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# Highlights of the Administration's FY 2025 Budget

This summary provides highlights of healthcare-related proposals included in the President's Budget for fiscal year (FY) 2025, based on materials released by the Biden Administration on March 11, 2024.[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 2025 proposes policies that OMB estimates would reduce federal deficits by a total of $3.227 trillion over the next 10 years (FYs 2025-2034). This total is comprised of a net increase of $2.5 trillion from mandatory spending, a decrease of $453 billion in discretionary programs ($307 billion decrease in nondefense programs and a $146 billion decrease in defense), $380 billion in reduced interest payments on the debt, and $4.9 trillion in additional revenue.[2]

HHS is proposed to have $1.7 trillion in mandatory budget authority and $130.7 billion in discretionary budget authority in FY 2025. The budget describes a number of health system priorities in the following areas:

**Negotiates Lower Drug Prices and Expands Access to Prescription Drugs**. As previously proposed, the budget calls for Medicare to negotiate prices for a greater number of drugs, sooner after drugs are launched than is currently permitted by the Inflation Reduction Act (IRA). The budget again proposes to expand some of the IRA's Medicare Part D policies to prescription drugs in commercial coverage, such as:

- Applying the IRA's inflation rebates,
- Capping annual out-of-pocket cost sharing for prescription drugs at $2,000, and
- Capping monthly out-of-pocket cost sharing including for insulin products at $35 per month.

[1] Particularly the HHS section of *Budget of the U.S. Government: Fiscal Year 2025* and the HHS *Budget in Brief*, hereafter collectively referred to as the budget.
[2] HPA calculations from Tables S-2, S-3, and S-4 of the budget.

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.

**Expands Access to Quality, Affordable Healthcare**. The budget again proposes to make permanent the increased premium tax credits extended through 2025 by the IRA and to provide Medicaid-like coverage for individuals in states that have not adopted the Medicaid expansion in the Affordable Care Act (ACA). The budget also says it would include a ban on unwarranted "facility fees" for telehealth and certain outpatient services in commercial insurance, while funding continued implementation of the No Surprises Act. For Medicaid and CHIP, the budget would provide two new options for continuous eligibility: (1) states would have the option to extend continuous eligibility for children from birth until they turn age six, and (2) for children under age 19, states could provide periods of continuous eligibility of up to 36 months at a time. The budget would also prohibit enrollment fees and premiums in CHIP.

**Protects and Strengthens Medicare and Medicaid**. The budget would extend the solvency of the Medicare Hospital Insurance (HI) trust fund indefinitely by increasing taxes on high-income individuals and transferring savings from the Part D reforms into the HI trust fund. The budget again proposes to limit the portion of Medicaid and CHIP managed care dollars spent on administration by establishing a medical loss ratio (MLR) of 85 percent in statute.[3]

**Protects Seniors' Health and Dignity**. The budget again calls for investing $150 billion over 10 years in Medicaid home and community-based services (HCBS), which would improve the quality of jobs for home care workers. 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.

**Supports Family Planning Services for More Americans**. The budget provides $390 million, an increase of nearly 36 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.

**Supports America's Promise to Refugees and Care for Unaccompanied Children**. The budget would provide $9.3 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 2025. As previously proposed, 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.

[3] In regulation, CMS' criteria for states' Medicaid managed care payment rates to be considered "actuarially sound" includes that the rates must be developed so that they "would reasonably achieve" an MLR of 85 percent (42 CFR 438.4(b)(9)). If a state chooses to establish a minimum MLR for its Medicaid managed care plans, it must be at least 85 percent (42 CFR 438.8(c)).

**Transforms Behavioral Healthcare**. To transform behavioral healthcare, the budget touts 3 elements, with specific proposals in each:

- Invests in Behavioral Healthcare. The budget would invest in expanding the 988 Suicide and Crisis Lifeline, mental healthcare and support services in schools, and the Centers for Disease Control and Prevention's (CDC) suicide prevention program to additional states. It would increase funding for the Children's Mental Health Initiative by $50 million, double funding for the Mental Health Crisis Partnership Program, invest in Certified Community Behavioral Health Clinics and Community Mental Health Centers, and provide $1 billion to advance health information technology adoption and engagement in interoperability for certain behavioral health providers.
- Expands Coverage of Behavioral Healthcare Services. For Medicare, the budget again calls for ensuring parity in coverage between behavioral health and medical benefits, lowering patients' costs for mental health services, and expanding the range of behavioral health provider types whose services would be covered. For those with commercial insurance, it would expand coverage of mental health benefits and strengthen requirements regarding the networks of behavioral health providers.
- Expands Access to Treatment for Substance Use Disorder. After describing recent advances in expanding access to treatment for opioid use disorder, the budget calls for increasing funding for the State Opioid Response grant program, which has provided treatment services to over 1.2 million people and enabled states to reverse more than 500,000 overdoses with over 9 million purchased overdose reversal medication kits, and investing in a new technical assistance center to strengthen health providers' understanding and treatment of women's mental health and substance use.

**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 investments of more than $2 billion in the Food and Drug Administration (FDA), CDC, Advanced Research Projects Agency for Health, the National Cancer Institute (NCI) and Indian Health Service (IHS).

**Promotes Maternal Health and Health Equity**. The budget includes proposals to reduce maternal mortality and morbidity by incentivizing states to reimburse a broad range of providers including doulas, community health workers, peer support initiatives, and nurse home visiting programs. It continues to propose that all states be required to provide continuous Medicaid coverage for 12 months postpartum.

**Enhanced Biodefense and Public Health Infrastructure**. The budget continues to propose $20 billion in mandatory funding for HHS public health agencies in support of the Administration's biodefense priorities outlined in the 2022 "National Biodefense Strategy and Implementation Plan for Countering Biological Threats, Enhancing Pandemic Preparedness, and Achieving Global Health Security." The budget would also increase Prevention and Public Health Fund funding by $499 million over the 2023 level (for a total of $9.8 billion) to bolster CDC's public health capacity.

**Strengthens Domestic Medical and Food Supply Chains**. The budget proposes additional funding for HHS' Administration for Strategic Preparedness and Response (ASPR) to manufacture more essential medicines, medical countermeasures, and critical inputs in the United States and $12 million to strengthen FDA's capacity to identify and address potential disruptions and shortage threats. The budget would also institutionalize HHS' supply chain resilience and shortage mitigation efforts in a new office that coordinates HHS-wide activities, strategy, and guidance for drugs, biologics, medical devices, and critical foods.

**Invests in the Treatment and Prevention of Infectious Diseases**. The budget continues to propose investing in the prevention and treatment of infectious diseases, including Hepatitis C, HIV, and vaccine-preventable diseases. Initiatives again include a new national program to expand screening, testing, treatment, prevention and monitoring of Hepatitis C infections. In addition, to end the HIV epidemic, the budget would eliminate barriers to accessing pre-exposure prophylaxis (PrEP) in Medicaid and proposes a new mandatory program to guarantee PrEP at no cost for all uninsured and underinsured individuals. The budget again proposes a new Vaccines for Adults program to provide uninsured adults with access to vaccines at no cost and expansion of the current Vaccines for Children (VFC) program to children enrolled in separate CHIP.

**Protects and Strengthens Public Health and Health Infrastructure**. In addition to some of the preceding items from prior budgets, the budget also highlights the following new initiatives under the broader aim of protecting and strengthening the public health and health infrastructure:

- Helps Communities Respond to and Recover from Gun Violence. The budget would invest a total of $2.5 billion over 10 years in CDC to support an evidence-based community violence initiative to address the causes of violence in communities and help reduce the health inequities that characterize such violence across the United States. It also includes $60 million for gun violence research across CDC and National Institutes of Health (NIH).
- Invests in Healthcare Cybersecurity. Due to the increases in large data breaches reported to HHS, including ransomware attacks, the budget includes funding for ASPR to coordinate HHS' cybersecurity efforts. The budget provides $800 million to help high-need, low-resourced hospitals cover the upfront costs associated with implementing essential cybersecurity practices, and $500 million for an incentive program to encourage all hospitals to invest in advanced cybersecurity practices. It also provides $141 million to continue strengthening HHS' ability to protect and defend HHS systems and information, including $11 million to expand and enhance HHS' capacity to protect the privacy and security of health information through Health Insurance Portability and Accountability Act of 1996 (HIPAA) modernization. The budget also invests in HHS' role in promoting the use of artificial intelligence in healthcare and public health while protecting against its risks.
- Modernizes Organ Donor Systems and Networks. The budget describes how, in 2023, the President signed into law the Securing the U.S. Organ Procurement and Transplantation Network Act to overhaul and break up the monopoly that controlled the organ transplant system for decades. This will help modernize the organ transplant system used to allocate and distribute donor organs to individuals waiting for transplants. The budget includes funding that would support reforms to the system to make it more agile, user friendly, accountable, and equitable, resulting in increased access to donor organs. The budget also

helps to facilitate and encourage transplants for Medicare beneficiaries through expanded support for living organ donors.

**Other HHS Initiatives**. The budget describes other HHS initiatives, again proposing to provide adequate and stable funding for the IHS, support rural health, advance child and family well-being in the child welfare system, and reduce home energy and water costs for low-income households. The budget also proposes to transform the way women's health research is funded at NIH, including by creating a new nationwide network of centers of excellence and innovation in women's health, and doubling existing funding for the Office of Research on Women's Health at NIH.

Overall, the budget includes $130.7 billion in FY 2025 discretionary funding for HHS, about $2.6 billion less than the current FY 2024 level (-2.0%). In a departure from prior years' budgets, HHS displays the discretionary changes as compared to two years prior (comparing FY 2025 to FY 2023), displaying an increase of $2.2 billion from the FY 2023 level (+1.7%).[4] HHS says it is doing such comparisons because "Congress has not yet set final discretionary funding levels for FY 2024."[5]

Proposed program level funding, which combines discretionary funding with mandatory funding and user fees, varies among HHS agencies. Compared to FY 2023, increases are proposed for the CDC of $4.6 billion, NIH of $2.4 billion, the Substance Use and Mental Health Services Administrations (SAMHSA) of $0.6 billion, and the FDA of $0.5 billion. CMS total program level management funding is proposed at nearly $7.6 billion, an increase of $442 million above FY 2023 levels; total program management includes discretionary administration spending, mandatory appropriations and user fees.

## MEDICARE PROPOSALS

The FY 2025 budget includes a package of proposed Medicare improvements and investments totaling $260.0 billion in savings over 10 years. The budget extends Medicare insolvency indefinitely by directing revenues from the net investment income tax, including tax code reforms on those making above $400,000 into the Part A Trust Fund. The budget also credits an amount equivalent to the savings from Medicare drug reforms into the Part A Trust Fund.

| MEDICARE PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2025 | | | |
|---|---|---|---|
| | Savings (-) /cost (+) in $ millions | | |
| | 2025 | 2025-2029 | 2025-2034 |
| **Medicare Legislative Proposals** | | | |
| **Drug Pricing** | | | |
| Expand Medicare Prescription Drug Price Negotiation, Extend Inflation Rebates to Commercial Market and Other Steps to Build on IRA | - | -45,000 | -200,000 |

[4] HHS FY 2025 Budget in Brief, p. 16.
[5] HHS FY 2025 Budget in Brief, p. 2.

| MEDICARE PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2025 | | | |
|---|---|---|---|
| | Savings (-) /cost (+) in $ millions | | |
| | 2025 | 2025-2029 | 2025-2034 |
| Limit Medicare Part D Cost-sharing on Certain Generic Drugs to $2 | - | 475 | 1,342 |
| Permit Biosimilar Substitution w/o FDA Interchangeability Determination | | - | - |
| **Total, Prescription Drug Proposed Policy** | **-** | **-44,525** | **-198,658** |
| **Transform Behavioral Health** | | | |
| Apply the Mental Health Parity and Addiction Equity Act of Medicare | * | * | * |
| Eliminate the 190-day Lifetime Limit on Inpatient Psychiatric Facility (IPF) services | 190 | 1,230 | 2,890 |
| Revise Criteria for Psychiatric Hospital Terminations from Medicare | - | - | - |
| Modernize Medicare Mental Health Benefits | * | * | * |
| Require Medicare to Cover Three Behavioral Health Visits without Cost-sharing | - | 560 | 1,470 |
| Broaden the Health Professional Shortage Area Incentive Program to Include Additional Non-physician and Behavioral Health Practitioners | * | * | * |
| **Total, Mental health** | 160 | 1,580 | 3,890 |
| **Increasing Preparedness** | | | |
| Provide Coverage of Drugs, Vaccines, and Devices during a Public Health Emergency | * | * | * |
| Enable the Secretary to Temporarily Modify or Waive Application of Specific Requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Act | * | * | * |
| **Total, Pandemic Preparedness** | * | * | * |
| **Long Term Care** | | | |
| Hold Long Term Care (LTC) Facility Owners Accountable for Noncompliant Closures and Substandard Care | - | - | - |
| Provide Authority for the Secretary to Collect and Expend Re-survey Fees | - | - | - |
| Increase Per Instance Civil Monetary Penalty (CMP) Authority for LTC Facilities | - | - | - |
| Improve the Accuracy and Reliability of Nursing Home Care Compare Data | - | - | - |
| Adjust Survey Frequency for High-Performing and Low-Performing Facilities | - | - | - |
| **Total, Long Term Care** | - | **-** | **-** |
| **Cancer Moonshot** | | | |
| Expand Cancer Care Quality Measurement | * | * | * |
| **Total, Cancer Moonshot** | * | * | * |
| **Nutrition** | | | |
| Expand and Enhance Access to Medicare Coverage of Nutrition and Obesity counseling | 4 | 591 | 1,840 |
| Conduct a Subnational Medicare Medically-tailored Meal Demonstration | * | * | * |
| **Total, Nutrition** | 4 | 591 | 1,840 |

| MEDICARE PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2025 | | | |
|---|---|---|---|
| | Savings (-) /cost (+) in $ millions | | |
| | 2025 | 2025-2029 | 2025-2034 |
| **Medicare Modernization and Benefit Enhancements** | | | |
| Provide Cybersecurity Support for Hospitals | | 1,098 | 1,348 |
| Fully Cover Costs for all Living Organ Donors for Medicare | - | - | - |
| Create a Permanent Medicare Diabetes Prevention Program Benefit | - | - | - |
| Implement Value-Based Purchasing and Quality Programs for Medicare Facilities | * | * | * |
| Create a Permanent Medicare Home Health Value-Based Purchasing Program | - | - | - |
| Add Medicare Coverage of Services Furnished by Community Health Workers | * | * | * |
| Authorize Tribal Health Programs to Pay Medicare Part B Premiums Directly on behalf of Tribal Members | - | - | - |
| **Total, Medicare Modernization and Benefit Enhancements** | - | 1,098 | 1,348 |
| **Good Governance and Quality Improvement** | | | |
| Prohibit Billing of Beneficiaries after Certain Medicare Bad Debt Payments | - | - | - |
| Create a Consolidated Medicare Hospital Quality Payment Program | - | - | - |
| Refine the Quality Payment Program (QPP): Measure development funding for QPP | 10 | 50 | 50 |
| Establish Meaningful Measures for the End Stage Renal Disease Quality Incentive Program | - | - | - |
| Strengthen Medicare Advantage by Establishing New Medical Loss Ratio Requirements for Supplemental Benefits | * | * | * |
| Require Average Sales Price (ASP) reporting for Oral Methadone | * | * | * |
| **Total, Good Governance and Quality Improvement** | **-** | **-** | **-** |
| **Other Technical Proposals** | | | |
| 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 | - | - | - |
| Increase Transparency by Disclosing Accreditation Surveys | - | - | - |
| Remove Restrictions on the Certification of New Entities as Organ Procurement Organizations and Increase Enforcement Flexibility | - | - | - |
| Change Medicare Appeal Council's Standard of Review | - | - | - |
| **Total, Other Technical Proposals** | - | - | - |
| **Subtotal, Legislative Proposals** | **204** | **-40,996** | **-191,060** |
| **Interactions** | | | |
| Establish the National Hepatitis C Elimination Program | 195 | 1,050 | -289 |
| Extension of Sequester | - | - | -68,505 |
| *Eliminate the 190-day Lifetime Limit on Psychiatric Hospital Services (Medicaid Impact – non-add)* | *-50* | *-330* | *-770* |
| **Total Outlays, Medicare Proposals** | **399** | **-39,946** | **-259,854** |
| **Medicare Proposed Policy** | | | |
| Savings from Program Integrity Investments | -260 | -2,200 | -5,040 |

| MEDICARE PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2025 | | | |
|---|---|---|---|
| | Savings (-) /cost (+) in $ millions | | |
| | 2025 | 2025-2029 | 2025-2034 |
| ***Total Outlays, Medicare Proposed Policies*** | ***139*** | ***-42,146*** | ***-264,894*** |

- Zero or Budget Neutral
* Not Scoreable
"Non-add" means the budgetary impact is not included in this table's totals, but in that of another program.
**Source:** Department of Health and Human Services, *Fiscal Year 2025 Budget in Brief.*

## Prescription Drug Reforms

**Expand Medicare Prescription Drug Price Negotiation, Extend Inflation Rebates to Commercial Market and Other Steps to Build on Inflation Reduction Act Provisions.** The Inflation Reduction Act (P.L. 117-169) caps out of pocket expenses under part D for Medicare beneficiaries at $2,000 per year, caps cost-sharing under Medicare for insulin at $35 for a monthly prescription, and establishes a Medicare Drug Price Negotiation Program.

This proposal would bring drugs into negotiation sooner after they launch, expanding inflation rebates and the $2,000 out-of-pocket prescription drug cost cap beyond Medicare and into the commercial market, and take other steps to build on the Inflation Reduction Act drug provisions. [$200.0 billion in savings over 10 years]

**Limit Medicare Part D Cost-Sharing on High Value Generic Drugs to $2.** This proposal would require all Part D plans, including both standalone prescription drug plans and Medicare Advantage prescription drug plans, to offer Medicare beneficiaries a standard list of generic drugs at a maximum copayment of $2 for a 30-day supply across all phases of the prescription drug benefit until the beneficiary reaches the out-of-pocket maximum. [$1.3 billion in costs over 10 years]

**Permit Biosimilar Substitution without Prior FDA Determination of Interchangeability.** This proposal would deem all approved biosimilars to be interchangeable with their respective reference products without an FDA determination. [Budget Neutral]

## Transform Behavioral Health

**Apply the Mental Health Parity and Addiction Equity Act to Medicare**. Under current law, Medicare is not subject to the 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].

**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 would eliminate the 190-day lifetime limit on inpatient psychiatric services in a freestanding psychiatric hospital. [$2.9 billion in costs 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. [Budget Neutral].

**Modernize Medicare Mental Health Benefits**. Under current law, a practitioner must have a Medicare benefit category in order to bill Medicare directly for services. This proposal would allow CMS to designate additional professionals beyond those listed in the statute who could be paid directly by Medicare when furnishing behavioral health services within their applicable state licensure or scope of practice if the services would otherwise be covered when furnished by a physician. [Not Scorable].

**Require Medicare to Cover Three Behavioral Health Visits Without Cost-Sharing**. This proposal would require Medicare, beginning in 2026, to cover up to three behavioral health visits per year without application of deductible or coinsurance. [$1.5 billion in costs over 10 years].

**Broaden the Health Professional Shortage Area Incentive Program.** Current law provides a 10 percent bonus on Medicare physician fee schedule payments for physicians who furnish medical services in areas that are designated as geographic Health Professional Shortage Areas. This proposal would extend the 10 percent bonus payment to nurse practitioners, physician assistants, and certified nurse specialists, as well as behavioral health practitioners, including clinical psychologists, licensed clinical social workers, mental health counselors, and marriage and family therapists starting in 2025. [Not Scoreable]

## Pandemic Preparedness

**Provide Coverage Drugs, Vaccines, and Devices during a Public Health Emergency.** This proposal would provide the Secretary with broader authority for limited and temporary coverage under Medicare, Medicaid, CHIP and for the uninsured of medically necessary drugs, vaccines and devices during a declared disaster, pandemic, or other public health emergency. [Not Scoreable].

**Enable the Secretary to Temporarily Modify or Waive Application of Specific Requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Act.** 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].

## Long-Term Care

**Hold Long Term Care (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. CMS would be able to prohibit an individual or entity from obtaining a Medicare or Medicaid provider agreement for a nursing home based on the Medicare compliance history of their other owned or operated facilities. [Budget Neutral].

**Provide Authority for the Secretary to Collect and Expend Re-survey Fees.** This proposal would permit the Secretary to charge skilled nursing facilities and nursing facilities a re-survey fee if a third visit is required to certify correction of deficiencies 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. [Budget Neutral].

**Increase Per Instance Civil Monetary Penalty (CMP) Authority for LTC Facilities.** CMPs for LTC facilities are currently capped at $21,000 for each day of noncompliance. This proposal would create a penalty scale based on the severity of the deficiencies within a facility up to a civil monetary penalty of $1 million for the most egregious violations. [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 a 2 percent reduction in payment on facilities that submit data that is found to be inaccurate in the validation process. [Budget Neutral].

**Adjust Survey Frequency for High-Performing and Low-Performing Facilities.** Currently, skilled nursing facilities and nursing facilities are required to be recertified annually for compliance with health and safety regulations. This proposal would allow CMS to take a risk-based approach to recertifying long-term care facilities as occurs with other provider-types rather than requiring all facilities to be resurveyed each year. [Budget Neutral].

## 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**. Currently, only a limited number of Medicare beneficiaries are seeking nutrition and obesity counseling services. This proposal would expand access to these services to additional beneficiaries with nutrition or obesity-related chronic diseases and make additional providers eligible to furnish services. [$1.8 billion in costs over 10 years]

**Conduct a Subnational Medicare Medically-Tailored Meal Demonstration.** Beginning in 2025, this proposal would establish a 3-year demonstration to test Medicare coverage of medically-tailored meals delivered to the home. Eligibility for this demonstration includes Medicare fee-for-service beneficiaries with a diet-impacted disease (e.g., kidney disease, congestive heart failure, diabetes, chronic obstructive pulmonary disease) likely to trigger an inpatient hospital stay and who have at least one activity of daily living limitation. The demonstration will operate out of at least 20 hospitals across 10 different states. [Not scorable].

## Medicare Modernization and Benefit Enhancements

**Provide Cybersecurity Support for Hospitals.** This proposal would invest $800 million from the Medicare Hospital Insurance Trust Fund over FY 2027 and FY 2028 to approximately 2,000 high-needs hospitals. Beginning in FY 2029, hospitals that fail to adopt essential cybersecurity standards face penalties of up to 100 percent of the annual market basket increase and beginning in FY 2031 potential additional penalties of up to 1 percent off the base payment. Critical Access Hospitals (CAH) that fail to adopt the essential practices would incur up to a one percent payment reduction (capped at 1 percent including any penalties under the Promoting Interoperability Program).

The proposal also invests $500 million from the Medicare Hospital Insurance Trust Fund for all hospitals to implement enhanced cybersecurity practices, available for FY 2029 and FY 2030. Beginning in FY 2031, hospitals and CAHs would be required to be in compliance with these cybersecurity practices or face the same penalties with respect to the update or payments described above. [$1.3 billion cost over 10 years]

**Fully Cover Costs for all Living Organ Donors for Medicare Beneficiaries.** Currently, any individual who donates a kidney for transplant surgery to a Medicare beneficiary is entitled to benefits under Parts A and B with respect to such donation to a Medicare beneficiary, with no donor liability for deductibles or coinsurance. There is no similar provision for living donors of non-renal organs, such as a portion of a liver or lung. This proposal entitles any living individual who donates a non-renal organ for transplant into a Medicare beneficiary to benefits under Medicare Part A and Part B directly related to such donation. [Budget Neutral]

**Create a Permanent Medicare Diabetes Prevention Program Benefit.** Using its authority under section 1115A of the Social Security Act, CMS expanded the Medicare Diabetes Prevention Program (MDPP) Model nationwide. This budget proposal would, beginning in 2025, establish the Medicare Diabetes Prevention Program model, as a permanent Medicare Part B benefit. [Not Scorable]

**Implement Value-Based Purchasing and Quality Programs for Medicare Facilities**. Beginning in 2027, this proposal would implement new value-based purchasing programs for inpatient psychiatric facilities, hospital outpatient departments, ambulatory surgical centers, long-term care hospitals, cancer hospitals, inpatient rehabilitation facilities, hospices, rural emergency hospitals, and community mental health centers. Community mental health centers

and rural emergency hospitals would also be required to report quality data or face a reduced update. [Not Scorable]

**Create a Permanent Medicare Home Health Value-Based Purchasing Program.** The Home Health Value-Based Purchasing Model, which the CMS Innovation Center launched in 2016 and expanded nationwide in 2022, successfully improved the quality of home healthcare at lower cost without evidence of adverse risks. This proposal converts the expanded model into a permanent Medicare program, similar to value-based purchasing programs already in place for other Medicare providers. [Budget Neutral]

**Add Medicare Coverage of Services Furnished by Community Health Workers.** Beginning in 2025, this proposal would provide direct Medicare Part B coverage of select services provided by community health workers working under the general supervision of a primary care provider. Payment would be for prevention services and care navigation for beneficiaries with chronic or behavioral health conditions. The payment would be for screening for social determinants of health and referring them to appropriate 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. [Not scorable.]

**Authorize Tribal Health Programs to Pay Medicare Part B Premiums Directly on behalf of Tribal Members.** This proposal would allow Tribal Health Programs to pay Medicare Part B premiums on behalf of their tribal members. [Budget Neutral]

**Good Governance and Quality Improvement**

**Prohibit Billing of Beneficiaries after Certain Medicare Bad Debt Payments**. This proposal would make Medicare Part A and certain Part B bad debt payments, along with payments for Part A and Part B covered items and services, represent payment in full for beneficiaries enrolled in Original Medicare. Once Medicare compensates a provider for bad debt, the provider would be prohibited from seeking payment from the beneficiary. If a hospital sells or intends to sell debt to a third-party buyer, the hospital cannot also count unpaid amounts for a Medicare beneficiary (Original Medicare or Medicare Advantage) as uncompensated care for purposes of Medicare Disproportionate Share Hospital payments. [Budget Neutral]

**Create a Consolidated Medicare Hospital Quality Payment Program.** Beginning in 2027, this proposal would 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 penalty for non-compliance would increase from two percentage points, by one percentage point per year until it reaches six percent. CAHs would be required to report only and would not be subject to a payment adjustment payment based on performance. [Budget Neutral]

**Refine the Quality Payment Program (QPP): Measure Development Funding for QPP.** This proposal would renew the expired funding appropriation for quality measure development for FYs 2025 – 2029, making $10 million available for each year. This proposal would also generate new measures for use in the transition to the MIPS Value Pathways and expands the types of measures that may be developed to include cost performance measures. [$50 million in costs over 10 years].

**Establish Meaningful Measures for the End Stage Renal Disease (ESRD) Quality Incentive Program (QIP).** Current law specifies quality measures for the ESRD QIP Program. This proposal would provide CMS with broad authority to use the rulemaking process to add or remove quality measures from the ESRD QIP. [Budget Neutral].

**Strengthen Medicare Advantage by Establishing New Medical Loss Ratio Requirements for Supplemental Benefits.** This proposal would require Medicare Advantage plans, excluding Employer Group Waiver Plans, to meet a minimum medical loss ratio of 85 percent specifically for supplemental benefits beyond basic Part A and B benefits, which aligns with the existing 85 percent medical loss ratio across all types of benefits. [Not Scoreable].

**Require Average Sales Price (ASP) Reporting for Oral Methadone.** Oral methadone is currently not separately payable as a drug or biological under Medicare Part B but is payable as part of payment to Opioid Treatment Programs (OTP). This proposal would require drug manufacturers to report ASP for oral methadone that will improve Medicare payment accuracy for OTPs. [Not Scoreable]

**Other Technical Proposals**

**Standardize Data Collection to Improve Quality and Promote Equitable Care.** This 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. [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. [Budget Neutral]

**Increase Transparency by Disclosing Accreditation Surveys.** Under current law, CMS is prohibited from disclosing accreditation survey results (other than with respect to home health agencies and hospice programs) by a national accreditation organization or body, except to the extent the survey, or information in the survey, relates to an enforcement. This proposal would remove this disclosure prohibition to allow for disclosure of survey information on providers that are not in compliance with accreditation requirements. [Budget Neutral]

**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. This 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. [Budget Neutral]

**Change Medicare Appeal Council's Standard of Review.** Under current law, if a party files a request for review of an Administrative Law Judge decision, the Medicare Appeal Council must review the decision de novo, from the beginning. This 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. [Budget Neutral]

## Medicare Interactions

**Establish the National Hepatitis C Elimination Program.** The national hepatitis C elimination program will have a significant impact on the Medicare population. Under this program, the federal government will pay 100 percent of cost-sharing for Medicare Part D beneficiaries. [Medicare portion: $289 million in savings 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)

| | 2023 actual | 2024 estimate | 2025 estimated |
|---|---|---|---|
| **Income under current law** | 424,260 | 452,706 | 472,097 |
| **Proposed:** | | | |
| FHI Trust Fund, Additional Transfers from General Fund (FICA Taxes) | | 11,218 | 57,936 |
| FHI Trust Fund, Additional Transfers from General Fund (FICA Taxes) | | 16,972 | 84,852 |
| FHI Trust Fund: Interest received by Trust Funds | | 328 | 3,022 |
| Offsetting governmental receipts: Income proposed | | 28,518 | 145,810 |
| ***Total cash income (with proposals):*** | 424,260 | 481,224 | 617,907 |
| **Cash outgo under current law** | -410,476 | -406,815 | -438,878 |
| **Proposed:** | | | |
| FHI Trust Fund | | | -418 |
| FHI Trust Fund | | | 367 |
| ***Total cash outgo (with proposals)*** | -410,476 | -406,815 | -438,929 |
| **Surplus or deficit (with interest included)** | 13,784 | 74,409 | 178,978 |
| Reconciliation adjustment | 2 | | |

| | 2023 actual | 2024 estimate | 2025 estimated |
|---|---|---|---|
| Total Change in Fund Balance | 13,786 | 74,409 | 178,978 |
| **Unexpended balance, end of year:** | | | |
| Uninvested balance | -2,376 | 30,033 | 181,981 |
| FHI Trust Fund | | | 421 |
| FHI Trust Fund | 194,362 | 236,362 | 263,362 |
| ***Total Balance, end of year*** | 191,986 | 266,395 | 445,373 |

**Source:** Based on Excerpts from Federal HI Trust Fund, Status of Funds Table on page 430 of the Appendix, Budget of the U.S. Government, Fiscal Year 2025: hhs_fy2025.pdf (whitehouse.gov).

## MEDICAID AND CHIP PROPOSALS

The Administration's legislative proposals for Medicaid are estimated to increase program spending by a net $140.6 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:

- As previously proposed—
  - 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 ($4.3 billion), and
  - Expand the Vaccines for Children Program ($4.1 billion).
- New in this budget—
  - Allow states to provide 36-month continuous eligibility for all children ($5.2 billion),
  - Allow states to provide continuous eligibility up to age 6 ($4.3 billion),

The proposed direct Medicaid savings would come from the following, all of which were previously proposed:

- Eliminating barriers to PrEP treatment for individuals with HIV ($-10.5 billion),
- Requiring remittance of Medical Loss Ratios (MLRs) in Medicaid and CHIP managed care ($-8.4 billion),
- Negotiating additional supplemental prescription drug rebates on behalf of states ($-5.2 billion), and
- Increasing CMS' enforcement tools applicable to Medicaid managed care ($-1.7 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 2025 | | |
|---|---|---|
| | Savings (-) /cost (+) in $ millions | |
| | FY25 | FY25-34 |
| **Medicaid Legislative Proposals** | | |
| Prescription Drug Savings and Other Reforms | | |
| Eliminate Barriers to PrEP under Medicaid and CHIP | -730 | -10,550 |
| Modify the Medicaid Drug Rebate Program in Territories | - | - |
| Authorize HHS to Negotiate Supplemental Drug Rebates on Behalf of States | - | -5,180 |

| MEDICAID AND CHIP PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2025 | | |
|---|---|---|
| | Savings (-) /cost (+) in $ millions | |
| | FY25 | FY25-34 |
| Modernizing Benefits and Lowering Health Care Costs | | |
| Allow States to Provide 36-Month Continuous Eligibility for All Children | 100 | 5,240 |
| Allow States to Provide Continuous Eligibility up to Age 6 | 30 | 4,160 |
| Align MSP and Part D LIS Eligibility Methodologies | 320 | 4,340 |
| Align QMB Renewal Period with Other Medicaid Groups | - | - |
| Unify Medicare and Medicaid Appeals Procedures | - | - |
| Allow Retroactive Coverage of Part B Premiums for Qualified Medicare Beneficiary Applicants | 50 | 890 |
| Promote Effective and Efficient Stewardship and Competition | | |
| Enhance Medicaid Managed Care Enforcement | -120 | -1,680 |
| Require Remittance of MLRs in Medicaid and CHIP Managed Care | - | -8,400 |
| *Require Medicaid Adult and HCBS Quality Reporting (non-add)* | *25* | *299* |
| Protecting the Health of All Americans | | |
| Require 12 Months of Postpartum Coverage[1] | 40 | 440 |
| Expand Access to Maternal Health Supports in Medicaid | 6 | 204 |
| Strengthening Long-Term Care in All Settings | | |
| Improving Medicaid HCBS | 3,000 | 150,000 |
| Other Legislative Proposals Impacting Medicaid | | |
| Expand the VFC Program | 378 | 4,104 |
| Convert Medicaid Certified Community Behavioral Health Clinics (CCBHCs) Demonstration into a Permanent Program | - | 11,418 |
| Add 20,000 Special Immigrant Visas | 35 | 550 |
| National Hepatitis C Elimination Program | -700 | -13,140 |
| Treat Certain Populations as Refugees for Public Benefit Purposes | 32 | 405 |
| Eliminate the 190-day Lifetime Limit on Psychiatric Hospital Services | -50 | -770 |
| Other Medicaid Interactions | -27 | -1,416 |
| *Social Security Administration Program Integrity (non-add)*[1] | *-23* | *-2,636* |
| **Net Outlays, Medicaid Legislative Proposals** | **2,364** | **140,615** |
| | | |
| **CHIP Legislative Proposals** | **-287** | **-4,782** |

- Zero or Budget Neutral
"Non-add" means the budgetary impact is not included in this table's totals but in that of another program.
[1] While the budget projects $440 million in costs to Medicaid over 10 years, it also notes this provision would result in overall net savings to the federal government of $707 million over 10 years.
**Source:** Department of Health and Human Services, *Fiscal Year 2025 Budget in Brief.*

## Prescription Drug Savings and Other Reforms

**Eliminate Barriers to PrEP under Medicaid**. The budget continues to propose requiring 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 $10.6 billion over 10 years.

**Modify the Medicaid Drug Rebate Program in Territories.** The budget continues to propose providing 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[6] 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 continues to propose establishing 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 $5.2 billion.

## Modernizing Benefits and Lowering Health Care Costs

**Allow States to Provide Continuous Eligibility up to Age 6.** The budget includes a new proposal that builds on the requirement to provide 12 months of continuous eligibility to children in Medicaid and CHIP, enacted in the Consolidated Appropriations Act, 2023. This proposal would establish a state option to provide continuous eligibility from birth until the child turns 6, to provide more stable coverage for young children, decrease state administrative burden, and potentially avoid higher costs by addressing preventable care needs. This is projected to result in $4.2 billion in additional federal Medicaid spending over 10 years.

**Allow States to Provide 36-Month Continuous Eligibility for All Children.** The budget includes a new proposal establishing a state option to provide 36 months of continuous eligibility for children under the age of 19. States selecting to implement this option in addition to the prior one would provide continuous eligibility to children until they turn 6, followed by continuous eligibility periods of 36 months until they turn 19. This specific proposal is projected to result in $5.2 billion in additional federal Medicaid spending over 10 years.

**Align MSP and Part D LIS Eligibility Methodologies.** To simplify eligibility processes for MSP and LIS, the budget again calls for removing elements of the income and asset determination process that apply to one program and not the other. This is expected to reduce administrative barriers and increase federal costs by $4.3 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.[7] No federal spending effect is projected.

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[6] The FY 2023 HHS Budget in Brief specifically cited average manufacturer price (AMP) and best price under the Medicaid Drug Rebate Program, although they were not mentioned in last year's or this year's documents.

[7] In September 2022, to align with statutory requirements under Modified Adjusted Gross Income (MAGI), 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). The budget proposes the statutory change necessary to bring QMBs into alignment with the proposed regulation

**Unify Medicare and Medicaid Appeals Procedures.** Individuals enrolled in both Medicare and Medicaid face a complex process to appeal service denials. Although CMS has taken action to unify Medicare and Medicaid appeal processes at the plan level, a statutory change is required to a Departmental hearing when enrollees appeal any plan decision to a higher level. Building on results from the Financial Alignment Initiative demonstrations, this proposal gives the Secretary authority to unify the procedures for Medicare and Medicaid review for individuals enrolled in integrated managed care plans by waiving amount-in-controversy minimums and allowing benefits to continue while an appeal is pending. This proposal is listed as not scoreable.

**Allow Retroactive Coverage of Part B Premiums for Qualified Medicare Beneficiary Applicants.** While many Medicaid eligibility groups allow for retroactive eligibility, the QMB program, by statute, does not. The budget would allow for retroactive coverage of Medicare Part B premiums for QMB applicants at a federal Medicaid cost of $890 million over 10 years.

**Promoting Effective and Efficient Stewardship and Competition**

**Enhance Medicaid Managed Care Enforcement.** The budget says that CMS has inadequate financial oversight and compliance tools in Medicaid managed care and again 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 $1.7 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).[8] The budget again proposes an 85 percent MLR, consistent with federal requirements for Medicare Advantage[9] and large employer plans.[10] States would be required to collect remittances from plans that fail to meet the minimum MLR.[11] This proposal is estimated to save $8.4 billion in Medicaid and $1.7 billion in CHIP over 10 years.

**Require Medicaid Adult and HCBS Quality Reporting.** The budget proposes again to provide $15 million annually for the Adult Quality Measurement and Improvement Program, since its

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requiring 12-month renewal periods for all other non-MAGI Medicaid eligibility groups. As of this writing, the final rule is still under review at OMB.

[8] 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)).

[9] Section 1857(e)(4) of the Social Security Act.

[10] Section 2718(b)(1)(A)(i) of the Public Health Service Act, which also permits a state to increase the percentage.

[11] 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).

current funding will be expended in FY 2025, and $10 million annually for a new HCBS Measurement Program. For both, states would be required to report on a core set of measures within 4 years of enactment, with aligned reporting requirements across states. This proposal is estimated to cost CMS $299 million in administrative costs over 10 years.

## Protecting the Health of All Americans

**Require 12 Months of Postpartum Coverage.** The budget continues to propose a requirement that states provide 12 months of postpartum coverage in Medicaid and CHIP. This is projected to increase federal Medicaid spending by $440 million over 10 years,[12] but result in overall net federal savings for $707 million.[13]

**Expand Access to Maternal Health Supports in Medicaid.** The budget includes an optional Medicaid maternal health support benefit that addresses equity in maternal health. The benefit would expand coverage of maternal health support services across the prenatal, labor and delivery, and postpartum periods— including coverage for services provided by doulas, community health workers, nurse home visiting, and peer support workers—with enhanced federal match available for the first 5 years. Services may include group and/or individual counseling, and labor and postpartum supports. The budget states that rigorous evaluation is integral to this optional benefit, informing future best practices for maternal care within the Medicaid program and beyond. Projected 10-year costs to Medicaid total $204 million.

## Strengthening Long-Term Care

**Improving Medicaid HCBS.** The budget again 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.

## Other Legislative Proposals Impacting Medicaid

**Expand the VFC to Separate CHIP Children.** The budget again calls for expanding the Vaccines for Children (VFC) program to separate CHIP children with no cost sharing, resulting in a net cost to the federal government of $1.9 billion over 10 years. That budgetary impact incorporates an increase of $4.1 billion to Medicaid and a reduction of $2.2 billion to CHIP.

**Convert Community Mental Health Services Demonstration to State Option.** This year's budget continues to propose to convert existing and new state Certified Community Behavioral

[12] This is substantially lower than the $2.4 billion 10-year Medicaid cost included in last year's budget. Since April 1, 2022, states have had a statutory option to adopt 12-month postpartum Medicaid coverage, which 46 states have now implemented. The lower federal Medicaid cost in this year's budget likely reflects the fact that there are fewer remaining states that would be affected by a federal 12-month postpartum coverage requirement.

[13] Federal savings may result from having these beneficiaries' coverage remain as Medicaid rather than to subsidized Exchange coverage, which can be more expensive and receive larger federal subsidies than Medicaid, or from effects of these beneficiaries not becoming uninsured and resulting in larger downstream, potentially avoidable healthcare costs.

Health Clinics (CCBHCs) demonstration programs into a permanent Medicaid state plan option. In the FY 2025 budget, federal costs to Medicaid are estimated at $11.4 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 ($405 million in Medicaid costs); and eliminate Medicare's 190-day lifetime limit on inpatient psychiatric facility services ($770 million in Medicaid savings).

## CHIP Proposals

The budget continues to propose applying 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 $2.2 billion over 10 years, but cost Medicaid $1.9 billion. The new proposal to prohibit CHIP enrollment fees and premiums would result in increased federal CHIP spending over 10 years of $850 million. The following are other legislative proposals that affect CHIP, with the projected 10-year (FY 2025-2034) federal CHIP spending implications shown:

- Allowing states to provide 36-month continuous eligibility for all children ($400 million),
- Allowing states to provide continuous eligibility up to age 6 ($180 million),
- Requiring 12 months of postpartum coverage (no budget effect),
- Requiring remittance of MLRs in Medicaid and CHIP managed care ($-1.7 billion),

In sum, the budget's legislative proposals are projected to reduce overall federal CHIP spending by $4.782 billion over 10 years.

## PRIVATE HEALTH INSURANCE PROPOSALS

The Administration's legislative proposals for private health insurance are estimated to increase government-wide federal spending by a net $521 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 ($273 billion) most recently extended through 2025 by the IRA. All of the proposals in the table below were in last year's budget, except for the new proposal to ban facility fees for telehealth and certain outpatient services in commercial insurance.

Last year's table also included a line for "Expand drug inflation rebates to the commercial market," with a 10-year projected savings of $40 billion. Even though this year's budget continues to include such a policy in its description of legislative proposals affecting private health insurance, that line is no longer in the table. However, the budget table in this year's Medicare section includes this policy, along with "other steps to build on Inflation Reduction Act drug provisions," with a 10-year savings of $200 billion.

| PRIVATE INSURANCE PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2025 | | |
|---|---|---|
| | Savings (-) /cost (+) in $ millions | |
| | FY25 | FY25-34 |
| **Private Insurance Legislative Proposals** | | |
| Protecting the Health of All Americans | | |
| *Permanently Extend Enhanced Premium Tax Credits (non-add)* | - | *272,703* |
| *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*** | ***472,703*** |
| Transforming Behavioral Health | | |
| *Improve Access to Behavioral Healthcare in the Private Insurance Market (non-add)* | - | *31,224* |
| *Require Coverage of Three Behavioral Health Visits and Three Primary Care Visits without Cost-Sharing (non-add)* | - | *18,714* |
| Provide Mandatory Funding for State Enforcement of Mental Health Parity Requirements | 10 | 125 |
| ***Subtotal, Government-wide Impact (non-add)*** | ***10*** | ***50,063*** |
| Promoting Effective and Efficient Stewardship and Competition | | |
| Replenish and Extend No Surprises Act Implementation Fund | 103 | 500 |
| *Extend Surprise Billing Protections to Ground Ambulance (non-add)* | - | *-1,031* |
| ***Subtotal, Government-wide Impact (non-add)*** | ***103*** | ***-531*** |
| Modernizing Benefits and Lowering Healthcare Costs | | |
| *Ban Facility Fees for Telehealth and Certain Outpatient Services in Commercial Insurance* | - | *-2,250* |
| *Limit Cost-sharing for Insulin at $35 a Month (non-add)* | *580* | *1,338* |
| ***Subtotal, Government-wide Impact (non-add)*** | ***580*** | ***-912*** |
| | | |
| ***Total, Government-wide Impact, Private Insurance Proposals (non-add)*** | ***9,163*** | ***521,323*** |

- Zero or Budget Neutral
"Non-add" means the budgetary impact is not included in this table's totals, but in that of another program.
**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).
**Source:** Department of Health and Human Services, *Fiscal Year 2025 Budget in Brief.*

**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 $43.1 billion over 10 years, but government-wide costs would be $273 billion.

**Permanently Extend Coverage to Low-income Individuals in States that have not Expanded Medicaid.** The budget again 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.[14]

**Improve Access to Behavioral Healthcare in the Private Insurance Market.** This proposal would again 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 $31 billion over 10 years (of which $1 billion 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 $18.7 billion over 10 years (of which $428 million is for ACA cost-sharing reductions).

**Provide Mandatory Funding for State Enforcement of Mental Health Parity Requirements.** This proposal again 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.

[14] 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.

**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 enforcement, oversight, data collection and program operation requirements.[15] 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 2026, 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.[16] This is projected to save the federal government $1 billion over 10 years.

**Limit Cost-sharing for Insulin at $35 a Month.** The IRA limited Medicare beneficiary cost sharing to $35 per insulin product for a month's supply. The budget again calls for extending the cap on patient cost sharing to insulin products in commercial markets, which would cost the federal government $1.3 billion over 10 years (of which $31 million is for ACA cost-sharing reductions).

**Ban Facility Fees for Telehealth and Certain Outpatient Services in Commercial Insurance.** This is the only new provision in this section of the budget, which notes that hospitals are expanding ownership of outpatient and physician office settings that is resulting in an uptick in healthcare costs due to "facility fees." This proposal would prohibit hospitals from billing "unwarranted facility fees" for telehealth services and for certain other outpatient services, with projected 10-year federal savings of $2.3 billion.

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[15] 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.

[16] The following sentence was included in this section of last year's budget narrative: "Unresolved disagreements between the plan or issuer and ground ambulance provider over payment for these services would be settled through the Federal Independent Dispute Resolution Process, as established by the No Surprises Act." This sentence was dropped from this year's description, perhaps due to continued litigation around the current Independent Dispute Resolution process.

**Expand Medicare Drug Negotiation, Extend Inflation Rebates to the Commercial Market, and Other Steps to Build on the IRA Drug Provisions.** As described earlier, in the Medicare section, the budget would significantly increase the pace of negotiation, bring more drugs into negotiation sooner after they launch, expand inflation rebates and the $2,000 out-of-pocket prescription drug cost cap beyond Medicare and into the commercial market, and take "other steps" to build on the existing IRA drug provisions. No mention of federal budget effects is discussed in this section of the HHS Budget in Brief.

## PROGRAM INTEGRITY PROPOSALS

The FY 2025 budget provides $2.9 billion in total mandatory and discretionary investments for the Health Care Fraud and Abuse (HCFAC) and Medicaid Integrity Programs. The budget includes a significant new investment in the mandatory HCFAC account totaling $4.1 billion over 10 years and a continuation of dedicated program integrity discretionary investments for HCFAC.

### Restructure Mandatory HCFAC

**Increase Mandatory HCFAC Funding**. The budget would grow all but 1 mandatory HCFAC funding stream by 20 percent over current law baseline levels; an account allocated between HHS and the U.S. Department of Justice, called the "Wedge" would grow by 10 percent. The mandatory HCFAC proposal also makes modifications to HCFAC statutory purposes, definitions, and reporting requirements that have not been changed since 1996, including:

- Expanding the HHS Office of Inspector General investigations of CMS programs to include Marketplaces and related activities, such as advanced premium tax credits, as their current authority is limited to Medicare and Medicaid activities;
- Clarifying that HCFAC allowable purposes apply to both public and private plans given there is some confusion among healthcare prosecutors that these authorities only apply to Medicare and Medicaid; and
- Including CHIP in the Medicare-Medicaid data match program so CMS can audit and investigate the $20.0 billion that providers bill to this program.

### Long-Term Care

**Increase Private Equity and Real Estate Investment Trust Ownership Transparency in Long-Term Care Facilities**. This proposal requires skilled nursing facilities with either of these ownership types, whether direct or indirect, to provide additional financial disclosures above and beyond other provider types. Additionally, for all Medicare providers/suppliers, the proposal expands the requirement that owners with a five percent or greater direct or indirect ownership must be reported on the provider/supplier's enrollment application, to require owners with any percentage-level of interest be reported. [Budget neutral]

## Good Governance

**Implement Targeted Risk-Adjustment Pre-Payment Review in Medicare Advantage (MA).** This proposal would confirm that diagnoses submitted by MA organizations for risk-adjustment match the medical record prior to CMS making risk adjusted payments. The proposal would focus 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 the MA Program.** This proposal would require MA plans to collect valid ordering, referring, or prescribing provider identifiers for healthcare services and report this information as part of encounter data submissions to CMS. [Not Scorable]

**Ensure Providers that Violate Medicare Safety Requirements and Have Harmed Patients Cannot Quickly Reenter the Program.** This proposal would provide 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 would disallow 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.

## Other FY 2025 Budget Policies

The FY 2025 budget includes a continuation of dedicated program integrity discretionary investments for the Social Security Administration to conduct continuing disability reviews and Supplemental Security Income redeterminations to confirm that participants remain eligible to receive benefits. These increased workloads are projected to yield savings to Medicare and Medicaid totaling $12.2 billion over 10 years and are incorporated into the adjusted baseline.

| PROGRAM INTEGRITY PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2025 | | | |
|---|---|---|---|
| | Savings (-) /cost (+) in $ millions | | |
| | 2025 | 2025-2029 | 2025-2034 |
| **Program Integrity Legislative Proposals** | | | |
| Long-Term Care | | | |
| Increase Private Equity and Real Estate Investment Trust Ownership Transparency in Long-Term Care 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 | ** | ** | ** |

| PROGRAM INTEGRITY PROPOSALS IN THE PRESIDENT'S BUDGET FOR FY 2025 | | | |
|---|---|---|---|
| | Savings (-) /cost (+) in $ millions | | |
| | 2025 | 2025-2029 | 2025-2034 |
| 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*** | | | |
| Increase Mandatory HCFAC Funding | | | |
| Gross Investment from 20% Rebasing of Funding Streams (non-add) | 217 | 1,780 | 4,064 |
| Gross Savings from Return-on-Investment (non-add) | 477 | -3,980 | -9,104 |
| **Net Savings: Increase Investment in Mandatory HCFAC and Other Mandatory HCFAC Modifications** | **-260** | **-2,200** | **-5,040** |
| **Savings from Discretionary Investment** | | | |
| Capture Savings to Medicare and Medicaid from HCFAC Discretionary Investments (net impact) | 773 | 3,825 | 8,338 |
| Savings from New Investment (non-add) | - | 858 | 3,079 |
| Capture Savings to Medicare and Medicaid from Social Security | -243 | -3,200 | -12,215 |
| Administration Discretionary Investments | | | |
| Medicare Impact (non-add) | -163 | -2,308 | -8,861 |
| Medicare Impact (non-add) | -80 | -892 | -2,636 |
| **Subtotal, Medicare and Medicaid Savings from Program Integrity Investment** | **-1,016** | **-7,025** | **-20,553** |

- Zero or budget neutral
* Not Scorable
"Non-add" means the budgetary impact is not included in this table's totals, but in that of another program.
**Source:** Department of Health and Human Services, *Fiscal Year 2025 Budget in Brief.*

## DISCRETIONARY HEALTH SPENDING PROPOSALS

Overall, the budget includes $130.7 billion in FY 2025 discretionary funding for HHS, about $2.6 billion (2%) less than the FY 2024 level.[17] Compared to the FY 2023 level, the HHS budget is $2.2 billion more. Proposed program level funding, which combines discretionary funding with mandatory funding and user fees, varies among HHS agencies. Substantial increases are

[17] HHS notes that its budget document compared FY 2025 budget totals to the most recent full year available at the time the document was finalized, which was the final FY 2023 level. The FY 2024 figures represent the annualized amounts provided in the FY 2024 Continuing Resolution (Division A of Public Law 118-15).

proposed for the National Institute of Health (NIH) of $3 billion, the Centers for Disease Control and Prevention (CDC) of $2.5 billion, the Indian Health Service (IHS) of $1.3 billion, and CMS Program Management of $692 million. These additional resources will be used by the NIH for the Cancer Moonshot initiative; by CDC for cancer prevention programs and public health initiatives to improve mental health and reduce injury prevention; by IHS to expand clinical and preventive health care services; and by CMS program management for program operations, including the Federally Facilitated Marketplace.

| **Proposed HHS Health-Related Agency/Office Funding for FY 2025 (Program levels, in $ millions)** | | | |
|---|---|---|---|
| **HHS Agency/Office** | **FY 2025** | **Change from 2023** | **Change from 2024*** |
| Advanced Research Projects Agency for Health (ARPA-H)** | 1,500 | - | - |
| Agency for Healthcare Research and Quality (AHRQ) | 513 | +29 | +21 |
| Centers for Disease Control and Prevention (CDC) | 19,803 | +4,554 | +2,500 |
| CMS Program Management | 7,556 | +442 | +616 |
| Food and Drug Administration (FDA) | 7,215 | +495 | +323 |
| Health Resources and Services Administration (HRSA) | 16,310 | +1,982 | +162 |
| Indian Health Service (IHS) | 8,223 | +1,118 | +1,015 |
| National Institutes of Health (NIH) | 50,117 | +2,438 | +3,008 |
| Substance use and Mental Health Services Administration (SAMHSA) | 7,570 | +199 | +199 |
| Office of Medicare Hearings and Appeals (OMHA) | 196 | - | - |
| Office of the National Coordinator for Health Information Technology (ONC) | 66 | - | - |
| Center for Medicare and Medicaid Innovation – obligations*** | 1,347 | +733 | +299 |

- Zero or Budget Neutral
* The FY 2024 figure represent the annualized amounts provided in the FY 2024 Continuing Resolution (Division A of Public Law 118-15).
**The FY 2025 Budget requests funding for ARPA-H as a separate appropriation within the National Institutes of Health.
***CMMI reports obligations and outlays in lieu of program level funding.
**Source:** Department of Health and Human Services, *Fiscal Year 2025 Budget in Brief.*

## Agencies for Healthcare Research and Quality (AHRQ)

The proposed $513 million funding for AHRQ is $21 million above FY 2024 levels.[18] This total includes $387 million in budget authority and $126 million in mandatory transfers from the Patient-Centered Outcomes Research Trust Fund.

The budget proposes to provide ongoing support for continued research on Long Covid and digital healthcare and for ongoing support of the Medical Expenditure Panel Survey. The budget proposes $18 million, an increase of $6 million above the FY 2024 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 2025. In FY 2023, the USPSTF issued 13 final recommendation statements.

[18] The FY 2024 total program funding level was $492 million.

## Centers for Disease Control and Prevention (CDC)

The proposed $19.8 billion funding for CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) is $2.5 billion above FY 2024 levels.[19] This total includes $8.6 billion in discretionary budget authority, $1.2 billion from the Prevention and Public Health Fund, and $10 billion in current and proposed mandatory funding. Proposed mandatory funding would again 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 and begin a Community Violence Intervention Initiative ($150 million). The FY 2025 budget includes mandatory funding across HHS for pandemic preparedness of which $6.1 billion is allocated to CDC.

The budget maintains funding at $724 million for crosscutting activities of which $225 million will support improvements in public health data including CDC's data modernization initiative; $60 million to manage the Response Ready Data Enterprise Integration platform that integrates data sources across federal, state, local governments and the healthcare industry; and $50 million for Insight Net, a national health security system for detecting disease outbreaks. The budget also includes $350 million for public health infrastructure and capacity gaps at the national, state, territorial, tribal, and local levels.

The budget proposes $969 million, an increase of $50 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 expansion of the Vaccines for Children Program to include all children under age 19 enrolled in a Children's Health Insurance Program (CHIP).

The budget proposes to maintain funding at $1.4 billion for 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 and global health security. The budget includes $220 million to end the HIV/AIDS epidemic in the U.S. The budget maintains CDC's efforts to strengthen global health security ($294 million) and continue work to end vaccine-preventable diseases ($230 million) and global HIV ($129 million).

The budget proposes $1.6 billion for chronic disease prevention and health promotion activities, an increase of $129 million from FY 2024 levels. To support the Cancer Moonshot Initiative the budget includes $756 million to support cancer prevention and control programs across CDC, including tobacco prevention, HPV prevention and environmental health activities. The budget also includes funding to reduce maternal mortality by providing additional funding for Maternal Mortality Review Committees and expansion of Perinatal Quality Collaboratives.

The budget proposes $943 million for injury prevention and control programs, an increase of $182 million from FY 2024 levels. This funding proposal will increase efforts to related to suicide prevention, adverse childhood experiences, firearm injury and morality research, community and youth violence, and opioid overdose.

[19] The FY 2024 total program funding level was $15.2 billion.

Proposed funding for environmental health is $267 million, an increase of $20 million from FY 2024. This increase includes $100 million to support state, tribal, local and territorial public health agencies to prepare for the health impacts of climate change. This increase includes additional funding for the Childhood Lead Poisoning Prevention Program. Proposed funding for the emerging and zoonotic infectious disease program is $781 million, an increase of $30 million from FY 2024 levels. The budget proposes $20 million to support CDC's wastewater surveillance activities used for surveillance of COVID-19 and other infectious diseases.

Proposed funding for public health and scientific services is $962 million, an increase of $207 million from FY 2024. This includes an increase over FY 2024 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 maintained at $85 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 $7.6 billion, an increase of $616 million above FY 2024 levels;[20] total program management includes discretionary administration, mandatory appropriations, user fees, and legislative proposals. This budget request also includes proposed funding to cover the costs associated with implementing proposed legislative changes for Medicare, Medicaid, and CHIP.

The discretionary budget funding is proposed at $4.3 billion, an increase of $204 million above FY 2024 levels. The budget requests $3.0 billion for Program Operations, an increase of $64 million. Approximately 33 percent ($1.0 billion) of the Program Operations request supports ongoing Medicare contractor operations. The budget includes $62 million to process second level Medicare appeals; $744 million for information technology system upgrades; $151 million for Medicaid and CHIP operations; and $12 million to support implementation of the Inflation Reduction Act. The budget also requests $15 million to build analytic capabilities to provide support to health equity initiatives.

The budget request for federal administrative costs is $858 million, which is $75 million above FY 2024 levels, and will increase the full-time staff level by 43 FTEs to 4,205. The budget requests $492 million for Survey and Certification, an increase of $85 million. The budget again requests two-year budget authority for the Medicare Survey and Certification program. In addition, the budget includes a proposal, effective in FY 2026, to shift funds for nursing home surveys from a discretionary appropriation to a mandatory appropriation and increase the funding to a level necessary to achieve a 100 percent survey frequency.

[20] The FY 2024 total program funding level was $6.9 billion.

The budget funds the National Medicare Education Program at $569 million, including $385 million in discretionary budget authority. The budget provides a program level of $299 million, including $180 million in budget authority, to support the 1-800-MEDICARE call center. 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 other CMS funding sources.

**Food and Drug Administration (FDA)**

The proposed program level funding of $7.2 billion would provide a $323 million increase above FY 2024 levels.[21] This includes $3.3 billion, an increase of $52 million from current user fees, and an additional $119 million from legislative proposals. This total includes $3.7 billion in discretionary budget authority and $3.5 billion in user fees. collected in support of FDA's prescription drug program would be increased by $29 million, the generic drug would be increased by $12 million and the medical device by $8 million. Legislative proposals would increase the tobacco user fee by $114 million and the export certification user fee by $5 million. The FY 2025 budget includes mandatory funding across HHS for pandemic preparedness of which $670 million is allocated to FDA.

Within the current FDA programs, most of the proposed increase in the program level funding is for tobacco products ($115 million), human drugs ($67 million), food ($61 million) and medical devices ($29 million). The proposed program level funding includes $12 million to enhance FDA's capabilities to respond to medical and food shortages and $10 million for a new supply chain coordination office within HHS. The budget provides an increase of $5 million, for a total of $55 million, to support FDA's continued medical product safety activities. The budget includes an additional $8 million to support the implementation of the Modernization of Cosmetics Regulation Act of 2022. In support of the Cancer Moonshot Initiative, the budget maintains $2 million to support FDA's Oncology Center of Excellence programs.

To support ongoing enterprise technology and data modernization efforts, the budget includes $8 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 $115 million to support FDA's workforce.

**Health Resources and Services Administration (HRSA)**

The proposed $16.3 billion for HRSA is $162 million above FY 2024 levels.[22] Funding increases are for health centers ($1.17 billion), health workforce ($240 million), family planning ($104 million), organ transplantation ($36 million), and maternal and child health ($16 million). The FY 2025 budget excludes $1.5 billion from program management activities in congressionally directed earmarks, which are for one-time projects. This largely contributes to the total reduction in HRSA discretionary budget authority.

[21]The FY 2023 total program funding level was $6.7 billion.
[22] The FY 2023 total program funding level was $14.3 billion.

Health centers would receive $8.1 billion in discretionary and proposed mandatory funding, which includes $1.7 billion in discretionary funding and $6.3 billion in proposed mandatory resources. This budget continues the President's three-year pathway to double the program's funding to address the gap in primary and behavioral health care services. It also continues its 2024 legislative proposal requiring all health centers provide behavioral health services.

Health care workforce activities would be funded at $2.6 billion ($240 million above FY 2024). This includes $916 million for the National Health Service Corps (same level as 2024 but an increase of $498 million from 2023 levels) to maintain funding for current staff levels. The budget also includes mandatory funding of $320 million (increase of $163 million) to support 1,800 residency slots for primary care physicians and dental residents that receive community-based training. It also includes $254 million (+$57 million) to train behavioral health providers, including in rural and underserved communities. It also includes $385 million for the Children's Hospital Graduate Medical Education Payment Program (same level as 2024) and $320 million for Nursing Workforce Development (+$20 million).

The Ryan White HIV/AIDS program would be funded at $2.6 billion ($10 million above FY 2024). 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. The budget also includes $175 million (+$10 million) designated to support Ending HIV Epidemic HIV/AIDS Program intended to target geographic locations with high proportions of new HIV diagnoses.

The budget also invests a total of $1.8 billion in HRSA's maternal and child health funding, an increase of $117 million from 2024 levels to build upon its current efforts to reduce maternal mortality and morbidity. The 340B Drug Pricing Program would receive $12 million to provide operations and oversight (no change from 2024). In addition, the FY 2025 budget provides $390 million (+ $104 million) to expand access to family planning services including improving access to reproductive and preventive health services.

## Indian Health Service (IHS)

The FY 2025 budget proposes $8.2 billion for IHS, an increase of $1.0 billion or 14 percent above FY 2024.[23] The Administration continues to support full mandatory funding for IHS and proposes this to begin in FY 2026 when funding would grow automatically to address inflationary factors, key operational needs, and existing backlogs. The budget notes that compared to other health systems in the U.S. the IHS is chronically underfunded which contributes to the stark health disparities in tribal communities, as American Indians/Alaska Natives (AI/AN) people born today have a life expectancy that is 10.9 years less than all other races in the U.S. population.

In FY 2025, the budget includes $5.1 billion in the Clinical Services account, an increase of $692 million, 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

[23] The FY 2023 total program funding level was $7.105 billion.

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. The budget document notes that the diabetes program has been effective at reducing the prevalence of diabetes and helping to avert cases of end-stage renal disease among the AI/AN. The budget provides $994 million for the Facilities account, an increase of $35 million above FY 2024 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.

The budget also includes several legislative proposals that are intended to provide IHS with new or expanded authorities to address workforce challenges. This would include, for example, extended Title 38 personnel authorities to enable IHS to offer specialized pay and benefits for health providers and enable it to pay on-call pay to healthcare providers, among other proposed changes.

**National Institutes of Health (NIH)**

The budget proposes NIH program level funding of $50.1 billion, an increase of $3 billion from FY 2024.[24] Total authorized funding available through the 21st Century Cures Account is $127 million. The budget proposes to reauthorize the Special Type 1 Diabetes Program for three years to provide $250 million in FY 2024, $260 million in FY 2025, and $270 million in FY 2026 and to exempt this funding from mandatory sequestration. 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.

Most of the institutes and centers have proposed funding levels at FY 2024 levels. The budget proposes increases for the National Cancer Institute ($522 million); the Office of the Director ($361 million); the National Institute of Mental Health ($207 million); the National Institute of Neurologic Disorders and Stroke ($24 million); the National Institute of Allergy and Infectious Diseases ($20 million); and the National Institute of Child Health and Human Development ($19 million).

For FY 2025, the budget proposes to maintain the funding level at $1.5 billion for the Advanced Research Projects Agency for Health (ARPA-H). This budget request funding for ARPA-H as a separate appropriation within NIH.[25] In FY 2025, ARPA-H will continue to support the President's Cancer Moonshot, proactively identify potential pandemics, and introduce innovative strategies to combat antimicrobial resistance.

**Substance Use and Mental Health Services Administration (SAMHSA)**

Proposed program level funding of $8.1 billion is sought for FY 2025 for SAMHSA, an increase of $612 million above FY 2024.[26] The Administration states that it continues to make significant

[24] The FY 2023 total program funding level was $47.7 billion.
[25] The FY 2025 budget captures ARPA-H within NIH for display purposes based on the ARPA-H FY 2023 authorization language.
[26] The FY 2023 total program funding level was $7.518 billion, same as FY 2024.

investments to expand behavioral health services, grow youth-oriented services, develop community harm reduction initiatives, and increase services for substance use treatment.

Over fifty percent of the budget (or $4.2 billion) is for substance use services. This includes $2 billion for the Substance Use Prevention, Treatment, and Recovery Block Grant (same level as FY 2024), a formula grant program that helps states finance substance use and prevention and treatment activities. This budget category also includes $1.6 billion for the State Opioid Response program to address opioid and stimulant misuse, a proposed increase of $20 million.

The remaining half of the budget (or $3.9 billion) is mostly for SAMHSA's mental health activities, an increase of $736 million over FY 2024. This includes investing $1 billion into the Community Mental Health Block Grant (an increase of $35 million over 2024), which provides states non-clinical coordination and support services that are not covered by Medicaid or other third-party insurance. It also dedicates $602 million for the National Suicide Prevention Lifeline and behavioral health crisis services to continue to improve the Lifeline infrastructure, state and local response, and expand the Public Awareness Campaign. The budget also includes additional resources for children's mental health needs; includes a $50 million increase in Project AWARE to identify and refer approximately school-aged children and train mental health and professionals. It also providing funding for projects to assist individuals in transition from homelessness, maintaining its budget at $67 million.

**Office of Medicare Hearings and Appeals (OMHA)**

The FY 2025 budget proposes OMHA program level funding of $196 million, the same as FY 2023 and 2024 levels. OMHA reports that it has successfully reduced the backlog of pending appeals to 16,000 (from a high of nearly 900,000 in FY 2016) leaving a caseload manageable within the 90-day adjudication time frame. To prevent a larger backlog, the Departmental Appeals Board (DAB) hired 3-year term appointees to assist with the influx of cases. The budget will allow further reduction of the pending appeals backlog (expected to be eliminated by FY 2026) and build capacity to help prevent a larger backlog from developing.

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

ONC funding is proposed at $86 million, an increase of $20 million from FY 2024.[27] 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 an increase of $10 million 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. It also includes an additional $5 million to fund a Behavioral Health Adoption Pilot program that will administer strategic pilots for behavioral health providers in care settings that need increased health IT adoption or improvements. The remaining $5 million increase is to support pay and non-pay inflationary costs for operational and administrative functions.

[27] The FY 2023 total program funding level was $66 million, same as FY 2024.

## 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 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 2023 was $8.723 billion. The estimated unexpired, unobligated balances for FY 2024 and FY 2025 are $7.675 and $6.328 billion, respectively. CMMI estimates that it will spend $1.347 billion in 2025. This reflects an increase of $299 million more than 2024 and $733 million more than 2023.

To date, CMMI has launched more than 60 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. The budget highlights several recently launched or soon to be released Innovation Center models under each of its objectives. These are briefly described below.

| Model Name | Description | Model Period |
|---|---|---|
| **Driving Accountable Care** | | |
| Accountable Care Organization Realizing Equity, Access, and Community Health Model (ACO REACH) | Promotes health equity through testing of increasing payment benchmarks for ACOs serving higher proportions of underserved beneficiaries, implementing a Health Equity Plan, and collecting and reporting demographic and social needs data. | Launched in 2023 and runs through 2026 |
| Making Care Primary | Provides a pathway for primary clinicians with different levels of experience with value-based care to adopt population-based payments and integrated behavioral and specialty care. | Will launch July 1, 2024 and will run for 10.5 years |
| Enhancing Oncology Model | Participating oncology practices take on financial and performance accountability for episodes of care for chemotherapy administration to patients with common cancer types | July 1, 2023 thru 2028 |
| **Advancing Health Equity** | | |
| Transforming Maternal Health Model | Aims to reduce disparities in maternal healthcare access and treatment. Works with state participants to improve outcomes, while reducing overall Medicaid expenditures | Expected to launch in fall 2024 and run for 10 years |
| Medicare Advantage Value-Based Insurance Design | Provides MA plans additional flexibilities to alter their benefit packages, test whether offering these flexibilities increases the update of high value services, reduces costs, and improves quality outcomes. | Launched in January, 2017 and runs thru December, 2030. |
| **Supporting Care Innovations** | | |
| Innovation in Behavioral Health Model | Aims to improve quality of care and outcomes for adults in Medicare/Medicaid that have moderate to severe mental health conditions | Launch expected in 2024 and run for 8 years. |

| Model Name | Description | Model Period |
|---|---|---|
| | and/or substance use disorders by connecting them to integrated physical, behavioral, and social supports. | |
| Guiding an Improved Dementia Experience Model | Tests an alternative payment model for provider participants who establish dementia care programs that provide ongoing, longitudinal care and support to people living with dementia and their caregivers. | Launch expected on July 1, 2024 and run for 8 years through June 2032. |
| **Addressing Affordability** | | |
| Cell & Gene Therapy Access | Coordinates and administer multi-state outcomes-based agreements with manufacturers for certain cell and gene therapies. | Anticipates a January 1, 2025 launch date with agreements expected to last for 6 years. |
| Medicare $2 Drug List | Allows Medicare Part D plans 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. This includes, for example, hypertension and hyperlipidemia. | Still under development. Linked to a legislative proposal that would establish this as a permanent change to Part D benefit design. |
| Accelerating Clinical Evidence | 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. | Still under development. Compiling stakeholder input and consulting with the FDA on model development. |
| **Partnering to Achieve Health System Transformation** | | |
| States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model | State total cost of care model. A participating state would be able to use its authority to assume responsibility for managing healthcare quality and costs across all payers, including Medicare, Medicaid, and private insurers. | First cohort of states enter the model in 2024 and the model runs for 10 years. |

The estimated effects of current CMMI initiatives are presented, some of which are shown in the table below for the next 5 projected years – the detailed budget table includes 10 projected years. No estimates were provided for certain models at this time, including the Bundled Payments for Care Improvement Advanced (BPCI-Advanced) Model, Pennsylvania All-Payer Rural Hospital Model, Vermont All-Payer Model, Medicare Advantage Value-Based Insurance Design (MA VBID), Maternal Opioid Misuse (MOM) Model, Integrated Care for Kids (InCK) Model, Guiding an Improved Dementia Experience (GUIDE), Advancing Health Equity Addressing Disparities (AHEAD), and Making Care Primary (MCP).

| **Approved and Implemented Demonstrations and Pilot Programs in Medicare Baseline** (Outlays in millions of dollars) | | | | | | |
|---|---|---|---|---|---|---|
| | **2024** | **2025** | **2026** | **2027** | **2028** | **2029** |
| **Maryland Total Cost of Care (TCOC)** | | | | | | |
| Baseline | 15,201 | 16,326 | 17,534 | 18,832 | | |
| Demonstration | 14,994 | 16,083 | 17,255 | 18,517 | | |
| **Kidney Care Choices** | | | | | | |
| Baseline | 13,380 | 13,400 | 13,400 | 3,350 | | |
| Demonstration | 13,310 | 13,320 | 13,310 | 3,420 | | |
| **Comprehensive Care for Joint Replacement** | | | | | | |
| Baseline | 1,456 | 368 | | | | |

| Approved and Implemented Demonstrations and Pilot Programs in Medicare Baseline (Outlays in millions of dollars) | | | | | | |
|---|---|---|---|---|---|---|
| Demonstration | 1,381 | 349 | | | | |
| **Medicare Diabetes Prevention Program** | | | | | | |
| Baseline | 31 | 43 | 56 | 70 | 85 | 101 |
| Demonstration | 31 | 43 | 56 | 70 | 85 | 101 |
| **ACO Realizing Equity, Access, and Community Health (ACO REACH)** | | | | | | |
| Baseline | 12,750 | 11,990 | 11,610 | 2,890 | | |
| Demonstration | 12,730 | 11,900 | 11,580 | 2,920 | | |
| **ESRD Treatment Choices (ETC)** | | | | | | |
| Baseline | 2,552 | 2,659 | 2,771 | 2,888 | 3,010 | |
| Demonstration | 2,544 | 2,648 | 2,754 | 2,874 | 3,011 | |
| **Part D Senior Savings (PDSS)*** | | | | | | |
| Baseline | 34,898 | | | | | |
| Demonstration | 34,875 | | | | | |
| **Home Health Value-Based Purchasing (HHVBP)** | | | | | | |
| Baseline | 21,365 | 22,715 | 24,230 | 25,890 | 6,578 | |
| Demonstration | 20,735 | 22,001 | 23,481 | 25,089 | 6,375 | |
| **Primary Care First (PCF)** | | | | | | |
| Baseline | 37,743 | 38,329 | 40,054 | 19,825 | | |
| Demonstration | 37,598 | 38,047 | 39,899 | 19,816 | | |
| **Enhancing Oncology Model** | | | | | | |
| Baseline | 7,700 | 6,430 | 4,200 | 3,600 | 900 | |
| Demonstration | 7,590 | 6,290 | 4,100 | 3,500 | 870 | |

**Source:** Excerpts from Table 22-4, "Impact of Regulations, Expiring Authorizations, and Other Important Assumptions in the Baseline," Analytical Perspectives for FY 2025, https://www.whitehouse.gov/omb/budget/analytical-perspectives/.