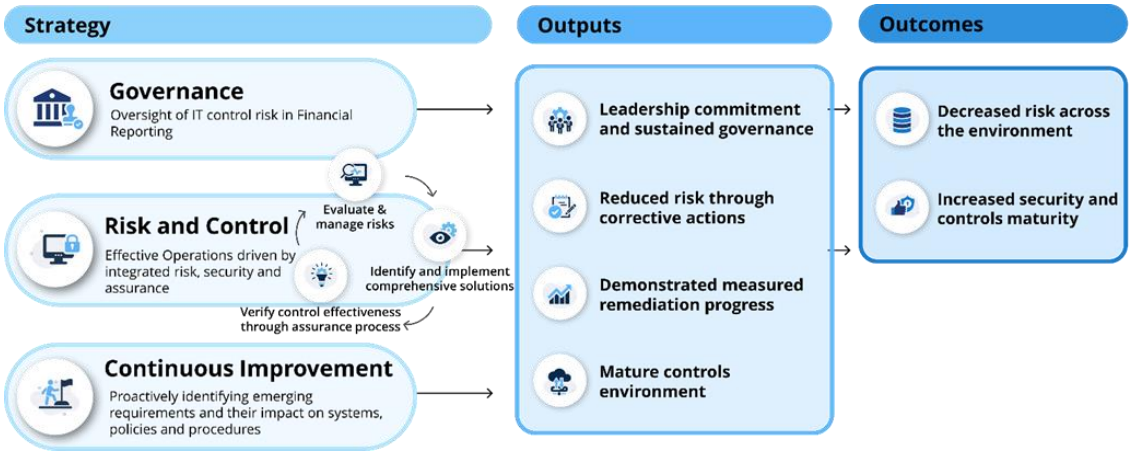
HHS continues to undertake various initiatives to capitalize on technological advances and enable innovative capabilities to streamline business processes and reduce manual burden.

- HHS initiated the modernization of its critical financial systems infrastructure to a modern cloud computing environment, Oracle Cloud Infrastructure (OCI), establishing a strong foundation for the next generation of financial systems, cloud-enabled data analytics, Artificial Intelligence capabilities, and a more scalable, agile, and cost-effective environment. During the initial phase, HHS migrated UFMS to a modernized cloud environment with the NBS migration scheduled for next year. Overall, these advancements position HHS for future success, enabling HHS to embrace cutting-edge technologies, optimize operations, and deliver superior services. In addition, as a Federal Risk and Authorization Management Program high provider, the environment will provide higher security features.
- HHS successfully expanded the HHS Automation-as-a-Service initiative through Robotic Process Automation (RPA) by automating manual processes across its financial management systems. OF has successfully implemented multiple automations to improve end-user business processes as well as bring efficiencies into financial system operations resulting in over 5,000 manual hours saved in FY 2023. Once fully matured, the automations are estimated to save over 9,000 manual hours annually. These automations will enable improved productivity, lower costs, and enhance business value while simultaneously maintaining compliance and security controls.
- HHS initiated the implementation of a virtual assistant (a.k.a., chatbot) Artificial Intelligence program that will improve users' experience by expanding a platform to ask system-related questions and receive answers, and helping users find and navigate to relevant FBIS reports, dashboards, training materials, and help desk information. This chatbot will direct users to the most appropriate information assets available as well as the usage and effectiveness of the pertinent reports.

4. Financial Systems Security and Internal Controls Program

The reliability, availability, and security of HHS's financial systems are paramount. HHS continues to implement its Department-wide comprehensive strategy to achieve the vision of a mature Financial Systems Control Environment (FSCE) that effectively mitigates risk. The strategy, shown in **Figure 18**, provides a 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.

Figure 18: FSCE Maturity Strategy



HHS made significant improvements toward its strategic vision by completing or closing 63 percent of the prior years' Federal Information System Controls Audit Manual audit weaknesses. Most notably, HHS continues to sustain its FSCE 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. HHS increased internal control governance by providing a FY 2023 financial systems A-123 Workshop, guidance, and templates that align with the new OMB A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, guidance focusing on risk, rather than compliance. HHS continued the standardization of IT control testing across the FSCE to promote risk understanding and awareness as well as collaboration among the CFO, Chief Information Officer (CIO), and Chief Information Security Officer communities.

In addition to regular reporting and monthly meetings, the Department hosted its sixth annual Financial Systems Audit, Internal Control, and Risk Management Summit in March 2023. Over 210 attendees from the CFO, CIO, and Chief Information Security Officer communities across the Department came together to celebrate accomplishments and share vision, strategy, and emerging technology practices with 10 panels focused on emerging opportunities and risk. The Summit advanced HHS's culture of recognition through team and individual contribution awards across the OpDivs for their efforts to mature the FSCE. Department CIO and CFO leadership have applauded the Summit as a vital platform for sharing best practices and driving Department-wide IT security and control maturity.

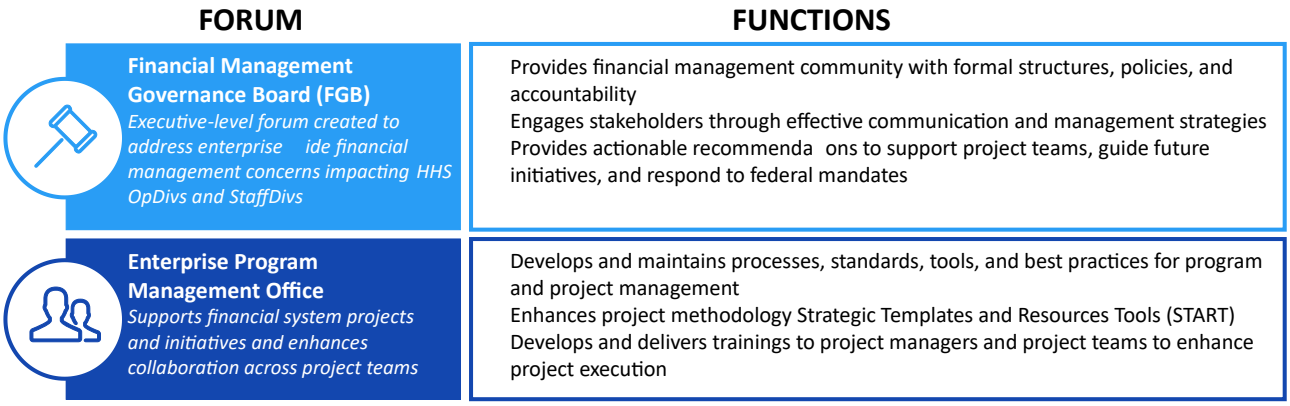
Risk management and control activities are the foundation of the Department-wide FSCE maturity strategy. These activities steward effective operations by integrating risk, security, and assurance processes. This integration is accomplished through tactical risk evaluations; comprehensive corrective action 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 technologies with guidance and best

practices. For example, HHS established an annual Management Assessment Framework (MAF) process to evaluate IT control risks within the FSCE using objective and quantifiable risk measurement criteria. The MAF has enabled management to assess the Department's progress toward achieving its vision of a mature FSCE that effectively mitigates risk. The FY 2023 MAF assessment determined that 93 percent of the controls tested were effective with no material weakness.

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 established 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 strategic goals, as illustrated in **Figure 19**.

Figure 19: Financial Management Governance and Enterprise Program Management Overview



In FY 2023, the FGB oversaw and guided major projects and initiatives including E-Invoicing, G-Invoicing, Technology Business Management, the Treasury's Financial Management QSMO initiative, and Grants QSMO. These projects and initiatives meet federal mandates; enhance data quality; improve cost accountability; align HHS financial management services with government-wide standards; and provide guidance and services to other government grant making agencies. Additionally, the Financial Management Governance structure allows for its working groups to guide HHS financial policies, provide unified data standards and accounting treatment, coordinate audits throughout the Department and management risks associated with financial systems. Initialized in 2013, the Financial Management Governance structure serves as one voice for the HHS financial management community.

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 2023, the Enterprise Program Management Office (EPMO) continued its efforts to transform project implementation and execution by refreshing its Strategic Templates and Resource Tools (START). This methodology provides a standardized framework to manage all project types and sizes, delivering training for Integrated Baseline Review and Risk Management process areas to align with Department and industry standards.

The EPMO also conducted its Annual Lessons Learned exercise with key stakeholders to gain insight into successes and challenges on FY 2022 projects 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 community 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 3 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* as enacted in the *Infrastructure Investment and Jobs Act*, signed on November 15, 2021, aims to 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. 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* is a once-in-generation investment in our nation that integrates a safer and healthier framework into all communities. In FY 2022, HHS received $4.0 billion to invest in the IHS Water and Sewer program to support crucial sanitation projects and the ACF Low-Income Home Energy Assistance Program (LIHEAP) to support low-income households with costly energy bills. In March 2023, ACF awarded $1.6 billion in funding for LIHEAP, which brings the total LIHEAP funding for FY 2023 to $6.1 billion.

The legislation will invest $3.5 billion ($700 million each year FY 2022 through 2026) 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, solid waste disposal facilities, and related support facilities. This funding supports the construction of crucial sanitation facilities projects which improve water supply and waste disposal systems throughout American Indian and Alaska Native communities across the country to prevent conditions related to respiratory, skin, soft tissue, and gastroenteric disease. In April 2023, IHS launched a new interactive website to provide information on Division of Sanitation Facilities Construction projects, which include projects associated with this law.

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.

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. The collaboration has led to PRAC publishing lessons learned, and OIG-established best practices and top priorities to prepare for future emergencies.

As directed under OMB Memorandum M-20-21, *Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019* (COVID-19), HHS reported COVID-19 funds by federal account, object class, program activity, and more at the obligation and outlay level. Beginning the third quarter of FY 2020, HHS has reported monthly on all disaster emergency fund codes associated with COVID-19. 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.

The Fiscal Responsibility Act of 2023

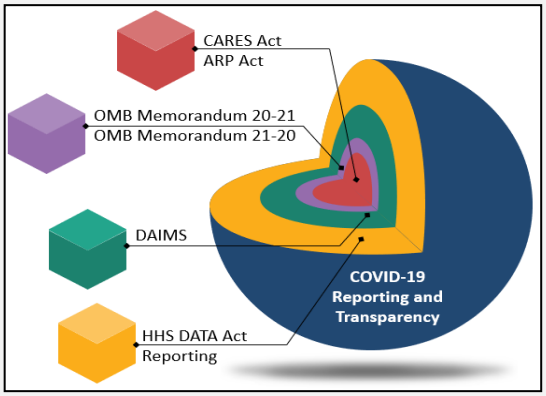
The *Fiscal Responsibility Act of 2023*, signed on June 3, 2023, suspends the limit on federal debt through January 1, 2025, along with a number of other provisions that affect the spending and revenues of the Federal government. The FRA aims to reduce the projected federal deficit by $1.5 trillion over the next 10 years.

The FRA permanently rescinds a range of unobligated funds to reduce discretionary spending and save taxpayer resources, but any obligated funds that have been partially spent will not be affected. While HHS continues to assess the full scope of programs affected by these rescissions, the Department acknowledges it is increasingly more vital to exercise diligent oversight and responsible stewardship of program funding.

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 aligned sets of internally maintained and externally managed data for valid and reliable 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 2023, DATA Act award-level obligations increased to $1,821.9 billion compared to $1,729.2 billion in FY 2022. HHS completely reconciled to an average of 99 percent of award-level obligations for FY 2023.

The diagram above represents how multiple COVID-19 legislative publications each built on the prior legislation to create the holistic reporting and transparency approach, beginning with Section 15011 of the CARES Act at the core. OMB clarified in OMB Memorandum M-20-21 that the DATA Act would be used as the reporting vehicle for COVID-19 spending data 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.

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.

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 (EIS) transition. HHS continued its efforts related to CIO authorities, delegation of authority, and responsibilities under the law.

In accordance with FITARA requirements, the HHS CIO successfully updated and published the HHS Chief Information Officer Delegation of Authorities memorandum in March 2023. This revised delegation memorandum clarified qualifications for delegation and limitations of authority, addressed IT managers in StaffDivs, clarified that the HHS CIO is the OS CIO unless otherwise delegated by the HHS CIO, enumerated OCIO Governance Programs, and provided appendix to map roles, responsibilities and delegations to relative OMB guidance and enabling legislation.

Through these efforts, HHS received its fifth consecutive "B" on the House Committee on Oversight and Reform's (COR) FITARA 15.0 Scorecard, released on December 15, 2022. In the 15.0 iteration, HHS performed better than 11 other federal agencies.

The COR graded agencies on a "pass/fail" basis for EIS. Because of HHS's commitment to transition from legacy contracts to EIS, the agency scored a "P" for passing, transitioning more than 99 percent of its networks as of September 30, 2022. HHS was one of only five federal agencies to receive a passing grade. All other federal agencies scored an "F" for this metric.

In addition, HHS's *Federal Information Security Management Act* score improved from "F" to "D," based on the agency's IG assessments against a Level 4 maturity.

The HHS CIO continued engagement 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 metric.

With that strong foundation, HHS will continue to focus on the larger FITARA related initiatives, such as Cybersecurity/*Federal Information Security Management Act*.

Going forward, the newly formed 2023 Subcommittee on Cybersecurity, Information Technology and Government Operations is expected to continue providing guidance and emphasis on strengthening the cybersecurity posture across federal agencies.

Federal Information Technology Acquisition Reform Act

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 Enterprise Risk Management 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, collaborate on 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 root cause of deficiencies and supported by active management oversight. Refer to the "Internal Control" section and the "Management Assurance" sections below for more information.

Inflation Reduction Act

The *Inflation Reduction Act*, signed on August 16, 2022, lowers prescription drug spending for millions of Medicare beneficiaries, redesigns the Part D program, stabilizes prescription drugs premiums, and strengthens the Medicare program. The law established the Medicare Prescription Drug Price Negotiation Program, which permits Medicare to directly negotiate with drug manufacturers for fair pricing of physician-administered drugs covered under Medicare Part B and retail prescription drugs covered under Medicare Part D. Manufacturers selling drugs through Medicare Part B and D must pay rebates to Medicare if they increase drug prices faster than consumer inflation.

In its first year, the law also lowered insulin costs for nearly four million seniors and other Medicare beneficiaries with diabetes. As of January 2023, people enrolled in Medicare were required to pay no more than $35 for a one-month supply of covered insulin products.

Additionally, this act fosters changes to vaccine costs for Medicare Part D, Medicaid, and CHIP recipients. In January 2023, the legislation eliminated out-of-pockets costs for adult vaccines recommended by the Advisory Committee on Immunization Practices and covered under Medicare Part D.

Beginning January 1, 2024, eligible seniors and people with disabilities will benefit even more through the expansion of the Extra Help program under Medicare Part D. The program is available to Medicare enrollees who earn less than 150 percent of the federal poverty level.

The *Inflation Reduction Act* lowers healthcare premiums for working families by extending enhanced premium tax credits originally enacted under ARP for 3 additional years through 2025. This has continued to reduce health insurance premiums by an average of $800 per year for the millions of people covered under the *Patient Protection and Affordable Care Act* (PPACA). In addition to the *Inflation Reduction Act*, the *No Surprises Act* also went into effect in 2022, strengthening the affordability of healthcare and protecting Americans with group and individual health plans from surprise medical bills. Consumers now have new billing protections when getting emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers, preventing an estimated one million surprise bills per month.

Patient Protection and Affordable Care Act

The PPACA established Health Insurance Marketplaces through which qualified individuals and qualified employers can purchase health insurance coverage. A record number of 16.4 million people signed up or re-enrolled for healthcare during the Open Enrollment Period in FY 2023.

Many individuals who enroll in Qualified Health Plans through individual Federally-facilitated 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 PPACA 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."

The 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. 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." In cases where documentation is missing or insufficient, payments may be labeled as "unknown" since their propriety cannot be determined. Furthermore, payments can be considered "technically improper" when they are made to the correct recipient for the correct amount but do not adhere to all relevant laws and regulations.

The *Payment Integrity Information Act of 2019* (PIIA) mandates that agencies assess their programs and activities to identify programs that may be susceptible to significant improper payments (also called risk-susceptible programs). These programs must calculate improper payment estimates, set reduction targets, and develop and implement corrective actions. HHS actively strives to prevent, detect, and reduce improper payments by scrutinizing its programs and activities utilizing robust risk models, statistical estimates, and internal controls.

HHS has demonstrated strong leadership in payment integrity. With a well-established estimation and reporting process spanning many years, HHS has implemented numerous corrective measures to prevent, detect, and reduce improper payments within its programs. In accordance with PIIA, HHS conducted 56 improper payment risk assessments in FY 2023 and did not identify any new risk-susceptible programs. Furthermore, HHS is publishing improper payment estimates and associated information for 10 of the 12 risk-susceptible programs in the FY 2023 AFR. Additionally, HHS uses the Do Not Pay portal to verify payments and recipients, identifying potential improper payments or ineligible recipients. In FY 2023, HHS screened approximately $793 billion in Treasury-disbursed payments using the Do Not Pay portal. For a comprehensive overview of HHS's efforts to reduce improper payments and combat fraud, please refer to the "Payment Integrity Report" in the "Other Information." section of this AFR.

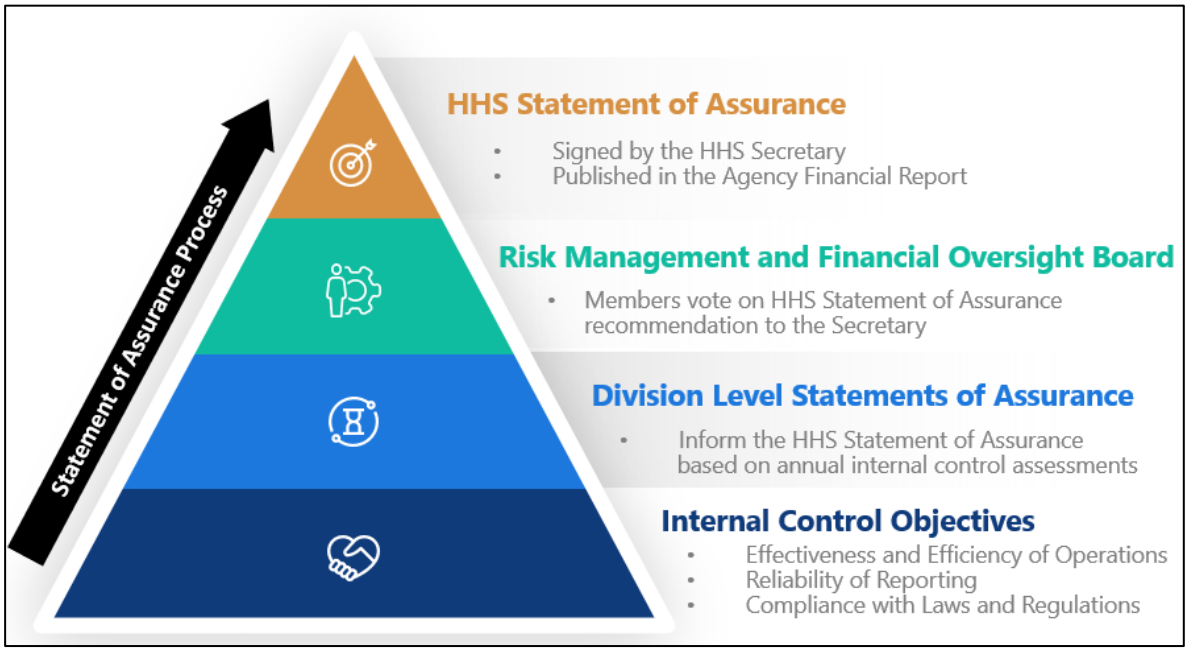
Internal Control

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 regulations. 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 Enterprise Risk Management 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.

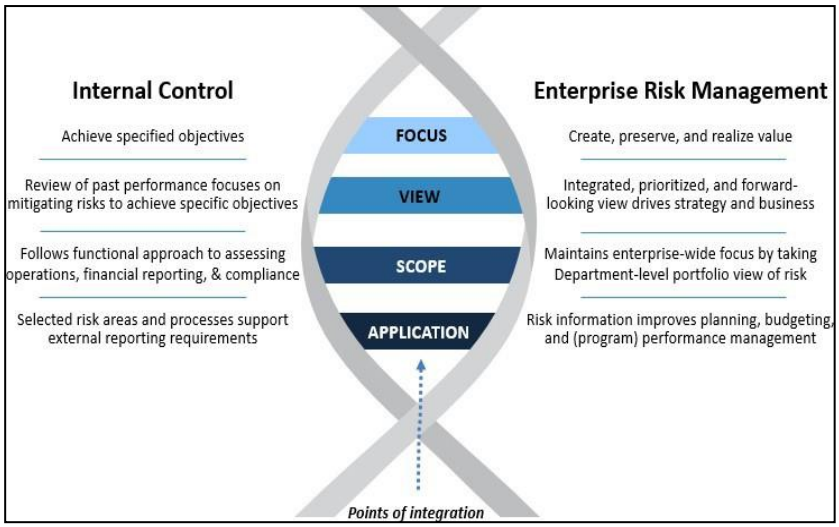
HHS management is directly responsible for establishing and maintaining effective internal controls. As part of this responsibility, management regularly assesses internal controls and executive leadership provides an annual assurance statement reporting on the effectiveness of those internal controls. 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 20**.

Figure 20: Secretary's Annual Statement of Assurance Process



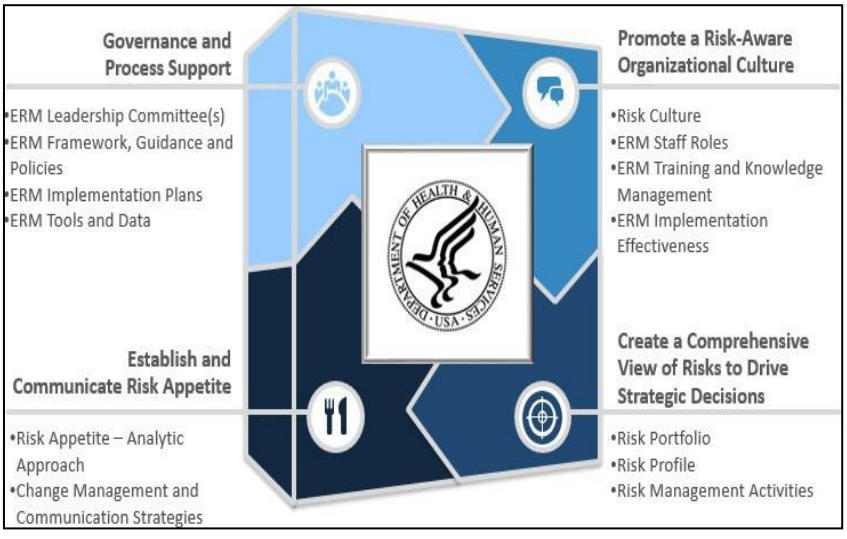
Enterprise Risk Management

Figure 21: 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 20**, 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.

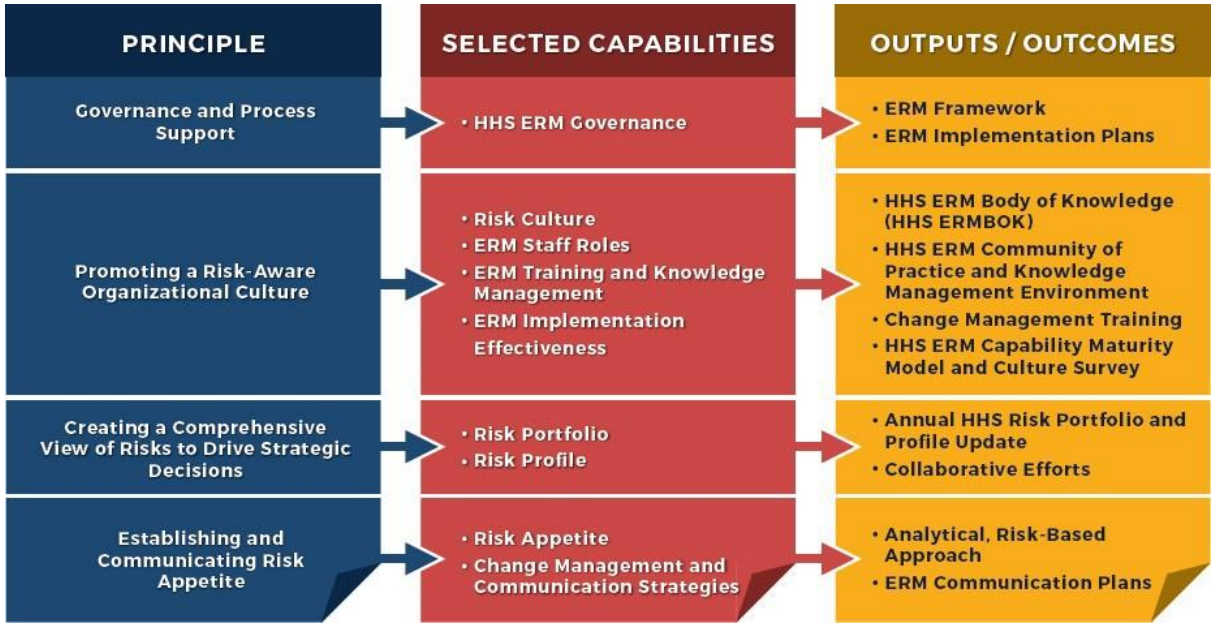
Figure 22: Principles-Based HHS ERM Framework and Capabilities



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 21** 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.

The HHS ERM Framework in **Figure 22** 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 23.**

Figure 23: HHS ERM Principles-Based Framework Translates Capabilities into Outputs and Outcome



Management Assurances

Statement of Assurance

U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary
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, 2023, with the exception of a material noncompliance with the *Payment Integrity Information Act of 2019 (PIIA).* HHS is taking corrective actions to address the noncompliance 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 strengthen its system of internal control and financial management systems.

/Xavier Becerra/

Xavier Becerra
Secretary
November 14, 2023

Summary

***Payment Integrity Information Act of 2019* (PIIA)**

HHS identified a material noncompliance with PIIA due to the Department not reporting (a) improper payment estimates and (b) improper estimates below the 10 percent statutory threshold.

The PIIA noncompliance issues, corrective actions, and expected timelines for resolution are outlined below and elaborated upon in the "Payment Integrity Report," which also covers other programs susceptible to improper payments.

a) Temporary Assistance for Needy Families (TANF)

The TANF program did not report an improper payment estimate due to statutory limitations (Section 417 of the *Social Security Act* (42 U.S.C. 617)) precluding HHS from requiring states to provide the data needed to develop and report an estimate. HHS reported these TANF statutory limitations in previous years and they remain in place.

HHS continues to pursue actions and methods to measure and report an improper payment estimate for the TANF program. In the FY 2024 President's Budget request, HHS proposed new statutory authority to gather more comprehensive data on TANF. The proposal aims to improve monitoring of TANF spending and the Department's development and reporting of an improper payment estimate.

b) Foster Care

The Foster Care program did not report an improper payment estimate due to the COVID-19 pandemic. At the onset of the pandemic in FY 2020, HHS suspended onsite Foster Care reviews to ensure the safety of state and federal reviewers. This prolonged delay has left the Department without recent data to calculate improper payment estimates. The Department will resume onsite reviews and report improper payment estimates in FY 2024.

c) Children's Health Insurance Program (CHIP)

The CHIP did not report an improper payment estimate below the PIIA statutory threshold of 10 percent.

HHS publishes CHIP scorecards quarterly on PaymentAccuracy.gov, offering insights into the root causes of monetary losses, anticipated impacts, and strategies to mitigate them. CMS and the Department continuously monitor CHIP, along with corrective actions, key milestones, and recent accomplishments. To address improper payments in the CHIP, corrective actions include:

- Offering training and support to state program integrity officials via the Medicaid Integrity Institute to reduce common errors causing improper payments, particularly related to inadequate or inaccurate documentation.
- Collaborating with states to create state-specific corrective action plans for reducing future payment errors, with a focus on providing enhanced technical support and guidance.
- Expanding access of states and territories to provider screening and enrollment data to ensure compliance with payment requirements.
- Ensuring accurate CHIP benefit eligibility determination by states through the Medicaid Eligibility Quality Control program and beneficiary audits.

Financial Summary and Highlights

For the 25th 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, 2023. HHS received a disclaimer on the Statement of Social Insurance (SOSI), Statement of Changes in Social Insurance Amounts (SCSIA), 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.

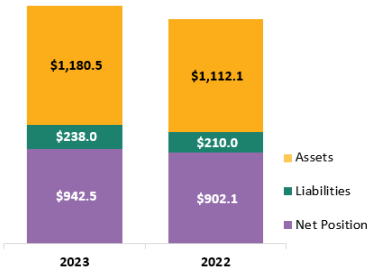
As a federal entity, HHS's financial position and activities are significant to the government-wide statements. Based on the *FY 2022 Financial Report of the United States Government*, HHS's net operating cost was the 2nd largest across the entire federal government.[1] A similar relationship exists 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 (FY)-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 2023 and FY 2022 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)

	2023	2022	$ Change (2023-2022)	% Change (2023-2022)
Fund Balance with Treasury	$ 695.6	$ 652.7	$ 42.9	7%
Investments, Net	360.4	351.6	8.8	3%
Accounts Receivable, Net	40.0	41.0	(1.0)	(2)%
Advances and Prepayments	47.7	41.6	6.1	15%
Other Assets	36.8	25.2	11.6	46%
Total Assets	**$ 1,180.5**	**$ 1,112.1**	**$ 68.4**	**6%**
Accounts Payable	$ 3.4	$ 4.0	$ (0.6)	(15)%
Debt	3.3	8.2	(4.9)	(60)%
Entitlement Benefits Due and Payable	159.5	141.2	18.3	13%
Accrued Liabilities	17.4	16.3	1.1	7%
Federal Employee and Veteran Benefits Payable	20.4	19.4	1.0	5%
Contingencies & Commitments	27.5	15.8	11.7	74%
Other Liabilities	6.5	5.1	1.4	27%
Total Liabilities	**$ 238.0**	**$ 210.0**	**$ 28.0**	**13%**
Net Position	**$ 942.5**	**$ 902.1**	**$ 40.4**	**4%**
Total Liabilities and Net Position	**$ 1,180.5**	**$ 1,112.1**	**$ 68.4**	**6%**



[1]HHS's net cost is 18 percent of the federal government's total costs, Department of Veterans Affairs' net cost is 21 percent, Department of Defense's net cost is 16 percent, Social Security Administration's net cost is 14 percent. All remaining agencies combined only represent 30 percent. Source: *FY 2022 Financial Report of the U.S. Government*.

Financial Summary and Highlights

Assets The total assets for HHS were $1,180.5 billion at year-end, representing the value of what HHS owns and manages. This is an increase of approximately $68.4 billion or 6 percent over September 30, 2022. Fund Balance with Treasury (FBwT) and Investments comprise $1,056.0 billion or 89 percent of HHS's total assets, and collectively increased $51.7 billion or 5 percent.

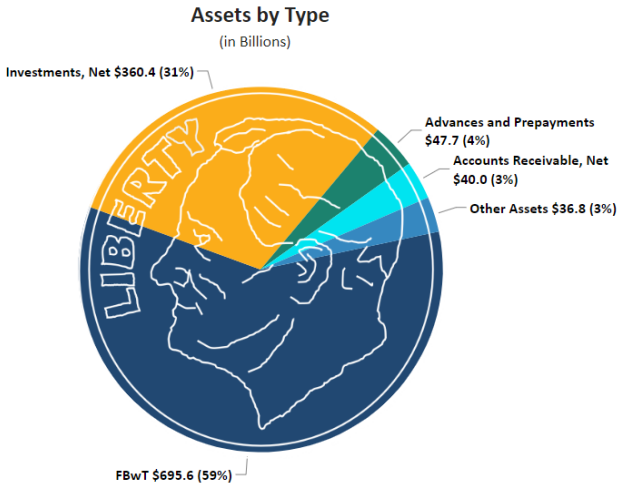
FBwT had an increase of $42.9 billion or 7 percent over FY 2022, which is primarily due to increases in Supplementary Medical Insurance (SMI) due to the Payments to the Healthcare Trust Funds allocations and CHIP due to grants not yet drawn by the states. These increases are offset by decreases in the Public Health and Social Services Emergency Fund and *Defense Production Act* from lower carryover balance for COVID-19 funding which was disbursed throughout the prior year.

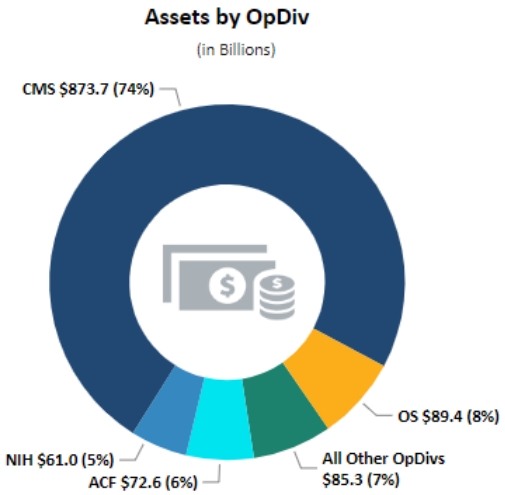
Advances and Prepayments had an increase of $6.1 billion or 15 percent over FY 2022, which is primarily due to the October 2023 Prescription Drug and Medicare Advantage benefit payments being prepaid on September 29 instead of October 1 and the reclass of COVID-19 Accelerated & Advance Payment (CAAP) advances to demanded receivables.

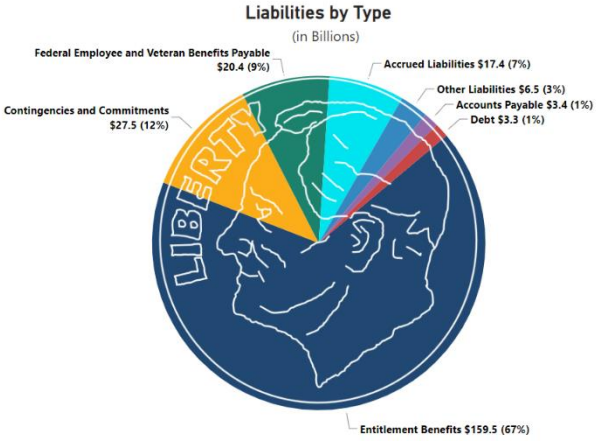
The HHS "Assets by OpDiv" chart shows asset distribution within HHS, excluding eliminations. The OpDiv asset balances ranged from $369 million at AHRQ (shown in All Other OpDivs) to $873.7 billion at CMS. CMS had the largest dollar increase of $108.3 billion or 14 percent primarily due to increases in FBwT, Investments, and Advances and Prepayments as mentioned above. OS had the largest percentage change, a decrease of $28.1 billion or 24 percent primarily due to less carryover COVID-19 funding.

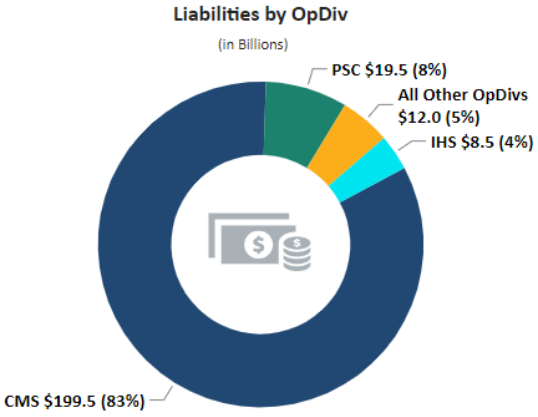
Liabilities The total liabilities for HHS were $238.0 billion at year-end, representing the amounts HHS owes from past transactions or events. Liabilities had an increase of approximately $28.0 billion or 13 percent over September 30, 2022.

This is mainly attributed to increases in Entitlement Benefits Due and Payable and Contingencies and Commitments. Entitlement Benefits had an increase of $18.3 billion or 13 percent over FY 2022, which is due to an increase in medical services and claims incurred but not reported. Contingencies and Commitments had an increase of $11.7 billion or 74 percent over FY 2022, which is due to Medicaid State Plan Amendment accrual for nursing home increases and legal contingencies. These increases are offset by a decrease in Debt of $4.9 billion or 60 percent under FY 2022, which is due to the repayment of FY 2021 SMI repayable advances to the Payments to the Healthcare Trust Funds.





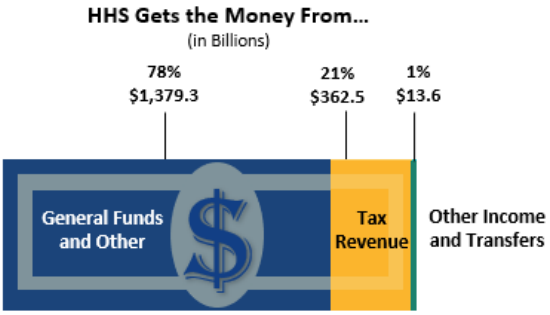




The HHS "Liabilities by OpDiv" chart shows liability distribution within HHS, excluding eliminations. The OpDivs with the largest and smallest asset balances are also the OpDivs with the largest and smallest liabilities. With the majority share, CMS reports $199.5 billion or 83 percent of the HHS liabilities, while AHRQ (shown in All Other OpDivs) has liabilities of $15 million. CMS had the largest OpDiv dollar value increase in liabilities over FY 2022 of $27.6 billion due to increases in Entitlement Benefits and Contingencies and Commitments offset by a decrease in Debt, as mentioned previously.

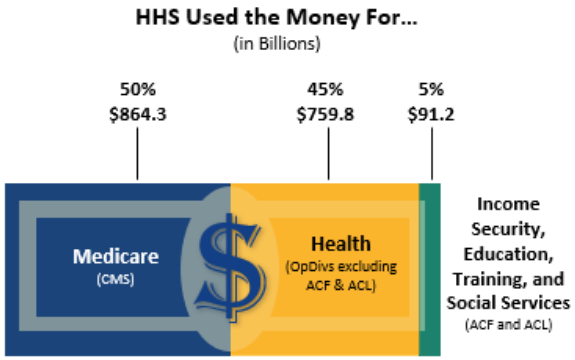
Statement of Changes in Net Position

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, increased $86.3 billion or 7 percent over FY 2022 and is primarily due to increases in SMI and Medicaid appropriations, offset by COVID-19 supplemental funding rescissions. The fluctuation in tax revenue of $18.8 billion or 5 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, 2023, totaled approximately $1,714.9 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 2023, total net costs for Medicare of $864.3 billion and Health of $759.8 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

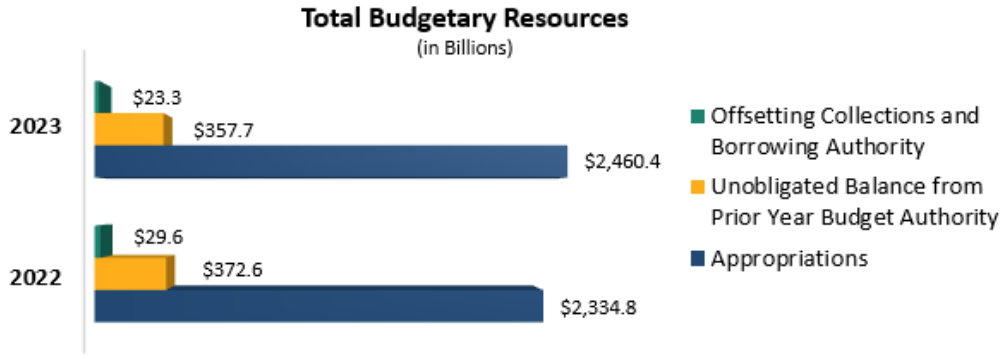
The table below presents FY 2023 Consolidated Net Cost of Operations, which breaks costs into Responsibility Segments between CMS and the remaining OpDivs in Other Segments. Net cost for CMS increased by $116.1 billion or 8 percent over FY 2022, which included increases in Medicare SMI and Hospital Insurance (HI) and Medicaid. SMI Part B benefit expenses increased by $26.0 billion and an increase of $21.0 billion due to a decrease in offsetting receipts. SMI Part D expenses increased by $8.7 billion primarily due to increase in benefit expense and increase from net year-to-year changes in receivables. Medicare HI increased primarily due to increases in HI benefit expenses of $26.6 billion and contingent liability of $10.4 billion. Medicaid benefit expense increase of $19.1 billion from higher grant awards to the States due to the continuation of the COVID-19 relief which is offset by $1.1 billion decrease in contingent liability expenses for the State Plan Amendments and audit and program disallowances. The decrease in total Net Cost of Operations for the remaining HHS segments of $62.0 billion or 22 percent under FY 2022 is primarily due to decrease in COVID-19 costs.

Net Cost of Operations
(in Billions)

	2023	2022	$ Change (2023-2022)	% Change (2023-2022)
Responsibility Segments:				
CMS Gross Cost	$ 1,654.1	$ 1,531.3	$ 122.8	8%
CMS Earned Revenue	(154.9)	(148.2)	(6.7)	5%
CMS Net Cost of Operations	$ 1,499.2	$ 1,383.1	$ 116.1	8%
Other Segments:				
Other Segments Gross Cost	$ 222.7	$ 284.7	$ (62.0)	(22)%
Other Segments Earned Revenue	(7.0)	(7.0)	-	-%
Other Segments Net Cost of Operations	$ 215.7	$ 277.7	$ (62.0)	(22)%
Net Cost of Operations	**$ 1,714.9**	**$ 1,660.8**	**$ 54.1**	**3%**

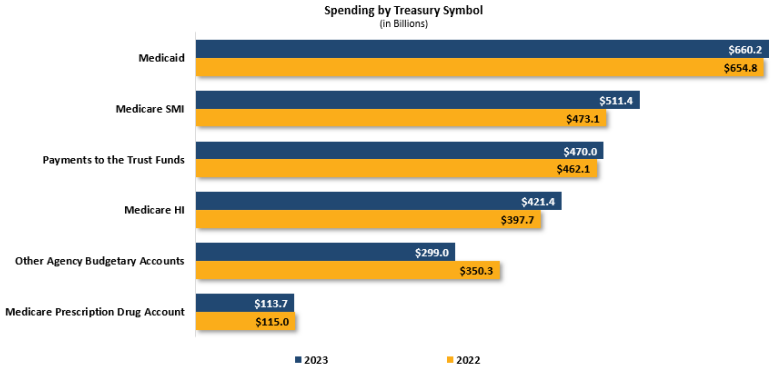
Statement of Budgetary Resources

The Combined Statement of Budgetary Resources displays the budgetary resources available to HHS throughout FY 2023 and FY 2022, and the status of those resources at the FY-end. The primary components of HHS's resources, totaling approximately $2.8 trillion for FY 2023, 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 2023 Budgetary Resources has remained consistent with FY 2022. The following graph highlights trends in these balances over the past two FYs.



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, 2023 and 2022 for the top five Treasury Account Symbols (TAS). The remaining TAS are presented in Other Agency Budgetary Accounts.



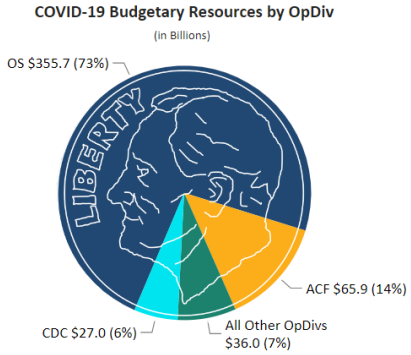
The New Obligations and Upward Adjustments line on the Combined Statement of Budgetary Resources is the same as Total Amounts Agreed to be Spent line on the Combined Schedule of Spending. Total obligations for FY 2023 were approximately $2.5 trillion or 1 percent increase over FY 2022.

The HHS's total spending is once again significantly represented by five of CMS's TAS (Medicaid, Medicare SMI, Payments to the Healthcare Trust Funds, Medicare HI, and Medicare Prescription Drug Account) at 88 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 $1.0 trillion or 42 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, 2023, HHS has obligated $466.6 billion to support efforts of which $393.9 billion has been outlayed. During FY 2023, the *Fiscal Responsibility Act of 2023* rescinded all unobligated balances from amounts made available through COVID-19 supplemental appropriations, except for amounts specifically enumerated within this Act. This resulted in $10.3 billion in COVID-19 funds being rescinded. HHS still has $7.8 billion available for future FYs 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 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 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal SMI Trust Funds. With two exceptions, the projections are based on the current-law provisions of the *Social Security Act*. The first exception is that the Part A projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted. The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November of 2020, is not reflected in the Part D projections. This final rule imposed a January 1, 2022, effective date; however, implementation was initially delayed until January 1, 2023. Since then, enacted legislation has three times imposed a moratorium on implementation, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

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

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

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

Actual fee-for-service per capita spending has been consistently below the pre-pandemic projections throughout the PHE, even into 2022 as the pandemic had diminishing effects on much of the economy and the healthcare delivery system. A number of factors have contributed to this lower spending, including the net effects of (i) lower average morbidity among the surviving population from COVID-related deaths; (ii) a greater share of dual-eligible beneficiaries enrolling in the Medicare Advantage program; and (iii) the shift of joint replacement procedures from an inpatient to an outpatient setting. These reductions are partially offset by certain PHE policies.

While these factors account for a significant amount of the difference between actual and expected experience for many of the categories of providers, others are still largely unexplained. For inpatient hospital, outpatient hospital, and SNF spending, these unexplained differences are expected to be eliminated by 2024; for home health services, they are expected to be gradually eliminated by 2026.

It should be noted that there is an unusually large degree of uncertainty with the COVID-related impacts and that future projections could change significantly as more information becomes available. 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 PHE period. Total payments of approximately $107.2 billion were made from March 2020 through June 2021: roughly $67.2 billion from the HI trust fund and $40.1 billion from the SMI Part B trust fund account. As of January 1, 2023, roughly 99 percent of these amounts have been repaid. The Trustees assumed in their report that the remaining balance would be fully repaid or converted to an extended repayment schedule by March of 2023.

The SOSI presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period;
- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;
- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period; and
- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) increased from $(5.1) trillion, determined as of January 1, 2022, to $(4.6) trillion, determined as of January 1, 2023.

When the combined HI and SMI trust fund assets are included, the present value increases. As of January 1, 2023, the future cash flow for all current and future participants is $(4.2) trillion for the 75-year valuation period. The comparable cash flow for the closed group of participants, including the combined HI and SMI trust fund assets, is $(14.1) trillion.

HI Trust Fund Solvency

Pay-as-you-go Financing

The HI trust fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive trust fund assets. In recent years, current expenditures have exceeded program income for the HI program; thus, the HI trust fund assets have been declining. The following table shows the HI trust fund assets, expressed as a ratio of the assets at the beginning of the FY to the expenditures for the year. This ratio steadily dropped from 63 percent at the beginning of FY 2019 to 45 percent at the beginning of FY 2023. This ratio is estimated to increase in 2023 due to higher trust fund assets at the beginning of the year and lower expenditures projected for 2023, mainly as a result of updated expectations for healthcare spending following the COVID-19 pandemic.

Trust Fund Ratio Beginning of Fiscal Year[3]					
	2019	**2020**	**2021**	**2022**	**2023**
HI	63%	50%	40%	39%	45%

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 (CY) are at least as large as program obligations for the year. Estimates in the 2023 Trustees Report indicate that the HI trust fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2023 Trustees Report, the HI trust fund ratio is estimated to increase in 2023 before decreasing for the rest of the projection period until the fund is depleted in CY 2031. Assets at the end of CY 2022 were $196.6 billion and after 2024 are expected to decrease steadily until depleted in 2031.

Long-Term Financing

The short-range financial outlook for the HI trust fund is more favorable than what was projected last year. After 2023, the trust fund ratio declines until the fund is depleted in 2031, three years later than projected in 2022. HI financing is not projected to be sustainable over the long-term with the projected tax rates and expenditure levels. Program cost is expected to exceed total income in all years. When the HI trust fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to decrease from 89 percent in 2031 to 81 percent in 2047, and then to increase to about 96 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 2022 to about 2.2 by 2097. 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 $4.4 trillion, which is 0.6 percent of taxable payroll and 0.3 percent of Gross Domestic Product (GDP) over the same period. Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. For more information, please refer to the Required Supplementary Information: Social Insurance disclosures required by the Federal Accounting Standards Advisory Board.

[3]Assets at the beginning of the year to expenditures during the year.

SMI Trust Fund Solvency

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

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

Unlike the Part B account, the appropriation for Part D has generally been set such that amounts can be transferred to the Part D account on an as-needed basis; under this process, there is no need to maintain a contingency reserve. In September 2015, a new policy was implemented to transfer amounts from the Treasury into the account 5 business 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 $(48.5) 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 2022, SMI incurred expenditures were 2.2 percent of GDP. By 2097, SMI expenditures are projected to grow to 4.2 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 expeditiously 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.

Financial Summary and Highlights

The following table presents key amounts from CMS's basic financial statements for FY 2021 through 2023.

Table of Key Measures[4]
(in Billions)

	2023	2022	2021
Net Position (end of fiscal year)			
Assets	$ 873.7	$ 765.4	$ 690.8
Less Total Liabilities	199.5	171.9	186.4
Net Position (assets net of liabilities)	**$ 674.2**	**$ 593.5**	**$ 504.4**
Costs (end of fiscal year)			
Net Costs	$ 1,499.6	$ 1,383.6	$ 1,272.4
Total Financing Sources	1,477.6	1,430.4	1,285.0
Net Change in Cumulative Results of Operations	**$ (22.0)**	**$ 46.8**	**$ 12.7**
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	$ (4,630)	$ (5,094)	$ (5,057)
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	$ (5,094)	$ (5,057)	$ (4,800)
Change in Present Value	**$ (464)**	**$ (37)**	**$ (257)**

Statement of Changes in Social Insurance Amounts

The SCSIA 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, 2023, decreased by $124 billion due to advancing the valuation date by 1 year and including the additional year 2097, by $283 billion due to changes in economic and healthcare assumptions, and by $315 billion due to changes in demographic assumptions. However, changes in the projection base and law increased the present value by $1,186 and $1 billion, respectively. The net overall impact of these changes is an increase in the present value of $464 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 *2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and*

[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.

Federal SMI Trust Funds, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

Limitations 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.C. §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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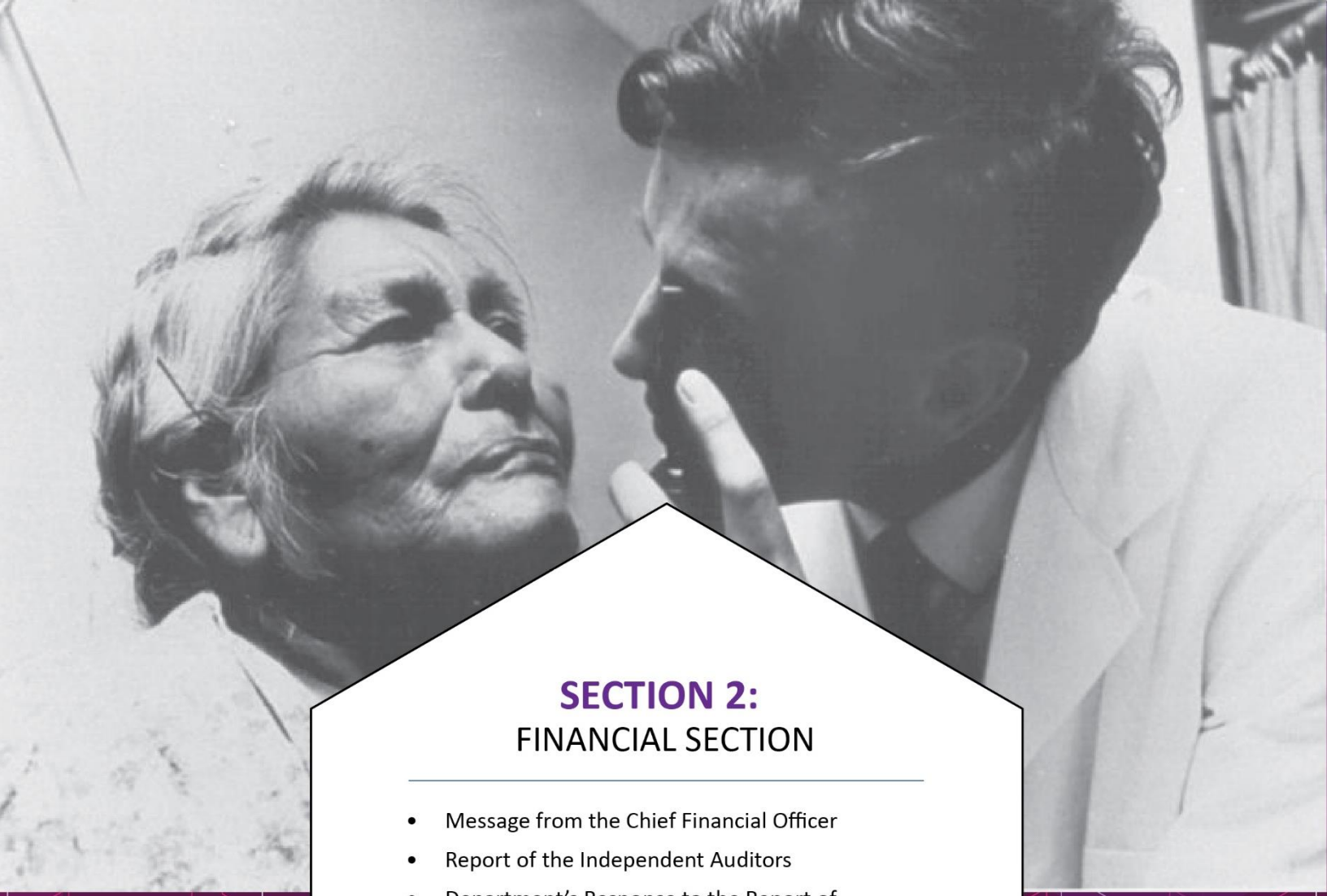

SECTION 2:
FINANCIAL SECTION

- 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 Deputy Chief Financial Officer

I am honored to join Secretary Becerra in presenting the Department of Health and Human Services' (HHS) Fiscal Year (FY) 2023 Agency Financial Report (AFR). The AFR represents HHS's accountability and stewardship over one of the largest budgets in the world. For the tenth consecutive year, HHS was recognized for demonstrating excellence in all aspects of accountability and transparency reporting.

During FY 2023, our HHS CFO community made significant progress on strategic initiatives related to workforce, governance, and technology in support of the HHS FY 2022-2026 Strategic Plan Goal 5 to "Advance Strategic Management to Build Trust, Transparency, and Accountability." We understand the vital role an engaged and inclusive workforce plays in achieving our mission, and I am proud to share that among large agencies, HHS placed second in the annual "Best Places to Work in the Federal Government" rankings. Building on this success, our HHS CFO community remains committed to upholding a financial management culture that attracts and retains top talent and invests in its people.

Through our HHS CFO community governance structure, we continue to promote the use of real-time data and analysis to make informed financial and programmatic decisions, and provide our workforce with the proper tools and skills to respond to the everchanging needs of our customers and stakeholders. Over the last decade we have steadily matured our financial systems control environment, resulting in more reliable and secure systems. In FY 2023, we transitioned our financial systems to a more modern cloud environment that positions HHS to adopt emerging technologies such as advanced analytics and Artificial Intelligence to enhance organizational performance.

For the 25th consecutive year, HHS received 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. The Department's effective internal controls, combined with our robust management process for identifying and resolving control issues, resulted in no auditor-reported material weaknesses. HHS continued to improve payment integrity in our risk-susceptible programs. In particular, HHS reported improper payment estimates for two new risk-susceptible programs and reduced estimated improper payments by more than $28 billion from FY 2022 to FY 2023.

I want to thank our HHS CFO colleagues and partners for their tremendous efforts and collaboration throughout this fiscal year and during the last 17 years I have served as the Deputy CFO and Deputy Assistant Secretary for Finance at HHS. It has been an honor to serve in these roles, and a distinct privilege to work alongside each member of the Department's Office of Finance. Together with our CFO community, we have made tremendous strides across the Department modernizing and strengthening our financial accountability, stewardship, and transparency in support of the HHS mission. I leave with full confidence in our visionary leaders, exemplary workforce and solid financial management foundation, and look forward to cheering on future HHS successes.

/Sheila Conley/

Sheila Conley
Deputy Chief Financial Officer and
Deputy Assistant Secretary for Finance
November 14, 2023

Report of the Independent Auditors

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

November 14, 2023

TO: The Secretary

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

SUBJECT: *Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2023*, A-17-23-00001

This memo transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2023 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, 2023 and 2022, 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, 2023, 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 24-01, *Audit Requirements for Federal Financial Statements.*

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2023 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, 2023, 2022, 2021, 2020, and 2019, and the related statements of changes in social insurance amounts for the periods ended January 1, 2023 and 2022. 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 three 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 three significant deficiencies related to HHS's Financial Reporting Systems, Analyses, and Oversight; Reconciliation, Monitoring, and Recording of Inventory; and Financial Information Systems as described below:

- *Financial Reporting Systems, Analysis and Oversight*—During the FY 2023 audit, Ernst & Young noted that HHS made progress in addressing certain issues. However, the FY 2023 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, grants, improper payments, Entitlement Benefits Due and Payable (EBDP), the Statement of Social Insurance, and Budgetary Resources. 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, over the past several years, has 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 prior years, 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 Management (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.

  HHS disbursed over $1.2 trillion in grant activity during FY 2023. For each Operating Division, HHS policy requires a monthly reconciliation between HHS's financial management systems and the Payment Management System (PMS). As of September 30, 2023, Ernst & Young noted that the Program Support Center (PSC), which manages the PMS, did not execute this control properly over the various HHS Operating Divisions for

which it provides accounting services. Ernst & Young identified that, although PSC performed the reconciliation for each HHS Operating Division and had the reconciliation reviewed and certified, the reconciliation was not completed properly. This deficiency in proper execution of the control initially resulted in over $7 billion in unresearched differences due to incomplete data. PSC resolved the issues with the data, and the differences were found to be immaterial. Ernst & Young also noted that, for one Operating Division, PSC utilized data from another Operating Division to perform the reconciliation. Ernst & Young determined PSC personnel did not adequately review the data, monitor the personnel performing the work, and conduct sufficient research to determine the cause of the increase prior to certifying.

The nature and volume of HHS expenditures present a substantial challenge in the quantification, evaluation, and remediation of improper payments. During FY 2023, 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 that HHS developed, executed, and reported improper payment estimates for 10 of its 12 risk-susceptible programs. For four other programs, HHS indicated that 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 (PIIA, P.L. No. 116-117) requires each agency to perform a risk assessment not less frequently than once every 3 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 56 program-specific risk assessments from the over 200 programs within the agency with outlays exceeding $10 million. HHS indicated to Ernst & Young that it had limited resources to execute a full rotation of risk assessments in FY 2023 but would expand its assessment process to cover all programs with outlays exceeding $10 million within the next 3 years.

At the Centers for Medicare & 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, Medicare Advantage (Part C), Medicare Prescription Drugs (Part D), Medicaid, Advance Premium Tax Credit (APTC) and the Children's 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 the CHIP program that continues to report improper payment rates above the statutory threshold of 10 percent. The Medicaid improper payment rate for Medicaid fell below the statutory threshold of 10 percent for this reporting year. Ernst & Young, however, noted that there is an increased risk that the Medicaid rate could exceed the statutory threshold of 10 percent when flexibilities afforded by the COVID-19 public health emergency expire. HHS continued to implement corrective actions to reduce the Medicare Part C improper payment rate. However, Ernst & Young noted that 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 use 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 2023 financial statements and is subject to volatility based on the complexity and judgment required in establishing this estimate. Also, the Medicare EBDP estimate experienced unusual changes in the data used and large fluctuations in the output of the actuarial calculation. Due to limitations with the data available, the actuaries were unable to perform further analysis to evaluate whether a change in methodology or refinements of the data were necessary to develop a reasonable Medicare EBDP estimate.

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 for both HHS and CMS collectively constitute a significant deficiency in internal control.

CMS is required to return all indefinite authority to the Treasury for funding that has not been obligated during the fiscal year. During its year-end close process, CMS processed the return of Medicaid indefinite authority. However, while conducting further examination and analysis before finalizing its financial statements, CMS identified an error on the report it used in its close process. Identifying this error resulted in CMS detecting additional unobligated funding that it should have returned to the Treasury. CMS subsequently processed this additional return as part of the financial statement finalization. Ernst & Young noted that controls did not initially identify that the information CMS produced that was used in the performance of the control was not complete and accurate.

- *Reconciliation, Monitoring, and Recording of Inventory* – During the fiscal year ended September 30, 2023, Ernst & Young noted that the Administration for Strategic Preparedness and Response (ASPR) did not properly reconcile all vendor-managed inventory with the ASPR accounting system. Additionally, Ernst & Young noted that ASPR failed to record the vendor-managed inventory as an asset in its books at the time of purchase; instead, ASPR recorded the transaction as an expense. ASPR subsequently corrected the error. However, Ernst & Young concluded that ASPR failed to implement adequate controls to ensure that vendor-managed inventory transactions are properly reflected in the financial records. This deficiency constitutes a significant deficiency.

- *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. HHS has made progress in remediating prior year issues associated with its core financial systems, 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's financial reporting. Examples of these deficiencies include: (1) HHS did not monitor or recertify access for key applications and underlying IT infrastructure or did not retain evidence of monitoring and recertification; and (2) 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 it continues to identify deficiencies in implementing and monitoring controls, including controls over privileged access to CMS's information systems. For example, HHS did not follow logical access control procedures related to the timely removal of access for terminated personnel supporting CMS. These deficiencies for both HHS and CMS collectively constitute a significant deficiency in internal control.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2023, HHS was not in full compliance with PIIA. As indicated previously, HHS has developed and reported improper payment rates for 10 of its 12 risk-susceptible programs. For the remaining two programs—the Temporary Assistance for Needy Families program and Foster Care program. 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 the CHIP program with an error rate in excess of the statutorily required maximum of 10 percent. Ernst & Young also noted that CMS did not comply with PIIA, as recovery activities were delayed for the identified improper payments of the Part C program. We will report further on agency compliance with improper payment reporting, as required by the PIIA, later in FY 2024.

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 PSC that occurred between FYs 2006 and 2011. 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 2023 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.

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-17-23-00001.

Attachment

cc:
Norris Cochran
Acting Assistant Secretary for Financial Resources

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

Ernst & Young LLP
Suite 310
1201 Wills Street
Baltimore, MD 21231

Tel: +1 410 539 7940
Fax: +1 410 783 3832
ey.com

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, 2023 and 2022, 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, 2023 and 2022, 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, 2023, 2022, 2021, 2020, and 2019, and the related statement of changes in social insurance amounts for the periods ended January 1, 2023 and 2022, and the related notes (collectively referred to as the "sustainability financial statements").

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

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS), in accordance with the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States (*Government Auditing Standards*), and in accordance with the provisions of Office of Management and Budget (OMB) Bulletin No. 24-01, *Audit Requirements for Federal Financial Statements*. Our responsibilities under those standards and the provisions of OMB Bulletin No. 24-01 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, 2023 and 2022, 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 (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, 2023, 2022, 2021, 2020, and 2019, 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, 2023, 2022, 2021, 2020 and 2019, and the related statement of changes in social insurance amounts for the periods ended January 1, 2023 and 2022.

Responsibilities of Management for the Financial Statements

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

Auditor's Responsibilities for the Audit of the Financial Statements

Except as described in the Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts section of our report, our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* and the provisions of OMB Bulletin No. 24-01 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. 24-01, 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 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, which considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. We were unable to apply certain limited procedures to the Required Supplementary Information related to the sustainability financial statements in accordance with GAAS because of the significance of the matters described in the Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts section of our report. We 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 GAAS, 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 GAAS. 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 Deputy Chief Financial Officer, Historical Timeline, Summary of Financial Statement Audit and Management Assurances, Civil Monetary Penalty Adjustment for Inflation, Grants Closeout Reporting, Payment Integrity Report, FY 2023 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.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our reports dated November 14, 2023, on our consideration of HHS's internal control over financial reporting and

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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, 2023

Ernst & Young LLP
Suite 310
1201 Wills Street
Baltimore, MD 21231

Tel: +1 410 539 7940
Fax: +1 410 783 3832
ey.com

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 with the provisions of Office of Management and Budget (OMB) Bulletin No. 24-01, *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, 2023, 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, 2023, and the related statement of changes in social insurance amounts for the period ended January 1, 2023, and the related notes (collectively referred to as the "sustainability financial statements"), and have issued our report thereon dated November 14, 2023. 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. We did not consider all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982, such as those controls relevant to preparing performance information and ensuring efficient operations.

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. We identified the following items in the current year's audit that indicate additional improvements in the financial reporting systems and processes are required.

Nonstandard Journal Voucher Processes

HHS posts a significant number of nonstandard journal vouchers to record entries that are unable to be recorded through routine systematic processing. During FY 2023, HHS was required to process 7,762 nonstandard journal vouchers totaling $216 billion to its National Institutes of Health (NIH) Business System (NBS) or Unified Financial Management Systems (UFMS). Although, the absolute dollar value of manual entries decreased compared to FY 2022, where 9,695 manual entries totaling an absolute value of $408 billion were recorded, the number of manual entries is still significant. These entries consist of nonstandard 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 are significant compared with the HHS's overall activity. During FY 2023, HHS developed and rolled out to its Operating Divisions a new policy, Financial Adjustments, which identifies minimum requirements for preparing, reviewing, approving, posting, and monitoring financial adjustments as a way to standardize the process consistently across HHS.

Grant Synchronization Process

During FY 2023, HHS disbursed over $1.2 trillion in grant activity. As HHS uses several information technology systems to award, obligate, expense, and disburse grants, reconciliations are required to ensure that the systems are synchronized. The HHS financial management policy requires a monthly reconciliation for each Operating Division between HHS's financial management systems and its Payment Management System, a centralized system used to interact with the grantees to disburse funds and monitor obligations and available funding. As of September 30, 2023, we noted that the Program Support Center (PSC) did not execute the reconciliation properly over the various Operating Divisions for which it provides accounting services. For example, although the Program Support Center performed the reconciliation for each PSC-serviced Operating Division, including having the reconciliation reviewed and certified, the reconciliation was not completed properly, which initially resulted in over $7 billion in unresearched differences due to incomplete data. Once notified of the discrepancy, the Program Support Center resolved the issues with the data, and differences were found to be immaterial. Additionally, we noted that for one PSC-serviced Operating Division, the Program Support Center utilized data from another Operating Division to perform the reconciliation. We determined that the Program Support Center's personnel did not adequately review the data, monitor the personnel performing the work, or conduct sufficient research to determine the cause of the increase prior to certifying.

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. Those potential violations reported were identified several years ago, and HHS management indicated that during FY 2023, they have continued to go through review to determine if an Antideficiency Act violation exists.

Consistent with prior years, HHS and our audit identified certain concerns related to accounting and reporting of procurement activities. For example, the NIH currently leverages two separate purchase request information systems for acquisitions management, including one that is not integrated with the NIH NBS. While the NIH NBS Purchase Request Information System Management (PRISM) system supports 26 NIH institutes and centers (ICs), the Contract Award Management System (CAMS) is a stand-alone purchase request information system with 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 nonintegrated 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. Although NIH has taken certain steps to mitigate

security risks, significant costs are associated with procuring and maintaining two PRISMs. These increased risks and additional costs would be nonexistent 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 improper payment rates for those programs that are deemed risk-susceptible, (3) developing corrective actions to remediate causes that result in improper payments, and (4) executing recovery activities to recoup improper payments. During FY 2023, although continued progress was noted, HHS continued to identify challenges that prevented the Department from meeting certain monitoring requirements of its programs for improper payments. For example:

- HHS developed, executed, and reported improper payments estimates for ten of its 12 risk-susceptible programs. HHS noted that for two programs, an estimate could not be achieved due to either statutory limitations or COVID-19 precautions precluding conducting on-site reviews. Management indicated that it is continuing its efforts to produce and report an estimate for each program deemed risk-susceptible in FY 2024.

- During FY 2023, the Department performed 56 program-specific risk assessments from the over 200 HHS programs whose annual 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 56 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 of the 200 programs in FY 2023 alone but would expand its assessment process to cover all programs whose outlays exceed $10 million by the end of FY 2025.

For the Centers for Medicare & Medicaid Services (CMS), health insurance claims represent the vast majority of 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 Benefit (Part D), Medicaid, Children's Health Insurance Program (CHIP) and the federally facilitated exchange component of 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 CHIP, which continues to report improper payment rates above the statutory threshold of 10%. The eligibility component of the reported Medicaid and CHIP improper payment rates was significantly impacted by flexibilities afforded by the Public Health Emergency (PHE), such as postponed eligibility determinations and eased requirements around provider enrollment/validations. While the Medicaid improper payment rate fell below the statutory threshold of 10% for this reporting year, there is an increased risk that the rate could exceed this 10% threshold as these flexibilities expire. In addition, while management continued to implement corrective actions to reduce the Medicare Part C 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 internal control, dated November 7, 2023. In that report, we outlined details of deficiencies noted and recommended improvements 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 (EBDP), budgetary resources, and the statements of social insurance.

Medicaid Entitlement Benefits Due and Payable

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.

In prior years, CMS implemented the Transformed-Medicaid Statistical Information System (T-MSIS), which modernizes and enhances the way states submit operational data about beneficiaries, providers, health plans, claims, and encounters. As of the end of fiscal year 2023, while data maintained within T-MSIS is utilized for operational purposes, management has determined that it requires additional verification before it would be considered reliable to utilize in the financial accounting and reporting for Medicaid, specifically Medicaid EBDP. CMS has continued to take steps to refine the data and continues to evaluate the adequacy of the information within this system. CMS should continue to evaluate whether financial reporting risks can be addressed by using T-MSIS data to identify outliers and unusual or unexpected results that

demonstrate abnormalities in state-related Medicaid expenditures that may require consideration in determining the Medicaid EBDP as of year-end, even if this data ultimately never becomes the basis for the EBDP estimate. Given the claims-level detail is not yet considered reliable for financial accounting and reporting, CMS is unable to perform a claims-level detailed look-back analysis for the Medicaid EBDP to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability calculated during prior periods, which could serve to validate the continued use of a similar methodology. The Medicaid EBDP is a significant liability on the FY 2023 financial statements and is subject to volatility based on the complexity and judgment required in establishing this estimate. This volatility is inherent in this type of estimate but could be more pronounced in a period of change, such as the current fiscal year due to the ending of the PHE. The lack of detailed claims data limits the ability to detect the impact of such a change, or other changes such as those related to the claims processing timing, on a timely basis or consider the potential impact of these items on the EBDP estimate, presenting a risk that potential updates to CMS's analysis will not be reflected in CMS's financial statements in a timely manner.

Medicare Entitlement Benefits Due and Payable

The estimate of retroactive settlements of cost reports is a portion of the EBDP liability for the Medicare program. This estimate includes amounts that may be due from or owed to providers for previous years' cost report for disproportionate share hospitals and teaching hospitals, as well as amounts that may be due/owed to hospitals for adjusted prospective payments. During the current year, an increase in the EBDP liability related to cost report settlements was identified by CMS during its review; however, due to limitations with the data available, further analysis was unable to be performed by the actuaries to evaluate whether changes to the methodology or refinements of the data were necessary to develop a reasonable EBDP estimate. CMS does not currently have detailed claims data nor the ability to accumulate the detailed claims data to evaluate whether outliers existed in the cost report population that should be isolated for the purposes of developing the EBDP estimate. In addition, due to the segregation of parties involved in developing this estimate, the parties exhibited a lack of understanding over the underlying data, which limited the actuaries' ability to evaluate the data that existed. 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.

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 CMS's policies and procedures.

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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 that which is generated from updating and running any macro in the spreadsheet, is checked by the reviewer. These checks include a comparison to the results from the year before and testing of the formulas that are part of the spreadsheet or macro to ensure that the projection output from the program is as expected and reasonable. During our procedures, formula errors were identified that were not detected by the organization's monitoring and review function, and, accordingly, the related control was not functioning at the level of precision as designed.

Budgetary Resources

At the end of each fiscal year, CMS is required to return all indefinite authority to Treasury for funding that has not been obligated during the fiscal year. During its year-end close process, CMS processed a return of Medicaid indefinite authority. However, subsequent examination and analysis performed by management prior to the finalization of the financial statements identified an error on the report used as part of the close process, resulting in additional unobligated funding that should have been returned. CMS subsequently processed this additional return as part of the finalization of the FY 2023 financial statements; however, controls associated to this process did not initially identify that the information produced by the entity used as part of the performance of this control were not complete and accurate.

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 nonstandard journal processes, we recommend that HHS continue to focus on automating and reducing the number of nonstandard 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. Finally, we recommend that HHS monitor the implementation of the new policy to ensure personnel are following the guidance.

- 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 be 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, identified, and remediated in a timely

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manner. Additionally, HHS should establish a process to evaluate whether pending Antideficiency Act violations are reportable and report those items that are declared on a timely basis. 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, 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 provide training for its personnel on its policies and procedures on the steps needed to analyze and reconcile grant activity between the various financial systems and remediate large differences on a timely basis. We would also suggest that HHS review its current policies and update them so that changes in processes are incorporated to provide personnel a roadmap to reconcile and analyze grant and other financial activity to identify any unusual activity or trends.

- HHS should continue to enhance the 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 the program 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 evaluate how the Medicaid claims-level data can be refined to analyze trends at a claims level to enable the performance of robust analytical procedures and measures against 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 used to record this liability.

    - Enhance management review controls surrounding the identification and return of unobligated indefinite authority to verify that reports used in the execution of this control are complete and accurate and consider enhancing fluctuation analyses as part of the overall financial statement review to further investigate unusual balances at year-end.

- Collaborate during FY 2024 to determine how the data available can be used, or how additional data can be gathered, to refine the cost report settlement EBDP estimate to gain a complete understanding of the rationale for fluctuations in the available information. When changes are identified in the resulting data used for the estimate, or when a large fluctuation results from the output of the calculation, for which management does not have a thorough understanding, further investigation should be performed, and data should be analyzed and documented prior to finalizing the estimate.

- 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.

Reconciliation, Monitoring, and Recording of Inventory

The Administration for Strategic Preparedness and Response (ASPR) leads the nation's medical and public health preparedness for, response to, and recovery from disasters and other public health emergencies. The Biomedical Advanced Research and Development Authority (BARDA), a division of ASPR, provides an integrated, systematic approach to the development of the necessary vaccines, drugs, therapies, and diagnostic tools for public health medical emergencies. ASPR enters into agreements with various industry partners to promote the advanced development of medical countermeasures and enhance preparedness against threats. ASPR often collaborates with industry partners and other federal agencies, including the U.S. Department of Defense, to prepare and respond to health emergencies. BARDA maintains a supply of inventory items, including therapeutics, national stockpile, etc. to support its mission. Most of these inventory items are considered vendor-managed inventory (VMI), which is held by the third-party vendor (strategic partner) and subsequently distributed to states, tribal nations, territories, and the largest metropolitan areas during public health emergencies. Arrangements with the vendors included, among other requirements, the manufacturing, storage, and distribution of the inventory items. There are two types of VMI that are differentiated by whether stock is rotated through a commercial market or held in reserve.

ASPR has developed a cycle memo for the inventory process that documents four sub-cycles of acquisition, distribution, inventory count, and disposals. This cycle memo has specific procedures to indicate that ASPR Finance performs and/or supports the monthly reconciliation of the Strategic National Stockpile and BARDA assets recorded in UFMS. During the fiscal year ended September 30, 2023, ASPR did not properly reconcile all vendor-managed inventory with the HHS accounting system. Additionally, ASPR failed to record the VMI as an asset in its books at the time of purchase; instead, ASPR recorded the transaction as an expense. ASPR subsequently corrected the error during its year-end close process. ASPR failed to implement adequate controls to ensure that VMI transactions are properly reflected in the financial records.

Recommendations

ASPR should enhance its internal controls to ensure that all inventory transactions are properly reconciled to the general ledger, tracked from the point of purchase to distribution, and adequately recorded in the accounting system in the proper period in accordance with HHS accounting treatment manual. Additionally, we recommend that ASPR and BARDA personnel receive additional training to emphasize the need to follow policies to provide for inventory balances within the financial statements to be fairly stated during each reporting period. Finally, a central point should be identified to oversee and monitor the communications between the various HHS contract officers and their vendors to identify and remediate issues and discrepancies timely between ASPR inventory balance records and vendor-managed reports.

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 oversight- and governance-related findings across the Department. There was also improvement identified within the control environment supported by mixed financial systems, but not all deficiencies were remediated within FY 2023.

In addition to the financial statement audit for non-CMS systems, we have performed a separate financial statement audit of the CMS for FY 2023, 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 herein.

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 Information System Access and Least Privileged 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. Without maintaining an appropriate level of access controls within HHS systems, the integrity of HHS's information resources could be compromised.

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

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

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

- Insufficient controls over segregation of duties were identified at various areas for different non-CMS 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 for access and monitoring of access is essential to provide a suitable framework for subsequent implementation and operation of the controls. Without adequate controls over managing access to critical systems the risk of errors, fraud or other illegal acts is increased.

Recommendations

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

- HHS and CMS guidance, including contractual requirements, is followed for the separation of workforce personnel, including the removal of any associated user accounts for HHS IT systems and/or applications.

- Privileged access for key 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 and recertification of access are being performed by CMS system teams timely and by appropriate personnel with the requisite knowledge and experience of the employee access requirements and necessary system functionality.

- Non-CMS system segregation of duties controls are implemented fully as defined by system-specific implementation plans.

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, 2023. 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, 2023, 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, 2023

Ernst & Young LLP
Suite 310
1201 Wills Street
Baltimore, MD 21231

Tel: +1 410 539 7940
Fax: +1 410 783 3832
ey.com

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 with the provisions of Office of Management and Budget (OMB) Bulletin No. 24-01, *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, 2023, 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, 2023, and the related statement of changes in social insurance amounts for the period ended January 1, 2023, and the related notes (collectively referred to as the "sustainability financial statements"), and have issued our report thereon dated November 14, 2023. 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, as well as the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA), noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and, accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and the provisions of OMB Bulletin No. 24-01, as described herein.

HHS's management determined that it may have potential violations of the Anti-deficiency Act (31 U.S.C. chapters 13 and 15.) For example, HHS identified potential violations 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 they may have potential violations of the Federal Acquisition Regulation related to contracting matters. These potential violations are still being evaluated.

The Payment Integrity Information Act of 2019 (P.L. 116-117) (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) establishes 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 ten of its 12 risk-susceptible programs. For the remaining two risk-susceptible programs, including its Temporary Assistance for Needy Families (TANF) program and the Foster Care program, HHS is working to address various challenges to enable it to develop and report an improper payment estimate. 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. Further, although HHS reported improper payment rate for its Children's Health Insurance Program (CHIP), the program's improper payment rates exceeded the statutorily required maximum of 10%. Finally, HHS is not in full compliance with the Act as recovery activities of the identified improper payments for Medicare Part C 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 tested 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.

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, 2023. 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, 2023, 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, 2023

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: Sheila O. Conley, Deputy Chief Financial Officer and Deputy Assistant Secretary for Finance

Subject: Fiscal Year 2023 Independent Auditors' Financial Statement Audit Reports

Thank you for the opportunity to comment on the Fiscal Year 2023 Independent Auditors' Reports. We appreciate and value the continuous dedication and diligence demonstrated 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 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 will continue to strengthen the control environment and implement effective corrective actions to resolve the identified findings. While the Department continuously encounters distinctive challenges due to the magnitude and complexity of our mission and operations, we will actively identify root causes of detected deficiencies, execute corrective actions, and monitor active remediation efforts.

We would like to thank the OIG and EY for your efforts on our behalf. We are proud of our achievements and will maintain our dedication to improving our stewardship, integrity, and transparency through continued collaboration with the OIG.

/Sheila Conley/

Sheila Conley
Deputy Chief Financial Officer and
Deputy Assistant Secretary for Finance
November 14, 2023

Principal Financial Statements

U.S. Department of Health and Human Services

Consolidated Balance Sheets

As of September 30, 2023 and 2022

(in Millions)

	2023	2022
Assets (Note 2)		
Intragovernmental Assets:		
Fund Balance with Treasury (Note 3)	$ 695,639	$ 652,672
Investments, Net (Note 4)	360,380	351,569
Accounts Receivable, Net (Note 5)	786	831
Advances and Prepayments (Note 8)	2,552	2,412
Total Intragovernmental Assets	**1,059,357**	**1,007,484**
Other than Intragovernmental Assets:		
Accounts Receivable, Net (Note 5)	39,196	40,128
Inventory and Related Property, Net (Note 6)	27,829	16,560
Property, Plant and Equipment, Net (Note 7)	8,399	8,276
Advances and Prepayments (Note 8)	45,177	39,188
Other Assets:		
Loans Receivable, Net	501	479
Other	10	10
Total Other than Intragovernmental Assets	**121,112**	**104,641**
Total Assets	**$ 1,180,469**	**$ 1,112,125**
Stewardship Land (Note 21)		
Liabilities (Note 9)		
Intragovernmental Liabilities:		
Accounts Payable	$ 1,576	$ 2,300
Debt (Note 10)	3,272	8,256
Advances from Others and Deferred Revenue	372	363
Other Liabilities (Note 14)	1,570	1,492
Total Intragovernmental Liabilities	**6,790**	**12,411**
Other than Intragovernmental Liabilities:		
Accounts Payable	1,802	1,727
Entitlement Benefits Due and Payable (Note 11)	159,543	141,177
Federal Employee and Veteran Benefits Payable (Note 12)	20,377	19,409
Environmental and Disposal Liabilities	384	312
Advances from Others and Deferred Revenue	3,245	1,714
Other Liabilities:		
Accrued Liabilities (Note 13)	17,435	16,257
Contingencies and Commitments (Note 15)	27,488	15,776
Other Liabilities (Note 14)	916	1,237
Total Other than Intragovernmental Liabilities	**231,190**	**197,609**
Total Liabilities	**237,980**	**210,020**
Net Position		
Unexpended Appropriations – Funds from Dedicated Collections (Note 20)	275,307	178,704
Unexpended Appropriations – Funds from Other Than Dedicated Collections	326,214	374,265
Total Unexpended Appropriations	**601,521**	**552,969**
Cumulative Results of Operations – Funds from Dedicated Collections (Note 20)	325,042	346,199
Cumulative Results of Operations – Funds from Other Than Dedicated Collections	15,926	2,937
Total Cumulative Results of Operations	**340,968**	**349,136**
Total Net Position	**942,489**	**902,105**
Total Liabilities and Net Position	**$ 1,180,469**	**$ 1,112,125**

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, 2023 and 2022
(in Millions)

	2023	2022
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Costs	$ 1,654,047	$ 1,531,319
Earned Revenue	(154,882)	(148,181)
CMS Net Cost of Operations	1,499,165	1,383,138
Other Segments:		
Administration for Children and Families (ACF)	87,942	85,134
Administration for Community Living (ACL)	3,002	2,752
Agency for Healthcare Research and Quality (AHRQ)	353	335
Centers for Disease Control and Prevention (CDC)	17,841	21,600
Food and Drug Administration (FDA)	6,686	6,246
Health Resources and Services Administration (HRSA)	15,390	15,398
Indian Health Service (IHS)	10,117	9,063
National Institutes of Health (NIH)	46,537	41,180
Office of the Secretary (OS)	23,919	91,771
Program Support Center (PSC)	2,977	2,330
Substance Abuse and Mental Health Services Administration (SAMHSA)	8,290	7,482
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	$ 223,054	$ 283,291
Actuarial (Gains) and Losses Commissioned Corps Retirement and Medical Plan Assumption Changes (Note 12)	(267)	1,440
Other Segments Gross Costs of Operations after Actuarial Gains and Losses	$ 222,787	$ 284,731
Earned Revenue	(7,009)	(7,076)
Other Segments Net Cost of Operations	215,778	277,655
Net Cost of Operations (Note 22)	**$ 1,714,943**	**$ 1,660,793**

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, 2023
(in Millions)

	Funds from Dedicated Collections (Note 20)	All Other Funds	Eliminations	Consolidated Total
Unexpended Appropriations:				
Beginning Balance	$ 178,704	$ 374,265	$ -	$ 552,969
Appropriations Received	593,543	896,208	-	1,489,751
Appropriations Transferred in/out	-	(1,964)	-	(1,964)
Other Adjustments	(19,046)	(89,486)	-	(108,532)
Appropriations Used	(477,894)	(852,809)	-	(1,330,703)
Net Change in Unexpended Appropriations	96,603	(48,051)	-	48,552
Total Unexpended Appropriations	**$ 275,307**	**$ 326,214**	**$ -**	**$ 601,521**
Cumulative Results of Operations:				
Beginning Balances	$ 346,199	$ 2,937	$ -	$ 349,136
Appropriations Used	477,894	852,809	-	1,330,703
Nonexchange Revenue:				
Nonexchange Revenue – Tax Revenue	362,511	-	-	362,511
Nonexchange Revenue – Investment Revenue	9,869	805	-	10,674
Nonexchange Revenue – Other	3,243	220	-	3,463
Donations and Forfeitures of Cash and Cash Equivalents	64	-	-	64
Transfers in/out without Reimbursement	(5,018)	4,487	-	(531)
Donations and Forfeitures of Property	-	72	-	72
Imputed Financing	80	1,073	(356)	797
Other	(27)	(951)	-	(978)
Net Cost of Operations	869,773	845,526	(356)	1,714,943
Net Change in Cumulative Results of Operations	(21,157)	12,989	-	(8,168)
Total Cumulative Results of Operations	**$ 325,042**	**$ 15,926**	**$ -**	**$ 340,968**
Net Position	**$ 600,349**	**$ 342,140**	**$ -**	**$ 942,489**

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
Combined Statement of Budgetary Resources
For the Years Ended September 30, 2023 and 2022
(in Millions)

	2023	2022
Budgetary Resources		
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory) (Note 16)	$ 357,657	$ 372,611
Appropriations (Discretionary and Mandatory)	2,460,478	2,333,804
Borrowing Authority (Discretionary and Mandatory)	-	40
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	23,268	29,547
Total Budgetary Resources (Note 23)	**$ 2,841,403**	**$ 2,736,002**
Status of Budgetary Resources		
New Obligations and Upward Adjustments (Note 23)	$ 2,475,687	$ 2,453,016
Unobligated Balance, End of Year:		
Apportioned, Unexpired Accounts	143,887	113,903
Exempt from Apportionment, Unexpired Accounts	1,821	220
Unapportioned, Unexpired Accounts	20,574	21,307
Unexpired Unobligated Balance, End of Year	166,282	135,430
Expired Unobligated Balance, End of Year	199,434	147,556
Unobligated Balance, End of Year	365,716	282,986
Total Budgetary Resources (Note 23)	**$ 2,841,403**	**$ 2,736,002**
Outlays, Net		
Outlays, Net (Discretionary and Mandatory)	$ 2,368,288	$ 2,342,422
Distributed Offsetting Receipts	(659,662)	(699,432)
Agency Outlays, Net (Discretionary and Mandatory) (Note 22)	**$ 1,708,626**	**$ 1,642,990**
Disbursements, Net	**$ (70)**	**$ 25**

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, 2023 and Prior Base Years
(in Billions)

	2023	Estimates from Prior Years 2022	2021	2020	2019
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	$ 15,360	$ 14,767	$ 13,029	$ 12,454	$ 11,805
SMI Part B	39,008	39,039	34,467	32,165	27,556
SMI Part D	6,865	7,372	6,881	6,975	7,181
Have attained eligibility age (age 65 or over)					
HI	862	793	664	637	559
SMI Part B	7,683	7,447	6,536	5,864	5,232
SMI Part D	1,315	1,164	1,061	1,016	1,052
Those expected to become participants					
HI	15,046	14,603	13,017	12,464	11,995
SMI Part B	9,934	10,131	9,010	8,567	6,864
SMI Part D	2,372	3,094	2,921	3,043	3,000
All current and future participants					
HI	$ 31,268	$ 30,163	$ 26,710	$ 25,554	$ 24,359
SMI Part B	56,625	56,618	50,013	46,596	39,652
SMI Part D	10,551	11,630	10,863	11,035	11,232
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	$ 23,622	$ 23,211	$ 20,940	$ 20,103	$ 20,028
SMI Part B	38,539	38,605	34,075	31,819	27,270
SMI Part D	6,865	7,372	6,881	6,975	7,181
Have attained eligibility age (age 65 and over)					
HI	7,215	7,010	6,230	6,073	5,348
SMI Part B	8,038	7,825	6,892	6,194	5,741
SMI Part D	1,315	1,164	1,061	1,016	1,052
Those expected to become participants					
HI	5,061	5,036	4,597	4,179	4,467
SMI Part B	10,048	10,188	9,046	8,583	6,641
SMI Part D	2,372	3,094	2,921	3,043	3,000
All current and future participants:					
HI	$ 35,897	$ 35,257	$ 31,767	$ 30,355	$ 29,843
SMI Part B	56,625	56,618	50,013	46,596	39,652
SMI Part D	10,551	11,630	10,863	11,035	11,232
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 26 and 27)					
HI	$ (4,630)	$ (5,094)	$ (5,057)	$ (4,800)	$ (5,484)
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	$ (4,630)	$ (5,094)	$ (5,057)	$ (4,800)	$ (5,484)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	198	177	198	195	200
SMI Part B	194	163	133	100	96
SMI Part D	18	20	10	9	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	$ (4,432)	$ (4,917)	$ (4,859)	$ (4,606)	$ (5,283)
SMI Part B	194	163	133	100	96
SMI Part D	18	20	10	9	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, 2023 and Prior Base Years
(in Billions)

	Estimates from Prior Years				
	2023	2022	2021	2020	2019
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)	$ 9,860	$ 9,404	$ 8,261	$ 7,517	$ 6,843
Expenditures	16,567	15,998	14,184	13,284	12,140
Income less expenditures	(6,707)	(6,595)	(5,922)	(5,766)	(5,297)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	61,232	61,178	54,377	51,594	46,542
Expenditures	69,026	69,188	61,895	58,897	54,479
Income less expenditures	(7,794)	(8,010)	(7,519)	(7,303)	(7,937)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(14,501)	(14,605)	(13,441)	(13,069)	(13,234)
Combined Medicare Trust Fund assets at start of period	410	360	341	303	305
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (14,091)	$ (14,244)	$ (13,100)	$ (12,766)	$ (12,929)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	$ 27,352	$ 27,828	$ 24,948	$ 24,074	$ 21,858
Expenditures	17,480	18,318	16,564	15,805	14,108
Income less expenditures	9,871	9,510	8,384	8,269	7,750
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(4,630)	(5,094)	(5,057)	(4,800)	(5,484)
Combined Medicare Trust Fund assets at start of period	410	360	341	303	305
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (4,220)	$ (4,734)	$ (4,716)	$ (4,497)	$ (5,179)

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, 2022 to January 1, 2023

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, 2022	$ 98,410	$ 103,504	$ (5,094)	$ 360	$ (4,734)
Reasons for change					
Change in the valuation period	2,206	2,331	(124)	(2)	(126)
Change in projection base	(1,961)	(3,148)	1,186	52	1,238
Changes in the demographic assumptions	(375)	(60)	(315)	-	(315)
Changes in economic and healthcare assumptions	2,873	3,156	(283)	-	(283)
Changes in law	(2,709)	(2,710)	1	-	1
Net changes	34	(431)	465	50	515
As of January 1, 2023	$ 98,444	$ 103,074	$ (4,630)	$ 410	$ (4,220)
HI - Part A (Note 28)					
As of January 1, 2022	$ 30,163	35,257	(5,094)	177	(4,917)
Reasons for change					
Change in the valuation period	571	696	(124)	(5)	(129)
Change in projection base	(174)	(1,361)	1,186	25	1,212
Changes in the demographic assumptions	(115)	200	(315)	-	(315)
Changes in economic and healthcare assumptions	824	1,107	(283)	-	(283)
Changes in law	-	(1)	1	-	1
Net changes	1,105	641	465	21	485
As of January 1, 2023	$ 31,268	$ 35,897	$ (4,630)	$ 198	$ (4,432)
SMI - Part B (Note 28)					
As of January 1, 2022	$ 56,618	$ 56,618	$ -	$ 163	$ 163
Reasons for change					
Change in the valuation period	1,355	1,355	-	13	13
Change in projection base	(2,135)	(2,135)	-	18	18
Changes in the demographic assumptions	(330)	(330)	-	-	-
Changes in economic and healthcare assumptions	2,386	2,386	-	-	-
Changes in law	(1,269)	(1,269)	-	-	-
Net changes	7	7	-	31	31
As of January 1, 2023	$ 56,625	$ 56,625	$ -	$ 194	$ 194
SMI - Part D (Note 28)					
As of January 1, 2022	$ 11,630	$ 11,630	$ -	$ 20	$ 20
Reasons for change					
Change in the valuation period	280	280	-	(10)	(10)
Change in projection base	348	348	-	8	8
Changes in the demographic assumptions	71	71	-	-	-
Changes in economic and healthcare assumptions	(337)	(337)	-	-	-
Changes in law	(1,440)	(1,440)	-	-	-
Net changes	(1,079)	(1,079)	-	(1)	(1)
As of January 1, 2023	$ 10,551	$ 10,551	$ -	$ 18	$ 18

Totals do not necessarily equal the sum of the rounded components.
The accompanying "Notes 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, 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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.

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 it is accountable for 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) 2023 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 (unaudited).

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

Health Insurance Marketplaces

Grants were provided to states to establish Health Insurance Marketplaces. 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.

The *Fiscal Responsibility Act of 2023,* was signed on June 3, 2023 and rescinds unobligated balances from amounts made available through COVID-19 supplemental appropriations, except for amounts specifically enumerated within this Act. Amounts exempt from rescission are being used to support research and development for next generation COVID-19 vaccines, operations for the SNS, strengthening the pharmaceutical supply chain, protecting priority investments in genomic surveillance and vaccine safety and effectiveness, and funding health workforce awards to address workforce shortages.

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.

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 Justice, State, and Treasury. HHS allocates funds, as the parent, to the Bureau of Indian Affairs of the Department of the Interior (DOI), Social Security Administration (SSA), and Departments of Commerce, Defense, Education, Labor (DOL), and Treasury.

H. Changes, Reclassifications and Adjustments

Reclassifications

The principal Balance Sheets, supplementary Balance Sheets, Statement of Budgetary Resources, and Combining Statement of Budgetary Resources, 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 2022 balances have been reclassified for comparability. For example, USSGL accounts previously mapped to Appropriations is currently mapped to Unobligated Balance from Prior Year Budget Authority, Net 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* 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 Healthcare Trust Funds. Section 1844 of the *Social Security Act* authorizes appropriated funds to match SMI premiums collected and outlines the ratio for the match as the method to fully compensate the trust fund if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Medicare Supplementary Medical Insurance Trust Fund – Part D

The *Medicare Modernization Act of 2003*, 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 Healthcare 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 full cost recovery with 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 amounts 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 *Federal Insurance Contributions Act* 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 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 Services program, interest accrued on over-payments, and cost settlements reported by the Medicare contractors.

M. Fund Balance with Treasury

The Fund Balance with Treasury is the aggregate amount of funds in the Department's accounts with Treasury. Fund Balance with Treasury is available to pay current liabilities and finance authorized purchases. Treasury processes cash receipts and disbursements for the Department's operations. HHS reconciles Fund Balance with Treasury 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, Medicare Secondary Payer accounts receivable, and Marketplace activities.

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

HHS recognizes grant expenses at the time of payment to the grant recipients. This process creates the advance and expenditure transaction at the time of payment. The accrual 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*. CAAP advances have been demanded and are reflected in the Medicare fee-for-service 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, BARDA, 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. Property, Plant and Equipment, Net

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 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 PP&E transferred from other federal entities is the transferring entity's net book value. Except for internal-use software, HHS capitalizes all PP&E with an initial acquisition cost of $100,000 or more and an estimated useful life of 2 years or more.

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.

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 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 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. 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* (H.R. 8337 enacted on October 1, 2020) 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 (unaudited), 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 financial statements are based on the selection of accounting policies and the application of significant accounting estimates, some of which require management to make significant assumptions. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist in understanding the effect of changes in assumptions to the related information.

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

	2023	2022
Non-Entity Intragovernmental Assets	$ 85	$ 25
Non-Entity Other than Intragovernmental Assets	48	58
Total Non-Entity Assets	133	83
Total Entity Assets	1,180,336	1,112,042
Total Assets	**$ 1,180,469**	**$ 1,112,125**

HHS reported an increase of $68.3 billion in Total Entity Assets primarily due to changes in Advances and Prepayments, Fund Balance with Treasury, Inventory and Related Property, and Investments. Refer to the respective footnotes below for additional information.

Note 3. Fund Balance with Treasury (in Millions)

	2023	2022
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 145,708	$ 114,123
Unavailable	220,008	168,863
Obligated Balance not yet Disbursed	425,355	438,808
Non-Budgetary Fund Balance with Treasury	(95,432)	(69,122)
Total Fund Balance with Treasury	**$ 695,639**	**$ 652,672**

The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of $42.9 billion as of September 30, 2023 ($29.1 billion as of September 30, 2022). 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 increase of $31.6 billion is primarily due to Payments to the Healthcare Trust Funds increase to be distributed to cover the advance of Health Maintenance Organization prepayments of $44.1 billion. These increases are offset by a decrease in funding for Public Health and Social Services Emergency Fund (PHSSEF) of $13.2 billion mainly related to *American Rescue Plan Act of 2021* and COVID-19.

The Unobligated Balance, Unavailable increase of $51.1 billion is primarily due to Payments to the Healthcare Trust Funds increase of $51.5 billion mostly from definite authority retained.

The Obligated Balance not yet Disbursed decrease of $13.5 billion is mostly due to the reduction of undelivered orders, which are unpaid since COVID-19 and *Defense Production Act* related obligations are continually being delivered and paid.

The Non-Budgetary Fund Balance with Treasury mostly represents amounts that have not yet been withdrawn from the Trust Funds.

Note 4. Investments, Net (in Millions)

	2023				
	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 353,899	$	$ 2,030	$ 355,929	$ 355,929
Non-Marketable: Market-Based	4,503	(64)	12	4,451	4,451
Total Intragovernmental	**$ 358,402**	**$ (64)**	**$ 2,042**	**$ 360,380**	**$ 360,380**

	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**

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, 2025, through June 30, 2037, with interest rates ranging from 1.500 percent to 3.875 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2024, with an interest rate of 4.250 percent.

Securities held by the Vaccine Injury Compensation Trust Fund will mature in FY 2024 through FY 2026. The Market-Based Notes paid rates ranging from 0.375 percent to 3.875 percent during October 1, 2022, to September 30, 2023. The Market-Based Bonds pay 6.875 percent through FY 2025.

The Non-Marketable Market-Based Securities held in the NIH gift funds yielded rates ranging from 3.311 percent to 5.426 percent from October 1, 2022 through September 30, 2023 depending on date purchased and length of time to maturity.

Note 5. Accounts Receivable, Net (in Millions)

	2023				
	Accounts Receivable, Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivable, Net
Intragovernmental					
Entity	$ 786	$ -	$ 786	$ -	$ 786
Total Intragovernmental	**$ 786**	**$ -**	**$ 786**	**$ -**	**$ 786**
Other than Intragovernmental					
Entity					
Medicare	$ 28,963	$ -	$ 28,963	$ (4,408)	$ 24,555
Medicaid	7,365	-	7,365	(787)	6,578
Other	9,335	383	9,718	(1,703)	8,015
Non-Entity	26	85	111	(63)	48
Total Other than Intragovernmental	**$ 45,689**	**$ 468**	**$ 46,157**	**$ (6,961)**	**$ 39,196**

	2022				
	Accounts Receivable, Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivables, 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**

As of September 30, 2023, the Accounts Receivable, Net decrease of $1.0 billion is primarily due to Medicare HI receivables decrease of $3.4 billion, offset by Medicare SMI receivables increase of $2.2 billion ($1.9 billion mainly related to Part D).

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

	2023	2022
Inventory Held for Sale or Use	$ 1,829	$ 563
Stockpile Materials Held for Emergency or Contingency	26,000	15,997
Total Inventory and Related Property, Net	**$ 27,829**	**$ 16,560**

The Inventory and Related Property, Net increase of $11.3 billion is mostly due to an increase in the PHSSEF for over-the-counter COVID-19 test kits, vaccines, and therapeutics. The largest increases between years are primarily for therapeutics that are utilized in the treatment of COVID-19.

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

			2023		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	N/A	N/A	$ 70	$ (5)	$ 65
Construction in Progress	N/A	N/A	1,793	-	1,793
Buildings, Facilities & Other Structures	Straight-Line	5-50 Yrs	7,158	(4,237)	2,921
Equipment	Straight-Line	3-20 Yrs	1,867	(929)	938
Internal Use Software	Straight-Line	5-10 Yrs	6,635	(3,983)	2,652
Assets Under Capital Lease	Straight-Line	1-30 Yrs	72	(59)	13
Leasehold Improvements	Straight-Line	*Life of Lease	34	(17)	17
Total			**$ 17,629**	**$ (9,230)**	**$ 8,399**

			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
Total			**$ 16,551**	**$ (8,275)**	**$ 8,276**

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

	2023			2022		
	Acquisition Cost	Accumulated Depreciation	PP&E, Net	Acquisition Cost	Accumulated Depreciation	PP&E, Net
Balance Beginning of Year	$ 16,551	$ (8,275)	$ 8,276	$ 16,408	$ (8,877)	$ 7,531
Capitalized Acquisitions	1,158	(54)	1,104	1,512	468	1,980
Dispositions	(80)	80	-	(1,390)	1,377	(13)
Depreciation Expense	-	(981)	(981)	-	(1,250)	(1,250)
Other	-	-	-	21	7	28
Balance End of Year	**$ 17,629**	**$ (9,230)**	**$ 8,399**	**$ 16,551**	**$ (8,275)**	**$ 8,276**

Note 8. Advances and Prepayments (in Millions)

	2023	2022
Intragovernmental		
Advances to Other Federal Entities	$ 2,552	$ 2,412
Total Intragovernmental	**$ 2,552**	**$ 2,412**
Other than Intragovernmental		
Prescription Drug and Medicare Advantage	$ 45,119	$ 37,751
COVID-19 Accelerated and Advance Payment Program	-	1,255
Grant Advances	42	152
Other	16	30
Total Other than Intragovernmental	**$ 45,177**	**$ 39,188**

As of September 30, 2023, Advances and Prepayments Other than Intragovernmental primarily represent Prescription Drug and Medicare Advantage benefit prepayments for October 2023 that occurred on September 29 instead of October 1.

Advances in the amount of $1.3 billion at September 2022 for accelerated payments made under the CAAP program have been demanded and are reflected in the Medicare fee-for-service accounts receivable balance.

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

	2023	2022
Intragovernmental:		
Accrued Payroll and Benefits	$ 46	$ 47
Debt (Note 10)	2,854	7,747
Other	1,457	1,349
Total Intragovernmental	**$ 4,357**	**$ 9,143**
Federal Employee and Veteran Benefits Payable (Note 12)	$ 20,368	$ 19,394
Contingencies and Commitments (Note 15)	27,488	15,776
Accrued Liabilities	7,750	7,270
Other	392	321
Total Liabilities Not Covered by Budgetary Resources	$ 60,355	$ 51,904
Total Liabilities Covered by Budgetary Resources	173,780	155,568
Total Liabilities Not Requiring Budgetary Resources	3,845	2,548
Total Liabilities	**$ 237,980**	**$ 210,020**

Liabilities Not Covered by Budgetary Resources had an increase of $8.5 billion, mostly due to increases in Contingencies of $11.7 billion, Federal Employee and Veteran Benefits Payable of $1.0 billion, and Accrued Liabilities of $0.5 billion. This is offset by a decrease in Debt of $4.9 billion.

Note 10. Debt (in Millions)

	2022 Beginning Balance	2022 Net Borrowing	2022 Ending Balance	2023 Net Borrowing	2023 Ending Balance
Debt to the Treasury					
COVID-19 Accelerated and Advance Payment Program	$ 29,352	$ (26,468)	$ 2,884	$ (2,730)	$ 154
Transitional SMI Contribution	6,960	(2,097)	4,863	(2,163)	2,700
Other	469	40	509	(91)	418
Total Debt to the Treasury	**$ 36,781**	**$ (28,525)**	**$ 8,256**	**$ (4,984)**	**$ 3,272**

HHS has $3.3 billion ($8.3 billion as of September 30, 2022) in total debt due to Treasury. Debt of $0.2 billion ($2.9 billion as of September 30, 2022) 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 $2.7 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 $2.7 billion ($4.9 billion as of September 30, 2022) 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 Healthcare Trust Funds of $2.2 billion.

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

	2023	2022
Medicare Fee-For-Service	$ 88,660	$ 65,883
Medicare Advantage/Prescription Drug Program	17,560	19,190
Medicaid	52,028	54,835
CHIP	1,295	1,269
Total Entitlement Benefits Due and Payable	**$ 159,543**	**$ 141,177**

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, 2023 and 2022 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, 2023.

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 as of September 30, 2023 and 2022.

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

	2023	2022
Other than Intragovernmental		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corps Pension Liability	$ 18,325	$ 17,478
PHS Commissioned Corps Post-Retirement Health Benefits	822	724
Workers' Compensation Benefits (Actuarial FECA Liability)	242	242
Unfunded Leave	979	950
Liabilities Covered by Budgetary Resources		
Other	9	15
Total Federal Employee and Veteran Benefits Payable	**$ 20,377**	**$ 19,409**

Public Health Service Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 5,516 active-duty officers, 91 individual ready reserve members, and 8,089 retiree annuitants and survivors. As of September 30, 2023, the actuarial accrued liability for the retirement benefit plan was $18.3 billion and $0.8 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, 2023 and September 30, 2022, were:

	2023	2022
Discount Rate	3.15 percent	3.22 percent
Annual Basic Pay Scale Increase	2.38 percent	2.31 percent
Annual Inflation	2.22 percent	2.44 percent

The table on the next page shows key valuation results as of September 30, 2023 and 2022, 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, 2023, and actuarial assumptions. The September 30, 2023, valuation includes an increase in liabilities of $1.0 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 2023 has increased relative to the prior year expense.

	2023	2022
Beginning Liability Balance	$ 18,202	$ 16,024
Expense		
Normal Cost	490	441
Interest on the Liability Balance	574	529
Actuarial (Gain)/Loss		
From Experience	862	409
From Assumption Changes		
Change in Discount Rate Assumption	210	442
Change in Inflation/Salary Increase Assumption	(544)	1,071
Change in New Medical Trends Assumption	48	(44)
Change in Others	19	(29)
Total From Assumption Changes	$ (267)	$ 1,440
Net Actuarial (Gain)/Loss	595	1,849
Total Expense	$ 1,659	$ 2,819
Less Amounts Paid	(714)	(641)
Ending Liability Balance	**$ 19,147**	**$ 18,202**

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 IBNR claims. The liability utilizes historical benefit payment patterns to predict the ultimate payment related to that period. For FYs 2023 and 2022, 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, 2023, and September 30, 2022, were:

	2023	2022
Wage Benefits	2.326% in Year 1 and years thereafter	2.119% in Year 1 and years thereafter
Medical Benefits	2.112% in Year 1 and years thereafter	1.973% 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:

	2023	2024	2025	2026	2027	2028
COLA	N/A	4.04%	4.29%	4.38%	4.13%	3.13%
CPI-M	N/A	3.25%	3.21%	3.51%	3.87%	4.03%

Note 13. Accrued Liabilities (in Millions)

	2023	2022
Grant Liability	$ 4,238	$ 4,597
Other Accrued Liabilities	13,197	11,660
Total Accrued Liabilities	**$ 17,435**	**$ 16,257**

Note 14. Other Liabilities (in Millions)

	2023	2022
Intragovernmental		
Legal Liabilities	$ 1,218	$ 1,217
Benefit Program Contribution Payable	125	150
Custodial Liabilities	139	114
Other	88	11
Total Intragovernmental	**$ 1,570**	**$ 1,492**
Other than Intragovernmental		
Accrued Payroll and Benefits	$ 299	$ 382
Custodial Liabilities	22	50
Other	595	805
Total Other than Intragovernmental	**$ 916**	**$ 1,237**

Legal Liabilities of $1.2 billion as of September 30, 2023, ($1.2 billion as of September 30, 2022) 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 and Legal Contingencies

The amount of $18.6 billion as of September 30, 2023 ($7.0 billion as of September 30, 2022) consists of $8.2 billion for Medicaid audit and program disallowances, reimbursement of state plan amendments and $10.4 billion for legal contingencies. 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 $6.4 billion as of September 30, 2023 ($6.1 billion as of September 30, 2022).

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)

	2023	2022
Unobligated Balance, End of Year (from Prior Year)	$ 282,986	$ 305,468
Adjustments to Unobligated Balance Brought Forward:		
Recoveries of Prior Year Unpaid Obligations	68,111	95,245
Recoveries of Prior Year Paid Obligations	28,442	19,023
Appropriation Withdrawn	(6,866)	(36,762)
Appropriation Temporarily Precluded from Obligation - Prior Year	(2,530)	(13)
Cancelled Authority	(12,982)	(11,125)
Prior Year Adjustments	5	214
Other	491	561
Total Unobligated Balance Brought Forward, October 1	**$ 357,657**	**$ 372,611**

Net adjustments to 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 $6.9 billion ($36.8 billion as of September 30, 2022) 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.

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 $236.4 billion, as of September 30, 2023 ($261.5 billion as of September 30, 2022) 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)

	2022			
	Budgetary Resources	New Obligations and Upward Adjustments	Distributed Offsetting Receipts	Outlays, net (discretionary and mandatory)
Combined Statement of Budgetary Resources	$ 2,736,002	$ 2,453,016	$ 699,432	$ 2,342,422
Expired Accounts	(148,781)	-	-	-
Other	2	(5)	44	(4)
Budget of the U.S. Government	**$ 2,587,223**	**$ 2,453,011**	**$ 699,476**	**$ 2,342,418**

The *Budget of the United States Government* (also known as the *President's Budget*), with the actual amounts for FY 2023, has not been published; therefore, no comparisons can be made between FY 2023 amounts presented in the Combined Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The *FY 2025 President's Budget* is expected to be released in February 2024 and may be obtained from OMB (unaudited) or from the Government Publishing Office (unaudited).

HHS reconciled the amounts of the FY 2022 column on the Combined Statement of Budgetary Resources to the actual amounts for FY 2022 from the Appendix in the *FY 2024 President's Budget* for budgetary resources, new obligations and upward adjustments, distributed offsetting receipts, and net outlays.

The *President's Budget* includes budgetary resources available for obligation. Budgetary resources that were not available are a reconciling item between the Combined Statement of Budgetary Resources and the *President's Budget*. The Expired Accounts line in the above table 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)

	2023			2022		
	Federal	Non-Federal	Total	Federal	Non-Federal	Total
Undelivered Orders, Paid	$ 2,406	$ 45,953	$ 48,359	$ 3,033	$ 39,522	$ 42,555
Undelivered Orders, Unpaid	16,349	240,246	256,595	33,199	254,578	287,777
Total Undelivered Orders	**$ 18,755**	**$ 286,199**	**$ 304,954**	**$ 36,232**	**$ 294,100**	**$ 330,332**

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 $305.0 billion of budgetary resources obligated for undelivered orders as of September 30, 2023 ($330.3 billion as of September 30, 2022). The Undelivered Orders, Paid increase of $5.8 billion is primarily due to advance and accelerated payments made for the CAAP program and the timing of Medicare Advantage and Prescription Drug benefit payments for October 2023, which occurred on September 29. The Undelivered Orders, Unpaid decrease of $31.2 billion is primarily due to COVID-19 and *Defense Production Act* 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.

Notes to the Principal Financial Statements

Balance Sheet	2023 Medicare	Other	Combined Funds from Dedicated Collections	Eliminations	Consolidated Funds from Dedicated Collections
Fund Balance with Treasury	$ 280,536	$ 20,305	$ 300,841	$ -	$ 300,841
Investments, Net	355,929	3,967	359,896	-	359,896
Accounts Receivable, Net	118,273	6,468	124,741	(124,107)	634
Advances and Prepayments	-	104	104	(98)	6
Other Assets	-	-	-	98	98
Total Intragovernmental Assets	**754,738**	**30,844**	**785,582**	**(124,107)**	**661,475**
Accounts Receivable, Net	24,555	7,297	31,852	-	31,852
Property, Plant and Equipment, Net	432	1,750	2,182	-	2,182
Advances and Prepayments	45,119	-	45,119	-	45,119
Other Assets	-	8	8	-	8
Total Other than Intragovernmental Assets	**70,106**	**9,055**	**79,161**	**-**	**79,161**
Total Assets	**$ 824,844**	**$ 39,899**	**$ 864,743**	**$ (124,107)**	**$ 740,636**
Accounts Payable	$ 127,916	$ 53	$ 127,969	$ (124,201)	$ 3,768
Debt	2,854	-	2,854	-	2,854
Other Liabilities	-	13	13	94	107
Total Intragovernmental Liabilities	**130,770**	**66**	**130,836**	**(124,107)**	**6,729**
Accounts Payable	173	312	485	-	485
Entitlement Benefits Due and Payable	106,220	-	106,220	-	106,220
Federal Employee and Veteran Benefits Payable	7	91	98	-	98
Advances from Others and Deferred Revenue	1,859	1,231	3,090	-	3,090
Other Liabilities	10,402	13,263	23,665	-	23,665
Total Other than Intragovernmental Liabilities	**118,661**	**14,897**	**133,558**	**-**	**133,558**
Total Liabilities	**$ 249,431**	**$ 14,963**	**$ 264,394**	**$ (124,107)**	**$ 140,287**
Unexpended Appropriations	271,601	3,706	275,307	-	275,307
Cumulative Results of Operations	303,812	21,230	325,042	-	325,042
Total Liabilities and Net Position	**$ 824,844**	**$ 39,899**	**$ 864,743**	**$ (124,107)**	**$ 740,636**
Statement of Net Cost					
Gross Program Costs	$ 1,006,024	$ 22,375	$ 1,028,399	$ (40)	$ 1,028,359
Less: Earned Revenues	(141,694)	(16,932)	(158,626)	24	(158,602)
Net Cost of Operations	**$ 864,330**	**$ 5,443**	**$ 869,773**	**$ (16)**	**$ 869,757**
Statement of Changes in Net Position					
Unexpended Appropriations:					
Beginning Balance	$ 174,874	$ 3,830	$ 178,704	$ -	$ 178,704
Appropriations Received	593,419	124	593,543	-	593,543
Other Adjustments	(19,035)	(11)	(19,046)	-	(19,046)
Appropriation Used	(477,657)	(237)	(477,894)	-	(477,894)
Total Unexpended Appropriations	**271,601**	**3,706**	**275,307**	**-**	**275,307**
Cumulative Results of Operations:					
Beginning Balance	324,469	21,730	346,199	-	346,199
Appropriations Used	477,657	237	477,894	-	477,894
Other than Intragovernmental Nonexchange Revenue:					
Nonexchange Revenue – Other	436	10	446	-	446
Intragovernmental Nonexchange Revenue	375,176	1	375,177	-	375,177
Donations and Forfeitures of Cash and Cash Equivalents	-	64	64	-	64
Transfers in/out without Reimbursement	(9,602)	4,584	(5,018)	-	(5,018)
Imputed Financing	6	74	80	(16)	64
Other	-	(27)	(27)	-	(27)
Net Cost of Operations	864,330	5,443	869,773	(16)	869,757
Net Change and Cumulative Results of Operations	(20,657)	(500)	(21,157)	-	(21,157)
Total Cumulative Results of Operations	**303,812**	**21,230**	**325,042**	**-**	**325,042**
Net Position, End of Period	**$ 575,413**	**$ 24,936**	**$ 600,349**	**$ -**	**$ 600,349**

Notes to the Principal Financial Statements

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
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 Other than Intragovernmental Assets	**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 Other than Intragovernmental Liabilities	**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**

Note 21. Stewardship Land

The IHS provides a wide range of clinical, public health, community, and facilities infrastructure services to approximately 2.6 million American Indians and Alaska Natives, who are members of 574 federally recognized tribes in 37 states. Comprehensive primary healthcare and disease prevention services are provided through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations. These facilities are predominately primary care settings and are managed by IHS, tribal, and urban Indian health programs. Health services are provided on tribal/reservation trust land that DOI assigned 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	2023	2022
Albuquerque	6	6
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**	**79**

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.

Notes to the Principal Financial Statements

	2023			2022		
	Intragovernmental	Other than Intragovernmental	Total	Intragovernmental	Other than Intragovernmental	Total
Net Cost of Operations	$ 24,565	$ 1,690,378	$ 1,714,943	$ 42,599	$ 1,618,194	$ 1,660,793
Components of Net Cost Not Part of the Budgetary Outlays:						
Property, Plant, and Equipment Depreciation Expense	-	(1,349)	(1,349)	-	(1,262)	(1,262)
Cost of Goods Sold	-	(28)	(28)	-	(25)	(25)
Applied Overhead/Cost Capitalization Offset	-	7,741	7,741	-	1,738	1,738
Gains/Losses on All Other Investments	-	239	239	-	(11)	(11)
	-	**6,603**	**6,603**	**-**	**440**	**440**
Increase/(Decrease) in Assets:						
Accounts Receivable	(45)	(938)	(983)	126	11,455	11,581
Securities and Investments	107	-	107	601	-	601
Advances and Prepayments	140	5,989	6,129	1,412	(30,893)	(29,481)
Other Assets	-	21	21	-	(8)	(8)
	202	**5,072**	**5,274**	**2,139**	**(19,446)**	**(17,307)**
(Increase)/Decrease in Liabilities:						
Accounts Payable	730	(75)	655	1,003	(271)	732
Debt	4,984	-	4,984	28,525	-	28,525
Benefits Due and Payable	-	(18,366)	(18,366)	-	(7,400)	(7,400)
Federal Employee and Veteran Benefits Payable	-	(968)	(968)	-	(2,144)	(2,144)
Accrued Liabilities	-	(1,178)	(1,178)	-	2,215	2,215
Contingencies and Commitments	-	(11,712)	(11,712)	-	(3,696)	(3,696)
Environmental and Disposal Liabilities	-	(71)	(71)	-	14	14
Other Liabilities	15	(1,153)	(1,138)	27	1,429	1,456
	5,729	**(33,523)**	**(27,794)**	**29,555**	**(9,853)**	**19,702**
Other Financing Sources:						
Imputed Financing	(797)	-	(797)	(675)	-	(675)
Total Components of Net Cost Not Part of the Budgetary Outlays	**5,134**	**(21,848)**	**(16,714)**	**31,019**	**(28,859)**	**2,160**
Components of Budgetary Outlays Not Part of Net Cost:						
Acquisition of Capital Assets	$ 13	7,349	7,362	$ 7	438	$ 445
Acquisition of Inventory	-	8,755	8,755	1	1,040	1,041
Acquisition of Other Assets	-	-	-	1	-	1
Other Financing Sources:						
Donated Revenue	-	(64)	(64)	-	(76)	(76)
Transfers (in)/out without Reimbursement	531	-	531	2,519	-	2,519
Total Components of Budgetary Outlays Not Part of Net Cost	**544**	**16,040**	**16,584**	**2,528**	**1,402**	**3,930**
Miscellaneous Items:						
Custodial/Non-Exchange Revenue	(10,113)	674	(9,439)	(6,418)	61	(6,357)
Non-entity activity	865	-	865	780	-	780
Other Temporary Timing Differences	-	-	-	-	246	246
Appropriated Receipts for Trust/Special Funds	-	9,418	9,418	-	8,117	8,117
Reconciling Items:						
Debt	(4,984)	-	(4,984)	(28,526)	-	(28,526)
Custodial/Non-Exchange Revenue	10,113	(674)	9,439	6,419	(62)	6,357
Miscellaneous Receipts	-	(477)	(477)	-	(1,661)	(1,661)
Investment Interest Receivable	(128)	-	(128)	-	-	-
Federal Share of Child Support Collections	(541)	-	(541)	(684)	-	(684)
Inventory Adjustment	-	(6,813)	(6,813)	-	-	-
Other Expenses Not Requiring Budgetary Resources	-	(5,966)	(5,966)	-	-	-
Return of Nonrecurring Expenses Fund and COVID-19 Rescinded Funds	1,981	-	1,981	-	-	-
Total Miscellaneous Items	**(2,807)**	**(3,838)**	**(6,645)**	**(28,429)**	**6,701**	**(21,728)**
Net Outlays	$ 27,436	$ 1,680,732	$ 1,708,168	$ 47,717	$ 1,597,438	$ 1,645,155
Other Reconciling Items			458			(2,165)
Agency Outlays, Net			$ 1,708,626			$ 1,642,990

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 come to fruition with 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 (unaudited), 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* (unaudited). 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 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, 2023 and 2022
(in Millions)

What Money is Available to Spend	2023	2022
Total Resources	$ 2,841,403	$ 2,736,002
Less Amount Available but Not Agreed to be Spent	145,708	114,123
Less Amount Not Available to be Spent	220,008	168,863
Total Amounts Agreed to be Spent	**$ 2,475,687**	**$ 2,453,016**

Who Did the Money Go To	2023	2022
Federal	$ 15,918	$ 48,647
Non-Federal	2,459,769	2,404,369
Total Amounts Agreed to be Spent	**$ 2,475,687**	**$ 2,453,016**

Total Amounts Agreed to be Spent increased by $22.7 billion, mostly due to increases in SMI, HI, Payments to the Healthcare Trust Funds, and Medicaid, primarily related to Medicaid grant awards to the states. 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,* as well as the *Defense Production Act.*

Combined Schedule of Spending by Object Class

For the Year Ended September 30, 2023

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Insurance Claims & Indemnities	Other Contractual Services	Personnel Compensation & Benefits	Other	Total
Medicaid	$ 660,165	$ 1	$ -	$ -	$ -	$ 660,166
Federal Supplementary Medical Insurance Trust Fund	-	503,687	179	1	7,493	511,360
Payments to the Healthcare Trust Funds	355,195	-	-	-	114,817	470,012
Federal Hospital Insurance Trust Fund	-	415,736	10	-	5,677	421,423
Medicare Prescription Drug Account	-	113,632	-	1	73	113,706
Taxation on OASDI Benefits, HI	34,968	-	-	-	-	34,968
Public Health and Social Services Emergency Fund	6,825	-	9,078	378	2,802	19,083
State Children's Health Insurance Fund	18,992	-	3	-	-	18,995
Temporary Assistance for Needy Families	16,702	-	93	16	1	16,812
Children and Families Services Programs	14,045	1	364	175	16	14,601
Refugee and Entrant Assistance	8,607	1	2,849	84	16	11,557
Payments for Foster Care and Permanency	10,145	-	52	1	-	10,198
Risk Adjustment Program Payments	-	9,245	-	-	-	9,245
Payment to States for the Child Care and Development Block Grant*	7,777	-	255	17	1	8,050
Indian Health Services	3,295	1	1,564	1,809	1,250	7,919
National Cancer Institute	4,454	-	2,002	741	154	7,351
CMS Program Management	119	-	6,079	820	200	7,218
National Institute of Allergy and Infectious Diseases	4,088	-	2,181	448	146	6,863
FDA Salaries and Expenses	318	1	2,477	3,466	588	6,850
Low Income Home Energy Assistance	6,110	-	8	1	-	6,119
Primary Health Care	5,399	-	306	106	8	5,819
Vaccines for Children Program	139	-	90	27	4,960	5,216
Payments to States for Child Support Enforcement and Family Support Programs	4,320	-	571	-	-	4,891
National Institute on Aging	3,927	-	409	125	40	4,501
Substance Abuse Treatment	4,026	-	107	48	-	4,181
National Heart, Lung, and Blood Institute	3,210	-	625	205	35	4,075
Child Care Entitlement to States*	3,634	-	52	-	-	3,686
National Institute of General Medical Sciences	3,127	-	107	41	-	3,275
Mental Health	2,889	-	198	32	2	3,121
National Institute of Neurological Disorders and Stroke	2,280	-	385	143	46	2,854
NIH Office of the Director	1,868	-	702	235	19	2,824
CDC-Wide Activities and Program Support	1,258	-	1,274	229	54	2,815
NIH Service and Supply Fund	-	-	1,913	387	421	2,721
Aging and Disability Services Programs	2,546	-	75	37	4	2,662
Ryan White HIV/AIDS Program	2,406	-	116	43	4	2,569
Health Care Fraud and Abuse Control Program	-	-	1,586	107	789	2,482
National Institute of Diabetes and Digestive and Kidney Diseases	1,993	-	284	157	24	2,458
National Institute of Mental Health	1,821	-	332	138	16	2,307
Defense Production Act Medical Supplies Enhancement	1,216	-	220	2	714	2,152
Other Agency Budgetary Accounts	25,664	765	12,286	6,720	3,147	48,582
Total Amounts Agreed to be Spent	**$ 1,223,528**	**$ 1,043,070**	**$ 48,832**	**$ 16,740**	**$ 143,517**	**$ 2,475,687**

*Funding from the Child Care and Development Fund

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 the Healthcare 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

Note 24. COVID-19 Activities (in Millions)

Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020	FY 2023	FY 2022	FY 2021	FY 2020
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 546	$ 663	$ 1,253	$ -
New Budget Authority	-	-	-	6,497
Rescissions/Other Changes to Budgetary Resources	(59)	-	-	-
Budgetary Resources Obligated	(254)	(117)	(590)	(5,244)
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	233	546	663	1,253
Outlays, Net	$ 389	$ 1,070	$ 2,439	$ 1,392
Families First Coronavirus Response Act	**FY 2023**	**FY 2022**	**FY 2021**	**FY 2020**
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 1	$ 6	$ 511	$ -
New Budget Authority	-	-	-	1,314
Budgetary Resources Obligated	(1)	(5)	(505)	(803)
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	-	1	6	511
Outlays, Net	$ 3	$ 34	$ 544	$ 719
Coronavirus Aid, Relief, and Economic Security Act	**FY 2023**	**FY 2022**	**FY 2021**	**FY 2020**
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 2,934	$ 5,486	$ 80,621	$ -
New Budget Authority	-	-	-	142,544*
Rescissions/Other Changes to Budgetary Resources	(342)	-	-	-
Budgetary Resources Obligated	(380)	(2,552)	(75,135)	(61,923)
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	2,212	2,934	5,486	80,621
Outlays, Net	$ 2,942	$ 11,045	$ 86,985	$ 33,813
Paycheck Protection Program and Health Care Enhancement Act	**FY 2023**	**FY 2022**	**FY 2021**	**FY 2020**
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 8,488	$ 35,416	$ 9,837	$ -
New Budget Authority	-	-	-	100,000
Rescissions/Other Changes to Budgetary Resources	(6,067)	-	-	-
Budgetary Resources Obligated	(1,998)	(26,928)	25,579	(90,163)
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	423	8,488	35,416	9,837
Outlays, Net	$ 2,450	$ 35,880	$ (25,897)	$ 77,533
Coronavirus Response and Relief Supplemental Appropriations Act, 2021	**FY 2023**	**FY 2022**	**FY 2021**	**FY 2020**
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 1,355	$ 13,487	$ -	$ -
New Budget Authority	-	-	73,175	-
Rescissions/Other Changes to Budgetary Resources	(556)	-	-	-
Budgetary Resources Obligated	(109)	(12,132)	(59,688)	-
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	690	1,355	13,487	-
Outlays, Net	$ 15,946	$ 23,066	$ 13,965	$ -
American Rescue Plan Act of 2021	**FY 2023**	**FY 2022**	**FY 2021**	**FY 2020**
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 20,874	$ 64,828	$ -	$ -
New Budget Authority	-	-	160,494	-
Rescissions/Other Changes to Budgetary Resources	(3,303)	-	-	-
Budgetary Resources Obligated	(13,352)	(43,954)	(95,666)	-
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	4,219	20,874	64,828	-
Outlays, Net	$ 38,555	$ 58,854	$ 11,682	$ -
Low-Income Household Drinking Water and Wastewater Emergency Assistance Program	**FY 2023**	**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	$ 326	$ 184	$ 1	$ -
Total COVID-19	**FY 2023**	**FY 2022**	**FY 2021**	**FY 2020**
Budgetary Resources: Unobligated Balance Carried Forward from Prior Year	$ 34,198	$ 119,886	$ 92,222	$ -
New Budget Authority	-	-	234,307	250,355*
Rescissions/Other Changes to Budgetary Resources	(10,327)	-	-	-
Budgetary Resources Obligated	(16,094)	(85,688)	(206,643)	(158,133)
Budgetary Resources: Ending Unobligated Balance to be Carried Forward	7,777	34,198	119,886	92,222
Outlays, Net	$ 60,611	$ 130,133	$ 89,719	$ 113,457

*The HHS Budget Authority was 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; National Institute of Allergy and Infectious Diseases; and National 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. This program ended on May 11, 2023, and HHS obligated $2.8 billion to provide COVID-19 tests.

The *Fiscal Responsibility Act of 2023* rescinded a portion of the unobligated balances from amounts made available through COVID-19 supplemental appropriations. Remaining amounts are being used to support research and development for next generation COVID-19 vaccines, operations for the SNS, strengthening the pharmaceutical supply chain, protecting priority investments in genomic surveillance and vaccine safety and effectiveness, and funding health workforce awards to address workforce shortages.

Refer to the following notes for additional information on COVID-19 activities: Summary of Significant Accounting Policies (Note 1), Fund Balance with Treasury (Note 3), Inventory and Related Property, Net (Note 6), Advances (Note 8), Debt (Note 10), Undelivered Orders (Note 19), Reconciliation of Net Cost to Net Outlays (Note 22), and Combined Schedule of Spending (Note 23).

Note 25. Reclassification of Financial Statement Line Items for Financial Report Compilation Process

Reclassification of Statement of Net Cost to Line Items Used for Government-wide Statement of Net Cost For the Year Ended September 30, 2023 (in Millions)						
FY 2023 HHS Statement of Net Cost		Line Items Used to Prepare FY 2023 Government-wide Statement of Net Cost				
Financial Statement Line	Amounts	Dedicated Collections Combined	Dedicated Collections Eliminations	All Other Amounts (with Eliminations)	Total	Reclassified Financial Statement Line
		$ 1,026,197	**$ -**	**$ 825,616**	**$ 1,851,813**	***Non-Federal Costs***
						Intragovernmental Costs
		455	-	2,095	2,550	*Benefit Program Costs*
		80	(17)	734	797	*Imputed Costs*
		1,528	(23)	19,671	21,176	*Buy/Sell Costs*
		-	-	14	14	*Purchase of Assets*
		-	-	11	11	*Borrowing and Other Interest Expense*
		139	-	615	754	*Other Expenses (w/o Reciprocals)*
		$ 2,202	**$ (40)**	**$ 23,139**	**$ 25,301**	**Total Intragovernmental Costs**
CMS: Gross Cost	$ 1,654,047					
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	223,054					
Total Gross Costs	**$ 1,877,101**	**$ 1,028,399**	**$ (40)**	**$ 848,756**	**$ 1,877,115**	***Total Reclassified Gross Costs***
		$ (158,577)	**$ -**	**$ (2,575)**	**$ (161,152)**	**Non-Federal Earned Revenue**
						Intragovernmental Earned Revenue
		(49)	24	(696)	(721)	*Buy/Sell Revenue*
		-	-	(14)	(14)	*Borrowing and Other Interest Revenue*
		-	-	(2)	(2)	*Purchase of Assets Offset*
		$ (49)	**$ 24**	**$ (712)**	**$ (737)**	**Total Intragovernmental Earned Revenue**
CMS: Earned Revenue	$ (154,882)					
Other Segments: Earned Revenue	(7,009)					
Total Earned Revenue	**$ (161,891)**	**$ (158,626)**	**$ 24**	**$ (3,287)**	**$ (161,889)**	***Total Reclassified Earned Revenue***
Actuarial (Gains) and Losses Commissioned Corps Retirement and Medical Plan Assumption Changes	(267)	-	-	(267)	(267)	Gain/Loss on Changes in Actuarial Assumptions (Non-Federal)
Net Cost	**$ 1,714,943**	**$ 869,773**	**$ (16)**	**$ 845,202**	**$ 1,714,959**	**Net Cost**

*Subtotals and totals may not equal due to rounding.

Reclassification of Statement of Changes in Net Position to Line Items Used for Government-wide Statement of Operations and Changes in Net Position For the Year Ending September 30, 2023 (in Millions)			
FY 2023 HHS Statement of Change in Net Position		Line Items Used to Prepare FY 2023 Government-wide Statement of Changes in Net Position	
Financial Statement Line	Amounts	Total	Reclassified Financial Statement Line
UNEXPENDED APPROPRIATIONS			
Unexpended Appropriations, Beginning Balance	$ 552,969	$ 552,969	Unexpended Appropriations, Beginning Balance
Appropriations Received	1,489,751	1,489,751	Appropriations Received
Appropriations Transferred In/Out	(1,964)	(1,964)	Appropriations Transferred In/Out
Appropriations Used	(1,330,703)	(1,330,703)	Appropriations Used
Other Adjustments	(108,532)	(108,532)	Other Adjustments
Total Unexpended Appropriations	**$ 601,521**	**$ 601,521**	**Total Unexpended Appropriations**
CUMULATIVE RESULTS OF OPERATIONS			
Cumulative Results, Beginning Balance	$ 349,136	$ 349,136	Cumulative Results, Beginning Balance
Other Adjustments	-	-	Other Adjustments
Appropriations Used	1,330,703	1,330,703	Appropriations Used
Nonexchange Revenue – Tax Revenue	362,511	362,511	Other Taxes and Receipts (RC 45)
Nonexchange Revenue – Investment Revenue	10,674	10,674	Federal Securities Interest Revenue, including Associated Gains/Losses (Non-Exchange)
		1,654	*Collections Transferred into a TAS Other Than the General Fund of the U.S. Government*
		3,018	*Other Taxes and Receipts (RC 45)*
		(1,208)	*Other Taxes and Receipts*
Nonexchange Revenue – Other	3,463	3,464	Total Other Taxes and Receipts
Donations and Forfeitures of Cash and Cash Equivalents	64	64	Donations and Forfeitures of Cash and Cash Equivalents
		981	*Expenditure Transfers in of Financing Sources (RC 09)*
		(3,494)	*Expenditure Transfers out of Financing Sources (RC 09)*
		1,981	*Nonexpenditure Transfer out of Financing Sources - Capital Transfers (RC 11)*
		1	*Transfers in without reimbursement (RC 18)*
Transfers in/out Without Reimbursement – Budgetary	(531)	(531)	Total Transfers in/out without reimbursement
Donations and Forfeitures of Property	72	72	Donations and Forfeitures of Property
Imputed Financing	797	797	Imputed Financing Sources
		-	*Other Taxes and Receipts*
		(2,006)	*Non-Entity Collections transferred to the General Fund*
		(111)	*Accrual for Non-Entity Amounts to be Collected and Transferred to the General Fund*
		1,153	*Other*
Other	(978)	(964)	Total Other
Total Financing Sources	**1,706,775**	**1,706,790**	**Total Financing Sources**
Net Cost of Operations	**1,714,943**	**1,714,959**	**Net Cost of Operations**
Ending Balance – Cumulative Results of Operations	**$ 340,968**	**$ 340,967**	**Total Cumulative Results of Operations**
Total Net Position	**$ 942,489**	**$ 942,488**	**Total Net Position**

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 2022 FR can be found at Fiscal Service's website (unaudited) and the 2023 FR will be posted to the site as soon as it is released.

The Statement of Net Cost and Statement of Changes in Net Position have immaterial differences primarily due to the presentations between HHS's financial statements and the reclassified financial statements. There is a difference of $16 million for the Statements of Net Cost and Statement of Changes in Net Position due to custodial activities. The remainder of the differences are due to rounding.

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 *2023 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and healthcare-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent completed review occurred with the 2016-2017 Technical Review Panel.

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

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

from negotiated prices and lower trends are initially more than offset by increased benefits and decreased manufacturer rebates.

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

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

Actual fee-for-service per capita spending has been consistently below the pre-pandemic projections throughout the public health emergency, even into 2022 as the pandemic had diminishing effects on much of the economy and the healthcare delivery system. A number of factors have contributed to this lower spending, including the net effects of (i) lower average morbidity among the surviving population from COVID-19-related deaths; (ii) a greater share of dual-eligible beneficiaries enrolling in the Medicare Advantage program; and (iii) the shift of joint replacement procedures from an inpatient to an outpatient setting. These reductions are partially offset by certain public health emergency policies.

While these factors account for a significant amount of the difference between actual and expected experience for many of the categories, others are still largely unexplained. For inpatient hospital, outpatient hospital, and skilled nursing facility (SNF) spending, these unexplained differences are expected to be eliminated by 2024; for home health services, they are expected to be gradually eliminated by 2026.

It should be noted that there is an unusually large degree of uncertainty with the COVID-19-related impacts and that future projections could change significantly as more information becomes available. 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 $67.2 billion from the HI trust fund and $40.1 billion from the SMI Part B trust fund account. As of January 1, 2023, roughly 99 percent of these amounts have been repaid. The Trustees assumed in their report that the remaining balance would be fully repaid or converted to an extended repayment schedule by March of 2023.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. They are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments and administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of *FICA* and *SECA* payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, premiums paid by, or on behalf of, aged uninsured beneficiaries, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the

Treasury. Fees related to brand-name prescription drugs are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

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

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

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

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

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 March 31, 2023, except that the projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund and the impact of the elimination of the safe harbor protection for manufacturer rebates.

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 2023 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2023. 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[5] (unaudited).

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2023

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage growth[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[11]
2023	1.70	2,030,000	798.0	0.15	4.15	4.00	0.7	5.3[9]	7.8[9,10]	2.5[10]	-1.0
2030	1.86	1,348,000	738.4	1.57	4.01	2.40	2.0	5.0	5.5	1.7	2.0
2040	1.97	1,291,000	679.9	1.20	3.63	2.40	1.9	4.2	4.9	3.6	2.3
2050	2.00	1,258,000	627.3	1.10	3.53	2.40	2.0	3.4	3.7	4.1	2.3
2060	2.00	1,241,000	580.7	1.12	3.55	2.40	2.0	3.3	3.8	4.0	2.3
2070	2.00	1,228,000	539.4	1.14	3.57	2.40	1.9	3.4	3.5	3.8	2.3
2080	2.00	1,220,000	502.7	1.13	3.56	2.40	2.0	3.5	3.7	3.9	2.3
2090	2.00	1,216,000	469.9	1.12	3.55	2.40	2.1	3.5	3.7	4.0	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. Annual percentage change in average wages adjusted for the average percentage change in 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 updated expectations for healthcare spending following the COVID-19 pandemic.
10. Reflects *Inflation Reduction Act*.
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.

[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.

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance FY 2023-2019

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage growth[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2023	2.0	1,216,000	469.9	1.12	3.55	2.40	2.1	3.5	3.7	4.0	2.3
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

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. Beginning with the 2023 Trustees Report, for consistency with other growth rate measures, the real-wage growth is defined as the annual percentage change in average wages adjusted for the average percentage change in the CPI. In the 2022 and earlier Trustees Reports it is presented as the difference between percentage increases in wages and the CPI and referred to as real-wage differential. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.
5. Average annual wage in covered employment. The value presented is the average annual percentage change from the 10th year of the 75-year projection period to the 75th year and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.
6. 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 negative in 2024 and 2025. Furthermore, additional payments totaling $500 million per year to one group of physicians and annual bonuses to another group are scheduled to expire in 2025 and 2026, respectively. Payment rate updates for most non-physician categories of Medicare providers are

reduced by the growth in economy-wide private nonfarm business total factor productivity[6] 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. 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.

Table 3 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	$ 31,268	$ 31,345
Part B	56,625	64,452
Part D	10,551	10,551
Expenditures		
Part A	35,897	42,272
Part B	56,625	64,452
Part D	10,551	10,551
Income less expenditures		
Part A	(4,630)	(10,927)
Part B	-	-
Part D	-	-

1. These amounts are not presented in the 2023 Trustees Report.
2. A set of illustrative alternative Medicare projections has been prepared under a hypothetical modification to current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.

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

[6]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.

higher than the current-law projections by roughly 18 percent and Part B expenditures would be higher than the current-law projections by roughly 14 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 14 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, 2022 to the period beginning on January 1, 2023, and the reconciliation from the period beginning on January 1, 2021 to the period beginning on January 1, 2022. 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, 2022 and ending January 1, 2023

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

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.

Change in the Valuation Period

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

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

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.

Change in Projection Base

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

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

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.

Changes in the Demographic Assumptions

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

The demographic assumptions used in the Medicare projections are the same as those used for the 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, 2023) are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

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

- Updates to near-term mortality assumptions to better reflect the effects of the COVID-19 pandemic led to an increase in death rates through 2024 compared to the prior valuation.
- Historical population data, other-than-lawful permanent resident (LPR) immigration data, and marriage and divorce data were updated since the prior valuation.

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

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

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.

Changes in Economic and Healthcare Assumptions

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

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

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

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

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

- The levels of GDP and labor productivity are assumed to be about 3.0 percent lower by 2026 and for all years thereafter relative to the prior valuation.
- The assumed real interest rates over the first 10 years of the projection period are generally higher than those assumed for the prior valuation.

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

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

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

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

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.

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.

Changes in Law

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

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

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

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

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

- The Secretary of HHS is required to negotiate prices for certain prescription drugs covered under Medicare. Specifically, CMS (on behalf of the Secretary) must negotiate maximum fair prices for certain high-expenditure single-source Part B or Part D drugs (brand-name drugs without generic or biosimilar equivalents). The maximum fair prices that are negotiated for the first set of drugs subject to negotiation will be in effect beginning in 2026. The number of drugs subject to negotiation is phased in, such that CMS must negotiate the prices of (i) 10 drugs covered under Part D for 2026; (ii) 15 drugs covered under Part D for 2027; (iii) 15 drugs covered under Part B or Part D for 2028; and (iv) 20 drugs covered under Part B or Part D for 2029 and each year thereafter. The selected drugs must be among the 50 drugs with the highest total expenditures over the most recent 12-month period under Part B or Part D and must have been approved or licensed, as applicable, by the Food and Drug Administration for at least 7 years (for drug products) or 11 years (for biologics). Excluded are (i) certain orphan drugs that are approved to treat only one rare disease or condition; (ii) plasma-derived products; (iii) drugs that account for less than $200 million

in annual Medicare spending (in 2021 and adjusted annually for inflation); and (iv) certain small biotech drugs (for 2026, 2027, and 2028). Manufacturers of drugs selected for negotiation that fail to comply with negotiation requirements are subject to civil penalties and/or excise taxes. If certain requirements are met, negotiations for certain biologics may be delayed for up to 2 years upon request by a manufacturer of a biosimilar for which the biologic is the reference product. Funds in the amount of $3 billion in fiscal year 2022 are provided to CMS, and are to remain available until expended, for the implementation of this provision.

- For Part B, with respect to each quarter beginning January 1, 2023, and for Part D, with respect to each 12-month applicable period beginning October 1, 2022, drug manufacturers must pay rebates to Medicare if they increase drug prices for a rebatable Part B or Part D drug at a rate that is faster than the rate of consumer inflation. In general, for both Part B and Part D, rebatable drugs include certain drugs and biologics that meet the statutory criteria and have an average cost of $100 or more per year per person, as determined by the Secretary. Manufacturers that fail to comply are subject to civil penalties. Beginning April 1, 2023, beneficiary coinsurance under Part B for a Part B rebatable drug will be adjusted downward to reflect inflation-adjusted payment amounts if the drug price increased more rapidly than the rate of inflation. Funds in fiscal years 2022–2031 are provided to CMS for the implementation of this provision.
- For insulin furnished under Part B through durable medical equipment, the Part B deductible is waived and cost sharing is not to exceed $35 per monthly prescription, effective July 1, 2023.
- For insulin products covered under each Part D plan and during all phases of the Part D benefit, beginning January 1, 2023, the deductible does not apply with respect to such products, and cost sharing for a 1-month supply of each covered insulin product must not exceed $35. (For plan year 2023, plans will receive retrospective subsidies equal to the difference between the plans' benefit packages, as submitted and approved under their 2023 bids, and the $35 statutory limit.) For plan years 2026 and later, when the negotiated maximum fair prices for selected drugs will be in effect, the cost sharing for each month's supply for covered insulin under Part D must be limited to the least of (i) the $35 copayment; (ii) 25 percent of the insulin's negotiated price under the plan; or (iii) 25 percent of the insulin's negotiated maximum fair price.
- For biosimilar products separately payable under Part B and administered in physician offices, hospital outpatient departments, and ambulatory surgical centers with an average sale price (ASP) of not more than the price of their associated reference biological product, the add-on payment (which is paid in addition to the biosimilar's ASP) is temporarily raised from 6 percent to 8 percent of the reference product's ASP for 5 years. The add-on payment for biosimilars that do not meet the ASP qualification will continue to be 6 percent of the reference biological product's ASP. (For existing qualifying year biosimilars for which payment was based on the ASP as of September 30, 2022, the 5-year period began on October 1, 2022. For new qualifying biosimilars for which payment based on the ASP is first made between October 1, 2022 and December 31, 2027, the 5-year period begins on the first day of the calendar quarter during which such payment is made.)
- For new biosimilar products furnished under Part B on or after July 1, 2024, the payment rate during the initial period, when an ASP is unavailable, will be the lesser of (i) the biosimilar's wholesale acquisition cost plus 3 percent or (ii) 106 percent of the associated reference biological product's ASP.
- The standard Part D benefit design (for beneficiaries not eligible for cost sharing and/or premium subsidies) is restructured as follows:
  (i) In 2024 and later, the 5-percent cost sharing currently required from the beneficiary during the catastrophic coverage phase (that is, after the beneficiary reaches the out-of-pocket threshold) is eliminated, thereby capping previously unlimited out-of-pocket costs for the beneficiary at the out-of-pocket threshold level. The allowed costs in the catastrophic coverage phase will be borne by the drug plan and by Medicare, at 20 percent and 80 percent, respectively, in 2024 (as opposed to the current

catastrophic cost distribution of 5 percent from the beneficiary, 15 percent from the drug plan, and 80 percent from Medicare).

(ii) Beginning in 2025, enrollees will have a $2,000 limit on their out-of-pocket costs for covered Part D drugs; that is, neither the initial coverage limit nor the period currently referred to as the coverage gap (the phase between the initial coverage limit and the out-of-pocket threshold)[7] will continue to exist, and the out-of-pocket cap for entering the catastrophic coverage phase (during which there will no longer be beneficiary cost sharing, as described above) will be reduced to $2,000. For 2026 and later, this $2,000 limit will be increased by the annual percentage increase used for other Part D benefit parameters.

(iii) Also beginning in 2025, for the entire period starting after the deductible is met and ending when the catastrophic coverage phase begins, beneficiary cost sharing will be 25 percent for drugs that are neither insulins nor specified vaccines. The remaining allowed costs (after the 25-percent beneficiary cost sharing) will be covered, in general, as follows: (i) for applicable drugs, by a 10-percent discount paid by the drug manufacturer[8] and a 65-percent benefit from the beneficiary's Part D plan, and (ii) for non-applicable drugs, by a 75-percent benefit from the beneficiary's Part D plan. (In contrast, through 2024, the Part D plan covers 75 percent of the remaining allowed costs until the beneficiary enters the coverage gap; then, during the coverage gap, the remaining allowed costs are covered as follows: (i) for applicable drugs, by a 70-percent discount paid by the drug manufacturer and a 5-percent benefit from the Part D plan, and (ii) for non-applicable drugs, by a 75-percent benefit from the Part D plan.) *Applicable* drugs are generally covered brand-name Part D drugs and biologics, including biosimilars; *non-applicable* drugs are generally covered non-brand-name—that is, generic—Part D drugs

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

(iv) In addition, and also beginning in 2025, the cost coverage distribution during the catastrophic coverage phase will change (from the distribution in 2024, which was previously described). Specifically, (i) Medicare's share will decrease from 80 percent (for all covered prescription drugs) to 20 percent for applicable drugs and to 40 percent for non-applicable drugs; (ii) drug manufacturers[9] will be required, in general, to provide a 20-percent discount on applicable drugs (whereas no manufacturer discount is required in the catastrophic phrase prior to 2025); and (iii) the 20-percent share borne by Part D plans will increase to 60 percent.

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

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

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

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

- For each of plan years 2024–2029, the base beneficiary premium increase is to be limited to no more than 6 percent from the prior year. Premiums for some Part D plans may increase by more than 6 percent per year during this period, but the national average is constrained. For plan years 2030 and later, CMS may determine a new beneficiary premium percentage, based on the 2029 constrained premiums, to replace the current value of 25.5 percent. This new percentage may not be less than 20 percent.
- Effective January 1, 2024, Part D low-income subsidies are expanded. Specifically, (i) the income limit for individuals to qualify for the full subsidy will increase from 135 percent to 150 percent of the Federal poverty level (FPL) (whereas, previously, individuals with incomes between 135 percent and 150 percent of the FPL had been eligible for only a partial subsidy); and (ii) the limit on resources required for the full subsidy will also increase (from the limit that had been in place for the partial subsidy, which will no longer exist).
- Effective January 1, 2023, Part D plans may not apply a deductible, coinsurance, or other enrollee cost-sharing amount for Part D-covered adult vaccines recommended by the Advisory Committee on Immunization Practices, such as the shingles (herpes zoster) vaccine. (By comparison, preventive vaccines required by statute to be covered under Part B already have no enrollee cost sharing, except for those vaccines used to treat an injury or exposure to a disease.)

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

- Medicare inpatient hospital add-on payments for certain low volume hospitals (those with fewer than 3,800 total discharges annually and located 15 road miles or more from the nearest like hospital) were extended through December 16, 2022 (from September 30, 2022). The sliding scale used to determine the add-on percentages is also extended.
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after September 30, 2022, was extended through December 16, 2022. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals, in light of what had been the impending expiration of the MDH program, may decline this reclassification and reinstate their MDH status.)

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

- Medicare inpatient hospital add-on payments for certain low-volume hospitals (those with fewer than 3,800 total discharges annually and located 15 road miles or more from the nearest like hospital) were extended through December 23, 2022 (from December 16, 2022). The sliding scale used to determine the add-on percentages is also extended. (See Public Law 117-180.)
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after December 16, 2022 (as described under Public Law 117-180), was extended through December 23, 2022. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals, in light of what had been the impending expiration of the MDH program, may decline this reclassification and reinstate their MDH status.)

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

- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by 1 year, through fiscal year 2032 (which, for sequestration purposes, covers April 1, 2032 through March 31, 2033). The benefit payment reductions for this newly added 12-month period are set at 2 percent for the first 6 months and 0 percent for the final 6 months. In addition, the benefit payment reductions for fiscal years 2030 and 2031 (covering April 1, 2030 through March 31, 2032) are changed back to a uniform 2 percent for the entire period (from 2.25 percent, 3 percent, 4 percent, and 0 percent for the first, second, third, and final 6-month periods, respectively).
- The 1-percent add-on payment is extended for 1 year (through December 31, 2023) for those home health agencies that serve beneficiaries in rural areas and that are classified in the low-population-density tier. (This tier is one of three used for determining rural add-on adjustments. The tiers are based on Medicare home health utilization and population density.)
- Medicare inpatient hospital add-on payments for certain low-volume hospitals (those with fewer than 3,800 total discharges annually and located 15 road miles or more from the nearest like hospital) are extended through September 30, 2024 (from December 23, 2022). The sliding scale used to determine the add-on percentages is also extended. (See Public Law 117-229.)
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after December 23, 2022 (as described under Public Law 117-229), is extended through September 30, 2024. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals, in light of what had been the impending expiration of the MDH program, may decline this reclassification and reinstate their MDH status.)
- Beginning in 2026, an additional 200 Medicare graduate medical education (GME) residency positions are provided for, half of which are to be reserved for psychiatry and psychiatry-subspecialty residencies.
- In the formula for determining payment rates under the physician fee schedule, the updates to the conversion factor are changed to be −0.5 percent, −1.2 percent, and −1.2 percent in 2023, 2024, and 2025, respectively (replacing −2.9 percent for 2023 and 0 percent for 2024 and 2025).
- Certain ground ambulance add-on payments that had been extended through December 31, 2022 under previous legislation are now extended through December 31, 2024. These add-on payments include a 3-percent bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.
- For physicians participating in advanced alternative payment models, a 1-year extension of incentive payment availability is provided, but the payments will be at 3.5 percent. (In recent years, physicians could earn a 5-percent incentive payment, but only through the end of performance year 2022, which is payment year 2024.) In addition, the current freeze on participation thresholds that must be met to qualify for the incentive payments is extended for an additional year (that is, for payment year 2025, which is performance year 2023).
- For the market-based system used to update the Medicare clinical laboratory fee schedule, laboratories are exempted for another year from the requirement that they report private payer rates. The next data-reporting period is now the first quarter of 2024 (instead of the first quarter of 2023). Also, during the phase-in period for this system, the caps in place to limit reductions in fee schedule payments from year to year are changed to 0 percent for 2022–2023 and 15 percent for 2024–2026 (as opposed to the previous statutory parameters of 0 percent for 2021–2022 and 15 percent for 2023–2025). That is, tests furnished under the fee schedule during 2022–2023 are to be paid at the same rates as under the 2021 fee schedule, and payments may not be reduced by more than 15 percent for services provided during 2024–2026.

- Marriage and family therapists and mental health counselors are allowed to receive payment from Part B for providing covered mental health services to beneficiaries, beginning January 1, 2024. (The qualifications for these professions are defined in the provision.)
- Effective January 1, 2024, Medicare's partial hospitalization benefit (which provides a structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care) is revised to provide coverage of intensive outpatient services.
- The use of blended payment rates for durable medical equipment in certain non-competitive bid areas, as provided for during the public health emergency by Public Law 116-136, is extended through December 31, 2023
- Compression garments furnished on or after January 1, 2024 for the treatment of lymphedema are covered under Part B as durable medical equipment.

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

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 was 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.

Required Supplementary Information

Combining Statement of Budgetary Resources

For the Year Ended September 30, 2023
(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)	$ 1,896	$ 2,411	$ 174,067	$ 52,602	$ 126,681	$ 357,657
Appropriations (Discretionary and Mandatory)	419,527	508,949	593,015	606,028	332,959	2,460,478
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	-	-
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	-	-	-	1,587	21,681	23,268
Total Budgetary Resources	**$ 421,423**	**$ 511,360**	**$ 767,082**	**$ 660,217**	**$ 481,321**	**$ 2,841,403**
Status of Budgetary Resources						
New Obligations and Upward Adjustments	$ 421,423	$ 511,360	$ 505,137	$ 660,166	$ 377,601	$ 2,475,687
Unobligated Balance, End of Year:						
Apportioned, Unexpired Accounts	-	-	80,067	50	63,770	143,887
Exempt from Apportionment, Unexpired Accounts	-	-	-	-	1,821	1,821
Unapportioned, Unexpired Accounts	-	-	7,811	1	12,762	20,574
Unexpired Unobligated Balance, End of Year	-	-	87,878	51	78,353	166,282
Expired Unobligated Balance, End of Year	-	-	174,067	-	25,367	199,434
Unobligated Balance, End of Year	-	-	261,945	51	103,720	365,716
Total Status of Budgetary Resources	**$ 421,423**	**$ 511,360**	**$ 767,082**	**$ 660,217**	**$ 481,321**	**$ 2,841,403**
Outlays, Net						
Outlays, Net (Discretionary and Mandatory)	$ 407,111	$ 497,949	$ 480,201	$ 610,833	$ 372,194	$ 2,368,288
Distributed Offsetting Receipts	(54,478)	(602,492)	-	-	(2,692)	(659,662)
Agency Outlays, Net (Discretionary and Mandatory)	**$ 352,633**	**$ (104,543)**	**$ 480,201**	**$ 610,833**	**$ 369,502**	**$ 1,708,626**
Disbursements, Net	**$ -**	**$ -**	**$ -**	**$ -**	**$ (70)**	**$ (70)**

Summary of Other Agency Accounts

	Budgetary Resources	Outlays, Net
ACF	$ 88,257	$ 88,183
ACL	2,753	3,013
AHRQ	422	348
CDC	23,553	17,216
CMS	218,936	145,137
FDA	8,964	2,829
HRSA	16,057	15,868
IHS	18,063	7,304
NIH	60,087	45,365
OS	32,446	34,930
PSC	2,371	1,048
SAMHSA	9,412	8,261
Totals	**$ 481,321**	**$ 369,502**

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 when 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 PP&E 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	2023	2022
PP&E		
Buildings	$ 5,094	$ 4,664
Other Structures	31	30
Total	**$ 5,125**	**$ 4,694**

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 PP&E 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.

The increase of $431.0 million from FY 2022 to FY 2023 is primarily due to growing needs of maintenance for buildings and structures held by NIH. However, this maintenance has been deferred due to limited funding.

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.

Estimated Acreage by Predominant* Use

	Operational				
	CDC	FDA	IHS	NIH	Total Estimated Acreage
PP&E Land					
Start of Prior Year	506	729	2,197	1,346	4,778
End of Prior Year/Start of Current Year	506	729	2,152	1,317	4,704
End of Current Year	525	730	2,087	1,319	4,661
Stewardship Land					
Start of Prior Year	-	-	1,108	-	1,108
End of Prior Year/Start of Current Year	-	-	1,108	-	1,108
End of Current Year	-	-	1,115	-	1,115
Held for Disposal or Exchange					
End of Prior Year	-	-	-	-	-
End of Current Year	-	-	5	-	5

*"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	2023	2022
Albuquerque	17	16
Bemidji	23	23
Billings	118	118
Great Plains	185	184
Navajo	703	700
Oklahoma City	6	6
Phoenix	30	29
Portland	3	3
Tucson	30	29
Total	**1,115**	**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 Medicare program and a discussion of trends revealed in the data.

RSI material is generally drawn from the *2023 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.

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

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

The Board of Trustees assumes that the IRA will affect the ultimate long-range growth rates for Part B and Part D drug spending differently. For Part B drugs, since the Trustees do not anticipate that the market pricing dynamics will be much different from those prior to the implementation of the IRA, they continue to assume that per capita spending growth rates will be similar to those for overall per capita national health expenditures. On the other hand, for Part D drugs, the Trustees assume that per capita spending will grow 0.2 percentage point more slowly than per

capita national health expenditures, since the inflation provisions of the IRA are likely to result in a trend rate that is lower than, and price growth that is closer to, the Consumer Price Index (CPI).

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

Actual fee-for-service per capita spending has been consistently below the pre-pandemic projections throughout the public health emergency, even into 2022 as the pandemic had diminishing effects on much of the economy and the healthcare delivery system. A number of factors have contributed to this lower spending, including the net effects of (i) lower average morbidity among the surviving population from COVID-19-related deaths; (ii) a greater share of dual-eligible beneficiaries enrolling in the Medicare Advantage program; and (iii) the shift of joint replacement procedures from an inpatient to an outpatient setting. These reductions are partially offset by certain public health emergency policies.

While these factors account for a significant amount of the difference between actual and expected experience for many of the categories, others are still largely unexplained. For inpatient hospital, outpatient hospital, and skilled nursing facility spending, these unexplained differences are expected to be eliminated by 2024; for home health agency services, they are expected to be gradually eliminated by 2026.

It should be noted that there is an unusually large degree of uncertainty with the COVID-19-related impacts and that future projections could change significantly as more information becomes available. 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 $67.2 billion from the HI trust fund and $40.1 billion from the SMI Part B trust fund account. As of January 1, 2023, roughly 99 percent of these amounts have been repaid. The Trustees assumed in their report that the remaining balance would be fully repaid or converted to an extended repayment schedule by March of 2023.

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 negative in 2024 and 2025. Furthermore, additional payments totaling $500 million per year to one group of physicians and annual bonuses to another group are scheduled to expire in 2025 and 2026, respectively. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business total factor productivity[10] 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.

[10]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); the *Protecting Medicare and American Farmers from Sequester Cuts Act* (Public Law 117-71, enacted on December 10, 2021); and the *Consolidated Appropriations Act, 2023* (Public Law 117-328, enacted on December 29, 2022).

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

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

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent challenges in projecting healthcare cost growth over time. The expenditure projections reflect the cost-reduction provisions required under current law. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes that (i) there would be a transition from current-law[11] 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[12] to payment updates that reflect the Medicare Economic Index; and (iii) the bonuses for qualified physicians in APMs, which are expected to end after 2025, and the $500 million payments for physicians in the MIPS, which are set to expire after 2024, would both continue indefinitely. The difference between the illustrative alternative and the current-law projections continues to demonstrate that the long-range costs could be substantially higher than shown throughout much of the report if the cost-reduction measures prove problematic and new legislation scales them back.

[11]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).

[12]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.

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 (410-786-6386) or can be downloaded from the CMS website (unaudited).

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.[13] 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.[14]

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 five categories of healthcare provider services:

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

HI services are inpatient hospital, skilled nursing facility, home health agency, and hospice. The primary Part B services affected are outpatient hospital, home health agency, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year cost growth rates for these provider services start at 3.7 percent in 2047, or GDP plus 0.1 percent, declining gradually to 3.4 percent in 2097, or GDP minus 0.3 percent.

[13]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.

[14]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 (unaudited)) and with Finding 3-2 of the 2016–2017 Medicare Technical Review Panel (final report available here (unaudited)).

(ii) *Physician services*

Payment rate updates are 0.75 percent per year for those qualified physicians assumed to be participating in advanced APMs and 0.25 percent for those assumed to be participating in MIPS. The year-by-year cost growth rates for physician payments are assumed to decline from 3.3 percent in 2047, or GDP minus 0.3 percent, to 2.9 percent in 2097, or GDP minus 0.8 percent.

(iii) *Certain SMI Part B services that are updated annually by the CPI increase less the increase in economy-wide productivity.*

Such services include durable medical equipment that is not subject to competitive bidding,[15] care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the year-by-year cost growth rates for these services to decline from 2.9 percent in 2047, or GDP minus 0.7 percent, to 2.6 percent in 2097, or GDP minus 1.1 percent.

(iv) *The remaining Part B services, which consist mostly of physician-administered drugs, laboratory tests, and small facility services.*

The Trustees assume that per beneficiary outlays for these other Part B services, which constitute about 33 percent of total Part B expenditures in 2032, grow at the same rate as the overall health sector as determined from the factors model. The services are assumed to grow similarly because their payments are established through market processes. For physician-administered Part B drugs, the key inflation provisions in the IRA are not anticipated to affect such payments over the long range. The corresponding year-by-year cost growth rates decline from 4.4 percent in 2047, or GDP plus 0.8 percent, to 4.1 percent by 2097, or GDP plus 0.4 percent.

(v) *Prescription drugs provided through Part D.*

Medicare payments to Part D plans are based on a competitive-bidding process, and prior to the IRA these payments were assumed to grow at the same rate as the overall health sector as determined from the factors model. While the negotiation provisions of the IRA are not anticipated to affect the long-range growth rates for Part D drugs, the inflation provisions would likely lower these trends relative to previous expectations. Specifically, the IRA requires the change in prices (before rebate adjustments) to be limited to the rate of growth in the CPI. Analysis of Part D pricing trends over recent years has consistently shown price growth in excess of the CPI, with a portion of these trends offset by increasing rebate percentages, and in prior reports it was assumed that such trends would continue over the long range. The inflation provisions in the IRA would likely lower these price trends, though it is expected that they would outpace the CPI due to certain manufacturer adaptations to the new law that may mitigate some of the pricing constraints, including new approaches regarding the development and release of new drugs. As a result, they are assumed to grow over the long range slightly more slowly than would be the case if they were determined strictly through market processes. The corresponding year-by-year cost growth rates decline from 4.2 percent in 2047, or GDP plus 0.6 percent, to 3.9 percent by 2097, or GDP plus 0.2 percent.

[15]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 2023 Medicare Trustees Report.

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 facility, and home health agency services—for which the distribution of spending is more concentrated in the period right before death. For Part B services and Part D, the incorporation of the TTD adjustment has a smaller effect.

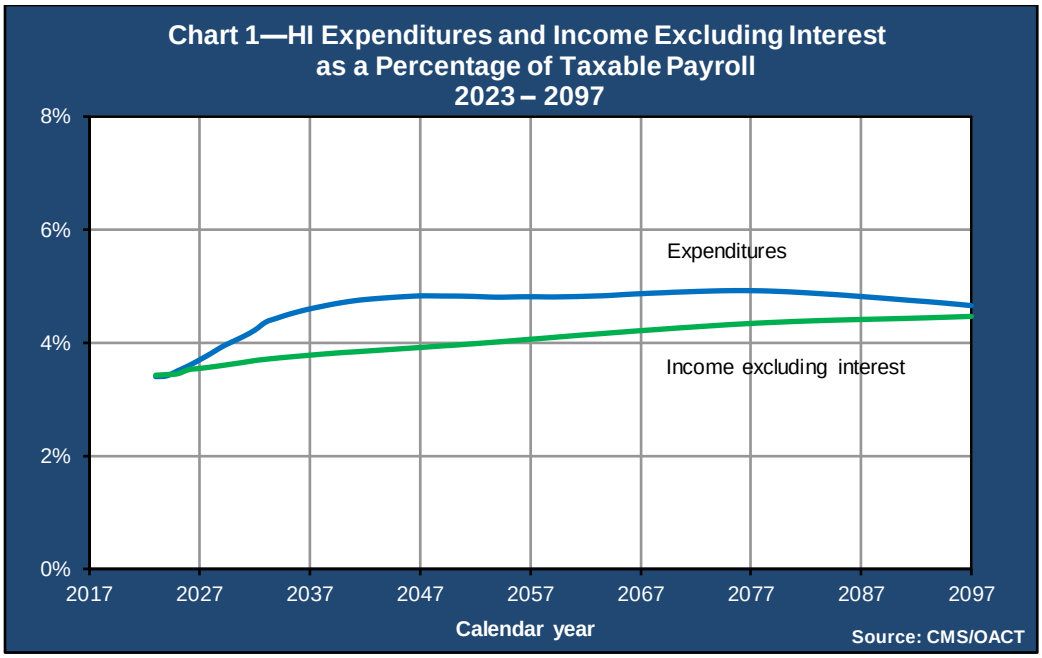
After combining the rates of growth from the four long-range assumptions, the weighted average cost growth rate for Part B is 3.8 percent in 2047, or GDP plus 0.2 percent, declining to 3.7 percent by 2097, or GDP plus 0.0 percent. When Parts A, B, and D are combined, the weighted average cost growth rate for Medicare is 3.8 percent, or GDP plus 0.2 percent in 2047, declining to 3.6 percent, or GDP plus 0.1 percent by 2097.

HI Cash Flow as a Percentage of Taxable Payroll

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

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI cost rates are lower than those from last year for all years because of (i) lower healthcare utilization through 2032 due to updated expectations for healthcare spending following the COVID-19 pandemic and (ii) higher taxable payroll in most years resulting from the changing economic and demographic assumptions.

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



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

In 2023 and beyond, as indicated in Chart 1, the cost rate is projected to rise, primarily due to the continued retirements of those in the baby boom generation and partly due to an acceleration of health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.5 percent through 2032 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 5.2 percent in 2048 and 7.0 percent in 2097.

[17]See section V.C7 of the *2023 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds* for more detailed information on the projection of income from taxation of Social Security benefits.

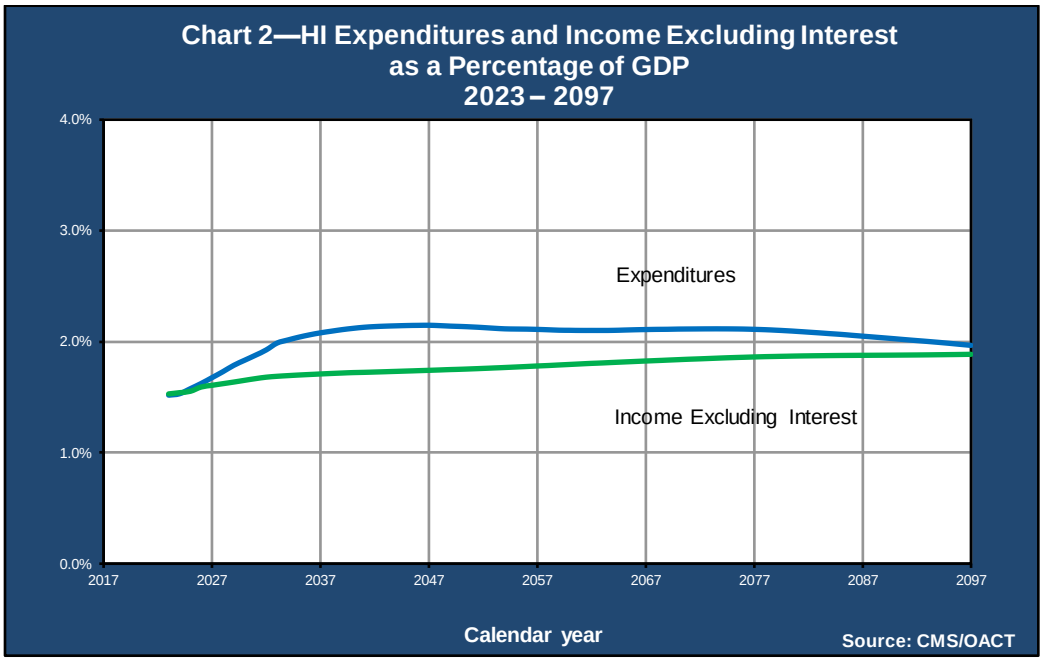
HI and SMI Cash Flow as a Percentage of GDP

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

HI

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2022, the expenditures were $342.7 billion, which was 1.3 percent of GDP.

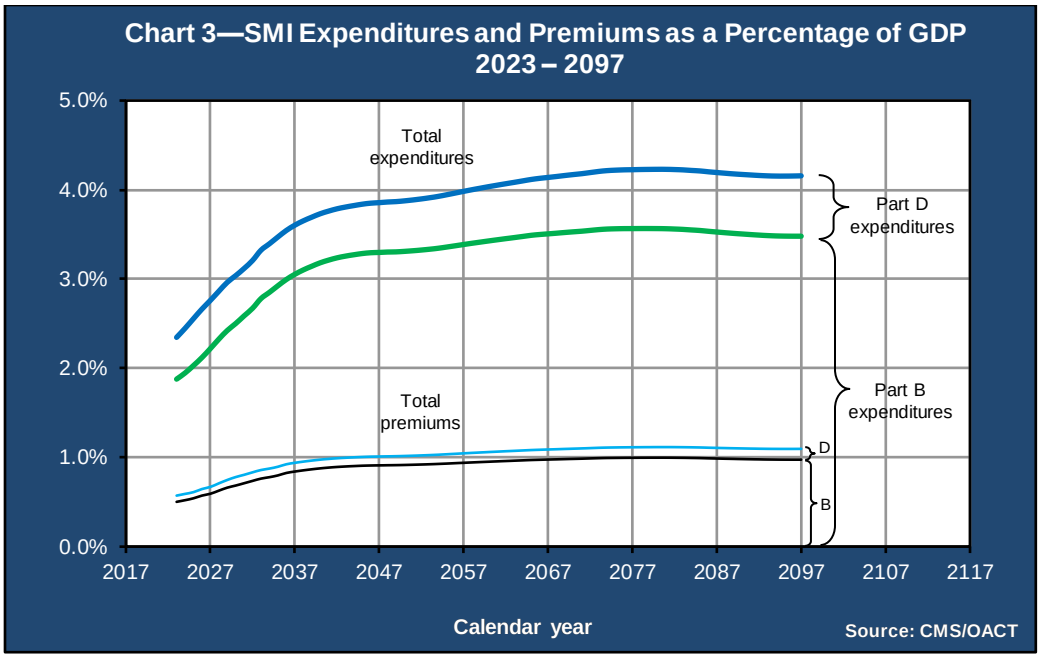
As Chart 2 illustrates, this percentage is projected to increase steadily until about 2046 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.0 percent in 2097.



SMI

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

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



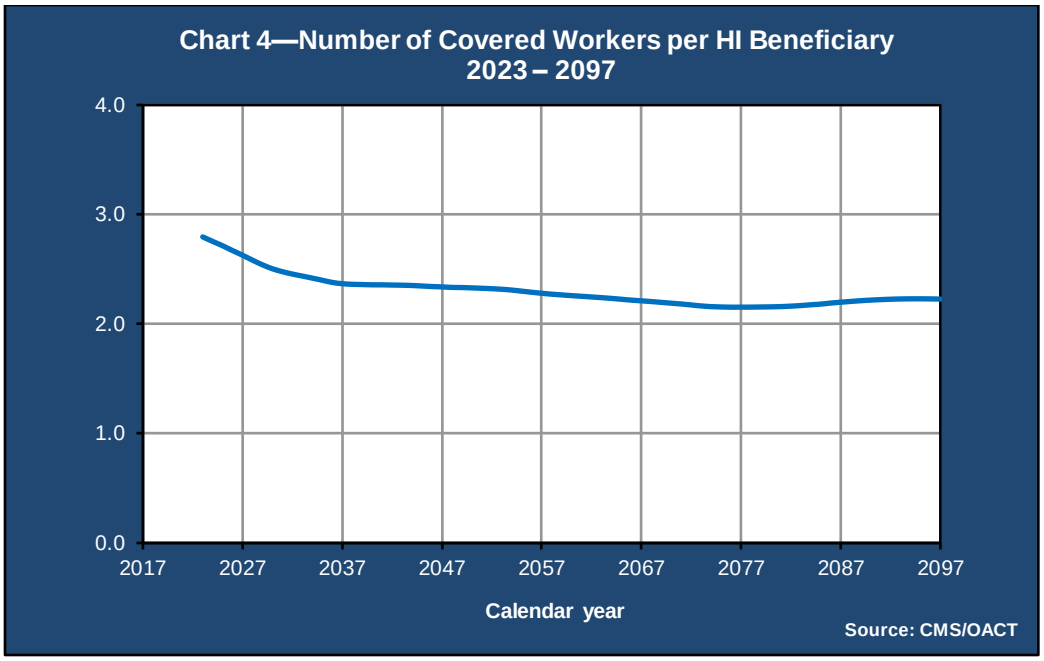
In 2022, SMI expenditures were $562.4 billion, or about 2.2 percent of GDP. Under current law, they would grow to about 3.9 percent of GDP within 25 years and to 4.2 percent by the end of the projection period, as demonstrated in Chart 3. Under the illustrative alternative, total SMI expenditures in 2097 would be 5.3 percent of GDP.

To match the faster growth rates for SMI expenditures, government contributions and beneficiary premiums would increase more rapidly than GDP over time but at a slower rate compared to the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2022 by about 4.2 percent annually. The associated beneficiary premiums—and general fund financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. State payments have increased faster than GDP for almost every year since 2015 and are projected to do so for most of the long-range period; for most of the short-range period, however, they are projected to increase more slowly than GDP.

Worker-to-Beneficiary Ratio

HI

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



In 2022, 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 2097.

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 growth, CPI, real-interest rate, fertility rate, and net immigration.[19]

For this analysis, the intermediate economic and demographic assumptions in the 2023 Medicare Trustees Report are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All

[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.

present values are calculated as of January 1, 2023 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values decrease through the first 20 to 25 years of the projection period, at which point they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process for computing present values, which is used to help interpret the net cash flow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Healthcare Cost Factors

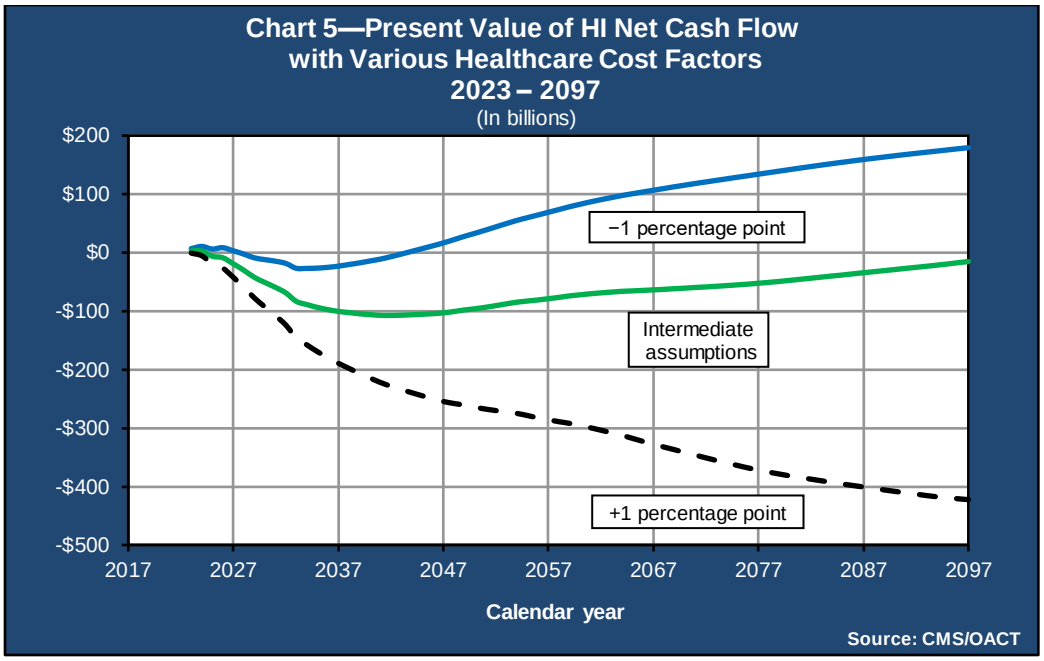
Table 1 shows the net present value of cash flow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered healthcare services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, 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)	$5,601	-$4,630	-$21,021

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by approximately $10,230 billion. On the other hand, if the ultimate growth rate assumption is approximately 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by about $16,392 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 Growth

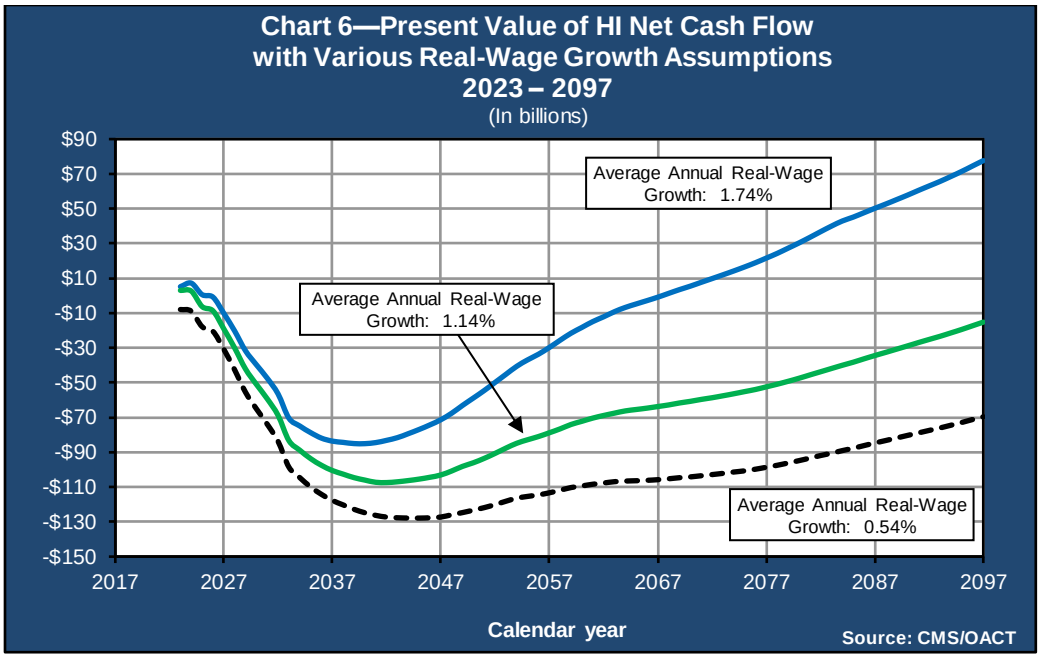
Table 2 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage growth assumptions: 0.54, 1.14, and 1.74 percentage points.[20] In each case, the assumed ultimate annual increase in the CPI is 2.4 percent.

Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Growth Assumptions			
Ultimate percentage increase in real-wage growth	0.54	1.14	1.74
Income minus expenditures (in billions)	−$7,186	−$4,630	−$850

As indicated in Table 2, for a half-point increase in the ultimate real-wage growth assumption, the deficit—expressed in present-value dollars—decreases by approximately $3,150 billion. Conversely, for a half-point decrease in the ultimate real-wage growth assumption, the deficit increases by about $2,130 billion.

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

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



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

Consumer Price Index

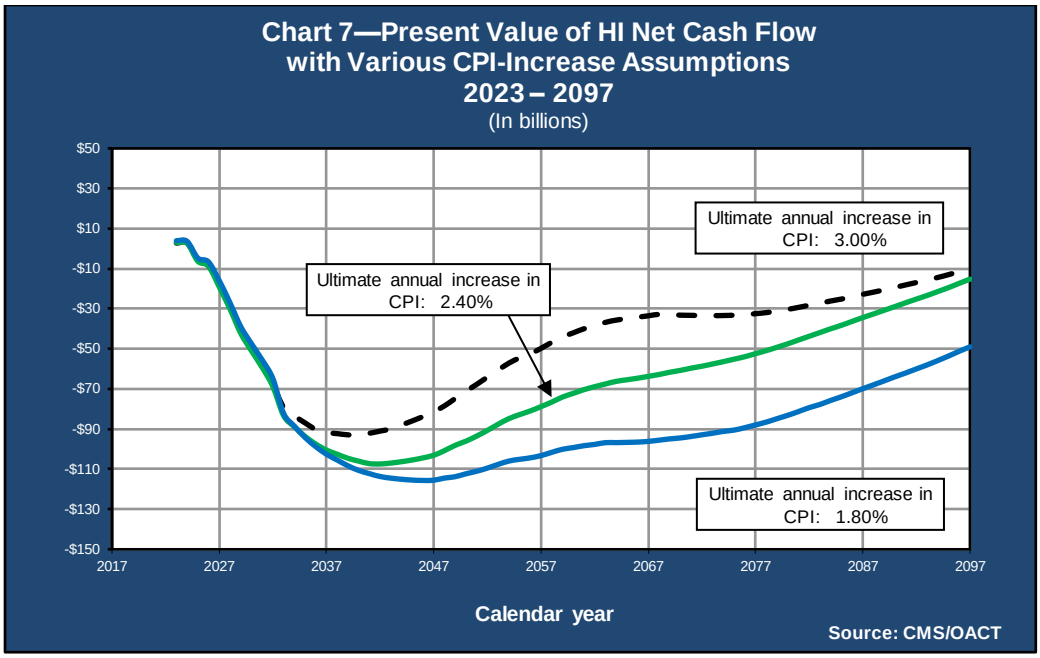
Table 3 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.0, 2.4, and 1.8 percent. In each case, the ultimate real-wage growth assumption is 1.14 percent.

Table 3—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in CPI	3.00	2.40	1.80
Income minus expenditures (in billions)	−$3,383	−$4,630	−$6,208

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.0 percent, the deficit decreases by $1,247 billion. On the other hand, if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by about $1,579 billion.

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



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

Real-Interest Rate

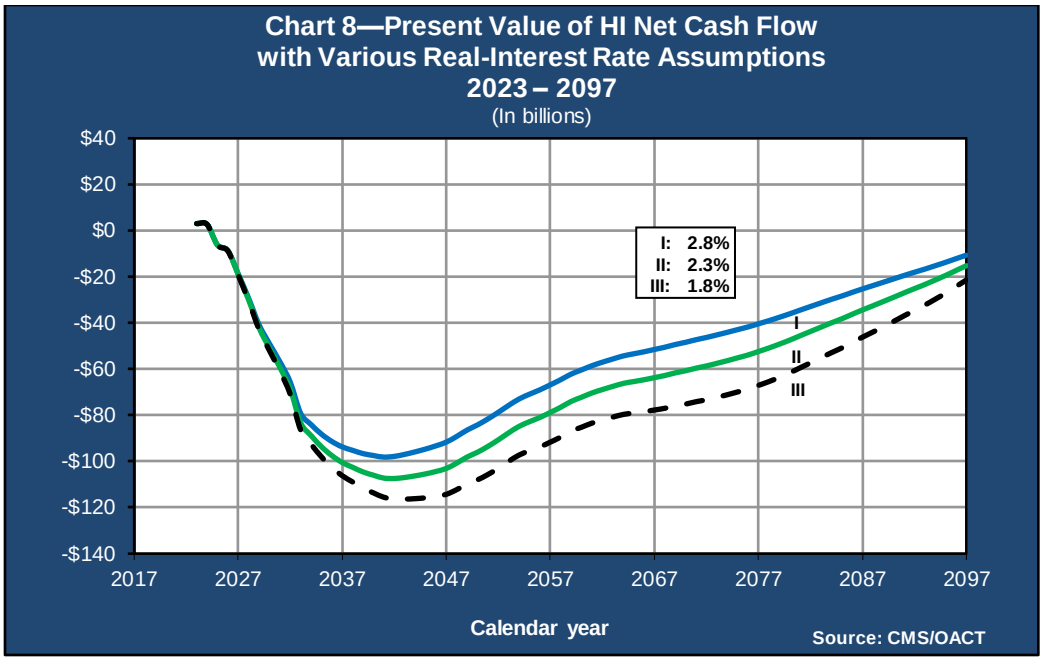
Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 1.8, 2.3, and 2.8 percent. In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, which results in ultimate annual yields of 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)	-$5,374	-$4,630	-$3,963

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 2031. 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.

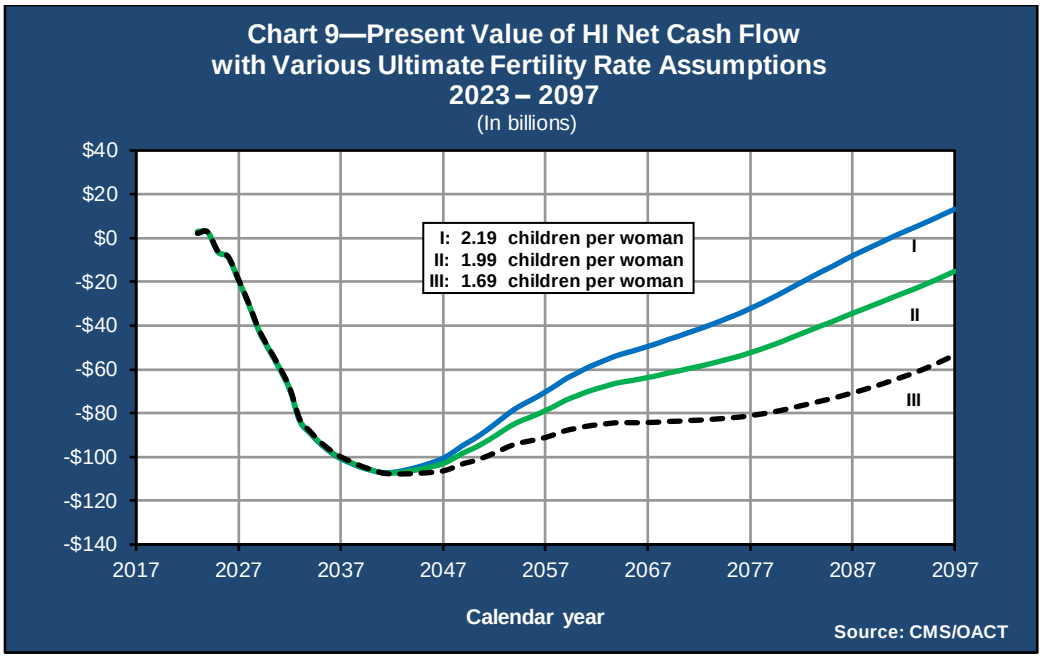
Table 5—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.69	1.99	2.19
Income minus expenditures (in billions)	−$5,845	−$4,630	−$3,764

[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 $420 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

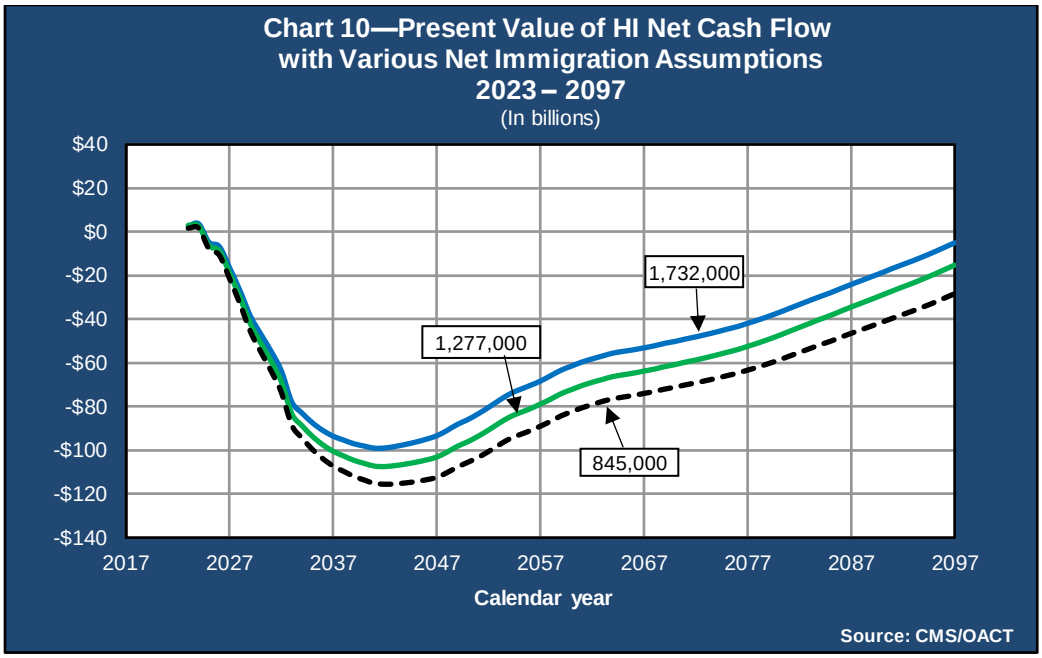
Table 6 illustrates the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 845,000 persons, 1,277,000 persons, and 1,732,000 persons per year.

Table 6—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	845,000	1,277,000	1,732,000
Income minus expenditures (in billions)	−$5,316	−$4,630	−$3,962

As indicated in Table 6, if the average annual net immigration assumption is 845,000 persons, the deficit—expressed in present-value dollars—increases by approximately $687 billion. Conversely, if the assumption is 1,732,000 persons, the deficit decreases by about $667 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 more favorable than the projections in last year's Medicare Trustees Report. The estimated depletion date for the HI trust fund is 2031, 3 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 through the short-range period mainly as a result of updated expectations for healthcare spending following the COVID-19 pandemic.

HI expenditures exceeded income each year from 2008 through 2015. In 2016 and 2017, however, there were fund surpluses amounting to $5.4 billion and $2.8 billion, respectively. In 2018, 2019, and 2020, expenditures again exceeded income, with trust fund deficits of $1.6 billion, $5.8 billion, and $60.4 billion, respectively. The large deficit in 2020 was mostly due to accelerated and advance payments to providers from the trust fund. In 2021, there was a small surplus of $8.5 billion as these payments began to be repaid to the trust fund, and this continued repayment resulted in a larger surplus in 2022 of $53.9 billion. The Trustees project deficits beginning in 2025 and continuing until the trust fund becomes depleted in 2031. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to healthcare services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

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

SMI

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

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

Medicare Overall

Federal law requires that the Board of Trustees issue a determination of excess general revenue Medicare funding if they project that under current law the difference between program outlays and dedicated financing sources[21] will exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2023–2029). For the 2023 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 2025 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 2022 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 2023 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policymakers to "work closely together to expeditiously address these challenges."

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

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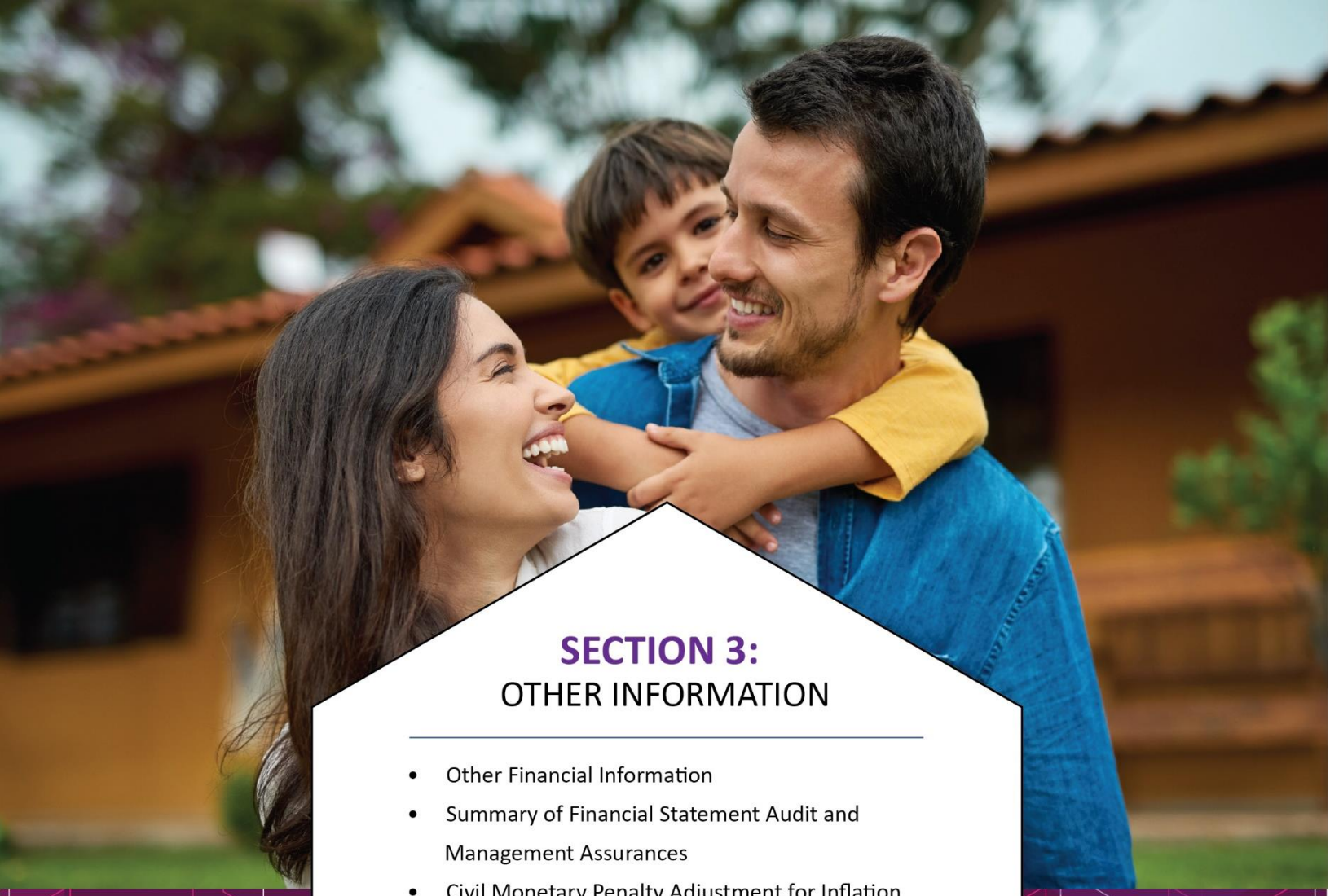

SECTION 3:
OTHER INFORMATION

- Other Financial Information
- Summary of Financial Statement Audit and Management Assurances
- Civil Monetary Penalty Adjustment for Inflation
- Grants Closeout Report
- Payment Integrity Report
- FY 2023 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, 2023

(in Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)							
Intragovernmental Assets							
Fund Balance with Treasury (Note 3)	$ 19,816	$ 340,881	$ 280,536	$ 54,406	$ 695,639	$ -	$ 695,639
Investments, Net (Note 4)	-	4,451	355,929	-	360,380	-	360,380
Accounts Receivable, Net (Note 5)	449	9,117	118,273	-	127,839	(127,053)	786
Advances and Prepayments (Note 8)	163	1,886	-	1,133	3,182	(630)	2,552
Total Intragovernmental Assets	**20,428**	**356,335**	**754,738**	**55,539**	**1,187,040**	**(127,683)**	**1,059,357**
Other than Intragovernmental Assets							
Accounts Receivable, Net (Note 5)	-	14,602	24,555	39	39,196	-	39,196
Inventory and Related Property, Net (Note 6)	-	27,829	-	-	27,829	-	27,829
Property, Plant and Equipment, Net (Note 7)	-	7,967	432	-	8,399	-	8,399
Advances and Prepayments (Note 8)	-	19	45,119	39	45,177	-	45,177
Other Assets	-	511	-	-	511	-	511
Total Other than Intragovernmental Assets	**-**	**50,928**	**70,106**	**78**	**121,112**	**-**	**121,112**
Total Assets	**$ 20,428**	**$ 407,263**	**$ 824,844**	**$ 55,617**	**$ 1,308,152**	**$ (127,683)**	**$ 1,180,469**
Stewardship Land (Note 21)							
Liabilities (Note 9)							
Intragovernmental Liabilities							
Accounts Payable	$ 11	$ 612	$ 127,916	$ 4	$ 128,543	$ (126,967)	$ 1,576
Debt (Note 10)	-	418	2,854	-	3,272	-	3,272
Advances from Others and Deferred Revenue	14	987	-	-	1,001	(629)	372
Other Liabilities (Note 14)	2	1,630	-	25	1,657	(87)	1,570
Total Intragovernmental Liabilities	**27**	**3,647**	**130,770**	**29**	**134,473**	**(127,683)**	**6,790**
Other than Intragovernmental Liabilities							
Accounts Payable	17	1,607	173	5	1,802	-	1,802
Entitlement Benefits Due and Payable (Note 11)	1	53,322	106,220	-	159,543	-	159,543
Federal Employee and Veteran Benefits Payable (Note 12)	20	20,342	7	8	20,377	-	20,377
Environmental and Disposal Liabilities	-	384	-	-	384	-	384
Advances from Others and Deferred Revenue	-	1,386	1,859	-	3,245	-	3,245
Other Liabilities:							
Accrued Liabilities (Note 13)	725	16,022	-	688	17,435	-	17,435
Contingencies and Commitments (Note 15)	-	17,088	10,400	-	27,488	-	27,488
Other Liabilities (Note 14)	3	886	2	25	916	-	916
Total Other than Intragovernmental Liabilities	**766**	**111,037**	**118,661**	**726**	**231,190**	**-**	**231,190**
Total Liabilities	**793**	**114,684**	**249,431**	**755**	**365,663**	**(127,683)**	**237,980**
Net Position							
Unexpended Appropriations – Funds from Dedicated Collections (Note 20)	-	3,706	271,601	-	275,307	-	275,307
Unexpended Appropriations – Funds from Other Than Dedicated Collections	19,505	251,897	-	54,812	326,214	-	326,214
Total Unexpended Appropriations	**19,505**	**255,603**	**271,601**	**54,812**	**601,521**	**-**	**601,521**
Cumulative Results of Operations – Funds from Dedicated Collections (Note 20)	-	21,230	303,812	-	325,042	-	325,042
Cumulative Results of Operations – Funds from Other Than Dedicated Collections	130	15,746	-	50	15,926	-	15,926
Total Cumulative Results of Operations	**130**	**36,976**	**303,812**	**50**	**340,968**	**-**	**340,968**
Total Net Position	**19,635**	**292,579**	**575,413**	**54,862**	**942,489**	**-**	**942,489**
Total Liabilities and Net Position	**$ 20,428**	**$ 407,263**	**$ 824,844**	**$ 55,617**	**$ 1,308,152**	**$ (127,683)**	**$ 1,180,469**

Other Financial Information

Consolidating Statement of Net Cost by Budget Function

For the Year Ended September 30, 2023
(in Millions)

Responsibility Segments	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra HHS Eliminations		Consolidated Totals
						Cost (-)	Revenue	
ACF	$ 17,373	$ -	$ -	$ 70,819	$ 88,192	$ (307)	$ 21	$ 87,906
ACL	3,013	-	-	-	3,013	(14)	3	3,002
AHRQ	-	352	-	-	352	(19)	12	345
CDC	-	17,699	-	-	17,699	(528)	228	17,399
CMS	-	635,299	864,330	-	1,499,629	(487)	23	1,499,165
FDA	-	4,032	-	-	4,032	(388)	13	3,657
HRSA	-	15,635	-	-	15,635	(310)	13	15,338
IHS	-	7,803	-	-	7,803	(262)	326	7,867
NIH	-	44,819	-	-	44,819	(273)	1,160	45,706
OS	-	24,173	-	-	24,173	(869)	544	23,848
PSC	-	1,656	-	-	1,656	(125)	934	2,465
SAMHSA	-	8,296	-	-	8,296	(51)	-	8,245
Totals	**$ 20,386**	**$ 759,764**	**$ 864,330**	**$ 70,819**	**$ 1,715,299**	**$ (3,633)**	**$ 3,277**	**$ 1,714,943**

Gross Cost and Earned Revenue

For the Year Ended September 30, 2023
(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	$ 1,294	$ (307)	$ 987	$ (36)	$ 21	$ (15)	$ 86,955	$ (21)	$ 87,906
ACL	33	(14)	19	(3)	3	-	2,983	-	3,002
AHRQ	47	(19)	28	(12)	12	-	325	(8)	345
CDC	1,489	(528)	961	(350)	228	(122)	16,880	(320)	17,399
CMS	1,342	(487)	855	(51)	23	(28)	1,653,192	(154,854)	1,499,165
FDA	1,836	(388)	1,448	(26)	13	(13)	5,238	(3,016)	3,657
HRSA	470	(310)	160	(13)	13	-	15,230	(52)	15,338
IHS	918	(262)	656	(377)	326	(51)	9,461	(2,199)	7,867
NIH	1,956	(273)	1,683	(1,305)	1,160	(145)	44,854	(686)	45,706
OS	18,855	(869)	17,986	(600)	544	(56)	5,933	(15)	23,848
PSC	570	(125)	445	(1,177)	934	(243)	2,265	(2)	2,465
SAMHSA	111	(51)	60	(50)	-	(50)	8,230	5	8,245
Totals	**$ 28,921**	**$ (3,633)**	**$ 25,288**	**$ (4,000)**	**$ 3,277**	**$ (723)**	**$ 1,851,546**	**$ (161,168)**	**$ 1,714,943**

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*.

Table 1: Summary of Financial Statement Audit

Audit Opinion			Unmodified for Four Financial Statements and Disclaimed Opinion on Statement of Social Insurance and Statement of Changes in Social Insurance Amounts		
Restatement			No		
Material Weakness	Beginning Balance	New	Resolved	Consolidated	Ending Balance
None	0	-	-	-	0
Total Material Weakness	*0*	-	-	-	*0*

Definition of Terms – Tables 1 And 2

(Reference: Office of Management and Budget [OMB] Circular A-136, *Financial Reporting Requirements*, May 19, 2023, page 109)

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 will be the beginning balance next year.

Summary of Financial Statement Audit and Management Assurances

Table 2: Summary of Management Assurances

Effectiveness of Internal Control over Reporting (FMFIA Section 2)

Statement of Assurance	Unmodified					
Material Weakness	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
No Material Weakness Noted	0	-	-	-	-	0
Total Material Weakness	*0*	*-*	*-*	*-*	*-*	*0*

Effectiveness of Internal Control over Operations and Compliance with Laws and Regulations (FMFIA Section 2)

Statement of Assurance	Modified					
Material Weakness/ Noncompliance	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Payment Integrity Information Act of 2019* (PIIA)	2	-	0	-	-	2
Social Security Act*	1	-	1	-	-	0
Total Material Weakness/ Noncompliance	*3*	*-*	*1*	*-*	*-*	*2*

*HHS identified a material noncompliance with PIIA resulting from (a) not reporting improper payment (IP) estimates for the Temporary Assistance for Needy Families (TANF) and Foster Care programs; and (b) not reporting IP estimates below the statutory threshold of 10 percent for the Children's Health Insurance Program (CHIP).

**In FY 2023, HHS resolved the material noncompliance with the *Social Security Act* of not meeting the Medicare Appeals Process 90-day statutory decision timeframe. This was achieved by reducing the appeals backlog at Level 3, Office of Medicare Hearings and Appeals, to a manageable level. Though HHS still faces difficulties in meeting the statutory decision timeframes at Level 4, Department of Appeals Board, funding and resources were allocated from Level 3 to Level 4 in FY 2023 to address this issue. This trend will continue in future years.

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
None	0	-	-	-	-	0
Total Noncompliance	*0*	*-*	*-*	*-*	*-*	*0*

Compliance with Section 803(a) of the *Federal Financial Management Improvement Act of 1996*

	Agency	Auditor
1. Federal Financial Management System Requirements	No Lack of Compliance	No Lack of Compliance
2. Applicable Federal Accounting Standards	No Lack of Compliance	No Lack of Compliance
3. U.S. Standard General Ledger at Transaction Level	No Lack of Compliance	No Lack of Compliance

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 (unaudited) 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)	2022	2023	$ 1,818

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)	2022	2023	$ 17,717

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)	2022	2023	$ 6,813

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)	2022	2023	$ 123,965
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)	2022	2023	2,479,282
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)	2022	2023	247,929
Penalty for any person who violates a requirement related to devices for each such violation.	21 U.S.C. 333(f)(1)(A)	2022	2023	33,483
Penalty for aggregate of all violations related to devices in a single proceeding.	21 U.S.C. 333(f)(1)(A)	2022	2023	2,232,281
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)	2022	2023	94,128

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2022	2023	470,640
Penalty for aggregate of all such violations related to adulterated food adjudicated in a single proceeding.	21 U.S.C. 333(f)(2)(A)	2022	2023	941,280
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)	2022	2023	14,262
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)	2022	2023	14,262
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)	2022	2023	356,580
Penalty for aggregate of all such above violations in a single proceeding.	21 U.S.C. 333(f)(4)(A)(i)	2022	2023	1,426,319
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)	2022	2023	356,580
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)	2022	2023	1,426,319
Penalty for aggregate of all such above violations adjudicated in a single proceeding.	21 U.S.C. 333(f)(4)(A)(ii)	2022	2023	14,263,186
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)	2022	2023	20,678
Penalty for aggregate of all such violations of tobacco product requirement adjudicated in a single proceeding.	21 U.S.C. 333(f)(9)(A)	2022	2023	1,378,541
Penalty per violation related to violations of tobacco requirements.	21 U.S.C. 333(f)(9)(B)(i)(I)	2022	2023	344,636
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)	2022	2023	1,378,541
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)	2022	2023	344,636
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)	2022	2023	1,378,541
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)	2022	2023	13,785,420
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)	2022	2023	344,636
Penalty for aggregate of for all such above violations adjudicated in a single proceeding.	21 U.S.C. 333(f)(9)(B)(ii)(I)	2022	2023	1,378,541
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)	2022	2023	344,636

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2022	2023	1,378,541
Penalty for aggregate above tobacco product requirement violations adjudicated in a single proceeding.	21 U.S.C. 333(f)(9)(B)(ii)(II)	2022	2023	13,785,420
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)	2022	2023	356,580
Penalty for each subsequent above violation in any 3-year period.	21 U.S.C. 333(g)(1)	2022	2023	713,160
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	2022	2023	345
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	2022	2023	687
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	2022	2023	2,757
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	2022	2023	6,892
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	2022	2023	13,785
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	2022	2023	345
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	2022	2023	687
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	2022	2023	1,379
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	2022	2023	2,757
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	2022	2023	6,892
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	2022	2023	13,785
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)	2022	2023	525,406
Penalty in the case of any other person (other than an individual) per above violation.	21 U.S.C. 335b(a)	2022	2023	2,101,618
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)	2022	2023	3,446
Penalty imposed for any related series of violations of requirements relating to electronic products.	21 U.S.C. 360pp(b)(1)	2022	2023	1,174,680
Penalty per day for violation of order of recall of biological product presenting imminent or substantial hazard.	42 U.S.C. 262(d)	2022	2023	270,180
Penalty for failure to obtain a mammography certificate as required.	42 U.S.C. 263b(h)(3)	2022	2023	21,018

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2022	2023	270,180

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	2022	2023	$ 323
Per Day (Maximum)	42 U.S.C. 300gg-18, 1302	2022	2023	5,926
Per day penalty for a hospital's non-compliance with making public standard charges for hospital items and services.	42 U.S.C. 300gg-18, 1302	2022	2023	328
Per day penalty for hospitals with equal to or less than 30 beds.	42 U.S.C. 300gg-18, 1302	2022	2023	323
Per day, per bed penalty for hospitals having at least 31 and up to and including 550 beds.	42 U.S.C. 300gg-18, 1302	2022	2023	11
Per day penalty for hospitals having greater than 550 beds.	42 U.S.C. 300gg-18, 1302	2022	2023	5,926
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)	2022	2023	323
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)	2022	2023	7,562
Maximum	42 U.S.C. 263a(h)(2)(B) & 1395w-2(b)(2)(A)(ii)	2022	2023	24,793
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)	2022	2023	125
Maximum	42 U.S.C. 263a(h)(2)(B) & 1395w-2(b)(2)(A)(ii)	2022	2023	7,437
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)	2022	2023	-
Each additional day of noncompliance	42 U.S.C. 263a(h)(2)(B) & 1395w-2(b)(2)(A)(ii)	2022	2023	-
Failure to provide the Summary of Benefits and Coverage.	45 U.S.C. 300gg-15(f)	2022	2023	1,362
Penalty for violations of regulations related to the medical loss ratio reporting and rebating.	45 U.S.C. 300gg-18	2022	2023	136
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	2022	2023	-

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalties for failure to comply with *No Surprises Act* requirements on providers, facilities, providers of air ambulance services.	42 U.S.C. 300gg-118 note, 300gg-134	2022	2023	11,445
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)	2022	2023	1,362
Maximum	42 U.S.C. 1320a-7h(b)(1)	2022	2023	13,625
Calendar Year Cap	42 U.S.C. 1320a-7h(b)(1)	2022	2023	204,384
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)	2022	2023	13,625
Maximum	42 U.S.C. 1320a-7h(b)(2)	2022	2023	136,258
Calendar Year Cap	42 U.S.C. 1320a-7h(b)(2)	2022	2023	1,362,567
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)	2022	2023	136,258
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)	2022	2023	681
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)	2022	2023	2,045
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)	2022	2023	4,087
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)	2022	2023	9,966
Penalty for violation of 42 U.S.C. 1320a-8(a)(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)	2022	2023	9,399
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)	2022	2023	7,805
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)	2022	2023	272,514
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)	2022	2023	408,769
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)	2022	2023	272,514
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)	2022	2023	184

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2022	2023	129
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2022	2023	7,752
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)	2022	2023	2,586
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2022	2023	25,847
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)	2022	2023	7,884
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2022	2023	25,847
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)	2022	2023	2,586
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2022	2023	25,847
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)	2022	2023	7,884
Per Day (Maximum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2022	2023	25,847
Per Instance (Minimum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2021	2023	2,586
Per Instance (Maximum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2022	2023	25,847
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)	2022	2023	7,884
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2022	2023	25,847

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2022	2023	129
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2022	2023	7,752
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)	2022	2023	2,586
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2022	2023	25,847
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)	2022	2023	1,158
Incremental increases for each subsequent occurrence	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2022	2023	579
Penalty for noncompliance by hospice program with requirements specified in Section 1395x(dd) of 42 U.S.C.	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	10,775
Adjustment to penalties. Maximum penalty assessment for each day a hospice is not in substantial compliance with one or more conditions of participation.	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	10,775
Penalty imposed for hospice condition-level deficiency that is immediate jeopardy. These amounts represent the upper range of penalty.	42 U.S.C. 1395i-6(c)(5)(B)(i)			
Minimum	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	9,158
Maximum	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	10,775
Penalty imposed for hospice condition-level deficiency that is immediate jeopardy. These amounts represent the upper range of penalty.	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	10,775
Penalty imposed for hospice condition-level deficiency that is immediate jeopardy. These amounts represent the upper range of penalty.	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	9,697
Penalty imposed for hospice condition-level deficiency that is immediate jeopardy. These amounts represent the upper range of penalty.	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	9,158
Penalty imposed for hospice repeat or condition-level deficiency or both that does not constitute immediate jeopardy but is directly related to poor quality patient care outcomes. These amounts represent the middle range of penalty.	42 U.S.C. 1395i-6(c)(5)(B)(i)			
Minimum	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	1,616
Maximum	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	9,158
Penalty imposed for hospice repeat or condition-level deficiency or both that does not constitute immediate jeopardy and are related predominantly to structure or process-oriented conditions rather than directly related to patient outcomes. These amounts represent the lower range of penalty.	42 U.S.C. 1395i-6(c)(5)(B)(i)			

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Minimum	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	539
Maximum	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	4,310
Penalty range imposed for per instance of hospice noncompliance.	42 U.S.C. 1395i-6(c)(5)(B)(i)			
Minimum	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	1,077
Maximum	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	10,775
Penalty for each per instance of hospice noncompliance, maximum per day per hospice program.	42 U.S.C. 1395i-6(c)(5)(B)(i)	2022	2023	10,775
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 1320a-7a(a)).	42 U.S.C. 1395l(h)(5)(D)	2022	2023	18,825
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. 1395l(i)(6)	2022	2023	4,960
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)	2022	2023	4,745
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 1320a-7a(a)).	42 U.S.C. 1395m(a)(11)(A)	2022	2023	18,825
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)	2022	2023	18,825
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)	2022	2023	18,825
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 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(h)(3)	2022	2023	18,825
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)	2022	2023	1,993
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 1320a-7a(a)).	42 U.S.C. 1395m(j)(4)	2022	2023	18,825

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2022	2023	12,551
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 1320a-7a(a)).	42 U.S.C. 1395m-1(a)	2022	2023	18,825
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)	2022	2023	18,825
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 1320a-7a(a)).	42 U.S.C. 1395u(b)(18)(B)	2022	2023	18,825
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)	2022	2023	18,825
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). (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(k)	2022	2023	18,825
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 1320a-7a(a)).	42 U.S.C. 1395u(l)(3)	2022	2023	18,825
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 1320a-7a(a)).	42 U.S.C. 1395u(m)(3)	2022	2023	18,825
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)	2022	2023	18,825
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 1320a-7a(a)).	42 U.S.C. 1395u(o)(3)(B)	2022	2023	18,825
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)	2022	2023	4,960

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2022	2023	16,108
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 1320a-7a(a)).	42 U.S.C. 1395w-4(g)(1)(B)	2022	2023	18,825
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 1320a-7a(a)).	42 U.S.C. 1395w-4(g)(3)(B)	2022	2023	18,825
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)	2022	2023	46,102
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)	2022	2023	18,442
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)	2022	2023	171,257
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)	2022	2023	11,162
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)	2022	2023	1,818
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)	2022	2023	3,988
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)	2022	2023	1,428
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)	2022	2023	1,428
Penalty for any person that fails to report information required by HHS under Section 1877(f) concerning ownership, investment, and compensation arrangements.	42 U.S.C. 1395nn(g)(5)	2022	2023	23,727
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)	2022	2023	18,825
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)	2022	2023	64,617

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)	2022	2023	33,483
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)	2022	2023	55,808
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)	2022	2023	33,483
Penalty for issuer that sells or issues a Medicare supplemental policy without an acknowledgement form.	42 U.S.C. 1395ss(d)(3)(B)(iv)	2022	2023	55,808
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)	2022	2023	33,483
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)	2022	2023	55,808
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)	2022	2023	33,483
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)	2022	2023	55,808
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)	2022	2023	55,808
Penalty for any person that fails to provide refunds or credits as required by Section 1882(r)(1)(B).	42 U.S.C. 1395ss(r)(6)(A)	2022	2023	55,808
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)	2022	2023	23,692
Penalty for any issuer of a Medicare supplemental policy that fails to fulfill listed responsibilities.	42 U.S.C. 1395ss(t)(2)	2022	2023	55,808
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)	2022	2023	24,163
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)	2022	2023	40,272
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)	2022	2023	5,171
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)	2022	2023	24,793
Penalty per day for home health agency's noncompliance (Upper Range):	42 U.S.C. 1395bbb(f)(2)(A)(i)			
Minimum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2022	2023	21,074
Maximum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2022	2023	24,793
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)	2022	2023	24,793
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)	2022	2023	22,313
Penalty for an isolated incident of noncompliance in violation of established Home Health Agency policy.	42 U.S.C. 1395bbb(f)(2)(A)(i)	2022	2023	21,074

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2022	2023	3,720
Maximum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2022	2023	21,074
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)	2022	2023	1,240
Maximum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2022	2023	2,479
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)			
Penalty for each day of noncompliance (Minimum)	42 U.S.C. 1395bbb(f)(2)(A)(i)	2022	2023	2,479
Penalty for each day of noncompliance (Maximum)	42 U.S.C. 1395bbb(f)(2)(A)(i)	2022	2023	24,793
Penalty for each day of noncompliance (Maximum)	42 U.S.C. 1395bbb(f)(2)(A)(i)	2022	2023	24,793
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)	2022	2023	46,102
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)	2022	2023	17,370
Maximum	42 U.S.C. 1395eee(e)(6)(B); 1396u-4(e)(6)(B)	2022	2023	115,802
Penalty for a PACE organization that charges excessive premiums.	42 U.S.C. 1395eee(e)(6)(B); 1396u-4(e)(6)(B)	2022	2023	46,102
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)	2022	2023	184,412
Penalty for any other violation specified in 42 C.F.R. 460.40.	42 U.S.C. 1395eee(e)(6)(B); 1396u-4(e)(6)(B)	2022	2023	46,102
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)	2022	2023	129
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2022	2023	7,752
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)	2022	2023	2,586
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2022	2023	25,847
Penalty per day for a nursing facility's failure to meet Category 3 certification:	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2022	2023	7,884
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2022	2023	25,847
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)	2022	2023	2,586
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2022	2023	25,847
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)	2022	2023	2,586
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2022	2023	25,847
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)	2022	2023	7,884
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2022	2023	25,847
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)	2022	2023	129
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2022	2023	7,752
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)	2022	2023	2,586
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2022	2023	25,847
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)	2022	2023	1,158
Incremental increases for each subsequent occurrence	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2022	2023	579
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)	2022	2023	12,924
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)	2022	2023	12,924
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)	2022	2023	2
Maximum	42 U.S.C. 1396t(j)(2)(C)	2022	2023	22,324
Penalty for a MCO that fails substantially to provide medically necessary items and services.	42 U.S.C. 1396u-2(e)(2)(A)(i)	2022	2023	46,102
Penalty for Medicaid MCO 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)	2022	2023	46,102

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for a Medicaid MCO that misrepresents or falsifies information to another individual or entity.	42 U.S.C. 1396u-2(e)(2)(A)(i)	2022	2023	46,102
Penalty for a Medicaid MCO that fails to comply with the applicable statutory requirements for such organizations.	42 U.S.C. 1396u-2(e)(2)(A)(i)	2022	2023	46,102
Penalty for a Medicaid MCO that misrepresents or falsifies information to the HHS Secretary.	42 U.S.C. 1396u-2(e)(2)(A)(ii)	2022	2023	184,412
Penalty for Medicaid MCO that acts to discriminate among enrollees on the basis of their health status.	42 U.S.C. 1396u-2(e)(2)(A)(ii)	2022	2023	184,412
Penalty for each individual that does not enroll as a result of a Medicaid MCO that acts to discriminate among enrollees on the basis of their health status.	42 U.S.C. 1396u-2(e)(2)(A)(iv)	2022	2023	27,661
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)	2022	2023	25,847
Penalty for each day, for each individual affected by the failure of a health insurance issuer or non-Federal governmental group health plan to comply with federal market reform provisions in part A or D of title XXVII of the PHS Act | 2022 | 174 | 177.	42 U.S.C. 1396w-2(c)(1)	2022	2023	13,785
Penalty for each day, for each individual affected by the failure of a health insurance issuer or non-Federal governmental group health plan to comply with federal market reform provisions in part A or D of title XXVII of the PHS Act.	42 U.S.C. 300gg-22(b)(2)(C)(i)	2022	2023	177
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)	2022	2023	187
Penalty for providing false information on Exchange application.	42 U.S.C. 18081(h)(1)(A)(i)(II)	2022	2023	34,065
Penalty for knowingly or willfully providing false information on Exchange application.	42 U.S.C. 18081(h)(1)(B)	2022	2023	340,641
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)	2022	2023	34,065
Maximum	42 U.S.C. 18081(h)(2)	2022	2023	348
Penalties for violation of applicable Exchange standards by consumer assistance entities in Federally-facilitated Exchanges:	42 U.S.C. 18041(c)(2)	2022	2023	41,774
Maximum (Per Day)	42 U.S.C. 18041(c)(2)	2022	2023	115

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)	2022	2023	$ 14,960
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)	2022	2023	187
Calendar Year Cap	42 U.S.C. 299b-22(f)(1)	2022	2023	47,061
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 U.S.C. 1320(d)-5(a)			
Minimum	42 U.S.C. 1320(d)-5(a)	2022	2023	137
Maximum	42 U.S.C. 1320(d)-5(a)	2022	2023	68,928
Calendar Year Cap	42 U.S.C. 1320(d)-5(a)	2022	2023	2,067,813
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)	2022	2023	1,379
Maximum	42 U.S.C. 1320(d)-5(a)	2022	2023	68,928
Calendar Year Cap	42 U.S.C. 1320(d)-5(a)	2022	2023	2,067,813
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)	2022	2023	13,785
Maximum	42 U.S.C. 1320(d)-5(a)	2022	2023	68,928
Calendar Year Cap	42 U.S.C. 1320(d)-5(a)	2022	2023	2,067,813
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)	2022	2023	68,928
Maximum	42 U.S.C. 1320(d)-5(a)	2022	2023	2,067,813
Calendar Year Cap	42 U.S.C. 1320(d)-5(a)	2022	2023	2,067,813

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	2022	2023	$ 23,727
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	2022	2023	23,727
Maximum	31 U.S.C. 1352	2022	2023	237,268
Penalty for the first time an individual fails to file or amend a lobbying disclosure form, absent aggravating circumstances.	31 U.S.C. 1352	2022	2023	23,727
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	2022	2023	23,727
Maximum	31 U.S.C. 1352	2022	2023	237,268
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	2022	2023	23,727
Maximum	31 U.S.C. 1352	2022	2023	237,268
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	2022	2023	23,727
Maximum	31 U.S.C. 1352	2022	2023	237,268
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	2022	2023	12,398
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	2022	2023	12,398

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)	2022	2023	$ 410,932
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)	2022	2023	821,868
Penalty per violation for committing information blocking.	42 U.S.C. 300jj-51	2022	2023	1,252,992
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)	2022	2023	24,164
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)	2022	2023	24,164

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2022	2023	36,246
Penalty for an excluded party retaining ownership or control interest in a participating entity.	42 U.S.C. 1320a-7a(a)	2022	2023	24,164
Penalty for remuneration offered to induce program beneficiaries to use particular providers, practitioners, or suppliers.	42 U.S.C. 1320a-7a(a)	2022	2023	24,164
Penalty for employing or contracting with an excluded individual.	42 U.S.C. 1320a-7a(a)	2022	2023	24,164
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)	2022	2023	120,816
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)	2022	2023	24,164
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)	2022	2023	120,816
Penalty for knowing of an overpayment and failing to report and return.	42 U.S.C. 1320a-7a(a)	2022	2023	24,164
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)	2022	2023	68,128
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)	2022	2023	36,246
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)	2022	2023	6,040
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)	2022	2023	6,040
Penalty for a physician who executes a document that falsely certifies home health needs for Medicare beneficiaries.	42 U.S.C. 1320a-7a(b)	2022	2023	12,081
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)	2022	2023	11,784
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)	2022	2023	58,921
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)	2022	2023	58,921
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)	2022	2023	61,458
Maximum per day	42 U.S.C. 1320a-7a(o)	2022	2023	12,308
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)	2022	2023	17,677

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2022	2023	46,102
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)	2022	2023	12,397
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)	2022	2023	61,982
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)	2022	2023	2,586
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)	2022	2023	12,924
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)	2022	2023	5,171
Penalty for a Medicare Advantage organization that substantially fails to provide medically necessary, required items and services.	42 U.S.C. 1395w-27(g)(2)(A)	2022	2023	47,061
Penalty for a MA organization that charges excessive premiums.	42 U.S.C. 1395w-27(g)(2)(A)	2022	2023	46,102
Penalty for a MA organization that improperly expels or refuses to reenroll a beneficiary.	42 U.S.C. 1395w-27(g)(2)(A)	2022	2023	46,102
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)	2022	2023	184,412
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)	2022	2023	27,661
Penalty for a MA organization misrepresenting or falsifying information to Secretary.	42 U.S.C. 1395w-27(g)(2)(A)	2022	2023	184,412
Penalty for a MA organization misrepresenting or falsifying information to individual or other entity.	42 U.S.C. 1395w-27(g)(2)(A)	2022	2023	46,102
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)	2022	2023	46,102
Penalty for a MA organization that employs or contracts with excluded individual or entity.	42 U.S.C. 1395w-27(g)(2)(A)	2022	2023	46,102
Penalty for a MA organization enrolling an individual in without prior written consent.	42 U.S.C. 1395w-27(g)(2)(A)	2022	2023	46,102
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)	2022	2023	46,102
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)	2022	2023	46,102
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)	2022	2023	46,102
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)	2022	2023	16,108
Penalty for improper billing by Hospitals, Critical Access Hospitals, or SNFs.	42 U.S.C. 1395cc(g)	2022	2023	6,266
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)	2022	2023	129,232
Penalty for a hospital with less than 100 beds dumping patients needing emergency medical care.	42 U.S.C. 1395dd(d)(1)	2022	2023	64,618
Penalty for a HMO or competitive medical plan if such plan substantially fails to provide medically necessary, required items or services.	42 U.S.C. 1395mm(i)(6)(B)(i)	2022	2023	64,618

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for HMOs/competitive medical plans that charge premiums in excess of permitted amounts.	42 U.S.C. 1395mm(i)(6)(B)(i)	2022	2023	64,618
Penalty for a 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)	2022	2023	64,618
Penalty for a 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)	2022	2023	258,464
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)	2022	2023	37,190
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)	2022	2023	258,464
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)	2022	2023	64,618
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)	2022	2023	64,618
Penalty for HMO that employs or contracts with excluded individual or entity.	42 U.S.C. 1395mm(i)(6)(B)(i)	2022	2023	59,316
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)	2022	2023	29,899
Penalty for circumvention schemes in violation of the Stark Law's restrictions on physician self-referrals.	42 U.S.C. 1395nn(g)(4)	2022	2023	199,338
Penalty for a material misrepresentation regarding Medigap compliance policies.	42 U.S.C. 1395ss(d)(1)	2022	2023	12,397
Penalty for selling Medigap policy under false pretense.	42 U.S.C. 1395ss(d)(2)	2022	2023	12,397
Penalty for an issuer that sells health insurance policy that duplicates benefits.	42 U.S.C. 1395ss(d)(3)(A)(ii)	2022	2023	55,808
Penalty for someone other than issuer that sells health insurance that duplicates benefits.	42 U.S.C. 1395ss(d)(3)(A)(ii)	2022	2023	33,483
Penalty for using mail to sell a non-approved Medigap insurance policy.	42 U.S.C. 1395ss(d)(4)(A)	2022	2023	12,397
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)	2022	2023	61,982
Penalty for a Medicaid MCO that charges excessive premiums.	42 U.S.C. 1396b(m)(5)(B)(i)	2022	2023	61,982
Penalty for a Medicaid MCO that improperly expels or refuses to reenroll a beneficiary.	42 U.S.C. 1396b(m)(5)(B)(i)	2022	2023	247,929
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)	2022	2023	37,190
Penalty for a Medicaid MCO misrepresenting or falsifying information to the Secretary.	42 U.S.C. 1396b(m)(5)(B)(i)	2022	2023	247,929
Penalty for a Medicaid MCO misrepresenting or falsifying information to an individual or another entity.	42 U.S.C. 1396b(m)(5)(B)(i)	2022	2023	61,982
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)	2022	2023	55,808
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)	2022	2023	2,586
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)	2022	2023	12,924
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)	2022	2023	5,171
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)	2022	2023	223,229
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)	2022	2023	22,324

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for knowing provision of false information by drug manufacturer with rebate agreement.	42 U.S.C. 1396r-8(b)(3)(C)(ii)	2022	2023	223,229
Penalty for notifying home and community-based providers or settings of survey.	42 U.S.C. 1396t(i)(3)(A)	2022	2023	4,465
Penalty for failing to report a medical malpractice claim to National Practitioner Data Bank.	42 U.S.C. 11131(c)	2022	2023	27,018
Penalty for breaching confidentiality of information reported to National Practitioner Data Bank.	42 U.S.C. 11137(b)(2)	2022	2023	27,018

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 2020 - 2021	3-5 Years FYs 2018 - 2020	More than 5 Years Before FY 2018
Number of Grants/Cooperative Agreements with Zero Dollar Balances	93	79	73
Number of Grants/Cooperative Agreements with Undisbursed Balances	613	571	490
Total Amount of Undisbursed Balances	**$506,617,105.46**	**$1,059,353,151.42**	**($296,285,886.42)[22]**

HHS continues to make grant 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 1,919 grant awards with POP end dates of September 30, 2021, 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, 2020, to the current requirement of September 30, 2021.

HHS remains committed to addressing and remediating the complexities that prevent the closeouts of open but expired accounts. During fiscal year (FY) 2023, an HHS project team continued its focus on open grant documents with expired POP dates greater than 5 years, reflecting a 73% decrease (from 2,077 to 563) in these grant documents originally reported in the FY 2022 AFR. 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 2024. Additionally, HHS will also utilize its Closeout Re-Engineering Council to improve the effectiveness and efficiency of the closeout process. The Closeout Re-Engineering Council is focusing on solutions in the areas of closeout policy, systems improvements, and enhanced training to support timely and accurate closeout of awards.

[22] HHS is currently working towards a resolution with a grant recipient that resulted in an abnormal balance.

Payment Integrity Report

OVERVIEW

An improper payment is any payment that does not meet legal requirements or is made in an incorrect amount and should not have been made. This encompasses payments to or for: ineligible recipients, ineligible goods or services, duplicates, unreceived goods or services (unless authorized by law), unauthorized payments, the wrong amount, and that fail to consider applicable discounts. An unknown payment is one where it is unclear if the payment is proper or improper due to insufficient documentation. If a program is still researching or reviewing a payment when it is time to complete its sampling and report results, that payment will be treated as an unknown payment for reporting that year. In improper payment estimation, unknown payments are both reported separately from the improper payment estimate and together in the improper payment plus unknown payment estimate.

HHS is committed to reducing improper and unknown payments across programs, enhancing services for recipients, and safeguarding taxpayer resources. The Department implements innovative solutions that target the underlying causes of improper and unknown payments while ensuring beneficiary access to health and human services.

HHS publishes detailed payment integrity information to PaymentAccuracy.gov. 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) 2023 Payment Integrity Report also includes detailed information on:

Payment Integrity Topics	
1.0	**Risk-Susceptible Programs**
2.0	**Payment Categories**
3.0	**Phases of Assessment:**
3.1	**• Phase 1: Risk Assessments**
3.2	**• Phase 2: Improper Payment Estimation & Reporting**
4.0	**Mitigation Strategies & Corrective Actions:**
4.1	**• Payment Integrity Efforts**
5.0	**Proper, Improper, and Unknown Payments for HHS's Risk-Susceptible Programs:**
5.1	**• Improper and Unknown Payment Performance**
6.0	**Improper and Unknown Payment Error Types**
7.0	**Program-Specific Reporting Information:**
7.1	**• Medicare Fee-for-Service (FFS) (Parts A and B)**
7.2	**• Medicare Advantage (Part C)**
7.3	**• Medicare Prescription Drug Benefit (Part D)**
7.4	**• Medicaid**
7.5	**• Children's Health Insurance Program (CHIP)**
7.6	**• Advance Premium Tax Credit (APTC)**
7.7	**• Provider Relief Fund (PRF) Payments**
7.8	**• COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program (UIP)**
7.9	**• Temporary Assistance for Needy Families (TANF)**
7.10	**• Foster Care**
7.11	**• Child Care and Development Fund (CCDF)**
7.12	**• Head Start**
8.0	**Recovery Auditing Reporting**

1.0 RISK-SUSCEPTIBLE PROGRAMS

HHS conducts risk assessments annually to identify programs that are susceptible to significant improper payments according to statutory thresholds. Annual improper payments and unknown payments, which include monetary and non-monetary loss improper payments, are considered significant if they exceed either:

1) 1.5 percent of program outlays and $10,000,000 in payments for the fiscal year reported, or
2) $100,000,000 irrespective of the improper payment percentage relative to total program outlays.

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 the states, to support enrollees in purchasing Qualified Health Plan coverage from state and federal Health Insurance Exchanges (Exchanges).
PRF	A federal program that provided payments to eligible healthcare providers for healthcare related expenses or lost revenues attributable to COVID-19.
UIP	A federal program that provided 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 low-income, preschool children ages three to five and their families.

OMB deems risk-susceptible programs as “high-priority” programs if the monetary loss estimates are over $100 million in a reporting year (RY). High-priority programs must fulfill additional requirements, including quarterly

reporting on activities to prevent and reduce improper payments. OMB designated the following seven programs as high-priority programs for 2023: Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, APTC, and PRF.

2.0 PAYMENT CATEGORIES

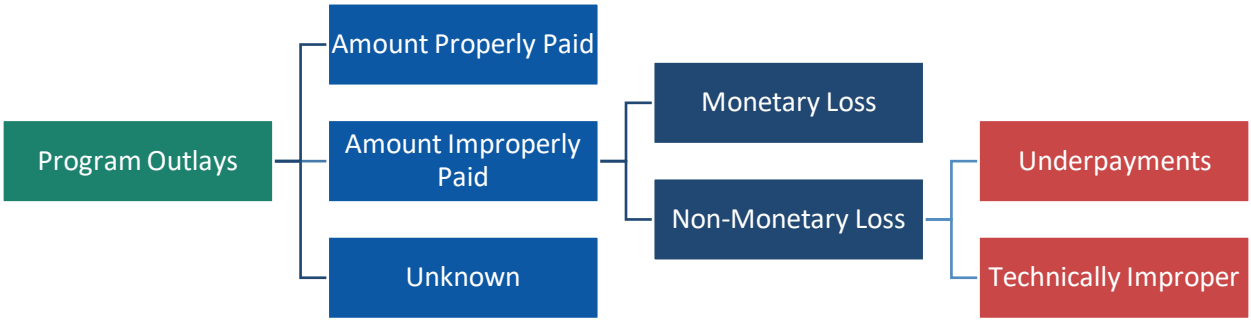
HHS estimates proper payments, improper payments, and unknown payments in its programs that are susceptible to significant improper payments. Under Appendix C of OMB Circular A-123, there are two types of improper payments:

1) **Monetary Loss:** Monetary loss is an overpayment. This is an amount that should not have been paid and is potentially recoverable.
2) **Non-monetary Loss:** Non-monetary loss can be an underpayment or technically improper payment, meaning a payment to the right recipient for the correct amount when the payment process did not comply with applicable regulations and statutes.

It is important to clarify that while payments resulting from fraud, waste, and abuse are improper payments, not all improper payments result from fraud. Moreover, improper payment estimates are not fraud estimates.

Figure 2 illustrates payment categories and improper payment types.

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 to determine susceptibility to significant improper payments) 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 and other information.

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. During FY 2023, to improve the improper payment risk assessment process, HHS updated the risk assessment questionnaire, the risk factor calculation, and Risk Assessment

Portal. HHS continued to develop policies, procedures, and supporting tools throughout FY 2023, particularly to facilitate coverage of all programs over $10 million in accordance with PIIA.

In FY 2023, HHS conducted 56 program-specific improper payment risk assessments 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 payment refer to PaymentAccuracy.gov.

3.2 PHASE 2: IP ESTIMATION & REPORTING

All risk-susceptible programs that reported improper payment estimates (e.g., Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, APTC, PRF, UIP, CCDF, and Head Start) complied with OMB guidance on sampling and estimation plans to produce a statistically valid methodology. In addition, two other risk-susceptible programs (e.g., Foster Care and TANF) are not reporting estimates for FY 2023.

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 the last three consecutive years.

In FY 2023, HHS updated the sampling and estimation methodology plans for Medicare FFS and Medicare Part D, established a new plan for Head Start, and implemented a previously completed plan for UIP. The statistical sampling and estimation processes—including any changes or updates in FY 2023—are detailed in Section 7.0: *Program-Specific Reporting Information*. 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 mitigation strategies and corrective actions to address them.

4.0 MITIGATION STRATEGIES & CORRECTIVE ACTIONS

HHS strives to improve payment integrity and prevent, reduce, and recover improper payments. HHS monitors existing corrective actions and considers 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, piloting, implementation, refinement (if needed), and completion. For programs with a baseline measurement, these planned actions help HHS set targets for reducing improper payments and a timeline to achieve those targets. HHS 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 evaluates the impact of mitigation strategies and corrective actions to refine program integrity activities.

See Section 7.0: *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.

4.1 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 7.0: *Program-Specific Reporting Information*.

Fraud Reduction

HHS adopted leading practices in fraud risk management presented in GAO's report, *A Framework for Managing Fraud Risks in Federal Programs* (GAO-15-593SP, Fraud Risk Management Framework). These fraud reduction efforts comply with PIIA, Principle 8 ("Assess Fraud Risk") of GAO's revised *Standards for Internal Control in the Federal Government* (GAO-14-704G), and OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*.

After surveying the Divisions and completing high-level fraud risk exposure assessments to provide a baseline of each Division's fraud risks and control activities in the previous fiscal year, HHS continued applying its Fraud Risk Management Implementation Plan in FY 2023. This plan 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:

- Launching the Fraud Risk Assessment Portal (FRAP), which is a tool that supports a structured, repeatable fraud risk assessment process that assists Divisions by evaluating the vulnerability of their programs to specific types of fraud schemes;
- Piloting FRAP with two Divisions and further developing the Fraud Risk Assessment methodology as a result;
- Developing and releasing the Fraud Risk Management Community of Practice, a centralized library of anti-fraud resources and information on initiatives to support Divisions' fraud risk management efforts;
- Developing a Fraud Risk Maturity Model to establish performance baselines, recognize incremental improvement, and prioritize next steps for Divisions in the fraud risk management process; and
- Conducting a training on fraud risk management for the Department's Financial Management community to help create an organizational culture focused on combatting fraud. The session highlighted government-wide fraud risk management requirements and resources; HHS initiatives, approaches, and tools; and one Division's experience and approach to implementing fraud risk management requirements.

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, or misconduct; continuous monitoring of grant recipients via audit resolution, special conditions/drawdown restrictions, site visits, performance reports, etc.; and leveraging tools like the Do Not Pay (DNP) system, Grant Solutions' Recipient Data Insights, and SAM.gov (e.g., Suspension and Debarment) to review potential or current recipients.

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, 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. By the end of FY 2023, the number of participants has increased to 300 public, private, and state partner organizations.

The Partnership commenced and/or completed studies by which a trusted third-party contractor used shared data from partners that actively submit claim level data (now numbering 85 partners) to analyze fraud, waste, and abuse, and 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 known 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 5,000 cases reviewed and law enforcement partners have made over 3,100 requests for CMS to refer reviewed cases. In FY 2023, CMS reviewed 1,106 cases at Major Case Coordination meetings, and law enforcement partners made 538 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. In FY 2023, HHS participated in 28 Medicaid Major Case Coordination meetings, and from those meetings, law enforcement partners made 46 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 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* (the 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. Medicaid program integrity collections (federal and state shares) totaled $566.49 million in FY 2023.[23] 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, 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.

[23] 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.

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. HHS reviews Medicaid audit findings to identify policies that require further clarification and uses this information to update sub-regulatory guidance in the Medicaid Provider Enrollment Compendium.

Due to COVID-19, many states used the Section 1135 waiver authority[24] 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). The requirements that HHS waived during COVID-19 resumed on May 18, 2023. 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; as a result, reducing the state 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. As required under the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Pub. L. No. 115-271), HHS developed the Health Plan Management System Program Integrity Portal for Fraud, Waste, and Abuse Reporting. This web-based portal allows plan sponsors to report fraud, waste, and abuse in the Medicare Part C and Part D programs and to share information among HHS, Medicare Part C and Part D plan sponsors, and the I-MEDIC to assist in combatting fraud, waste, and abuse. The information that must be reported includes payment suspensions based on credible allegations of fraud by pharmacies and information on

[24] 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.

inappropriate prescribing of opioids. Plan sponsors may also report referrals of substantiated or suspicious activities of fraud, waste, and abuse.

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 "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 for five percent or greater owners 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 over 2.7 million distinct Medicare enrollments through the Provider Enrollment, Chain, and Ownership System (PECOS).

Public Assistance Reporting Information System

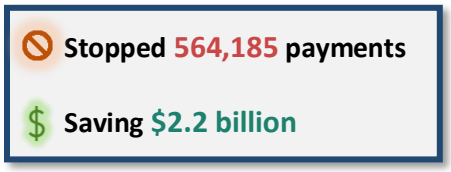
ACF's Office of the Chief Technology Officer oversees the Public Assistance Reporting Information System, which provides state public assistance agencies in all 50 states, the District of Columbia, and Puerto Rico with matching data to verify program eligibility and to detect and deter improper payments 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 2022 to May 2023), states submitted over 334.9 million records for matching and received average match records of 2.6 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 California Department of Health Care Services reports its usage of the interstate match resulted in $86.3 million in annualized cost avoidance for FY 2022-2023 across multiple aid categories
- The Connecticut Department of Social Services reports its usage of the interstate match resulted in $2.1 million in cost avoidance from July 2022 to June 2023;
- The Iowa Department of Health and Human Services reports its usage of the interstate match resulted in $16.9 million in cost avoidance from October 2022 to July 2023;
- The Michigan Department of Health and Human Services, Office of Inspector General reports its usage of the interstate match resulted in $20.5 million in annualized cost avoidance in FY 2022;
- The New York's Office of Temporary and Disability Assistance closed or removed active clients from public assistance cases for projected cost savings of $63 million between August 2022 and March 2023; and
- The Washington State Health Care Authority's Veterans Program had approximately $11.64 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 2022 and June 2023.

For more information, refer to the Public Assistance Reporting Information System.

Results of the DNP Initiative in Preventing Improper Payments



Several Divisions use the government wide Do Not Pay system 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; Electronic Verification of Vital Events Fact of Death Data (a newly added commercial data source that contains information about death certificates from 44 participating states and jurisdictions); and American InfoSource Death Data[25] in the DNP portal daily to identify improper payments. The Department screened over 1.2 million payments against these death record databases, representing $792.9 billion. While the Department identified 15 potential improper payments over the past year through these daily matches, upon further investigation, HHS confirmed 0 payments as improper. Lastly, CMS also checks certain payments against PIIA-listed databases[26] outside of the DNP portal. CMS screened 1.1 billion payments against PIIA-listed databases, representing $415.8 billion in payments. Through these checks, CMS stopped 564,185 payments, representing a savings of $2.2 billion.

Single Audit Resolution

Federal financial assistance recipients that expend at least $750,000 per year are required to have an 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 or other types of recipients are required to conduct Single Audits. HHS works with recipients to analyze Single Audit material non-compliance findings related to programs and to implement corrective actions to address these findings.

Vulnerability Collaboration Council

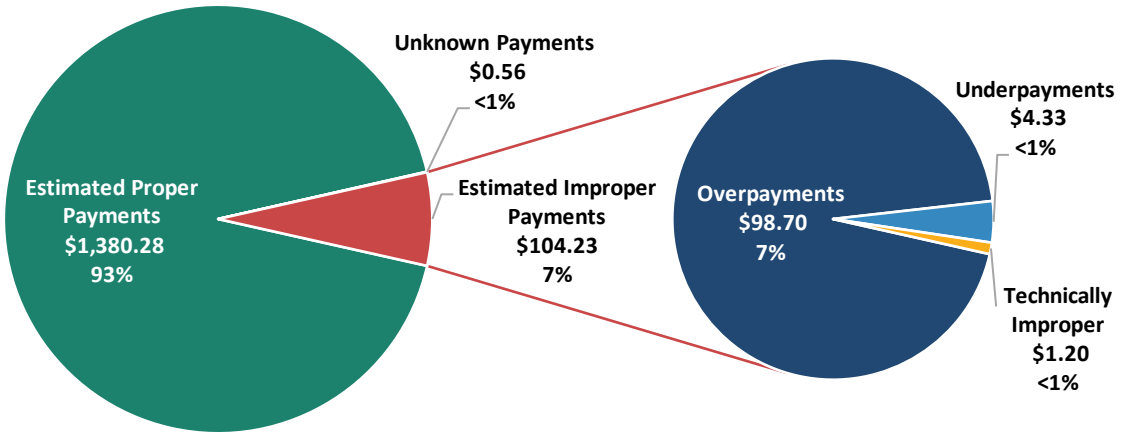
CMS utilizes a centralized vulnerability management process to identify, prioritize, track, and mitigate vulnerabilities that affect the integrity of federal health programs. The centralized component of this process, known as the Vulnerability Collaboration Council (the Council), is comprised of CMS 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. In FY 2023, CMS conducted five program integrity risk assessments focused on hospice, skilled nursing facilities and labs in the Medicare program, and managed care and non-emergency medical transportation in the Medicaid program. Additionally, CMS continued its work on potential vulnerabilities arising from COVID-19 waivers and flexibilities.

5.0 PROPER, IMPROPER, AND UNKNOWN PAYMENTS FOR HHS'S RISK-SUSCEPTIBLE PROGRAMS

The vast majority of the Department's payments are proper, going to the right recipient for the right amount in compliance with legally applicable requirements. Under OMB's current 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, unknown payment, and technically improper payment estimates for all of HHS's risk-susceptible programs.

[25] A commercial data source that gathers information from funeral homes, newspapers, and county probate records.
[26] 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 2023 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.

5.1 Improper and Unknown Payment Performance

Each year, HHS reports estimated improper payment amounts and percentages for payment categories and error types in the Payment Integrity Report. The RY is the fiscal year when improper payment estimates are reported, and it may not correspond to the review period, which is the timeframe used for national annual improper and unknown payment rate calculations. **Table 1** displays the following data, as applicable, for each risk-susceptible program:

- For the current 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 rate and amount. **Figure 4** provides the equation for calculating the improper plus unknown payment rate.

Figure 4: Improper Plus Unknown Payment Rate Equation

$$\text{Improper + Unknown Payment Rate} = \frac{\text{Overpayments} + \text{Underpayments} + \text{Technically Improper} + \text{Unknown}}{\text{Total Payments Actually Made}}$$

The improper plus unknown payment rate is the official program rate for payments that are not verifiably proper and is included in **Table 1**.

Payment Integrity Report

Table 1: HHS's Risk-Susceptible and High-Priority Programs' Improper Payment Results and Outlook

RY 2023 (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	$423,008.64 [a]	92.62%	$391,779.84	7.38%	$31,228.80	7.38% [b]	$31,228.80	0.00%	$0.00	$425,549.81 [c]	7.28%	$30,980.03
Medicare Part C	$275,605.96 [d]	93.99%	$259,055.21	6.01%	$16,550.76	6.01%	$16,550.76	0.00%	$0.00	$432,362.00 [e]	6.38% [f]	$27,584.70
Medicare Part D	$90,074.96 [g]	96.28%	$86,720.18	3.72%	$3,354.78	3.72%	$3,354.78	0.00%	$0.00	$111,960.00 [h]	N/A [i]	N/A
Medicaid	$586,908.83 [j]	91.42%	$536,576.77	8.58%	$50,332.06	8.58% [k]	$50,332.06	0.00%	$0.00	$603,243.47 [j]	7.34%	$44,251.54
CHIP	$16,670.27 [l]	87.19%	$14,534.69	12.81%	$2,135.58	12.81% [m]	$2,135.58	0.00%	$0.00	$17,702.00 [l]	10.28%	$1,819.83
APTC	$46,497.89 [n]	99.42%	$46,226.14	0.58%	$271.75	0.58% [o]	$271.75	0.00%	$0.00	$55,742.05 [n]	N/A [o]	N/A
PRF	$21,414.37 [p]	99.90%	$21,392.06	0.10%	$22.31	0.10%	$22.31	0.00%	$0.00	$6,181.20 [p]	0.32% [q]	$19.78
UIP	$5,356.74 [r]	99.27%	$5,317.71	0.73%	$39.03	0.73%	$39.03	0.00%	$0.00	$18,972.62 [r]	N/A [s]	N/A
TANF	$15,590.36 [t]	N/A	N/A	N/A	N/A	N/A [u]	N/A	N/A	N/A	$15,879.65 [t]	N/A	N/A
Foster Care	$1,892.00 [v]	N/A	N/A	N/A	N/A	N/A [w]	N/A	N/A	N/A	$1,867.00 [v]	N/A	N/A
CCDF	$8,699.10 [x]	96.45%	$8,390.06	3.55%	$309.04	1.15%	$99.65	2.41%	$209.39	$13,691.10 [y]	N/A [z]	N/A
Head Start	$10,844.10 [aa]	94.90 %	$10,290.58	5.10%	$553.52	1.83%	$197.93	3.28%	$355.59	$11,689.00 [bb]	N/A [cc]	N/A

[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 2023 Medicare FFS Improper Payments Report (based on claims submitted from July 2021 – June 2022).

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 0.23 percentage points to 7.38 percent or $31.23 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 2024 President's Budget*.

d) Medicare Part C RY outlays reflect 2021 Part C payments, as reported in the FY 2023 Medicare Part C Payment Error Final Report.

e) Medicare Part C RY+1 outlays are based on the *FY 2024 President's Budget*.

f) CMS made significant methodology changes during the past two years' reporting (FY 2021 and FY 2022), and FY 2023 establishes a baseline. CMS expects the FY 2024 rate to be statistically similar to the FY 2023 rate; however, CMS will continue to observe how the rate fluctuates over the next couple of years when setting CY+1 targets. For FY 2024, CMS establishes a relationship mid-way between the upper limit of the 95 percent confidence interval and the current year estimated error rate to provide a realistic outyear target.

g) Medicare Part D RY outlays reflect 2021 Part D payments, as reported in the FY 2023 Medicare Part D Payment Error Final Report.

h) Medicare Part D RY+1 outlays are based on the *FY 2024 President's Budget*.

i) Medicare Part D is not reporting a RY+1 improper payment reduction target for FY 2024 due to numerous methodology changes implemented in the FY 2023 reporting period and a baseline has not yet been established.

j) Medicaid RY outlays are based on FY 2022 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 2024 President's Budget*.

k) HHS calculated and is reporting the national Medicaid estimates based on measurements conducted in FYs 2021, 2022, and 2023. The national Medicaid component improper payment estimates are: Medicaid FFS: 6.9 percent, Medicaid managed care: 0 percent, and Medicaid eligibility: 5.95 percent.

l) CHIP RY outlays are based on FY 2022 expenditures, and RY+1 outlays are based on the *FY 2024 President's Budget*.

m) HHS calculated and is reporting the national CHIP estimates based on measurements conducted in FYs 2021, 2022, and 2023. The national CHIP component improper estimates are: CHIP FFS: 7.09 percent, CHIP managed care: 0.59 percent, and CHIP eligibility: 10.86 percent.

n) APTC RY outlays are for the Federally-facilitated Exchange only and are based on internal financial reporting.

o) 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 report a full baseline. See Section 7.6: *APTC* for more information.

p) PRF RY outlays are based upon PRF payments made during the sampling timeframe between March 27, 2021, and March 26, 2022, and RY+1 outlays between March 27, 2022, and March 26, 2023. PRF outlays are based on the *Coronavirus Aid, Relief, and Economic Security Act* (Pub. L. No. 116–136); *Paycheck Protection Program and Health Care Enhancement Act* (Pub. L. No. 116–139); *Consolidated Appropriations Act* (Pub. L. No. 116-260); and *American Rescue Plan Act of 2021* (Pub. L. No. 117–2).

q) PRF is reporting a RY +1 improper payment plus unknown payment reduction target for FY 2024 that is higher than the FY 2023 rate due to the extremely low rate reported for FY 2023.

r) UIP outlays are based upon adjusted claims payments during the period March 27, 2020, through March 26, 2021, and RY+1 outlays between March 27, 2021, and March 26, 2022. UIP outlays are based on the *Families First Coronavirus Response Act* (*Pub. L. No. 116–127*); *Pub. L. No. 116–136; Pub. L. No. 116–139*; and Pub. L. No. 117–2.

s) UIP is not reporting a RY+1 improper payment plus unknown payment reduction target for FY 2024 since FY 2023 was the first year of error rate reporting and the program is still establishing a baseline.

t) TANF RY and RY+1 outlays are based on the *FY 2024 President's Budget* baseline (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs and excluding the TANF Contingency Fund).

u) The TANF program is not reporting estimates for FY 2023. Statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement.

v) Foster Care RY and RY+1 outlays are based on the *FY 2024 President's Budget* baseline and reflect the federal share of maintenance payments.

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w) Foster Care is not reporting an error rate for FY 2023 or a RY+1 improper payment plus unknown payment target for FY 2024. HHS was unable to resume Title IV-E reviews in FY 2023 since the Department was finalizing the Title IV-E Foster Care Eligibility Review Instrument (IV-E instrument) to reflect changes in Title IV-E eligibility requirements enacted through the *Family First Prevention Services Act of 2018*. In addition, HHS needed to train HHS regional staff, IV-E agencies and other stakeholders on the IV-E instrument and provide other technical assistance prior to recommencing Title IV-E reviews. HHS is planning to resume conducting onsite Title IV-E Reviews in FY 2024. 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.

x) CCDF RY outlays are based on the *FY 2023 President's Budget* baseline. Beginning in FY 2023, to better align the outlays to the period under review, instead of reporting the current year outlays in Table 1, HHS is reporting outlays that correspond to the period under review. For FY 2023, the period under review is October 1, 2021, through September 30, 2022. For this reason, the RY outlays reported in the FY 2023 AFR will be the same as those reported in the FY 2022 AFR. This will only occur this year as HHS makes the change in approach.

y) CCDF RY+1 outlays are based on the *FY 2024 President's Budget* baseline.

z) CCDF is not reporting a RY+1 improper payment plus unknown payment reduction target for FY 2024. 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 childcare 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 2023, 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 2024 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.

aa) Head Start RY outlays are based on the *FY 2024 President's Budget* baseline. Beginning in FY 2023, to better align the outlays to the period under review, instead of reporting the current year outlays in Table 1, HHS is reporting the outlays that correspond to the period under review. For FY 2023, the period under review is October 1, 2021, through September 30, 2022. For this reason, the RY outlays reported in the FY 2023 AFR will be the same as those reported in the FY 2022 AFR. This will only occur this year as HHS makes the change in approach.

bb) Head Start RY+1 outlays are based on the *FY 2024 President's Budget* baseline.

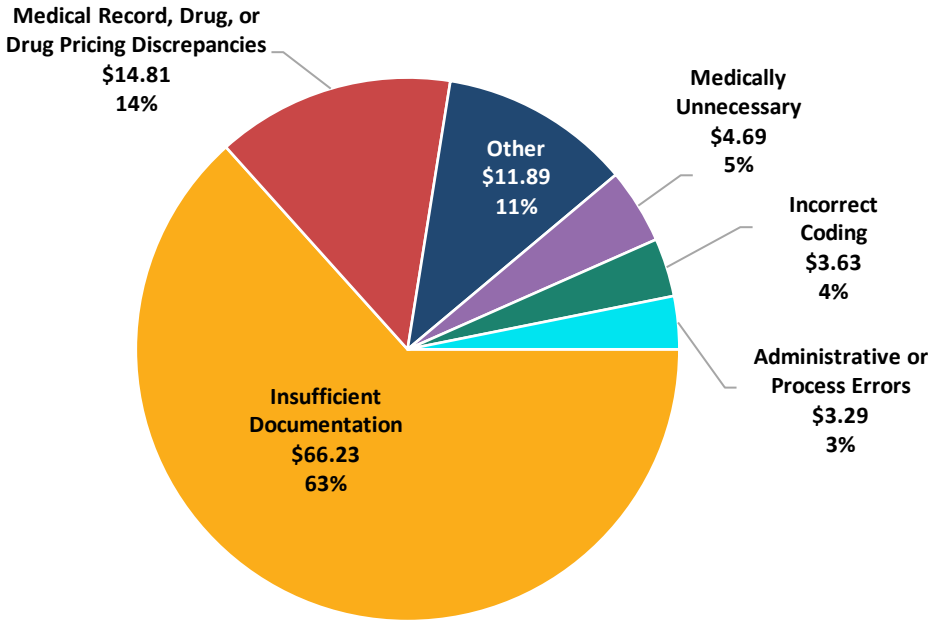
cc) Head Start is not reporting a RY+1 improper payment plus unknown payment reduction target for FY 2024 since FY 2023 was the first year of error rate reporting and the program is still establishing a baseline. HHS anticipates establishing a baseline in FY 2024 and reporting a target in the FY 2024 AFR.

6.0 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 2023 on PaymentAccuracy.gov for information that aligns with OMB's root cause categories.

Section 7.0: *Program-Specific Reporting Information* provides additional programmatic information on error types, mitigation strategies, and corrective actions.

Figure 5: RY 2023 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 ($0.0002 billion and $0.03 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 are distributed between overpayments, underpayments, and technically improper for each program, as displayed in **Table 2** below. Overpayments classify as monetary loss, whereas underpayments and technically improper are non-monetary loss. 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 IP by Program

RY 2023 (in Millions)

	Overpayments		Underpayments		Technically Improper	
Program or Activity	Amount	Percent of Total Payments	Amount	Percent of Total Payments	Amount	Percent of Total Payments
Medicare FFS	$30,213.46	**7.14%**	$1,015.34	**0.24%**	$0.00	**0.00%**
Medicare Part C	$14,648.72	**5.32%**	$1,902.04	**0.69%**	$0.00	**0.00%**
Medicare Part D	$2,334.94	**2.59%**	$1,019.84	**1.13%**	$0.00	**0.00%**
Medicaid	$48,820.01	**8.32%**	$336.21	**0.06%**	$1,175.84	**0.20%**
CHIP	$2,121.52	**12.73%**	$0.97	**0.01%**	$13.09	**0.08%**
APTC	$260.73	**0.56%**	$0.00	**0.00%**	$11.03	**0.02%**
PRF	$0.00	**0.00%**	$22.31	**0.10%**	$0.00	**0.00%**
UIP	$30.95	**0.58%**	$8.08	**0.15%**	$0.00	**0.00%**
CCDF	$81.74	**0.94%**	$17.91	**0.21%**	$0.00	**0.00%**
Head Start	$187.96	**1.73%**	$9.97	**0.09%**	$0.00	**0.00%**
Total [1]	**$98,700.03**	**6.65%**	**$4,332.67**	**0.29%**	**$1,199.96**	**0.08%**

[1] Totals do not necessarily equal the sum of the rounded components.

7.0 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.

7.1 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], Skilled Nursing Facilities [SNF], and hospice);
- Part A hospital Inpatient Prospective Payment System claims;
- Part B claims (e.g., physician, laboratory, and ambulance services); and
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

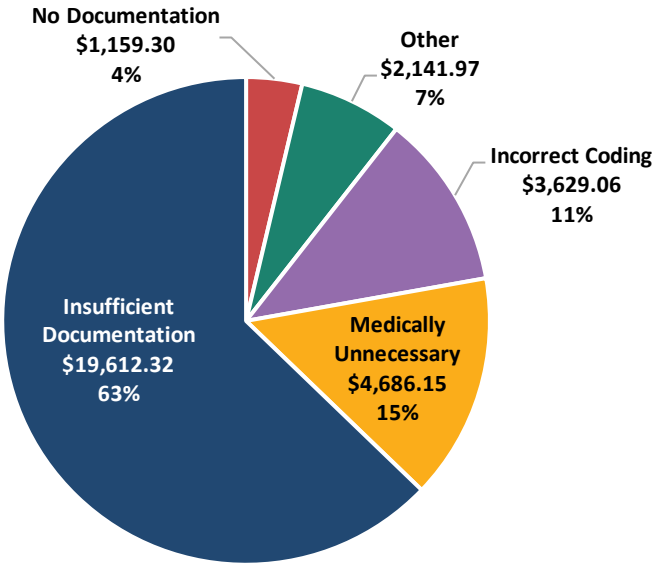
HHS adjusted the sample size for the FY 2023 Medicare FFS program and sampled approximately 37,500 claims. The rate estimated from this sample reflects all claims processed by the Medicare FFS program from July 1, 2021, through June 30, 2022. Additional information on the Medicare FFS improper payment methodology is on pages 166-167 of HHS's FY 2012 AFR.

Calculations and Findings

Medicare FFS properly paid an estimated 92.62 percent of total outlays or $391.78 billion. The improper payment estimate is 7.38 percent of total outlays or $31.23 billion. The improper payment estimate due to missing or insufficient documentation is 4.91 percent or $20.77 billion, representing 66.51 percent of total improper payments.

Figure 7 shows the estimated percentage and amount of improper payments associated with each error type.

Figure 7: RY 2023 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, IRF, and hospice claims were major contributing factors to the Medicare FFS estimate, comprising 38.19 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:[27]

- **SNF:** Insufficient documentation continues to be the major error reason for SNF claims. The improper payment estimate for SNF claims decreased from 15.10 percent in RY 2022 to 13.76 percent in RY 2023; however, this change is not statistically significant. The primary reasons for these errors are missing or insufficient documentation to support the SNF coverage criteria requirements (e.g., level of care requirements, certification/recertification) and missing or insufficient documentation to support the required component(s) for the billed code.
- **Hospital Outpatient:** Insufficient documentation continues to be the major error reason for hospital outpatient claims. The improper payment estimate for hospital outpatient claims decreased from 5.43

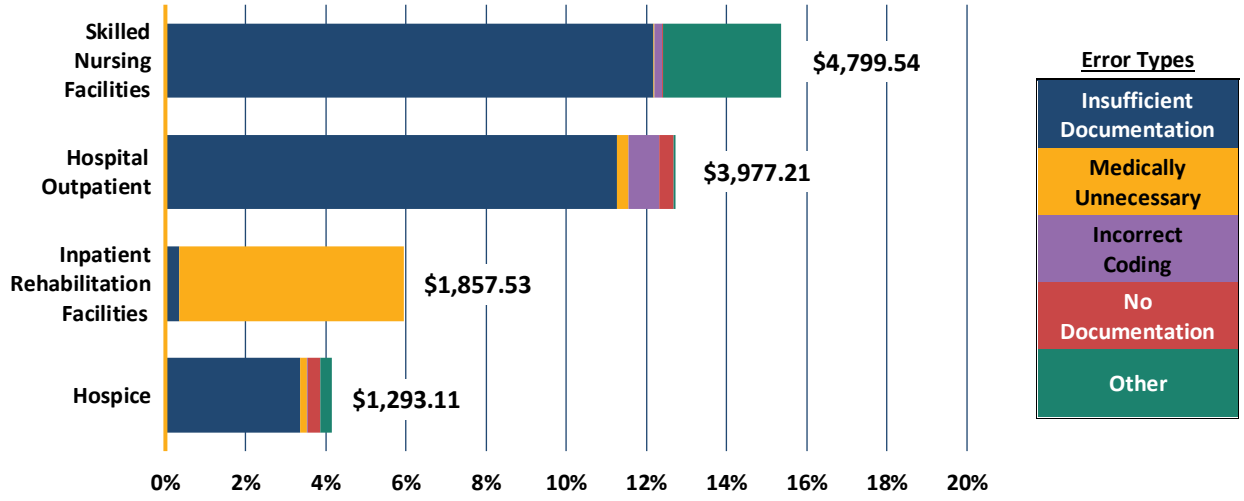
[27] Although increases and decreases are identified, some are not statistically significant. An increase or decrease estimated from a statistical sample is said to be "not statistically significant" if the estimate's margin of error is too wide to conclude that the improper payment rate is different from the previous year.

percent in RY 2022 to 5.20 percent in RY 2023; 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.

- **IRF:** The leading cause of errors in claims for IRF is the lack of medical necessity. The improper payment estimate for IRF claims increased from 19.22 percent in FY 2022 to 27.33 percent in FY 2023. These errors primarily occur because the documentation does not substantiate the beneficiary's requirement for an intensive rehabilitation program, close supervision by a rehabilitation physician, or sufficient stability to actively engage in an intensive rehabilitation therapy program.
- **Hospice:** Insufficient documentation is the major error reason for hospice claims. The improper payment estimate for hospice claims decreased from 12.04 percent in RY 2022 to 5.36 percent in RY 2023. The primary reason for these errors is missing or insufficient documentation to support the certification or recertification.

Figure 8 shows the RY 2023 Medicare FFS drivers for SNF, hospital outpatient, IRF, and hospice claims by error type.

Figure 8: RY 2023 Medicare FFS Service Areas with the Largest Estimated IP Dollar Amounts: Percentage Share of Medicare FFS IP by Error Type (Dollar Amounts in Millions)



Medicare FFS Mitigation Strategies and Corrective Actions

HHS employs a multifaceted approach to combat improper payments in Medicare FFS. This includes implementing corrective action plans and fostering interagency collaboration to address emerging risks. Additionally, HHS has devised preventative measures for high-risk service areas like SNF, hospital outpatient, hospice, and home health, aiming to curb improper payments through targeted actions. HHS mitigates improper payments in Medicare FFS through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Automation	• **Automated Edits:** HHS uses automated edits to detect and prevent inappropriate Medicare claims due to their high volume and cost of conducting medical reviews. HHS also employs the National Correct Coding Initiative to prevent improper payments for Medicare Part B and Medicaid claims. The savings achieved in FY 2023 through these measures will be reported in the upcoming Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **DMEPOS Supplier Education:** HHS educated providers and DMEPOS suppliers by posting 31 articles known as "Provider Compliance Tips" on the Medicare Learning Network. These articles, covering various DMEPOS-related service areas, are regularly updated to address improper payments and reflect changes in regulations and policies, such as the Calendar Year 2022 Diabetic Supplies Provider Compliance Tip and the DMEPOS Final Rule (CMS-1713-F).
Internal Process or Policy Change	• **Hospital Outpatient Prior Authorization:** On November 23, 2022, HHS included Facet Joint Interventions in the nationwide prior authorization process for hospital outpatient department services. This change was made in the Calendar Year 2023 Outpatient Prospective Payment System/Ambulatory Surgical Center Final Rule (CMS-1772-FC) and applies to services provided on or after July 1, 2023. HHS added Facet Joint Interventions to the existing list of services requiring prior authorization, which includes Blepharoplasty, Botulinum Toxin Injections, Panniculectomy, Rhinoplasty, Vein Ablation, Implanted Spinal Neurostimulators, and Cervical Fusion with Disc Removal. HHS provisionally affirmed (i.e., approved) 152,990 services through this process. • **DMEPOS Prior Authorization:** On March 20, 2023, HHS implemented a voluntary prior authorization program for 53 power mobility device (PMD) accessories. This program allows suppliers to submit prior authorization requests for specific DMEPOS accessories along with DMEPOS items listed on the Required Prior Authorization List (CMS-1713-F). HHS also continued nationwide prior authorization for 46 PMD codes, five pressure reducing support surface codes, six lower limb prosthetic codes, and five lower limb orthoses codes. Through this process, HHS provisionally affirmed (i.e., approved) 158,540 DMEPOS items. • **Ambulance Transport Prior Authorization:** In FY 2023, HHS continued nationwide prior authorization for the Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model and provisionally affirmed (i.e., approved) 22,760 ambulance prior authorization requests.[28] • **Provider and Supplier Screening for Existing Medicare Providers and Suppliers:** HHS conducted 253,875 initial enrollment screenings, deactivated 227,172 enrollments, and revoked 3,338 enrollments. • **Provider and Supplier Screening for New Medicare Providers and Suppliers:** HHS conducted 51,564 site visits for non-durable medical equipment (DME) Medicare FFS providers and suppliers, as well as 16,029 site visits for Medicare DME suppliers, leading to 275 revocations based on non-operational site visit findings. • **Medical Review Strategies:** HHS and its contractors use improper payment data to create targeted medical review strategies. These strategies require Medicare review contractors to prevent documentation errors in high-risk claim types like SNF, hospital outpatient claims, IRF, hospice, and home health. • **Medical Review Accuracy Award Fee Metric:** HHS incorporates the Medical Review Accuracy Award Fee Metric into the Award Fee Plan for Medicare Administrative Contractors (MACs) handling Part A, Part B, and DME claims. This metric evaluates the accuracy of complex medical review decisions made by MACs. It promotes consistency in medical review decisions across MACs, ensuring consistent provider education on all improper payments, including those related to medical necessity

[28] 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**
	and insufficient documentation errors. Additionally, the project aims to identify and simplify unclear or burdensome policy requirements to reduce unnecessary denials. • **Overpayment Recoveries Related to Regulatory Provisions:** In December 2022, HHS issued a proposed rule to align the knowledge standard for reporting and returning self-identified Medicare overpayments with the False Claims Act standard, aiming to reduce improper payments (CMS-4201-P). Since FY 2017, HHS received $2.2 billion in voluntary refund collections. Of this total amount, HHS collected over $436 million in FY 2023. • **Review Choice Demonstration for IRF Services:** On May 15, 2023, HHS announced the initiation of the Review Choice Demonstration for IRF services in Alabama, starting from August 21, 2023. This demonstration, as outlined in the September 8, 2021 Federal Register Notice, provides flexibility and choice for IRFs, as well as a risk-based approach to reduce burden on providers demonstrating compliance with Medicare IRF rules. The demonstration also offers applicable IRF providers two initial options: pre-claim review or post-payment review. Provider compliance with Medicare billing, coding, and coverage requirements determines their subsequent steps within the demonstration. HHS obtained OMB Paperwork Reduction Act (PRA) approval for this demonstration on March 22, 2022. Since its launch, HHS has provisionally affirmed (i.e., approved) 884 pre-claim review requests through this process. • **Review Choice Demonstration for Home Health Services:** On September 1, 2023, HHS announced expansion to the Review Choice Demonstration for Home Health Services to Oklahoma, starting December 1, 2023. This demonstration is also ongoing in Illinois, Ohio, North Carolina, Florida, and Texas. It offers Jurisdiction M providers three initial options: 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 determines their subsequent steps in the demonstration. HHS has provisionally affirmed (approved) 1,785,429 billing periods for home health services. • **Provider Billing Review Evaluation:** In FY 2023, HHS released 10 Comparative Billing Reports, each covering a different topic: (1) Initial Nursing Facility Evaluation and Management Services, (2) Bronchodilator Nebulizer Medications, (3) Chiropractic Manipulative Treatment of the Spine, (4) Immunosuppressive Drugs**,** (5) Laboratory Testing: Urinalysis, (6) Hospice, (7) End-Stage Renal Disease Related Services, (8) Lower Endoscopy, (9) Subsequent Annual Wellness Visits, and (10) Laboratory Testing: Blood Counts. • **Hospice Program Integrity Strategy:** In FY 2023, HHS revamped its hospice program integrity strategy to counter fraud, taking these steps: (1) Conducted nationwide unannounced site visits to all Medicare-enrolled hospices to verify their operational status at the address listed during enrollment. In FY 2023, CMS visited more than 6,700 hospices and took action against 28 hospices. In addition, 537 non-operational practice locations were removed for hospices that had multiple locations. (2) Implemented a Provisional Period of Enhanced Oversight (PPEO) for new hospices in certain states. During PPEO (lasting up to a year), HHS reviews claims before payment. In FY 2023, 111 hospices underwent PPEO. (3) Launched a pilot project to review hospice claims after the first 90 days of care. In FY 2023, HHS reviewed 104 hospice claims under this program. (4) Proposed regulatory changes in the Calendar Year (CY) 2024 Home Health Prospective Payment System Proposed Rule (CMS-1780-P) to detect and prevent hospice fraud. More details can be found on the CMS Blog.

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Audits	• **Targeted Probe and Educate:** MACs continued the Targeted Probe and Educate process and offered extensions due to ongoing COVID-19 effects.[29] This process entails three rounds, each reviewing 20-40 claims and offering one-on-one education after each round. HHS conducted medical reviews in various service areas, including hospital outpatient, IRF, SNF, home health, hospice, and DMEPOS. MACs reviewed 3,888 hospital outpatient providers, 193 IRF providers, 1,356 SNF providers, 1,033 home health agencies, 762 hospice providers, and 5,073 DME suppliers. • **Supplemental Medical Review Contractor (SMRC) Reviews:** SMRC conducted post-payment Medicare FFS reviews for hospital outpatient, IRF, SNF, hospice, and DMEPOS claims. After completing reviews, SMRC shares results with MACs for claim adjustments. Providers receive detailed SMRC review result letters and MAC demand letters for overpayment recovery, including educational information on billing errors. SMRC conducted post-payment reviews for 7,936 hospital outpatient claims, 4,588 SNF claims, 7,184 IRF claims, 38,604 hospice claims, 5,897 DME claims, and more. • **Recovery Audit Contractor (RAC) Reviews:** Medicare FFS RACs identified and recovered improper payments in IRF, SNF, professional services, home health, and DMEPOS claims. The majority of Medicare FFS RAC recoveries, 30 percent, came from hospital outpatient overpayments, with an additional 5 percent originating from SNF overpayments. • **RAC DME Reviews:** The national Medicare FFS DME RAC performed comprehensive reviews for DME items, assessing medical necessity, documentation adequacy, valid orders, and service delivery. They also conducted automated reviews for inappropriate billing practices, excessive units, and medical necessity of DME items. 16 percent of RAC recoveries came from DME.
Predictive Analytics	• **Fraud Prevention System Models:** The Fraud Prevention System employs advanced algorithms to focus investigative efforts, detect suspect claims or providers, and aid investigations in cases of severe or unusual activity. It provided information for 1,994 existing and 1,137 new leads or investigations opened by program integrity contractors.[30] Contractors initiated actions against 1,095 providers as a result.

7.2 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 (i.e., the CMS Hierarchical Condition Category [CMS-HCC]) submitted by the Medicare Advantage Organization (MAO). To calculate the improper payment estimate, 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 (CY) 2021 and reviewed medical records of the diagnoses submitted by plans for the sample beneficiaries. As one of the last

[29] See the CMS website for additional information on Targeted Probe and Educate.

[30] HHS quantifies leads and investigations to describe how FPS contributes to program integrity investigative activities. As additional context, HHS notes that more than one FPS alert may inform a lead/investigation, and there may be more than one lead/investigation on the same provider if, for example, multiple complaints are received about that provider.

key steps in the process outlined in **Figure 9**, 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.

In FY 2023, HHS implemented a revised sample allocation methodology to reallocate the sampled beneficiaries across the strata proportionally according to stratum size rather than evenly. By evaluating the variances within and between strata, HHS determined the alternative sample allocation method would yield a more precise overall error estimate and a more efficient sample. In FYs 2021[31] and FY 2022,[32] HHS implemented methodology and policy changes, and FY 2023 establishes a baseline. The FY 2023 error rate calculation follows those previously implemented policy changes. While FY 2023 and FY 2022 are comparable, they are not directly comparable to earlier reporting years.

Figure 9: Part C Improper Payment Measurement Process

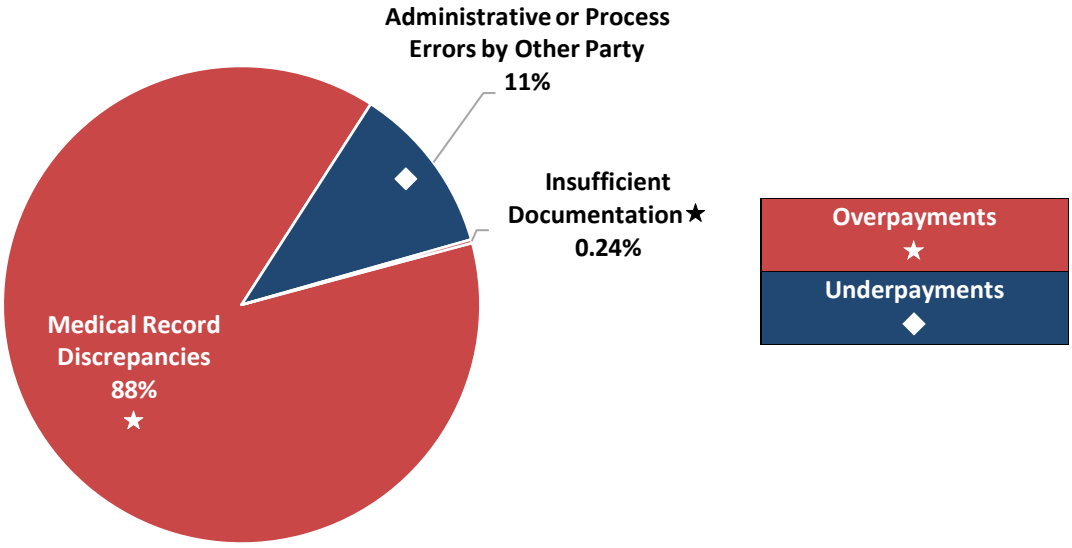
Calculations and Findings

Medicare Part C properly paid an estimated 93.99 percent of total outlays or $259.06 billion. The improper payment estimate is 6.01 percent of total outlays or $16.55 billion. The improper payment estimate due to missing or insufficient documentation is 0.01 percent or $0.04 billion, representing 0.24 percent of total improper payments.

The primary error type of Medicare Part C improper payments consists of medical record discrepancies (5.3 percent in overpayments and 0.69 percent in underpayments), with a smaller portion of improper payments resulting from insufficient documentation to determine whether proper or improper (0.01 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 CMS-HCCs that were not included in risk scores because related diagnoses were identified during the medical review process that the MAO did not submit to be used in the risk score calculation.[33] The breakdown of Medicare Part C improper payments is displayed in **Figure 10** below.

[31] FY 2021 methodology changes are described on pages 219-220 of HHS's FY 2021 AFR.
[32] FY 2022 methodology changes are described on pages 233-234 of HHS's FY 2022 AFR.
[33] Unsubmitted risk scores result from additional CMS-HCCs that are abstracted during medical review. Spontaneous additional CMS-HCCs occur during the medical review process where the medical record submitted by the MAO supports an CMS-HCC that was never submitted for payment. These do not meet the definition of an improper payment and are excluded under HHS's methodology, starting in FY 2022 and going forward. Within-hierarchy additional CMS-HCCs occur where the medical record supports a diagnosis more severe within the same hierarchy as the HCC that was submitted for payment. Within-hierarchy additional CMS-HCCs are included under HHS's methodology.

Figure 10: RY 2023 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 mitigates improper payments in Medicare Part C through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Comprehensive Training:** In March 2023, HHS held a Medicare Part C Fraud, Waste, and Abuse webinar covering the latest schemes, trends, data analysis, and investigations. The training featured presentations by law enforcement, plan sponsors, and program integrity contractors. • **Outreach**: HHS maintained formal outreach to plan sponsors for incomplete or invalid documentation to address potential improper payments during the sample submission period. Furthermore, HHS sent Final Findings Reports to all Part C sponsors participating in the improper payment measurement, offering feedback on their submissions and validation results compared to all participating sponsors.
Audits	• **Risk Adjustment Data Validation (RADV) Audits:** Contract-level RADV audits are HHS's primary strategy to recover Part C overpayments. RADV uses medical record reviews to confirm the accuracy of diagnoses submitted by MAOs for risk-adjusted payments. These audits are expected to improve data quality because they incentivize MAOs to provide valid and accurate diagnosis information. Additionally, contract-level RADV audits encourage MAOs to identify, report, and return overpayments. On February 1, 2023, HHS finalized CMS-4185-F2, a regulation that codifies HHS's practice of extrapolating RADV audit findings starting from payment year (PY) 2018 as part of the RADV audit methodology. • **I-MEDIC Investigations:** In FY 2023, the I-MEDIC launched 692 investigations, made 65 recommendations for provider revocations, sent 174 referrals to law enforcement (including 63 immediate advisements), and submitted 181 referrals to other entities like state pharmacy and medical boards, Medicare quality improvement organizations, and other Medicare contractors.[34]

[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.

7.3 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.[35] 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 then undergoes a simulation to estimate their Part D improper payments by resampling gross drug cost errors from the PDE sample. HHS then extrapolates those improper payments to the entire Part D population to produce the Part D improper payment estimate.

In FY 2023, HHS implemented methodology refinements that contributed to an increase in the FY 2023 improper payment rate estimate. Specifically, HHS adjusted the methodology to recognize payment errors resulting from the use of incorrect benefit parameters. In those instances, sponsors were not utilizing HHS-approved benefit parameters in the original processing of a PDE. Other technical methodology changes included: improving the accuracy of the simulation by using a more appropriate sampling unit,[36] decreasing the number of simulation iterations to align to statistical literature, aligning the confidence interval calculation to the estimation method,[37] and improving the simulation by applying more accurate parameter assumptions when benefit parameters are missing or incomplete. Due to the methodology changes introduced in FY 2023, the rates for FY 2022 and FY 2023 are not comparable.

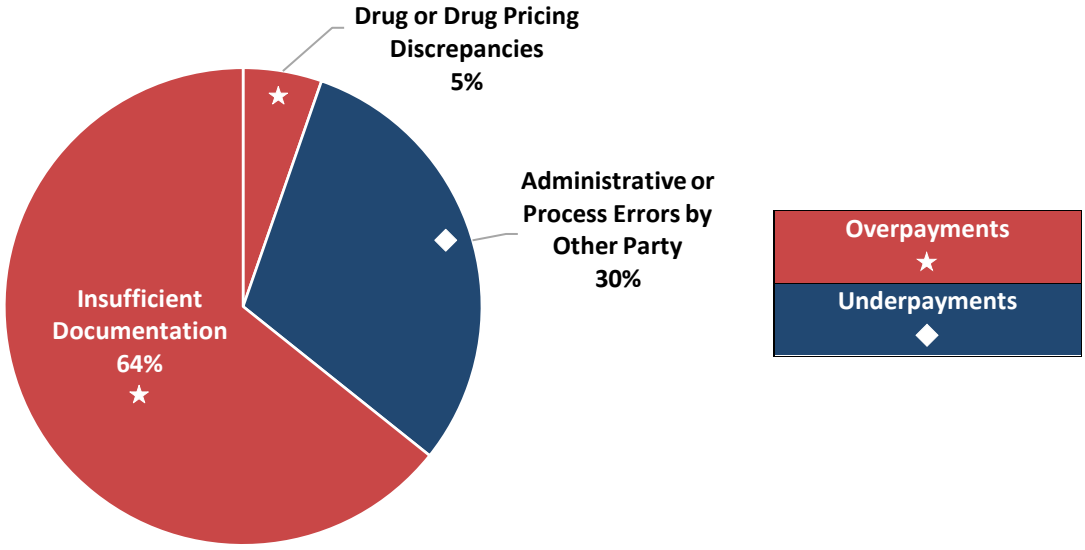
Calculations and Findings

Medicare Part D properly paid an estimated 96.28 percent of total outlays or $86.72 billion. The improper payment estimate is 3.72 percent of total outlays or $3.35 billion. The improper payment estimate due to missing or insufficient documentation is 2.39 percent or $2.16 billion, representing 64.27 percent of total improper payments. The increase from the prior year's estimate of 1.54 percent is attributed to the multiple methodological changes implemented for the FY 2023 improper payment estimate. A baseline for improper payments in Medicare Part D has not yet been established, as the RY 2023 estimate reflects numerous methodology changes.

The Medicare Part D improper payment error categories are drug or drug pricing discrepancies (0.20 percent in Overpayments and 1.13 percent in Underpayments) and insufficient documentation to determine whether they are proper or improper (2.39 percent). Improper payments due to drug or drug pricing discrepancies occur when the submitted prescription documentation indicates that an overpayment occurred. Underpayments result when prescription record hard copies (or medication orders) indicate that HHS should have paid a greater amount. The breakdown of Medicare Part D improper payments is displayed in **Figure 11** below.

[35] Prescription drug event (PDE) data represents the summary record of each time a beneficiary fills a prescription under Medicare Part D.
[36] HHS modified the simulation so that during any one iteration, gross drug cost errors are consistently mapped to all of the PDEs associated with the prescription. For any one prescription for any one member of the beneficiary sample, the same resampled gross drug cost error is applied to all of that prescription's PDEs.
[37] In the new method, HHS calculates the confidence interval by sorting the improper payment rate values of the 250 iterations of the simulation from the smallest to largest and taking the value of the 6th iteration as the lower bound and the 245th iteration as the upper bound.

Figure 11: RY 2023 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 mitigates improper payments in Medicare Part D through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Comprehensive Trainings:** HHS conducted Opioid Education Mission webinars in November 2022 and May 2023. In September 2023, an in-person Opioid Education Mission took place at the Atlanta Regional Office. • **Outreach:** HHS maintained formal outreach to plan sponsors for incomplete or invalid documentation to address potential improper payments during the sample submission period. Furthermore, HHS sent Final Findings Reports to all Part D sponsors participating in the improper payment measurement, offering feedback on their submissions and validation results compared to all participating sponsors.
Audits	• **Part D Audits:** HHS audits Part D plan sponsors to address high-risk drugs and educate sponsors on fraud, waste, and abuse. These audits have varying scopes but share the goal of reducing and recovering improper Part D payments. In FY 2023, HHS recovered approximately $6.6 million for 4 audits through data analysis projects and self-audits by Part D plan sponsors.[38] • **I-MEDIC Investigations:** In FY 2023, the I-MEDIC launched 692 investigations, made 65 recommendations for provider revocations, sent 174 referrals to law enforcement (including 63 immediate advisements), and submitted 181 referrals to other entities like state pharmacy and medical boards, Medicare quality improvement organizations, and other Medicare contractors.[39] • **Program Integrity Audits:** HHS audits Part D plan sponsors to reduce improper payments and detect non-compliance with program integrity requirements. In FY

[38] 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.

[39] 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.

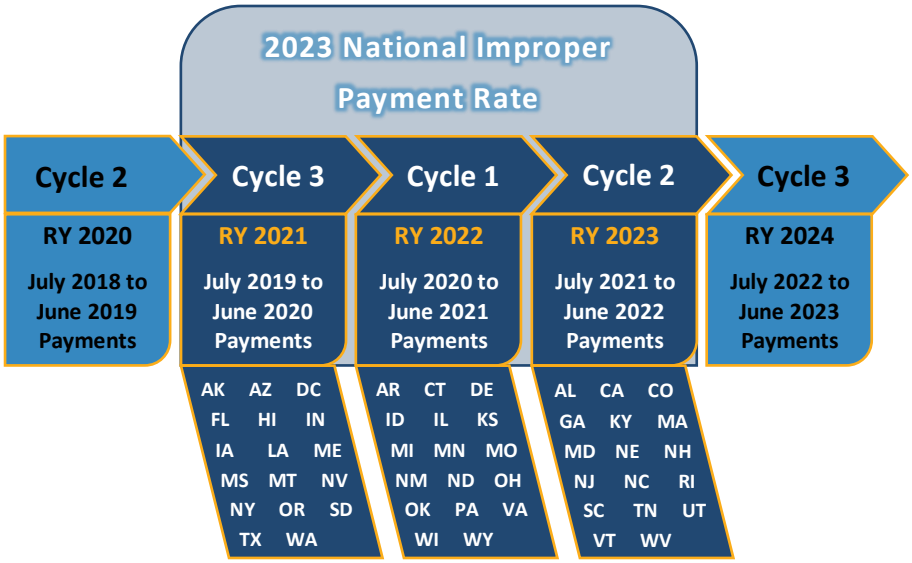
Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
	2023, HHS conducted four Program Integrity Audits, aiming to educate plan sponsors about fraud, waste, and abuse issues.

7.4 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 capitation 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 2021, 2022, and 2023 as seen in **Figure 12**.

Figure 12: RY 2023 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. Under a managed care delivery system, a state makes a monthly periodic (usually monthly) capitation payment to a managed care plan,[40] which is responsible for managing beneficiary care and paying providers. States submit adjudicated claims data quarterly and HHS randomly selects a sample of FFS claims and managed care payments. Each selected FFS claim undergoes a medical and data processing review, whereas managed care capitation payments undergo 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 established capitated payment sampled and, thus, is not included in the managed care component.

[40] Includes managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans as defined in 42 CFR 438.2.

Additionally, HHS selects a combination of FFS claims and managed care capitation payments for eligibility review. Based on each state's expenditures, historical FFS, and managed care payment data, the FFS sample size was between 152 and 1,782 claims per state, the managed care sample size was between 38 and 200 capitation payments per state, the eligibility FFS sample size was between 51 and 534 per state, and the eligibility managed care sample size was between 52 and 578 per state. When a state's FFS claims or managed care component capitation payments accounted for less than two percent of the state's total Medicaid expenditures, HHS combined the state's FFS claims and managed care claims capitation payments 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: enrolling an ineligible beneficiary; determining a beneficiary to be eligible for the incorrect eligibility category, resulting in an ineligible good/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 91.42 percent of total outlays or $536.58 billion. The national Medicaid improper payment estimate is 8.58 percent or $50.33 billion. The improper payment estimate due to missing or insufficient documentation is 7.02 percent or $41.19 billion, representing 81.84 percent of total improper payments.

The national Medicaid improper payment estimate for each component is:

- *Medicaid FFS*: 6.90 percent;
- *Medicaid managed care*: 0.00 percent; and
- *Medicaid eligibility*: 5.95 percent.

The decrease in the national Medicaid improper payment estimate can be attributed to two main factors. First, it is due to reviews that considered certain flexibilities given to states during COVID-19, such as suspending eligibility determinations and reducing requirements for provider enrollment and revalidations, which were previously part of the improper payment reviews. Second, it is a result of improved state compliance with other program rules. While HHS cannot precisely determine the extent to which the decrease is due to the COVID-19 flexibilities or better state compliance, it seems that the flexibilities played a role in reducing the rate. It is important to note that this data does not account for any effects of reversing these COVID-19 flexibilities, which will be covered in future reports. HHS will publish supplemental information related to the Medicaid results on the CMS website following AFR publication.

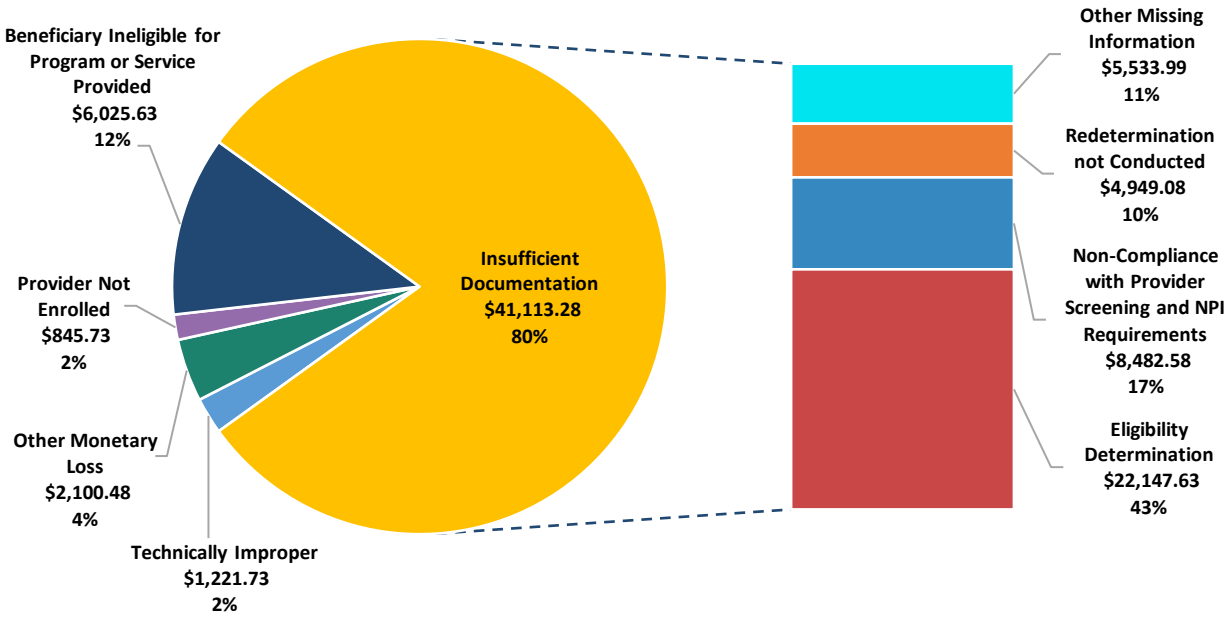
The areas driving the Medicaid improper payment estimate are:

- **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.
    - During RY 2023, HHS worked with states to independently verify certain situations where the state could not provide documentation to support state actions. This process included HHS independently accessing databases and reviewing submitted eligibility determination information, that had been produced after the original claim payment or determination date, to evaluate if a provider or beneficiary would have been eligible to provide or receive goods/services. Of these 226 claims eligible for independent verification, HHS independently verified 75 claims through receipt of verification or access to system information provided by states. Of these 75 claims, HHS deemed 68 claims technically improper (i.e., the payment was to the right recipient for the correct amount, but the payment process did not comply with applicable regulations and statutes). The effect of these independent verifications is reflected as technically improper payments in the reported improper and unknown payment rates.
- **State Non-Compliance:** Represents noncompliance with federal eligibility redetermination requirements; enrolled providers not appropriately screened by the state; 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 10.42 percent in RY 2022 to 6.9 percent in RY 2023. COVID-19 review flexibilities afforded to states should also be considered in the identified decrease in the Medicaid FFS and eligibility components between RY 2022 and RY 2023.

Despite independent verification efforts, a majority of Medicaid improper payments were still 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 ineligible providers or on behalf of ineligible beneficiaries. Had the missing information been on the claim and/or had the state complied with the enrollment or redetermination requirements, then the claims may have been payable. Conversely, had the missing documentation 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 good/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 2023 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 and Table 2 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

As Medicaid is a federal-state partnership, HHS collaborates closely with all states to develop strategies to address root causes of improper payments. Each state is accountable for carrying out, overseeing, and assessing the impact of these strategies and actions. State efforts concentrate on making system or process improvements to decrease errors, such as introducing new claims processing checks, upgrading to an advanced claims processing system, enhancing provider enrollment procedures, improving beneficiary enrollment and redetermination processes, and enhancing provider communication and education to minimize errors related to documentation requirements.

HHS mitigates improper payments in Medicaid through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Medicaid Integrity Institute:** HHS provides training and support to state Medicaid program integrity officials through the Medicaid Integrity Institute, offering courses such as provider auditing, certified coding, fraud prevention, Do Not Pay, and more. Despite the shift to virtual courses during COVID-19, state interest and participation remained strong. Further details are on the Medicaid Integrity Institute website.
Internal Process or Policy Change	• **Enhanced State Corrective Action Plan Process:** HHS collaborates with states to establish an effective state-specific Corrective Action Plan (CAP) process, offering enhanced technical assistance and guidance. This involves coordinating with states to create CAPs that address identified errors and deficiencies. HHS monitors each state's progress in implementing these corrective actions and provides training to ensure federal policy compliance. For instance, in July 2023, HHS

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
	conducted a quarterly training session on school-based services for fee-for-service individualized educational plan billing programs and the Payment Error Rate Measurement difference resolution and appeals process. Lessons learned will be used to shape future guidance and education for states.
Cross Enterprise Sharing	• **State Medicaid Provider Screening and Enrollment:** In FY 2023, Pennsylvania, Oklahoma, Colorado, New York, Mississippi, New Hampshire, and Rhode Island participated in the data compare service. • **Death Master File (DMF)**: To address state cost concerns in performing the Social Security Administration's DMF check during provider screening, HHS collaborated with the Social Security Administration to supply states with DMF data. Subsequently, HHS improved states' access to DMF data via the Data Exchange, a system for sharing data between HHS and state Medicaid programs. All 50 states, the District of Columbia, and Puerto Rico now have access to DMF data through the Data Exchange. • **Transformed Medicaid Statistical Information System:** HHS created the Transformed Medicaid Statistical Information System to streamline state claims data submission, enhance the dataset, and enable real-time assessment of data completeness and quality. This system helps HHS obtain better data quality, leading to fewer data requests to states, and is an important resource for program integrity activities. HHS analyzes this data to identify risk areas, prioritize audits, and aid investigations, potentially leading to recovery of overpayments. HHS actively monitors monthly data submissions to assess and enhance data quality.
Audits	• **Medicaid Eligibility Quality Control (MEQC) Program:** The MEQC program enables states to assess and enhance Medicaid and CHIP eligibility determination processes through pilot projects. MEQC reviews encompass determinations not covered by the Payment Error Rate Measurement program, including denials and terminations. States have flexibility in pilot design, focusing on identified vulnerable or error-prone areas. These pilots occur during the "off-years" between states' triennial reviews, allowing for prospective process improvements. CMS approved Cycle 2 state pilot planning documents in the fall of 2022, and these states began their MEQC pilots in January 2023. Cycle 3 states submitted MEQC reports and corrective action plans in November 2022, while Cycle 1 states completed MEQC reviews and prepared reports and plans for submission in August 2023. Starting with Cycle 1 in January 2022, COVID-related streamlined reporting requirements have ceased. • **Beneficiary Eligibility Audits:** As per HHS's Comprehensive Medicaid Integrity Plan for FYs 2019-2023, HHS conducted eligibility determination audits in high-risk states, selected based on improper payment rates, GAO or OIG reports, MEQC program findings, and HHS's oversight processes. In FY 2023, HHS carried out these audits in Connecticut, Kansas, Missouri, and Pennsylvania. • **Unified Program Integrity Contractors (UPIC):** UPICs, HHS's program integrity contractors, combat Medicare and Medicaid fraud, waste, and abuse through audits and investigations. UPICs work within defined geographic areas and perform various functions to detect, prevent, and deter Medicaid integrity risks. They primarily audit and investigate hospitals, clinics, physicians, pharmacies, pharmacists, hospices, DME suppliers, and labs, and managed care organizations. Managed care network providers and plans accounted for over 60 percent of these audits and investigations.

7.5 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 2023 CHIP rate is based on measurements from RYs 2021, 2022, and 2023.

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 7.4: *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 92 and 1,074 claims per state, the managed care sample size was between 36 and 47 capitation payments per state, the eligibility FFS sample size was between 42 and 368 per state, and the eligibility managed care sample size was between 52 and 454 per state. When a state's FFS claims or managed care capitation payments for a state accounted for less than two percent of the state's total CHIP expenditures, HHS combined the state's FFS claims and managed care capitation payments 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 good/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 87.19 percent of total outlays or $14.53 billion. The national CHIP improper payment estimate is 12.81 percent or $2.14 billion. The improper payment estimate due to missing or insufficient documentation is 8.72 percent or $1.45 billion, representing 68.05 percent of total improper payments.

The national CHIP improper payment estimate for each component is:

- *CHIP FFS*: 7.09 percent;
- *CHIP managed care*: 0.59 percent; and
- *CHIP eligibility*: 10.86 percent.

The decrease in the national CHIP improper payment estimate can be attributed to two main factors. First, it is due to reviews that considered certain flexibilities given to states during COVID-19, such as suspending eligibility determinations and reducing requirements for provider enrollment and revalidations, which were previously part of the improper payment reviews. Second, it is a result of improved state compliance with other program rules. While HHS cannot precisely determine the extent to which the decrease is due to the COVID-19 flexibilities versus or better state compliance, it seems that the flexibilities played a role in reducing the rate. It is important to note that this data does not account for any effects of reversing these COVID-19 flexibilities, which will be included in future reports. 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:

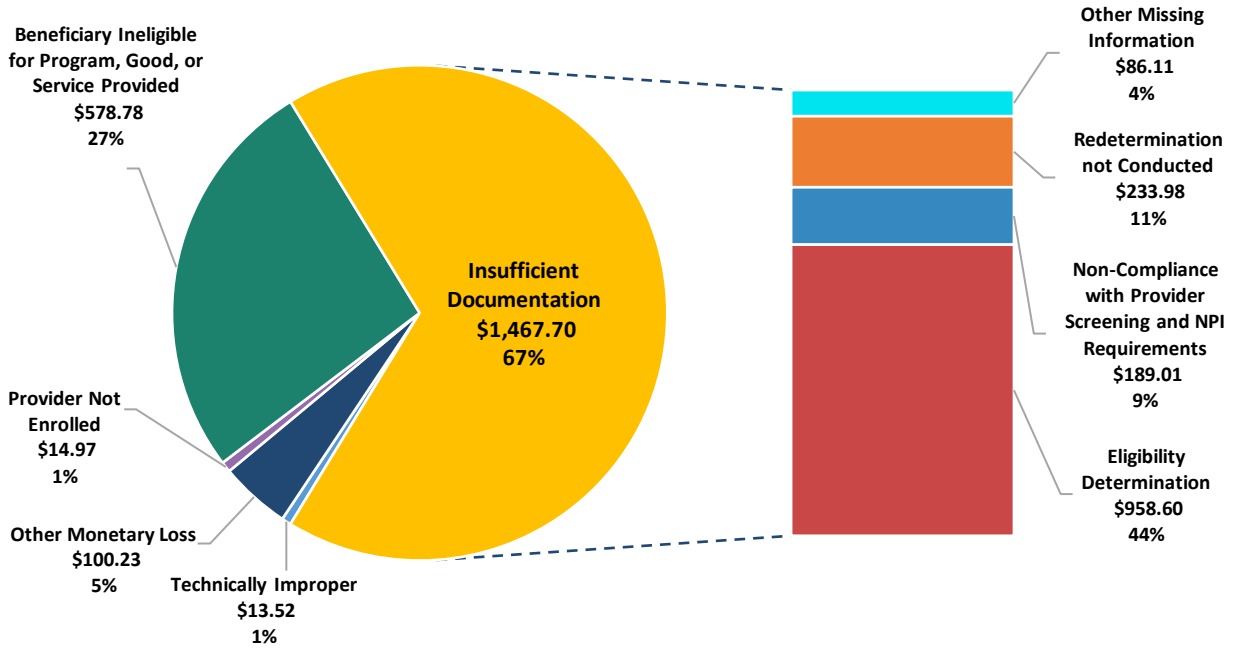
- **Insufficient Documentation:** Represents situations where the required verification of eligibility data, such as income, was not done at all and where there is an indication that eligibility verification was initiated but the state provided no documentation to validate that the verification process 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.
    - During RY 2023, HHS worked with states to independently verify certain situations where the state could not provide documentation to support state actions. This process included independently accessing databases and reviewing submitted eligibility determination information that had been produced after the original claim payment or determination date, to evaluate if a provider or beneficiary would have been eligible to provide or receive goods/services. Of these 104 claims eligible for independent verification, HHS independently verified 17 claims through receipt of verification or access to system information provided by states. Of these 17 claims, HHS deemed 13 claims technically improper (i.e., the payment was to the right recipient for the correct amount, but the payment process did not comply with applicable regulations and statutes). The effect of these independent verifications is reflected as technically improper payments in the reported improper and unknown payment rates.
- **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 approximately 21 percent or $0.41 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 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 11.23 percent in RY 2022 to 7.09 percent in RY 2023. COVID-19 review flexibilities afforded to states should also be considered in the identified decrease in the CHIP FFS and eligibility components between RY 2022 and RY 2023.

Despite independent verification efforts, a majority of CHIP improper payments were still 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 ineligible providers or on behalf of ineligible beneficiaries. Had the missing information been on the claim and/or had the state complied with the enrollment or redetermination requirements, then the claims may have been payable. Conversely, had the missing documentation 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 illustrates the breakdown of CHIP's payment error types. The improper payments include those with provider not enrolled; beneficiary ineligible for program or good/service; incorrect coding; and other errors like claims processing errors, duplicate claims, or pricing mistakes. The insufficient documentation errors include claims with missing information, or states that did not follow processes to determine if a payment was proper or improper.

Figure 14: RY 2023 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 and Table 2 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

As CHIP operates as a federal-state partnership, HHS collaborates closely with all states to develop strategies and actions aimed at addressing root causes of improper payments in CHIP. Many of the actions states implement to tackle Medicaid improper payments, as outlined in Section 7.4: *Medicaid*, are also applicable to CHIP.

7.6 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.[41] **Figure 15** below depicts the sampling process.

[41] Relevant regulatory requirements are generally contained within 45 CFR 155.

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 are representative of all health insurance applications with APTC payments processed by the Federally-facilitated Exchange for CY 2021. A federal contractor, which obtains consumer application information and Exchange data, conducts a detailed review of health insurance applications, and forms an independent expectation of an application's outcomes based on applicable regulatory requirements. The federal 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.

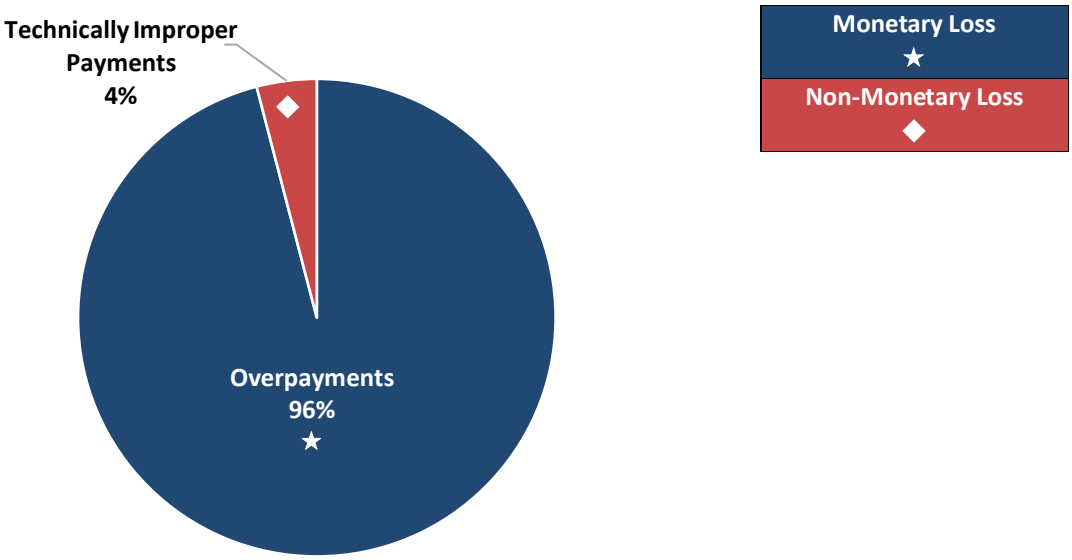
State-based Exchanges: For CY 2021, 14 states and the District of Columbia did not use the Federally-facilitated Exchange to administer the APTC program, and instead operated independent State-based Exchanges.[42] For CY 2021, State-based Exchanges made payments totaling approximately $16.52 billion, or 26.21 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 will begin the Improper Payment Pretesting and Assessment (IPPTA) program in 2024 to prepare states for the upcoming measurement. HHS will continue to update the AFR in future years with the status of measurement program implementation. 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 99.42 percent of total outlays or $46.23 billion. The improper payment estimate is 0.58 percent of total outlays or $271.75 million. None of the improper payment estimate is associated with missing or insufficient documentation. The improper payment estimate is made up of 95.94 percent of overpayments ($260.73 million) and 4.06 percent of technically improper payments ($11.03 million). **Figure 16** below provides a breakdown of the APTC improper payment estimate by improper payment categories.

[42] For 2021, states not using the Federally-facilitated Exchange include California, Colorado, Connecticut, Idaho, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Washington. Additionally, Washington D.C. did not use the Federally-facilitated Exchange.

Figure 16: RY 2023 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.

The causes of overpayments include manual administrative errors (60.71 percent of overpayments, or $158.28 million) and automated process errors (39.29 percent of overpayments, or $102.44 million) associated with determining consumer eligibility for APTC payments.

Manual administrative errors generally relate to the Federally-facilitated Exchange's processing of additional documentation provided by consumers in situations where the Federally-facilitated Exchange was unable to verify consumer eligibility using automated processes. Manual eligibility verification involves complex rules and a large variety of documentation types and formats, and therefore have a heightened risk of error as compared to automated eligibility verification. The nature of manual administrative errors may vary between reporting periods. For calendar year 2021, the primary driver of manual errors related to the Federally-facilitated Exchange accepting consumer-submitted documents which did not contain elements required by policy.

Automated process errors generally relate to the Federally-facilitated Exchange's processing of application information and eligibility verification information provided by trusted data sources. The nature of automated process errors may vary between reporting periods. For CY 2021, the primary driver of automated errors related to the Federally-facilitated Exchange was failing to conduct periodic verifications of consumer eligibility due to technical problems interacting with trusted data sources.

Combined IP Information

The APTC program represents the first of two potential[43] 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 (or 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 CY 2021 reported[44] Net PTC claims of $1.97 billion, improper payments of $512.71 million, and an improper payment rate of 26.04 percent. The combined APTC and Net PTC improper payment estimate is $784.46 million out of $48.47 billion total Premium Tax Credit outlays /

[43] 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.
[44] Please also see the Fiscal Year 2023 U.S. Department of the Treasury's Agency Financial Report for more information.

claims, or 1.62 percent. Similar to the APTC improper payment information provided above, this combined APTC and Net PTC improper payment information does not reflect payments made by State-based Exchanges.

In the ordinary course of preparing their tax filing, a consumer may claim a total Premium Tax Credit that is less than the APTC payments made on behalf of the consumer for the respective tax year. For example, a consumer's income for the tax year may exceed what the consumer anticipated when the consumer enrolled in health insurance coverage, resulting in eligibility for a lesser Premium Tax Credit benefit than expected. The amount paid in APTC that exceed the total Premium Tax Credit a consumer is entitled to is referred to as "Excess APTC." A consumer may have an obligation to repay Excess APTC amounts, and such repayments may relate to amounts that are recognized as improper payments. The combined APTC and Net PTC improper payment information does not reflect any effects related to the repayment of Excess APTC.

APTC Mitigation Strategies and Corrective Actions

HHS mitigates improper payments in APTC through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Automation	• **Systems Automation:** Errors in APTC payments can arise from both their generation and the application of associated policies or procedures. HHS takes corrective actions by identifying and fixing system defects within the Exchanges, often identified through internal quality control and external reviews. HHS constantly evaluates policies and procedures tied to APTC automation to address emerging weaknesses. HHS also proactively enhances automated processes, such as upgrading the Verify Lawful Presence service with the Department of Homeland Security for better accuracy and timeliness. HHS has introduced process automation to minimize human errors during documentation adjudication. Further automation will be encouraged and required to enhance accuracy and quality in adjudication tasks.
Training	• **Eligibility Support Contractor Education:** Personnel undergo thorough onboarding training, annual refreshers, and quick lessons for policy or operations updates. Ad-hoc training is provided as needed. HHS conducted extra training sessions for Data Matching Issues verifications, casework, and outreach.
Audits	• **Internal and External Controls:** The Exchanges undergo rigorous annual testing of internal controls, per OMB Circular A-123 Appendix C requirements, covering both automated and manual processes. External audits by OIG and GAO also identify payment integrity risks in the Exchanges by evaluating APTC eligibility determinations against federal statutes and regulations.
Predictive Analytics	• **Agent/Broker Risk Model:** The Marketplace Program Integrity Contractor uses a risk model to assess agents' and brokers' potential fraud or misconduct. This model calculates a risk score for each agent or broker based on various risk factors. Agents or brokers with the highest risk scores are investigated first. The risk profile is also used to prioritize investigations, guide interview questions, or provide evidence for case findings.

7.7 PRF

PRF Statistical Sampling Process

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, 2021, through March 26, 2022. 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

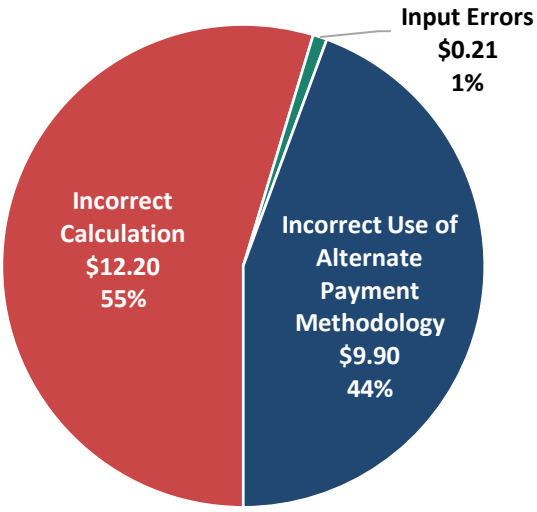
PRF properly paid an estimated 99.9 percent of total outlays or $21.39 billion. PRF's improper payment estimate is 0.1 percent of total outlays or $22.31 million.

The PRF payment error types are as follows:

- **Input Errors:** Improper payment estimate due to input errors (i.e., an incorrect payment calculation was used due to an input error) is $0.21 million, representing approximately 1 percent of total improper payments.
- **Incorrect Use of Alternate Payment Methodology:** Improper payment estimate due to the incorrect use of an alternate payment methodology for the payment calculation (i.e., incorrect determination that the information submitted by the payment recipient was inaccurate or unreliable) is $9.9 million, representing approximately 44 percent of total improper payments.
- **Incorrect Calculation:** Improper payment estimate due to incorrect calculation (i.e., an incorrect percent was used when calculating payments) is $12.2 million, representing approximately 55 percent of total improper payments.

Figure 17 provides a breakdown of the PRF estimated payment error types.

Figure 17: RY 2023 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

On June 3, 2023, the *Fiscal Responsibility Act of 2023* (FRA) was enacted. With the passage of FRA and related rescission of program funds, no further PRF payments will be made to providers, including reconsideration

payments. HHS strives to support the enhancement of PRF payment integrity through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Automation	• **Robotic Process Automation:** HHS made substantial updates to its manual validation results programmatically to ensure consistency in applying calculations and determining the outcomes. HHS is continuously working on its robotic process automation to enhance program integrity in post-payment reviews of PRF applications. This reduces manual data review; boosts efficiency, accuracy, and quality by minimizing human errors; and helps identify improper payments through ongoing internal controls.
Behavioral/Psychological Influence	• **Application Portal:** HHS changed the format of provider-reported patient care revenue. HHS went from asking for whole number percentages to dollar amounts, which led to greater precision by providers.
Training	• **Payment Disbursement Training:** HHS offers training to personnel and contractors on conducting payment disbursement audits and reviews, including resolution, covering federal laws and internal policies.
Internal Process or Policy Change	• **Process Improvement:** HHS established standardized practices for calculating payments and deductions, involving pay files, systems, and verifying recipient eligibility and payment history through exploratory analysis. Additionally, as the program matures, HHS continues to record and track standards and guidelines throughout the program lifecycle to avoid confusion and alleviate discrepancies. • **Risk Management**: HHS has a robust risk management process to help identify threats, risks, and vulnerabilities to the PRF program and implement controls to detect improper payments. • **Pre-Payment Controls:** HHS introduced pre-payment controls, including manual validation of high-dollar payments and additional peer reviewers, to identify and correct errors before making payments.
Cross Enterprise Sharing	• **Post-Payment Controls:** HHS employs a process of post-payment analysis for in-depth review and investigation to identify potential payment errors, including incorrect payment issued. This will help to enable the identification of potential improper payments prior to testing. • **Post-Pay Review:** HHS enhanced records management to accommodate future payment methodology changes and address post-payment review process issues.
Audits	• **Provider Reporting and Audits:** Recipients, in line with their fund receipt agreement, commit to cooperating in audits by HHS, HHS OIG, or the Pandemic Response Accountability Committee. They must also comply with audit requirements in 45 CFR 75 Subpart F. HHS established post-payment reviews, audit strategies, reporting, and system implementation and enhancements to support detective measures and payment integrity through repayment of inaccurate and improper payments. To date, 12 audits have been completed. • **Internal and External Reviews:** HHS undergoes reviews as part of the OMB Circular A–123 requirement to establish and maintain proper internal controls. External audits by GAO and OIG also identify risks and issues for resolution.

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Predictive Analytics	• **Anomaly Detection:** HHS employs a system that flags anomalies for in-depth analysis and investigation to rectify potential errors or clarify why the anomaly is not an error.

7.8 UIP

UIP Statistical Sampling Process

In FY 2021, HHS conducted an improper payment risk assessment and identified UIP as susceptible to significant improper payments. As a result, HHS developed a Sampling and Estimation Methodology Plan for UIP in accordance with Appendix C of OMB Circular A-123, the UIP Assessment Strategy Manual (which outlines the audit evaluation criteria and associated detailed protocols), and the UIP Distribution Terms and Conditions. HHS performed the following procedures including: developing payment cycle risk points definitions, identifying root causes, and assessing controls, policies, and procedures.

HHS used a stratified random sampling methodology to select a statistically valid and rigorous sample from the claims population for UIP reimbursed within the 12-month period of March 27, 2020, through March 26, 2021. HHS stratified the population by a combination of dollar sign (positive, negative, and zero) and payment amount. Positive dollar amounts, negative dollar amounts, and zero-dollar amounts were placed into mutually exclusive buckets. Positive dollar amounts were further stratified into sub-strata based on payment size with a census stratum containing large payment amounts. Negative dollar and Zero-dollar amounts were placed into two and one stratum, respectively, each given their small size relative to the positive dollar amounts.

HHS selected a random sample of UIP payments from each stratum for testing and extrapolated the improper payment results.

Calculations and Findings

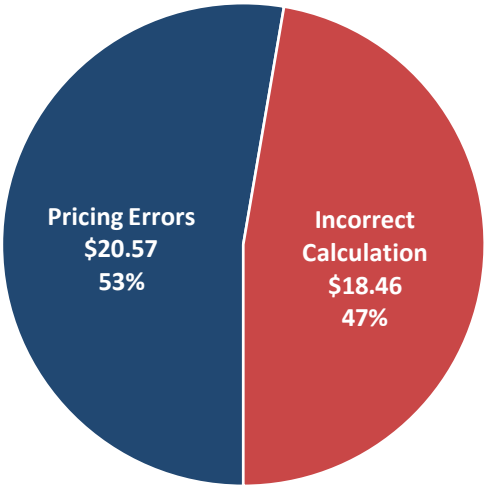
UIP properly paid an estimated 99.27 percent of total outlays or $5.32 billion. UIP's improper payment estimate is 0.73 percent of total outlays or $39.03 million.

The UIP claims reimbursement error types are as follows:

- **Pricing Errors:** Improper payment estimate due to pricing errors (i.e., incorrect claims reimbursements due to pricing errors associated with Healthcare Common Procedure Coding System (HCPCS) rates) is $20.57 million, representing approximately 53 percent of total improper payments.
- **Incorrect Calculation:** Improper payment estimate due to incorrect calculation (i.e., incorrect claims reimbursements due to the use of prior published rates when calculating payments or recalculated amounts not reconciling) $18.46 million, representing approximately 47 percent of total improper payments.

Figure 18 below provides a breakdown of the UIP estimated claims reimbursement error types.

Figure 18: RY 2023 UIP Claims Reimbursement Error Types[1] (Dollar Amounts in Millions)



UIP Mitigation Strategies and Corrective Actions

Due to a lack of sufficient funds, the UIP stopped accepting testing and treatment claims on March 22, 2022, and on April 5, 2022, for vaccine administration claims. With the passage of FRA and the related rescission of program funds, no additional claims will be reimbursed under the UIP. Despite the shift in focus away from UIP claims reimbursements, HHS mitigates improper payments in UIP through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Internal Process or Policy Change	• **Historical Records:** HHS continues to prioritize organizing historical records of policy and program decisions already made into one accessible location. • **Claims Reprocessing:** HHS reprocessed claims incorrectly paid due to federal government error, such as internal adjudication or payment errors.
Cross Enterprise Sharing	• **Collaboration with the UIP Contractor:** HHS continues to work with the UIP contractor to address any data needs and brainstorm methods to address these needs, including any data integrity or quality issues. HHS is working with IT and Security partners, as well as the UIP contractor, to bring UIP data in-house in a secure manner, which can then be used for various requests, audits, and assessments.
Audits	• **Recipient Assessment:** Recipients of the UIP program are subject to review as set forth in the UIP Terms and Conditions. HHS conducts reviews of UIP claims reimbursement recipients to ensure compliance with applicable legislation and the UIP Terms and Conditions. HHS will begin to close out UIP assessments in the next calendar year.

7.9 TANF

TANF Statistical Sampling Process

Statutory limitations, specifically Section 417 of the Act (42 U.S.C. 617), preclude HHS from requiring states to collect the necessary information to conduct an improper payment measurement. As a result, the TANF program is not reporting an estimate.

TANF Mitigation Strategies and Corrective Actions

Because HHS lacks the authority to mandate state participation in a TANF improper payment measurement, it cannot gather essential data for implementing and reporting mitigation strategies and corrective actions. While states administer TANF and are responsible for reducing improper payments, HHS still supports state-level efforts to enhance TANF program integrity and prevent improper payments through the following actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Internal Process or Policy Change	• **Risk Assessment:** HHS conducts regular improper payment risk assessments, with the most recent TANF risk assessment completed in FY 2022. Information from these assessments helps to identify areas for risk mitigation and is used to inform refinements to the multi-faceted approach to supporting states. • **Budget Proposal:** In the FY 2024 President's Budget request, HHS proposed new statutory authority to gather more comprehensive data on TANF and maintenance-of-effort expenditures for non-governmental subrecipients. This is aimed at enhancing the monitoring of TANF spending and activities and establishing an improper payment rate.
Cross Enterprise Sharing	• **Data Sources:** States utilize the Public Assistance Reporting Information System, the National Directory of New Hires, and the Income and Eligibility Verification System to reduce improper payments.

7.10 FOSTER CARE

Foster Care Statistical Sampling Process

In response to COVID-19, HHS suspended Title IV-E reviews to protect the health and safety of state and federal reviewers and to ensure that state child welfare officials focused on 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 suspended 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 will re-establish the baseline for Foster Care's improper payment measurement once Title IV-E reviews resume and all states are included in the new cycle. To prepare for the resumption of the reviews, HHS updated the Title IV-E Foster Care Eligibility Review Instrument (IV-E Instrument) and Instructions to reflect the changes to the aspects of eligibility made by the *Family First Prevention Services Act*,[45] primarily relating to placements of children in childcare institutions or congregate care. On March 15, 2023, HHS released Program Instruction ACYF-CB-PI-23-06, which includes the updated Title IV-E Review Guide, with revised IV-E instrument and instructions, and announced plans for resuming onsite reviews in FY 2024.

Foster Care Mitigation Strategies and Corrective Actions

As Foster Care is administered by states, efforts to mitigate improper payments occur at the state level. HHS develops strategies and actions to assist states in addressing the primary contributors to Title IV-E improper payments. These improper payments result exclusively from state agencies incorrectly classifying cases and processing payments. The FY 2020 AFR contains information on the most recent underlying issues and prevalent

[45] 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.

payment errors. Although Title IV-E reviews were temporarily halted, HHS maintained other program integrity initiatives and used past data and experiences to update the following strategies and actions:

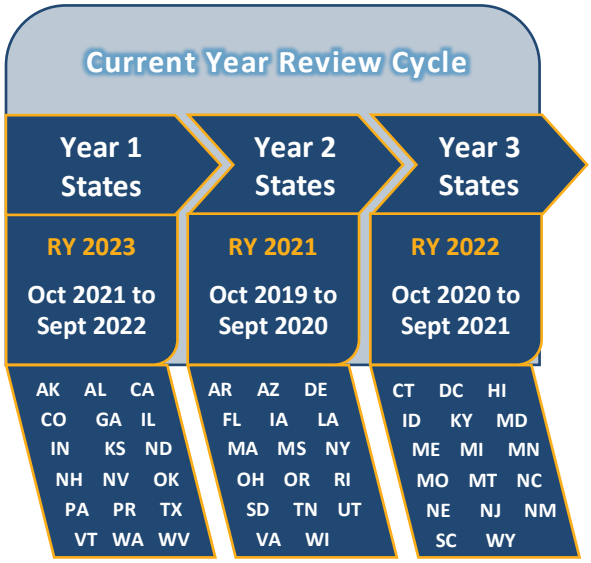
Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Training Webinar for HHS Staff**: To prepare for resuming Title IV-E Reviews, HHS conducted two training webinars in March 2023 for HHS staff, covering IV-E Instrument and Title IV-E Review Instructions. • **Training Webinars for Title IV-E Agencies**: In April 2023, HHS staff conducted two training webinars for Title IV-E agencies, offering guidance on using the IV-E Instrument and Instructions to assess eligibility when reviews resume in FY 2024. • **Program Improvement Support:** HHS maintains ongoing communication with states to offer guidance for strengthening their programs, fostering organizational growth, and enhancing program effectiveness.
Internal Process or Policy Change	• **Issued New IV-E Review Guide:** HHS updated the IV-E Review Guide, IV-E Instrument, and Instructions, and issued them through Program Instruction ACYF-CB-PI-23-06. The issuance included technical clarifications and outlined the Children's Bureau's plans for resuming IV-E Reviews with the revised IV-E Instrument. • **Updated Title IV-E Review Section of the Children's Bureau website:** HHS updated the website with the IV-E review materials and FY 2024 review schedule. • **Outreach Regarding Changes in Federal Requirements:** HHS reviewed state policy documentation and addressed eligibility-related questions. These interactions helped clarify Title IV-E requirements, documentation criteria, and supported states in understanding complex policy concepts for foster care maintenance payments.
Cross Enterprise Sharing	• **Emphasize Quality Improvement:** HHS collaborated with state Title IV-E Foster Care agencies to improve comprehension of program compliance requirements and share successful strategies among states. • **Information System:** States may receive federal financial support to develop and implement a Comprehensive Child Welfare Information System (CCWIS) in accordance with federal regulations at 45 CFR 1355.50 through 1355.59. • **CCWIS Self-Assessment Tools:** HHS provides Title IV-E agencies developing a CCWIS with a technical bulletin containing information on technical assistance, self-assessment tools (including one for Title IV-E Foster Care Eligibility), and CCWIS monitoring reviews.
Audits	• **Claims Reviews:** HHS continually reviewed states' Title IV-E quarterly claims to address and rectify claiming errors and anomalies.

7.11 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 19**.

Figure 19: CCDF Improper Payment Rate Review Cycle and RY



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.

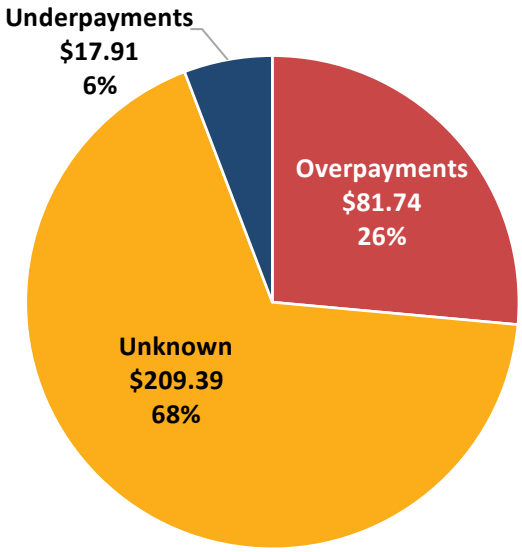
Calculations and Findings

CCDF properly paid an estimated 96.45 percent of total outlays or $8.39 billion. The CCDF improper plus unknown payment estimate is 3.55 percent or $309.04 million. HHS attributes the decrease, from 3.96 percent in RY 2022 to 3.55 percent in RY 2023, to HHS's successful multi-pronged approach to supporting states as they continue to comply with the CCDF reauthorization and related regulations. For example, in addition to more flexible time-limited policies related to COVID funding, HHS continued to provide technical assistance.

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 20 shows that unknown payments were considerably larger (at about 67.75 percent of total improper plus unknown payments or $209.39 million) than improper payments (the sum of overpayments, at about 26.45 percent or $81.74 million, and underpayments, at about 5.8 percent or $17.91 million).

Figure 20: RY 2023 CCDF Payment Categories[1] (Dollar Amounts in Millions)

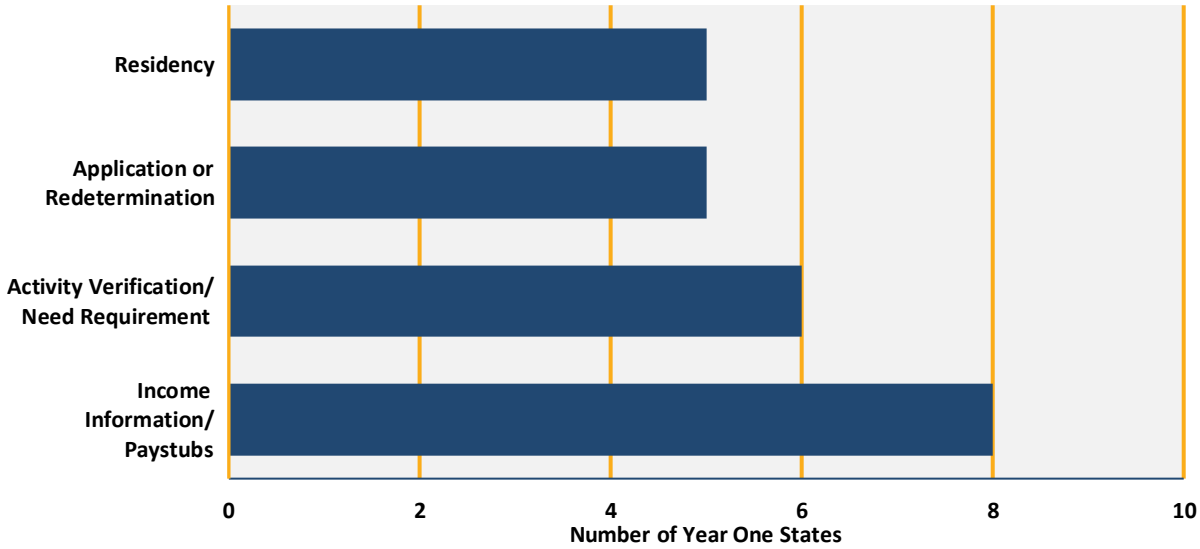


[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

Missing or insufficient documentation (67.75 percent or $209.39 million) and administrative errors made by a state or local agency (32.25 percent or $99.65 million; $81.74 million overpayments and $17.91 million underpayments) drive CCDF improper and unknown payments.

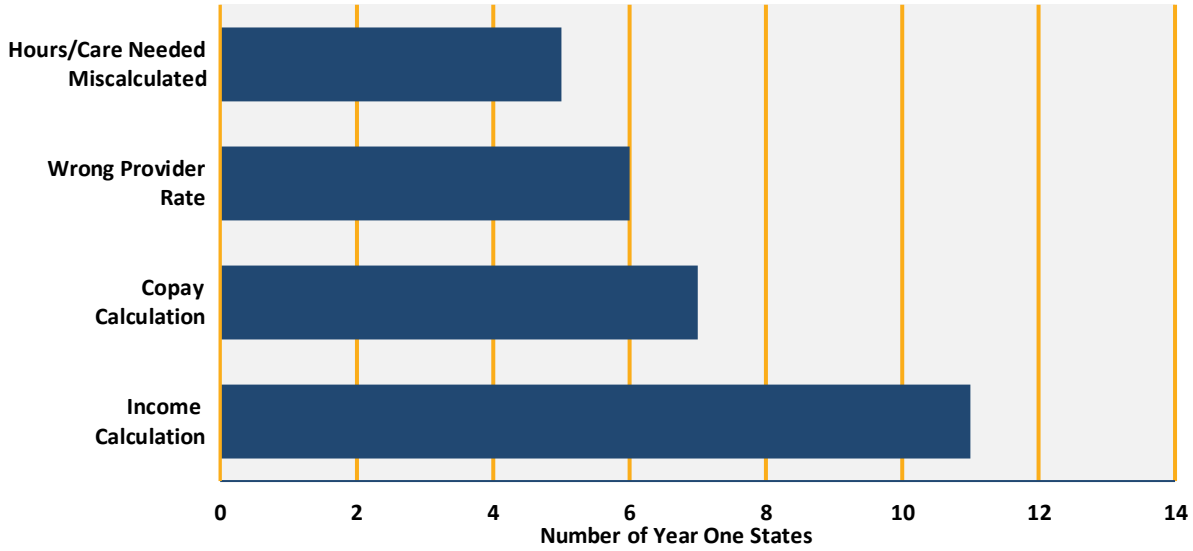
Missing or insufficient documentation errors accounted for an estimated 39.3 percent of the total number of payment errors identified in the CCDF review process. Errors were primarily due to missing or insufficient documentation in the case record. **Figure 21** presents the most frequently cited errors.

Figure 21: Most Frequently Cited Errors Due to Missing or Insufficient Documentation for CCDF



Administrative errors represent approximately 60.7 percent of the total number of errors noted in the Year One reviews. These errors consist of the failure to apply policy correctly, as shown in **Figure 22**.

Figure 22: Most Frequently Cited Errors Due to Administrative Errors for CCDF



CCDF Mitigation Strategies and Corrective Actions

As CCDF is administered by states, efforts to reduce improper payments are carried out at the state level. HHS assists states in developing mitigation strategies and corrective actions. States are required to report the causes of errors identified in both the previous and current review cycles, along with the actions planned to address these causes.

Year One states plan to:

- Provide guidance and training to eligibility workers;
- Review and update policies and procedures as needed;
- Meet with Eligibility Agencies to discuss errors;
- Develop new tools and procedures for eligibility staff;
- Conduct ongoing reviews and audits;
- Implement IT system fixes and updates; and
- Provide technical assistance to eligibility staff.

HHS mitigates improper payments in CCDF through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• Visited states needing assistance to address root causes. • Offered states technical assistance to meet new CCDBG requirements through policy and procedure changes. • 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, accountability, and reauthorization requirements. • Provided technical assistance to states improving or developing IT systems to enhance practices and reduce errors. • Offered training on improper payments methodology, including error rate reviews, and sharing best practices among states.

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
	• Conducted Joint Case Reviews involving all reporting states and both state and federal staff. These efforts provided insights into error measurement methodology implementation and offered technical assistance to ensure consistency in reviews. • Deployed written CAP Review Protocol to enhance CAP implementation and its effectiveness in addressing identified root causes of improper payments.

7.12 HEAD START

Head Start Statistical Sampling Process

The Office of Head Start (OHS) annually awards over $10 billion in federal grants to approximately 2,000 funding recipients in the Head Start program. Each recipient reports a draw amount, which is the total amount withdrawn from their award within the period under review. For FY 2023 reporting, the period under review is October 01, 2021, through September 30, 2022. The draw amount encompasses each transaction or payment made by the recipient and reflects recipient spending and utilization during the period identified. For the improper payment calculation, OHS evaluated each payment in the period under review to determine if it was a proper or improper payment.

The sampling universe is the full list of payments made in the period under review for each recipient of Head Start funding. To maintain that the sample was reflective of the universe of recipients from which the sample was drawn, Head Start recipients were stratified into five strata based on their draw amounts. The total draw amount across all recipients was divided by five to determine the total expenditures to be allocated to each stratum, so that each stratum consisted of 20 percent of the total expenditures. Recipients were then sorted in descending order by draw amounts. The top stratum consisted of recipients with the largest draw amounts and 20 percent of total expenditures. This sequence repeated until all five strata were created, with each stratum including 20 percent of the total expenditures.

Since stratification was based on draw amounts, the top stratum contained the fewest number of recipients, and the bottom stratum contained the highest number of recipients. Recipients with the highest draw amounts were in the top stratum, and recipients with the lowest draw amounts were in the bottom stratum, respectively. To create a representative sample, 30 recipients were sampled from each of the five strata, for a total sample size of 150.

HHS estimated the total improper payments using a hybrid ratio estimator to calculate the overall improper payment rate and confidence intervals. The overall improper payment rate combined improper payment rates from each sampling stratum by their relative share of payments in the universe.

Calculations and Findings

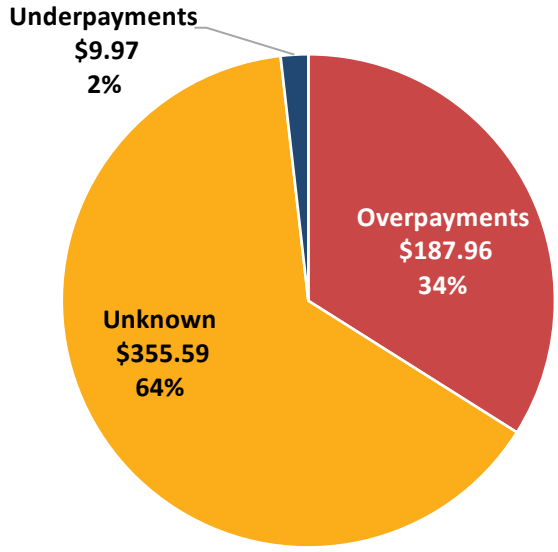
Head Start properly paid an estimated 94.9 percent of total outlays or $10.29 billion. The Head Start improper payment plus unknown payment estimate is 5.1 percent or $553.52 million.

Missing or insufficient documentation errors related to Salaries and Wages and Fringe Benefits account for the majority of Head Start improper payments (20.44 percent or $113.15 million). A portion of the improper overpayments were related to unsupported staff appreciation and wellness purchases (6.53 percent or $36.15 million). Two grant recipients accounted for the unknown payment amount. The first of these recipients was unable to provide documentation at the level of detail that could be tested under the methodology, which accounts for 40

percent or $221.41 million. The second recipient is the subject of an active fraud investigation and was not tested, accounting for 24.24 percent or $134.18 million.

Figure 23 below provides a breakdown of the Head Start estimate by payment type.

Figure 23: RY 2023 Head Start 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.

Head Start Mitigation Strategies and Corrective Actions

HHS mitigates improper payments in Head Start through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Audits	HHS plans to take recovery action on payment errors identified during improper payment reviews and continues to issue disallowances on errors discovered through HHS Office of Inspector General audits, HHS program reviews, and Single Audits.
Internal Process or Policy Change	In September 2023, HHS enhanced the monitoring tool to include transaction reviews. HHS also plans to issue Information Memorandum and Program Instructions as needed to ensure fiscal and program integrity.
Training	Throughout FY 2023, HHS provided training in areas such as procurement, source documentation, cost allocation, and other common fiscal challenges identified by subject matter experts.

8.0 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 7.0: *Program-Specific Reporting Information* and the following subsections. HHS considers lessons learned from these experiences as it implements this requirement. Reported

recoveries in this section represent the amounts recovered in FY 2023, which may encompass various reporting years in which HHS identified overpayments.

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.[46] All Medicare FFS RAC contracts are renewed on a rolling basis. In FY 2023, a new contractor became operational in RAC Region 2. As required by Section 1893(h), RACs are paid on a contingency fee basis.

The Medicare FFS RAC program identified approximately $352.5 million in overpayments and recovered $273.15 million. Outpatient claims represented the majority of Medicare FFS RAC collections. Medicare FFS RACs made 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 one 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-GHP (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.

The CRC identified approximately $432.69 million and collected $260.93 million in mistaken payments. The MSP RAC recommended HHS improve program operations by:

- Implementing an electronic Duplicate Primary Payment process, reducing processing costs for the CRC and Part A/B MACs; and
- Enhancing the MSP GHP recovery portal to enable users to submit correspondence or inquiries, with the primary goals of providing better customer support and improving work inventory management, thereby reducing processing costs.

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 requirement. These steps are discussed on page 243 of HHS's FY 2021 AFR.

[46] 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.

Despite their success in Medicare FFS, RACs have found Medicare Part C does not represent an appealing business case for them because of differing payment structures, a narrow scope of payment error, and unlimited appeal 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 4.1: *Payment Integrity Efforts*, based on the PPI MEDIC's data analysis projects and Part D plan sponsor self-audits, HHS recovered $6.6 million 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 exemptions 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 $215.74 million and reflect overpayments collected, adjusted, or refunded to HHS, as reported by states on the Form CMS-64, Medicaid Statement of Expenditures.[47]

Recovery Auditing Reporting Table

Table 3 provides information on HHS's recovery auditing programs and other efforts to recover IP.

[47] This amount may differ from 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.

Table 3: Overpayments Recovered through and Outside of Recovery Audits

FY 2023 (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]				$24.25	$16.76
Medicare FFS Recovery Auditors	$352.50	$273.15	77%		
MSP Recovery Auditor	$432.69	$260.93	60%	N/A	N/A
Medicare Contractors [3]				$13,393.14	$14,712.70
Medicaid Integrity Contractors—Federal Share [4]				$35.60	$13.81
State Medicaid Recovery Auditors—Federal Share [5]	N/A	$215.74	N/A		
ACF Error Rate Measurements [6]				$0.08	$0.01
ACF OIG Reviews [7]				$15.48	$1.02
ACF Program Reviews [8]				$16.10	$16.10
ACF Single Audits [9]				$13.62	$15.55
Single Audits [10]				$869.73	$278.73
HRSA National Health Service Corps				$14.77	$5.72
TOTAL [11]	**$785.19**	**$749.82**	**95%**	**$14,382.77**	**$15,060.40**

Notes:

1. The amount reported in the Amount Recovered column is the amount recovered in FY 2023, regardless of the year HHS identified the overpayment.
2. This 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 2023 report period were $22,649,410.87. The MACs recovered the identified overpayments via standard payment recovery methods. As of the report publication date, MACs reported collecting $16,583,931.47 or 73.22 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 2023 report period were $1,459,435.90 for Medicaid and $145,238.89 for CHIP. HHS recovered $65,650 for Medicaid and $111,811 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. 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. This row contains Amount Identified information for the CCDF and Head Start programs for which the amounts were identified during the current reporting year. Since HHS suspended Foster Care reviews, no new reviews have taken place and consequently HHS identified no overpayments or recoveries during the current reporting year. 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 unintentional worker error identified in the improper payments review. For CCDF's portion of the Amount Identified and Amount Recovered information, data reported in FY 2023 represent improper payments recovered in FYs 2020 through 2022 by the Year One states based on improper payments identified in FY 2020. States reported identifying $66,718. and recovering $7,605. For Head Start, HHS identified $8,998 in improper payments during the FY 2023 report period and made no recoveries; however, HHS is continuing recovery activities in FY 2024 for the program.
7. This row contains Amount Identified information for all ACF programs for which the amounts from an HHS OIG Report were sustained from August 1, 2022 to July 31, 2023.
8. This row contains Amount Identified information for all ACF programs for which the amounts from an ACF conducted program review was sustained from August 1, 2022 to July 31, 2023.
9. This row includes results from August 1, 2022 to July 31, 2023.
10. This row includes information for all Divisions except ACF and represents results for the full FY 2023.
11. Totals do not necessarily equal the sum of the rounded components.

FY 2023 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: October 31, 2023

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 2023

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 2023 are:

1. Safeguarding Public Health
2. Ensuring the Financial Integrity of HHS Programs
3. Improving Outcomes in Medicare and Medicaid
4. Protecting HHS Beneficiaries
5. Securing Data and Technology

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 who are enrolled in these programs. If you have any questions or comments, please contact me, or your staff may contact Megan Tinker, Chief of Staff, at (202) 539-6271 or Megan.Tinker@oig.hhs.gov.

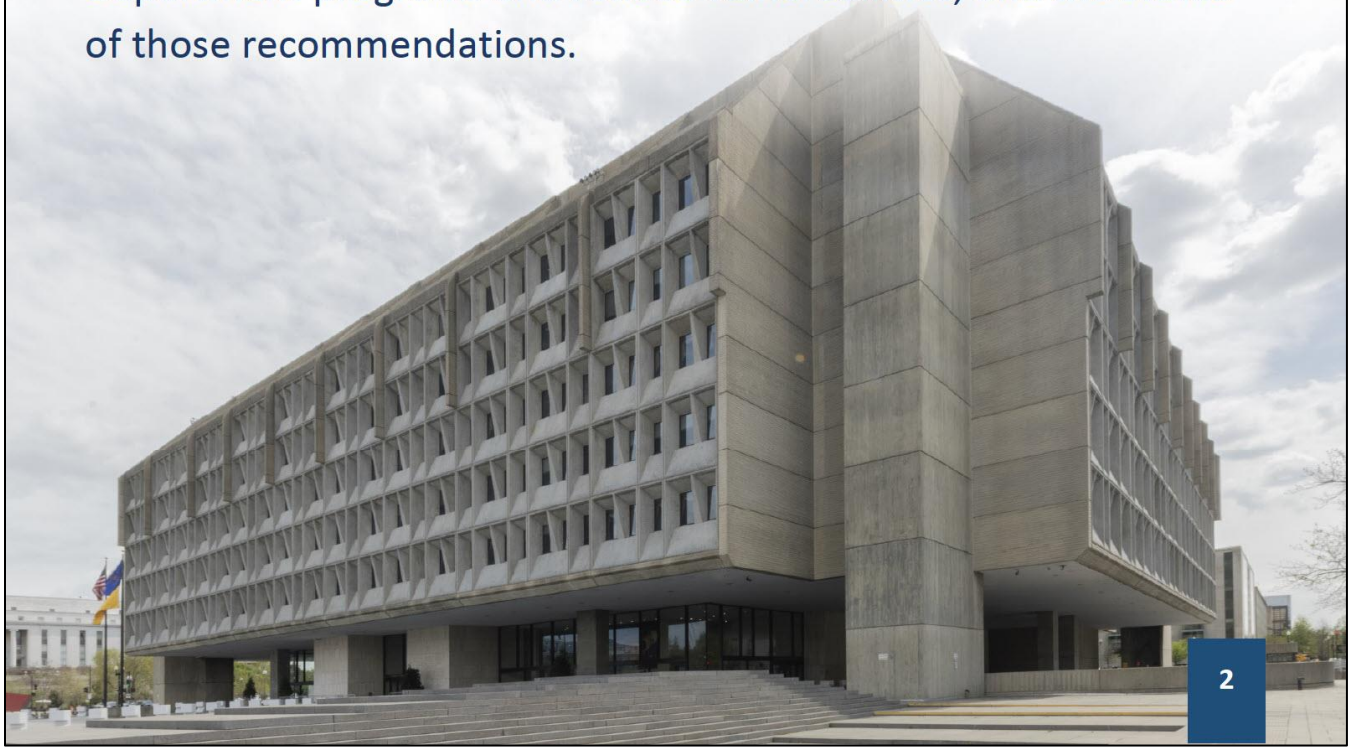
FY 2023 Top Management and Performance Challenges Identified by the Office of Inspector General

Contents

Introduction

Every year, the Department of Health and Human Services (HHS or the Department), Office of Inspector General (OIG) fulfills its statutory obligation to produce the *Top Management and Performance Challenges Facing HHS*. While the Department has made efforts to address the challenges that we identify in this document, considerable opportunities exist for further progress. This document helps the Department fulfill its mission to enhance the health and well-being of all Americans by directing the Department's focus on the top management and performance challenges identified by OIG.

OIG's website offers additional oversight resources, including all reports mentioned here, OIG recommendations to improve Department programs and reduce vulnerabilities, and the status of those recommendations.



1 | Safeguarding Public Health

Elements of the Challenge

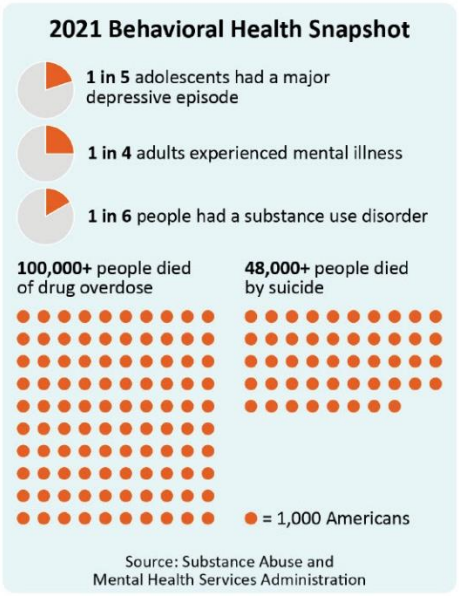
- Addressing the mental health and substance use disorder crises
- Improving maternal health
- Strengthening emergency preparedness and response capabilities
- Ensuring the safety, effectiveness, and availability of Food and Drug Administration-regulated products

HHS must work to better safeguard public health, including the following key areas:

Addressing the Mental Health and Substance Use Disorder Crises

In 2021, more than 1 in 5 American adolescents had a major depressive episode, nearly 1 in 4 American adults experienced mental illness, nearly 1 in 6 Americans had a substance use disorder, more than 48,000 Americans died by suicide, and more than 100,000 Americans died from drug overdoses. Challenges obtaining high-quality care for mental health and substance use compound the devasting effects of the Nation's mental health and substance use disorder crises.

HHS programs must improve behavioral health care and supports, such as by expanding community-based prevention efforts, enhancing access to affordable behavioral health treatments, and developing a diverse behavioral health workforce that can serve the public well and meet the needs of people from diverse backgrounds, understandings, and communication abilities.



Improving Maternal Health

Too many Americans die during pregnancy, childbirth, and the postpartum period. More than 4 in 5 of these pregnancy-related deaths are preventable. Black people, American Indian and Alaska Native people, and residents of rural areas suffer disproportionately high rates of maternal mortality and other pregnancy complications. The Department must work to improve pregnancy-related care and eliminate racial, ethnic, geographic, and socioeconomic disparities in health outcomes for parents and newborns.

Strengthening Emergency Preparedness and Response Capabilities

Public health emergencies (PHEs), such as communicable diseases and storms, fires, and human-caused disasters, severely strain public health and medical infrastructure.

As PHEs increase in frequency and severity, HHS must build resilience and enhance preparation and response efforts to limit negative impacts on HHS programs and the public when these emergencies occur. Additionally, HHS must strengthen the Nation's emergency preparedness and response capabilities by enhancing public health infrastructure, including establishing highly functional data systems with accurate information about risk and response, a well-developed public health workforce, and mechanisms for effective coordination with States, localities, Tribes, and Federal intragovernmental partners. HHS must foster public trust and improve communication to better lead response and recovery in future PHEs.

Ensuring the Safety, Effectiveness, and Availability of Food and Drug Administration-Regulated Products

HHS's Food and Drug Administration (FDA) regulates crucial consumer products, including human and veterinary drugs, biological products, medical devices, food, cosmetics, products that emit radiation, tobacco, and infant formula. Fifteen cents of every dollar American consumers spend goes to these FDA-regulated products. Reliance on overseas manufacturing, increasingly complex supply chains, novel threats from cyberattacks and other security vulnerabilities, and PHE-related disruptions complicate FDA's mission. FDA must account for these threats and ensure the safety, effectiveness, quality, security, and availability of FDA-regulated products.

OIG Highlighted Work

- Opioid Overdoses and the Limited Treatment of Opioid Use Disorder Continue To Be Concerns for Medicare Beneficiaries
- Instances of IHS Labor and Delivery Care Not Following National Clinical Guidelines or Best Practices
- Toolkit: Insights for Communities From OIG's Historical Work on Emergency Response
- The Food and Drug Administration's Foreign For-Cause Drug Inspection Program Can Be Improved To Protect the Nation's Drug Supply

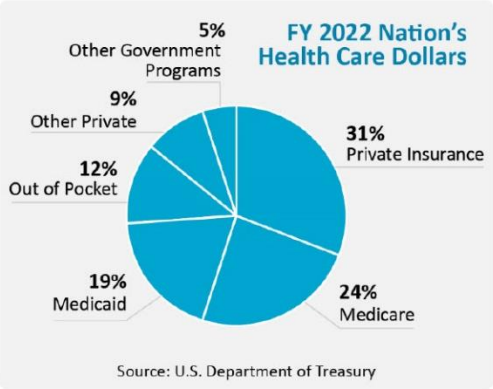
4

2 | Ensuring the Financial Integrity of HHS Programs

Elements of the Challenge

- Preventing, reducing, and recovering improper payments
- Protecting programs from fraud, waste, and abuse
- Controlling costs by ensuring prudent payments
- Monitoring and reporting on the integrity of HHS financial management

Given the $2.4 trillion investment in the HHS budget for fiscal year (FY) 2022 and the critical importance of the programs that HHS funds, the Department must work to ensure sound stewardship and combat fraud, waste, and abuse.



Source: U.S. Department of Treasury

Preventing, Reducing, and Recovering Improper Payments

In FY 2022, improper payments for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) were estimated at $131.6 billion. Improper payments duplicate other payments, fund ineligible services, enrich ineligible providers, cover care for ineligible recipients, or violate other program rules.

- Within the Medicare fee-for-service program, reducing improper payments remains a challenge despite the Centers for Medicare & Medicaid Services' (CMS's) efforts targeting longstanding areas of concern, such as hospice, home health, hospital outpatient, and skilled nursing facility care. Emerging areas of concern, such as aberrantly high-billing labs, upcoded hospital stays to increase reimbursement, and genetic testing, also require attention.

- In the Medicaid program, HHS estimated that the FY 2022 improper payment rate exceeded 15 percent of all payments. Exacerbating Medicaid's challenges, the end of the COVID-19 PHE triggered Medicaid and CHIP eligibility changes that could impact millions of people. States' Medicaid enrollment and renewal processes must meet Federal statutory and regulatory requirements. CMS has an oversight responsibility to ensure that these programs serve and maintain coverage for eligible beneficiaries. Correcting eligibility errors and recouping overpayments from State Medicaid agencies could be particularly challenging.

- HHS also disburses taxpayer dollars via grants and contracts. The Department must provide guidance and up-to-date policies to inform grant recipients and subrecipients on financial management, internal controls, and Federal and Departmental Regulations. This includes ensuring sufficient visibility into subrecipients' use of grant funds to ensure grants are being used for their intended purpose. For contracts, HHS needs to continue its efforts to improve the contract management and closeout processes.

Protecting Programs From Fraud, Waste, and Abuse

The Department must prevent, identify, and remedy fraud, waste, and abuse to ensure that taxpayer money serves important program goals and is not diverted for inappropriate, unauthorized, or illegal purposes. The Department must enhance oversight and internal controls to guard against fraud schemes, including embezzlement and theft. Novel fraud schemes, such as scams that use social media to offer fake grants, increase the need for vigilance.

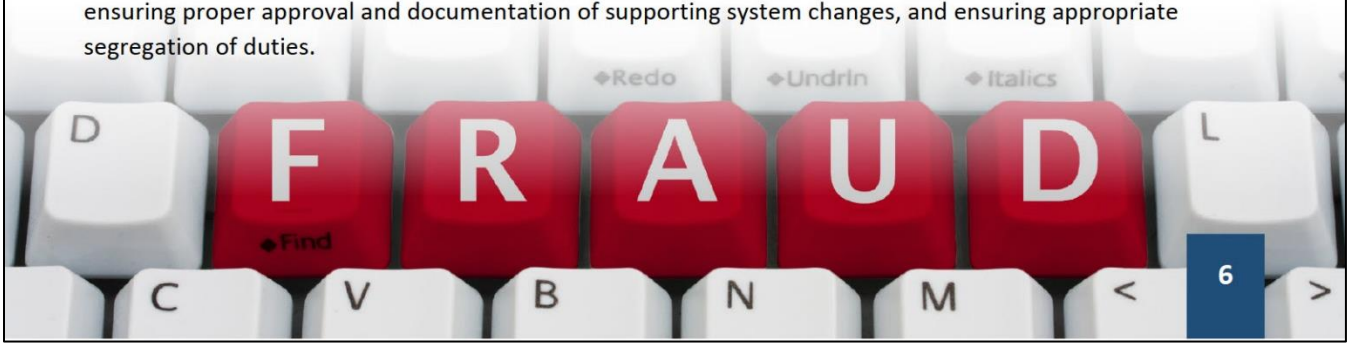
Suspension and debarment programs promote integrity for Federal grants and contracts by ensuring that the Federal Government does business only with responsible people. HHS has improved its suspension and debarment programs by offering outreach, training, and guidance, but additional efforts are needed.

Controlling Costs by Ensuring Prudent Payments

HHS must assess its payment policies, including identifying problematic policies that create perverse incentives for providers or impede patients' access to needed care. To the extent feasible under current law, CMS should establish prudent payment policies that control costs and promote appropriate utilization. Prescription drugs are one area in which policymakers seek to reduce spending and increase coverage. The Inflation Reduction Act requires the Department to implement certain complex new authorities, including negotiating prices for certain high-expenditure Medicare drugs. The Department announced in August 2023 the first 10 drugs subject to negotiation.

Monitoring and Reporting on the Integrity of HHS Financial Management

Within HHS, deficiencies persist in internal controls over segregation of duties, configuration management for approved changes to HHS financial systems, and access to HHS financial systems that could compromise financial management. Although the Department has taken steps to improve its financial systems, it must take additional actions to address and resolve these issues, including continuing efforts to control user access, ensuring proper approval and documentation of supporting system changes, and ensuring appropriate segregation of duties.



OIG Highlighted Work

- CMS's Oversight of Medicare Payments for the Highest Paid Molecular Pathology Genetic Test Was Not Adequate To Reduce the Risk of up to $888 Million in Improper Payments
- HHS's Suspension and Debarment Program Helped Safeguard Federal Funding, But Opportunities for Improvement Exist
- Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States
- UPICs Hold Promise To Enhance Program Integrity Across Medicare and Medicaid, But Challenges Remain
- Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks
- Technical Assistance Brief: Implementation of Inflation-Indexed Rebates for Part B Drugs
- Medicare Could Have Saved up to $216 Million Over 5 Years if Program Safeguards Had Prevented At-Risk Payments for Definitive Drug Testing Services
- Trend Toward More Expensive Inpatient Hospital Stays in Medicare Emerged Before COVID-19 and Warrants Further Scrutiny

3 | Improving Outcomes in Medicare and Medicaid

Elements of the Challenge

- Combating fraud, waste, and abuse
- Improving quality and safety in nursing homes
- Strengthening oversight of managed care programs
- Fostering equitable access to high-quality care

More than 147 million American seniors, individuals with disabilities, people in low-income households, and individuals with end-stage renal disease and other complex health needs rely on Medicare and Medicaid, so HHS must ensure that these programs deliver high-quality care without disparate outcomes or barriers to access.

Combating Fraud, Waste, and Abuse

Minimizing fraud, waste, and abuse is critical to helping Medicare and Medicaid programs deliver quality to enrollees and value to taxpayers. HHS must focus on fraud prevention (e.g., provider enrollment screening and revalidation), detection (e.g., claims and other data analysis), and enforcement to recover misspent funds, protect patients from harm, and hold wrongdoers accountable. The Department must remain vigilant to protect Medicare and Medicaid programs from fraud, waste, and abuse across all service and provider types, but especially those in high-risk areas, such as durable medical equipment, home health, hospice, genetic testing, treatment for substance use disorder, COVID-19 test billing, and medical identity theft. Different CMS programs (e.g., managed care, traditional Medicare, value-based care models) have different risks because they pay for services or coverage differently. As HHS revises payment policies and incentives, it must anticipate and guard against exploitation of specific payment designs.

Payment Incentive Risk Areas

Traditional Fee-for-Service:

- Inappropriate increased utilization
- Selection of more expensive services than needed
- Improper patient steering

Managed Care

- Denying care
- Discriminating against patients who require costly care and services
- Manipulating/falsifying risk adjustment data

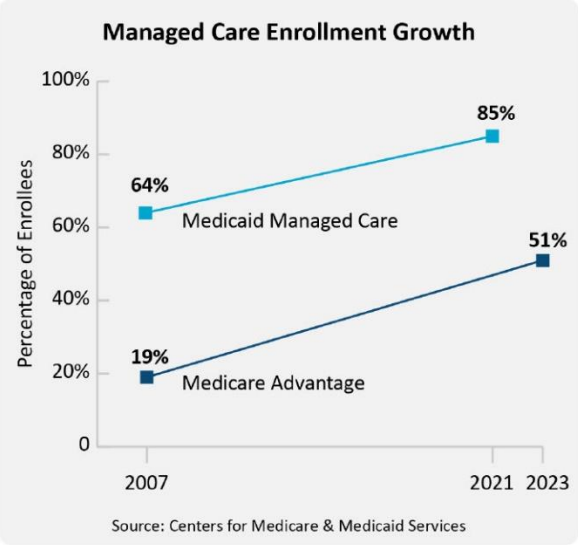
Improving Quality and Safety in Nursing Homes

Nursing home residents deserve safe, high-quality care, yet improving nursing homes remains one of the most complex and intransigent challenges facing the American health care system. The unprecedented COVID-19 pandemic had widespread negative effects across the health care system. It posed novel challenges for nursing home staff, residents, and families, and highlighted longstanding problems in areas such as emergency preparedness and infection control; staffing shortages; frontline oversight by CMS and State survey agencies; and health disparities based on race, ethnicity, and geography.

HHS must continue to focus on improving nursing home performance, including ensuring sufficient staffing to meet residents' needs, expanding transparency of private equity and other ownership information to better understand linkages to quality of care, and bolstering emergency preparedness and infection control. The Department must continue to take meaningful steps to foster safe, high-quality, dignified care for residents in areas such as chemical restraints, facility-initiated discharges, and preventing abuse and neglect. Finally, the Department must remain attentive to strengthening the effectiveness of State survey agency performance and the response to poor-performing nursing homes, such as through the Special Focus Facility Program. Improving nursing home care will require partnerships and sustained commitment from Government and private stakeholders to achieve positive change.

Strengthening Oversight of Managed Care Programs

As managed care continues to expand, now covering more than half of Medicare enrollees and more than 80 percent of Medicaid enrollees, HHS must ensure that managed care operates effectively and efficiently. The Medicare Advantage program suffers when Medicare Advantage organizations claim additional government payments by making their enrollees appear sicker than they might be or when plans avoid costs by denying care that would otherwise be covered by Medicare. CMS must improve its oversight, including of chart reviews and health risk assessments conducted by plans, to ensure accurate risk-adjusted payments that truly reflect enrollees' health status. CMS must also improve its oversight of Medicare and Medicaid managed care to reduce inappropriate prior authorization and payment denials that serve plan profits over enrollees' health. Recently, CMS has taken steps to increase transparency and improve the information Medicare enrollees can access about Medicare Advantage organizations' prior



authorization and coverage decisions, and it began phasing in updates to the Medicare Advantage risk adjustment model to improve the accuracy of Medicare Advantage.

Fostering Equitable Access to High-Quality Care

Disparities in access and quality of care and in health outcomes persist for Medicare and Medicaid enrollees in some geographic areas, members of some racial and ethnic groups, and individuals with intellectual and physical disabilities. Disparities may be even more pronounced for access to high-quality prenatal care, mental health services, and treatment for substance use disorder. During the COVID-19 PHE, Congress temporarily expanded access to telehealth for Medicare enrollees, resulting in a dramatic increase in use of telehealth. However, telehealth use varied greatly among enrollees in different geographic areas and among certain demographic groups. As the Department implements new telehealth policies, it must balance concerns about issues such as access, quality of care, health equity, privacy and security, and program integrity. As HHS works to reduce health disparities, it must improve the accuracy of relevant data to help measure and facilitate progress in reducing disparities.

OIG Highlighted Work

- Oversight of Managed Care for Medicare and Medicaid
- Medicare Advantage Compliance Audit of Diagnosis Codes That Humana, Inc., (Contract H1036) Submitted to CMS
- High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care
- Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care
- CMS Should Take Further Action To Address States With Poor Performance in Conducting Nursing Home Surveys

4 | Protecting HHS Beneficiaries

Elements of the Challenge

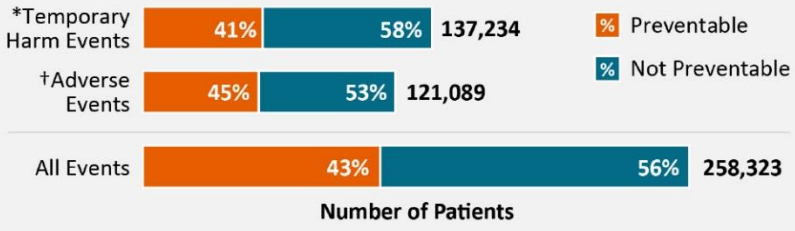
- Ensuring safety and quality in Federal health care programs
- Protecting the health and safety of children
- Preventing abuse and neglect

HHS programs provide and/or fund critical health care, child care, and educational services for diverse populations in hospitals, clinics, child care facilities, shelters, nursing homes, and peoples' own homes. Ensuring that intended beneficiaries receive appropriate services that meet standards for quality, are free from abuse or neglect, and do not experience preventable harm represents a major challenge for the Department.

Ensuring Safety and Quality in Federal Health Care Programs

Federal health care programs must deliver care that meets quality and safety standards and that intended beneficiaries can access without undue burden or disparities. Although HHS has made progress, more work remains to improve access to and quality of all types of care. Too often, health care results in patient harm, much of which is preventable.

Patient Harm Events:
OIG Analysis of Hospital Stays for Medicare Patients in October 2018



Source: OIG analysis of hospital stays for Medicare patients in October 2018 using medical record review of a simple random sample of 770 patients.

* The rate and projected 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 projected 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.

Protecting the Health and Safety of Children

In addition to health care, HHS operates or funds programs that provide child care, education, and residential care to many children, such as children living in foster care and children in the Unaccompanied Children (UC) Program. The Administration for Children and Families should work with States to increase compliance with Federal requirements to protect children in foster care from human trafficking. Unaccompanied children who enter the United States without lawful immigration status are referred to the custody of the Office of Refugee Resettlement (ORR). Most children are released from ORR care to a sponsor, usually a parent or other family member. HHS strives to limit children's time in ORR care while ensuring safe and appropriate release to vetted sponsors.

For children who remain in ORR care, the Department must ensure that UC Program-funded facilities meet all health and safety requirements and provide adequate medical and mental health care. HHS must continue to enhance efforts to ensure that all individuals with access to children have passed required background checks.

Preventing Abuse and Neglect

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. Most providers earn this trust and work hard to serve people well. However, some providers harm people, and the Department must better protect those enrolled in its programs from abuse and neglect. The Indian Health Service recently initiated extensive measures to protect patients from sexual predators after an Indian Health Service pediatrician went to prison for sexually assaulting boys he treated as patients. These measures reflect meaningful progress, but better attention to protecting people of all ages at risk for abuse and neglect in all care settings is needed.

Thoroughly vetting providers and staff by using background checks helps prevent potential predators from gaining access to victims in Federal programs. The Department must ensure adequate background checks in HHS-funded child care programs and health care settings.

Although awareness may be highest in pediatric settings and nursing homes, people in all care settings are at risk of abuse and neglect. Identifying and reporting abuse and neglect is important but may be particularly challenging in non-facility settings, such as home and community-based services or group homes. All States have enacted mandatory reporting laws that require professionals, such as teachers or nursing home staff, to report suspected abuse or neglect targeting certain individuals, but more must be done to help victims and hold wrongdoers accountable.

States and other partners should use claims data to better identify unreported abuse and neglect, and 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 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 that requires attention and cooperation from all stakeholders.

OIG Highlighted Work

- Adverse Events in Hospitals: A Quarter of Medicare Patients Experienced Harm in October 2018
- The Office of Refugee Resettlement Needs To Improve Its Oversight Related to the Placement and Transfer of Unaccompanied Children
- The Office of Refugee Resettlement Needs To Improve Its Practices for Background Checks During Influxes
- Toolkit: Insights from OIG's Work on the Office of Refugee Resettlement's Efforts To Care for Unaccompanied Children
- Medicaid Data Can Be Used To Identify Instances of Potential Child Abuse or Neglect
- All Six States Reviewed Had Partially Implemented New Criminal Background Check Requirements for Childcare Providers, and Five of the States Anticipate Full Implementation by Fiscal Year 2020
- In Five States, There Was No Evidence That Many Children in Foster Care Had a Screening for Sex Trafficking When They Returned After Going Missing
- A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect

5 | Securing Data and Technology

Element of the Challenge

- Improving cybersecurity for HHS programs, related industry sectors, and individuals

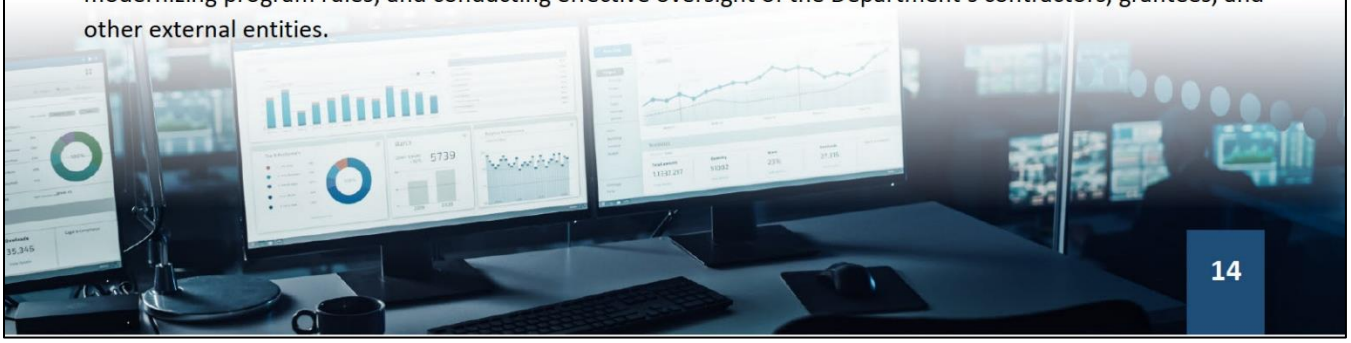
HHS faces persistent cybersecurity threats that exacerbate the challenges associated with data and technologies used to carry out the Department's vital health and human service missions. The large scale of HHS's mission and information technology environments requires that the Department simultaneously address a range of cybersecurity risks along with the specific data and technology needs for each Operating Division/Staff Division (OpDiv/StaffDiv) or program.

HHS faces persistent cybersecurity threats that exacerbate the challenges associated with data and technologies used to carry out the Department's vital health and human service missions.

Improving Cybersecurity for HHS Programs, Related Industry Sectors, and Individuals

Cyberattacks and related threats can imperil critical HHS operations and programs, potentially compromising the health and welfare of individuals HHS serves. Disparate organizational approaches to cybersecurity that vary by OpDiv/StaffDiv within the Department and across the Government complicate HHS's preparedness efforts to prevent or respond to cybersecurity risks. Improving cybersecurity posture requires significant resource investments and cultural and organizational change across HHS. The Department must ensure that its agencies and programs employ a risk-based approach to identifying and implementing information system security solutions to protect technology and data.

Comprehensive cybersecurity solutions must be implemented not just within the Department but also by the thousands of HHS contractors, grantees, and other external entities. For many HHS programs, effective cybersecurity will depend on these multiple parties implementing comprehensive security solutions that mitigate cyber threats specific to their operations. Protecting technology and data also requires broader efforts beyond implementing technical cybersecurity fixes, such as establishing clear expectations; modernizing program rules; and conducting effective oversight of the Department's contractors, grantees, and other external entities.



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HHS must also address significant cybersecurity threats for sectors it oversees. For example, the health care industry remains a prime target for cyberattacks. Bad actors continue to leverage the threat of interrupting patient care to extract ransoms or other value from health care entities. The diffuse nature of HHS cybersecurity authorities and responsibilities complicates response efforts. Some HHS OpDivs/StaffDivs have limited or no authority or expertise to address cybersecurity risks affecting sectors they oversee. Besides HHS, other Federal departments, such as Federal law enforcement and the Department of Homeland Security Cybersecurity and Infrastructure Security Agency, share cybersecurity responsibilities, adding coordination and communication challenges.

To address these challenges, the Department must lead a network of Federal agencies to improve the cybersecurity of the health care and public health sectors. HHS has employed public-private partnerships to improve threat communication with industry partners, but challenges remain that the Department has limited tools to address, including the industry's reliance on legacy technology and workforce challenges.

New approaches to delivering health care, such as expansion of telehealth and remote patient monitoring, can improve access to and quality of care while greater provider interconnectivity can enhance care coordination, but HHS must identify and address the cybersecurity risks associated with their use. As cybersecurity threats and potential targets increase, HHS must maintain vigilance, expeditiously address vulnerabilities, and help the health care industry adapt.

The Department must also work to protect the privacy of sensitive individual data replete throughout the health care system. HHS's actions to enforce the decades-old Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and HIPAA Security Rule may not be sufficient to address contemporary privacy concerns or changes in how patient information is collected and used. The Department must adapt as privacy and security needs evolve and provide guidance for patients and providers.

OIG Highlighted Work

- The Centers for Medicare & Medicaid Services Should Improve Preventative and Detective Controls To More Effectively Mitigate the Risk of Compromise
- The IHS Telehealth System Was Deployed Without Some Required Cybersecurity Controls
- Maryland MMIS and E&E System Security Controls Were Partially Effective and Improvements Are Needed
- Michigan MMIS and E&E Systems Security Controls Were Generally Effective, but Some Improvements Are Needed
- Massachusetts MMIS and E&E System Security Controls Were Generally Effective, but Some Improvements Are Needed

Conclusion

Careful attention to these top management challenges will help the Department achieve its crucial mission to manage taxpayer dollars responsibly, safeguard public health, and deliver high-quality care and services.

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Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

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Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

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Anyone may request confidentiality. The Privacy Act, the Inspector General Act, and other applicable laws protect complainants. The Inspector General Act of 1978 states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

Department of Health and Human Services
Office of Inspector General

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: Fiscal Year 2023 Top Management and Performance Challenges Facing HHS

Thank you for the Office of Inspector General's (OIG) work in assessing the key management and performance challenges facing the Department of Health and Human Services (HHS). The OIG's commitment to improving HHS operations through its oversight and analysis provides critical benefits to our stakeholders and the beneficiaries who rely on HHS to help improve their health and well-being.

HHS faces several long-term challenges. The suggestions you offer to address our challenges will help inform and improve our decisions relating to safeguarding data and technology, program integrity, and other mission-critical functions. It is important we find innovative ways to work more efficiently.

We appreciate the opportunity to review and comment on the report. HHS will continue to earnestly address these challenges and other issues as we focus on improving the health and well-being of the American people. We look forward to partnering with you as we execute our vital mission.

/Andrea Palm/

Andrea Palm
Deputy Secretary
November 14, 2023

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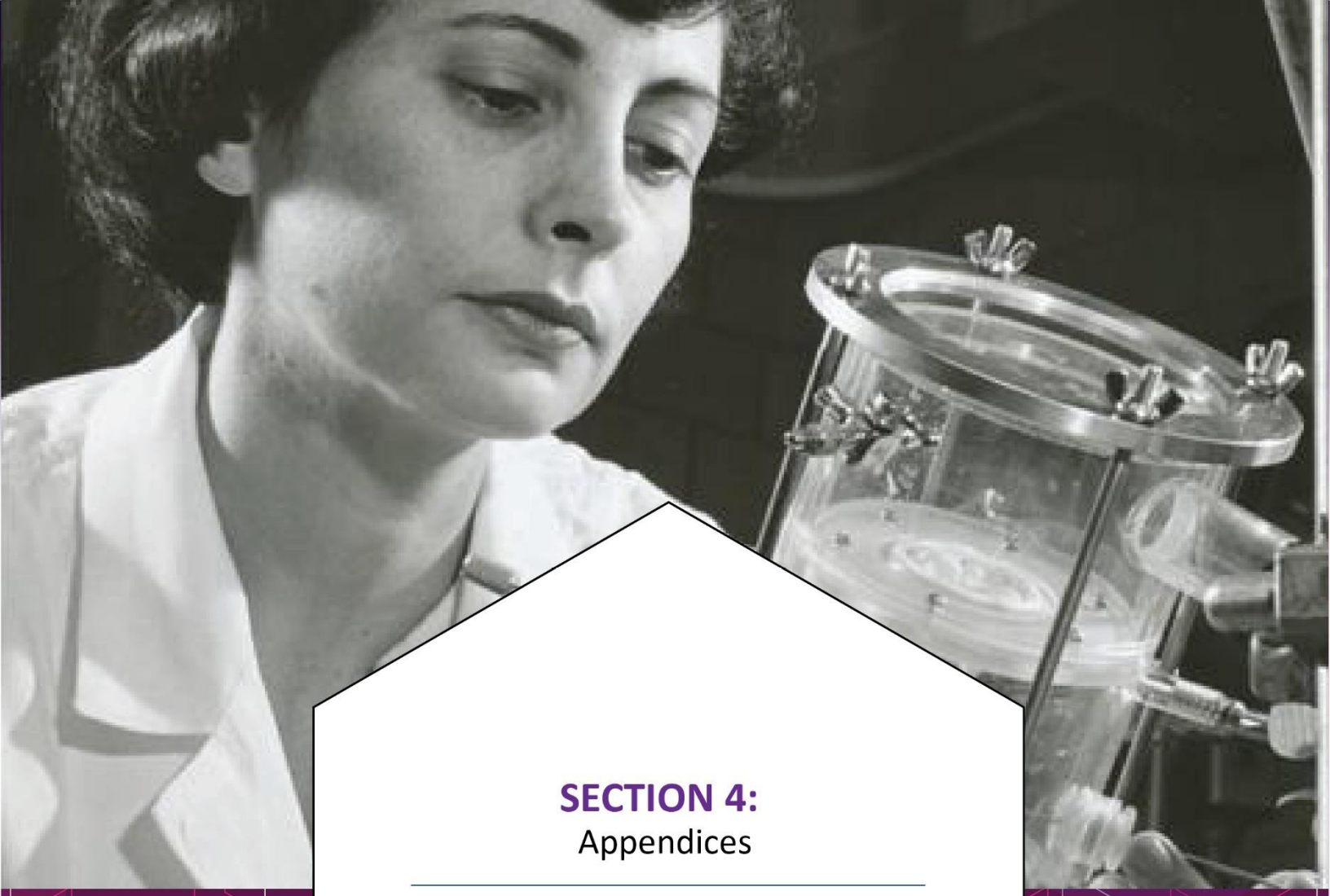

SECTION 4:
Appendices

- 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
APG	Agency Priority Goal
APTC	Advance Premium Tax Credit
ARP	*American Rescue Plan Act of 2021*
ASFR	Office of the Assistant Secretary for Financial Resources
ASPA	Office of the Assistant Secretary for Public Affairs
ASPE	Office of the Assistant Secretary for Planning and Evaluation
ASPR	Administration 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
CAP	Corrective Action Plan
CARES Act	*Coronavirus Aid, Relief, and Economic Security Act*
CCDF	Child Care and Development Fund
CCWIS	Comprehensive Child Welfare Information System
CDC	Centers for Disease Control and Prevention
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFRS	Consolidated Financial Reporting System
CHIP	Children's Health Insurance Program
CIO	Chief Information Officer
CMP	Civil Money Penalty
CMS	Centers for Medicare & Medicaid Services
COFFA	Council on Federal Financial Assistance
COLA	Cost of Living Adjustment
COVID-19	Coronavirus Disease
CPI	Consumer Price Index
CRC	Commercial Repayment Center
CSRS	Civil Service Retirement System
CX	Customer Experience
CY	Calendar year
DAB	Departmental Appeals Board
DATA Act	*Digital Accountability and Transparency Act of 2014*
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
DOL	Department of Labor
DRA	*Deficit Reduction Act of 2005*
E-Invoicing	Electronic Invoicing
EIS	Enterprise Infrastructure Solutions
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
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
FRA	*Fiscal Responsibility Act of 2023*
FSCE	Financial Systems Control Environment
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
HCC	Hierarchical Condition Category
HEW	Department of Health, Education, and Welfare
HHS	Department of Health and Human Services
HI	Hospital Insurance
HIPAA	*Health Insurance Portability and Accountability Act of 1996*

Acronyms

HMO	Health maintenance organizations
HRSA	Health Resources and Services Administration
IBNR	Incurred But Not Reported
IGT	intra-governmental
IHS	Indian Health Service
I-MEDIC	Investigations Medicare Drug Integrity Contractor
IP	Improper Payments
IRA	*Inflation Reduction Act*
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
IT	Information Technology
LIHEAP	Low-Income Home Energy Assistance Program
LIHWAP	Low-Income Household Drinking Water and Wastewater Emergency Assistance Program
LPR	Lawful Permanent Resident
MA	Medicare Advantage
MACs	Medicare Administrative Contractors
MAF	Management Assessment Framework
MAO	Medicare Advantage Organization
MCO	Medicaid Managed Care Organization
MDH	Medicare-Dependent Hospital
MEDIC	Medicare Drug Integrity Contractor
MEQC	Medicaid Eligibility Quality Control
MIPS	Merit-based Incentive Payment System
MSP	Medicare Secondary Payer
NAIC	National Association of Insurance Commissioners
NBS	National Institutes of Health Business System
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
OCIO	Office of the Chief Information Officer
OCR	Office for Civil Rights
OGA	Office of Global Affairs
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
OS	Office of the Secretary
PACE	Program of All-Inclusive Care for the Elderly
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 Act	*Public Health Service Act*
PHS	Public Health Service
PHSSEF	Public Health and Social Services Emergency Fund
PIIA	*Payment Integrity Information Act of 2019*
POP	Period of Performance
PP	Proper Payments
PP&E	Property, Plant and Equipment
PPACA	*Patient Protection and Affordable Care Act*
PPEO	Provisional Period of Enhanced Oversight
PPI	Plan Program Integrity
PRAC	Pandemic Response Accountability Committee
PRF	Provider Relief Fund
PSA	Public Service Announcement
PSC	Program Support Center
RAC	Recovery Auditor Contractor
RADV	Risk Adjustment Data Validation
REMS	Risk evaluation and mitigation
RSI	Required Supplementary Information
RY	Reporting Year
SAMHSA	Substance Abuse and Mental Health Services Administration
SCSIA	Statement of Changes in Social Insurance Amounts
SECA	*Self-Employment Contribution Act*
SFFAS	Statement of Federal Financial Accounting Standards
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
SSP	Shared Service Providers SSP
StaffDiv	Staff Division
STLT	State, Tribal, Local, and Territorial
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TAS	Treasury Account Symbol
The 2015 Act	*Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015*
Treasury	U.S. Department of the Treasury
TTD	Time-to-Death
U.S.	United States
U.S.C.	United States Code
UIP	Uninsured Program

Acronyms

UP	Unknown Payments	USSGL	United States Standard General Ledger
UPIC	Unified Program Integrity Contractors	VFC	Vaccines for Children
USPS	United States Postal Service		

Appendix B: Connect with HHS

On behalf of the Department, we sincerely thank and acknowledge all the individuals who provided support, either through content contribution or review feedback, to produce the FY 2023 AFR. We could not have prepared the FY 2023 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 2023 AFR. We welcome your comments on how we can make this report more informative. Please send your comments to:

Mail: U.S. Department of Health and Human Services
Office of Finance/Office of Financial Reporting and Policy
Mail Stop 549D
200 Independence Avenue, S.W.
Washington, D.C. 20201

Email: HHSAFR@hhs.gov

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

200 Independence Ave, S.W. ● Washington, D.C. 20201

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