Documents for the Record

Full Committee Markup

April 29, 2025

Majority

1. Letter of support for the Seniors' Access to Critical Medications Act of 2025, from the American Medical Association to Rep. Harshbarger and Rep. Wasserman Schultz, submitted by Rep. Harshbarger.
2. Letter of support for the Seniors' Access to Critical Medications Act of 2025, from LUGPA, Integrated Practices Comprehensive Care to Rep. Harshbarger, Rep. Wasserman Schultz, Rep. Miller, Rep. Davis, Rep. Crenshaw, and Rep. Soto, submitted by Rep. Harshbarger.
3. Letter of support for the Seniors' Access to Critical Medications Act of 2025, from the Community Oncology Alliance to Rep. Harshbarger and Rep. Wasserman Schultz, submitted by Rep. Harshbarger.
4. Letter of support for the Seniors' Access to Critical Medications Act of 2025, from the US Oncology Network to Chairmen Guthrie and Carter and Ranking Members Pallone and DeGette, submitted by Rep. Harshbarger.
5. An article from Behavioral Health Business title "Trump Plan Merges SAMHSA into Newly Formed Administration for a Healthy America," submitted by Rep. Palmer.
6. A letter from Rep. Craig to Chairman Guthrie and Ranking Member Pallone in support of Rep. James's amendment to the amendment in the nature of a substitute to H.R. 283, the SUPPORT for Patients and Communities Reauthorization Act of 2025, submitted by Rep. James.

Minority

1. Article from the Washington Post titled "Internal budget document reveals extent of Trump's proposed health cuts," submitted by Ranking Member Pallone.
2. Article from Statnews titled "Leaked budget document outlines how Kennedy may cut up HHS to build new AHA," submitted by Ranking Member Pallone.
3. Department of Health and Human Services (HHS) 2026 Discretionary Budget Passback, submitted by Ranking Member Pallone.
4. Article from Politico titled "HHS funding slashed by 30 percent in budget proposal," submitted by Ranking Member Pallone.
5. Article from Wired title "Here's All the Health and Human Services Data DOGE Has Access To," submitted by Ranking Member Pallone.
6. A letter from CBO to Ranking Member Pallone and Ranking Member Boyle, submitted by Rep. Fletcher.

7. Letter from Alliance for Aging Research to Senators Thune and Schumer and Reps. Johnson and Jefferies, submitted by the Minority.
8. Letter from undersigned community provider organizations to Senators Thune and Schumer and Reps. Johnson and Jefferies, submitted by the Minority.
9. Letter from Consortium for Constituents with Disabilities to Reps. Johnson and Jefferies, submitted by the Minority.
10. Letter from National Association of Specialty Pharmacy to Chairman Guthrie and Ranking Member Pallone, submitted by the Minority.
11. Justice in Aging newsletter, submitted by the Minority.
12. Letter from Leading Age to Senators Thune and Schumer and Reps. Johnson and Jefferies, submitted by the Minority.
13. Letter from Leukemia and Lymphoma Society to Reps. Johnson and Jefferies, submitted by the Minority.
14. Statement from the National Association of Chain Drug Stores, submitted by the Minority.
15. Letter from National Multiple Sclerosis Society to Members of the United States House of Representatives, submitted by the Minority.
16. Statement from The Arc, submitted by the Minority.

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
James.madara@ama-assn.org

April 4, 2025

The Honorable Diana Harshbarger
U.S. House of Representatives
167 Cannon House Office Building
Washington, DC 20515

The Honorable Debbie Wasserman Schultz
U.S. House of Representatives
270 Cannon House Office Building
Washington, DC 20515

Dear Representatives Harshbarger and Wasserman Schultz:

On behalf of our physician and medical student members, the American Medical Association (AMA) is writing in support of the "Seniors' Access to Critical Medications Act of 2025," which would amend the Social Security Act to clarify the application of the in-office ancillary services exception to the physician self-referral prohibition for drugs furnished under the Medicare program. The AMA believes that physician practices with in-office pharmacies should have the ability to mail or ship Part B prescriptions to patients, as these types of services are more convenient for patients and often less costly than the same services offered at a hospital or a stand-alone outpatient pharmacy.

Physician offices with in-office pharmacies mail or ship medications to non-Medicare patients when they are unable to come to the office for any reason. The Centers for Medicare & Medicaid Services does not allow this practice under Medicare, stating in sub-regulatory guidance that "incident to" services must be administered to patients who are physically present in the physician office in order for the in-office ancillary services exception to apply. This has adversely impacted Medicare beneficiaries' timely access to medications, and it is administratively burdensome for physician practices. Therefore, the AMA strongly supports the Seniors' Access to Critical Medications Act's initiative to clarify that delivery of medicine to Medicare beneficiaries using the Postal Service, a commercial package service, or by a trusted surrogate, does not violate the in-office exception of the Stark Law.

The AMA commends your ongoing commitment to this important issue, and we look forward to working with you to further advance this legislation.

Sincerely,

James L. Madara, MD

March 31, 2025

The Honorable Diana Harshbarger
United States House of Representatives

The Honorable Debbie Wasserman Schultz
United States House of Representatives

The Honorable Carol Miller
United States House of Representatives

The Honorable Don Davis
United States House of Representatives

The Honorable Dan Crenshaw
United States House of Representatives

The Honorable Darren Soto
United States House of Representatives

Dear Representatives Harshbarger, Wasserman Schultz, Miller, Davis, Crenshaw, and Soto:

On behalf of LUGPA, which represents 150 independent urology group practices and more than 2,100 physicians providing over one-third of the nation's urology services, we strongly support the Seniors' Access to Critical Medications Act. This critical legislation will enhance patient access to essential medications by removing unnecessary barriers that prevent Medicare Part D prescriptions from being picked up by caregivers or delivered via mail or courier when prescribed through in-office ancillary services.

LUGPA practices serve as centers of excellence in urban, suburban, and rural communities, delivering fully integrated urologic care, including medical, surgical, and advanced cancer treatments—in outpatient settings. Unlike fragmented care models that force patients to travel between multiple providers, LUGPA practices ensure seamless, efficient, patient-centered care. However, restrictive policies on in-office dispensing (IOD) and growing challenges with medical transportation place an undue burden on patients, particularly seniors and those in rural areas.

This bill introduces practical, patient-friendly reforms while maintaining essential safeguards, such as requiring a prior face-to-face visit and an ongoing provider-patient relationship. These provisions will strengthen care continuity, ensuring Medicare beneficiaries can access their medications without unnecessary delays. Additionally, the legislation mandates a Government Accountability Office (GAO) study to assess its impact, reinforcing a data-driven approach to optimizing policy.

The Importance of In-Office Dispensing

In-office dispensing (IODs) refers to physician practices that directly dispense medications to their patients that are intended for self-administration by the patient in their home (either orally or injectable) and, when applicable, have benefits outlined by Part D of Medicare. While IOD models are most recognized as involving *in-office* dispensing of drugs, many IOD models involve a blended model that incorporates courier delivery or mailing of drugs to the patient's home when the timing of filling or refilling a medication neither corresponds to nor requires an office visit.

The COVID-19 pandemic accelerated a shift in the delivery of care that allowed for remote visits, including adaptations in resources and infrastructure to allow for more and more sophisticated care delivery in the home, thereby encouraging more providers to mail/deliver drugs to a patient's home.

The drugs delivered to a patient's home by an IOD are generally covered under Part D. The physician practices that employ IOD models participate in Part D plan pharmacy networks and dispense drugs consistent with state law and applicable coverage policies established by the patient's specific Part D plan.

The indications and applicability of anti-cancer (oncolytic) medications taken orally and administered under the Part D program as either primary or adjunctive treatment for advanced therapeutic care, particularly for prostate cancer has expanded dramatically in recent years. Oral oncolytics have obvious patient and system-wide benefits, often with the advantage of markedly reduced side effect profiles from traditional intravenously administered chemotherapy protocols.

IOD models that involve the home delivery of drugs have expanded access to advanced therapeutics and provided seriously ill patients with an alternative to in-person care while assuring continuity and supervision of care. This coincides with the ongoing evolution of urological practices as a primary steward for many patients with advanced genitourinary malignancies, in addition to their historical role as the principal caregivers of benign urological conditions.

From a clinical management perspective, IOD home delivery models utilize navigation services that provide ongoing follow up to assess patient compliance with medication regimens, ensure laboratory and imaging studies are completed in a timely manner, coordinate visits with the care team and determine tolerability of the medical regimen between visits. These functions have been shown to enhance patient adherence, lower overall healthcare costs and improve patient satisfaction—most importantly, survival, even for locally advanced and metastatic cancers, increases when patients are guided through the care process.

The services provided by IOD home delivery models have been shown to provide value to patients and practices, [1] [2] and in addition to the clinical benefits outlined above, have been shown to have economic benefits as well in reducing costs for both payors and patients when compared to their mail-order counterparts. [3]

We urge Congress to swiftly pass the Seniors' Access to Critical Medications Act to support physician-led dispensing models that enhance patient care, reduce logistical barriers, and improve treatment adherence. Thank you for your leadership on this critical issue. We welcome the opportunity to discuss this further and work together to advance patient-centered healthcare solutions.

Sincerely,

Scott B. Sellinger, MD
President

Mara Holton, MD
Chair, Health Policy

[1]Reff MJ. Physician Dispensing: Adding Value to Patients and the Practice. Oncology Issues. 2014 May 1;29(3):38-43.

[2] Leach JW, Eckwright D, Champaloux S, et. al. Medically integrated dispensing (MID) clinical and cost outcomes compared to specialty pharmacies (SP). Journal of Clinical Oncology, 2022 40:16_suppl, e18645-e18645

[3]Howard A, Kerr J, McLain M, Modlin J. Financial impact from in-office dispensing of oral chemotherapy. Journal of Oncology Pharmacy Practice. 2019 Oct;25(7):1570-5.

COMMUNITY ONCOLOGY ALLIANCE

Dedicated to Advocating for Community Oncology Patients and Practices

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April 7, 2025

The Honorable Diana Harshbarger
United States House of Representatives
167 Cannon House Office Building
Washington, DC 20515

The Honorable Debbie Wasserman Schultz
United States House of Representatives
270 Cannon House Office Building
Washington, DC 20515

Dear Representatives Harshbarger and Wasserman Schultz:

On behalf of the Board of Directors of the Community Oncology Alliance (COA), I want to sincerely thank you both for once again sponsoring the *Senior's Access to Critical Medications Act* (H.R. 2484) in this Congress. As a pharmacist and a cancer survivor, I know you both understand how critical it is that seniors with cancer and other serious illnesses face no unnecessary barriers to receiving potentially life-saving therapies. It is difficult to understand how the prior Centers for Medicare & Medicaid Services (CMS) could construct barriers to care for seniors who are too sick to travel or lack reliable transportation.

As you both well know, this legislation is simply about the "delivery" of a drug, which is in all respects separate from the "dispensing" of a drug. For years, as far back as oral cancer drugs have been available, community oncology practices and other medical practices have been delivering drugs to patients who are too sick or do not have reliable transportation, especially in rural areas, to personally pick up their drugs. Alternatively, a family or caregiver was allowed to pick up the drugs for patients. That was until CMS arbitrarily made "delivery" a Stark violation after the COVID public health emergency, for a reason we have yet to understand and uncover.

Pharmacy benefit managers (PBMs) and their associated specialty and mail order pharmacies want to stop practices from being able to deliver drugs or allow family or caregiver pick-up of drugs *because they want to control these drugs and mail them out.* Their interests are pure financial greed and have nothing to do with patient well-being and medical outcomes, something that is a critical priority for oncologists and other physicians. Unfortunately, when the PBMs and their specialty and mail order pharmacies mandate that patients use their facilities, it is well documented that the results are delays in patients getting their medications, denials of the prescribed medication, waste when the drug and/or dosage is changed, and higher patient costs. These profit-seeking corporations do not care about patient well-being; they simply want to make money, which is most often at patients' expense.

Now, the PBMs and specialty pharmacies have pulled out all stops, and have incentivized pharmacy and other advocacy groups to distort your simple but potentially life-saving bill by making wild accusations and statements that are simply false. Note that 11 of the top 15

pharmacies in this country have specialty pharmacies, seven have mail order pharmacies, and the top four include the three largest PBMs that control 80 percent of the prescription drug market.

Largest 15 U.S. Pharmacies, By Total Prescription Revenues, 2024

Company	Stock Ticker	Estimated 2024 Prescription Revenues (billions)	Share of 2024 Prescription Revenues	Change in Revenues vs. 2023	Primary Dispensing Format(s)
CVS Health Corporation	CVS				
• Retail/LTC pharmacy[1]		$100.7	14.7%	+10.1%	Chain drugstore/Long-term care pharmacy
• Pharmacy Services		$70.9	10.4%	+4.2%	Mail & specialty pharmacy
Walgreens Boots Alliance[3]	WBA	$99.5	14.6%	+9.2%	Chain drugstore / Mail & specialty pharmacy
Cigna[4]	CI	$72.5	10.6%	+10.3%	Mail & specialty pharmacy
UnitedHealth Group[5]	UNH	$46.5	6.8%	+10.2%	Mail & specialty pharmacy / Community pharmacies
Walmart Stores, Inc.[6]	WMT	$32.7	4.8%	+7.0%[2]	Mass merchant with pharmacy / Mail & specialty pharmacy
The Kroger Company[7]	KR	$15.3	2.2%	+7.9%[2]	Supermarket with pharmacy / Specialty pharmacy
Humana	HUM	$10.7	1.6%	+2.6%	Mail & specialty pharmacy
Rite Aid Corporation	Private	$10.1	1.5%	-18.3%	Chain drugstore / Mail & specialty pharmacy
Publix	Private	$9.8	1.4%	+26.0%[2]	Supermarket with pharmacy
Albertsons Companies	ACI	$9.5	1.4%	+16.8%	Supermarket with pharmacy
BrightSpring Health Services	BTSG	$8.8	1.3%	+34.2%	Long-term care pharmacy / Specialty pharmacy
Elevance Health[8]	ELV	$5.8	0.8%	n.a.	Mail & specialty pharmacy
PANTHERx Rare Pharmacy	Private	$4.7	0.7%	+30.6%	Specialty pharmacy
Costco Wholesale Corporation	COST	$4.2	0.6%	+24.7%[2]	Mass merchant with pharmacy
Ahold Delhaize	ADRNY	$3.1	0.4%	+9.3%[2]	Supermarket with pharmacy
Subtotal Top 15		$504.6	73.9%		
Total prescription dispensing revenues		$682.9	100.0%		

Source: *The 2025 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Drug Channels Institute, Exhibit 34. Totals may not sum due to rounding. Includes revenues from all pharmacy dispensing formats. Excludes estimated infusion services covered by medical benefit. Revenues reflect pro forma calendar year 2024, which may not correspond to fiscal year or public reporting. Excludes revenues from administration of COVID-19 vaccines. LTC = long-term care.

The National Chain Drug Stores (NACDS) has voiced concerns about your legislation because they represent the very chain drug stores that have affiliated PBMs, specialty and mail order pharmacies, which will profit from stopping practices from making sure their patients get their medications in cases where they are unable to pick them up in person. Your bill does not require or mandate that patients get their medications from their medical practice; it simply allows the practice to "deliver" the drug to a too-sick patient. It also does not empower a medical practice to "dispense" drugs because that is already what they are legally allowed to do under federal and state laws.

To show you the lengths the PBMs and specialty pharmacy advocates are willing to go, they have enlisted the American Economics Liberties Project (AELP), which obviously does not understand health care, to make totally fabricated concerns that your bill empowers the big wholesalers, which is simply removed from reality. The bill has absolutely nothing to do with wholesalers, which anyone who understands health care delivery knows. Physicians are going to prescribe and dispense oral drugs as they have been doing, and wholesalers do not enter into that at all. Your bill is simply about how the patient gets a "dispensed" drug "delivered" to ensure that there are no barriers to treatment.

Regardless of any affiliation a practice may have with a wholesaler; no physician is going to do the wrong thing by their patients, and especially risk malpractice, by allowing some corporation to "treat" their patients. Ironically, that is exactly what the PBMs and their affiliated insurers do now on a daily basis by

practicing medicine and mandating treatments through utilization management such as "fail first" step therapy. Sadly, AELP is effectively arguing for a different set of corporations – the largest PBMs and their insurers, specialty and mail order pharmacies.

And I would like to underscore that independent pharmacies do not even enter into this argument in that, as anyone who understands health care knows, they do not stock expensive cancer and other specialty drugs. I also note that the wholesalers basically distribute drugs to virtually all medical and pharmacy providers, so these wholesaler arguments are simply straw men.

It is really disturbing and disgusting that corporate greed is trying to place any and all obstacles in the way of cancer patients and other sick Americans who are already fighting PBMs and their insurers daily to get the treatments they need. I have attached just a few stories out of the hundreds and hundreds we have about how cancer patients are adversely impacted by CMS's misplaced and inhumane restrictions. And I wonder how all the greed-filled arguments by advocacy groups now coming out of the woodwork to raise unfounded concerns about your legislation would react if a family member or loved one was one of the Americans facing obstacles getting their life-saving treatments?

We cannot thank you both enough for your leadership in reintroducing this important bipartisan legislation, which in the 118th Congress advanced through the Energy and Commerce Committee and then passed the full House. We hope for fast passage of this bill in the House during the early stages of the 119th Congress, with the Senate following suit.

Sincerely,

Ted Okon
Executive Director

Actual Patient Stories Relating to CMS Drug Delivery Restrictions

72 year old male with prostate cancer, below the knee amputee, severe COPD, reliant on friends / family / community resources for transportation opted not to treat his cancer as the process of getting medication became a burden.

69 year old male went without medication for nearly a month due to weather conditions that didn't allow him to drive and no family to pick up his medications for him.

77 year old male, on 2 oral medications. Patient resides in an assisted living facility and relies on his daughter to pick up his medication and bring it to his home. Daughter fell ill and was unable to get to the office for nearly 3 weeks so pt went without. In this time, his cancer did progress and became metastatic.

Elderly male who has limited mobility and his caregiver is his wife who does not drive.

We have 2 patients who cannot get their drugs due to limited mobility and their caregivers are their adult children who work full time jobs and cannot make it to our clinic on time to drive their parents.

My mother, [redacted], Requires medicine that m
be picked up at the Dr. Office in person. Due to her
condition she cannot consistently pick up the medicine
person. I am listed on her medical power of Attorney
but I also cannot always come by to pick up the
medicine in person. I work long hours, and I am workin
in Berytown which is at least 45 minutes away from the
Dr. Office which would require at least two hours away
from my post at work. Please allow the
medicine to be delivered to our home.

I am writing to ask for your help in modifying the existing Stark Law, which has negatively impacted me as to how I obtain my requisite monthly prescription of Imbruvica. The prescription is required to treat my form of Non-Hodgkin's Lymphoma, specifically known as Waldenstrom's Macroglobulinemia. I was diagnosed with this blood disease on 3/14/18. Without taking this drug daily, I would already be deceased.

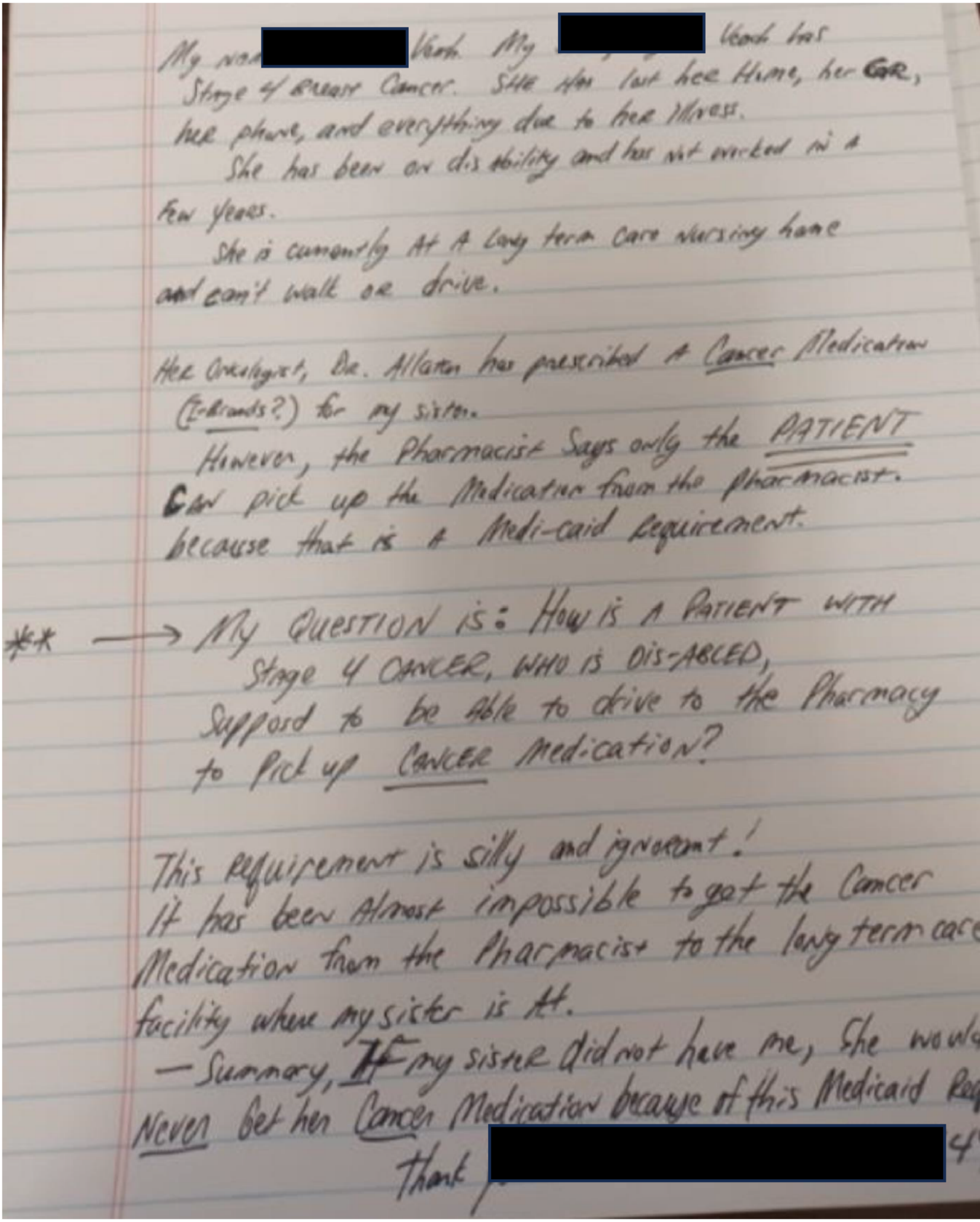
I moved from Houston, TX to Alpine, TX on 9/02/2020. At the time, my oncologist (Dr. Ronjay Rakkhit of the practice Oncology Consultants PA located in Houston, TX) was able to write my prescription, send it to the practice's affiliated pharmacy (OCRx Pharmacy Solutions) and it would be shipped directly to my address here in Alpine via UPS. Imbruvica is a very expensive drug (over $17,000 per month) and is one of the ten drugs that CMS/Medicare will be negotiating with the pharmaceutical manufacturing companies this year to reduce the prices for elderly patients. In addition to filling the prescription, OCRx also assists in sourcing third party financial support to help me cover my annual out of pocket cost for the drug, which would be more than $10,000 per annum. Dr. Rakkhit, OCRx and their financial support staff have seamlessly provided my medical care for over past five years.

On 5/11/23, I was informed by OCRx that the Stark Law, which had been suspended during the Covid Pandemic, would be reinstated, thus precluding OCRx from shipping my Imbruvica

prescription directly to me. This prohibition will require me to drive 569 miles (9.5 hours each way) from my home in Alpine to personally pick up my drug refill every three months in Houston. I have made two such trips, one in July and the second this month. The fuel costs alone for my two trips was $300. I am fortunately able to stay with friends during the journey to help defray some of the costs, but I still must pay for food during the trip.

Switching to a specialty pharmacy, approved by my Medicare Part D insurance provider is an option, but these pharmacies do not provide the financial support services offered by OCRx. Thus, switching pharmacies would result in my having to pay the annual out of pocket costs of $10,000, or otherwise attempt to personally source third party financial assistance myself: a process for which I have no knowledge of where to begin, or if it is even feasible.

The Stark Law only impacts Medicare patients. If I were under 65 and thus, not on Medicare, OCRx could send me my prescription refills quarterly without violating any law or regulation. If the Stark Law were to be modified or otherwise repealed, this would not be an issue. The Stark Law, therefore, is essentially prejudicial to elderly cancer patients both in terms of (a) the physical impact of having to make a long-distance drive or flight (assuming the patient is physically able to make such a trip) and (b) the monetary impact (transportation/fuel, food and lodging costs). Essentially, I am forced to choose between either making the quarterly drive or otherwise paying the $10,000 out of pocket cost that would be required upon losing the third-party financial support services provided by OCRx.



My [redacted] Week. My [redacted] Week has Stage 4 Breast Cancer. She has lost her Home, her Car, her phone, and everything due to her Illness.
She has been on disability and has not worked in a few years.
She is currently At A Long term care nursing home and can't walk or drive.

Her Oncologist, Dr. Allaton has prescribed A Cancer Medication (Erbrands?) for my sister.
However, the Pharmacist Says only the PATIENT Can pick up the Medication from the pharmacist. because that is a Medi-caid Requirement.

** → My QUESTION IS: How is A PATIENT WITH Stage 4 CANCER, WHO is DIS-ABLED, Supposd to be able to drive to the Pharmacy to Pick up Cancer Medication?

This Requirement is silly and ignorant!
It has been Almost impossible to get the Cancer Medication from the Pharmacist to the long term care facility where my sister is At.
— Summary, If my sister did not have me, She would Never Get her Cancer Medication because of this Medicaid Req
Thank [redacted] 4

April 8, 2025

The Honorable Brett Guthrie
Chairman
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington DC, 20515

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce
2322A Rayburn House Office Building

The Honorable Earl L. "Buddy" Carter
Chairman
Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Dianna DeGette
Ranking Member
Subcommittee on Health
2322A Rayburn House Office Building
Washington, DC 20515

Dear Chair Guthrie, Ranking Member Pallone, Subcommittee Chair Carter, and Subcommittee Ranking Member DeGette:

On behalf of The US Oncology Network (The Network), which represents more than 10,000 oncology physicians, nurses, clinicians, and cancer care specialists nationwide, I write to express strong support for H.R. 2484, the Seniors' Access to Critical Medications Act, and to thank you for considering it during the Energy and Commerce markup on April 8.

As an independent physician who has dedicated my career to providing comprehensive, high-quality, integrated cancer care, I see firsthand the potential this legislation has for my patients. If passed, H.R. 2484 would give Medicare patients of independent physician practices greater flexibility in how they access the prescriptions they need. This would benefit millions of Americans, including cancer patients treated all across The US Oncology Network.

The bipartisan bill would allow independent, community practices to deliver medications directly to Medicare patients through the mail or courier service; or let a patient's family or caregiver pick up the medications on their behalf. Oftentimes, cancer patients are extremely frail due to treatment side effects and many live in rural areas; this is a meaningful opportunity to reduce their burden.

Community oncology practices across the country have evolved in a way that supports medically integrated dispensing (MID), which has proven effective at managing medication adherence, while also reducing total cost, patient out-of-pocket costs, and drug waste.

Prior to 2021, independent oncologists and physician practices with MIDs were able to deliver patients' prescriptions directly to them, with few if any issues. By all accounts, this worked extremely well for patients until CMS released a Frequently Asked Questions (FAQ) document in 2021 related to the in-office ancillary services exception (IOASE) to the Physician Self-Referral Law (often called Stark Law). At the height of the COVID-19 pandemic, CMS expressed an interpretation that the IOASE requires patients to pick up their prescriptions from a physician's office in person.

This new FAQ immediately placed an enormous burden on the backs of one of our most medically vulnerable patient populations: seniors and Americans with disabilities. Many of these patients struggle with mobility or transportation limitations. This is especially true for patients living in rural communities, who must often travel longer distances to reach their physician's office or their closest pharmacy. However, it is perhaps most burdensome for Medicare patients battling cancer, who may be too ill to make the trip or unable to drive or get a ride to their oncologist's office regularly.

Oral oncolytics currently account for 25-30% of the oncology drug market. This underscores a transformative shift in cancer care. These medications provide more convenient and less invasive treatment options, significantly enhancing patient experience and adherence, with this pipeline of oral chemotherapy anticipated to rise in the coming years.

By preventing independent physician practices from mailing or delivering medications to Medicare patients and blocking patients' family and caregivers from picking up these medications, at-risk cancer patients are left with two equally bad options: drive long distances when they need to pick up their medications or use their health plan's pharmacy benefit manager (PBM).

Forcing cancer patients to rely on PBMs to access their medications exposes them to increased safety risks, potentially harmful access delays, and potentially higher copays. Given the PBM industry's track record with inflating the cost of prescription drugs — including ones used to treat cancer, HIV, and diabetes patients — it is especially concerning that CMS' current restriction on MIDs seems to favor these entities over independent, community-based physician practices.

The Seniors' Access to Critical Medications Act would extend CMS' original waiver for five years, ensuring continuity of care for cancer patients who rely on their trusted, independent physician for care. If passed, the bill would once again allow Medicare patients to have their independent physicians' offices mail or courier their medications to them or have a family member or caregiver pick up their medications.

Passing H.R. 2484 and allowing independent oncologists and oncology practices to mail or deliver oral prescription cancer drugs to Medicare patients will help protect patients' access to independent cancer care nationwide.

Thank you again for considering H.R. 2484 and special thanks to the members of the Committee who reintroduced this vital legislation—Congresswoman Diana Harshbarger (R-TN), Congressman Dan Crenshaw (R-TX), and Congressman Darren Soto (D-FL). On behalf of the nation's leading community cancer care providers, I urge the Committee to advance this legislation and protect local access to cancer care.

Sincerely,

Debra Patt, M.D., PhD, MBA
Medical Director for Public Policy
The US Oncology Network

CC:

The Honorable Diana Harshbarger
167 Cannon House Office Building
Washington DC 20515

The Honorable Debbie Wasserman-Schultz
1114 Longworth House Office Building
Washington DC 20515

REGULATION

Trump Plan Merges SAMHSA into Newly Formed Administration for a Healthy America

By **Laura Lovett** | March 27, 2025

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The Trump administration has announced its plans to c
Mental Health Services Administration (SAMSHA)

Services Administration (HRSA), the Agency for Toxic Substances and Disease Registry (ATSDR), and the National Institute for Occupational Safety and Health (NIOSH).

This comes as the Department of Health and Human Services (HHS) announced its plans to cut 10,000 jobs in an effort to save $1.8 billion a year. The agency plans to go from 28 divisions to 15 divisions. The job cuts will impact the FDA and CDC as well.

"We're going to eliminate an entire alphabet soup of departments and agencies while preserving their core functions by merging them into a new organization called the Administration for a Health America," HHS Secretary Robert F. Kennedy, Jr., posted on social media Thursday morning. " We have two goals. The first is obvious, to save the taxpayer money by making our departme
radically i

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Trump Tracker: The Latest Behavioral Health Updates

April 17, 2025

HIV/AIS work and the workforce, according to an HHS fact sheet.

"Over time, bureaucracies like HHS become wasteful and inefficient even when most of their staff are dedicated and competent civil servants," Kennedy said in a press release. "This overhaul will be a win-win for taxpayers and for those that HHS serves. That's the entire American public, because our goal is to Make America Healthy Again."

Historically, SAMSHA has led public health efforts related to mental health and substance use disorders (SUD). The agency was responsible for providing funding opportunities for organizations focused on promoting mental health, preventing substance misuse and fostering recovery.

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Washington, DC 20515-2302

The Honorable Brett Guthrie
Chairman
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Frank Pallone, Jr.
Ranking Member
House Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, D.C. 20515

Chairman Guthrie and Ranking Member Pallone:

I am writing today in support of the *Kid PROOF* amendment led by Representative James (MI-10) to H.R. 2483, the *SUPPORT for Patients and Communities Reauthorization Act of 2025*.

The *Kid PROOF* amendment seeks to empower parents when their child is experiencing an overdose or suicidal crisis. The underlying bill has bipartisan support and will help address the rising rates of youth overdose and suicide, potentially saving 22 teenagers between 14-18 dying each day from overdose.

The *Kid PROOF* amendment is an evidence-based approach that focuses on helping parents whose children are in crisis by giving them tools to prevent suicide and overdose. Children's healthcare providers would be able to offer parents, with their consent, the option to receive a lockbox or safe to store dangerous items securely that a child may considering using for self-harm or suicide. Devices like lockboxes and safes have been proven to prevent 95% of individuals from not going on to die by suicide. Further, research has shown that 9 in 10 families used a medication lockbox when provided. The *Kid PROOF* amendment will allow children's healthcare providers and parents to work together to save children's lives.

As a former member of this Committee and leader of the *Kid PROOF Act* in the 118th Congress, I believe the *Kid PROOF Act* has the power to save children's lives. It is a bipartisan solution that prioritizes and protects our nation's children and young people. Thank you for your attention to this matter.

Sincerely,

Angie Craig

Angie Craig
Member of Congress

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Democracy Dies in Darkness

EXCLUSIVE

Internal budget document reveals extent of Trump's proposed health cuts

HHS would be asked to absorb a $40 billion cut, about one-third of its discretionary budget.

April 16, 2025

By Lena H. Sun, Carolyn Y. Johnson, Rachel Roubein, Joel Achenbach and Lauren Weber

The Trump administration is seeking to deeply slash budgets for federal health programs, a roughly one-third cut in discretionary spending by the Department of Health and Human Services, according to a preliminary budget document obtained by The Washington Post.

The HHS budget draft, known as a "passback," offers the first full look at the health and social service priorities of President Donald Trump's Office of Management and Budget as it prepares to send his 2026 fiscal year budget request to Congress. It shows how the Trump administration plans to reshape the federal health agencies that oversee food and drug safety, manage the nation's response to infectious-disease threats and drive biomedical research.

The 64-page document calls not only for cuts, but also a major shuffling and restructuring of health and human service agencies.

Agencies are allowed to appeal to HHS for changes but have been told they cannot change the bottom line, according to a federal health official who spoke on the condition of anonymity because of the sensitivity of the negotiations.

While Congress often ignores the president's budget request, this has not been a typical transition to a new administration. Trump and his allies in Congress have made clear they want to smash the status quo by drastically reducing the size of the federal government and scrubbing it of programs and research efforts seen as wasteful or contrary to administration priorities.

The administration already has downsized HHS by about one-fourth of its workforce, with about 20,000 imminent departures since Trump took office. The Centers for Disease Control and Prevention staff who worked on programs to prevent drowning and gun violence, improve worker safety and test for sexually transmitted illnesses and hepatitis were among those laid off.

National Institutes of Health staffers who specialize in managing scientific funding have been ordered to terminate contracts and cancel hundreds of grants that fund research on topics such as vaccine hesitancy, transgender health and covid.

HHS had a discretionary budget of about $121 billion in fiscal 2024, but under the Trump administration's preliminary outline, it would see a decrease to $80 billion.

The proposed cuts are aimed at some of the prevention-focused health-care efforts HHS Secretary Robert F. Kennedy Jr. has said he wants to prioritize, said Anand Parekh, chief medical adviser at the Bipartisan Policy Center, a Washington, D.C., think tank.

"These are the efforts that try to get ahead of health-care problems," he said. "You can expect the costs of the Medicare and Medicaid program just to go up. That's the shortsightedness of reducing the sliver of the budget that is discretionary when that is the main opportunity you have to reduce health burden in America and get ahead of health problems."

Spokespeople for the White House and HHS did not immediately respond to requests for comment.

- The proposal would reduce the more than $47 billion budget of the NIH to $27 billion — a roughly 40 percent cut. It would consolidate NIH's 27 institutes and centers into just eight. Some of its institutes and centers would be eliminated, including the National Institute on Minority Health and Health Disparities and the National Institute of Nursing Research.
- Many of NIH's institutes would be fused. A National Institute on Body Systems, for example, would absorb three separate institutes: the institute focused on heart and lung diseases; the institute focused on diabetes, kidney and digestive disorders; and a third focused on muscle, skeletal and skin diseases.
- A new, $20 billion agency named the Administration for a Healthy America would be created. AHA would include many pieces of other agencies that are being consolidated — such as those focused on primary care, environmental health and HIV.
- AHA would have $500 million in policy, research and evaluation funding to be allocated by Kennedy to support "Make America Healthy Again" initiatives, including a focus on chronic childhood diseases. But many specific programs would be eliminated under AHA, according to the document, including programs focused on preventing childhood lead poisoning, bolstering the health-care workforce, advancing rural health initiatives and maintaining a registry of patients with amyotrophic lateral sclerosis, or ALS.
- The proposal would fund the Food and Drug Administration at a level that allows it to continue to collect drug and medical device fees from the industries the agency regulates. Unless the agency is funded at a certain level, the FDA's ability to use these funds, which help expedite safety reviews for devices, drugs and other products, would be limited.
- The proposal would cut the CDC's budget by about 44 percent, from $9.2 billion to about $5.2 billion, and would eliminate all of the agency's chronic disease programs and domestic HIV work. The chronic disease programs being eliminated include work on heart disease, obesity, diabetes and smoking cessation.
- Rural programs formerly under the Health Resources and Services Administration appear to be hard-hit. The rural hospital flexibility grants, state offices of rural health, rural residency development program and at-risk rural hospitals program grants are listed as eliminations under AHA.
- Money for the Head Start program, which provides early child care and education for low-income families and is funded by HHS's Administration for Children and Families, would be eliminated. "The

federal government should not be in the business of mandating curriculum, locations and performance standards for any form of education," the document says.

"President Trump has committed to balancing the budget while providing adequate funding for critical nondefense discretionary priorities — securing our borders, caring for our veterans, and continued infrastructure investment," the document states in an introduction.

"Reaching balance requires: resetting the proper balance between federal and state responsibilities with a renewed emphasis on federalism; eliminating the federal government's support of woke ideology; protecting the American people by deconstructing a wasteful and weaponized bureaucracy; and identifying and eliminating wasteful spending."

It is unclear which proposed cuts will stand in the budget proposal to Congress — and whether lawmakers will accept them. During the first Trump administration, Congress rejected some of the administration's proposals, including a 20 percent cut to NIH.

But those who depend on this funding said the cuts would pose an existential threat to some programs.

"It would be catastrophic," said Tommy Sheridan, deputy director of the National Head Start Association. "More than a million parents wouldn't be able to go to work from all those children, or they would have to scramble to find some other type of option. In a lot of communities, Head Start is the only early childhood provider in the community — especially rural America."

Alan Morgan, chief executive of the National Rural Health Association, said rural residents would suffer if the health initiatives proposed for elimination were cut.

"Those are essential to ensuring access to care for rural Americans and critical to keeping rural hospitals open," he said. "If that would come to fruition it would be absolute shocking news, because these programs have had such bipartisan support," he added, noting Kennedy himself had expressed support for the importance of rural hospitals.

What readers are saying

The comments overwhelmingly criticize the proposed one-third cut in discretionary spending by the Department of Health and Human Services under the Trump Administration. Many express concern that these cuts will disproportionately harm vulnerable populations, including rural... Show more

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POLITICS

Leaked budget document outlines how Kennedy may cut up HHS to build new AHA

Chronic disease agency would incorporate parts of current agencies but substantial cuts elsewhere are proposed

Adobe

By Isabella Cueto April 16, 2025

Chronic Disease Reporter

An internal budget document leaked to the press on Wednesday gives the clearest vision yet of Robert F. Kennedy Jr.'s planned chronic disease-fighting agency, the Administration for a Healthy America.

The Office of Management and Budget document, which STAT obtained, has not been authenticated by the Department of Health and Human Services — and would require Congress' approval to become real — but it sketches out a new HHS. Even after mass layoffs, some divisions would experience even deeper cuts as part of the restructuring, losing programs related to everything from firearm injury to HIV/AIDS treatment, worker safety and chronic diseases.

The document, labeled "Pre-decisional," envisions a major budget cut and substantial reorganization at the National Institutes of Health. The NIH budget would drop nearly 40 percent, going from $47 billion budget to $27 billion, and the NIH's 27 institutes would be consolidated down to just eight.

"Many difficult decisions were necessary to reach the funding level provided in this passback," says the introduction to the document, titled Department of Health and Human Services (HHS) 2026 Discretionary Budget Passback. Passback is the term for an official OMB reply to an agency's budget proposal.

Along with more cuts to the nation's health agencies, the document, dated April 10, offers a glimpse of what the AHA might look like. It will include branches for: the Surgeon General, primary care, maternal and child health, mental health, environmental health, HIV/AIDS, "health workforce" and policy, research and evaluation. The AHA would be an over $14 billion agency if Congress grants the budget request, making up almost one-fifth of the total HHS budget, per the proposal, which was first reported by The Washington Post.

The presidential Make America Healthy Again Commission, which was created to identify chronic health problems and solutions, would also take on a more influential role in shaping AHA's work, according to the plan. Some $500 million in the budget would be given to Kennedy to spend on "MAHA Activities" determined at least in part by the commission.

The policy, research and evaluation office would also include funding for health surveillance and data work, including through the National Center for Health Statistics, and work previously led by the Substance Abuse and Mental Health Services Administration.

Some HHS offices and programs — such as ones for maternal and child health, developmental disabilities, organ transplantation, Hansen's disease and bone marrow transplantation — would be revived inside of AHA, the document says. Rural health programs having to do with black lung disease and telehealth would also continue, as would centers on infant health, autism and maternal health. The 988 hotline for suicide and mental health crises would be funded at 2024 levels.

But many others would disappear, including those related to: HIV/AIDS care for low-income people, State Offices of Rural Health, family planning, adverse childhood experiences, firearm injury and mortality prevention research, traumatic brain injury, drowning, newborn screening, teen pregnancy prevention and more. Mental health programs tailored to particular groups, such as Asian Americans or LGBTQ+ youth, would be eliminated.

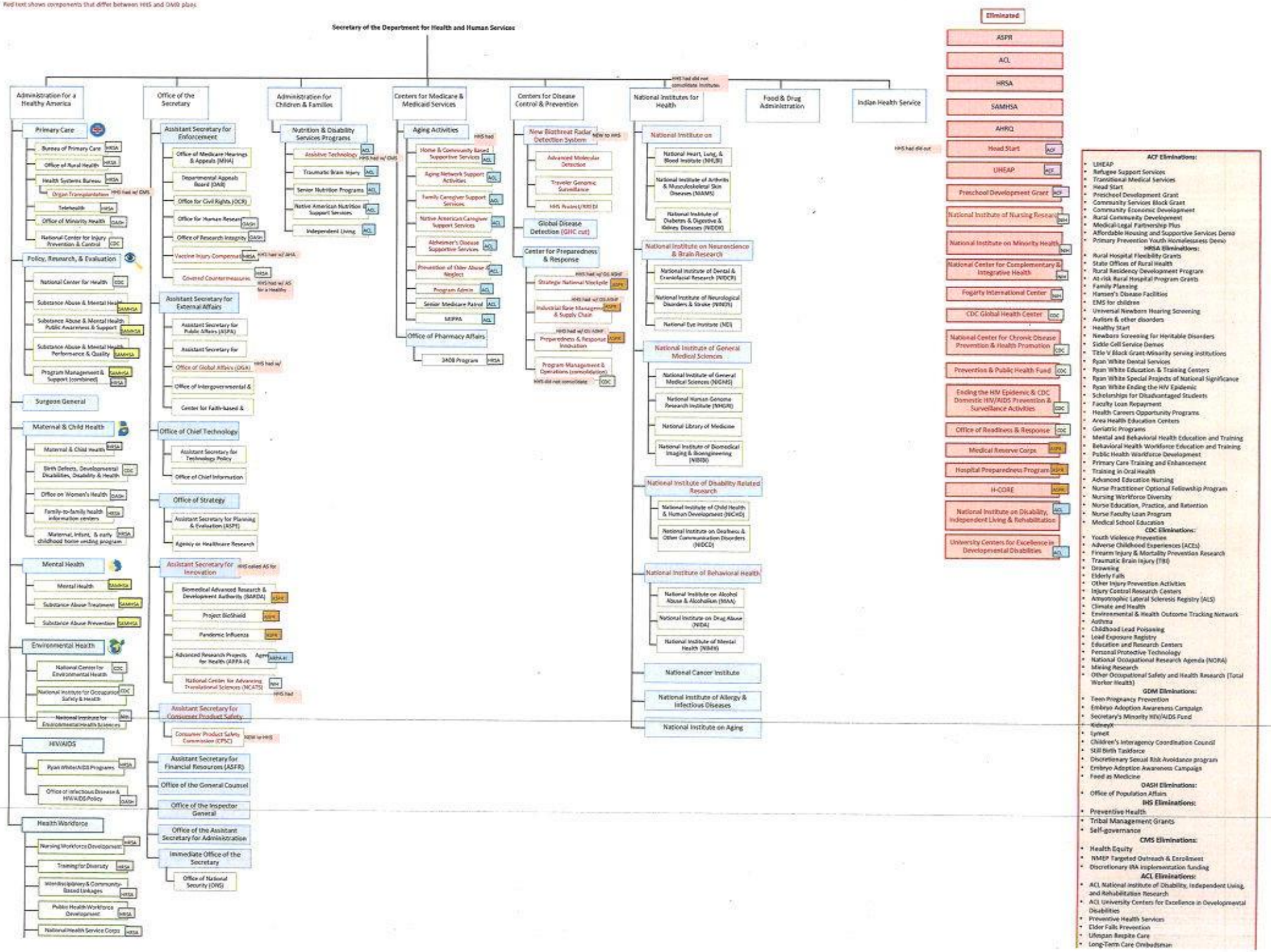
Suicide prevention, opioid overdose prevention and surveillance, and the National Violent Death Reporting System would continue, but the rest of the funding for injury prevention programs (previously in the Centers for Disease Control and Prevention) would be cut.

Some health agencies that were already gutted by reductions in force earlier this month would be all but erased from HHS. The National Institute for Occupational Safety and Health, which by some estimates lost over 90% of its workforce, would lose everything except its registries for firefighter cancer and mesothelioma, and a health treatment program for World Trade Center first responders, plus a few other mandatory programs. Environmental health offices would be consolidated into the AHA's branch for the same issue.

Registries for ALS and lead exposure, and programs working on childhood lead poisoning, climate and health, and research on the health effects of mining would be gone.

STAT's coverage of chronic health issues is supported by a grant from Bloomberg Philanthropies. Our financial supporters are not involved in any decisions about our journalism.

Red text shows components that differ between HHS and OAW plans



- Chronic Disease Self-Management Education
- Elder Rights Support Activities
- Elder Justice/Adult Protective Services
- Aging and Disability Resource Centers
- State Health Insurance Assistance Programs
- State Councils on Developmental Disabilities
- Developmental Disabilities Projects of National Significance
- Paralysis Resource Center
- Limb Loss Resource Center
- Voting Access for People with Disabilities

SAMHSA Eliminations:

- Mental Health Awareness Training
- Project LAUNCH
- Healthy Transitions Infant and Early
- Childhood Mental Health
- Children and Family Programs
- Interagency Task Force on Trauma Informed Care
- MH System Transformation and Health Reform
- Crisis Response Grants
- Criminal and Juvenile Justice Programs
- Primary and Behavioral Health Integration (including TA)
- Tribal Behavioral Health Grants
- Minority Fellowship Program MH
- Homeless Prevention Programs (including TA)
- Consumer and Family Network Grants
- Minority AIDS Initiative Assertive
- Community Treatment for Individuals with SMI
- Seclusion and Restraint
- Minority Fellowship Program
- Tribal Behavioral Health
- Minority AIDS Initiative
- Strategic Prevention Framework
- STOP Act Pregnant and Post-partum Women
- Improving Access to Overdose Treatment
- Criminal Justice Activities
- Overdose Prevention (naloxone)
- First Responder Training (naloxone)
- Peer Support Assistance Center
- Emergency Department Alternatives to Opioids
- Comprehensive Opioid Recovery Centers
- Screening, Brief Intervention, and Referral to Treatment
- Children and Families

Pre-decisional

Department of Health and Human Services (HHS) 2026 Discretionary Budget Passback

April 10th, 2025

OVERVIEW

President Trump has committed to balancing the budget while providing adequate funding for critical nondefense discretionary priorities—securing our borders, caring for our veterans, and continued infrastructure investment. Reaching balance requires: resetting the proper balance between Federal and State responsibilities with a renewed emphasis on federalism; eliminating the Federal Government's support of woke ideology; protecting the American people by deconstructing a wasteful and weaponized bureaucracy; and identifying and eliminating wasteful spending.

Passback levels reflect the reforms necessary to enable agencies to fulfill their statutory responsibilities in the most cost-effective manner possible. Many difficult decisions were necessary to reach the funding level provided in this Passback.

OMB looks forward to working with you as we finalize the FY 2026 President's Budget request.

Pay Adjustment

FY 2026 Passback levels reflect a pay freeze for civilian employees and a 3.8 percent military pay increase for military personnel in calendar year 2026.

Overseas Building Operations

The FY 2026 Budget will request a $2.2 billion investment in the Department of State's Capital Security Cost Sharing (CSCS) and Maintenance Cost Sharing (MCS) programs. This amount includes contributions from the Department of State and other agencies with staff under the authority of the Chief of Mission overseas. Agencies with staff in diplomatic facilities overseas that pay into the CSCS-MCS programs should contact their OMB Representative for the final FY 2026 agency allocations based on the OMB Passback level.

GSA Technology Transformation Services

OMB Passback for HHS includes $1,571,602 for agency contributions to the Technology Transformation Services reimbursable program in alignment with the FY 2025 full-year CR. The FY 2026 Budget contributions will continue to support GSA's shared technology programs. These technology programs are well-suited for a reimbursable model as they provide direct benefits to agencies that are, in most cases, required to use the programs through statute and OMB policy. For any questions, agencies may contact FCSFagencycollections@gsa.gov.

Federally Funded Research & Development Center (FFRDC) Compensation Reimbursement Cap

Passback directs agencies to cap reimbursement of direct costs of compensation for employees at all Federally Funded Research and Development Centers (FFRDCs) to no more than the President's salary ($400,000 per year) or the limit set by Section 702 of the Bipartisan Budget Act of 2013 (BBA; P.L. 113-67), whichever is lower. The cap set by the BBA allows the heads of agencies to establish exceptions for scientists, engineers, or other specialists; the new cap for FFRDCs directed by Passback does not allow such exceptions. The new cap should be implemented at the next appropriate opportunity to update the contract or other agreement establishing the FFRDC. By May 30, 2025, agencies should provide their RMO Representative with their strategy for implementing this cap.

Further, by April 30, 2025, agencies that fund FFRDCs should submit to their RMO Representative a list of all current exceptions to the current BBA cap mentioned above and the actual reimbursement paid to each individual whose reimbursable salary is above the current cap.

Indirect Cost Policy Changes Associated with Uniform Grants Guidance

The FY 2026 Budget assumes that OMB will be updating its indirect cost policy in 2 CFR 200, also known as the "Uniform Grants Guidance," to close loopholes, decrease complexity, increase transparency, and ultimately cap recoverable costs. Agency budget documents and materials, as appropriate, should acknowledge this change.

Title 42 Annual Pay Cap

The Budget establishes a cap on annual total compensation for employees hired under Title 42 authority (42 U.S.C. 209(f)) at $235,100 per year. HHS should develop legislative language for OMB review to prepare for a potential transmittal to Congress.

PHS Evaluation Tap

The Budget assumes a PHS Evaluation tap of 2.5 percent and allocates this funding within CDC, NIH, GDM, the Administration for a Health America (AHA), and the Assistant Secretary for Strategy. The Budget assumes all programs currently authorized by the Public Health Service Act and funded for 2026 will be reauthorized and tapped under the new HHS organization structure.

Account Flexibility

The Budget policy provides HHS flexibility to allocate administrative dollars appropriately to support the reorganization.

Ending the HIV Epidemic Initiative The Budget eliminates HHS funding for the Ending the HIV Epidemic (EHE) Initiative.

HHS Funding by Operating Division (dollars in millions)		
Operating Division		**2026 Budget**
Administration for a Healthy America	BA	14,059.404
AHA PL	PL	*19,804.203*
Food and Drug Administration	BA	2,926.866
FDA PL	PL	*6,515.261*
Health Resources and Services Administration	BA	0
Indian Health Service	BA	6,001.000
Centers for Disease Control and Prevention	BA	4,979.625
CDC Discretionary PL	PL	*5,184.625*
National Institutes of Health	BA	26,676.690
Substance Use and Mental Health Services Administration	BA	0
Agency for Healthcare Research and Quality	BA	0
Centers for Medicare and Medicaid Services	BA	4,137.980
Administration for Children and Families	BA	16,208.980
Administration for Community Living	BA	0
General Departmental Management	BA	297.442
Assistant Secretary for External Affairs (non-add)	*BA*	*36.160*
Assistant Secretary for Enforcement	BA	241.241
Assistant Secretary for Innovation	BA	3,235.812
Assistant Secretary for Strategy	BA	239.530
Strategy PL	PL	*282.773*
Assistant Secretary for Consumer Product Safety	BA	135.000
Office for Civil Rights	BA	0

Assistant Secretary for Technology Policy	BA	0
ASTP PL	PL	*0*
Medicare Hearings and Appeals	BA	0
Program Support Center: Medicare Eligible Retiree Accrual	BA	41.924
Office of Inspector General	BA	87.000
Administration for Strategic Preparedness and Response	BA	0
HHS Closeout Costs	BA	200.000
HCFAC Base & Cap	PL	941.000
NEF Cancellation	BA	0
Total HHS BA[1]		**80,409.494**
Total PHS Evaluation Fund[2]		**821.492**
Total Prevention and Public Health Fund		0

1/ The total does not include funding for NIH CURES, MedPAC, or resources from the Department of Justice and U.S. Courts Vaccine Injury Compensation Trust Fund.

2/ The 2026 Budget assumes a 2.5 percent PHS Evaluation tap and allocates this funding within CDC, NIH, GDM, AHA, and the Assistant Secretary for Strategy.

ADMINISTRATION FOR A HEALTHY AMERICA

Summary

The tables below summarize the 2026 Budget.

Administration for a Healthy America ($, millions)	
	2026 Budget
AHA Policy, Research, and Evaluation, BA	$737.995
AHA Policy, Research, and Evaluation, PL	$945.220
Surgeon General (Immediate Office of ASH and SG activities), BA	$28.588
Surgeon General (Immediate Office of ASH and SG activities), PL	$33.473
Primary Care, BA	$2,728.562
Primary Care, PL	$6,988.562
Maternal and Child Health, BA	$1,094.656
Maternal and Child Health, PL	$1,713.606
Mental Health, BA	$5,607.216
Mental Health, PL	$5,707.455
Environmental Health, BA	$826.950
Environmental Health, PL	$826.950
HIV/AIDS, BA	$2,340.117
HIV/AIDS, PL	$2,340.117
Health Workforce, BA	$695.320
Health Workforce, PL	$1,248.820
AHA TOTAL, BA	**14,059.404**
AHA TOTAL, PL	**19,804.203**

Administration for a Healthy America: Policy, Research, and Evaluation

The tables below summarize the 2026 Budget for AHA Policy, Research, and Evaluation.

The President's Make America Healthy Again (MAHA) Commission is tasked with investigating and addressing the root causes of America's escalating health crisis, with an initial focus on childhood chronic diseases. The Budget includes $500 million in AHA Policy, Research, and Evaluation, to be allocated by the Secretary, for activities that support the Administration's MAHA initiative. To the extent possible, funds should align with the Commission's priorities and recommendations. By April 15th, please provide an allocation of the $500 million.

AHA Policy, Research, and Evaluation ($, millions)	**2026 Budget**
Health Surveillance and Statistics	
National Center for Health Statistics (Formerly in CDC), BA	$0.000
PHS Evaluation (non-add)	*$175.297*
National Center for Health Statistics, PL	$175.297
Substance Abuse and Mental Health Surveillance (Formerly in SAMHSA), BA	$20.195
PHS Evaluation (non-add)	*$30.428*
Substance Abuse and Mental Health Surveillance, PL	$50.623
Drug Abuse Warning Network (Formerly in SAMHSA)	$0.000
Behavioral Health Workforce Data and Development (Formerly in SAMHSA)	
PHS Evaluation (non-add)	*$0.000*
SAMHSA Data Request and Publication User Fees (non-add)	$1.500
Total Health Surveillance and Statistics, BA	**$20.195**
Total Health Surveillance and Statistics, PL	**$227.420**
Substance Abuse and Mental Health Public Awareness and Support (Formerly in SAMHSA)	$5.000
Substance Abuse and Mental Health Performance and Quality Information Systems (Formerly in SAMHSA)	$10.200
Program Management and Support (Formerly in HRSA and SAMHSA)	$202.600
Earmarks (Formerly in HRSA and SAMHSA)	$0.000
MAHA Activities to be allocated by the Secretary	$500.000
AHA Policy, Research, and Evaluation, BA	**$737.995**
AHA Policy, Research, and Evaluation, PL	**$945.220**

Administration for a Healthy America: Surgeon General

The table below includes a proposed allocation for the 2026 Budget for the Office of Surgeon General to continue its management of the U.S. PHS Commissioned Corps, and other programs/activities as the Nation's Doctor, providing Americans with the best scientific information available on how to improve their health and reduce the risk of illness and injury. Please let us know by April 24, if HHS suggests a different allocation for this Office.

Surgeon General ($, millions)	**2026 Budget**
Program Support	28.588
Evaluation and Planning (PHS Eval)	4.885
Total, Surgeon General, Program Level	**33.473**

Administration for a Healthy America: Primary Care

The tables below summarize the 2026 Budget for AHA Primary Care.

Health Centers

The Budget extends mandatory funding for Health Centers through 2026. The Budget will propose two new policies related to Health Center funding in 2026:

1. HHS will establish a process to update Medically Underserved Area and Medically Underserved Population designations to ensure that health centers grantees are continuing to serve as a safety net for low-income and medically underserved communities.
2. Health Center Program grant terms and conditions for health centers participating in the 340B Program should require that patients at or below 200 percent of the Federal Poverty Level be charged no more than the 340B price plus a dispensing fee for drugs purchased under the 340B Program.

National Center for Injury Prevention and Control (NCIPC) (formerly in CDC)

The Budget consolidates the Domestic Violence and Sexual Violence, Domestic Violence Community Projects, and Rape Education and Prevention programs into a single grant program. The Budget includes funding for Suicide Prevention, Opioid Overdose Prevention and Surveillance, and the National Violent Death Reporting System programs. Funding for all other NCIPC programs is discontinued.

Primary Care **Budget Authority ($, millions)**	**2026 Budget**
Primary Care (Formerly in HRSA)	
Health Centers	$1,580.522
Federal Tort Claims Act	$120.000
Health Centers Subtotal	$1,700.522
Free Clinics Medical Malpractice	$1.000
Primary Care Subtotal	$1,701.522
Healthcare Systems (Formerly in HRSA)	
C.W. Bill Young Cell Transplantation Program (Bone Marrow)	$33.009
National Cord Blood Inventory	$8.266
Organ Transplantation	$54.049
Hansen's Disease Center	$13.706
Payment to Hawaii	$1.857
Healthcare Systems, Subtotal	$110.887

Office of Rural Health (Formerly in HRSA)	
Outreach Grants	$100.975
Policy Development (Rural Health Research)	$11.076
Black Lung Clinic	$12.190
Radiogenic Diseases	$1.889
Rural Communities Opioids Response Program (RCORP)	$145.000
Office of Rural Health, Subtotal	$271.130
Office for the Advancement of Telehealth (Formally in HRSA)	$42.050
Office of Disease Prevention and Health Promotion (Formerly in OASH)	$7.894
Office of Minority Health (Formerly in OASH)	$45.000
National Center for Injury Prevention and Control (Formerly in CDC)	
Suicide Prevention	$12.000
Consolidated DV, SV, DELTA, and Rape Prevention/Edu Grant	$38.000
Opioid Overdose Prevention and Surveillance	$475.579
NVDRS	$24.500
Subtotal, National Center for Injury Prevention and Control, BA	$550.079
Total Primary Care, Discretionary BA	**$2,728.562**
Total Primary Care, Discretionary, PL	**$2,728.562**
Health Centers (Formerly in HRSA)	**$4,260.00**
Total Primary Care, PL	**$6,988.562**

AHA Primary Care Program Eliminations
Rural Hospital Flexibility Grants
State Offices of Rural Health
Rural Residency Development Program
At-Risk Rural Hospitals Program Grants
Family Planning
Hansen's Disease Facilities
Youth Violence Prevention
Adverse Childhood Experiences (ACEs)
Firearm Injury and Mortality Prevention Research
Traumatic Brain Injury (TBI) (formerly in CDC)
Drowning
Elderly Falls (formerly in CDC)
Other Injury Prevention Activities
Injury Control Research Centers

Administration for a Healthy America: Maternal and Child Health

The tables below summarize the 2026 Budget for AHA Maternal and Child Health.

The Budget extends mandatory funding for Family-to-Family Health Information Centers through 2026. The Budget reallocates $10 million in Title V SPRANS funding for Minority Serving Institutions to the Title V State Block Grant awards.

AHA Maternal and Child Health Budget Authority ($, millions)	**2026 Budget**
Maternal and Child Health (Formerly in HRSA)	
Maternal and Child Health Block Grant	$813.700
State Block Grant Awards (non-add)	$603.308
Special Projects of Regional and National Significance (SPRANS) (non-add)	$200.116
Community Integrated Service Systems (CISS)	$10.276
Alliance for Innovation in Maternal Health	$15.300
Integrated Services for Pregnant and Postpartum Women	$10.000
Maternal Health Hotline	$7.000
Screening for Maternal Depression	$11.000
Pediatric Mental Health Care Access	$13.000
Poison Control Centers	$26.846
Subtotal, Maternal Child Health Programs, BA	**$896.846**
Birth Defects, Developmental Disabilities, Disability & Health (Formerly in CDC)	
Birth Defects	$19.000
Fetal Death	$0.900
Fetal Alcohol Syndrome	$11.000
Folic Acid	$3.150
Infant Health	$8.650
Autism	$23.100
Disability Health (Child Development Studies)	$36.000
Tourette Syndrome	$2.000
Early Hearing Detection and Intervention	$10.760
Muscular Dystrophy	$6.000
Attention Deficit Hyperactivity Disorder	$1.900
Fragile X	$2.000
Spina Bifida	$7.000
Congenital Heart Failure	$7.000
Hemophilia	$8.600

Public Health Approaches to Blood Disorders	$6.400
Thalassemia	$2.100
Neonatal Abstinence Syndrome	$2.250
Surveillance for Emerging Threats to Mothers and Babies	$10.000
Subtotal, Birth Defects and Developmental Disabilities, BA	**$167.810**
Office on Women's Health (Formerly in OASH)	$30.000
Total Maternal and Child Health, Discretionary, BA	**1,094.656**
Mandatory	
Family-to-Family Health Information Centers (Formerly in HRSA)	$6.000
Maternal, Infant, and Early Childhood Home Vesting Program (Formerly in HRSA)	$612.950
Total Maternal and Child Health, PL	**1,713.606**

AHA Maternal and Child Health Program Eliminations
Autism and Other Disorders
Healthy Start
Newborn Screening for Heritable Disorders
Sickle Cell Service Demonstrations
Universal Newborn Hearing Screening
EMS for Children
Title V Block Grant - Minority Serving Institutions (Consolidation)
Teen Pregnancy Prevention (TPP) program (Formerly in GDM)
Office of Population Affairs (Formerly in OASH)
Embryo Adoption Awareness Campaign (Formerly in GDM)

Administration for a Healthy America: Mental Health

The tables below summarize the 2026 Budget for AHA Mental Health.

The Budget funds the 988 Suicide Prevention and Crisis Lifeline at 2024 Enacted levels. The Budget maintains the $10 million for specialized services for Spanish speakers seeking access to 988 services through texts or chats and eliminates the 2024 Congressionally-directed set-aside within the 988 for Specialized Services for LGBTQ+ Youth. By April 15, please provide a proposed allocation of 988 funding.

The Budget does not include funding for the LBG Center of Excellence, the African American Behavioral Health Center of Excellence, the Asian American, Native Hawaiian, and Pacific Islander Behavioral Health Center of Excellence, Hispanic/Latino Behavioral Health Center of Excellence, and LGBTQ Youth Family Support Program.

AHA Mental Health **Budget Authority ($, millions)**	**2026 Budget**
Mental Health (Formerly at SAMHSA)	
Programs of Regional & National Significance (PRNS)	
Capacity	
Project AWARE	$120.501
Suicide Activities	
988 Suicide and Crisis Lifeline	$519.618
National Strategy for Suicide Prevention	$28.200
GLS Youth Suicide Prevention-States	$43.806
GLS Youth Suicide Prevention-Campus	$8.488
GLS Youth Suicide Prevention-Resource Center	$11.000
AI/AN Suicide Prevention	$3.931
Subtotal Suicide	$615.043
Subtotal, Capacity, BA	$735.544
Science to Service	
Practice Improvement and Training	$7.828
Consumer and Consumer Supported Technical Assistance Centers	$1.918
Disaster Response	$1.953
Subtotal, Science to Service, BA	$11.699
Total Mental Health PRNS, BA	$747.243

Children's Mental Health Services	$130.000
Projects for Assistance in Transition from Homelessness	$66.635
Protection and Advocacy for Individuals with Mental Illness	$14.146
National Child Traumatic Stress Initiative	$98.887
Assisted Outpatient Treatment	$21.420
Community Mental Health Services Block Grant (MHBG)	$986.532
PHS Evaluation Funds (non-add)	*$21.039*
MHBG, PL	$1,007.571
Total Mental Health, BA	**$2,064.863**
Total Mental Health, PL	**$2,085.902**
Substance Abuse Treatment (Formerly at SAMHSA)	
Programs of Regional & National Significance (PRNS)	
Capacity	
Opioid Treatment Program and Regulatory Activities	$10.724
Subtotal, Capacity, BA	$10.724
Science to Service	
Addiction Technology Transfer Centers	$9.046
Subtotal, Science to Service, BA	$9.046
Total Substance Abuse Treatment PRNS, BA	$19.770
Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) BA	$1,928.879
PHS Evaluation Funds (non-add)	*$79.200*
SUBG, PL	$2,008.079
State Opioid Response Grants	$1,575.000
Total Substance Abuse Treatment, BA	**$3,523.649**
Total Substance Abuse Treatment, PL	**$3,602.849**
Substance Abuse Prevention (Formerly at SAMHSA)	
Programs of Regional & National Significance (PRNS)	
Capacity	
Federal Drug Free Workplace	$5.139
Subtotal, Capacity, BA	$5.139

Science and Service	
Center for the Application of Prevention Technologies	$9.493
Science and Service Program Coordination	$4.072
Subtotal Substance Abuse Treatment PRNS, BA	$13.565
Total Substance Abuse Treatment PRNS, BA	$18.704
Total Substance Abuse Prevention, BA	**$18.704**
Total Substance Abuse Prevention, PL	**$18.704**
AHA Mental Health, BA	**$5,607.216**
AHA Mental Health, PL	**$5,707.455**

AHA Mental Health Program Eliminations

Mental Health PRNS Eliminations

- Mental Health Awareness Training
- Project LAUNCH
- Healthy Transitions
- Infant and Early Childhood Mental Health
- Children and Family Programs
- Interagency Task Force on Trauma Informed Care
- MH System Transformation and Health Reform
- Crisis Response Grants
- Criminal and Juvenile Justice Programs
- Primary and Behavioral Health Integration (Including TA)
- Tribal Behavioral Health Grants
- Minority Fellowship Program MH
- Homeless Prevention Programs (Including TA)
- Consumer and Family Network Grants
- Minority AIDS Initiative

- Assertive Community Treatment for Individuals with SMI
- Seclusion and Restraint

Substance Abuse Prevention PNRS Eliminations

- Minority Fellowship Program
- Tribal Behavioral Health
- Minority AIDS Initiative
- Strategic Prevention Framework
- STOP Act

Substance Abuse Treatment PNRS Eliminations

- Pregnant and Post-partum Women
- Improving Access to Overdose Treatment
- Criminal Justice Activities
- Overdose Prevention (naloxone)
- First Responder Training (naloxone)
- Peer Support Assistance Center
- Emergency Department Alternatives to Opioids
- Comprehensive Opioid Recovery Centers
- Screening, Brief Intervention, and Referral to Treatment
- Children and Families
- Minority Fellowship Program
- Treatment, Recovery, and Workforce Support
- Building Communities of Recovery
- Recovery Community Services Program
- Treatment Systems for Homelessness
- Minority AIDS Initiative
- Targeted Capacity Expansion
- Youth Prevention and Recovery Initiative

Other Eliminations

- Certified Community Behavioral Health Centers (CCBHCs)

Administration for a Healthy America: Environmental Health

The tables below summarize the 2026 Budget for AHA Environmental Health.

National Center for Environmental Health (NCEH) (formerly in CDC)

The Budget includes funding Environmental Health Laboratory, All Other Environmental Health, and Safe Water programs. Funding for all other NCEH programs is discontinued.

National Institute for Occupational Safety and Health (NIOSH) (formerly in CDC)

The Budget includes funding for Firefighter Cancer Registry and National Mesothelioma Registry & Tissue Bank as well as the World Trade Center Health and the Energy Employees Occupational Illness Compensation Program Act mandatory programs. Funding for all other NIOSH programs is discontinued.

National Institute of Environmental Health Sciences (NIEHS) (formerly in NIH)

The Budget includes funding for NIEHS within the newly created AHA: Environmental Health.

AHA Environmental Health Budget Authority ($, millions)	**2026 Budget**
Agency for Toxic Substances and Disease Registry (Formerly in CDC), BA	$78.000
National Center for Environmental Health (Formerly in CDC)	
Environmental Health Laboratory	$70.750
Environmental Health Activities	$25.600
All Other Environmental Health (non-add)	*$17.00*
Safe Water (non-add)	*$8.600*
Subtotal, NCEH, BA	**$96.350**
National Institute for Occupational Safety and Health (Formerly in CDC)	
Firefighter Cancer Registry	$5.500
National Mesothelioma Registry & Tissue Bank	$1.200
Subtotal, NIOSH, BA	**$6.700**
National Institute for Environmental Health Sciences (Formerly in NIH)	
NIEHS, LHHS	$594.086
NIEHS, Interior	$51.814
Subtotal, NIEHS BA	**$645.900**

Total Environmental Health BA	**$826.950**
Total Environmental Health PL	**$826.950**

AHA Environmental Health Program Eliminations

NCEH Eliminations (formerly in CDC)

- Amyotrophic Lateral Sclerosis Registry (ALS)
- Climate and Health
- Environmental & Health Outcome Tracking Network Asthma
- Childhood Lead Poisoning
- Lead Exposure Registry

NIOSH Eliminations (formerly in CDC)

- Education and Research Centers
- Personal Protective Technology
- National Occupational Research Agenda (NORA)
- Mining Research
- Other Occupational Safety and Health Research (Total Worker Health)

Administration for a Healthy America: HIV/AIDS

The tables below summarize the 2026 Budget for AHA Health Workforce.

AHA HIV/AIDS **Budget Authority ($, millions)**	**2026** **Budget**
Ryan White HIV/AIDS Program (Formerly in HRSA)	
Emergency Relief (Part A)	680.752
Comprehensive Care (Part B)	$1,364.878
Base formula grants to States (non-add)	$464.565
AIDS Drug Assistance Program (non-add)	$900.313
Early Intervention (Part C)	$208.970
Children, Youth, Women, & Families (Part D)	$77.935
Subtotal, Ryan White HIV/AIDS	$2,332.535
Office of Infectious Disease and HIV/AIDS Policy (Formerly in OASH)	$7.582
Total HIV/AIDS BA	**$2,340.117**
Total HIV/AIDS PL	**$2,340.117**

AHA HIV/AIDS Program Eliminations
• Ryan White HIV/AIDS Ryan White Dental Services Ryan White Education and Training Centers Ryan White Special Projects of National Significance (SPNS) Ryan White Ending HIV Epidemic • Secretary's Minority HIV/AIDS Fund (Formerly in GDM)

Administration for a Healthy America: Health Workforce

The tables below summarize the 2026 Budget for AHA Health Workforce.

Mandatory Funding: The Budget extends mandatory funding for the National Health Service Corps (NHSC) and Teaching Health Centers GME (THCGME) through 2026.

AHA Health Workforce Budget Authority ($, millions)	**2026 Budget**
Health Workforce (Formally in HRSA)	
National Health Service Corps	$128.600
Nursing Workforce Development	
NURSE Corps	$92.635
Subtotal, Nursing	$92.635
Training for Diversity	
Centers of Excellence	$28.422
Subtotal, Training for Diversity	$28.422
Interdisciplinary and Community-Based Linkages	
Substance Use Disorder Treatment and Recovery Loan Repayment Program	$40.000
Subtotal, Interdisciplinary and Community-Based Linkages	$40.000
Public Health Workforce Development	
Health Professions Workforce Information and Data Analysis	$5.663
Children's Hospital GME	$390.000
Pediatric Subspeciality Loan Repayment Program	$10.000
Total Health Workforce, Discretionary	**$695.320**
User Fees	
Data Banks	$33.500
Total Health Workforce, Discretionary Program Level	**$728.820**
Mandatory Funding	
National Health Service Corps	$345.000

Teaching Health Centers GME	$175.000
Total Health Workforce, Program Level	**$1,248.820**

AHA Health Workforce Program Eliminations
• Scholarships for Disadvantaged Students • Faculty Loan Repayment • Health Careers Opportunity Programs • Area Health Education Centers • Geriatric Programs • Mental and Behavioral Health Education and Training • Behavioral Health Workforce Education and Training • Public Health Workforce Development • Primary Care Training and Enhancement • Training in Oral Health • Advanced Education Nursing • Nurse Practitioner Optional Fellowship Program • Nursing Workforce Diversity • Nurse Education, Practice, and Retention • Nurse Faculty Loan Program • Medical School Education

FOOD AND DRUG ADMINISTRATION (FDA)

The attached table summarizes the Budget for FDA. The 2026 Budget will include the following budget and legislative policies.

Routine Food Facility Inspections

The Budget eliminates FDA's direct role in routine inspections of food facilities. FDA will expand the current state contracts for routine food facility inspections program to cover 100 percent of all routine foods. HHS will submit an implementation plan that includes timeframes by state no later than May 1, 2025.

Food Safety

The Budget will include short- and long-term administrative actions to strengthen and streamline FDA's regulatory oversight of food programs, so chemicals and other additives in food and food packaging can be expeditiously removed from our food supply.

Medical Product Review

The Budget provides sufficient budget authority levels to meet statutory requirements necessary for FDA to collect medical product user fees in support of its premarket review activities.

Food and Drug Administration 2026 Budget ($ in Millions)	
	2026 Budget
Foods	1,002.161
Human Drugs	575.632
Biologics	213.704
Animal Drugs	183.490
Medical Devices	449.501
NCTR	62.004
Headquarters/OC	157.099
Other Rent & Rent Related	108.415
White Oak	41.998
GSA Rent BA	132.863
Subtotal, S&E	**2,926.866**
Buildings and Facilities	0.000
Subtotal, BA	**2,926.866**
21st Century Cures Act	*0.000*
Transfer to OIG	*0.000*
Total, BA	**2,926.866**
Current Law, User Fees	**3,588.395**
PDUFA	1,543.267
MDUFA	445.807
MQSA (Indefinite)	19.758
ADUFA	34.143
AGDUFA	26.502
Biosimilar User Fee Act	55.731
Generic Drug User Fee Act	665.439
Export Cert (perm. Indefinite)	5.185
Cert Fund/FOIA (Indefinite)	11.109
Tobacco	712.000
Food Reinspection fee	7.907
Voluntary Importer program	6.536
Food and Feed Recall fee	1.769
Outsourcing (Pharmacy Compounding)	1.874
Third Party Auditor	0.878
Priority Review Voucher: Tropical diseases	3.030
Priority Review Voucher: Pediatric diseases	9.479
Priority Review Voucher: Medical Countermeasures	0.000
Over-the-counter monograph fee	37.981
TOTAL Program Level	**6,515.261**

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

For HRSA, see Administration for a Healthy America, CMS for the Office of Pharmacy Affairs, and the Assistant Secretary for Enforcement for Injury Compensation Programs for these activities.

INDIAN HEALTH SERVICE (IHS)

Advance Appropriation (AA):
Language changes in the Budget will allow AA to be used for the following IHS Programs, Projects, or Activities (PPA) that do not currently receive AA: Electronic Health Records, the Indian Health Care Improvement Fund, Sanitation Facilities Construction, and Health Care Facilities Construction. The Budget will also rescind $897 million of the FY 2026 advance appropriation: -$735 million from the Services account and -$162 million from Facilities.

The 2026 Budget will not include an AA for FY 2027.

See Table 1 for high-level allocations.

Services:
Across the Services account, there is no funding for new grants, scholarships, or loan repayment recipients, only continuations. This includes not awarding any Joint Venture Construction Project from Traditional and Long-Term Care notices of funding announcements.

Any funding from the AA that was expected to go to Preventive Services and other eliminated activities, should be redirected to the Clinical Services PPA.

New Tribes are funded at $6 million.

Facilities:
Programmatic funding is eliminated for Sanitation Facilities Construction (SFC) in FY 2026. IHS has Infrastructure Investment and Jobs Act balances available through FY 2026 for these activities. FTE and support services are maintained to administer these SFC funds.

There are no funds to begin construction of new facilities projects and only funding to continue progress on facility construction projects that have already started.

Please include Table 2 as part of IHS' Congressional Justification submission for construction projects receiving funds in FY 2026 and show the per project anticipated total costs, how much has been obligated to date, and how much is left to be funded after FY 2026.

Table 2

$ in millions	FY Project Construction Started	Anticipated FY Project will be Completed	Anticipated Total Project Funding Level across FYs	Project's Obligations Pre-FY 2025	Anticipated Project's FY 2025 Obligations	Anticipated Projects FY 2026 Obligations
Project A						
Project B						

Contract Support Costs (CSC):
The CSC estimate in the table below reflects the *Becerra v. San Carlos Apache Tribe* decision and a lower level of CSC funding consistent with an overall decrease in the IHS topline. IHS should provide to OMB an updated CSC estimate for FY 2026 if these estimates are different from the level below.

Section 105(l) Leases:
IHS estimates that Lease payments will total at least $413 million in FY 2025. The Budget assumes this same level for Leases in FY 2026.

Special Diabetes Program for Indians (SDPI):
The Budget proposes to extend SDPI for one year at the FY 2025 annualized rate ($159 million).

Table 1: IHS FY 2026 All Purpose Table

All Purpose Table **Indian Health Service** *(Dollars in Millions)*			
	FY 2026 Advance Appropriation	**Rescission of the FY 2026 Advance Appropriation**	**2026 Discretionary Budget Request**
Clinical Services			3,823.812
Preventive Health			0.000
Other Services			163.921
Tribal Management Grants			*0.000*
Self-Governance			*0.000*
SERVICES, TOTAL	**4,722.738**	(735.005)	**3,987.733**
Maintenance & Improvement			41.000
Sanitation Facilities Construction			15.000
Health Care Facilities Construction			50.000
Facilities & Environ Health Support			210.413

Equipment			32.598
FACILITIES, TOTAL	**510.774**	(161.763)	**349.011**
CONTRACT SUPPORT COSTS, TOTAL			**1,251.000**
SECTION 105(*l*) LEASES			**413.000**
IHS, TOTAL	**5,233.512**	**(896.768)**	**6,000.744**

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

The attached table summarizes the Budget for CDC.

Reforming and Restructuring CDC

The Budget reforms the Centers for Disease Control and Prevention to refocus CDC on emerging and infectious disease surveillance, outbreak investigations, preparedness and response, and maintaining the Nation's public health infrastructure. The Budget includes funding to support NSC's Biothreat Radar Detection System. The Budget also discontinues funding for the Emerging Infectious Diseases and Preventing Chronic Disease monthly peer-reviewed journals. Funding for the Morbidity and Mortality Weekly Report is maintained.

Prevention and Public Health Fund (PPHF)

The Budget eliminates the PPHF. With the exception of the Immunization Program, all other CDC PPHF-funded programs are discontinued. The Budget funds the Immunization Program with discretionary budget authority. More information is provided in the table below.

PHS Evaluation Fund (PHS Eval)

The Budget provides $205 million from the PHS Evaluation Fund to support the following programs:

- Data Modernization ($100M)
- HHS Protect/RREDI ($55M)
- Center for Forecasting and Outbreak Analytics (CFA) ($50M)

Biothreat Radar Detection System

In coordination with NSC, the Budget establishes a new biodetection system that can rapidly detect novel pathogens with 24-hour turnaround times. Unlike many of the USG's current biosurveillance systems, the proposed biodetection system would be pathogen agnostic. The new surveillance system consists of four components across DoD and HHS/CDC. Of the four components, three are in CDC: Advanced Molecular Detection (AMD), Traveler Genomic Surveillance (TGS), and HHS Protect/RREDI. The Budget includes $52 million for these activities across AMD and TGS.

- **Clinical Metagenomic Surveillance (AMD) ($26 million):** The Biothreat Radar will build upon CDC's recently launched pilot program through the AMD program that implements metagenomic sequencing on pooled, PCR-negative respiratory samples from major commercial laboratories. The pilot program will be expanded to routinely conduct metagenomic surveillance on pooled clinical samples for an up-to-date snapshot of all pathogens in the U.S. patient population, with the goal of detecting a novel pathogen before it reached 0.017% of the U.S. population.

- **Traveler Metagenomic Surveillance (Quarantine) ($26 million):** The Biothreat Radar will expand the Traveler Genomic Surveillance program in the Quarantine PPA to conduct daily metagenomic surveillance on airplane wastewater samples and nasal swabs at 16 major airports, with the goal of detect novel pandemic pathogens before they infected 0.086% of the air traveler population.

- **Integrated Data Platforms/Systems (HHS/CDC, DOD, IC) (No additional funds needed):** The Biothreat Radar will leverage HHS Protect/RREDI alongside other USG platforms to track baseline pathogen levels, detect anomalies, support attribution using classified signature libraries and Artificial Intelligence-enabled algorithms, and request follow up data collection when an alert or flag is found in the data.

National Center for Viral Hepatitis, STD, and TB Prevention

The Budget eliminates funding for the Ending the HIV Epidemic Initiative and CDC Domestic HIV/AIDS Prevention and Surveillance activities. The Budget gives states more flexibility to address local needs by consolidating funding for Infectious Disease and Opioids, Viral Hepatitis, Sexually Transmitted Infections, and Tuberculosis programs into one grant program.

National Center for Emerging and Zoonotic Infectious Diseases

The Budget discontinues funding for the Lyme Disease, Prion Disease, Chronic Fatigue Syndrome, and the Harmful Algal Bloom programs to prioritize funding for core infectious disease and surveillance activities. The Budget also includes $25 million for the wastewater surveillance program within the Emerging Infectious Diseases PPA.

National Center for Chronic Disease Prevention and Health Promotion

The Budget eliminates the National Center for Chronic Disease Prevention and Health Promotion and all of the funding for programs in this Center.

National Center for Birth Defects and Developmental Disabilities

Please see the AHA Maternal Health section.

National Center for Environmental Health

Please see the AHA Environmental Health section.

National Center for Injury Prevention and Control

Please see the AHA Primary Care section.

National Institute for Occupational Safety and Health

Please see the AHA Environmental Health Section.

National Center for Health Statistics

Please see the AHA Policy, Research, and Evaluation Section.

Global Health Center

The Budget eliminates GHC. The Department has discretion to determine where to move the continuing Global Disease Detection and Other Programs PPA within CDC. Funding for all other GHC programs is discontinued.

Center for Preparedness and Response

The Budget eliminates CDC's Office of Readiness and Response and establishes the Center for Preparedness and Response. The Budget moves the CDC Preparedness and Response PPA to the newly established Center. The Budget moves the following programs from the Administration for Strategic Preparedness and Response to this new Center:

- **Program Management and Operations**. The Budget consolidates the following PPAs and all CPR salaries and expenses into a new line: Preparedness and Emergency Operations, Policy and Planning, and Operations. Please provide an allocation of funding across the aforementioned programs and an updated estimate for salaries and expenses for all programs in this Center (not including CDC Preparedness and Response) in 2026 by April 15, 2025. CDC should work toward consolidating all Center salaries and expenses into this line.

- **Strategic National Stockpile**. The Budget directs SNS to sell surplus supplies consistent with the authority provided in the PREVENT Pandemics Act. Please provide an estimate for anticipated warehousing and disposal costs for 2025 and 2026 in the Congressional Justification.

- **Health Care Readiness and Recovery**. The Budget eliminates the Hospital Preparedness Program Cooperative Agreement.

- **Medical Reserve Corps**. The Budget eliminates the Medical Reserve Corps.

- **HHS Coordination Operations and Response Element**. The Budget eliminates H-CORE.

- **Pandemic Preparedness and Biodefense**. The Budget includes $10 million for the Center for Industrial Base Management and Supply Chain to support end-to-end visibility of medical supply chains for priority drugs and devices.

- **Preparedness and Response Innovation**. The Budget includes $4 million to support activities that advance domestic health security.

CDC (dollars in millions)	2026 PB
Immunization and Respiratory Diseases	
Immunization, BA	681.933
AFM	-
Influenza	231.358
Subtotal, Immunization and Respiratory Diseases, BA	**913.291**
Viral Hepatitis, STD, & Tuberculosis Prevention	
2026 Consolidated Hepatitis STD, & Tuberculosis Grant	898.000
Subtotal, Viral Hepatitis, STD, & TB Prevention, BA	**898.000**
Emerging and Zoonotic Infectious Diseases	
Vector Borne Diseases	87.8170
Emerging Infectious Diseases	255.8970
Antimicrobial Resistance	197.0000
Food Safety	72.0000
National Healthcare Safety Network	24.0000
Advanced Molecular Detection	66.0000
NSC Biothreat Radar/Clinical Metagenomic Surveillance (non-add)	*26.0000*
Quarantine	79.7720
NSC Biothreat Radar/Traveler Metagenomic Surveillance (non-add)	*26.0000*
Subtotal, Emerging and Zoonotic Infectious Diseases, BA	**782.4860**
Public Health Scientific Services	
Surveillance, Epi, & Informatics	297.600

CDC (dollars in millions)	2026 PB
Public Health Data Modernization, BA	-
Public Health Data Modernization, PHS Eval	*100.000*
Public Health Data Modernization, PL	**100.000**
Advancing Laboratory Science	23.000
Public Health Workforce	56.000
Subtotal, Public Health Scientific Services, BA	**376.600**
Subtotal, Public Health Scientific Services, PHS Eval	***100.000***
Subtotal, Public Health Scientific Services, PL	**476.600**
CDC-Wide Activities and Program Support	
Public Health Leadership and Support	113.570
Infectious Diseases Rapid Response Reserve Fund	25.000
Public Health Infrastructure and Capacity	260.000
Center for Forecasting and Outbreak Analytics, PHS Eval	*50.000*
Global Disease Detection and Other Programs	293.200
HHS Protect/RREDI, BA	-
HHS Protect/RREDI, PHS Eval	*55.000*
HHS Protect/RREDI, PL	**55.000**
Subtotal, CDC-Wide Activities, BA	**691.770**
Subtotal, CDC-Wide Activities, PHS Eval	***105.000***
Subtotal, CDC-Wide Activities, PL	**796.770**
Buildings and Facilities	**40.000**
Center for Preparedness and Response/ASPR	
CDC Preparedness and Response	139.000
National Disaster Medical System	64.904
Pediatric Disaster Care Program (non-add)	*7.000*
Public Health Preparedness Equipment (non-add)	-
Mission Zero (non-add)	*4.000*
Health Care Readiness and Recovery (formerly Hospital Preparedness)	29.774
Hospital Preparedness Program (non-add)	-

CDC (dollars in millions)	2026 PB
NETEC (non-add)	*7.000*
RESPTCs (non-add)	*21.000*
CIP (non-add)	*1.774*
Medical Reserve Corps	-
Strategic National Stockpile	750.000
H-CORE	-
Pandemic Preparedness and Biodefense	10.000
Preparedness and Response Innovation (PRI)	4.000
Program Management and Operations	279.800
Subtotal, Center for Preparedness and Response, BA	**1,277.478**
Total, CDC BA	**4,979.625**
Total, CDC PHS Eval	***205.000***
Total CDC Discretionary PL	**5,184.625**
Total, ASPR BA	**1,138.478**

NATIONAL INSTITUTES OF HEALTH (NIH)

(Dollars in Millions)

Discretionary BA	**26,676.690**
21st Century Cures Act	226.000
PHS Evaluation Funds	250.000
Discretionary PL	**27,152.690**
Mandatory Diabetes[1]	159.000
Total, PL	**27,311.690**

1/ The Budget proposes to extend for one year at the 2025 annualized rate.

Maximizing the Impact of NIH Research

Eliminated Institutes and Centers

The Budget eliminates the National Institutes for Nursing Research, National Center for Complementary and Integrative Health, Fogarty International Center, and National Institute on Minority Health and Health Disparities.

Institute and Center Reorganization

The Budget reorganizes the remaining ICs into an 8 institute structure. The following ICs will be retained as currently structured: National Cancer Institute, National Institute of Allergy and Infectious Diseases, and National Institute on Aging. The remaining ICs will be restructured into new consolidated institutes: National Institute on Body Systems (NHLBI, NIAMS, NIDDK), National Institute on Neuroscience and Brain Research (NIDCR, NINDS, NEI), National Institute of General Medical Sciences (NIGMS, NHGRI, NLM, NIBIB), National Institute of Disability Related Research (NICHD, NIDCD), and National Institute of Behavioral Health (NIAA, NIDA, NIMH).

Institute and Center Moved Outside of NIH

For Advanced Research Projects Agency for Health, and National Center for Advancing Translational Sciences see Assistant Secretary for Innovation section. For National Institute of Environmental Health, see Administration for a Healthy America, Environmental Health section.

Indirect Costs

The Budget assumes that the 2025 NIH indirect cost policy that caps indirect cost rates at 15% will be continued and implemented in 2026. The Budget will propose to eliminate the General Provision that prohibits changes to NIH indirect cost policies. In addition, the Budget assumes that OMB will be updating its indirect cost policy in 2 CFR 200 to close loopholes, decrease complexity, increase transparency, and ultimately cap recoverable costs. Agency budget documents and materials, as appropriate, should acknowledge this change.

Full Funding Grants Policy
The Budget continues the 2025 policy to fully fund all new grant starts in 2026.

Alignment with Executive Orders
The Budget directs NIH to continue to comply with all Executive Orders in prioritizing extramural and intramural research projects and awards.

Buildings & Facilities.
The Budget provides $210 million in BA for B&F. OMB requests that HHS include a list of projects that will be funded in 2026 in the Congressional Justification.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

For SAMHSA, see the Administration for a Healthy America.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

For AHRQ, see the new Office of Strategy section within the Office of the Secretary.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

The below narrative/table summarizes the 2026 Budget for CMS.

Program Operations

The 2026 Budget assumes:

- Assumes comparable 1-800 Medicare Call Center average speed to answer to previous years.
- A shift from four Medicare Summary notices to three notices, annually. The Budget also assumes all associated mailing costs are financed by existing Penalty Mail resources.
- Beneficiaries will continue to receive the Medicare and You Handbook in print copy.
- Provides $48.000 million for CMS Quality Activities. Please provide a 4-year wind-down plan of CMS quality activities currently funded from discretionary CMS Program Management resources by June 27, 2025.
- Research, Demonstrations, and Evaluation funding allocation is within the Program Operations topline.
- Elimination of the following CMS activities:
    - Health Equity
    - NMEP Targeted Outreach and Enrollment
    - Discretionary IRA implementation funding

- **ACL Aging Programs (shift from ACL to CMS):** The Budget shifts ACL's aging programs to CMS. The table below shows the funding amounts associated with those programs.
    - The Budget eliminates several programs that existed within ACL, but allows states to use grant funding they receive from funded formula grant programs to provide or invest in services provided by programs that the Budget eliminates. Please work with OMB to determine whether additional flexibilities are required for CMS to carry out this Budget policy.
        - **ACL Aging Programs Eliminated**
            - Preventive Health Services
            - Elder Falls Prevention
            - Lifespan Respite Care
            - Long-Term Care Ombudsman
            - Chronic Disease Self-Management Education
            - Elder Rights Support Activities
            - Elder Justice/Adult Protective Services
        - **ACL Aging Programs Discretionary Funding Eliminated**
            - Aging and Disability Resource Centers
            - State Health Insurance Assistance Programs

  - The Budget includes a one-year extension of the Medicare Improvements for Patients and Providers Act (MIPPA) program for $50 million.

- **HRSA's Office of Pharmacy Affairs (shift from HRSA to CMS):** The Budget proposes new authority to regulate all aspects of the 340B Program and to require covered entities to report on use of 340B savings. This will enable HHS to set clear enforceable standards for participation in the 340B Program and ensure that the program is used to benefit low-income and uninsured patients of the covered entities.

CMS Digital Services Team
The 2026 Budget includes $3.000 million to support corresponding staffing costs at CMS.

Medicaid and CHIP Program Operations
The 2026 Budget includes $129.611 million for Medicaid and CHIP initiatives within the Program Operations total. This includes funding for Adult Health Quality Measures.

Survey and Certification
The 2026 Budget:

- Prioritizes mandatory Survey and Certification surveys.
- Provides the Survey and Certification program two-year funding period of availability.

Federal Exchange Funding
The 2026 Budget:

- Assumes a decline in Federal Exchange enrollment due to the expiration of the enhanced premium tax credits under current law at the end of 2025.
- Assumes a reduction in outreach and enrollment activities, including reduced funding for Exchange navigators and other enrollment assisters.
- Assumes all Federal Exchange activities are funded via user fees (FFE and Risk Adjustment), HCFAC, and Penalty Mail. The Budget includes the following General Provision:

SEC. XXX. Any assessment or user fee charged pursuant to section 1311(d)(5)(A) of the Patient Protection and Affordable Care Act credited to the "Centers for Medicare and Medicaid Services – Program Management" account shall be available for any other Federal administrative expenses the Secretary incurs for activities related to the Exchange program, in addition to any other purposes authorized by law and shall remain available until expended for the purposes described in this section.

Centers for Medicare and Medicaid Services
(Dollars in millions)

	2026 Budget
Program Operations	$ 2,962.980
ACL Aging Programs (non-add BA)	*$674.650*
HRSA's Office of Pharmacy Affairs (non-add BA)	*$12.238*
Federal Administration	$733.000
Survey and Certification	$442.000
Total CMS PM Discretionary BA	**$4,137.980**

	2026 Budget
Federal Exchange/Risk Adjustment User Fees	$2,026.000
HCFAC	$38.000
Penalty Mail	$49.000
Federal Exchange Budget Authority	$0.00
Federal Exchange Program Level	$2,113.000

ACL Aging Programs	2026 Budget
Home and Community Based Supportive Services	$410.000
Aging Network Support Activities	$13.051
Holocaust Survivor Assistance (non-add)	*$8.500*
National Eldercare Locator and Engagement (non-add)	*$2.038*
Pension Counseling and Retirement Information (non-add)	*$1.858*
National Resource Centers on Native Americans (non-add)	*$0.655*
Family Caregiver Support Services	$207.000
Native American Caregiver Support Services	$12.000
Alzheimer's Disease Supportive Services	$16.800

Prevention of Elder Abuse and Neglect	$5.000
ACL Program Administration Shift to CMS	$10.799
Total ACL Discretionary BA Shifting to CMS	**$674.650**
HCFAC Senior Medicare Patrol	$35.000
Medicare Improvements for Patients and Providers Act	$50.000
State Health Insurance Assistance Programs (non-add)	*$15.000*
Area Agencies on Aging (non-add)	*$15.000*
Aging and Disability Resource Centers (non-add)	*$5.000*
National Center on Benefits Outreach and Enrollment (non-add)	*$15.000*
Total ACL Mandatory BA Shifting to CMS	**$85.000**
Total ACL Program Level Shifting to CMS	**$754.592**

HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT (HCFAC)

The Budget includes $941 million in discretionary funding for the HCFAC account in FY 2026, the same level as authorized for FY 2025. In addition to the $311 million discretionary base funding, BBEDCA authorized a $630 million discretionary cap adjustment for FY 2025.

FY2026 HCFAC Budget Request

	FY2026 Funding Level ($ millions)
Department of Justice	132.207
Department of Health and Human Services:	
OIG	107.735
CMS	699.058
TOTAL	941.000

Note: Medicare, Medicaid, and Federal Exchange amounts are included for internal planning purposes. These allocations are based on the FY 2025 splits appropriated by Congress across CMS, HHS Office of Inspector General (OIG), and Department of Justice (DOJ).

Cost Report Auditing

In 2014, pursuant to the Patient Protection and Affordable Care Act (PPACA), Medicare implemented base-payment reductions in its Home Health Prospective Payment System (PPS) to address overpayments for home health services. The amount by which CMS rebased the Home Health PPS was determined after conducting thorough audits of Home Health Agency cost reports and reviewing claims data.

CMS requested $190 million in HCFAC mandatory funds for Medicare Administrative Contractors (MACs) for Provider Cost Report Auditing in FY 2025 (FY 2024 actuals were $162 million). We are requesting additional information from CMS on (1) how much is currently spent on hospital cost report auditing, (2) the percent of hospital cost reports that are currently audited, and (3) how much it would cost to expand and improve hospital cost report auditing, including to address issues identified in the HHS OIG audit A-04-22-06264, to ensure accurate reporting of costs for purposes of reimbursement and determining whether payments are appropriately aligned with costs under prospective payment systems.

ADMINISTRATION FOR COMMUNITY LIVING (ACL)

See Centers for Medicare & Medicaid Services for aging programs; the Administration for Children and Families for disability and nutrition programs; and Office of Strategy for National Institute of Disability, Independent Living, and Rehabilitation Research and University Centers for Excellence in Developmental Disabilities.

ADMINISTRATION FOR STRATEGIC PREPAREDNESS AND RESPONSE (ASPR)

For BARDA, Project BioShield, and Pandemic Influenza, see the Assistant Secretary for Innovation section within the Office of the Secretary.

For the following programs, see the Center for Preparedness and Response section within the Centers for Disease Control and Prevention:

- National Disaster Medical System
- Health Care Readiness and Recovery
- Medical Reserve Corps
- Strategic National Stockpile
- H-CORE
- Pandemic Preparedness and Biodefense
- Preparedness and Response Innovation
- Preparedness and Emergency Operations
- Operations
- Policy and Planning

ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF)

The 2026 Budget provides a total of **$16,208.980 million** for ACF discretionary-funded programs, including $1,629.939 million to administer programs previously housed in the Administration for Community Living (ACL).

Budget Authority in Millions	2026 Budget
Total, ACF Discretionary Funding	***16,208.980***
Refugee and Entrant Assistance	**4,421.755**
Victims of Torture	19.000
Victims of Trafficking	30.755
Unaccompanied Alien Children	4,243.000
UAC Contingency Fund /1	129.000
Child Care and Development Block Grant	**8,746.387**
Children and Families Services Programs	**1,375.074**
Runaway and Homeless Youth	125.283
Service Connection for Youth on the Streets	21.000
Child Abuse State Grants	105.091
Child Abuse Discretionary Activities	36.000
Community Based Child Abuse Prevention	60.660
Child Welfare Services	268.735
Child Welfare Research, Training, & Demonstration	21.984
Adoption Opportunities	53.000
Adoption Incentives	75.000
Independent Living Vouchers	44.257
Social Services Research and Demonstration	27.510
Native American Programs	60.500
Domestic Violence Hotline	20.500
FVPSA Shelters and Services	240.000
Disaster Human Services Case Management	1.864
Federal Administration	213.690
Shift from ACL to ACF [NA]	*26.690*
Promoting Safe and Stable Families	**62.515**
Nutrition and Disability Services Programs	**1,603.249**
Senior Nutrition Program	1,058.684
Congregate Nutrition Services [NA]	*565.342*
Home-Delivered Nutrition Services [NA]	*381.342*
Nutrition Services Incentive Program [NA]	*112.000*

Native American Nutrition and Supportive Services.....	38.264
Traumatic Brain Injury.....	13.118
Independent Living.....	453.183
Independent Living State Grants [NA].....	*351.078*
Centers for Independent Living [NA].....	*102.105*
Assistive Technology.....	40.000
Program Eliminations	
LIHEAP:	
Discretionary Funding.....	--
Infrastructure Investment and Jobs Act (IIJA) Funding /2.....	--
Refugee and Entrant Assistance:	
Transitional Medical Services.....	--
Refugee Support Services.....	--
Children and Families Services Programs:	
Head Start.....	--
Preschool Development Grants.....	--
Community Services Block Grant.....	--
Community Economic Development.....	--
Rural Community Development.....	--
Medical-Legal Partnerships Plus.....	--
Affordable Housing and Supportive Services Demo.....	--
Primary Prevention Youth Homelessness Demo.....	--
Nutrition and Disability Services Programs:	--
State Councils on Developmental Disabilities.....	--
Developmental Disabilities Protection and Advocacy.....	--
Developmental Disabilities Projects of National Significance...	--
Paralysis Resource Center.....	--
Limb Loss Resource Center.....	--
Voting Access for People with Disabilities.....	--

1/Additional resources from a contingency fund become available when trigger is met. The Contingency Fund is classified as discretionary funding, not emergency-designated funding.
2/The Budget will propose to cancel the LIHEAP FY 2026 IIJA appropriation. This funding is classified as emergency funding, and therefore, HHS should not treat it as an offset to the ACF or HHS toplines.

CROSSCUTTING POLICY

Agency RIF and Reorganization Plans and DOGE Coordination. We appreciate the agency's work in compiling a plan to optimize its workforce. We look forward to working with you to gather more granular data for ACF to ensure the budget is consistent with HHS's ARRP, including moving certain programs from ACL to ACF (as reflected in Passback) and reducing FTEs in program offices to align with budget policy.

In addition, by April 15, please provide a rack-up of ACF contracts and grants that have been terminated since January 20, 2025. These contracts and grants should be grouped together by account and program name so that it can easily be cross-walked to the Budget. This list will be used to crosswalk DOGE-effectuated cuts with the 2026 Budget proposed actions.

Reintroduce Common Sense and American Values into Programs that Serve Youth. The Budget will scrub ACF programs of all grants and contracts that promote abortions and high-risk sexual behavior, inflict radical gender ideology on already vulnerable children, and facilitate discriminatory practices in service delivery. This messaging should be reflected in Budget materials. OMB is tracking the following examples specifically, but requests ACF/HHS provide more examples as soon as possible. Examples: The Budget (1) ends Federal dollars for facilitating abortions for migrant children, and (2) eliminates grants to woke NGOs that promote abortion and teach kids how to engage in high-risk sexual behavior in the Personal Responsibility Education Program (PREP).

Preserve Public Benefits for American Citizens. Consistent with the America First policy of this Administration, the Budget ends the dependence of immigrants on hard-earned taxpayer resources by making all non-citizens, including lawful permanent residents, ineligible for public benefit programs. ACF Congressional Justifications will also describe actions planned or taken in compliance with the President's Order, *Ending Taxpayer Subsidization of Open Borders*. Additional details are forthcoming in mandatory passback.

Increase Family Incomes Through Work. Where relevant, Budget materials should highlight efforts to incentivize work under development through the PCC on *Building a Universal Work Requirement for Able-Bodied Adults Receiving Welfare and Other Federal Benefits*. Work gives individuals a purpose in life, improves mental health, and increases household resources, which improves life outcomes for children. Additional details are forthcoming in mandatory passback.

DISCRETIONARY PROGRAMS

Refugee and Entrant Assistance

The Budget provides $4,421.755 million for Refugee and Entrant Assistance, or $4,292.755 million when excluding the current probabilistic score for a UC contingency fund, discussed below. The Budget proposes a 15 percent transfer authority for the Refugee and Entrant Assistance account.

Unaccompanied Alien Children. The Budget funds the UAC program at $4,243.000 million, refocusing the program on its core mission of sheltering UAC and protecting them from child trafficking.

UAC Contingency Fund. In addition to the regular discretionary funding discussed above, the Budget proposes a discretionary emergency uncapped contingency fund that would provide additional resources for the Unaccompanied Children Program in any month when a trigger is met. The Budget will modify the parameters of the contingency fund enacted in 2024 and continued in 2025 so that the fund will pay out $15 million for each increment of 500 referrals above a threshold of 10,000 UC referrals in a month, with a minimum annual payout of $100 million. The probabilistic score for this fund is $129.000 million based on a forecast model developed by OMB's Economic Policy team.

Transitional and Medical Services (TAMS) and Refugee Support Services (RSS). The Budget does not fund TAMS and RSS because refugees and those entering the United States should not expect government handouts and should not be a burden to taxpayers.

Children and Families Services Programs

Head Start. The Budget does not fund Head Start. HHS/ACF should work with OMB to ensure to the extent allowable FY 2025 funds are made available to close out the program. This elimination is consistent with the Administration's goals of returning education to the States and increasing parental choice. The Federal government should not be in the business of mandating curriculum, locations, and performance standards for any form of education.

Social Services Research and Demonstration (SSRD). The Budget funds SSRD at $27.510 million. Within this total, there is $20.000 million for the Diaper Distribution Pilot Program, and $7.510 million for the base program.

Federal Administration. The Budget provides $213.690 million for ACF Federal Administration. This funding level will support the salaries, benefits, and associated expenses to administer ACF programs funded in the Budget, including the programs absorbed from ACL. To ensure consistency with the Agency RIF and Reorganization Plan (ARRP), please provide OMB with the following materials by April 15:

- ACF FTE table by office and account for estimated FTE for FY 2025 and FY 2026.
- The anticipated voluntary departure for VERA, VISP, and Deferred Resignation Program, as well as an outline of how ACF will address costs associated with actions specified in its ARRP.

Promoting Safe and Stable Families

The Budget funds $62.515 million for the discretionary portion of PSSF, including $59.765 million for grants and $2.750 million for the Title IV-E Prevention Services Clearinghouse.

Nutrition and Disability Services Programs

The Budget shifts ACL disability and nutrition programs to ACF, as displayed in the table above. Please communicate to OMB as soon as possible HHS's preferred account display for these programs (e.g., add programs to the existing Children and Families Services Programs account, or create a new appropriations account within ACF). Please also provide to OMB as soon as possible the corresponding appropriations language and any authorizing changes that need to be added as a general provision.

Independent Living. The Budget provides $453.183 for Independent Living. The $325 million above 2024 Enacted will go towards Independent Living State Grants. The grants should provide flexibility to states to use the funding to provide services and supports provided by the disability programs the Budget eliminates.

Program Eliminations. The Budget eliminates several programs that existed within ACL, but allows States to use grant funding they receive from funded formula grant programs to provide or invest in services provided by programs that the Budget eliminates. Please work with OMB to determine whether additional flexibilities or authorities are required for ACF to carry out this Budget policy.

OFFICE OF THE SECRETARY

GENERAL DEPARTMENTAL MANAGEMENT (GDM)

For 2026, the Budget:

- Provides:
  - $7.000 million to cover the cost of ETS transition
  - $5.000 million to bolster efforts that improve overall grants management, including implementation of GREAT Act, and to implement the new process and structure related to collection and distribution of grants standards and Grants QSMO funding. For outyears, OMB expects the Office of Grants to develop and carry out a plan by end of CY 2025, to work with all relevant agencies to ensure sufficient funds are collected annually to help sustain grants standards and QSMO related efforts.
- Includes a new Office of the Chief Technology Officer (OCTO) and provides:
  - $94.000 million for HHS Office of the Chief Information Officer to support department wide cybersecurity efforts.
  - $9.000 million to consolidate functions from the Assistant Secretary for Technology Policy within the OCTO and fund existing staff to continue carrying out mission critical functions.
- Consolidates the following offices within the new Assistant Secretary for External Affairs
  - Assistant Secretary for Public Affairs; Assistant Secretary of Legislation; Office of Global Affairs; Internal and External Affairs; Center for Faith Based and Neighborhood Partnerships.
- For OASH programs, please see the Administration for a Healthy America section.
- For Assistant Secretary for Planning and Evaluation, please see the Office of Strategy section.

Eliminated Programs:

- KidneyX
- LymeX
- Children's Interagency Coordination Council
- Still Birth Taskforce
- Discretionary Sexual Risk Avoidance program
- Embryo Adoption Awareness Campaign
- Food as Medicine

The following table displays the funding for GDM. By April 24th, please let us know the allocation of GDM funding across programs/staff divs.

General Departmental Management (GDM)	2026 Budget ($, millions)
GDM BA	**297.442**
Assistant Secretary of External Affairs (non-add)	36.157
Assistant Secretary of Financial Resources, including Grants QSMO (non-add)	44.883
Immediate Office of the Secretary (Includes Office of National Security) (non-add)	22.442
Office of the Chief Technology Officer (non-add)	103.00
PHS Evaluation Fund	
Immediate Office of Secretary Public Health Activities	8.800
ASFR	*1.100*
Total PHS Evaluation Fund	**9.900**
Total Program Level (PL)	**307.342**

ASSISTANT SECRETARY FOR ENFORCEMENT (ASE)

The Budget consolidates the offices in the below table into the new Assistant Secretary for Enforcement.

	FY2026 Budget
Assistant Secretary for Enforcement (BA)	**241.241**
MHA	180.000
OMHA	*146.000*
DAB	*34.000*
OCR	39.798
Vaccine Injury Compensation Program (formerly in HRSA)	15.200
Covered Countermeasures Injury Compensation Program (formerly in HRSA)	7.000
Office for Human Research Protections (formerly in OASH)	6.243
Office of Research Integrity (non-add) funded by NIH through IAA (formerly in OASH)	-

OFFICE OF STRATEGY

The Budget consolidates the Office of the Assistant Secretary for Planning and Evaluation (ASPE) with the Agency for Healthcare Research and Quality into the new Office of Strategy.

For 2026, the Budget prioritizes long term statistical activities and includes funding for the Medical Expenditure Panel Survey (MEPS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS), and the Healthcare Cost and Utilization Project (HCUP).

The Budget includes funding for continuing grants formerly administered by AHRQ, to preserve long-term and high-impact work. The Budget focuses resources on continuing grants and contract/IAA funding that supports statistical healthcare research.

Please include a proposal to offset some data management and dissemination costs with user fees from non-governmental users, but do not rely on this new user fee to meet guidance.

Eliminated Programs:

- Digital Healthcare Research
- Patient Centered Outcomes Research
- ACL University Centers for Excellence in Developmental Disabilities
- ACL National Institute of Disability, Independent Living, and Rehabilitation Research

Office of Strategy	2026 Budget
Healthcare Research (BA) (formerly AHRQ)	239.530
Mandatory Transfers from the PCORTF	*0.00*
Healthcare Research PL, with Transfers	**239.530**
Patient Safety	47.247
Digital Healthcare Research/ Health IT	0.000
U.S. Preventive Services Task Force	7.400
Heath Services Research, Data, and Dissemination	65.640
MEPS	71.791
Program Support (formerly AHRQ)	47.452
Planning and Evaluation (PHS Eval) (formerly ASPE/GDM)	43.243
Total Program Level (PL)	**282.773**

ASSISTANT SECRETARY FOR INNOVATION (ASI)

The Budget consolidates the Advanced Research Projects Agency for Health (ARPA-H), the National Center for Advancing Translational Sciences, and the Biomedical Advanced Research and Development Authority into the new Assistant Secretary for Innovation.

ARPA-H Contract Updates

The Budget directs ARPA-H to update all contracts to include a clause for the Agency to recoup profits for invested products. These profits will be used to fund the newly created United States Sovereign Wealth Fund. OMB will follow up with HHS/ARPA-H on implementation of this proposal.

Pandemic Influenza

The Budget includes $307.991 million for domestic pandemic influenza, of which $280 million is x-year and $27.991 million is annual. The Budget eliminates funding for the Office of Global Affairs.

Public Health and Social Services Emergency Fund

The Budget does not include funding for PHSSEF.

	2026 Budget ($M)
Assistant Secretary for Innovation	**3,235.812**
Advanced Research Projects Agency for Health	945.000
National Center for Advancing Translational Sciences	603.410
BARDA	654.411
Project BioShield	725.000
Pandemic Influenza	307.991

ASSISTANT SECRETARY FOR CONSUMER PRODUCT SAFETY (ASCPS)

The Budget provides $135 million for the Assistant Secretary for Consumer Product Safety, a new staff division (StaffDiv) within the Office of the Secretary that will absorb functions and staff from the Consumer Product Safety Commission (CPSC). The Budget eliminates CPSC and reduces funding for CPSC's administrative and support functions that can be carried out by existing StaffDivs within the Office of the Secretary. ASCPS will continue carrying out CPSC's mission to protect the public from unreasonable risks of injury or death from consumer products through education, safety standards activities, regulation, and enforcement.

OFFICE FOR CIVIL RIGHTS (OCR)

For the Office for Civil Rights, see the Assistant Secretary for Enforcement section within the Office of the Secretary.

ASSISTANT SECRETARY FOR TECHNOLOGY POLICY (ASTP)

For the Assistant Secretary for Technology Policy, see General Departmental Management.

MEDICARE HEARINGS AND APPEALS (MHA)

For the Office of Medicare Hearings and Appeals and the Departmental Appeals Board, see the Assistant Secretary for Enforcement section within the Office of the Secretary.

OFFICE OF INSPECTOR GENERAL (OIG)

The Budget includes $87 million in discretionary funding, and eliminates the $1.5 million transfer from FDA, and the $5 million transfer from NIH.

Office of Inspector General
(Dollars in millions)

	FY 2026 Budget
Total PHHS Oversight	87.000
Sub-Total PHHS Oversight	**87.000**
HCFAC (Discretionary)	107.735
HCFAC (Mandatory)	249.203
Sub-Total Medicare and Medicaid Oversight	**356.938**
HCFAC Estimated Collections	9.000
Total Program Level	**452.938**

NON-RECURRING EXPENSES FUND

Please submit to OMB a plan for proposed uses of the NEF in FY 2026 that takes into account HHS's plan for FY 2025. Please continue to engage with OMB on FY 2025 planned uses.

OTHER GOVERNMENT-WIDE GUIDANCE

Better Services for American Taxpayers: Aligning Agency RIF and Reorganization Plans (ARRP) with the FY 2026 Budget

On February 26, OMB and OPM issued *Guidance on Agency RIF and Reorganization Plans Requested by Implementing The President's "Department of Government Efficiency" Workforce Optimization Initiative*. Pursuant to this guidance, agencies will submit Agency RIF and Reorganization Plans (ARRPs) to OMB and OPM outlining how each agency plans to effectuate the President's directive for a more effective and efficient Government and better service delivery for the American people. Agencies submitted Phase 1 ARRPs on March 13. Agencies are working on Phase 2 ARRPs, and monthly status updates on the implementation of the plans are requested through the end of the fiscal year.

Agencies should ensure that their submitted Phase 2 ARRPs: 1) are consistent with FY 2026 Budget funding levels and policy; 2) drive a positive effect on the delivery of services; and 3) position the agency to implement the President's Budget.Notably, the Phase 2 ARRPs should:

- Achieve necessary FTE reductions and agency reorganizations that, at a minimum, reflect the assumed FTE levels and administrative efficiencies supported by the FY 2026 President's Budget request.
- Articulate the framework and criteria used to define and determine the efficient use of existing personnel and funds to improve services and the delivery of services.
- Include certification from the agency head, CIO, and relevant program managers that implementation will have a positive effect on the delivery of services.

OMB looks forward to working with the agency on this alignment.

Real Property Transparency

All CFO Act agencies are required to submit their FY 2026–FY 2030 real property capital plans to OMB no later than one week after the release of the President's FY 2026 Budget. Following submission of these plans, in December 2025 all agencies are required to identify their owned mission critical real property assets in the Federal Real Property Profile (FRPP) database. This data will enable appropriate resourcing of real property assets that house functions directly required by statute or regulation.

E-Government (E-Gov) and Lines of Business Initiatives (LoB)

HHS should continue to contribute to the E-Government and Lines of Business (E-Gov/LoB) initiatives and should access the E-Gov and LoB Initiative MAX Community page for further information and guidance. Please email Mary Keller (Mary.W.Keller@omb.eop.gov) for any questions or access issues to the OMB Collect exercise housing the contribution data.

Scaling and Securing the FedRAMP Cloud Marketplace
In support of M-24-15, Modernizing the Federal Risk and Authorization Management Program (FedRAMP), agencies should establish Governance, Risk and Compliance (GRC) tools that can ingest machine readable authorization artifacts to increase the speed of implementing cloud solutions and minimize burden in leveraging security capabilities related to leveraged systems. Agencies should clearly identify funding within their FY 2026 Budget request to support scaling the FedRAMP Marketplace and GRC tools.

Government-wide Council and CAP Goal Contributions
Major Federal agencies currently contribute resources to the General Services Administration in support of Cross-Agency Priority (CAP) Goal projects and interagency management councils. These contributions have supported numerous cross-agency management reforms and efficiencies for more than a decade, as well as efforts to improve coordination, reduce duplication, and make progress on carrying out the President's Management Agenda. The FY 2026 Budget will continue to request authority to collectively transfer funds to support these efforts and priorities, with prior notification to the Congress by the Director of OMB. In FY 2026, the Department of Health and Human Services should plan to contribute $678,994 to Government-wide Council funding and $599,113 to CAP Goal funding.

FY 2026 Annual Evaluation Plan
Agencies are directed to develop and publish a FY 2026 Annual Evaluation Plan (AEP) as required by the Evidence Act that includes between two and four evaluations. All evaluations should reflect the agency head's top priorities and the AEP should not exceed 10 pages. Agencies are instructed to streamline AEPs to alleviate burden and focus only on agency priorities. All evaluations in the FY26 AEP should be able to be conducted with the staff and resources included in Passback, and must be designed to produce actionable results to inform decisions within one year. Agencies should submit a draft plan to OMB no later than April 30 and integrate OMB feedback into their final, published AEP and planned evaluations. AEPs should be published by agencies concurrent with the FY 2026 President's Budget.

FY 2026 Agency Performance Plan
Agencies are directed to develop and publish a significantly streamlined and concise FY 2026 Agency Performance Plan (APP) that is no more than 10 pages. Agencies are instructed to streamline the APPs to alleviate burden and reflect the agency head's top goals and the current Administration's priorities—as reflected in guidance, Executive Orders, and other Presidential directives. Performance goals and targets set in the FY 2026 APP should be designed to drive actionable performance improvements and results within their respective one-year periods of performance that are aligned to and can be accomplished within their topline resource levels. Agencies should submit a draft plan to OMB no later than April 30, and integrate OMB feedback

into their final published APP. The FY 2026 APP should be published by agencies concurrent with the FY 2026 President's Budget.

Leverage Federal Dollars by Buying American and Hiring American

Agency budget requests for FY 2026 should prioritize implementation of the President's Made in America agenda and existing Made in America laws. Agencies are asked to use all tools available, consistent with law, to maximize the use of goods, products, and materials produced in the United States, minimize the use of waivers, and provide clear and consistent demand signals to industry on Federal demand for critical items. Agencies should also identify resources that can help interagency partners identify domestic sources of goods and reduce or eliminate the need for Made in America waivers.

Within 30 days of release of the 2026 Budget, agencies should provide information to their RMO Representative and Callie Conroy (callie.h.conroy@omb.eop.gov) on how the agency's 2026 budget request will support implementation of Made in America Laws. This should include information on resource allocations and FTEs supporting Made in America implementation, any implementation challenges, and assistance agencies need to support implementation. In particular, agencies should provide:

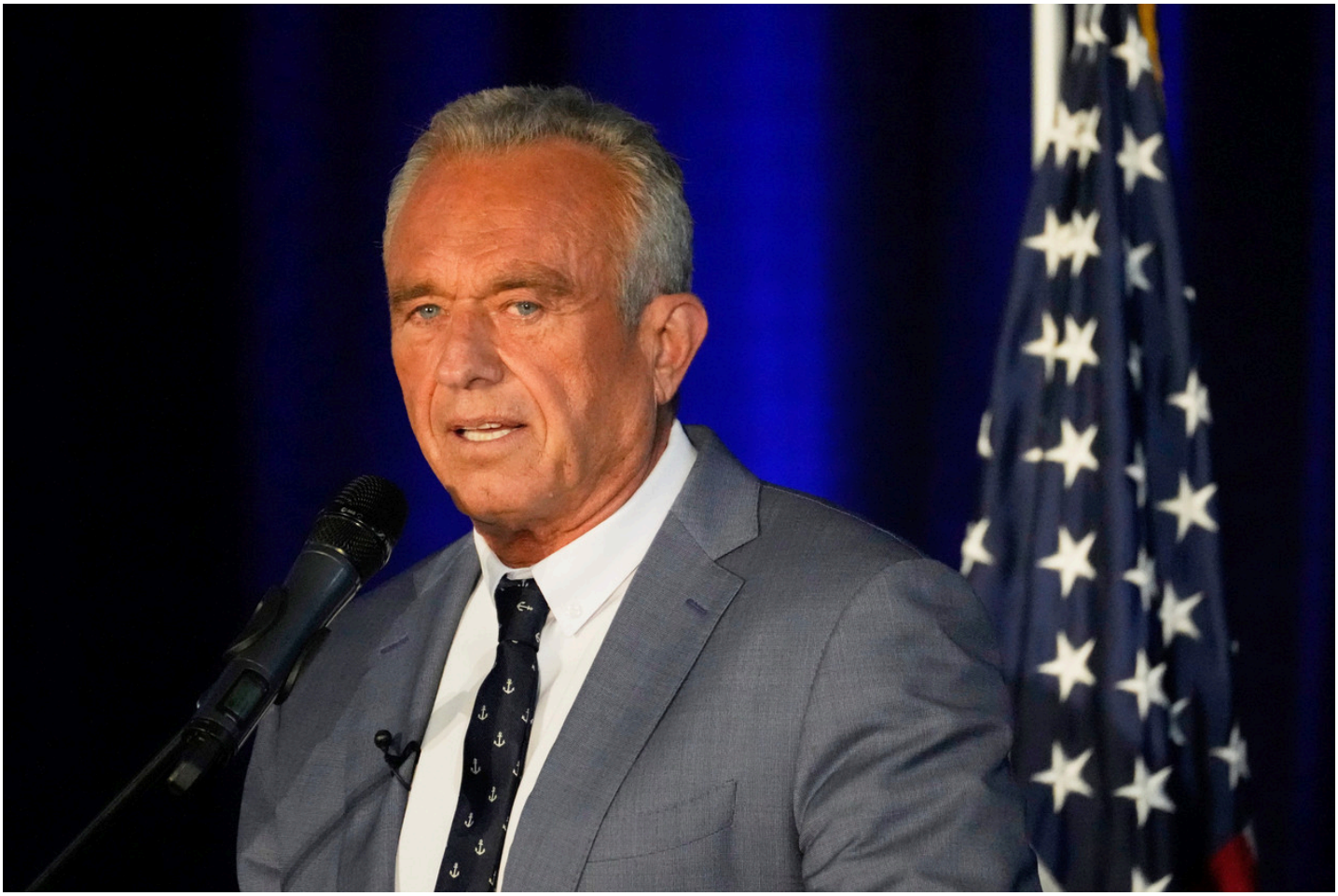
- Plans for evaluating and implementing internal processes related to the review of waivers of Made in America laws (e.g., the Build America, Buy America Act, Buy American Act, Make PPE in America Act and other domestic preference laws). Processes should be implemented to ensure waivers are narrowly tailored and consistent with Administration policy.
- Proactive actions by agencies to identify domestic sources in advance of program needs to reduce or eliminate the need for waivers. This should include budget activities related to market research, industry engagement, and other actions that agencies are engaged in to eliminate the need for waivers.
- Opportunities where agency resources can support other agencies in implementing Made in America requirements (e.g., market research, supply chain, or supplier scouting capabilities).

In the coming days, OMB will provide a template for agency responses.

POLITICO

HHS funding slashed by 30 percent in budget proposal

The Trump administration is mulling sharp budget cuts at health agencies.



HHS Secretary Robert F. Kennedy Jr. has already shrunk the department's workforce, laying off roughly 10,000 employees earlier this month on top of another 10,000 who have taken buyouts or early retirement. | Stephanie Scarbrough/AP

By **ADAM CANCRYN**
04/16/2025 05:25 PM EDT
Updated: 04/16/2025 05:50 PM EDT

The Trump administration is considering a more than 30 percent cut to the budget for the Department of Health and Human Services, as part of a

sweeping reorganization that would eliminate dozens of programs and consolidate key health agencies.

Public health initiatives aimed at HIV/AIDS prevention would no longer exist. Major parts of the National Institutes of Health would be abolished. The Food and Drug Administration would cease routine inspections at food facilities. And funding for many of the administration's priorities are on the chopping block, including federal programs focused on autism, chronic disease, drug abuse and mental health.

Overall, the proposal outlined by the White House Office of Management and Budget recommends slashing HHS' overall discretionary funding to roughly

"Many difficult decisions were necessary to reach the funding level provided in this Passback," OMB wrote in the document, referring to the practice of notifying department officials what to expect in its funding request for the coming fiscal year.

The proposal, which was dated April 10 and obtained by POLITICO, is still subject to change as the White House prepares to send a formal budget proposal to Congress. An HHS spokesperson referred questions to OMB. OMB spokesperson Rachel Cauley said that "no final funding decisions have been made."

Yet the document provides the most detailed look yet at the striking changes under consideration by Trump officials, which would fundamentally reshape HHS and narrow the scope of the government's health care capabilities.

HHS Secretary Robert F. Kennedy Jr. has already shrunk the department's workforce, laying off roughly 10,000 employees earlier this month on top of another 10,000 who have taken buyouts or early retirement.

The OMB document shows how he might now follow through on his vow to streamline HHS' activities and overhaul its priorities, after criticizing the department as bloated and failing in its core mission of improving Americans' health.

The overall cutback in HHS funding would be driven by zeroing out the budgets of several smaller agencies and programs, including those focused on substance abuse and services for low-income and older Americans, to shift a slimmed-down selection of their activities into a new division called the Administration for a Healthy America.

The National Institutes of Health and Centers for Disease Control and Prevention would also face sharp funding cuts, with the proposal slashing funding for both public health agencies by more than 40 percent.

In the April 10 document, OMB wrote that these reduced levels reflect the reforms necessary for agencies to fulfill their legal obligations in the most cost-effective manner, while also driving toward a bigger goal that President Donald Trump has often floated: balancing the government's overall budget.

In perhaps the most significant element of the restructuring, the proposal suggests eliminating funding for the Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, Agency for Healthcare Research and Quality, and Administration for Community Living, along with a handful of other smaller programs.

Some of the work done at those agencies would continue under the Administration for a Health America, which would get roughly $14 billion in budget authority under the plan. Yet that funding is well below the collective amount allocated to those agencies in past years. It would also mean eliminating dozens of programs, including programs on autism, teen pregnancy prevention, substance abuse initiatives focused on minority populations and firearm injury and mortality prevention research.

The proposal also recommends a major overhaul of the CDC, slashing its budget and focusing it more narrowly on infectious disease work and preparedness for public health threats. The Administration for Strategic Preparedness and Response would be merged into the CDC under the blueprint.

And several prominent elements of CDC would be abolished as part of the overall squeeze on its resources, including nearly the entire Prevention and Public Health Fund, funding for the agency's Ending the HIV Epidemic

Initiative and its domestic HIV/AIDS prevention and surveillance activities, and its National Center for Chronic Disease Prevention and Health Promotion.

The NIH would see a similarly drastic downsizing and reorganization, with its discretionary funding cut to roughly $27 billion, from a current budget of about $47 billion. Several centers, including the National Institute on Minority Health and Health Disparities, would be eliminated.

The OMB document also cements a controversial plan to impose a 15 percent cap on the indirect costs that the NIH pays to aid research at universities — a cut that university presidents have warned would decimate their ability to do critical laboratory work and that was later halted in court.

The proposal seeks a major change at the Food and Drug Administration as well. The plan would end the agency's direct role in routine inspections of food facilities, instead expanding state-level contracts to handle all of that work.

CORRECTION: An earlier version of this report misstated the name for the Substance Abuse

FILED UNDER: ROBERT F. KENNEDY JR., HEALTH AND HUMAN SERVICES

MATT GILES LEAH FEIGER ZOË SCHIFFER CAROLINE HASKINS POLITICS APR 22, 2025 4:26 PM

Here's All the Health and Human Services Data DOGE Has Access To

Elon Musk's DOGE has access to 19 sensitive systems at HHS. In at least one instance, it appears that access was granted without the proper security training.


of the United States government
U.S. Department of
Health and Human
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About HHS
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PHOTOGRAPH: MARIO GUTI/GETTY IMAGES

SAVE

Affiliates from Elon Musk's so-called Department of Government Efficiency (DOGE) have significant access to 19 sensitive systems at the Department of Health and Human Services (HHS), according to a recent court filing. Nine of those are previously undisclosed.

This wide-ranging access, which includes a centralized accounting system for all Centers for Medicare and Medicaid (CMS) programs, the cloud for a "robust" and "high-volume data warehouse," and several additional HHS accounting systems that pay government contractors, demonstrates the breadth of DOGE's takeover at the federal agency charged with securing health care for millions of Americans.

HHS submitted the filing as part of an ongoing lawsuit. The document—which is related to a motion for preliminary injunction—shows that a total of four DOGE affiliates now have access to the Healthcare Integrated General Ledger Accounting System (HIGLAS), which pays out federal grants and is used for accounting by the Centers for Medicare and Medicaid Services. A previous court filing claimed three

DOGE operatives had access to HIGLAS, which could theoretically allow them to cut off Medicaid payments to states, according to NPR.

HHS did not immediately respond to an official request for comment from WIRED.

DOGE's access to some of the databases in the new court filing were first revealed in a March court filing and reporting from NPR and The Guardian. However, the full scope has come into focus as a result of the American Federation of Labor and Congress of Industrial Organizations's continued lawsuit attempting to restrict DOGE's data access at HHS, the Department of Labor, and the Consumer Financial Protection Bureau. As part of the AFL-CIO's motion, the plaintiffs allege the agencies have given DOGE "unfettered, on-demand access to their most sensitive systems of records" because the affiliates "invoke the incantation of 'waste, fraud, and abuse.'" According to the plaintiffs, "'waste, fraud, and abuse' are not magic words, and they cannot conjure up a need to grant DOGE Team members on-demand access to Americans' most sensitive and personal information."

As part of the discovery process, federal agencies have been required to disclose which databases DOGE has accessed, which were attached to the plaintiffs' recent motion.

Jeffrey Levi, an emeritus professor of health policy and management at George Washington University's Milken Institute School of Public Health, tells WIRED that "anything that has the potential of delaying payments to parts of the health system" runs the risk of disrupting care for the millions of Americans that rely on it. Levi notes that places with "minimal financial flexibility"—like rural hospitals and Federally Qualified Health Centers, which disproportionately serve people who use Medicaid and Medicare—are particularly vulnerable.

The filing lists known DOGE affiliates, including Luke Farritor, Marko Elez, Edward Coristine, Rachel Riley, Aram Moghaddassi, Zachary Terrell, and Kyle Schutt, among those who have access to HHS systems. Coristine, who has gone by the name "Big Balls" online, previously worked for a company that employed convicted and reformed hackers, WIRED reported.
Elez, a young engineer who has worked at Musk's X and SpaceX, has also appeared at the Department of Labor, the Social Security Administration, and the Department

of the Treasury. While at the Treasury, WIRED reported, Elez had both read and write access to sensitive payments systems. In early February, Elez briefly resigned from DOGE after racist comments posted by an account he was linked to were discovered by The Wall Street Journal, though Elez returned to DOGE after Musk and Vice President JD Vance posted in defense of him on X.

The court filing raises legal and ethical questions around how personal information is currently being treated in the federal government, says Elizabeth Laird, the Center for Democracy and Technology's director of Equity in Civic Technology.

"It just underscores why for so long we have had protections that have really centered someone's right to privacy and [required] consent for sharing that level of sensitivity of information about them," Laird says. "Just in this agency, with this level of sensitivity, that's a right that's been stripped away from every person who is included in there."

Below is a chart that details DOGE's access to HHS, complete with the names of the agencies impacted, the Personally Identifiable Information (PII) contained in those agencies, and the DOGE operatives who have, or had, access. This information is contained in the court filing.

NAME	PII	DOGE ACCESS
Centers for Medicare and Medicaid Services (CMS) Acquisition Lifecycle (CALM) (This manages the contract acquisition process, including "writing contracts, tracking milestones, and performing contract audits.")*	Vendor name, address, phone number, taxpayer ID number, employer ID number, etc.	Amy Gleason, Luke Farritor, Edward Coristine, Marko Elez, Aram Moghaddassi, Rachel Riley
CMS Healthcare Integrated General, Ledger Accounting System (HIGLAS) (This is one of HHS's central accounting systems.)	SSN, Name, DOB, Financial account information, taxpayer ID, Health insurance claim, employee ID number, salary	Luke Farritor, Edward Coristine, Marko Elez, Aram Moghaddassi

NAME	PII	DOGE ACCESS
CMS Integrated Data Repository Cloud (IDRC) (This is a "high-volume data warehouse integrating Medicare claims" with data from patients and healthcare providers.)	SSN, name, date of birth, email address, phone numbers, mailing address, medical records number, medical notes, health insurance claim number (HICN), unique physician, identification number (UPIN), race, sex, diagnosis, codes, procedure codes, user credentials	Luke Farritor, Edward Coristine, Marko Elez, Aram Moghaddassi, Zachary Terrell
NIH ES Electronic Research Administration (eRA) (This is the NIH's system for processing research grant applications.)	SSN, name, date of birth, email address, mailing address, phone numbers, education, records, disability, persistent, digital identifiers, disadvantage background, user credentials, current position, affiliated organization, sex, demographic, information, professional, performance, and provincial history, service, payback obligation, financial data, employment data	Luke Farritor
NIH ES NIH Business System (NBS) (This includes “the general ledger, finance, budget, procurement, supply, travel, and property management systems.”)	SSN, name, email address, phone numbers, financial accountant, information, employment status, taxpayer ID, employee ID number	Luke Farritor, Rachel Riley
OS ASA OHR Enterprise Human Capital Management (EHCM) Investment (This is used by HHS to process its internal "personnel actions" and "administer benefits" to its employees.)	SSN, name, email address, phone numbers, certificates, education, records, military status, date of birth, photographic, identifiers, mailing address, financial account information, employment status, user credentials	Luke Farritor (admin, read only), Zachary Terrell, Rachel Riley (read only)
OS ASA PSC Payment Management System (PMS) (This is "a shared service provider and a leader in processing grant payments for the federal government.")	SSN (limited, used as TIN), name, email address, phone numbers, taxpayer ID, mailing address, financial account information, user credentials	Luke Farritor (admin), Zachary Terrell, Rachel Riley

NAME	PII	DOGE ACCESS
OS ASFR Grant Solutions (This is "a grants management services provider.")	Taxpayer ID, user credentials, email address, mailing address, name, phone numbers, employer ID number	Luke Farritor, Zachary Terrell, Conor Fennessy, Jeremy Lewin, Rachel Riley, Aram Moghaddassi
OS ASFR HHS Consolidated Acquisition Solution (This manages purchase requests and business transactions across HHS, with the exception of CDC.)	SSN, name, email address, phone numbers, education, records, taxpayer, ID, mailing address, financial account information, legal documents, user credentials	Luke Farritor, Conor Fennessy, Rachel Riley
ACF Expanded Federal Parent Locator Service (FPLS) FPLS comprises four systems critical to child support: 1) National Directory of New Hires, a database of employment data; 2) Federal Case Registry of Child Support Orders, a database of child, support cases and orders; 3) Debtor File which helps states collect delinquent child support; 4) Parent Child Support Portal, which provides a secure gateway for FPLS web applications (This houses information about children placed into foster care so that the relatives of these children can be notified.)	National Directory of New Hires (2025 draft): SSN, date of birth, name, mailing address, military status, employment status	Marko Elez, Aram Moghaddassi (both deactivated)
Integrated Contracts Expert system at CDC (This is HHS’s accounting system specific to the CDC.)	SSN, name, email address, employer ID number	Luke Farritor
Acquisition, Performance and Execution system at CDC (This is a platform for the CDC to procure private sector contracts and work.)	SSN, name, email address, employment, status, employer ID number	Luke Farritor
Grants.gov (This is a platform for people and organizations to apply for government grants.)	SSN, taxpayer ID, user credentials, email address, education, records, mailing address, name, phone numbers, financial account info, others—	Luke Farritor (admin), Conor Fennessy

NAME	PII	DOGE ACCESS
	chart no., TIN, DUNS, provider license number	
Unaccompanied Alien Children ACF Unaccompanied Children Portal (This houses the information about unaccompanied children that is collected by Customs and Border Protection after the children are apprehended.)	Manages a large amount of information, including personal information, medical notes, educational information, and sponsorship information. There are four major groups of individuals:1. UCs—information includes: name, DOB, a number, photographs, biometrics, medical notes, country of birth, education, information, progress reports.2. Sponsors—information includes: name, DOB, SSN, email address, drivers license number, passport number, phone number(s), mailing address, financial account information, employment, status, and income information, legal documents, marital status, gender, country of residency3. Sponsor’s household—information includes: names, DOBs, gender, age, and relationship to UC4. System users — name, email address, phone number, fax number, mailing address, username, password, and roll/privileges	Kyle Schutt
Component: Financial Business Intelligence Systems Name of ATO Boundary: Unified Financial Management System Portfolio (The FBIS "retrieves, combines, consolidates, and reports data from the core financial system." The UFMS is one of the three major core accounting systems at HHS.)	SSN, taxpayer ID, email address, mailing address, name, phone numbers, financial account info, others—chart no., TIN, DUNS, provider license number	Zachary Terrell, Rachel Riley

NAME	PII	DOGE ACCESS
Business Intelligence Information System-Cloud (This houses HHS "payroll, time and attendance, personnel, and recruiting data.")	SSN, mother, maiden name, user credentials, email address, date of birth, mailing address, name, phone numbers, military status, employment status, financial account info	Rachel Riley
HRSA Electronic Handbooks (This platform lets officials sign documents that create binding government contracts.)	Name, email address, phone number numbers, taxpayer ID, mailing address, user credentials, others—fax no.	Zachary Terrell, Jeremy Lewin, Conor Fennessy
Unified Financial Management System (This is HHS's "integrated department-wide financial management system.")	SSN, taxpayer ID, email address, mailing address, name, phone numbers, financial account info, other—HHSID	Zachary Terrell, Rachel Riley
NIH Workforce Analytics Workbench (This lets users examine "current and historical NIH workforce data," including headcount and retirement information.)	NIH Workforce Insights—FTE counts, HR actions, etc.	Rachel Riley

**Explanations added by WIRED. The rest is recreated from the court filing.*

DOGE affiliates were given access to HHS systems as a result of three executive orders signed by President Donald Trump, according to an April 8 deposition by Jennifer Wendel, chief information officer at HHS, who is stepping down this spring. The first was the January 20 order that established DOGE's existence. The second was a February order on implementing the DOGE agenda, and the third was an order to eliminate waste, fraud, abuse and data silos.

The orders—and in particular the mandate to root out fraud—gave DOGE wide-ranging access to government systems. The team was required to speak with system owners before accessing certain tools, according to Wendel. In theory, the owner could deny access if they felt that DOGE access was not justified. In practice, Wendel said, access at HHS has never been denied.

That appears to have been the case even though one DOGE affiliate failed to receive the proper security training needed to access a particularly sensitive system.

Before someone is allowed to access the Healthcare Integrated General Ledger Accounting System and the Integrated Data Repository (IDR), they're required to go through a security training, according to the April 8 deposition by Wendel and another that occurred on the same day by Garey Rice, the principal deputy assistant secretary for operations at HHS. The depositions come as part of the AFL-CIO lawsuit.

During the depositions, an attorney for the plaintiffs tried to ascertain whether DOGE affiliate Aram Moghaddassi had been through the proper training to access the HIGLAS and IDR systems. In a previous government filing, Moghaddassi was not listed as having read-only access to any of the HHS systems, including HIGLAS, despite court records indicating he was detailed to the agency in early March. Rice confirmed that there was no record of Moghaddassi completing the required security briefing.

Got a Tip?

Are you a current or former government employee who wants to talk about what's happening? We'd like to hear from you. Using a nonwork phone or computer, contact the reporter securely on Signal at MattGiles45.42.

Attorneys for the labor groups tried to figure out why DOGE affiliates Elez and Moghaddassi had access to, for example, the national directory of new hires, a system that tracks child support payments and which includes sensitive information like social security numbers, mailing address, and employment status. "In order to determine if there was potential waste, fraud, and abuse within the system," Wendel responded. "What kind of fraud, waste and abuse did HHS think might be in the system?" the attorney probed. "I do not know," Wendel responded.

Wendel testified that she did not believe DOGE operatives had not shown people outside of HHS the records they had access to. However, asked whether the team could take their laptops home and access HHS records remotely, Wendel said yes.

"Do you know if the DOGE team affiliates have literally just shown someone, outside HHS, HHS records?" the attorney asked. "I do not know that," Wendel responded.

According to the filing, Elez and Moghaddassi previously had access to the "Expanded Federal Parent Locator Service," a service that notifies relatives when a child has been placed in foster care, but they have since been "deactivated," meaning their access has been revoked.

Some of these systems were not actively in use by agencies at HHS. "We don't use [Integrated Contracts Expert] anymore. APEX replaced that in October," an employee at HHS tells WIRED. APEX, or Acquisition Performance and Execution, which Farritor also has access to, is the CDC's contract-writing and acquisition-management system. "APEX has everything," the employee says. "So many details. Amounts paid, approvals, history, contact info, and more."

The filing affirms previous reports that DOGE affiliate Kyle Schutt has access to a database with health records about children who come into the US unaccompanied. Laird tells WIRED that access to this data—which includes biometrics, medical notes, photographs, and information about their sponsors—is particularly concerning.

"What's the reason—if you're looking for fraud, waste, and abuse—to have data about children who are present in the US without their family?" Laird says. "We're increasingly seeing this type of information being used for purposes other than fraud, waste, and abuse, like immigration enforcement."

As reported by WIRED, DOGE operatives are building a master database at the Department of Homeland Security that includes voting records from Pennsylvania and Florida, Social Security Administration data, and Internal Revenue Service data that has the potential to identify and surveil immigrants at a massive scale.

WIRED also reported that DOGE operatives at the Department of Labor have been given access to databases that house the personal information of migrant farm workers, including applicants for temporary work visas. They also had access to information that could be combined with other datasets in order to determine the immigration status of people benefitting from certain federal programs.

Federal officials and labor leaders have also raised concerns about DOGE's potential to access unredacted DOL files that would identify corporate whistleblowers, and detailed information about safety inspections at private companies.

The most recent court filing that discloses DOGE's data access at the DOL is from March 29. It claims Elez had access to four record systems at the DOL and had "not accessed any of the systems," but had installed Python and a tool for editing software code. The systems included databases that manage federal employees' access to government buildings and systems, and a database that tracks unemployment benefit claims.

Earlier this month, thousands of employees at HHS agencies, including doctors and scientists at the Food and Drug Administration and the Centers for Disease Control and Prevention, were purged from the agency as DOGE continues to drastically slash the size of the federal workforce. The cuts also hit some administrative employees at HHS who manage critical cybersecurity infrastructure and hundreds of millions of dollars worth of federal contracts.

Written by WIRED Staff

TOPICS DOGE ELON MUSK DONALD TRUMP BUSINESS PRIVACY GOVERNMENT

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Phillip L. Swagel, Director

March 5, 2025

Honorable Brendan F. Boyle
Ranking Member
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Re: Mandatory Spending Under the Jurisdiction of the House Committee on Energy and Commerce

Dear Ranking Member Boyle and Ranking Member Pallone:

In response to your request, this letter provides information about projections of mandatory spending for the 2025–2034 period for the list of programs, excluding Medicare, that you indicated are under the jurisdiction of the House Committee on Energy and Commerce.

In CBO's January 2025 baseline budget projections, mandatory outlays for the accounts you asked about total $8.8 trillion for the 2025–2034 period. Medicaid outlays account for $8.2 trillion, or 93 percent, of that amount (see Table 1).

You also asked for two subtotals of projected outlays in Table 1:

- Outlays other than for Medicaid total $581 billion through 2034.
- Outlays other than for Medicaid and CHIP total $381 billion over the 10-year period.

Table 1.
Outlays From Accounts Indicated to Be Under the Jurisdiction of the House Committee on Energy and Commerce

	By Fiscal Year, Billions of Dollars											
	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025-2029	2025-2034
Medicaid	656	695	738	767	803	837	871	910	948	986	3,658	8,209
CHIP	21	21	22	22	23	23	23	16	15	15	108	201
Other Listed Programs												
Risk Adjustment Program	12	15	16	15	15	15	16	17	18	18	73	158
Universal Service Fund	9	9	8	9	9	9	9	9	9	9	43	87
CHIPS	3	4	5	6	6	5	3	2	1	0	24	36
Offsetting Receipts[a]	-2	-4	-3	-3	-3	-3	-3	-2	-2	-2	-15	-27
Interest Earnings[a]	-3	-3	-3	-3	-3	-3	-3	-4	-4	-4	-15	-32
Other	25	21	19	20	18	14	12	10	10	10	103	159
Subtotal, Other	44	42	43	43	41	37	33	33	32	32	213	381
Total Outlays	**720**	**759**	**802**	**832**	**867**	**897**	**928**	**959**	**995**	**1,033**	**3,979**	**8,791**

Data source: Congressional Budget Office: *The Budget and Economic Outlook: 2025 to 2035* (January 2025), https://www.cbo.gov/publication/60870.

Components may not sum to totals because of rounding.

Outlays are for all programs except Medicare, which is under the jurisdiction of more than one Committee.

CHIP = Children's Health Insurance Program; CHIPS = Creating Helpful Incentives to Produce Semiconductors.

a. Offsetting receipts and interest earnings are classified in the budget as direct spending.

Among the largest programs other than Medicaid and CHIP are the risk adjustment program, in which health insurers make payments to the government or receive payments from it according to the health of their enrollees ($158 billion), and the Universal Service Fund ($87 billion). The risk adjustment program, however, is budget neutral with revenues offsetting spending. Spending from the Universal Service Fund is derived from fees that are classified as revenues on certain telecommunication services. Outlays for all other programs total $135 billion, on net, over the period, encompassing spending for a variety of federal activities.

I hope this information is helpful. Please contact me if you have further questions.

Sincerely,

Phillip L. Swagel
Director

cc: Honorable Jodey Arrington
Chairman
House Committee on the Budget

Honorable Brett Guthrie
Chairman
House Committee on Energy and Commerce

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February 27, 2025

Sen. John Thune
511 Dirksen Senate Office Building
Washington, DC 20510

Rep. Mike Johnson
568 Cannon House Office Building
Washington, DC 20515

Sen. Charles E. Schumer
322 Hart Senate Office Building
Washington, DC 20510

Rep. Hakeem S. Jeffries
2267 Rayburn House Office Building
Washington, DC 20515

Re: Budget cuts to Medicaid and the Supplemental Nutrition Assistance Program (SNAP)

Dear Majority Leader Thune, Minority Leader Schumer, Speaker Johnson, and Minority Leader Jeffries,

We, the undersigned organizations, urge you to oppose any cuts to Medicaid and the Supplemental Nutrition Assistance Program (SNAP), including those called for in the proposed budget resolution. We are concerned about the negative impact these deep cuts will have on all Americans living with chronic disease and other disabilities, but we are writing to draw your attention to how devastating they will be on those with Alzheimer's disease and related diseases (ADRD), including frontotemporal degeneration and Lewy Body dementia, and their family caregivers.

Today there are more than 7 million Americans living with Alzheimer's, with no immediate cure in sight. Of these, as many as 200 thousand are younger than age 65, with what is known as early-onset Alzheimer's disease. Regardless of age of onset, costs of Alzheimer's care are expensive and primarily fall on families (70 percent) and the Medicaid program (16 percent). This is because most care costs are for non-medical personal care services — such as at-home help with bathing, eating, and using the bathroom.

Almost all people living with Alzheimer's are enrolled in the Medicare program. However, due to high out-of-pocket costs and lack of long-term care insurance coverage, about one in four (24%) of those are "dual eligible" and rely on Medicaid coverage. Medicaid covers services that Medicare does not, such as long-term care in nursing homes, certain aspects of assisted living, and at-home care. Home- and community-based care helps individuals with routine self-care tasks, such as eating, bathing, and dressing, and household activities, such as preparing meals, managing medication, and doing laundry. A recent survey of 48 states by KFF found that shortages in home health workers are most likely to be caused by low reimbursement rates. Seventy percent of home health services are currently paid by Medicaid, and cuts of the magnitude proposed would severely compound this problem.

More broadly, many of our nation's older adults are living in poverty (10%) or near poverty (22%) and are unlikely to be able to afford paid help. Medicaid coverage helps many of the most vulnerable adults with ADRD in our communities, and its necessity is only going to increase as our population ages. Some states provide vision, dental, and hearing care for adult Medicaid beneficiaries, often the only way adults may obtain that coverage. Medicaid also covers premiums, deductibles, co-payments, and out-of-pocket costs for acute care services, which are often cost prohibitive for older and disabled adults (e.g. individuals with early-onset Alzheimer's disease) with low or no incomes. In addition—depending on the state—Medicaid may cover in-home physical and occupational therapy, telehealth consults, adult day care programs, nonmedical transportation, emergency call systems (e.g. Lifeline pendants), and respite for family caregivers; as well as incontinence products, shower benches, wheelchairs and other equipment including the cost of home adaptations for people with mobility challenges.

We also strongly oppose any additional work requirements that have been proposed. Work requirements would take away coverage and have outsized impact on the ADRD community, as they are problematic for those with major family caregiving responsibilities and those with chronic illnesses or disabilities. The ADRD community cannot be carved out from the harm.

Perhaps most significantly, wholesale cuts to the Medicaid program will increase costs to states for Alzheimer's-related care. Research cited by the Family Caregivers Alliance shows that when basic assistance for the needs of daily life is not available, older adults wind up in high-cost settings—notably hospitals and nursing homes—and overall costs increase. ***Home care services are at greatest risk of major cuts because they are optional under Medicaid while nursing home care is mandatory.*** According to the 2023 LTSS Expenditure Report, among states reporting, nearly two-thirds of Medicaid funding for long-term care (63%) was spent on home- and community-based services aimed at keeping people of all ages out of institutions.

The cost of care at home is usually significantly lower than in an institution. KFF reports that, in 2023, the national median annual cost of a private nursing home room was $116,800 annually, while the median cost of a home health aide was $68,640. Many people with Alzheimer's disease in nursing homes do not need to be there, but they are placed there due to prohibitive costs related to home care for families paying out of pocket.

The eligibility criteria for receiving Medicaid-covered home- and community-based services (HCBS) vary by state. The proposed sharp cuts to Medicaid supported by some in Congress and included in the current bill text will put states with higher aging populations at a disadvantage. Required cuts to Medicaid would accelerate over time, just as an increasing number of baby boomers will begin to need home- and community-based services. This will not only put their physical and financial health in jeopardy but will also increase costs to states as care gets shifted to high-cost settings such as emergency rooms and nursing homes. Furthermore, there is already significant unmet need for HCBS and any cuts to Medicaid will only increase the need and lead to more unnecessary institutionalization. On behalf of the millions of American families facing Alzheimer's disease and related dementias, we implore you to oppose any Medicaid cuts.

We also *oppose* any cuts to the Supplemental Nutrition Assistance Program (SNAP). SNAP is our nation's most effective tool to fight hunger, reaching over 40 million children, parents, older adults, disabled people, workers, and other low-income people each month, or about 1 in 8 Americans. It is a valuable resource for those who qualify who suffer from ADRD, ensuring that they can access healthy

food and do not go hungry. Food insecurity is a major risk factor for older adults with chronic illness. SNAP benefits can also be coordinated with meal delivery services like Meals on Wheels, which provide not only nutritious meals but also crucial social interaction, mitigating the negative effects of social isolation and loneliness that are often associated with cognitive decline.

Thank you for considering our views. We stand ready to work with you to develop policies that will ensure people with ADRD and their family caregivers have access to robust coverage that provides necessary benefits at an affordable price. With questions, please reach out to Scott Frey, Senior Vice President of Public Policy and Government Relations at the Alliance for Aging Research, at sfrey@agingresearch.org.

Sincerely,

Alliance for Aging Research

Aging Life Care Association
Alliance for Patient Access
Alzheimer's Association and Alzheimer's Impact Movement
Alzheimer's Los Angeles
Alzheimer's New Jersey
Alzheimer's Orange County
Alzheimer's San Diego
American Academy of Neurology
American Association of People with Disabilities
American Association on Health and Disability
American Federation for Aging Research
American Geriatrics Society
American Medical Women's Association
American Society on Aging
Benjamin Rose Institute on Aging
CareForth
Caregiver Action Network
CaringKind, The Heart of Alzheimer's Caregiving
Caring Across Generations
Center for Caregiver Serenity
Community Legal Aid Society, Inc.
Compassion & Choices
Dementia Alliance International
Dementia Alliance of North Carolina
Dementia Darling
Disability Law Center (MA)
Disability Law Center of Alaska
Disability Rights Arizona
Disability Rights California
Disability Rights Center – NH
Disability Rights Florida
Disability Rights Idaho
Disability Rights Iowa
Disability Rights Maine
Disability Rights New Jersey
Disability Rights North Carolina
Disability Rights Oregon
Disability Rights Pennsylvania
Disability Rights South Carolina
Diverse Elders Coalition
Elder Justice Coalition
Georgetown University
Gerontological Society of America
Global Alzheimer's Platform Foundation
Global Coalition on Aging
Greater Wisconsin Agency on Aging Resources, Inc.
Hand in Hand: The Domestic Employers Network
Hawaii Family Caregiver Coalition
HealthyWomen
Hilarity for Charity
ICAN, International Cancer Advocacy Network
Justice in Aging
Kentucky Protection and Advocacy
Lakeshore Foundation
Leader's Engaged in on Alzheimer's Disease (LEAD) Coalition
Lewy Body Dementia Association
Lewy Body Dementia Resource Center
Lifelines Neuro
LuMind IDSC Foundation
Lupus and Allied Diseases Association, Inc.

Medicare Rights Center
MomsRising
National Alliance for Caregiving
National Association of Activity Professionals
National Association of State LTC Ombudsman Programs
National Caucus and Center on Black Aging
National Consumer Voice for Quality Long-Term Care
National Consumers League
National Council on Aging
National Disability Rights Network (NDRN)
National Indian Council on Aging, Inc.
National Respite Coalition
National Rural Health Association
National Minority Quality Forum
Nevada Disability Advocacy & Law Center
NHCOA
North Dakota Protection & Advocacy Project
Partnership to Fight Chronic Disease
Pentara Corporation
PHI
Post-Acute and Long-Term Care Medical Association
PrognusUs
RetireSafe
Second Wind Dreams, Inc.
The American Association for Geriatric Psychiatry
The Association for Frontotemporal Degeneration (AFTD)
The Balm in Gilead, Inc.
The Ohio Council of Cognitive Health
University of Pennsylvania
UsAgainstAlzheimer's
USAging
Virtual Dementia Tour
Voices of Alzheimer's
Volunteers of America
Well Spouse Association
Wisconsin Aging Advocacy Network

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Andrea Gilmore Bykovskyi, PhD, RN (University of Wisconsin School of Medicine & Public Health)
Joette Giovinco, MD, MPH (University of South Florida)
Gerardo R. Godinez, MSc (Noah Homes)
Lea T. Grinberg, MD, PhD (University of California San Francisco, School of Medicine)
Lisa Gwyther, MSW, LCSW (Duke University Medical Center)
Megan Thomas Hebdon (College of Nursing University of Utah)
Ula Hwang, MD, MPH (New York University Grossman School of Medicine)
Philip Insel, PhD, MS (University of California San Francisco School of Medicine)

Khalid Iqbal, PhD (New York State Institute for Basic Research in Developmental Disabilities)
Charles Jennings, Phd (Mass General Brigham)
Lee A. Jennings, MD, MSHS (University of Oklahoma Health Sciences Center)
Suzee Lee (University of California, San Francisco)
Cynthia A. Lemere, PhD (Brigham and Women's Hospital, Harvard Medical School)
Yvonne Lu, PhD, RN, FGSA, FAAN (Indiana School of Nursing)
David X. Marquez, PhD (Department of Kinesiology and Nutrition, University of Illinois at Chicago)
Eric McDade, DO (Washington University School of Medicine)
Elizabeth Mormino, PhD (Stanford University School of Medicine)
Esther Oh (Johns Hopkins University School of Medicine)
Lisa Ost-Beikman (National Association of Activity Professionals)
Katherine L. Possin, PhD (University of California San Francisco, Memory and Aging Center)
Anupam Raina, PhD (University of Alabama Birmingham, Department of Pathology)
Emily Rogalski, PhD (University of Chicago, Healthy Aging & Alzheimer's Research Care Center)
S. Ahmad Sajjadi, MD, Phd (University of California Irvine)
Sharon Sha (Stanford University)
Amanda G. Smith, MD (University of South Florida Byrd Alzheimer's Institute)
B. Joy Snider, MD, PhD (Washington University School of Medicine)
Jodi Southerland (East Tennessee State University)
Robert C. Speth, PhD, FAAAS, FAHA (Nova Southeastern University)
MaryAnne Sterling (The George Washington University Milken Institute School of Public Health)
Donald Sullivan, MD, MA, MCR (Oregon Health and Science University)
Pierre N. Tariot, MD (Banner Alzheimer's Institute, University of Arizona College of Medicine)
Elena Tsoy, PhD (University of California San Francisco)
Keith Vossel, MD, MSc (Mary S. Easton Center for Alzheimer's Disease Research, David Geffen School of Medicine at UCLA
Sarah Walter (ACTC-DS)
Donna M. Wilcock, PhD (Indiana University)
Nancy Wilson, MA, LCSW (Baylor College of Medicine)
Charles Windon, MD (Weill Institute for Neurosciences, University of California, San Francisco)
Mia Yang (Wake Forest University School of Medicine)

April 1, 2025

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, DC

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC

The Honorable John Thune
Majority Leader
U.S. Senate
Washington, DC

The Honorable Chuck Schumer
Minority Leader
U.S. Senate
Washington, DC

RE: *Reject Medicaid Cuts*

Dear Leader Thune, Leader Schumer, Speaker Johnson, and Leader Jeffries:

The undersigned more than 1,600 community provider organizations write in opposition to the Medicaid reductions contemplated by the House's FY 2025 budget resolution—in particular, the instruction to the House Energy and Commerce Committee to make cuts of at least $880 billion. Cuts to Medicaid would weaken this nation's system of community-based services that support people with disabilities. We urge you to protect access to critical supports and services for people with disabilities and reject harmful Medicaid cuts.

Community providers offer a broad range of person-centered supports to make community inclusion a reality for people with intellectual and developmental disabilities (I/DD)—from helping people with activities of daily living, such as meal preparation, medication management, and communication, to employment support and assistance in pursuing personal goals. Medicaid is the foundation for these supports that enable people with I/DD to live full and independent lives in their homes and communities.

Reductions in federal Medicaid funding will have negative impacts on states. Medicaid operates as a partnership between states and the federal government. States determine the scope and payment for services to be provided for beneficiaries, and the federal government provides matching funds. This combined funding is then used to pay community providers for the services they deliver to people with I/DD. Medicaid cuts shift the costs away from the federal government and onto the states.

Even if reductions do not specifically target funding for I/DD services, the resulting pressure on state budgets that exists when federal funding is reduced will create an elevated risk of further limits and cuts to services for individuals with I/DD. When federal Medicaid funding is reduced, states must find new funding to balance the shortfall in state budgets. If new funding cannot be found, states have historically reduced and terminated non-mandatory services like community-based services, restricting access to essential supports for people with I/DD.

Community-based services are already in a fragile state, with providers grappling with a workforce shortage that has led to diminished access for people with I/DD to community-based services. Across the country, more than 500,000 people with I/DD are on states' waiting lists for home- and community-based services. Wait times are often several years long, and people with disabilities either go without the support they need or are forced to seek services in hospitals and large-scale institutions. Decades of underinvestment in the Medicaid program, coupled with insufficient reimbursement rates, have left community providers unable to offer wages that are competitive with those of hourly-wage industries, such as fast food, retail, and convenience stores, leading to further closures and program terminations without sufficient staffing to meet the need.

To keep the promise of community living for people with I/DD a reality, we must invest in—not divest from—the Medicaid program. Medicaid enables community providers to support individuals with disabilities and helps contribute to a stronger America for everyone. Please support community providers and reject harmful cuts to Medicaid funding.

Sincerely,

1,680+ Community Providers Listed by State

Alabama
ARC-Baldwin County, Inc.
Bridget's Home, Inc.
Central Alabama Wellness
Easterseals, Alabama
Giv Care, Inc.
Greater Etowah MR 310 Board
Inspiritus, Inc.
Progressive Healthcare Providers
SafeinHome, Inc.
Sevita
The Arc Central Alabama
The Arc of Alabama
The Arc of Walker County
United Ability, Inc.
United Cerebral Palsy of Huntsville and Tennessee Valley
United Cerebral Palsy of Mobile, Inc.
United Cerebral Palsy of West Alabama
United Cerebral Palsy-National Office
Volunteers of America Southeast

Alaska
1 Alliance Care Coordination
9 Tales Care Coordination, LLC
AADSP Alaska Alliance of DSP
Access Alaska, Inc.
AK Nurtured Living
Alaska Association for Personal Care Supports
Alaska Association on Developmental Disabilities
Alaska Behavioral Health Association
Alaska Care Connections, Inc.
Alaska Center for Children and Adults
Alaska Governor's Council on Disabilities and Special Education
Alaska Premier Assisted Living, LLC
Alpenglow Care Coordination, LLC
Alzheimer's Resource/Care Coordination Resource of Alaska
Assets, Inc.
Branching Out Supported Services
Care Coordination Advocates of Alaska
Choice Care, LLC
Christine, Inc.
Cindy and Vic's R&R, Inc.
Community Connections Inc
Connecting Ties, Inc.
Cornerstone Home Care
Eagle Crest ALH, LLC
Easterseals, Alaska
Fairbanks Assisted Living

Fairbanks Resource Agency
Fitchett's Assisted Living Home, LLC
Frontier Community Services
Giv Care, Inc.
Golden Angel Assisted Living Home
Home on Mulchatna
Hope Community Resources
In His Image, LLC
Inclusion Care Coordination, Inc.
Island Care Services, LLC
Kachemak Care Coordination
LINKS Resource Center
Matanuska Mama
Mat-Su Services for Children & Adults
Me Myself and I
Nadon Family Home, LLC
One Source Home Care Services, LLC
Pathfinder Care Coordination
Quintessence Planning and Care Coordination
REACH, Inc.
ResCare Community Living All Ways Caring HomeCare
Residential Adults with Disabilities, LLC DBA RAD, LLC
Shine Bright Care, LLC
South Peninsula Behavioral Health Services LLC
Southeast Alaska Independent Living, Inc.
The Arc of Anchorage
The Cozy Chalet Assisted Living home LLC
TIDES LLC
Westcare Mgt
Yukon Kuskokwim Health Corporation

Arizona
Abrio Family Services and Supports, Inc
Absolute HCBS
Advanced Independence, LLC
AIRES, LLC
Alexander's Abilities, Inc.
Arion Care Solutions
Arizona Advanced Therapy
Arizona Association of Providers for People with Disabilities
Arizona Cooperative Therapies
Arizona Training & Evaluation Center, Inc. (AZTEC)
Beacon Group, Inc.
Blanca Roebuck Sunrise therapy
Clarissa Beltran Frausto
Community Options, Inc.
Creative Innervisions, LLC
Dana Hutchings
Danville Services of Arizona, LLC
Desert Valley Pediatric Therapy
Dine Bii Association for Disabled Citizens, Inc.
Douglas ARC
Easterseals, Arizona
Endeavor HCBS, LLC.
Essential Therapy Solutions
Family Care Connections
Giv Care, Inc.
Gompers
Guthrie Mainstream Services
Health Care Alternatives, Inc.
Hiliana Barajas
Human Resource Training, Inc. dba Clarvida 2
Huppert Pediatric Therapy, Inc.
Life Challenge, Inc.
LOU Corporation
LTO Ventures
Making Milestones PLLC
Meadows Catalina LLC
Mosaic
NeuroRestorative/Sevita
Nobody's Perfect Inc.
Our Choice Human Services
Quality Connections Inc
ResCare Community Living All Ways Caring HomeCare
Rise Above Support Services
SafeinHome, Inc.
Saguaro Foundation Community Living Programs
Scottsdale Training & Rehabilitation Services (STARS)
Stepping Stones Pediatric Therapy, LLC.
Sunrise Therapy Services

Sunrise Therapy/ Arizona Early Intervention Services
Theracare Pediatric Services
United Cerebral Palsy of Central Arizona
United Cerebral Palsy of Southern Arizona
Wee Care Corporation
Yavapai Exceptional Industries

Arkansas
Achieve Community Alliance
Arkansas Family Supports, Inc.
Building Bridges Developmental and Community Services, Inc.
C. B. King Memorial School
Developmental Disabilities Provider Association
Easterseals Arkansas
Evergreen Life Services
Focus, Inc.
Giv Care, Inc.
Independent Living Services, Inc.
Integrity, Inc.
Lawrence County Cooperative School
Life Styles, Inc.
Network of Community Options, Inc.
NeuroRestorative/Sevita
Newton County Special Service Corporation, Inc.
Ouachita Enrichment Centers
Rainbow of Challenges, Inc.
South Arkansas Development Center for Children & Families
Special Services Learning Center, Inc.
The Doni Martin Center for Developmental Services
The Sunshine School, Inc.
United Cerebral Palsy-National Office

California
AbilityPath
AbleLight
Adjoin
Ala Costa Centers
Alchemia
Anthesis
Arc of Imperial Valley
Association of Regional Center Agencies
Bayberry, Inc.
California Community Opportunities
California Disability Services Association
Cedars
Devereux Advanced Behavioral Health
Dungarvin, California
Easterseals, California
Easterseals Northern California
Empowered Living SLS, Inc.
Escuela del Rio
EXCEED
FRW
Futures Explored
Giv Care, Inc.
Home of Guiding Hands
Hope Services
InAlliance
Inland Respite, Inc.
Kings View
Kreative Community Services
Las Trampas School, Inc.
Lifehouse, Inc.
Mains'l Services
Marin Ventures
MDH Network
Momentum Agencies
Momentum WORK, Inc.
NCI Affiliates, Inc.
NeuroRestorative/Sevita
New Horizons: Serving Individuals with Special Needs
Noah Homes, Inc.
North Bay Housing Coalition
On My Own Independent Living Services
Options For All
PathPoint
ResCare Community Living All Ways Caring HomeCare
SafeinHome, Inc.
San Gabriel Valley Residential Facility
Support Development Associates
The Roland Center
UCP of Sacramento/N. California

UCP of San Diego County
UCP of Stanislaus County
UCP of the North Bay
United Cerebral Palsy of San Joaquin, Calaveras and Amador Counties
United Cerebral Palsy of the Inland Empire
Vocation Plus Connections, Inc.
VTC
Yolo Employment Services

Colorado
A&I Avenues
AbleLight
Alliance
Alpine Adult Day Care, LLC
Alpine Homecare, LLC
Ariel Clinical Services
Artsify, LLC
Blue Peaks Developmental Services, Inc. Early Intervention CO
Cheyenne Village
Children's Specialty Clinic of the San Luis Valley
ClearPath Behavior Services
Colorado Bluesky Enterprises
Community Advantage
Community Connections, Inc.
Community Link
Community Living Alternatives, Inc.
Community Options, Inc.
Continuum of Colorado
DDRC
Dose Health
Dungarvin, Colorado
Dynamic Dimensions, Inc.
Eastern Colorado Services for the Developmentally Disabled, Inc.
Easterseals Colorado
Eleos Services
Elevated Supports
Emmé
Encouraging Development Inc
Envision
Giv Care, Inc.
Imagine!
Inspiration Field
Jewish Family Service of Colorado
Jordan Residential & Vocational Services, Inc.
Laradon
Laurie Stratman Consulting
Mosaic
Mountain Valley Developmental Services, Inc.
NeuroRestorative/Sevita
North Metro Community Services, Inc.
Overture
Parker Personal Care Homes, Inc.
PASCO
Randolph Host Home
ResCare Community Living All Ways Caring HomeCare
Roundup Fellowship
SafeinHome, Inc.
Schaefer Enterprises
Sevita, Colorado
Soul Dogs Inc.
Starpoint
Support Development Associates
The Resource Exchange
Vista Care
Wellspring Community

Connecticut
Allied Community Programs
Alternative Services-NE
ARC of Greater New Haven, Inc.
ARI of Connecticut, Inc.
Aspire Living & Learning
Careforth
Center of Hope Foundation, Inc.
CIL
Community Residences, Inc.
Community Resources for Justice
Community Systems, Inc.
Community Vocational Services, Inc.
CT Community Nonprofit Alliance
Dungarvin, Connecticut
Easterseals Capital Region & Eastern CT
Easterseals of Greater Waterbury
Giv Care, Inc.
Harc, Inc.

Jewish Association for Community Living
KenCrest
Keystone Human Services
LTO Ventures
Lumibility
MidState Arc, Inc.
Mosaic, Connecticut
Network, Inc.
Oak Hill Easterseals
Opportunity House, Inc.
Options Unlimited, Inc.
Pyramid Healthcare, Inc.
ResCare Community Living All Ways Caring HomeCare
Residential Resources, Inc.
SafeinHome
Sarah Seneca Residential Services, Inc.
Seabird Enterprises, Inc
Sunrise Community, Inc.
The Arc Eastern CT, Inc.
The Arc of Litchfield County, Inc.
The Arc of Southington
The Caring Community of CT, Inc.
The Kennedy Collective, Inc.
Thornfield Hall, Inc.
United Cerebral Palsy of Eastern CT
Viability, Inc.
We Do Life Together- Affiliation of ICES, Inc.
Whole Life, Inc.

District of Columbia
Caring Consulting group
Chimes International
DC Coalition of Disability Service Providers
Easterseals DC MD VA
Giv Care, Inc.
Health & Joy Services
Individual Advocacy Group
L'Arche Greater Washington, D.C.
RCM of Washington
United Cerebral Palsy, D.C.
Vista Supports, LLC
Volunteers of America Chesapeake & Carolinas

Delaware
Bancroft
Chimes International
Community Systems, Inc.
Easterseals
Giv Care, Inc.
KenCrest
Keystone Human Services
Montgomery County Chapter NYSARC, Inc.
Mosaic
SafeinHome
Sevita
The Salvation Army DDP
Vista Supports, LLC

Florida
Centerstone
Community Based Care, LLC
Devereux Advanced Behavioral Health
Easterseals Northeast Central Florida
Easterseals South Florida
Evergreen Life Services
Giv Care, Inc.
NeuroRestorative/Sevita
Opportunity Services Inc.
Parc Center for Disabilities
Progressive Healthcare Providers
ResCare Community Living All Ways Caring HomeCare
SafeinHome, Inc.
Sevita, Florida
Sunrise Community, Inc.
United Cerebral Palsy, Florida
United Community Options of South Florida

Georgia
Brightstar Homes and Services Inc.
Careforth
Chanan Foundation Inc.
Compass Coordination, Inc.
Creative Consulting Services
Devereux Advanced Behavioral Health
Diversified Enterprises
Easterseals Middle Georgia, Inc.
Floyd Training and Service Center, Inc.

Giv Care, Inc.
Griffin Area Resource Center, Inc.
Hope Haven of Northeast Georgia, Inc.
InCommunity of Georgia
Inspiritus, Inc.
Meritan, Inc.
NeuroRestorative/Sevita
People Making Progress Inc.
Progressive Healthcare Providers
Pyramid Healthcare, Inc
ResCare Community Living All Ways Caring HomeCare
Sangha Unity Network
Sonja J. Law
Support Development Associates
The Jessamine Place
United Cerebral Palsy of Georgia
Volunteers of America Southeast, Inc.
Wise

Hawaii
Easterseals Hawaii
Full Life Hawaii
Giv Care, Inc.
Support Development Associates
The Arc of Kona
United Cerebral Palsy, Hawaii

Idaho
Branch Management, LLC
Cache Employment and Training Center
Center for Independent Living
Developmental Options
Easterseals, Idaho
Giv Care, Inc.
Grand Teton Human Services
Milestone Decisions
NeuroRestorative/Sevita
Northwest Center
ResCare Community Living All Ways Caring HomeCare
Westcare Mgt
Witco, Inc.

Illinois
Ada S. McKinley Community Services Inc.
Association for Individual Development (AID)
Avenues to Independence
Blue Island Citizens for People with Intellectual Developmental Disabilities (dba Blue Cap)
Bryan Manor
CCAR Industries
Centerstone
Clearbrook
Crosspoint Human Services
CTF Illinois
DDNA (Developmental Disabilities Nursing Association)
DSC
Easterseals Joliet Region, Inc.
Easterseals Midwest
EP!C
Garden Center Services
Giv Care, Inc.
Glenkirk
Goldie B. Floberg Center
Horizon House of Illinois Valley, Inc.
Individual Advocacy Group
Institute on Public Policy for People with Disabilities
Jewish United Fund/Jewish Federation of Chicago
Kaskaskia Workshop, Inc., Penta Group, Inc.
Penta Nascent Corp.
Keystone Alliance
Kreider Services, Inc.
Lambs Farm
Little City Foundation
Little Friends, Inc.
LTC Support Services, LLC
Mosaic, Illinois
NeuroRestorative/Sevita
Orchard Village
Pathfinder Services, Inc.
Pioneer Center for Human Services
Ray Graham Association
ResCare Community Living All Ways Caring HomeCare

Riverside Foundation
Search, Inc.
Sertoma Star Services
Service Inc. of Illinois
Shore Community Services
South Chicago Parents and Friends, Inc.
Southern Illinois Community Services, d.b.a. My Life My Home
St. Coletta of Wisconsin, Inc.
Trinity Services, Inc
Turning Pointe Autism Foundation
UCP Seguin of Greater Chicago
United Cerebral Palsy - Center for Disability Services
Vista Care

Indiana
Abilities Services, Inc.
ADEC, Inc.
Bi-County Services, Inc.
Careforth
Carey Services, Inc.
Centerstone
Developmental Services, Inc.
Dungarvin, Inc.
Easterseals Crossroads
Easterseals Northeast Indiana
Easterseals Rehabilitation Center, Inc.
First Chance Center
Giv Care, Inc.
Hillcroft Services, Inc.
Hopewell Center, Inc.
INARF (Indiana Association of Rehabilitation Facilities)
Jay-Randolph Developmental Services, Inc. (JRDS)
Kaiser Home Support Services
KCARC
Kestrel Behavioral Health
LTO Ventures
Marshall Starke Development Center
Mosaic, Indiana
New Hope of Indiana, Inc.
New Hope Services, Inc.
Noble Inc.
Opportunities for Positive Growth, Inc.
Opportunity Enterprises
Paladin, Inc.
Plans to Prosper
Putnam County Comprehensive Services, Inc.
ResCare Community Living All Ways Caring HomeCare
Respite Care Services, Inc.
SafeinHome, Inc.
Sevita
Southern Indiana Resource Solutions, Inc (DBA SIRS)
Stone Belt Arc
Support Development Associates
Tangram, Inc.
The Arc Noble County Foundations
The Arc of Evansville
The Arc of Greater Boone County, Inc.
The Arc of LaGrange County
The Village of Merici, Inc.
United Cerebral Palsy
Village of Merici, Inc.
Wabash Center, Inc.

Iowa
Candeo
Christian Opportunity Center
Community Options Inc.
Comprehensive Systems, Inc.
CROSSROADS, Inc.
Easterseals Iowa
Elderbridge Agency on Aging
Exceptional Persons, Inc.
Family Resource Center
Giv Care, Inc.
Hands of Heartland
Horizons Unlimited of Palo Alto County
Howard Center, Inc.
Imagine the Possibilities
LifeWorks Community Services
Mainstream Living
Monroe County Professional Management
Mosaic, Iowa
NeuroRestorative/Sevita
New Hope

Nishna Productions Inc
One Vision
Pathway Living Center, Inc.
Plains Area Mental Health, Inc.
Premier Payee Inc.
Respite Connection
SafeinHome, Inc.
Sunrise Community, Inc.
The Arc of East Central Iowa
The Community Supports Network, Inc
Trivium Life Services
United Cerebral Palsy-National Office
Vocational Development Center, Inc.
WCDC Inc.

Kansas
AbleLight
Big Lakes Developmental Center, Inc.
COF Training Services
Cottonwood, Inc.
Developmental Services of Northwest Kansas, Inc.
Doniphan County Services and Workskills, Inc.
Easterseals Midwest
Futures Unlimited, Inc.
Giv Care, Inc.
Harvey-Marion CDDO
Hetlinger Developmental Services, Inc.
Community Developmental Disabilities Organization
Mosaic, Kansas
OCCK Inc.
Paradigm Services Inc
ResCare Community Living All Ways Caring HomeCare
Starkey, Inc.
TARC
Tri-Ko, Inc.
Twin Valley Developmental Services, Inc.
Wise

Kentucky
Advantage Case Management
AlmCare
Cedar Lake Park Place
Dreams With Wings
Dungarvin, Kentucky
Easterseals
Evergreen Life Services
Giv Care, Inc.
Hands of Hope Services
Infinite Abilities & Supports
Kentucky Association of Private Providers
LifeSkills, Inc. & Pennyroyal Center
Marpe Therapy Services
NeuroRestorative/Sevita
NorthKey Community Care
Pathways Inc.
Peak Community Supports, Inc.
REACH of Louisville
ResCare Community Living All Ways Caring HomeCare
Seven Counties Services, Inc.
St. Mary's Center
Therapeutic Intervention Services
Tri-Generations
United Cerebral Palsy

Louisiana
Alexander Milne Developmental Services
Arc of Acadiana, Inc.
CARC
Careforth
Community Bridges South
Community Provider Association of Louisiana
Delta American Healthcare, Inc.
Dose Health
Easter Seals Louisiana, Inc.
Evergreen Life Service, Central Louisiana
Evergreen Life Services
Giv Care, Inc.
Lafourche Arc
Leading Home Care
Liberty Six Community Homes
Medical Management Enterprise
OPTIONS, Inc.
Quality Support Coordination Inc
REM Mississippi and DDMS Louisiana

ResCare Community Living All Ways Caring HomeCare
Sevita, Louisiana
The Arc Caddo-Bossier
The Arc of Acadiana, Inc.
The Arc of Greater New Orleans
United Cerebral Palsy
Volunteers of America North Louisiana
Volunteers of America Southeast Louisiana

Maine
Affinity
Alternative Services-NE
AMHC
Amicus
Azel Residential Care LLC
BFLI
Bridge Support Services
Casa inc.
Children's Odyssey
Citizens of Maine, LLC
Community Living Association
Community Social Services
Creative Options
Creative Works
Danforth Habilitation Association
Dragonfly Academy, LLC
Easterseals
Elmhurst Inc.
Essential Learning Solutions
Giv Care, Inc.
GMS
Goodwill Northern New England
Granite Bay Care
Great Bay Services
Green Leaf Residential Care
Happy Haven
Hope Association
Hope Family Partners
Independence Advocates of Maine
Independence Association
John F. Murphy Homes, Inc.
KFI
LEAP, Inc.
Legends Residential Care
Living Innovations, a Service of Mosaic
Maine Association for Community Service Providers (MACSP)
Maine Developmental Services Oversight and Advisory Board
Maine Family Services
MERT Enterprises Inc.
Mobius, Inc.
MVRA
Northern Aroostook Alternatives, Inc.
Northern Maine General
OHI
One Love HomeCare, LLC
Opportunity Enterprises
Pathways of Maine, dba Clarvida
PCS Family Homes
Penquis
Personal Onsite Development
Pine Tree Society
Pledge Residential Care
Port Resources
PSL Services STRIVE
Quality care access
Residential Resources
Serenity Residential Care
SKILLS, Inc.
Special Children's Friends
Spurwink Services
The Progress Center
Uplift, Inc.
Victory Residential Services
Waypoint Maine, Inc.
WE THRIVE LLC
Woodfords Family Services
Work First, Inc.

Maryland
Aspire Living & Learning
Bello Machre, Inc.
Benedictine
Calmra, Inc.
Caring Consulting group
Chimes International
Community Options Inc.
Compass, Inc.

Easterseals DC MD VA
HomeCare
Giv Care, Inc.
Individual Advocacy Group
Jubilee Association of Maryland
Makom
MPower Me
NeuroRestorative/Sevita
Northwest Center
Pyramid Healthcare, Inc
ResCare Community Living All Ways Caring
Service Coordination, Inc.
Support Development Associates
The Arc Central Chesapeake Region
United Cerebral Palsy
Vista Supports, LLC
Volunteers of America Chesapeake & Carolinas

Massachusetts
Advocates
Almadan, Inc.
Alternative Supports, Inc.
Aspire Living & Learning
Association of Developmental Disabilities Providers (ADDP)
Attleboro Enterprises, Incorporated
Autism Services Association, Inc.
BAMSI
Bay Cove Human Services
Beaverbrook STEP, Inc.
Behavioral Health Network
Berkshire Hills Music Academy
Better Community Living, Inc.
Bridgewell, Inc.
Cape Abilities
Careforth
Caring Consulting group
Center of Hope Foundation, Inc.
Charles River Center
Communitas Inc.
Community Resources for Justice
Community Systems, Inc.
Delta Projects
Devereux Advanced Behavioral Health
Easterseals
Evergreen Center, Inc.
Gandara Mental Health Center, Inc.
Giv Care, Inc.
Grow Associates
Guidewire, Inc.
Incompass Human Services, Inc.
Jewish Family & Children's Service of Greater Boston
Kennedy Donovan Center
L'Arche Boston North, Inc.
Living Independently Forever, Inc.
Melmark, Inc.
Multicultural Community Services
New England Village
Northeast Arc
NuPath, Inc.
Open Sky Community Services, Inc.
Opportunity Works
People Incorporated
Resources For Human Development
RFK Community Alliance
Riverside Community Care
Riverside Industries, Inc.
Road To Responsibility, Inc. (RTR)
SafeinHome, Inc.
Seven Hills Foundation
The Arc of Bristol County
The Arc of Opportunity in North Central Massachusetts, Inc.
The Arc of Plymouth and Upper Cape Cod
The Guild for Human Services
The PLUS Company, Inc.
The Price Center
Toward Independent Living and Learning, Inc
Transitions Centers, Inc.
Turning Point Inc.
UCP of Western MA
United Cerebral Palsy of Metro Boston, Inc.
Venture Community Services
Viability, Inc.

Michigan
Alternative Choices
Alternative Services-NE

Autism Alliance of Michigan
Beacon Specialized Living, Inc.
Easterseals
Giv Care, Inc.
MI-UCP
NeuroRestorative/Sevita
ResCare Community Living All Ways Caring HomeCare
United Cerebral Palsy

Minnesota
Ability Building Community
ABLE, Inc.
AbleLight
Accord
Aitkin County Developmental Achievement Center, Inc.
Anita Garner AFC
Arrowhead House Foster Care
ARSYS, LLC
Association of Residential Resources in MN (ARRM)
Axis, Inc
Beacon Specialized Living, Inc.
Becker County DAC
Blue Sky Inc.
CCRI, Inc.
Cedar Hills Foster Care
Chez Nous, Inc.
Client Community Services, Inc.
Community Based Care, LLC.
Community Options & Resources (COR)
Cottonwood County Developmental Achievement Center
Covenant Ability Network of MN
Crescent Cove
Dose Health
Dungarvin, Minnesota
Easterseals, Minnesota
Employment Enterprises, Inc.
Enriched Living, LLC
EON, Inc.
Epic Enterprise Inc.
Episcopal Group Homes, Inc.
Floodwood Services & Training, Inc.
Fridgen Foster Care
Giv Care, Inc.
Great River Homes, Inc.
Health Providers
Hiawatha Homes, Inc.
Hiawatha Manor, Inc.
Home and Community Options, Inc.
Hubbard County Developmental Achievement Center, Inc.
J & K Cozy Care Family Residential Services
Jobs Plus Incorporated
Joyful Living
Lake County DAC, Inc.
Lakes Area DAC
Laura Baker Services Association
Lifetime Resources, Inc.
Lifeworks Services, Inc.
Living Well Disability Services
LTO Ventures
Lutheran Social Service of Minnesota
Main Street Industries and Training Center, Inc.
Mains'l Services
Maple Leaf Services
Mary T. Associates
MRCI
MSS
NeuroRestorative/Sevita
Northeast Contemporary Services, Inc.
Northern Cass DAC, Inc.
Occupational Development Center, Inc.
Opportunity Partners, Inc.
Opportunity Services Inc.
Options, Inc.
Partnership Resources, Inc.
Peace of Mind Duluth
Personal
PHASE-Industries
Pine River Group Home, Inc.
Pinewood-Cloquet, Inc.
PossAbilities of Southern Minnesota
Presbyterian Family Foundation (PFF)
ProAct Inc
Rainy River Waivered Serves Inc.
Reach for Resources

ReliaCare Home Health Inc.
ResCare Community Living All Ways Caring HomeCare
Rise, Inc.
Rudolph Community and Care
SafeinHome, Inc.
Service Enterprises, Inc. of Minnesota
Share-A-Home, Inc.
SMART Public Transit
SMB Disability Solutions Inc.
St. David's Center
STAR Services, Inc.
Stepping Stones for Living, LLC
Stevens County Developmental Achievement Center, Inc.
Support Development Associates
Swift County Developmental Achievement Center, Inc.
The Phoenix Residence Inc. & Phoenix Service Corporation
TSE, Inc.
Udac, Inc.
United Cerebral Palsy, Minnesota
Volunteers of America MN/WI
Wabasha County DAC

Mississippi
Easterseals, Mississippi
Giv Care, Inc.
Meritan, Inc.
NeuroRestorative/Sevita
REM Mississippi and DDMS Louisiana
Volunteers of America Southeast, Inc.

Missouri
731 Investments, LLC
AbleLight Inc.
Austen-Dooley Company, LLC
Avant Supported Living
Beacon Specialized Living, Inc.
Behavior Intervention Services
Boone County Family Resources
Center for Developmentally Disabled (CDD)
Center for Human Services
Cole County Residential Services, Inc.
Community Access
Complete Healthcare Solutions
Day Solutions, Inc.
Developmental Disability Resource Board of Jasper County
Dose Health
Easterseals Midwest
Emmaus Homes
Gingerbread House, Inc.
Giv Care, Inc.
Green Hills Superior Care, Inc.
Hearo Technologies
Impact Support Services
K and C Stepping Stones, LLC
Lafayette County Board of Services (LCBS)
L'Arche St. Louis
Learning Opportunities Quality Works, Inc.
Life Unlimited, Inc.
LTO Ventures
Marion County Services, Inc. dba Abilities
NeuroRestorative/Sevita
Pony Bird, Inc.
Ray County Board of Services
ResCare Community Living All Ways Caring HomeCare
RJD, Inc.
SafeinHome, Inc.
Sherwood Center for the Exceptional Child dba Sherwood Autism Center
Specialized Support Services, Inc.
St. Louis Arc
Starling Missouri
Summit Future Foundation
The Center for Autism Education
The Community Supports Network, Inc
The Farmer’s House
TNC Community
United Cerebral Palsy of Northwest Missouri
Unlimited Opportunities, Inc.
Warren County Pathfinders
Woodhaven Learning Center

Montana
Easterseals, Montana
Giv Care, Inc.

Overture
ResCare Community Living All Ways Caring HomeCare

Nebraska
ABLED, Inc
Compassionate Services and Consulting
Developmental Educational and Behavioral Outcomes, LLC
Easterseals
Elite Disability Services of Nebraska
Envisions of Norfolk, Inc.
Giv Care, Inc.
Hands of Heartland
Home At Last, LLC
Madonna Ability Alliance
Mosaic, Nebraska
Nebraska Association of Service Providers
North Platte Opportunity Center
NorthStar Services
Region II Services
ResCare Community Living All Ways Caring HomeCare
The Community Supports Network, Inc.
United Cerebral Palsy of Nebraska
Vocational Development Center, Inc.

Nevada
Dungarvin, Nevada
Easterseals, Nevada
Giv Care, Inc.
Overture
ResCare Community Living All Ways Caring HomeCare
Sevita, Nevada
State of Nevada Association of Providers - SNAP
United Cerebral Palsy, Nevada
Vista Care

New Hampshire
Aspire Living & Learning
Chesco
Community Options Inc.
Community Partners for Change Inc.
Community Resources for Justice
Easterseals, New Hampshire
Gateways Community Services
Giv Care, Inc.
GMS
Great Bay Services
Living Innovations, a Service of Mosaic
Monadnock Worksource Inc.
NeuroRestorative/Sevita
Residential Resources
Seven Hills Foundation
Siddharth Services, Inc.
The Moore Center
The PLUS Company, Inc.

New Jersey
AbleLight
Abound Health, LLC
Advancing Opportunities
Advantage Supports, LLC
Alliance for the Betterment of Citizens with Disabilities
Bancroft
Beacon Specialized Living, Inc.
Children's Aid and Family Services
Children's Center Programs
Chimes International
Community Access Unlimited
Community Options Inc.
Creative Living Support Services
DAWN Center for Independent Living
Devereux Advanced Behavioral Health
Disability Navigators LLC
Dungarvin, New Jersey
Durand Incorporated
Easterseals, New Jersey
ECLC of New Jersey
Everas Community Services, Inc.
Experienced Support Coordination
Family Resource Associates, Inc.
Family Resource Network
Giv Care, Inc.
Goodwill Industries of Greater NY and Northern NJ

Hackensack Meridian JFK/Johnson Rehabilitation Institute, Pediatric Rehabilitation
Hasc Center Inc.
Heritage Homestead Day Center LLC
Hope Christian Services
Infinity Today
Jewish Association for Developmental Disabilities (J-ADD)
Jewish Family Service of MetroWest New Jersey
Keystone Human Services
LADACIN Network
Matheny Medical and Education Center
Mt. Bethel Village
Navigation Support Coordination
NeuroRestorative/Sevita
New Jersey Association of Community Providers
North Jersey Elks Developmental Disabilities Agency
Our House, Inc.
Pillar Care Continuum
PLAN|NJ
PrimeTime Center
Pyramid Healthcare, Inc
Regal Group Homes Corp
RHA Health Services
Skylands Family Support
Special Needs Residence, LLC & Mt Bethel Day Program
Spectrum for Living Development, Inc.
Support Development Associates
The Arc of Atlantic County Inc.
The Arc, Ocean County Chapter
The Center for Family Support
Theranorth Services, LLC
UCP of Hudson County
United Cerebral Palsy, New Jersey
Vista Rehab Services
Woods System of Care

New Mexico
Abrazos Family Support Services
Association of Developmental Disabilities Community Providers - ADDCP
CARC, INC.
Community Options Inc.,
Dungarvin, New Mexico
Giv Care, Inc.
J&J Home Care, Inc.
Mandy's Farm
ResCare Community Living All Ways Caring HomeCare
Wise
Zia Therapy Center, Inc.

New York
Abilities First, Inc.
AccessCNY
Accessible Academics
ACHIEVE - A Chapter of The Arc NY
ACLD
ADAPT Community Network
Adult Resources Center
Advocacy and Resource Center
AHRC Nassau
AHRC NYC
AIM Services, Inc.
Arc Herkimer
Association for Neurologically Impaired Brain Injured Children, Inc. (AKA-ANIBIC)
Beyond Support Network
Birch Family Services
Bornhava
Buffalo Hearing and Speech Center
Caring Consulting group
Chautauqua County Chapter, NYSARC, Inc., dba The Resource Center
Citizen Advocates
City Access New York, Inc
Community Options Inc.
Community Resources for Justice
Community Resources Staten Island
Community Services for Every1
Constructive Partnerships Unlimited
CP State
Cradle Beach, Inc.
Daybreak Independent Services Inc

Developmental Disabilities Institute
Devereux Advanced Behavioral Health
Directions in Independent Living
Easterseals, New York
Empowering People's Independence
EPIC LI and South Shore Guidance Center
Esperanza Center
Family Residences & Essential Enterprises, Inc
Giv Care, Inc.
Goodwill Industries of Greater NY and Northern NJ
Hasc Center Inc.
Heartshare Human Services of New York
Heaven's Hands Community Services, Inc.
Helping Celebrate Abilities
Heritage Christian Services, Inc.
Independent Group Home Living (IGHL)
Independent Living Association, Inc.
Independent Support Services
Inter Agency Council of Developmental Disabilities Agencies, Inc.
Jawonio
JM Murray
L'Arche Long Island
Lifespire
Living Resources Corp.
LTO Ventures
Manhattan Mothers and Others
Montgomery County Chapter NYSARC, Inc.
NeuroRestorative/Sevita
New Horizons Resources, Inc.
New Vision Services, Inc.
New York Alliance for Inclusion and Innovation
Nicholas Center Ltd
Northwest Center
Onondaga County Chapter NYSARC Inc
Pathfinder Village, Inc.
Person Centered Care Services, Inc.
Queens Centers for Progress
Racker
Residential Resources
Resources for Children with Special Needs d/b/a INCLUDEnyc
Richmond Community Services
SASI (Suburban Adult Services, Inc.)
SCO Family of Services
Services for the Underserved
St. Joseph's Addiction Treatment & Recovery Centers
Stepping Stone Day School
Support Development Associates
The Arc Jefferson-St. Lawrence
The Arc New York
The Arc of Rensselaer County
The Arc Ontario
The Arc Otsego
The Arc Westchester
The Center for Discovery
The Center for Family Support
The Institutes of Applied Human Dynamics, Inc. (IAHD)
The Kennedy Collective, Inc.
The Summit Center, Inc.
Therapy and Learning Center
United Cerebral Palsy Association of the Rochester Area, Inc.
United Cerebral Palsy of Long Island
United Way of New York State
Vanderheyden
Viability, Inc.
Vista Supports, LLC
WellLife Network Inc.

North Carolina

Abound Health, LLC
Autism Society of North Carolina
Careforth
Chimes International
Community Based Care, LLC
Creative Living Support Services
Dungarvin, North Carolina
Easterseals PORT Health
Giv Care, Inc.
Hansel Union Consulting, PLLC
Liberty Corner Enterprises, Inc
Melmark, Inc.
MPower Me
North Carolina Providers Council
Pyramid Healthcare, Inc

ResCare Community Living All Ways Caring HomeCare
Residential Services, Inc.
RHA Health Services
Skill Creations Inc.
Support Development Associates
United Cerebral Palsy, North Carolina
Volunteers of America Chesapeake & Carolinas
Wise

North Dakota
4th Corporation
Alpha Opportunities Inc
Community Living Services, Inc.
Development Homes, Inc.
Easterseals, North Dakota
Fraser Ltd
Giv Care, Inc.
Grand Forks Growth and Support Center
Kalix
North Dakota Association of Community Providers
Poppy's Promise
Triumph, Inc.

Ohio
A New Beginning Community Care, LLC
Beacon Specialized Living, Inc.
Breaking the Labels, Adult Service Providers
Capabilities
Careforth
Champaign Residential Services, Inc.
Clear Skies Ahead LLC
CLI Incorporated
Columbus Center for Human Services, Inc.
Community Based Care, LLC
Dose Health
Dreamers Home Health Care LLC
Dungarvin, Ohio
Easterseals, Ohio
Echoing Hills Village, Inc.
Epilepsy Center of Northwest Ohio
Giv Care, Inc.
Graceworks Enhanced Living
Hattie Larlham
Highco
Horizons of Tuscarawas and Carroll Counties, Inc
I Am Boundless
LTO Ventures
MPower Me
NCC Solutions, Inc.
NeuroRestorative/Sevita
Ohio Valley Residential Services, Inc.
Renaissance House, Inc.
ResCare Community Living All Ways Caring HomeCare
Resident Home Corporation, dba Envision
RHDD
The Society for Handicapped Citizens of Medina County, Inc.
United Cerebral Palsy of Greater Cleveland
United Cerebral Palsy, Ohio
United Disability Services, Inc.
United Rehabilitation Services
Wasco, Inc.
Welcome House, INC.

Oklahoma
Central State Community Services Oklahoma, Inc.
Dose Health
Dungarvin, Oklahoma
Easterseals, Oklahoma
Employment Resources Inc.
Evergreen Life Services
Giv Care, Inc.
Hands of Heartland
Independent Opportunities, Inc.
MPower Me
ResCare Community Living All Ways Caring HomeCare
Sequoyah Enterprises Inc.
Soundly Speaking Therapy Services, PLLC
United Cerebral Palsy, Oklahoma
Viability, Inc.
Volunteers of America of Oklahoma, Inc.

Oregon
Abilities at Work
AbleLight Inc.
Advocates for Life Skills and Opportunity, Inc.
Albertina Kerr
Alternative Services-NE.
Artsify LLC
Ashland Supportive Housing and Community Outreach
Center for Continuous Improvement
Chamberlin House Inc.
Community Access Services II, Inc.
Community Pathways
Community Services, Incorporated
Community Support Services
Cornerstone Associates Inc.
Diversability Inc.
Dose Health
Dungarvin, Oregon
Easterseals, Oregon
Edwards Center, Inc.
Enable, LLC
Encompass Person Centered
Full Access
Garten Services, Inc.
Giv Care, Inc.
Harmony Care
Integrated Supports for Living
Jessica Leitner Consulting, LLC
Lifempowered
Living Opportunities Inc
Marie Mills Center, Inc.
New Day Enterprises, Inc.
Ohana Loving Care
Oregon Mennonite Residential Services
Oregon Resource Association
Parents for Alternate Support Solutions
Partnerships In Community Living, Inc.
Pathway Enterprises, Inc.
Pearl Buck Center, Inc.
ResCare Community Living All Ways Caring HomeCare
Rockwest Training Company, Inc.
Ron Wilson Center for Effective Living, Inc.
RoyalCare, Inc
SERP Enterprises
Shangri-La
Smart Living, Learning & Earning with Autism
Southern Oregon Aspire
Step Forward Activities Inc
Sunshine Industries Unlimited
Support Development Associates
Supported Employment Services, Inc.
Supported Independence Services of Oregon
TVW INC.
Uful, LLC.
UHI- Umpqua Homes, Inc.
United Cerebral Palsy
Valor Associates, LLC
Westcare Mgt
Willamette Vocational Resource Community
Wise
Witco, Inc.
Work Unlimited

Pennsylvania
A New Beginning Community Care, LLC
Abound Health, LLC
Access Services
Accessible Academics
Advanced Behavior Treatment
Alleghenies United Cerebral Palsy
Allegheny Children's Initiative
Alliance Health Allegheny Inc
American Safety Options Inc
Applied Counseling and Consulting Services
Aspire Child & Family Services
Bancroft
Beacon Specialized Living, Inc.
Bell Socialization Services, Inc.
Better Outcomes Living Diversely Inc
Cambria Residential Services
Careforth
Cares of Western PA
Center for Community Resources
Chimes International
COMHAR
Communities of Don Guanella and Divine Providence
Community Options Inc.

Community Services Group
Consulting For Human Services
Cori's Place
Developmental Enterprises Corporation
Devereux Advanced Behavioral Health
Easter Seals Western and Central Pennsylvania
Easterseals, Pennsylvania
EIG Services LLC
Emmaus Community of Pittsburgh
Emmaus Home, Inc
Excentia Human Services
Fayette Resources, Inc
Flat Iron Supports LLC
Gesu
Giv Care, Inc.
Harborcreek Youth Services
Inglis
KenCrest
Keystone Human Services
KZL Agency
Lighthouse
LinGroup Inc
LTO Ventures
Martha Lloyd Community Services
Melmark, Inc.
NeuroRestorative/Sevita
Occupational Development Center
Partners For Quality
Person Directed Supports Inc.
Prospectus Associates, Inc. DBA ProBerco
Pyramid Healthcare, Inc
Quality Progressions
RCPA
ResCare Community Living All Ways Caring HomeCare
RHA Health Services
SafeinHome, Inc.
Sevita, Pennsylvania
Shared Support, Inc
Shawn McGill Consulting Inc.
SpArc Philadelphia (The Arc of Philadelphia and Delaware Counties, and SpArc Services)
Suncom Industries, Inc
Sunny Days Adult Daily Living Center, Inc.
Sunrise Community, Inc.
Sunrise Human Services
Support Development Associates
Sydandi LLC dba Care Lync
Terrapin House Inc
The Arc Alliance
The Arc Lancaster Lebanon
The Arc of Centre County, PA Inc
The Arc of Lehigh & Northampton Counties
The Arc of NEPA
The Institute for Human Resources and Services
The Kennedy Collective, Inc.
The Salvation Army DDP
The Shadowfax Corporation
Threshold Rehabilitation Services
United Cerebral Palsy of Central Pennsylvania, Inc.
United Cerebral Palsy of Northeastern PA
Valley Community Services
Venango Training & Development Center, Inc.
Verland
Vista Autism Services
Woods System of Care

Rhode Island
Avatar Residential
Careforth
Community Based Care, LLC.
Community Residences, Inc.
Community Resources for Justice
Devereux
Easterseals, Rhode Island
Gateways to Change, inc
Giv Care, Inc.
Living Innovations, a Service of Mosaic
Looking Upwards
Opportunities Unlimited, inc.
Seven Hills Foundation
The Arc of Blackstone Valley
The Kennedy Collective, Inc.
United Cerebral Palsy, Rhode Island
Viability, Inc.
West Bay RI

South Carolina
Ability Beyond Barriers
Babcock Center
Carolina Behavior & Beyond
Chimes
Community Options Inc.,
Easterseals SC
Georgetown County Board of Disabilities and Special Needs
Giv Care, Inc.
MPower Me
ResCare Community Living All Ways Caring HomeCare
Sevita, South Carolina
South Carolina Human Services Providers Association
Sunrise Community, Inc.
The Arc of South Carolina
The disABILITIES Board of Charleston County
Tri-Development Center of Aiken County, Inc.
United Cerebral Palsy of South Carolina
Volunteers of America Chesapeake & Carolinas

South Dakota
Advance
Black Hills Works
Careforth
Community Connections, Inc.
DakotAbilities Inc.
Giv Care, Inc.
Human Service Agency
NeuroRestorative/Sevita
Northern Hills Training Center
Sesdac, Inc.
Valiant Living Incorporated
Vista Care
VOA Dakotas

Tennessee
Adult Community Training
Autism Breakthrough Corporation
Buffalo River Services, Inc
Centerstone
Community Options, Inc.
Compass Coordination, Inc.
Connexus Incorporated
Dawn of Hope, Inc.
Developmental Services of Dickson County
Easterseals, Tennessee
Emory Valley Center
Evergreen Life Services
Giv Care, Inc.
Helen R. Tucker Adult Developmental Center
Independent Opportunities, Inc.
Madison Haywood Developmental Services INC
Meritan, Inc.
Michael Dunn Center
MillarRich
Northwest Center
Open Arms Care
Progress, Inc.
ResCare Community Living All Ways Caring HomeCare
RHA Health Services
Rhea of Sunshine, Inc.
Rochelle Center
SafeinHome, Inc.
Sertoma Center Inc.
Sevita, Tennessee
Stones River Center
Sunrise Community, Inc.
Sunshine Services
Support Development Associates
Tennessee Community Organizations (TNCO)
The Arc Mid-South
United Cerebral Palsy
Vista Supports, LLC
Waves, Inc.

Texas
21st Century Living, Inc
A Better HCS Home Inc.
A Texas Heart for Families, Inc.
AAA Special Health Services, LLC.
Able Family Services
Advancing Abilities Inc
Advantage Care Services

All The Little Things Count, L.C.
Assured Quality Care Services, LLC
Autism Treatment Center San Antonio
Avondale House
Best Friends Community Services
BNCFRANCO LLC, dba CARING MATTERS
CALAB, Inc.
Community Living Concepts, Inc.
Community Options Inc.,
Community Service Associates, LLC
Dazona Life and Learning Center
Disability Resources, Inc.
Draco Services Inc.
Easterseals Lonestar
Evergreen Life Services
Family of Faith Service Providers
Gateway Community Partners, Inc.
Giv Care, Inc.
Golden Rule Services, Inc.
Gray Legacy Services
Hands of Heartland
Helping Restore Ability
iCare Services, Inc.
Institute of Cognitive Development, Inc.
J.C.E. & Associates, LLC
JADE Quality Care. Inc.
JAMM Microboard
Language Resource Center, Inc.
Lauren McKenna HCS, LLC
Living Resources LLC
Lone Star HCS Inc
LTO Ventures
Mission Road Ministries
NeuroRestorative/Sevita
New Horizons
Northwest Center
PPAT
PRIDE HCS
Private Providers Association of Texas
Reaching Maximum Independence
Regency Community Services, Inc
ResCare Community Living All Ways Caring HomeCare
Shine Bright Care, LLC
Soundly Speaking Therapy Services, PLLC
Southlake Educational Center, Inc
Spectrum of Solutions
Support Development Associates
Tejas Management Systems Inc
Texarkana Special Education Center, dba, Opportunities, Inc.
Texas HCS
The Arc of San Antonio
The Village Centers
Treasures of JOY
Twogether Consulting, Limited
Versatile Care Inc.
Vita Living, Inc.
Volunteers of America Texas
Walnut Creek Residential Services, Inc
Yes I Can Inc.

Utah
Adult Ability Center
Cache Employment and Training Center
Community Options Inc.
CTA Community Supports
Dose Health
Easterseals, Utah
Giv Care, Inc.
Imber Inc
JNK Management LLC dba Pioneer Care Living
Life-Skills and Individual Needs Center
OPPO, LLC
Vista Care

Vermont
Aspire Living & Learning
Easterseals, Vermont
Giv Care, Inc.
Green Mountain Support Services
Health Care and Rehabilitation services
Howard Center, Inc.
NeuroRestorative/Sevita
United Counseling Service
Upper Valley Servies
Vermont Care Partners

Virginia
180 Degree Support Services LLC

Alpha Omega Adult Home Care LLC
Beacon Specialized Living, Inc.
Beyond Disabilities, LLC
Brain Injury Services
Branches of Life LLC
Capriccio Elite, LLC
Caring Consulting Group
Chimes International
Cione McQueen Residences
Collins and Collins, Inc.
Commonwealth Lifespan Services, LLC
Community Based Care, LLC
Community Living Alternatives
Community Systems, Inc.
Cross Roads Point, Inc
Dennis R. Brown, LLC
DePaul Community Resources
Diversity Residential Homes
Easterseals DC MD VA
Easterseals PORT Health
enCircle
Every Citizen Has Opportunities, Inc.
Family Sharing, Inc
Fidura & Associates, Inc.
Gabriel Homes, Inc.
Giv Care, Inc.
Gray's Family Services
Hansel Union Consulting, PLLC
Hartwood Foundation, Inc.
Health & Joy Services
Hope House Foundation
HumanKind
Imperial Care, LLC
Individuals First, Inc.
L&R of Chesterfield
Langley Residential Support Services
L'Arche Greater Washington, D.C.
Life's Journey
Makom
MPower Me
Next Step Therapy and Vocational LLC
Noble Care LLC
Northwest Center
PAMCO CARE
Peaceable Life Therapeutic Services Inc
Pleasant View Inc.
Positive Behavior Consulting LLC
Pyramid Healthcare, Inc.
Quality Divine Services, Inc.
ResCare Community Living All Ways Caring HomeCare
Riggins Residential and Riggins Day Support Sevita, Virginia
Sponsored Residential Services of Central Virginia
Strengthening Our System Inc
Sunrise Community, Inc.
Support Services of Virginia, Inc.
T.L. & Family LLC
The Arc of Greater Prince William/INSIGHT, Inc.
The Arc of Southside
The Choice Group
The disAbility Resource Center of the Rappahannock Area, Inc.
The Faison Center
The Peninsula Community Care Center
ULLC Family Services
United Cerebral Palsy, Virginia
Virginia Family Services
Vista Supports, LLC
Volunteers of America Chesapeake & Carolinas
Wall Residences, Inc.
Wanda Scarbough
Winston’s Residential, LLC

Washington

AbleLight
Access Living, Inc.
Alpha Supported Living Services
Banchero Disability Partners
Camelot Society
Community Living
CRSA - Community Residential Services Association
Dungarvin, Washington
Easterseals, Washington
Evergreen Supported Living
Exceptional Foresters Inc.

Giv Care, Inc.
Hasc Center Inc.
Holly Community Services
Hope Human Services, LLC
Inglewood Residential & Community Services
KTSS inc
L'Arche Tahoma Hope
Merry Glen
Northwest Center
Peralta LLC
PROVAIL
Puget Sound Regional Services
R.O.A.R.
ResCare Community Living All Ways Caring HomeCare
Service Alternatives
Shared Journeys
Soundview Association
Support Development Associates
The Arc of Spokane
Total Living Concept.org
United Cerebral Palsy
Volunteers of America Western Washington
Westcare Mgt
Wise

West Virginia
Easterseals, West Virginia
Giv Care, Inc.
Hansel Union Consulting, PLLC
Pyramid Healthcare, Inc
ResCare Community Living All Ways Caring HomeCare
Sevita, West Virginia
Starlight Behavioral Health
United Cerebral Palsy
Unlimited PossAbilities, Inc.
WV Behavioral Healthcare Providers Association

Wisconsin
AbleLight Inc.
Beacon Specialized Living, Inc.
Community Living Connections, Inc.
Dose Health
Dungarvin, Wisconsin
Easterseals, Wisconsin
Giv Care, Inc.
Limitless Possibilities LLC
LTO Ventures
NeuroRestorative/Sevita
Options In Community Living, Inc
ResCare Community Living All Ways Caring HomeCare
Rise, Inc.
St. Coletta of Wisconsin, Inc.
United Cerebral Palsy of Greater Dane County, Inc.
Vista Care
Volunteers of America MN/WI

Wyoming
Easterseals, Wyoming
Giv Care, Inc.
Overture

**Some organizations may appear multiple times where they operate as separate entities in the various states where they provide supports.*

The Disability and Aging Collaborative

&

CONSORTIUM FOR CONSTITUENTS WITH DISABILITIES

February 21, 2025

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, DC

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC

Dear Speaker Johnson, Leader Jeffries, and Members of the House of Representatives:

The co-chairs of the Disability and Aging Collaborative (DAC) and the Health and Long-Term Services and Supports Task Forces of the Consortium for Constituents with Disabilities (CCD) write to **urge you to reject the FY 2025 budget resolution passed out of committee**. The resolution calls for the committee that oversees Medicaid to cut a *minimum* of $880 billion, with pressure to make even deeper cuts. Any funding cut would punch multi-billion dollar holes in state budgets, shifting responsibility to state legislatures and forcing them to cut coverage and care for millions of Americans, including people with disabilities and older adults.

As the attached letter from 400+ aging, disability, and allied organizations from every state explains, at least 17 million people with disabilities and older adults, as well as family caregivers and their children, direct care workers, and other low-income individuals and families depend on Medicaid every day for their health, safety, and independence. Medicaid enables our communities to go to work and to care for our loved ones. It is our communities' lifeline, and we cannot afford for any part of it to be cut.

Medicaid is already lean and efficient. Funding cuts, caps, or changes that limit eligibility for or make it harder to enroll in or maintain coverage threaten the longstanding Medicaid guarantee for people with disabilities, older adults, and their families. Medicaid is critical not only as primary coverage for health care, but also as the primary payer for long-term services and supports (LTSS) that support people with disabilities and older adults. It pays for nearly 70% of home and community-based services and care for five out of eight nursing home residents. Furthermore, Medicaid helps 12.5 million seniors and people with disabilities with Medicare's high out-of-pocket costs and covers benefits that Medicare does not, including dental, vision, hearing, and non-emergency medical transportation. In short, cuts to Medicaid are cuts to Medicare as well.

We strongly oppose any budget resolution that calls for or leads to Medicaid cuts as well as any efforts to impose per capita caps, block grants, work requirements, restrictions on eligibility, barriers to enrollment, or any other harmful changes to the Medicaid program. Exemptions or carve-outs to Medicaid cuts meant for people with disabilities and older adults will not save them from harm.

Over 15 million Medicaid enrollees reported having a disability in 2023 through the American Community Survey (ACS), six million more people than those who qualify for Medicaid through having a disability. The number of people with disabilities on Medicaid is likely even higher as the ACS undercounts the total number of people with disabilities in the country. This discrepancy exists because Medicaid uses the most stringent definition of disability for eligibility, leaving many out. Medicaid expansion changed this, providing coverage to millions; however, that is now at risk. The bottom line is that any of these cuts and harmful changes lead to the same result: taking away coverage from people with disabilities, older adults, and others who cannot otherwise afford health care and long-term services and supports.

Access to Medicaid is a matter of life, death, and independence for millions of Americans with disabilities, older adults, and their families and communities. Medicaid is a lifeline, not a piggy bank. We will oppose cuts in every form because they will all harm people with disabilities and older adults.

If you have any questions, contact Natalie Kean, nkean@justiceinaging.org; Nicole Jorwic, nicole@caringacross.org; and John Poulos jpoulos@autisticadvocacy.org.

Sincerely,

Co-Chairs of the Disability and Aging Collaborative
Nicole Jorwic, Caring Across Generations
Natalie Kean, Justice in Aging
John Poulos, Autistic Self Advocacy Network

Co-Chairs of the Consortium for Constituents with Disabilities LTSS Task Force
Elise Aguilar, American Network of Community Options and Resources (ANCOR)
Tory Cross, Caring Across Generations
Jennifer Lav, National Health Law Program
Kim Musheno, The Arc of the United States
Gelila Selassie, Justice in Aging

Co-Chairs of the Consortium for Constituents with Disabilities Health Task Force
Caroline Bergner, American Speech-Language-Hearing Association
Michael Lewis, American Association of People with Disabilities (AAPD)
David Machledt, National Health Law Program
Julie Schurman, Disability Belongs
Greg Robinson, Autistic Self Advocacy Network

NATIONAL ASSOCIATION OF SPECIALTY PHARMACY

April 28, 2025

The Honorable Brett Guthrie
Chairman
House Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Committee on Energy & Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Guthrie and Ranking Member Pallone:

On behalf of the National Association of Specialty Pharmacy (NASP), I wanted to provide timely feedback and raise specialty pharmacy's concerns regarding, **H.R. 2484, the *Seniors' Access to Critical Medications Act***, scheduled for full committee mark up on Tuesday April 29, 2025. NASP has shared concerns and prospective edits for the legislation, however, those concerns have yet to be addressed. We continue to welcome an opportunity to work with the Committee and sponsors to adopt commonsense edits to protect patients and pharmacies, however, we oppose H.R. 2484 in its current form.

We remain concerned that the legislation, as currently drafted, could unintentionally harm patient safety and access to lifesaving pharmacy services. We are also concerned it drastically undermines the Stark Law and will exacerbate anticompetitive market practices in Medicare Part D.

While proponents of the legislation have emphasized its intent to improve the convenience of accessing cancer drugs for patients and their caregivers, it's important to note the bill is not limited to cancer treatments but rather applies to all Part D drugs. We are particularly concerned that the bill could unintentionally create a perverse financial incentive to steer patients toward affiliated pharmacy entities, rather than ensuring patients have access to the pharmacy of their choice.

Additionally, the legislation would undermine the intent of long-standing prohibitions against physician self-referral within the Medicare program. The Stark Law is meant to prevent unnecessary medical services driven by financial interests rather than clinical necessity and also the steering of patients to entities with whom the provider has a financial relationship. Unfortunately, this legislation will eliminate the long-standing prohibition against physician self-referral and would allow physicians and physician practices to steer patients to entities with which they have a financial interest for high-margin drugs.

Finally, while current law allows physicians to dispense medications directly to patients within their offices, H.R. 2484 would permit physicians and physician-owned pharmacies to dispense any Part D medications for up to a year by mail or courier, following only one in-person visit. This pivots significantly from the standards that are required of accredited pharmacies that dispense specialty, high-touch drugs, where frequent patient communication and direct evaluation of the drug's use is critical to patient safety and management.

While not the intention of the sponsors, the bill's current approach raises concerns about the increased risks of over prescribing, overutilization, medication errors, and adverse events related to the dispensing of complex therapies for any specialty medical condition.

NASP requests to work with the House Energy & Commerce Committee, bill sponsors and leadership to address the concerns raised before H.R. 2484 further advances.

Sincerely,

Sheila Arquette, RPh.

President and CEO

cc: Members, House Committee on Energy & Commerce

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Today, House Republicans are marking up the budget resolution they released yesterday that would require Congress to dramatically cut programs to pay for trillions of dollars in tax cuts for the wealthy. In particular, they direct the House Energy and Commerce Committee, which has jurisdiction over Medicaid, to cut nearly $900 billion in federal spending, putting Medicaid funding at grave risk.

These massive cuts threaten the health care of millions of older adults who rely on Medicaid for their health and long-term care needs. Medicaid is not just a safety net; it is a lifeline for seniors. Without it, they could not afford home-based or nursing facility care and would struggle to meet high out-of-pocket costs associated with Medicare. The proposed cuts would starve Medicaid, forcing states to reduce spending by cutting access to these essential benefits, leaving older adults without health care and support they need.

And Medicaid is not the only program on the chopping block that supports older adults. **The budget resolution also includes deep cuts to SNAP benefits that would make it even harder for older adults to buy groceries.**

It is imperative for lawmakers to reject any budget that uses public programs as a piggy bank to fund tax breaks for the wealthy and corporations at the expense of the well-being of older adults. Instead, Congress should prioritize lowering the costs of health and long-term care for our aging population. We urge lawmakers to be champions for older adults and to ensure they have access to the care and supports they need.

Call your lawmakers and demand that they protect Medicaid for older adults: 866-426-2631.

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info@justiceinaging.org

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April 1, 2025

The Honorable John Thune
Majority Leader
United States Senate
511 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Mike Johnson
Speaker
United States House of Representatives
568 Cannon House Office Building
Washington DC, 20515

The Honorable Chuck Schumer
Democratic Leader
United States Senate
322 Hart Senate Office Building
Washington, DC 20510

The Honorable Hakeem Jeffries
Democratic Leader
United House of Representatives
2267 Rayburn House Office Building
Washington, DC 20515

Dear Leader Thune, Speaker Johnson, Leader Schumer, and Leader Jeffries,

LeadingAge represents more than 5,400 nonprofit aging services providers and other mission-driven organizations serving older adults that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, community-based services, hospice, and home-based care.

We write to express great concern related to the proposed $880 billion dollars in spending cuts assigned to the House Energy and Commerce Committee in the House passed budget resolution. The Energy and Commerce Committee cannot achieve that level of spending cuts without touching the Medicaid program. Our members across the continuum rely on Medicaid to care for older adults in their communities and to sustain their operations. We write to share examples from our communities. These are but a few of the many similar stories we have heard from our members during the past few months.

Medicaid sustains long term services and supports – there is no other option for to pay for these services. The jobs that are created to deliver Medicaid-funded services will be lost in the event of Medicaid financing changes.[1] The real world effect of what is being discussed – whether it is a work requirement, a change to the structure of health care taxes, or a change in the federal medical assistance percentage (FMAP) formula for any segment of the Medicaid population -is large holes to be filled in state budgets. The downstream impact of having to fill those holes will be cuts to essential services, benefit packages, and/or provider rates. Aside from raising state taxes or cutting non Medicaid budget items, there are no other steps that states can take. The end result is that the health and wellbeing of older adults around the country will be severely harmed.

1https //ccf georgetown edu/2025/02/14/number-of-hospitals-and-nursing-facilities-and-related-employment-by-county-2023/

In the words of our members:

- *At a Minnesota Adult Day Program, we currently 45 enroll individuals with 93% of them on Medicaid services. Any cut to Medicaid would be devastating. Some of them live with family. Cuts would take away the needed respite to not only allow family members to maintain their employment but also reduce caregiver burnout. With our individuals that live independently, this is their only source of safe engagement within their community, keeping them active and well. We have longstanding clients – some people have been coming to the Center over 10+ years. One member is 98 and another will be 102. Our program has helped keep them active and allowed them to remain in their community. Adult day services as a whole keep people living in their homes longer and with a higher quality of life. Taking these benefits from them will increase isolation, reduce physical wellness and force the need for higher level care, which will be far more costly.*

- *NM, an older adult in New Jersey, has attended an adult day program 5 days a week since October 2022. She lives in her own apartment and is connected with a case management organization. She has no family or friends who contact her. NM receives assistance with showers, laundering her clothing, support in the bathroom for incontinence, medication administration, and health monitoring. Prior to coming to adult day, NM was not taking her medication daily or managing her hygiene needs. She was not accepting support coming to her home. When NM had COVID and was unable to attend the program while sick, she returned to the program over a week later in the same clothing and incontinence products that she was assisted to put on during her last day of attendance prior to her illness. Without the support of adult day, this would be her reality daily. She has developed friendships, a social outlet, activity engagement, and access to a health and wellness program supporting her with her pain management. Without adult day, funded by Medicaid, she would require nursing home placement.*

- *The Pittsburgh Post Gazette recently cited one of our members talking about what would happen to nursing home residents if Medicaid were cut. "Many elderly nursing home residents turn to Medicaid because they have simply run out of money," said Samantha Rapuk, executive director of St. John Community. "They're fathers, they're mothers, they were active in their communities," she told the group on Monday. "But they outlived their resources." Medicaid pays for care for 100 of the 140 skilled care patients at St. John's, Ms. Rapuk said. The program's low reimbursement levels means the center loses about $30 a day per Medicaid patient — a shortfall that the complex must make up with revenue from services provided to private pay residents.*[2]

- *A New York nursing home organization is in a rural part of the state where overall Medicaid utilization for long term care is 70% and their own Medicaid utilization rate is between 69-79% across their three homes. The center that is 79% Medicaid has an operating margin of negative 12.7%. The leadership of this organization is trying to be as operationally efficient as possible – they have taken C-Suite level pay cuts and are trying to cut costs on things like blankets (switching to thinner ones) and less expensive food rather than close beds or*

[2] Medicaid cuts will have wide ranging fallout, attendees say at Butler conference | Pittsburgh Post-Gazette

reduce staff that is needed to maintain quality. These facilities are already hanging on by a thread; any cuts to Medicaid would force closure or reduction in available beds.[3]

- *Two-thirds of older adults in the U.S. Department of Housing and Urban Development's (HUD's) Section 202 Supportive Housing for the Elderly program are enrolled in Medicaid. There are not nearly enough Medicaid assisted living beds to cover the needs of this population and cuts to Medicaid would exacerbate that problem immensely. Furthermore, Medicaid services allow older adult residents of HUD-assisted housing to age in community by receiving the healthcare supports they need to age independently and avoid nursing home care, which is much more costly to U.S. taxpayers than home- and community-based services. HUD-assisted older adults have more chronic health conditions than non-HUD-assisted older adults with the same incomes living in the same neighborhoods; the pairing of Medicaid and affordable housing allows hundreds of thousands of older adults to age in community.*

We ask that no changes be made to the federal financing component of the Medicaid program during reconciliation. Medicaid is efficient[4] and the only program that supports long term services and supports for older adults. Our providers that take Medicaid have already streamlined operations to the extent possible – the only options that will be left will be closure or to stop accepting Medicaid. This will leave huge gaps in care and services for older adults and ultimately, be more expensive to the health care system overall.

We are happy to discuss any potential proposals in more detail and describe the cascading impacts on the long-term services and supports landscape. Please reach out to Mollie Gurian, Vice President of Policy and Government Affairs, at mgurian@leadingage.org with any questions or to discuss further.

Sincerely,

Katie Smith Sloan
President and CEO
LeadingAge

[3]Our state affiliate, LeadingAge New York, has posted an interview with Capital Tonight Spectrum which is a local news program in Albany. In this interview, there is discussion of the dire Medicaid funding situation in New York State currently and an interview with another of our members who had to close a campus in November due to insufficient Medicaid reimbursement.

[4]Frequently Asked Questions About Medicaid | Center on Budget and Policy Priorities

LEUKEMIA & LYMPHOMA SOCIETY®

February 24, 2025

The Honorable Mike Johnson
Speaker of the House
US House of Representatives
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
US House of Representatives
Washington, DC 20515

Dear Speaker Johnson & Minority Leader Jeffries,

At LLS, our mission is to cure blood cancer and improve the quality of life of all patients and their families. In light of that mission, LLS urges Members of the House to vote NO on the Concurrent Resolution on the Budget for Fiscal Year 2025 as passed by the House Budget Committee, to prevent Congress from making cuts to Medicaid that are ill-conceived, unpopular, and deeply harmful to patients with cancer.

As passed by the Budget Committee, the FY25 Budget Resolution would create not just the opportunity but the obligation for the House Committee on Energy & Commerce to make dangerous cuts to the Medicaid program in the budget reconciliation process expected in the coming weeks. **The hundreds of billions in cuts demanded by the budget resolution can not be achieved without slashing benefits for enrollees or altogether taking away Medicaid coverage from millions of Americans.**

To be clear, LLS and the patients we represent are clamoring for Congress to lower health care costs. But the framework before the House today would pave the way for policies that do just the opposite—putting affordable access to health care out of reach for millions of Americans.

LLS firmly believes that all patients and consumers should have access to high-quality, stable coverage to ensure that they are able to receive appropriate and timely care. Medicaid serves a vital role in making sure that no one is left without access to such coverage. The drastic cuts being considered to reach the savings target outlined in the budget resolution before the Committee clearly threaten access to necessary care for the tens of millions of working families, children, seniors, and people with disabilities who rely on Medicaid.

We urge Members to vote NO on the FY25 budget resolution and instead bring forward a framework that does not demand harmful cuts to Medicaid.

Sincerely,

Brian Connell
Vice President, Federal Affairs
The Leukemia & Lymphoma Society

Pharmacies. The face of neighborhood healthca

NACDS: Changes Needed to "Seniors' Access to Critical Medications Act"

NACDS urges changes to adequately protect patients and pharmacies.

The National Association of Chain Drug Stores (NACDS) is providing the followin statement to address questions about the House Energy and Commerce Committee's anticipated markup of *The Seniors' Access to Critical Medications Act* (H.R. 2484) and its implications for patients and their pharmacies:

"In its current form, this bill would undermine the pro-patient benefits of the pharmacist's role in medication dispensing. It also would undermine safeguards in current law that prohibit physician self-referral within the Medicare program.

We want members of Congress to know clearly that, contrary to this bill’s positioning, the legislation currently is not limited to cancer treatments. Rather, i applies broadly to all Part D drugs.

“NACDS has provided recommendations that would prevent harm to patients, to the Medicare program, to pharmacies, and to all who rely on them. NACDS looks forward to continuing to work with leaders in Congress to amend the legislation as needed. At this time, and until adequate changes are made, NACDS has no choice but to oppose the legislation.

“NACDS appreciates the leadership of Committee members to advance issues of vital importance to Americans and to their pharmacies. NACDS continues to advocate for necessary legislative priorities, and to prevent the unintended consequences of other bills as they arise.”

National
Multiple Sclerosis
Society

February 20, 2025

Dear Members of the United States House of Representatives:

We are writing on behalf of people affected by multiple sclerosis (MS) to urge you to protect Medicaid from proposed cuts. We are extremely concerned about the budget resolution that will soon be considered by the U.S. House of Representatives instructing the House Energy and Commerce Committee to cut spending by $880 billion, with most of these cuts expected to come from the Medicaid program. Medicaid is a vital program that provides health coverage and long-term services and supports for 80 million low-income individuals, people living with disabilities, and families across the United States—including those affected by MS. As you consider legislative proposals that will impact the future of Medicaid, we ask that you recognize the program's life-saving role in ensuring access to comprehensive, affordable healthcare. We urge you to vote NO on this budget resolution.

MS is an unpredictable disease of the central nervous system. Currently, there is no cure. Symptoms vary from person to person and may include disabling fatigue, mobility challenges, cognitive changes, and vision issues. An estimated 1 million people live with MS in the United States. Early diagnosis and treatment are critical to minimize disability. Significant progress is being made to achieve a world free of MS.

The National Multiple Sclerosis Society (Society), founded in 1946, is the global leader of a growing movement dedicated to creating a world free of MS. The Society provides global leadership, funds research for a cure, drives change through advocacy, and provides programs and services to help people affected by MS live their best lives. Additionally, the Society sees itself as a partner to the government in many critical areas. While we advocate for the government's involvement in accelerating the discovery, development, and delivery of new treatments, we do so as an organization whose research investment exceeds $1.2 billion.

The Critical Role of Medicaid for Individuals Living with Multiple Sclerosis

For individuals living with MS and their carepartners, Medicaid is more than just a safety net—it is a critical lifeline. We estimate that Medicaid covers 15% of people living with MS; however, that number does not capture the percentage that receives long-term services and support through Medicaid.[1] Analysis of Komodo's Healthcare Map, which is derived primarily from medical claims data, indicated that within a nationally

[1] Komodo Health. Demographics of the U.S. Multiple Sclerosis Population [Internet]. Komodo Insights; 2025 Feb 19. Available from: https://www.komodohealth.com/insights/ms-demographics-2015-2023

represented cohort between 2015-2023, 108,659 (12%) of individuals living with MS utilized Medicaid Managed Care as their payer, while 22,667 (3%) used Medicaid services.[2]

Managing MS requires continuous care, including prescription medications known as disease-modifying therapies (DMTs). To prevent further disease progression, it is essential that individuals begin an FDA-approved DMT as soon as possible following diagnosis, and continued adherence to medication is essential for treatment effectiveness. Delays or gaps in necessary diagnostic tests or treatments can worsen the prognosis for an individual living with MS and may lead to serious, long-term, and irreversible consequences and disease progression. However, without adequate medical and prescription drug coverage, managing this disease becomes financially impossible for many individuals.

- The average annual cost of living with MS is $88,487 per year.[3]
- The median annual cost of brand DMTs was over $107,000 as of July 2024.

For individuals and families already struggling financially, these costs are insurmountable without access to Medicaid. Ensuring continuous and adequate coverage reduces the risk of disease progression, prevents costly hospitalizations, and enables people with MS to remain engaged in their communities and the workforce.

Medicaid provides access to more than just medications. Bladder dysfunction occurs in at least 80% of people living with MS. Medicaid provides coverage for incontinence supplies, which are expensive to pay for out-of-pocket. Medicaid also covers wound care supplies that can be critical in preventing serious health conditions. This is essential for people living with MS, who are more at risk for pressure sores due to factors like decreased sensation in the skin, mobility challenges which can lead to increased sitting or lying down, and cognitive confusion.

Medicaid helps people living with MS access a range of healthcare providers. Since the symptoms of MS vary from person to person, some individuals require access to a neurologist and a primary care provider—while others need access to a more comprehensive care team. For example, people living with MS may seek treatment from a urologist, a mental health professional, a physical therapist, an occupational therapist, and other providers. For many people living with MS, losing access to their Medicaid providers could be catastrophic and would lead to significantly worse health outcomes.

Finally, Medicaid plays a crucial role for individuals living with MS who are in the two-year waiting period for Medicare. When someone qualifies for Social Security Disability Insurance due to MS, they typically must wait two years before accessing Medicare. During this time, Medicaid can provide healthcare coverage to fill the gap so they can manage their MS, if they meet income and asset requirements.

[2] Komodo Health. Demographics of the U.S. Multiple Sclerosis Population [Internet]. Komodo Insights; 2025 Feb 19. Available from: https://www.komodohealth.com/insights/ms-demographics-2015-2023
[3] The Economic Burden of Multiple Sclerosis in the United States

Medicaid Is a Lifeline for People with Disabilities Who Need Access to Long-Term Services and Supports

Medicaid serves as a cornerstone of support for over 10 million children and adults living with disabilities in the United States, comprising about 15% of all Medicaid beneficiaries.[4] This program is pivotal in providing health coverage and long-term services and support (LTSS), including home and community-based services (HCBS). HCBS enables individuals living with disabilities to lead more independent lives within their communities. HCBS not only aligns with the preference of many individuals to receive care in their own homes and communities, but it is offered at a lower cost than care in a skilled nursing facility (SNF) and allows states to comply with the *Olmstead* decision. HCBS enable people living with disabilities to remain at home and connected to their communities.

Many people living with MS do not need the level of care provided by an SNF but cannot remain living independently at home without access to in-home care. This includes people in their 30s and 40s living with progressive MS, who are much better served by living at home versus in a nursing home setting. HCBS can include access to skilled nursing care and therapies at home, and personal care (e.g., dressing, bathing, toileting, eating, transferring to or from a bed or chair, etc.). Medicaid also provides critical coverage for durable medical equipment (DME), including items such as canes, walkers, and commodes. Medicaid covers equipment that helps prevent falls, injuries, and hospitalization. Total Medicaid spending attributable to non-fatal older adult falls is approximately $3.5 billion annually.[5] In addition, Medicaid covers items such as hospital beds, specialized mattresses to prevent wounds, and Hoyer lifts to help with transferring—all of which help people remain safely in their homes, and cost significantly less than a stay in a hospital or a skilled nursing facility.

Travel-related barriers to care can be significant for the person living with MS and potentially a carepartner, including the actual time to and from a physician visit, the cost of gasoline, and time off work (either paid or unpaid). Without transportation, getting to their doctors and treatments can be unaffordable or even impossible. Many people living with MS, including those in rural areas, are reliant on non-emergency medical transportation (NEMT) provided via Medicaid HCBS for assistance getting to and from medical appointments. Additionally, lack of access to neurologic care disproportionately affects people living in rural areas, with only 13% of rural areas having full access, as measured by neurologist density and travel distance.[6] In most rural communities, the closest neurologist is over 60 minutes away. In summary, access to HCBS improves health outcomes for people living with MS and reduces Medicaid expenditures by preventing serious and life-threatening problems.

The Importance of Medicaid Access for Carepartners

MS profoundly affects not only those diagnosed but also their families and carepartners. The unpredictable nature of MS, characterized by symptoms like fatigue, mobility challenges, and cognitive impairments, necessitates varying levels of support. This often places significant emotional, physical, and financial burdens

[4] Medicaid Provides Health Coverage for People with Disabilities
[5] Healthcare spending for non-fatal falls among older adults, USA
[6] Desert Mapping to Promote Health Equity in Multiple Sclerosis Care: Julie Fiol, MSCN; Andreina Barnola, MD, MPH

on carepartners. Due to their responsibilities, carepartners frequently face employment disruptions. Studies indicate that 40% of MS carepartners reported missing work in the past year, with 24% reducing their hours or leaving their jobs to provide care.[7] These employment challenges can lead to a loss of employer-sponsored health insurance, leaving carepartners vulnerable to health-related financial strains. Medicaid supports the ability of carepartners providing intensive support for their loved ones to receive some reimbursement for the provision of care, secure respite and take care of their own healthcare needs.

Medicaid Funding Cuts Would Destabilize Hospitals and Health Systems—and Jeopardize Access to Care

Medicaid is essential for individuals' health and reduces costs across the healthcare system. When individuals do not have access to adequate coverage, they are less likely to seek early treatment and adhere to medications and more likely to utilize costly emergency room visits or hospitalizations. Without Medicaid reimbursement, hospitals and healthcare providers would bear the financial burden of uncompensated care. The size and scale of the potential cuts to Medicaid would have enormous ramifications—especially in rural and underserved communities. Safety-net hospitals serve a higher proportion of Medicaid patients. This dynamic makes hospitals in rural and underserved areas particularly vulnerable to financial instability due to the proposed cuts. Such reductions may lead to decreased access to care for Medicaid beneficiaries and could force hospitals to limit services or close entirely.

The National Multiple Sclerosis Society Urges Congress to Protect Medicaid

The Society strongly opposes reductions to Medicaid, including cuts to the Federal Medical Assistance Percentage (FMAP) for the expansion population, the implementation of per capita caps, and work reporting requirements. These measures would fundamentally alter Medicaid's financing structure, shift significant costs to states, and jeopardize healthcare access for millions of Americans, particularly low-income individuals, people living with disabilities, and children. Instead, we encourage you to support policies that strengthen and expand Medicaid to ensure that all individuals—particularly those living with chronic conditions and disabilities—can receive the healthcare they need to live their best lives.

If you have any questions please contact Okey Enyia, Associate Vice President of Federal Government Relations, at okey.enyia@nmss.org.

Sincerely,

Bari Talente

Bari Talente, Esq.
Executive Vice President, Advocacy and Healthcare Access
National Multiple Sclerosis Society

[7] Caregiver Burden in Multiple Sclerosis: Recent Trends and Future Directions

Why We Must Protect Medicaid in 2025

What is Medicaid?

Medicaid is a big health program that helps millions of people get the health care they need. It helps people with disabilities, older adults, people with low incomes, pregnant women, and kids. Medicaid also helps people with disabilities stay at home and live in their communities.

Medicaid is run by both the federal government and each state. The government makes basic rules about who can get Medicaid and how it is paid for. Each state can add extra services or rules to the program in their state.

Why is Medicaid in trouble in 2025?

This year, Congress, the President, and other leaders will discuss changes to Medicaid. Many changes would make it harder for people with disabilities to get the help they need.

Here are some changes that may be discussed:

- **Work requirements:** People who use Medicaid would have to prove they can't work because of an illness or disability. It would ask people to fill out **a lot more** paperwork. If someone is not able to keep up with the paperwork, they could lose Medicaid.
- **Limits on provider taxes:** States would have fewer ways to raise money to run Medicaid.
- **Block grants or per capita limits:** These plans may not consider how many people need Medicaid. In the end, this would mean less federal money for Medicaid.
- **Ending Medicaid expansion:** Fewer people with low incomes could get Medicaid.

- **Changes to how states get federal money:** Some states would get less money for Medicaid.

All these changes mean cutting Medicaid funding. Medicaid cuts mean that states would have to make tough decisions about Medicaid. States might need to raise taxes, take money from other programs, or change Medicaid services. This could lead to fewer services, longer waitlists, lower pay for doctors and caregivers, and fewer hours of care.

What's happening now?

Right now, Medicaid doesn't have enough money to pay for everyone who needs it.

Over 710,000 people are waiting for services, sometimes for years. Many people still live in institutions or nursing homes instead of at home with their families and friends.

The workers who help people with disabilities, called direct support professionals (DSPs), don't get paid enough. Because of this, many quit their jobs. This makes it hard for people to get the care they need.

What does all this mean?

Instead of making Medicaid better by investing in workers and improving services, the government is talking about cutting Medicaid.

These cuts could hurt millions of people with disabilities and their families.

We believe everyone should be able to live with their family and friends and get the care they need. The only way to make this happen is by working together to protect Medicaid.

Act Now and Tell Congress to Protect Medicaid From Cuts!