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Highlights of the Administration's FY 2024 Budget

This summary provides highlights of healthcare-related proposals included in the President's budget for fiscal year (FY) 2024, which was released by the Biden Administration on March 9, 2023.[1] All budget estimates shown are those provided by the Office of Management and Budget (OMB) or drawn from the Department of Health and Human Services (HHS) *Budget in Brief*. As usual, the Congressional Budget Office (CBO) is expected to prepare an analysis of the President's budget proposals, and CBO scoring may differ.

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BUDGET OVERVIEW

President Biden's budget for FY 2024 proposes policies that OMB estimates would reduce federal deficits by a total of $2.857 trillion over the next 10 years (FYs 2024-2033). This total is comprised of a net increase of $2.5 trillion from mandatory spending, a decrease of $311 billion in discretionary programs ($100 billion decrease in nondefense programs and a $211 billion decrease in defense), $326 billion in reduced interest payments on the debt, and $4.7 trillion in additional revenue.[2]

For HHS, which is proposed to have $1.7 trillion in mandatory budget authority in FY 2024, the budget describes a number of health system priorities in the following areas:

Expands Access to Quality, Affordable Healthcare. The budget proposes to make permanent the increased premium tax credits extended through 2025 by the Inflation Reduction Act (IRA) and to provide Medicaid-like coverage for individuals in states that have not adopted the Medicaid expansion in the Affordable Care Act (ACA). Over 10 years, $150 billion would be invested in Medicaid home and community-based services (HCBS), which would improve the quality of jobs for home care workers and support family caregivers. The budget also lists an agenda to improve the safety and quality of nursing home care, provide adequate funding to conduct nursing home inspections, increase inspection of low-performing nursing homes, and expand financial penalties for substandard facilities.

Reduces Drug and Other Healthcare Costs for All Americans. The budget calls for Medicare to negotiate prices for a greater number of drugs, sooner after drugs are launch, than is currently

[1] "Budget of the U.S. Government: Fiscal Year 2024," https://www.whitehouse.gov/wpcontent/uploads/2023/03/budget_fy2024.pdf, hereafter referred to as the budget.
[2] Tables S-2, S-3, and S-4 of the budget.

permitted by the IRA. Medicare Part D cost sharing would also be limited to no more than $2 for high-value generic drugs, such as those to treat hypertension and high cholesterol. For Medicaid, HHS could negotiate supplemental drug rebates on behalf of states seeking to pool their purchasing power. For commercial insurance, the budget proposes to curb inflation in prescription drug prices and cap enrollees' out-of-pocket cost sharing[3] for insulin products at $35 per month.

Protects and Strengthens Medicare. With no cuts to benefits, the budget would extend the solvency of the Medicare Hospital Insurance (HI) trust fund by at least 25 years by increasing taxes on high-income individuals, combined with savings from the Part D reforms.

Advances Progress toward Cancer Moonshot Goals. With goals including to reduce the cancer death rate by at least 50 percent over the next 25 years, the budget proposes additional targeted investments in the Advanced Research Projects Agency for Health ($1 billion increase), the National Cancer Institute (NCI) and others to drive innovative health research and speed the implementation of breakthroughs.

Transforms Behavioral Healthcare. The budget would expand private health insurance coverage of mental health benefits and strengthen requirements regarding the networks of behavioral health providers. For Medicare, it would lower patients' costs for mental health services, require parity in coverage between behavioral health and medical benefits, and expand the range of behavioral health provider types whose services would be covered.

Invests in Community Health Centers and the Nation's Healthcare Workforce. The budget would put the Health Center Program on a path to double in size. The healthcare workforce would be bolstered by expanding the National Health Service Corps and other programs.

Supports Family Planning Services for More Americans. The budget provides $512 million, an increase of nearly 79 percent from the 2023 enacted level, to the Title X Family Planning program, which provides family planning and preventive health services to low-income communities.

Pandemic and Biological Threat Preparedness. The budget makes new investments in pandemic preparedness and biodefense across HHS public health agencies. Agencies funded under this priority including the Office of the Assistant Secretary for Preparedness and Response, the Centers for Disease Control and Prevention (CDC), the National Institute of Health (NIH), and the Food and Drug Administration (FDA), along with funding to state and local agencies. The Budget also proposes new authorities to improve preparedness, incorporating lessons learned from recent public health emergencies (PHEs), such as to enhance the visibility and the resilience of the medical product supply chain.

Maternal Health and Health Equity. The budget includes proposals to reduce maternal mortality and morbidity; expand maternal health initiatives in rural communities; implement implicit bias training for healthcare providers; create pregnancy medical home demonstration

[3] In the White House's main budget document, this provision is described as capping the "prices" of insulin, while the more detailed HHS Budget in Brief refers to capping "patient cost-sharing."

projects; address the highest rates of perinatal health disparities, including by supporting the perinatal health workforce; and increase funding for the Maternal, Infant, and Early Childhood Home Visiting program, which serves families at risk for poor maternal and child health outcomes. The budget would also strengthen collection and evaluation of sociodemographic data. It would also require all states to provide continuous Medicaid coverage for 12 months postpartum.

Treatment and Prevention of Infectious Diseases. The budget invests in the prevention and treatment of infectious diseases, including Hepatitis C, HIV, and vaccine-preventable diseases. Initiatives include a new national program to expand screening, testing, treatment, prevention and monitoring of Hepatitis C infections. In addition, the budget includes $850 million across HHS to reduce new HIV cases, increase access to pre-exposure prophylaxis (PrEP), and ensure equitable access to services and supports for those living with HIV. It would require coverage of PrEP under Medicaid. It also proposes a PrEP Delivery Program funded with direct spending of $9.7 billion over 10 years to guarantee PrEP at no cost for all uninsured and underinsured individuals; provide essential wrap-around services through states, IHS and tribal entities, and localities; and establish a network of community providers to reach underserved areas and populations. The budget also proposes a new Vaccines for Adults program to provide uninsured adults with access to vaccines at no cost, and would expand the current Vaccines for Children (VFC) program to children enrolled in separate CHIP.

Reduces Hunger and Diet-Related Chronic Diseases and Improves Food Safety. To address specific commitments made as part of the White House Conference on Hunger, Nutrition, and Health and corresponding National Strategy, the budget requests $137 million to conduct nutrition research, expand CDC's State Physical Activity and Nutrition Program to all states and territories, improve food labeling, enhance dietary and physical activity guidelines, and increase support for senior nutrition programs. The budget also calls for Medicare coverage nutrition and obesity counseling services as well as pilot coverage of medically tailored meals.

Supports America's Promise to Refugees. The budget provides $7.3 billion to the Office of Refugee Resettlement (ORR) to rebuild the nation's refugee resettlement infrastructure and support the resettling of up to 125,000 refugees in 2024. The funding would also ensure that unaccompanied immigrant children receive appropriate support and services while in ORR's care, are united with relatives and sponsors as safely and quickly as possible, and have access to counsel to help children navigate complex immigration court proceedings.

Other HHS Initiatives. The budget describes other HHS initiatives, proposing to provide adequate and stable funding for the Indian Health Service (IHS), support rural health, advance child and family well-being in the child welfare system, support survivors of domestic violence and other forms of gender-based violence, and reduce home energy and water costs for low-income households.

Overall, the budget includes $144.3 billion in FY 2024 discretionary funding for HHS, about $17 billion (13.6%) above the FY 2023 level. Proposed program level funding, which combines discretionary funding with mandatory funding and user fees, varies among HHS agencies. Substantial increases are proposed for the CDC of $5.0 billion, the Substance Use and Mental

Health Services Administrations (SAMHSA) of $3.3 billion, NIH of $0.9 billion, and the FDA of $0.5 billion. CMS total program level management funding is proposed at $7.7 billion, an increase of $777 million above FY 2023 levels; total program management includes discretionary administration spending, mandatory appropriations and user fees.

MEDICARE PROPOSALS

The FY 2024 budget includes legislative proposals that invest a net $8 billion into the Medicare program over 10 years. When combined with program integrity investments, the budget yields net savings to Medicare of $216 billion over 10 years. Unless otherwise noted, the proposals would be implemented in fiscal year or calendar year 2024.

The budget includes proposals to extend the solvency of the Federal Hospital Insurance (HI) trust fund by at least 25 years, by increasing the net investment income tax rate and additional Medicare tax rate for high-income taxpayers and directing the revenue from the net investment income tax, as well as savings from proposed Medicare drug reforms, to the HI trust fund. The savings from the proposed Medicare drug reforms include savings from the expansion of the Medicare prescription drug price negotiation program and the extension of the Medicare drug rebate policies enacted in the Inflation Reduction Act to commercial health insurance, and are projected to amount to $200 billion over 10 years.

MEDICARE PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2024			
	Savings (-) /cost (+) in $ millions		
	2024	**2024-2028**	**2024-2033**
Medicare Legislative Proposals			
Prescription drugs			
Expand Medicare prescription drug price negotiation	-	-35,000	-160,000
Limit Medicare Part D cost-sharing on certain generic drugs to $2	-	469	1,328
Total, Prescription Drug Proposed Policy	**-**	**-34,531**	**-158,672**
Long Term Care and Home Care			
Adjust Survey Frequency for High-Performing and Low-Performing Facilities	-	-	-
Provide authority for the Secretary to collect and expend re-survey fees	-	-	-
Increase per instance Civil Monetary Penalty (CMP) authority for long-term care (LTC) facilities	-	-	-
Hold LTC facility owners accountable for noncompliant closures and substandard care	-	-	-
Improve the accuracy and reliability of Nursing Home Care Compare data	-	-	-
Total, Long term care and home care	-	**-**	**-**

MEDICARE PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2024			
	Savings (-) /cost (+) in $ millions		
	2024	2024-2028	2024-2033
Mental health			
Eliminate the 190-day lifetime limit on inpatient psychiatric facility (IPF) services	160	1,030	2,440
Require Medicare to cover three behavioral health visits without cost-sharing	-	550	1,450
Revise criteria for psychiatric hospital terminations from Medicare	-	-	-
Apply the Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicare	-	-	-
Modernize Medicare mental health benefits	-	-	-
Total, Mental health	160	1,580	3,890
Pandemic Preparedness			
Authorize coverage for specific products and services, including drugs, vaccines, and devices authorized for emergency use	-	-	-
Enable the Secretary to temporarily modify or waive the application of specific requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Act	-	-	-
Total, Pandemic Preparedness	-	-	-
Cancer Moonshot			
Expand Cancer Care Quality Measurement	-	-	-
Total, Cancer Moonshot	-	-	-
Nutrition			
Expand and enhance access to Medicare coverage of nutrition and obesity counseling	20	570	1,740
Conduct a subnational Medicare medically-tailored meal demonstration	-	-	-
Total, Nutrition	20	570	1,740
Oversight, Quality, Benefit Enhancements, Good Governance, and Other Technical Proposals			
Refine the Quality Payment Program (QPP): Measure development funding for QPP	-	-	-
Strengthen Medicare Advantage by establishing new Medical Loss Ratio requirements for supplemental benefits	-	-	-
Create a consolidated Medicare hospital quality payment program	-	-	-
Standardize data collection to improve quality and promote equitable care	-	-	-
Allow collection of demographic and social determinants of health data through CMS quality reporting and payment programs	-	-	-
Create a permanent Medicare Home Health Value-Based Purchasing program	-	-	-

MEDICARE PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2024			
	Savings (-) /cost (+) in $ millions		
	2024	2024-2028	2024-2033
Create a permanent Medicare Diabetes Prevention Program benefit	-	-	-
Use Administrative Law Judge (ALJ) written decisions rather than hearings for claims with no material fact in dispute	-	-	-
Change the Medicare Appeal Council's standard of review to appellate-level to expedite adjudication procedures and timelines	-	-	-
Implement value-based purchasing programs for inpatient psychiatric facilities, outpatient hospitals, and ambulatory surgical centers	-	-	-
Increase transparency by disclosing accreditation surveys	-	-	-
Require Average Sales Price (ASP) reporting for oral Methadone	-	-	-
Remove restrictions on the certification of new entities as Organ Procurement Organizations and increasing enforcement flexibility	-	-	-
Establish meaningful measures for the End Stage Renal Disease Quality Incentive Program	-	-	-
Add Medicare Coverage of Services Furnished by Community Health Workers			
Total, Oversight, Quality, Benefit Enhancements, Good Government, and Other Technical Proposals	**-**	**-**	**-**
Subtotal, Legislative Proposals	180	-32,381	-153,042
Medicare Interactions			
Eliminate the 190-day Lifetime Limit on Psychiatric Hospital Services (Medicaid Impact – non-add)	*-40*	*-275*	*-655*
National Hepatitis C Elimination Program	183	1,177	984
Extension of Sequester	-	-	-36,774
Total Outlays, Medicare Proposals	**363**	**-31,204**	**-188,832**
Savings from Program Integrity Proposals	*-1,502*	*-10,415*	*-27,153*
Total Outlays, Medicare Proposed Policies	***-1,139***	***-41,619***	***-215,985***

Prescription Drugs

The Inflation Reduction Act (P.L. 117-169), enacted into law last year, lowers prescription drug costs, including by capping out of pocket expenses under part D for Medicare beneficiaries at $2,000 per year, capping cost-sharing under Medicare for insulin at $35 for a monthly prescription, and establishing a Medicare Drug Price Negotiation Program. The 2024 budget proposal builds on the Inflation Reduction Act by expanding the Medicare prescription drug price negotiation program and limiting the Medicare part D cost-sharing on certain generic drugs to $2.

Expand Medicare Prescription Drug Price Negotiation. Under the Medicare Drug Price Negotiation Program established by the Inflation Reduction Act, the Secretary of Health and Human Services (HHS) directly negotiates with drug manufacturers drug prices for certain non-excluded high expenditure, single source brand name drugs that are covered under part B or part D of Medicare and selected for negotiation. As set in statute, there are to be 10 negotiation-eligible covered part D drugs selected for which maximum fair prices (MFPs) are to be negotiated for application in 2026, an additional 15 negotiation-eligible covered part D drugs selected for which MFPs are to be negotiated for application in 2027, an additional 15 covered part D drugs and part B drugs selected for which MFPs are negotiated for application in 2028, and an additional 20 covered part D drugs and part B drugs selected for which MFPs are negotiated for application in 2029 and subsequent years. Under current law, drugs are not eligible for negotiation unless a period of at least, in the case of small-molecule drugs, 9 years or, in the case of biological products, 13 years, has passed since FDA approval or licensure. The 2024 budget proposal indicates that there would be increases in the number of drugs subject to negotiation under the Medicare Drug Price Negotiation Program and that it would make drugs eligible for negotiation sooner after their launch. However, HHS does not include details for the proposal, such as the timing of the increase in the number of drugs subject to negotiation, the number by which they are increased, the type of drugs subject to the increase, and the new timeframe for drugs after FDA approval or licensure. This is estimated to reduce Federal spending by $160 billion over 10 years.

Limit Medicare part D Cost-sharing on Certain Generic Drugs. The 2024 budget proposal limits cost-sharing under all Medicare part D prescription drug plans and MA-PD plans for covered part D drugs included on a Medicare standard list of high-value generic drugs (such as certain drugs used for chronic conditions) to no more than $2 for a 30-day supply until the beneficiary reaches the out-of-pocket maximum. This is estimated to increase Federal spending by $1.3 billion over 10 years.

Long-Term Care

Adjust Survey Frequency for High-Performing and Low-Performing Facilities. Currently, under sections 1819(g) and 1919(g) of the Social Security Act, and subpart B of part 483, title 42, CFR, for participation under Medicare and Medicaid, skilled nursing facilities and nursing facilities are required to be recertified annually by States as complying with safety, quality, and other Federal requirements. The budget proposal would allow CMS to base the frequency of such recertification for Medicare participation on the quality of the facilities, with high-performing facilities being surveyed less frequently and low-performing facilities being surveyed more frequently.

Provide authority for the Secretary to collect and expend re-survey fees. This proposal permits the Secretary of HHS to charge skilled nursing facilities and nursing facilities a re-survey fee, after a third visit is required, for purposes of certifying compliance with federal health and safety standards, to validate the correction of deficiencies that were identified during prior survey visits. The proposal indicates that the amounts from the fee are to be expended to help ensure quality of care in historically poor performing facilities when revisit surveys are required. This is estimated to be budget neutral.

Increase per instance CMP authority for LTC facilities. Under current law (sections 1819(h) and 1919(h) of the Social Security Act and section 488.438 of title 42, CFR), the Secretary of HHS has authority to impose enforcement mechanisms, including a civil monetary penalty, in the case of skilled nursing facilities and nursing facilities that fail to comply with federal participation requirements under Medicare or Medicaid, respectively. Such a civil monetary penalty is currently statutorily capped at approximately $21,000 (after adjustment for inflation) for each day of noncompliance. The budget proposal would increase the level of such civil money penalties and create a penalty scale based on the severity of the deficiencies within a facility (determined by thresholds specified by rulemaking), up to a civil monetary penalty of $1 million for the most egregious violations. This is estimated to be budget neutral.

Hold LTC facility owners accountable for noncompliant closures and substandard care. This proposal would change the party subject to a civil money penalty from "administrator" to "owner, operator, or owners or operators" of a facility and add a provision that would ensure the Secretary has the authority to impose enforcement on the owners of a facility, after the facility has closed. This is estimated to be budget neutral.

Improve the accuracy and reliability of Nursing Home Care Compare data. This proposal would require CMS to validate data submitted by nursing facilities for the Nursing Home Care Compare website and authorize CMS to apply an enforcement method (such as a percent reduction in payment similar to the current payment reduction for facilities that do not submit complete SNF reporting data) against facilities that submit data that is found to be inaccurate by the validation process. This is estimated to be budget neutral.

Mental Health

Eliminate the 190-day Lifetime Limit on Psychiatric Hospital Services. Under current law, there is a 190-day lifetime limit on care as an inpatient in a freestanding psychiatric hospital but not a distinct part psychiatric unit of a general acute care hospital. This proposal will eliminate the 190-day lifetime limit on inpatient psychiatric services in a freestanding psychiatric hospital. Estimated costs are $2.4 billion over 10 years.

Require Medicare to Cover Three Behavioral Health Visits Without Cost-Sharing. This proposal would require Medicare, beginning in 2025, to cover up to three behavioral health visits per year without application of deductible or coinsurance. Estimated costs are $1.45 billion over 10 years.

Revise Criteria for Psychiatric Hospital Terminations from Medicare. Current law requires CMS to terminate psychiatric hospital participation in Medicare after six months of non-compliance with conditions of participation, even if the deficiency does not jeopardize patient health and wellbeing. No analogous provision applies to any other provider category. This proposal would give CMS flexibility to allow a psychiatric hospital to continue receiving Medicare payments when deficiencies are not considered to immediately jeopardize the health and safety of its patients and where the facility is actively working to correct the deficiencies identified in an approved plan of correction. No cost.

Apply the Mental Health Parity and Addiction Equity Act to Medicare. Under current law, Medicare (including fee-for-service and Medicare Advantage) is not subject to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which requires certain health plans that offer mental health and substance use disorder benefits to provide coverage for such benefits that is no more restrictive than the financial requirements or treatment limitations that apply to the medical and surgical benefits offered by the plan. This proposal would expand application of mental health parity to Medicare. Not Scoreable.

Modernize Medicare Mental Health Benefits. The Consolidated Appropriations Act, 2023 expanded Medicare part B to include coverage of services furnished by marriage and family therapists and mental health counselors. The 2024 budget proposal allows additional professionals (including clinical social workers, peer support workers, and certified addiction counselors) identified by the Secretary, to enroll in Medicare and be paid for behavioral health services furnished within their applicable state licensure or scope of practice if the services otherwise would be covered when furnished by a physician. The proposal also authorizes direct billing and payment under Medicare for these practitioners, removes limits on the scope of services for which they can be paid by Medicare, and provides for additional expansion of coverage of such services. Not Scorable.

Pandemic Preparedness

Authorize coverage for specific products and services, including drugs, vaccines, and devices authorized for emergency use. This proposal would modify the emergency waiver authorities under section 1135 of the Social Security Act to provide the Secretary of HHS authority, after providing Congress certification and advance notice, to provide for limited, temporary coverage with no cost-sharing under Medicare, Medicaid, and CHIP for unapproved drugs, vaccines, or devices that are authorized by FDA for emergency use, or other items and services used to treat a specific disease that is pandemic-related during a public health emergency. This proposal would allow for CMS to use reconciliation of costs to make part C and part D plan sponsors whole in providing for such coverage. Not Scoreable.

Enable the Secretary to Waive Specific Requirements of the Clinical Laboratory Improvement Amendments of 1988 Act (CLIA). Rather than relying on enforcement discretion as was done during the COVID-19 pandemic, this proposal would enable the Secretary to temporarily waive or modify the application of CLIA to ensure laboratory services are accessible to the maximum extent feasible in any federally declared emergency period and area. Not Scorable.

Cancer Moonshot

Expand Cancer Care Quality Measurement. This proposal would consolidate cancer care measures and data across all Medicare quality programs and create a unified cancer care quality data reporting program for all Medicare providers. Not scoreable.

Nutrition

Expand and Enhance Access to Medicare Coverage of Nutrition and Obesity Counseling. Under current law, medical nutrition therapy services defined in section 1861(vv) of the Social Security Act (nutritional diagnostic, therapy, and counseling services for the purpose of disease management) furnished by a registered dietician or nutrition professional are covered under Medicare part B for certain beneficiaries with diabetes or renal disease. This proposal would expand access to additional Medicare beneficiaries with nutrition or obesity-related chronic diseases and make additional providers eligible to furnish nutrition and obesity counseling services under Medicare. This is estimated to cost $1.74 billion over 10 years.

Conduct a Subnational Medicare Medically-Tailored Meal Demonstration. This proposal would establish a three-year demonstration, beginning in 2024, to test coverage under original fee-for-service Medicare of medically-tailored meals for beneficiaries who have a diet-impacted disease (such as kidney disease, congestive heart failure, diabetes, or chronic obstructive pulmonary disease) likely to trigger an inpatient hospital stay and who have at least one activity of daily living limitation. The design of the demonstration proposed is similar to that proposed in the Medically Tailored Home-Delivered Meals Demonstration Pilot Act of 2021 (H.R. 5370 introduced in the 117th Congress). Not scorable.

Additional Proposals Related to Quality, Benefit Enhancements, Good Governance, Oversight, and Other Technical Matters

Refine the Quality Payment Program (QPP): Measure development funding for QPP. The Consolidated Appropriations Act, 2021, funded quality measure development activities carried out under sections 1890 and 1890A of the Social Security Act through fiscal year 2023, with the amount of $20,000,000 transferred from the part A and part B Trust Funds for fiscal year 2023. The budget proposal would extend this funding for quality measure development for fiscal years 2024 through 2028, allowing for the development of new measures for use in the transition to the Merit-based Incentive Payment System Value Pathways (the voluntary reporting structure introduced for the 2023 performance year) and the inclusion of cost performance measures among the types of measures that may be developed. This is estimated to be budget neutral.

Create a consolidated Medicare hospital quality payment program. This proposal would, beginning in 2027, establish a consolidated, unified hospital quality reporting and payment program that combines the Inpatient Quality Reporting Program, Hospital Value-Based Purchasing Program, Hospital-Acquired Condition Reduction Program, Hospital Readmissions Reduction Program, and Hospital Medicare Promoting Interoperability Program. Under the consolidated program, the Medicare payment withhold amount for inpatient hospital services furnished by acute care hospitals would increase from the current two percent, by one percentage point per year until it reaches six percent, and, based on the performance of a hospital determined under such program, the hospital would be able to reduce the percentage withheld with respect to such hospital. Critical Access Hospitals would be required to report only and would not be subject to the adjustment to payment based on performance. This is estimated to be budget neutral.

Implement Value-Based Purchasing Programs for Inpatient Psychiatric Facilities, Outpatient Hospitals, and Ambulatory Surgical Centers. The budget proposal would implement, beginning in calendar year 2026, value-based purchasing programs for inpatient psychiatric facilities, hospital outpatient departments, and ambulatory surgical centers. Under each of the programs, a percentage of payments otherwise payable under Medicare for services furnished by the facilities, departments, and centers would be based on the performance of such providers with respect to quality and outcome measures. Each value-based purchasing program would be structured such that the total payment increases and adjustments would be budget neutral. The proposal is projected to be budget neutral.

Standardize data collection to improve quality and promote equitable care. Under current law, post-acute care providers are required under section 1899B of the Social Security Act to submit, in the same manner as their quality reporting requirements, to the Secretary of HHS standardized patient assessment data. The budget proposal would add social determinants of health as a new category of standardized patient assessment data, on which post-acute care providers would be required to report. This is estimated to be budget neutral.

Allow collection of demographic and social determinants of health data through CMS quality reporting and payment programs. This proposal would allow quality reporting programs under Medicare to collect patient demographic data and social determinants of health data. This is estimated to be budget neutral.

Establish meaningful measures for the End Stage Renal Disease Quality Incentive Program. The End-Stage Renal Disease Quality Incentive Program is established under section 1881(h) of the Social Security Act. Current law specifies quality measures on which performance is to be under the Program. The budget proposal would provide the Secretary of HHS with broad authority to, through rulemaking, add and remove measures from application under the Program, and give preference to measures (such as patient outcomes, patient and family engagement, patient safety, hospital readmissions, cost, and efficiency). This proposal is projected to be budget neutral.

Create a permanent Medicare Home Health Value-Based Purchasing program. The Home Health Value-Based Purchasing Model was implemented by the Center for Medicare and Medicaid Innovation pursuant to section 1115A of the Social Security Act and finalized in the CY 2016 Home Health Prospective Payment System (HH PPS) final rule. The original model was expanded nationwide in the final CY 2022 HH PPS rule. The budget proposal would make permanent the expanded Home Health Value-Based Purchasing Model. This is estimated to be budget neutral.

Create a permanent Medicare Diabetes Prevention Program Benefit. The Medicare Diabetes Prevention Program (MDPP) Expanded Model was implemented by the Center for Medicare and Medicaid Innovation pursuant to section 1115A of the Social Security Act. The model was designed to provide training (with respect to long-term dietary change, increased physical activity, and behavior change strategies) to individuals with prediabetes for such individuals to manage their health to prevent the onset of Type 2 diabetes. The CY 2017 Medicare Physician Fee Schedule (PFS) final rule established the expansion of the demonstration. The CY 2018 PFS

final rule and the CY 2022 PFS final rule each further established policies and changes to the demonstration. The budget proposal would, beginning in 2025, establish the Medicare Diabetes Prevention Program Expanded model, as a permanent Medicare Part B benefit. This proposal is not scorable.

Strengthen Medicare Advantage by Establishing New Medical Loss Ratio Requirements for Supplemental Benefits. Under current law section 1857(e)(4) of the Social Security Act, as part of the contract requirements, Medicare Advantage plans are required to have a medical loss ratio (as calculated under section 422.2420 of title 42, CFR) for each contract year of at least 85 percent. The medical loss ratio of a plan is reported at the contract level and represents the percentage of the plan's revenue used for patient care (as opposed to administrative expenses or profit). This proposal would, in addition, require Medicare Advantage plans, excluding Employer Group Waiver Plans, to meet a minimum medical loss ratio of 85 percent specifically for supplemental benefits offered by the plans. Not scoreable.

Use Administrative Law Judge (ALJ) Written Decisions Rather Than Hearings for Claims with No Material Fact in Dispute. The budget proposal would expedite Medicare appeals (other than beneficiary appeals) for cases for which there is no material fact in dispute, also viewed as cases involving procedural issues and technical denials, by allowing the Office of Medicare Hearings and Appeals to issue decisions on the record without holding a hearing.

Change the Medicare Appeal Council's Standard of Review to Appellate-Level to Expedite Adjudication Procedures and Timelines. Under section 1869(d)(2) of the Social Security Act, if a party files a request for review of an Administrative Law Judge decision, the Departmental Appeals Board's Medicare Appeal Council must review the decision de novo, from the beginning. The budget proposal would change the standard of review from a de novo to an appellate-level standard of review. The proposal allows the Council to focus on specific issues, thus reducing process redundancies and increasing adjudication capacity by up to an estimated 30 percent. The proposal would not apply to beneficiary appeals. The proposal is projected to be budget neutral.

Increase Transparency by Disclosing Accreditation Surveys. Under current law (section 1865(b) of the Social Security Act), the Secretary of HHS is prohibited from disclosing accreditation surveys (other than with respect to home health agencies and hospice programs) made and provided to the Secretary by a national accreditation organization or body, except to the extent the survey, or information in the survey, relates to an enforcement action taken by the Secretary. The budget proposal would remove this disclosure prohibition to allow for disclosure of survey information on providers that are not in compliance with accreditation requirements. The proposal is projected to be budget neutral.

Require Average Sales Price (ASP) reporting for oral Methadone. Oral methadone is currently covered under Medicare part B as part of the opioid disorder treatment services benefit provided pursuant to section 1861(s)(2)(HH) of the Social Security Act. Under section 1834(w) of such Act, opioid treatment programs are paid a bundled payment amount for furnishing opioid disorder treatment services to Medicare beneficiaries during an episode of care. In the CY 2020 Physician Fee Schedule (PFS) final rule (84 FR 62667), CMS finalized a policy regarding the

payment for the drug component of episodes of care under such benefit. Under the policy finalized at §410.67(d)(2)(i)(B), if Average Sales Price (ASP) data are available, the payment amount for such drug component, in the case of oral medications, is 100 percent of ASP. However, oral methadone is not separately payable as a drug or biological under Medicare part B. Thus, manufacturers are not required to report on it under the ASP reporting requirements under section 1927(b)(3)(A)(iii) of the Social Security Act, and ASP information voluntarily reported with respect to oral methadone is limited. The budget proposal would require drug manufacturers to report ASP data for oral methadone. This policy is not scoreable.

Remove restrictions on the certification of new entities as Organ Procurement Organizations and increasing enforcement flexibility. Current law prevents new entities from becoming certified as an organ procurement organization. The budget proposal would allow CMS to certify new entities as such organizations and, under certain conditions, recertify organ procurement organizations that have recently taken control of a low-performing service area and have shown significant improvement during the re-certification cycle, but which do not yet meet the criteria for recertification based on outcome measures. The policy is projected to be budget neutral.

Add Medicare Coverage of Services Furnished by Community Health Workers. Services furnished by community health workers are not currently covered under Medicare. The budget proposal would, beginning with calendar year 2025, provide coverage under Medicare part B of certain evidence-based services furnished to Medicare beneficiaries by community health workers under the supervision of a primary care provider for prevention and care navigation for chronic or behavioral health conditions, and for screening for social determinants of health to refer such beneficiaries with appropriate to social supports. Under the new coverage, preventive services would be exempt from Medicare cost-sharing. Additionally, services furnished by a community health worker would be billed by the Medicare-enrolled provider under whose supervision the service is furnished or under a new category of Medicare-enrolled community health worker pursuant to a formal care arrangement with the Medicare-enrolled provider. This proposal is not scoreable.

Medicare Interactions

National Hepatitis C Elimination Program in the United States. The budget proposal would establish a national Hepatitis C elimination program that would procure treatments over five years for all individuals living with Hepatitis C who are uninsured, enrolled in Medicaid, or incarcerated, at a fixed cost to the federal government. It would also expand screening, testing, treatment, prevention, and monitoring of Hepatitis C. Under this program, the federal government pays 100 percent of cost-sharing for Medicare Part D beneficiaries. The Medicare portion of the score for the program would be $1 billion in costs over 10 years.

Revenue Raising Proposal for the Medicare Part A Trust Fund

The proposal would increase the additional Medicare tax rate by 1.2 percentage points for taxpayers with more than $400,000 of earnings. When combined with current-law tax rates, this would bring the marginal Medicare tax rate up to 5 percent for earnings above the $400,000

threshold. The proposal would also increase the Net Investment Income Tax (NIIT) rate by 1.2 percentage points for taxpayers with more than $400,000 of income, which would bring the marginal NIIT rate to 5 percent for investment income above the threshold. The threshold would be indexed for inflation. The proposals are estimated to generate revenues of $344 billion over 10 years.

Status of Federal Hospital Insurance Trust Fund and Supplementary Medical Insurance Trust Fund

The following tables show the status of funds in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund, respectively, and how the status of funds in the Trust Funds are estimated to be affected by the budget proposals.

Federal Hospital Insurance (FHI) Trust Fund
Showing Changes in Status of Funds, as Estimated, with Proposals
(Funds in millions of dollars)

	2022 actual	2023 estimate	2024 estimated
Income under current law	436,286	420,831	435,558
Proposed:			
FHI Trust Fund, Additional Transfers from General Fund (FICA Taxes)		21,598	36,607
FHI Trust Fund, Additional Transfers from General Fund (FICA Taxes)		29,853	58,345
FHI Trust Fund: Interest received by Trust Funds		86	943
Offsetting governmental receipts: Income proposed		51,537	95,895
Total cash income (with proposals):	436,286	472,368	531,453
Cash outgo under current law	-394,352	-406,422	-409,846
Proposed:			
FHI Trust Fund			441
FHI Trust Fund			-421
Total cash outgo (with proposals)	-394,352	-406,422	-409,826
Surplus or deficit (with interest included)	41,934	65,946	121,627
Reconciliation adjustment	-1		
Total Change in Fund Balance	41,933	65,946	121,627
Unexpended balance, end of year:			
Uninvested balance	803	52,429	77,449
FHI Trust Fund			421
FHI Trust Fund	117,397	191,717	287,903
Total Balance, end of year	178,200	244,146	365,773

Source: Based on Excerpts from Federal HI Trust Fund, Status of Funds Table on page 448 of the Appendix, Budget of the U.S. Government, Fiscal Year 2024 hhs_fy2024.pdf (whitehouse.gov).

Federal Supplementary Medical Insurance (FSMI) Trust Fund
Showing Changes in Status of Funds, as Estimated, with Proposals
(Funds in millions of dollars)

	2022 actual	2023 estimate	2024 estimated
Income under current law	614,037	609,353	657,228
Proposed:			
Offsetting receipts (proprietary):			
Premiums collected for Medicare Prescription Drug Account, FSMI			39
Payments from States, Medicare Prescription Drug Account, FSMI			45
Premiums collected for the aged, FSMI Fund			-27
Premiums collected for disabled, FSMI Fund			-3
Inflation rebate, FSMI			
Offsetting governmental receipts:			
Federal Contributions, FSMI Fund			-120
Contributions for Benefits, Prescription Drug Account, SMI			183
Income Proposed			117
Total cash income (with proposals):	614,037	609,353	657,345
Cash outgo under current law	-588,215	-603,221	-626,532
Proposed:			
FSMI Trust Fund			10
FSMI Trust Fund			140
Medicare Prescription Drug Account, FSMI Trust Fund			-267
Total outgo proposed			-117
Total cash outgo (with proposals)	-588,215	-603,221	-626,649
Surplus or deficit (with interest included)	25,822	6,132	30,696
Reconciliation adjustment	2		
Total Change in Fund Balance	25,824	6,132	30,696
Unexpended balance, end of year:			
Uninvested balance	-4,493	1,260	1,766
FSMI Trust Fund	167,964	168,343	198,683
FSMI Trust Fund			-140
FSMI Trust Fund			-10
Total Balance, end of year	163,471	169,603	200,299

Source: Based on Excerpts from Federal HI Trust Fund, Status of Funds Table on page 452 of the Appendix, Budget of the U.S. Government, Fiscal Year 2024 hhs_fy2024.pdf (whitehouse.gov).

MEDICAID AND CHIP PROPOSALS

The Administration's legislative proposals for Medicaid are estimated to increase program spending by a net $137.5 billion over 10 years when all interactions are taken into account. Most of the direct costs would come from CMS proposals to do the following:

- Improve HCBS ($150.0 billion),
- Align Medicare Savings Programs (MSP) such as Qualified Medicare Beneficiaries (QMB) with the Part D Low-Income Subsidy (LIS) eligibility methodologies ($5.8 billion), and
- Expand the Vaccines for Children Program ($3.2 billion).

Much of the proposed Medicaid savings would come from:

- Requiring remittance of Medical Loss Ratios (MLRs) in Medicaid and CHIP managed care ($-20 billion),
- Eliminating barriers to PrEP treatment for individuals with HIV ($-10.2 billion),
- Negotiating additional supplemental prescription drug rebates on behalf of states ($-5.3 billion), and
- Increasing CMS' enforcement tools applicable to Medicaid managed care ($-1.5 billion).

The Medicaid and CHIP proposals are displayed in the following table and described below.

MEDICAID AND CHIP PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2024		
	Savings (-) /cost (+) in $ millions	
	FY24	**FY24-33**
Medicaid Legislative Proposals		
Address Pandemic and Public Health Threats		
Eliminate Barriers to PrEP under Medicaid	-710	-10,230
Strengthen Long-Term Sustainability and Integrity of CMS Programs		
Modify the Medicaid Drug Rebate Program in Territories	--	--
Authorize HHS to Negotiate Supplemental Drug Rebates on Behalf of States	--	-5,280
Enhance Medicaid Managed Care Enforcement	--	-1,500
Require Remittance of MLRs in Medicaid and CHIP Managed Care	--	-20,000
Promote Equity and Address Social Determinants of Health		
Require Medicaid Adult and HCBS Quality Reporting (non-add)	*25*	*278*
Align MSP and Part D LIS Eligibility Methodologies	100	5,840
Align QMB Renewal Period with Other Medicaid Groups	--	--
Require 12 Months of Postpartum Coverage	200	2,360
Modernize and Enhance Program Benefits		
Improving Medicaid HCBS	3,000	150,000
Other Legislative Proposals Impacting Medicaid		
Expand the VFC Program	470	3,180
Convert Medicaid Certified Community Behavioral Health Clinics (CCBHCs) Demonstration into a Permanent Program	--	20,056
Add 20,000 Special Immigrant Visas	35	550
National Hepatitis C Elimination Program	-1,130	-7,180
Treat Certain Populations as Refugees for Public Benefit Purposes	50	363
Eliminate the 190-day Lifetime Limit on Psychiatric Hospital Services	-40	-655
Social Security Administration Program Integrity (non-add)[1]	*-26*	*-2,155*
Net Outlays, Medicaid Legislative Proposals	**1,975**	**137,504**
CHIP Legislative Proposals	**-460**	**-6,910**

[1] Budgetary impact not included in this table's totals.

Address Pandemic and Public Health Threats

Eliminate Barriers to PrEP under Medicaid. The budget would require state Medicaid programs to cover PrEP, treatment that can reduce the risk for an individual of getting HIV by at least 74 percent. In addition to the PrEP itself, states must cover associated laboratory services. No cost sharing for the drug or its associated laboratory services would be permitted. The proposal is estimated to result in savings to Medicaid of $10.2 billion over 10 years.

Strengthen Long-Term Sustainability and Integrity of CMS Programs

Modify the Medicaid Drug Rebate Program in Territories. The proposal would provide the territories with a new flexibility to opt out of the Medicaid Drug Rebate Program without a waiver. In addition, the budget proposes to exclude sales in the territories from certain drug pricing calculations[4] to ensure continued discounted drug prices for territories. The proposal is expected to be budget neutral.

Authorize HHS to Negotiate Supplemental Drug Rebates on Behalf of States. Although states currently may negotiate supplemental rebates, there is no federal program to negotiate supplemental rebates for high-cost drugs on behalf of state Medicaid programs. The budget proposes to establish a program for CMS and participating states to partner with a private-sector contractor to negotiate supplemental rebates, projected to produce 10-year federal savings of $5.3 billion.

Enhance Medicaid Managed Care Enforcement. The budget includes a proposal to add an enforcement option for CMS applicable to compliance failures of Medicaid managed care plans. Under existing law, the only compliance tool available to CMS is to withhold all federal financial participation under the contract, which it calls an untenable compliance option given potential beneficiary harm and disruption to the state's Medicaid program. The budget proposes to permit CMS to withhold federal financial participation on a service-by-service basis and to permit additional but unspecified enforcement options. The proposal is estimated to save $1.5 billion over 10 years.

Require Remittance of MLRs in Medicaid and CHIP Managed Care. The budget notes that Medicaid and CHIP are the only federal healthcare programs without a statutory minimum Medical Loss Ratio (MLR).[5] The budget proposes an 85 percent MLR, consistent with federal

[4] Last year, the HHS Budget in Brief specifically cited average manufacturer price (AMP) and best price under the Medicaid Drug Rebate Program, although they are not mentioned in this year's document.

[5] Current federal regulations describe policies if a state elects to mandate a minimum MLR, which must be at least 85 percent (for example, see 42 CFR 438.8(c)). On the other hand, federal regulations require states to develop capitation rates so that managed care plans would reasonably achieve an MLR of at least 85 percent (42 CFR 438.4(b)(9)).

requirements for Medicare Advantage[6] and large employer plans.[7] States would be required to collect remittances from plans that fail to meet the minimum MLR.[8]

Promote Equity and Address Social Determinants of Health

Require Medicaid Adult and HCBS Quality Reporting. The budget provides $15 million annually for the Adult Quality Measurement and Improvement Program and $10 million annually for the HCBS Measurement Program. Currently, state-level reporting on these two programs voluntary and uneven. The budget would institute aligned reporting requirements across states.

Align MSP and Part D LIS Eligibility Methodologies. To simplify eligibility process for MSP and LIS, the budget calls for removing elements of the income and asset determination process that apply to one program and not the other.[9] This is expected to reduce administrative barriers and increase federal costs by $5.8 billion over 10 years.

Align QMB Renewal Period with Other Medicaid Groups. The budget would establish in statute a 12-month renewal period for QMBs, reducing the risk of additional churn off Medicaid and improving maintenance of eligibility for these beneficiaries.[10]

Require 12 Months of Postpartum Coverage. The budget would require states to provide 12 months of postpartum coverage in Medicaid and CHIP, with a $2.4 billion federal cost to Medicaid over 10 years.

Modernize and Enhance Program Benefits

Improving Medicaid HCBS. The budget calls for investing $150 billion in Medicaid HCBS, by far the largest line-item increase among the Medicaid proposals. This would enable seniors and people with disabilities to remain in their homes and stay active in their communities. Increased HCBS funding would also promote better quality jobs for home care workers and enhance supports for family caregivers, many of whom are forced out of the workforce due to the demands of caring for a loved one.

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[6] Section 1857(e)(4) of the Social Security Act.
[7] Section 2718(b)(1)(A)(i) of the Public Health Service Act, which also permits a state to increase the percentage.
[8] Current federal regulations require Medicaid managed care plans not meeting the MLR minimum of 85 percent (or higher as set by the state) to provide a remittance, if an MLR is required by the state and if the state requires such a remittance (42 CFR 438.8(j); see also 81 FR 27523).
[9] This would build on other efforts. In 2008, Congress enacted the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) with new requirements that states leverage LIS to help enroll likely eligible individuals in MSPs. In September 2022, CMS proposed regulations to require states to adopt a number of changes to simplify and align methodologies for counting income and assets for MSPs with LIS. For example, see proposed 42 CFR 435.952(e) at 87 FR 54848 and the corresponding discussion in the preamble (e.g., 87 FR 54767).
[10] In September 2022, to align with statutory MAGI requirements, CMS proposed regulations requiring 12-month renewal periods for all but one non-MAGI group. QMBs were the sole exception (see discussion at 87 FR 54782), based on the statutory ability for states to perform renewals for QMBs at less than 12 months but no more frequently than once every 6 months (§1902(e)(8) of the Social Security Act).

Other Legislative Proposals Impacting Medicaid

Expand the VFC to Separate CHIP Children. The budget would expand the Vaccines for Children (VFC) program to separate CHIP children with no cost sharing, resulting in a net cost to the federal government of $310 million over 10 years. That budgetary impact incorporates an increase of $3.2 billion to Medicaid and a reduction of $2.9 billion to CHIP.

Convert Community Mental Health Services Demonstration to State Option. Although this year's budget did not provide details, last year's proposal would permit all states and territories to participate in the Certified Community Behavioral Health Clinics (CCBHCs) demonstration program by converting the program to a Medicaid state plan option; as under the demonstration, payments for mental health services provided by CCBHCs would be subject to an enhanced federal matching rate. In the FY 2024 budget, federal costs to Medicaid are estimated at $20 billion over 10 years.

Other proposals. Several other proposals, some described elsewhere in this document or in non-health parts of the budget, would impact Medicaid spending over the 10-year budget window. They include proposals to add 20,000 Special Immigrant Visas ($550 million in Medicaid costs); treat certain immigrants as refugees for public benefit purposes ($363 million in Medicaid costs); and eliminate Medicare's 190-day lifetime limit on inpatient psychiatric facility services ($655 million in Medicaid savings).

CHIP Proposals

The budget proposes to apply Medicaid drug rebates to separate CHIP, which would save $2.3 billion over 10 years. As previously mentioned, it would also expand VFC to separate CHIP children, which would save CHIP another $2.9 billion over 10 years, but cost Medicaid $3.2 billion. Other legislative proposals affecting CHIP are the requirement for 12 months of postpartum coverage (no budget effect) and requiring MLR remittances ($1.7 billion in savings over 10 years).

PRIVATE HEALTH INSURANCE

The Administration's legislative proposals for private health insurance are estimated to increase federal spending by a net $391 billion over 10 years. Most of this spending is to permanently extend coverage to low-income individuals in states that have not expanded Medicaid ($200 billion) and to permanently extend exchange subsidies ($183 billion) most recently extended through 2025 by the IRA.

PRIVATE INSURANCE PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2024		
	Savings (-) /cost (+) in $ millions	
	FY24	FY24-33
Private Insurance Legislative Proposals		
Promote Equity and Address Social Determinants of Health		
Permanently Extend Enhanced Premium Tax Credits (non-add)	--	*183,011*
Permanently Extend Coverage to Low-income Individuals in States that have not Expanded Medicaid (non-add)	*8,500*	*200,000*
Subtotal, Government-wide Impact (non-add)	***8,500***	***383,011***
Transform Behavioral Health		
Improve Access to Behavioral Healthcare in the Private Insurance Market (non-add)	--	*29,137*
Require Coverage of Three Behavioral Health Visits and Three Primary Care Visits without Cost-Sharing (non-add)	--	*17,624*
Provide Mandatory Funding for State Enforcement of Mental Health Parity Requirements	10	125
Subtotal, Government-wide Impact (non-add)	***10***	***46,886***
Strengthen Long-Term Sustainability and Integrity of HHS Programs		
Replenish and Extend No Surprises Act Implementation Fund	--	500
Extend Surprise Billing Protections to Ground Ambulance (non-add)	--	*-948*
Subtotal, Government-wide Impact (non-add)	***--***	***-448***
Prescription Drug Reforms		
Expand Drug Inflation Rebates to the Commercial Market	--	-40,000
Limit Cost-sharing for Insulin at $35 a Month (non-add)	*572*	*1,363*
Subtotal, Government-wide Impact (non-add)	***572***	***-38,637***
Total, Government-wide Impact, Private Insurance Proposals (non-add)	***9,082***	***390,812***

Note: For brevity, this table shows the totals for each initiative, but not the accounting breakdowns shown in the HHS Budget in Brief separately for premium tax credits, cost-sharing reductions, and other government-wide impacts. The subtotals shown are the overall government-wide impact (non-add), rather than the small fraction of the total also shown in the Budget in Brief as added to HHS specifically from these private insurance proposals (for example, amounts attributable to the cost-sharing reductions for exchange coverage, but not the much larger amounts for premium tax credits or other government-wide impacts).

Permanently Extend Enhanced Premium Tax Credits. The enhanced premium tax credits, originally established under the American Rescue Plan Act (ARP) and extended under the Inflation Reduction Act (IRA) through 2025, would be extended permanently under this budget. The following policies would be made permanent:

- Eliminate required contribution for individuals and families making 100 percent to 150 percent of the federal poverty level (FPL),
- Limit the maximum income contributions toward benchmark plans to 8.5 percent of income (rather than 9.5 percent), and
- Remove the 400 percent FPL ($120,000 for a family of four) cap on premium tax credit eligibility.

The budget would also eliminate the annual indexing of the required contribution percentage, leading to more certainty for consumers as they calculate their required share of potential health insurance premiums.

Under the HHS line of the budget (for cost-sharing reductions), these policies would cost $18.4 billion over 10 years, but government-wide costs would be $383 billion.

Permanently Extend Coverage to Low-income Individuals in States that have not Expanded Medicaid. The budget says that it would extend Medicaid-like coverage to individuals in states that have not expanded Medicaid, paired with financial incentives to ensure States maintain their existing expansions. The government-wide costs for this policy would total $200 billion over 10 years.[11]

Improve Access to Behavioral Healthcare in the Private Insurance Market. This proposal would require all issuers of private insurance in the individual and group markets, as well as employer-based plans, to provide mental health and substance use disorder benefits. To improve compliance with behavioral health parity standards, plans and issuers would be required to use medical necessity criteria for behavioral health services that are consistent with the criteria developed by nonprofit medical specialty associations (none specifically mentioned). The Secretaries of HHS, Labor and Treasury would be authorized to regulate behavioral health network adequacy and to issue regulations on a standard for parity in reimbursement rates based on the results of comparative analyses submitted by plans and issuers. This would increase federal spending by $29 billion over 10 years (of which $760 million is for ACA cost-sharing reductions).

Require Coverage of Three Behavioral Health Visits and Three Primary Care Visits without Cost-Sharing. All issuers of private insurance in the individual and group markets, as well as employer-based plans, would be required to cover three behavioral health visits and three primary care visits each year without charging a copayment, coinsurance or deductible-related fee. This provision would increase federal spending by $17.6 billion over 10 years (of which $310 million is for ACA cost-sharing reductions).

Funding for State Enforcement of Mental Health Parity Requirements. This proposal provides $125 million in mandatory funding over five years for grants to states to enforce mental health and substance use disorder parity requirements, with any funds not expended at the end of five fiscal years available to the HHS Secretary to make additional mental health parity grants.

Replenish and Extend No Surprises Act Implementation Fund. The No Surprises Act and Title II Transparency provisions created new consumer protections from surprise medical bills and entrusted the Departments of HHS, Labor, and the Treasury with many new or enhanced

[11] While no further details appear to be available in the budget materials, a temporary program expansion of exchange subsidies was proposed in section 137304 of the first House-passed version of H.R. 5376 of the 117th Congress. This proposal was dropped in the legislation that ultimately became enacted as the IRA. The expansion in the first House-passed version of H.R. 5376 would have provided premium tax credits for tax years 2022 through 2025 (rather than a permanent extension) for individuals under 138 percent FPL.

enforcement, oversight, data collection and program operation requirements.[12] While the $500 million original appropriated for implementation costs expires after 2024, the federal responsibilities continue, including:

- Enforcement of plan, issuer, and provider compliance,
- Complaints collection and investigation, and
- Auditing comparative analyses of non-quantitative treatment limits for mental health and substance-use disorder plan benefits.

The budget provides $500 million in additional mandatory funding for continued implementation of the No Surprises Act and Title II Transparency provisions.

Extend Surprise Billing Protections to Ground Ambulance. The No Surprises Act established protections for enrollees of health plans from surprise medical bills when they receive emergency services (including certain post-stabilization services), certain non-emergency services from nonparticipating providers at participating facilities, and air ambulance services from nonparticipating providers of air ambulance services under certain circumstances. However, ground ambulance services are excluded from these protections. Beginning in 2025, this proposal would extend surprise billing protections to ground ambulance bills across the commercial market, so that people who take an out-of-network ground ambulance ride during an emergency would only be subject to their in-network cost-sharing amount. Unresolved disagreements between the plan and ground ambulance provider over payment for these services would be settled through the Federal Independent Dispute Resolution Process. This is projected to save the federal government $948 million over 10 years.

Expand Drug Inflation Rebates to the Commercial Market. The IRA requires manufacturers to pay rebates to Medicare when drug prices for certain Medicare Part B or Part D drugs rise faster than inflation. The budget would extend the formula to include drug units used by commercial plans, which would provide additional savings while discouraging manufacturers from raising drug prices for commercial coverage (employer-sponsored plans, Marketplace plans, and other individual and group market plans). This is projected to save the federal government $40 billion over 10 years.

Limit Cost-sharing for Insulin at $35 a Month. The IRA limits Medicare beneficiary cost sharing to $35 per insulin product for a month's supply. The budget would extend the cap on patient cost sharing to insulin products in commercial markets, which would cost the federal government $1.4 billion over 10 years.

PROGRAM INTEGRITY PROPOSALS

The FY 2024 budget provides $2.8 billion in total mandatory and discretionary investments for the Health Care Fraud and Abuse (HCFAC) and Medicaid Integrity Programs. The budget

[12] The No Surprises Act was enacted as Title I of Division BB of the Consolidated Appropriations Act (CAA), 2021 (P.L. 116-260, enacted December 27, 2020. Title II of Division BB of CAA, 2021, focused on transparency. Section 118 of the No Surprises Act provided $500 million for implementation funding, available until expended through 2024.

requests $2.7 billion for the HCFAC an increase in $289 million in mandatory funding and $44 million in discretionary funding above the FY 2023 enacted level. A top priority for increased investment in this account is Medicare medical review.

Major legislative proposals would increase investment in mandatory HCFAC; implement targeted risk-adjustment pre-payment review in Medicare Advantage; and improve governance.

Restructure Mandatory HCFAC. This proposal would increase the mandatory HCFAC funding stream by 20 percent over current law baseline levels and is projected to total $3.8 billion over 10-years. This proposal also makes modifications to the HCFAC statutory requirements including expanding the scope of OIG investigations to include Marketplaces and related activities, clarify that HCFAC allowable purposes apply to both public and private plans, and include CHIP in the Medi-Medi data match to allow CMS to audit and investigate this program.

Long-Term Care

This proposal requires skilled nursing facilities with private equity or real estate investment trust ownership, whether direct or indirect, to provide additional financial disclosures above and beyond other provider types. The proposal also requires all Medicare providers/suppliers with any percentage-level direct or indirect ownership must be reported on the provider/supplier's enrollment application instead of the current requirement of 5 percent ownership. Not Scorable.

Good Governance

Implement targeted risk-adjustment pre-payment review in Medicare Advantage. This proposal confirms diagnoses submitted by Medicare Advantage Organizations for risk-adjustment with the medical record prior to CMS making risk adjusted payments. The proposal focuses prepayment review on plans, diagnosis, or beneficiaries at elevated risk of improper payments and determine which plans would be required to submit medical record documentation in support of the risk-adjustment. Budget Neutral.

Expand tools to identify and investigate fraud in Medicare Advantage. This proposal requires MA plans to collect referring provider identifiers for healthcare services and report this information as part of encounter data to CMS. This proposal would not require additional funding. [Not Scorable]

Ensure providers that violate Medicare safety requirements and have harmed patients cannot quickly reenter the program. This proposal provides the Secretary with authority to enforce an exception to Medicare's reasonable assurance period for Medicare-certified providers/suppliers in cases of patient harm or neglect. Budget Neutral.

Prohibit Unsolicited Medicare Beneficiary Contacts. This proposal disallows certain ordering or referring providers (and other individuals or entities acting on their behalf) from making unsolicited contacts with Medicare beneficiaries. The proposal would grant rulemaking authority to the Secretary to modify the restrictions consistent with emerging fraud threats.

PROGRAM INTEGRITY PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2024			
	Savings (-) /cost (+) in $ millions		
	2024	2024-2028	2024-2033
Program Integrity Legislative Proposals			
Long-Term Care			
Require Additional Disclosures from Private Equity or Real Estate Investment Trust Ownership to Improve Quality of Care in Skilled Nursing Facilities	-	-	-
Subtotal Outlays, Long Term Care Proposed Policy	-	-	-
Subtotal, Medicare Impact (non-add)	-	-	-
Subtotal, Medicaid Impact (non-add)	N/A	N/A	N/A
Good Governance			
Implement Targeted Risk-Adjustment Pre-Payment Review in Medicare Advantage	**	**	**
Ensure Providers that Violate Medicare Safety Requirements and Have Harmed Patients Cannot Quickly Reenter the Program	-	-	-
Prohibit Unsolicited Medicare Beneficiary Contacts	**	**	**
Expand Tools to Identify and Investigate Fraud in the Medicare Advantage Program	**	**	**
Subtotal Outlays, Good Governance Proposed Policy	-	-	-
Subtotal, Medicare Impact (non-add)	-	-	-
Subtotal, Medicaid Impact (non-add)	N/A	N/A	N/A
Program Integrity Legislative Proposals			
Subtotal Outlays, Program Integrity Legislative Proposals	-	-	-
Subtotal, Medicare Impact (non-add)	-	-	-
Subtotal, Medicaid Impact (non-add)	N/A	N/A	N/A
Non-PAYGO Savings[13]			
Capture Savings to Medicare and Medicaid from HCFAC Allocation Adjustment	-1,178	-6,542	-14,336
Capture Savings to Medicare and Medicaid from Social Security Administration Allocation Adjustment	-60	-2,577	-10,784
Subtotal, Medicare Impact (non-add)	-34	-1,953	-8,629
Subtotal, Medicaid Impact (non-add)	-26	-624	-2,155
Increase Investment in Mandatory HCFAC and Other Mandatory HCFAC Modifications			
Gross Investment from 20% Rebasing of Funding Streams (non-add)	205	1,665	3,806
Gross Savings from Return-on-Investment (non-add)	-525	-4,035	-9,176
Net Savings: Increase Investment in Mandatory HCFAC and Other Mandatory HCFAC Modifications	**-320**	**-2,370**	**-5,370**
Subtotal, Medicare and Medicaid Savings from Program Integrity Investment	**-1,558**	**-11,489**	**-30,490**

** Not Scorable

[13] Includes non-PAYGO savings from continuing allocation adjustments in HCFAC and the Social Security Administration program integrity activities.

DISCRETIONARY HEALTH SPENDING

Overall, the budget includes $144 billion in FY 2024 discretionary funding for HHS, about $17 billion (13.3%) above the FY 2023 level. Proposed program level funding, which combines discretionary funding with mandatory funding and user fees, varies among HHS agencies. Substantial increases are proposed for the Centers for Disease Control and Prevention (CDC) of $5.0 billion, the Substance Use and Mental Health Services Administrations (SAMHSA) of $3.3 billion, Indian Health Service (IHS) of $2.5 billion, and the Health Resources and Services Administration (HRSA) of $1.5 billion. These additional resources will be used by CDC for pandemic preparedness and increased access to vaccines, by SAMHSA to expand access to behavioral health services and grow investments in crisis response, by IHS to expand clinical and preventive health care services, and by HRSA to expanding access to behavioral health care services in health centers and expansion of health workforce capacity.

Proposed HHS Health-Related Agency/Office Funding for FY 2024 (Program levels, in $ millions)		
HHS Agency/Office	**FY 2024**	**Change from 2023**
Agency for Healthcare Research and Quality (AHRQ)	564	+79
Centers for Disease Control and Prevention (CDC)	19,508	+5,042
CMS Program Management	7,711	+778
Food and Drug Administration (FDA)	7,241	+521
Health Resources and Services Administration (HRSA)	15,865	+1,536
Indian Health Service (IHS)	9,650	+2,545
National Institutes of Health (NIH)	48,598	+920
Substance use and Mental Health Services Administration (SAMHSA)*	10,834	+3,317
Office of Medicare Hearings and Appeals (OMHA)	199	+3
Office of the National Coordinator for Health Information Technology (ONC)	104	+37
Center for Medicare and Medicaid Innovation – obligations**	636	-44
*The FY 2023 budget proposed to change the name to remove "abuse" from the agency name. **CMMI reports obligations and outlays in lieu of program level funding. **Source:** Department of Health and Human Services, *Fiscal Year 2024 Budget in Brief*		

Agencies for Healthcare Research and Quality (AHRQ)

The proposed $564 million funding for AHRQ is $79 million above FY 2023 levels. This total includes $403 million in budget authority, $45 million in Public Health Service Evaluation Set Aside funding, and $116 million in mandatory transfers from the Patient-Centered Outcomes Research Trust Fund.

The budget proposes $297 million, an increase of $68 million of which $59 million is for health service research, data, and dissemination. This budget is proposed to support new behavioral health activities, the development of an all-payer claims database, and evaluation of telehealth on health outcomes. The budget proposes $18 million, an increase of $6 million above the FY 2023 levels, for the U.S. Preventive Services Task Force (USPSTF). This increase will allow the

USPSTF to expand the number of clinical preventive reviews in FY 2023. In FY 2022, the USPSTF issued 12 final recommendation statements.

Centers for Disease Control and Prevention (CDC)

The proposed $19.5 billion funding for CDC (and the Agency for Toxic Substances and Disease Registry (ATSDR)) is $5.0 billion above FY 2023 levels. This total includes $10.5 billion in discretionary budget authority, $1.2 billion from the Prevention and Public Health Fund, and $8 billion in current and proposed mandatory funding. New proposed mandatory funding would establish a Vaccines for Adults program ($1.0 billion) to provide uninsured adults with access to all vaccines recommended by the Advisory Committee on Immunization Practices at no cost. The budget also includes an increase of $1.6 billion for a legislative proposal to expand the Vaccines for Children program to include all individuals enrolled in the Children's Health Insurance Program. The FY 2024 budget includes mandatory funding across HHS for pandemic preparedness of which $6.1 billion is allocated to CDC.

The budget proposes $1.0 billion, an increase of $315 million, in crosscutting activities of which $590 million will support improvements in public health data including CDC's data modernization initiative. The budget also includes $600 million, an increase of $250 million for leadership, communication and public health innovation.

The budget proposes $1.3 billion, an increase of $337 million, for immunization and respiratory diseases. In addition to legislative proposals to develop the Vaccines for Adults program and expand the Vaccines for Children program, the budget includes an increase of $10 million above the $240 million FY 2023 level for the Global Immunization Program to increase vaccinations and prevent and mitigate large outbreaks.

The budget proposes $1.5 billion, an increase of $153 for domestic HIV/AIDS, viral hepatitis, sexually transmitted infections and tuberculosis prevention activities to support state, tribal, local, and territorial health departments' responses to infectious disease outbreaks. This budget includes $310 million, an increase of $90 million, to continue to advance HHS' efforts to end the HIV/AIDS epidemic. To improve laboratory capacities at federal, state and local levels, the budget includes an additional $40 million above FY 2023 levels to expand CDC's core emerging infectious disease work.

The budget proposes $1.8 billion for chronic disease prevention and health promotion activities, an increase of $383 million from FY 2023 levels. To support the Cancer Moonshot Initiative the budget includes $839 million to support cancer prevention and control programs across CDC, including tobacco prevention, HPV prevention and environmental health activities. The budget proposes expanding the State Physical Activity and Nutrition (SPAN) program to all states and territories and includes an additional $72 million above FY 2023 levels. The SPAN program works to reduce chronic disease by improving physical activity and nutrition. The budget also includes an increase of $56 million to reduce maternal mortality by providing additional funding for Maternal Mortality Review Committees and expansion of Perinatal Quality Collaboratives.

The budget proposes $1.4 billion for injury prevention and control programs, an increase of $590 million from FY 2023 levels. This funding supports efforts to reduce all forms of violence, including gun, partner, gender-based and sexual violence. Included in this funding request is $713 million for CDC's opioid overdose prevention and surveillance programs and $35 million for research to identify the most effective ways to prevent firearm injuries and death.

Proposed funding for environmental health is $421 million, an increase of $174 million from FY 2023. This increase includes $100 million to bolster efforts in supporting state, tribal, local and territorial public health agencies as these prepare for the health impacts of climate change. This increase also includes $39 million for the Childhood Lead Poisoning Prevention Program. Proposed funding for public health and scientific services is $962 million, an increase of $207 million from FY 2023. This includes an increase over FY 2023 funding of $200 million for continued improvements in CDC's data modernization initiative and $2 million for the National Center for Health Statistics to enhance data collection activities including increasing the sample size of the National Health Interview Survey.

Funding for ATSDR is $86 million for activities related to protecting communities from harmful environmental exposures.

Center for Medicare & Medicaid Services (CMS) Program Management

CMS total program level management funding is proposed at $7.7 billion, an increase of $777 million above FY 2023 levels; total program management includes discretionary administration, mandatory appropriations and user fees. This budget request also includes $300 million in proposed mandatory funding to cover the costs associated with implementing proposed legislative changes for Medicare, Medicaid, and CHIP.

The discretionary budget funding is proposed at $4.6 billion, an increase of $425 million above FY 2023 levels. The budget requests $3.0 billion for Program Operations, an increase of $215 million. Approximately 30 percent ($1.0 billion) of the Program Operations request supports ongoing Medicare contractor operations. The budget includes $61 million to process second level Medicare appeals, $681 million for information technology system upgrades, $353 million for Medicaid and CHIP operations, and $10 million to support implementation of the Inflation Reduction Act. The budget also requests $25 million to provide grants to States and tribes to advance health equity.

The budget request for federal administrative costs is $854 million, which is $71 million above FY 2023 levels and will increase the full-time staff level by 100 FTEs to 4,330. The budget requests $566 million for Survey and Certification, an increase of $159 million. CMS projects this request will allow states to fully complete surveys for all provider types. The budget requests two-year budget authority for the Medicare Survey and Certification program.

The budget funds the National Medicare Education Program at $528 million, including $359 million in discretionary budget authority. The budget requests $2.3 billion for federal administrative expenses associated with operating the Federally Facilitated Marketplace; $2.1 billion with be funded by Marketplace and Risk Adjustment user fees and $247 million will be funded by program management.

Food and Drug Administration (FDA)

The proposed program level funding of $7.2 billion would provide a $521 million increase in program level funding above FY 2023 levels. This includes $3.3 billion, an increase of $45 million from current user fees and $105 million from legislative proposals. The user fees collected in support of FDA's prescription drug program would be increased by $26 million, the generic drug would be increased by $12 million and the medical device by $6 million. Legislative proposals would increase the tobacco user fee by $100 million and the export certification user fee by $5 million. In addition, the proposed program level funding includes $670 million in mandatory funding to support HHS pandemic preparedness.

Within the current FDA programs, most of the proposed increase in the program level funding is for food ($153 million), tobacco products ($103 million), human drugs ($99 million) and medical devices ($46 million). In support of the Cancer Moonshot Initiative, the budget includes an additional $48 million to support FDA's Oncology Center of Excellence programs. The budget provides an increase of $23 million to support FDA's activities to reduce the opioid epidemic including the development of opioid reversal treatments and treatments for opioid use disorder, and new funding to develop and evaluate digital health medical devices to address opioids use disorder. The budget includes an additional $25 million to support a range of medical product safety activities including strengthening FDA post-market safety activities and strengthening public health supply chains.

To support ongoing enterprise technology and data modernization efforts, the budget includes an increase of $10 million which would be used to strengthen the common data infrastructure across the agency and modernize food and medical product safety data efforts. To maintain FDA's workforce the budget includes as increase of $105 million to cover increases in pay costs for FDA's employees.

Health Resources and Services Administration (HRSA)

The proposed $15.9 billion for HRSA is $1.5 billion above FY 2023 levels. Funding increases are for health centers ($1.345 million), health workforce ($892 million), family planning ($226 million), maternal and child health ($205 million), long COVID (130 million), Ryan White HIV/AIDS Program ($125 million), rural health ($63 million), organ transplantation ($36 million), and other health care system activities including the 340B Drug Pricing Program ($5 million). The FY 2024 budget excludes $1.5 billion from program management activities in congressionally directed earmarks, which are for one-time projects. This contributes to the total reduction in HRSA budget authority.

Health centers would receive $7.1 billion in discretionary and proposed mandatory funding, which includes $1.9 billion in discretionary funding and $5.2 billion in proposed mandatory resources. The budget proposes a three-year pathway to double the program's funding to address the gap in primary and behavioral health care services. It is also intended to improve access by supporting increased hours of operation, such as extended or weekend hours, and patient support.

Health care workforce activities would be funded at $2.7 billion ($892 million above FY 2023). This includes $966 million for the National Health Service Corps (+ $548 million) to maintain

funding from pandemic relief efforts that resulted in historic growth in staff levels. The budget also includes mandatory funding of $157 million in FY 2024 and extends and increases funding through FY 2026 to support over 2,000 residency slots for primary care physicians and dental residents that receive community-based training. It also includes $387 million (+$190 million) to train 18,000 behavioral health providers to help respond to mental health and substance use crisis. It also includes $385 million for the Children's Hospital Graduate Medical Education Payment Program (same level as 2023) and $350 million for Nursing Workforce Development (an increase of $50 million).

The Ryan White HIV/AIDS program would be funded at $2.7 billion ($125 million above FY 2023). Most of this total amount funds primary medical care, essential support services, and medication for low-income people living with HIV/AIDS by providing support to states, counties, cities, and local community-based organizations (same funding levels as 2023). The budget also includes $290 million designated to support Ending HIV Epidemic HIV/AIDS Program (an increase of $125 million) – intended to target geographic locations with high proportions of new HIV diagnoses.

The budget also invests a total of $1.9 billion in HRSA's maternal and child health funding, an increase of $205 million from 2023 levels to build upon its current efforts to reduce maternal mortality and morbidity. The 340B Drug Pricing Program would receive $17 million to improve operations and oversight (an increase of $5 million). In addition, the FY 2024 budget provides $130 million in new resources to fund Long COVID Integrated Diagnostics and Care Units, which will provide care for uninsured patients with Long COVID as well as provide primary care providers information and support about Long COVID diagnostics and treatment.

Indian Health Service (IHS)

The FY 2023 budget proposes $9.7 billion for IHS, an increase of $2.5 billion or 36 percent above FY 2023. The Administration continues to support full mandatory funding for IHS and proposes this to begin in FY 2025 when funding would grow automatically to address inflationary factors, key operational needs, and existing backlogs. The budget also establishes a new dedicated funding stream of $150 million in FY 2025 that grows to $500 million annually over the 10-year budget window to address public health capacity and infrastructure needs. This mandatory funding approach would also provide increased funding to complete the construction projects on its Healthcare Facilities Construction Priority List (an almost 30-year-old list).

In FY 2024, the budget includes $7 billion in the Services account, an increase of $2.1 billion, which primarily funds direct health care services the IHS provides through its network of more than 1,200 hospitals, clinics, and health stations on or near Indian reservations. The budget also proposes to reauthorize the Special Diabetes Program for Indians and provide $250 million in FY 2024, $260 million in FY 2025, and $270 million in FY 2026 in new mandatory funding. This diabetes program has been effective at reducing the prevalence of diabetes and helping to avert cases of end-stage renal disease among the American Indians and Alaska Natives. The budget provides $1.1 billion for Facilities program, an increase of $108 million above FY 2023 to support construction projects, purchase medical equipment, and fund other related activities. The budget also fully funds IHS' Electronic Health Record modernization efforts over the next five years.

National Institutes of Health (NIH)

The budget proposes NIH program level funding of $48.6 billion, an increase of $920 million from FY 2023. Total funding available through the 21st Century Cures Account is $407 million. As part of the broader HHS pandemic preparedness program, $2.7 billion is proposed for research and development of vaccines, diagnostic and therapeutic agents, biosafety, and expanding laboratory capacity. The budget proposes to reauthorize the 21st Century Cures Act Cancer Moonshot through 2026 and provides $1.45 billion for each year and to reauthorize the Special Type 1 Diabetes Program for three years.

Most of the institutes and centers have proposed funding levels at FY 2023 enacted levels. The budget proposes increases for the National Cancer Institute ($503 million); the National Institute of Mental Health ($200 million); the National Institute of Environmental Health Sciences ($25 million); the National Institute of Neurologic Disorders and Stroke ($6 million); and the Office of the Director ($251 million).

For FY 2024, the budget proposes $2.5 billion for the Advanced Research Projects Agency for Health (ARPA-H), and increase of $1.0 billion over FY 2023 funding. This budget request funding for ARPA-H is as a separate appropriate within NIH.[14] This budget will allow ARPA-H to make important investments in breakthrough technologies to support many cross-cutting initiatives, including the Cancer Moonshot.

Substance Use and Mental Health Services Administration (SAMHSA)

Proposed program level funding of $10.8 billion is sought for FY 2024 for SAMHSA, an increase of $3.3 billion above FY 2023. The Administration states this investment will expand access to behavioral health care, invest in crisis response, harm reduction, the behavioral workforce, services to people experiencing homelessness, and recovery services.

Over fifty percent of the budget (or $5.5 billion) is for substance use services. This includes $2.7 billion for the Substance Use Prevention, Treatment, and Recovery Block Grant (an increase of $700 million over FY 2023), a formula grant program that helps states finance substance use and prevention and treatment activities. This budget category also includes $2.0 billion for the State Opioid Response program to address opioid and stimulant misuse, a proposed increase of $425 million.

The remaining half of the budget (or $4.9 billion) is mostly for SAMHSA's mental health activities, an increase of $2.2 billion over FY 2023. This includes investing $1.7 billion into the Community Mental Health Block Grant (an increase of $645 million over 2023), which provides states non-clinical coordination and support services that are not covered by Medicaid or other third-party insurance. It also provides $836 million for the National Suicide Prevention Lifeline and behavioral health crisis services, an increase of $334 million over FY 2023. This funding will support the 24/7 9-8-8 lifeline and increase capacity for the 9-8-8 lifeline to respond. The

[14] Funding in FY 2022 and FY 2023 enacted was appropriated to the Office of the Secretary account and transferred to NIH after congressional notification.

budget also includes additional resources for children's mental health needs and projects to assist individuals in transition from homelessness.

Office of Medicare Hearings and Appeals (OMHA)

The FY 2024 budget proposes OMHA program level funding of $199 million, an increase of $3 million from FY 2023. OMHA reports that it has successfully reduced the backlog of pending appeals by 98 percent to 60,000 appeals (from a high or nearly 900,000 in FY 2016) leaving a caseload manageable within the 90-day adjudication time frame. The budget will allow further reduction of the pending appeals backlog and help build capacity to help prevent a larger backlog from developing. It is currently hiring three-year term appointees to assist with the influx of cases.

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

ONC funding is proposed at $104 million, an increase of $37 million from FY 2023. This office leads the federal government in health information technology (IT) efforts by supporting the development of standards and advancing policies that ensure equitable access to electronic healthcare data for all patients. The budget includes $39 million, an increase of $18 million over FY 2023, on efforts to accelerate the adoption and expansion of exchange through the Trusted Exchange Framework and Common Agreement (TEFCA) and advance interoperability work. TEFCA establishes a common legal agreement and technical standards for health information exchange. The FY 2024 budget also continues to administer the Health IT Advisory Committee (HITAC) as a method for obtaining routine input from a group of 27 health IT experts and six federal representatives. In addition, ONC will update its Health IT Certification Program according to the 21st Century Cures Act final rule.

Center for Medicare & Medicaid Innovation (CMMI)

CMMI (also known as the CMS Innovation Center) was established by section 1115A of the Social Security Act as added by Section 3021 of the ACA. The ACA appropriated $10 billion to support the activities work of CMMI for 2011-2019 and the same amount for each subsequent 10-year fiscal period. CMMI is now in its second decade of mandatory funding and operations (i.e., FY 2020-2029). Its actual, unexpired, unobligated balance at the end of FY 2022 was $9.268 billion. The estimated unexpired, unobligated balances for FY 2023 and FY 2024 are $8.588 and $7.952 billion, respectively. CMMI estimates that it will spend $636 million in 2024, $44 million less than 2023.

To date, CMMI has launched more than 50 models, ranging from accountable care organizations to bundled episode payment models. CMMI also implements demonstrations established directly by Congress (e.g., the Medicare Shared Savings Program). In October 2021, CMMI embarked on a *Strategy Refresh*, setting the following objectives for its models through 2030: Drive Accountable Care, Advance Health Equity, Support Innovation, Address Affordability, and Partner to Achieve System Transformation.

To build on the IRA and President's Biden Executive Order 14087, "Lowering Prescription Drug Costs for Americans," the HHS Secretary selected three models for the Innovation Center to test and help lower the cost of drugs and promote access.

- In the $2 Drug List model, Medicare Part D plans are encouraged to offer a low fixed co-payment, no more than $2, across all cost-sharing phases of the Part D drug benefit for a standardized Medicare list of generic drugs.
- In the Cell & Gene Therapy Access model, CMS would coordinate and administer multi-state outcomes-based agreements with manufacturers for certain cell and gene therapies.
- In the Accelerating Clinical Evidence model, CMS would develop payment methods for drugs approved under accelerated approval, in consultation with FDA to encourage timely confirmatory trial completion and improve access to post-market safety and efficacy data.

The estimated effects of current CMMI initiatives are presented, some of which are shown in the table below. No estimates were provided for certain models at this time, including the Bundled Payments for Care Improvement Advanced (BPCI-Advanced) Model, Medicare Advantage Value-Based Insurance Design (MA VBID), Maternal Opioid Misuse (MOM) Model, Integrated Care for Kids (InCK) Model, Community Health Access and Rural Transformation (CHART) Model, and Emergency Triage, Treat, and Transport (ET3) Model.

Approved and Implemented Demonstrations and Pilot Programs in Medicare Baseline (Outlays in millions of dollars)						
	2023	**2024**	**2025**	**2026**	**2027**	**2028**
Maryland Total Cost of Care (TCOC)						
Baseline	14,154	15,201	16,326	17,534	18,832	
Demonstration	13,982	14,994	16,083	17,255	18,517	
Pennsylvania All-Payer Rural Health						
Baseline	1,193	301				
Demonstration	1,177	297				
Vermont All-Payer Model						
Baseline	330					
Demonstration	328					
Kidney Care Choices						
Baseline	6,370	6,760	6,770	6,770	1,690	
Demonstration	6,340	6,690	6,690	6,680	1,760	
Comprehensive Care for Joint Replacement						
Baseline	1,389	1,456	368			
Demonstration	1,318	1,381	349			
Medicare Diabetes Prevention Program						
Baseline	20	31	43	56	70	85
Demonstration	20	31	43	56	70	85
ACO Realizing Equity, Access, and Community Health (ACO REACH)*						
Baseline	14,260	12,750	11,990	11,610	2,890	
Demonstration	14,170	12,730	11,900	11,580	2,920	
ESRD Treatment Choices (ETC)						
Baseline	2,419	2,504	2,592	2,684	2,778	2,876
Demonstration	2,420	2,496	2,581	2,667	2,764	2,877
Part D Senior Savings (PDSS)*						
Baseline	130,070	34,898				

Approved and Implemented Demonstrations and Pilot Programs in Medicare Baseline (Outlays in millions of dollars)						
Demonstration	129,990	34,875				
Home Health Value-Based Purchasing (HHVBP)						
Baseline	19,903	21,365	22,715	24,230	25,890	6,578
Demonstration	19,624	20,735	22,001	23,481	25,089	6,375
Prior Authorization Repetitive Nonscheduled Ambulance Transport (RNSAT PA)						
Baseline	602	602	602	602	602	602
Demonstration	304	304	304	304	304	304
Primary Care First (PCF)						
Baseline	38,344	37,743	38,329	40,054	19,825	
Demonstration	38,342	37,598	38,047	39,899	19,816	
Enhancing Oncology Model						
Baseline	1,930	7,700	6,430	4,200	3,600	900
Demonstration	1,910	7,590	6,290	4,100	3,500	870

* President's budget notes that the Inflation Reduction Act covers most of the covered insulin benefits provided through the PDSS and CMS will terminate the model at the end of CY 2023.

Source: Excerpts from Table 21-4, "Impact of Regulations, Expiring Authorizations, and Other Important Assumptions in the Baseline," Analytical Perspectives for FY 2024, https://www.whitehouse.gov/omb/budget/analytical-perspectives/.