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**Memorandum**

Date: February 16, 2018

To: Interested Health Clients

From: Holland & Knight

**Re: Trump Administration Fiscal Year (FY) 2019 Budget and Healthcare Programs.**

The Trump Administration on Feb. 12 released its Fiscal Year (FY) 2019 budget request, titled "An American Budget." Unlike last year's budget, which was released in late May, the release of this budget conforms to the typical budget calendar where the administration presents its budget blueprint to Congress in February ahead of congressional appropriations work in the spring and summer. The budget proposal does not carry with it force of the law – it is, instead, the President's recommendation to the Congress, which ultimately decides whether and how to implement the proposed appropriations funding levels and other changes.

President Donald Trump's budget proposal comes just days after Congress finally reached a two-year agreement on appropriated spending limits. Under that agreement, defense and domestic spending caps are being substantially revised upward for both FY 2018 and FY 2019. Final FY 2018 appropriations levels should be established in an omnibus appropriations bill that needs to be enacted before temporary funding runs out on March 23. Because of the delays in the process, the new budget proposal cannot be precisely compared to FY 2018 funding levels. For FY 2019, the new budget proposal tracks the higher funding cap for defense programs but proposes less domestic spending than allowed under the two-year budget deal. The administration argues that the domestic spending target is a "cap" not a "floor." It is unlikely that Congress will go along with the proposal to appropriate fewer dollars for domestic programs than permitted under the two-year deal.

President Trump's FY 2019 budget request includes proposals designed to reduce deficits by $3.6 trillion over 10 years and lower debt levels as a percentage of gross domestic product (GDP). Notably, the proposal calls for steep funding cuts to health initiatives, in part by proposing to enact Affordable Care Act (ACA) repeal-and-replace legislation, consolidating the activities of the Agency for Healthcare Research and Quality (AHRQ), overhauling Medicaid and implementing Medicare payment reforms. The budget proposal also includes a number of proposals aimed at lowering prescription drugs costs for Medicare and Medicaid beneficiaries. It is unclear whether Congress will have the time or inclination to work on dramatic changes to Medicaid and Medicare given the congressional calendar, the political difficulty and the striking failure in 2017 to "repeal and replace" the ACA.

Surprisingly, the administration calls for legislation that would fully fund the ACA's risk corridor program that ended in 2016. The administration also asks Congress to appropriate funding for the ACA's cost-

sharing reduction (CSR) payments to insurers. Previously, the administration had discontinued these payments based on a determination that they required an appropriation. Legislation to fund the CSR payments is under active discussion in Congress.

Additional links to relevant budget documents are available at the end of this memo.

The following are key healthcare highlights from the White House's proposal:

**Programmatic Changes**

***Medicaid***

The budget includes a number of proposals that would generate savings of $1.438 billion over 10 years, mostly through shifting the program to a per-capita-cap or block grant structure. Further, the budget proposes several provisions related to the opioid epidemic, including expanding Medicaid Assisted Treatment options for those suffering from opioid addiction, requiring the Centers for Medicare and Medicaid Services (CMS) to release guidance setting minimum standards for State Drug Utilization Reviews, and requiring states to track high prescribers of prescription drugs.

In addition, the administration is looking to address the issue of high drug prices partially through changes to programs overseen by Medicaid. For instance, the budget calls for a new Medicaid demonstration authority to test financing and drug coverage reforms in up to five states that "build on private sector best practices." Under this proposal, states would be able to choose their own drug formularies and would address beneficiary needs by creating an appeals process for patients who need to access non-covered drugs due to medical need.

***Children's Health Insurance Program (CHIP)***

The FY 2018 budget proposes to extend funding for CHIP through FY 2019 with modifications to incur savings of nearly $1 billion over 10 years. However, the extension of CHIP funding is tied to several programmatic proposals that would have adverse effects on funding for children's health services that could impact coverage levels. The budget would not extend the 23 percentage point increase in the federal CHIP matching rate that took effect in 2015 and will expire at the end of FY 2017. Although the *HEALTHY KIDS Act*, which was signed into law on Jan. 22, would extend an enhanced federal matching rate of 11.5 percentage points before returning to traditional CHIP matching rates. An automatic repeal of this match would result in many states losing billions of dollars in federal support for their CHIP programs. Further, the budget proposes to repeal CHIP's maintenance of effort requirement, which would give states the flexibility to reduce benefits for children within their CHIP programs or allow states to dismantle their CHIP programs entirely. The budget also creates a federal cap on CHIP coverage to those under 250 percent of the federal poverty level, which is lower than the eligibility level used by over half of states, and would allow states the ability to move children between ages six and 18 from Medicaid into CHIP, reducing their Medicaid rolls while putting additional stress on CHIP programs that may see weakened funding due to these and other legislative proposals.

Most of these proposals are the same as those that were put forward in the administration's FY 2018 proposal published last May. Not only would the CHIP proposals made in the budget garner little traction in Congress but also the recently signed *Bipartisan Budget Act of 2018* includes 10 years' worth of funding for CHIP, through FY 2027, without changing the underlying structure of the program.

***Medicare***

Unlike the administration's FY 2018 budget request, the FY 2019 makes several proposed changes related to the Medicare program, many of which are designed to address drug prices or other similar issues. These changes are purported to generate $494 billion in savings over 10 years.

*Drug Prices and Medicare Part D*

The budget request makes five modifications to the Medicare Part D drug program, including:

- requiring Part D sponsors to apply at least 33 percent of total rebates and price concessions at the point of sale to improve transparency
- establishing an out-of-pocket cap in the Part D catastrophic phase. More specifically, the budget proposes to increase sponsors' plan liability over four years from 15 percent to 80 percent while decreasing the Medicare program's reinsurance liability from 80 percent to 20 percent over the same period while decreasing beneficiary coinsurance from 5 percent to zero percent
- excluding manufacturer discounts from true out-of-pocket cost calculations for those in the coverage gap
- requiring a minimum of one drug per category or class rather than two within formularies while also expanding the use of management tools for specialty drugs to realize process savings
- eliminating cost-sharing for generic drugs and biosimilars to increase access

The budget request also permanently authorizes a demonstration that allows CMS to "contract with a single plan to provide Part D coverage to low-income beneficiaries while their eligibility is processed." The current demonstration runs through 2019. It also authorizes the U.S. Department of Health and Human Services (HHS) to consolidate certain Part B drugs into Part D if the Secretary calculates that there is savings to be realized from higher pricing competition.

The *Bipartisan Budget Act of 2018*, signed Feb. 9, included its own modifications to the Part D program, including both a positively received provision to include biosimilar products in the coverage gap to improve access to these products. Many of the provisions in the FY 2019 involve fairly radical policy changes that may not receive much traction in Congress. The budget's characterization of biosimilar products as generics or multi-source drugs is inaccurate given not only their U.S. Food and Drug Administration (FDA) approval process but also how they are coded and reimbursed.

*Other Medicare Provisions Related to Drug Prices*

The budget includes several other proposals related to drug prices within the Medicare program:

- requiring all Medicare Part B drug manufacturers, beginning in 2019 to report average sales price (ASP) data to improve pricing accuracy. New Part B drugs are priced based on wholesale acquisition cost (WAC) for two quarters, and it is unclear whether this proposal would modify this timing
- indexing ASP growth to the Consumer Price Index for all Urban Consumers (CPI-U), and would require CMS to reimburse at the cheaper of ASP + 6 percent or the index-adjusted ASP + 6 percent
- redistributing savings from a new CMS proposal reducing hospital payment for 340B drugs, which would reduce reimbursement for non-pass-through drugs from ASP + 6 percent to ASP – 22.5 percent, to hospitals based on their share of uncompensated care. Any hospital that does not have at least 1 percent of its patient care costs billed as uncompensated care would not be eligible to collect these funds, which would instead be returned to the Medicare Trust Fund

- reducing single-source Part B drug payment within the first two quarters, i.e. when drugs are too new to have their price based on average sales price (ASP), from WAC + 6 percent to WAC + 3 percent

Finally, the budget renews several changes in the FY 2018 budget request to the process for appealing Medicare claims decisions, including providing $1.1 billion in mandatory funding to HHS to invest in addressing the appeals backlog, remanding appeals to the first level of appeal when new evidence is submitted at higher appeals levels, increasing and indexing the minimum amount in controversy required for adjudication, and reducing overhead costs at the Office of Medicare Hearings and Appeals by allowing the Office to issue decisions without a corresponding hearing if there is no material fact in dispute.

*Payment and Delivery Reforms*

In order to generate additional savings and more closely align Medicare with policies applicable to private payers, the administration's budget request includes numerous proposals, among others, related to payment and delivery reform, especially within the Medicare system:

- allows Medicare beneficiaries with high-deductible plans to make tax-deductible contributions to Health Savings or Medicare Savings Accounts
- removes uncompensated care payments from the Inpatient Prospective Payment System (IPPS) and to distribute uncompensated care payments based on charity care reported on the S-10 Worksheet. This proposal, which would take effect in FY 2020, does not affect disproportionate share hospital (DHS) payments
- consolidates skilled nursing facilities, home health agencies, inpatient rehabilitation facilities and long-term care hospitals into a unified post-acute care payments system, with payments at these facilities based on episodes of care rather site of service. This payment system would take effect in FY 2024 with funding generated from a lower payment update at these facilities from FY 2019 to FY 2023
- reduces Medicare reimbursement of bad debts from 65 percent to 25 percent over three years but would not apply to critical access hospitals, rural health clinics and Federally Qualified Health Centers
- eliminates exemption of off-campus hospital outpatient departments from site neutral payments, including some emergency departments, cancer hospitals and grandfathered outpatient departments
- allows HHS to base beneficiary assignment within Accountable Care Organizations (ACOs) to include nurse practitioners, physician assistants and clinical nurse specialists
- proposes to simplify the Merit-based Incentive Payment System (MIPS) by utilizing claims and measures that assess clinician performance only on the group level, with payment adjustments made only to payments under the Physician Fee Scheduler rather than to all payments. The proposal would allow "the Secretary to set the performance threshold for MIPS during the 2019-2020 transition years"
- modifies thresholds to allow clinicians to receive a 5 percent bonus on physician fees schedule revenues received through the Advanced Alternative Payment Models, rather than receiving a bonus only if clinicians meet or exceed payment or patient thresholds

*Medical Liability Reform*

The budget proposes similar changes to the nation's medical liability system as the FY 2018 budget request, including a cap on non-economic damage awards starting at $250,000 and indexed for inflation,

a three-year statute of limitations on malpractice claims, flexibility for courts to modify attorney's fee arrangements, creation of a safe harbor for clinicians following evidence-based clinical practice guidelines and the ability for states to create expert panels to review medical liability cases, among others. These reforms are estimated to create $52.1 billion in savings over 10 years.

***Telehealth and Electronic Health Records***

The administration's FY 2019 budget proposal eliminates the requirement for Medicare Advantage (MA) organizations to provide Part B services explicitly through in-person visits, thereby promoting telehealth services within the MA system. In addition, the proposal would modify Medicare meaningful use (MU) programs by providing both hospitals and physicians by eliminating "low-value metrics of meaningful use" and reducing reporting requirements. No other details were given regarding which metrics might be eliminated. However, the President's budget did mention that the Office of the National Coordinator for Health Information Technology will lessen provider burden by reducing documentation requirements and implementing new business models while also increasing investment in intuitively designed health IT tools. Finally, the budget proposes to focus on how application programming can be used to improve workflow and enhance patient access to their healthcare data.

***Temporary Assistance for Needy Families (TANF)***

The budget proposes a 10 percent cut to the TANF compared with current law budget authority, similar to cuts to the program made in the FY 2018 budget request. This action is taken to align with the elimination of the social services block grant program, and would eliminate the TANF contingency fund, a supplemental fund that allows states additional relief during times of economic downturn. These programmatic changes would result in a multiple billion dollar cut to the program over 10 years. The budget justifies the cuts in order to streamline the program and reduce waste, shifting resources instead to the Health Profession Opportunity Grants through discretionary funding within the Administration for Children and Families.

***Supplemental Nutrition Assistance Program (SNAP)***

Of the welfare programs addressed in the FY 2019 budget request, and as with the FY 2018 budget request, SNAP would see one of the largest funding and resource reductions. While the budget request does not include many details as to any proposed changes, presumably given the drastic cuts proposed to the program in the budget, which would result in a $213 billion cut over 10 years, there are likely changes included similar to those proposed in FY 2018, including limiting categorical eligibility of participants in the program and modifying and income and benefit calculations to reduce program usage. The budget does specifically mention "outcome-based employment strategies" and improving program integrity.

*Independent Payment Advisory Board* (IPAB)

The budget proposes to repeal the IPAB and rescind any unobligated funds for the program. However, the *Bipartisan Budget Act of 2018* repealed the IPAB, making this provision non-applicable.

**Funding Levels**

Below please find a summary of the budget's proposals concerning health-related agencies and programs:

**U.S. Department of Health and Human Services (HHS)**

The President's FY 2019 budget request includes $68.4 billion for HHS, which represents nearly flat funding from last year's request but represents a $17.9 billion or 21 percent decrease from the 2017 enacted level. Although this cut is significant, the President's budget includes $5 billion in new resources over the next five years for the opioid epidemic as well as $5 billion for mental and behavioral health.

**Opioids and Mental Health**

As mentioned previously, the FY 2019 budget provides unprecedented funding to combat the opioid crisis and address serious mental illness. This increase attempts to counter several recent controversial moves by the administration, including providing little funding for a declared public health emergency related to the opioid epidemic and largely gutting the White House's Office of National Drug Control Policy (ONDCP). Overall, the request would include $3 billion in initial allocations for multiple agencies across HHS, including:

- $1.2 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), $1 billion of which would supplement the State Targeted Response (STR) to the Opioid Crisis program originally authorized by the *21st Century Cures Act* (Public Law 114-255)
- $550 million to the Health Resources and Services Administration (HRSA)
- $175 million to the Centers for Disease Control and Prevention (CDC) to expand the Prescription Drug Overdoes Prevention Program
- $750 million to the National Institutes of Health (NIH) to support public-private collaborative research
- $150 million to the Indian Health Service for grants to combat opioid abuse
- $10 million to the Food and Drug Administration (FDA) to accelerate development of abuse deterrent opioids and support optimal medication-assisted treatment delivery
- $125 million for HHS-wide activities

The remaining $7 billion will be available over a period of five years for inter-Departmental transfer to be used as needed to address the opioid crisis.

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

The budget provides $9.56 billion to HRSA, an increase of $3.3 billion increase in discretionary funding over the FY 2017 enacted level. However, this is a result of shifting traditional mandatory funding to discretionary coffers and reducing total funding by $953 million below the FY 2018 CR level to the agency that oversees healthcare workforce programs, among many others. This policy affects mandatory funding health centers, the National Health Service Corps, Teaching Health Center Graduate Medical Education, Home Visiting and Family-to-Family Health Information Centers, and the cut to total funding for HRSA would appear more drastic without the additional of $550 million to fight the opioid crisis. As with the FY 2018 budget, and despite evidence to the contrary, the FY 2019 budget eliminates $740 million in health professions and nursing training programs due to lack of effectiveness, as well as eliminating funding for the Emergency Medical Services for Children program and the Universal Newborn Hearing Screening Program. However, the budget will continue to fund Healthy Start and Home Visiting programs.

A major policy change proposed in this year's budget request is the consolidation of the Children's Hospital Graduate Medical Education program, which is zeroed out in the FY 2019, to be joined into a consolidate graduate medical education (GME) program with the Medicare and Medicaid programs that will be a capped grant program. In this program, funding would be distributed to hospitals "based on the number of residents at a hospital (up to its existing cap) and the portion of the hospital's inpatient days accounted for by Medicare and Medicaid patients." HHS would also have flexibility to modify the amounts distributed based on medical specialty and other educational priorities. The budget details that such a consolidation would realize $48.1 billion in total savings over 10 years. While Congress took initial interest in restructuring the GME programs in 2013 and 2014, no such legislative proposals have yet come to fruition and Congress has consistently maintained support for these programs.

Although the agency saw significant cuts or restructuring overall, the budget preserved or increased funding for certain programs, such as the Ryan White HIV/AIDS Program, the Title X Family Planning Program and the 340B Drug Pricing Program at $2.3 billion, $286 million and $26 million, respectively (although an additional $16 million fund was generated through user fees imposed on covered entities). Interestingly, the budget request only mentions the Community Health Center program in the context of the opioid epidemic, which will receive $400 million total with $200 million for quality incentive payment programs to address behavioral health and addiction.

**Office of the National Coordinator for Health Information Technology**

The FY 2019 budget request reduces funding the Office of the National Coordinator for Health Information Technology (ONC) by $22 million compared with the FY 2017 enacted level. The budget request explicitly mentions a commitment to interoperability while allowing patient flexibility to access their medical records. The budget request also discusses a commitment to the efforts of the Health IT Advisory Committee (HITAC) as part of the *21st Century Cures Act* and its efforts to provide feedback on ONC's draft Trusted Exchange Framework, also authorized by the Cures Act. Despite a commitment to coordinate standards development and implementation, the budget request justifies reduced funding for ONC by continuing cost reductions related to "information technology, space, staff training, and agency travel."

**Centers for Medicare and Medicaid Services (CMS)**

The budget focuses on multiple programmatic changes to the health programs overseen by CMS, especially Medicaid and CHIP, and makes only a few proposals related to operations funded through discretionary dollars within the budget. Most significantly, the budget aims to curb waste, fraud and abuse in the Medicare and Medicaid programs, and includes $127 million per year in mandatory funding to address Medicare appeals and $770 million for the Health Care Fraud and Abuse Control (HCFAC) program at CMS, which represents increases of $45 million compared with the FY 2017 enacted level.

**U.S. Food and Drug Administration (FDA)**

Unlike FY 2018, when the administration significantly reduced discretionary budget authority by calling for an increase in user fees, the FY 2019 request remains more traditional. The budget proposes $3.25 billion in total discretionary resources for the agency with increases in funding for many of the review divisions, especially human drugs and medical devices with increases of $523 million and $188 million, respectively. User fees would be increased by $190 million. The non-user fee increase was a

combination of maintaining a focus on approving new and innovative medical products, including regenerative medicine therapies, while also adding back in budget authority through the *Bipartisan Budget Act of 2018* that was removed in the original budget (see Addendum for more information) to promote a provision providing 100 percent user fee funding for premarket review activities. As with other health agencies, the FDA will also receive $10 million to aid the administration's efforts to combat the opioid epidemic, including to develop abuse-deterrent formulations of opioids. Finally, the budget includes $1.4 billion for food safety across the agency, which is $10 million above current funding levels, and $24.5 million to support the development of medical countermeasures.

**Public Health Emergencies**

Prior to the passage of the *Bipartisan Budget Act of 2018*, the President's FY 2019 budget request would have provided level funding for the **Hospital Preparedness Program (HPP)** at $255 million. However, the increased discretionary budget caps allowed for a last-minute increase included in the OMB addendum of $27 million for HPP, $48 million in pandemic influenza preparedness, and a $75 million increase in the Public Health Emergency Fund through previously capitalized resources. The budget also included modest increase for the Biomedical Advanced Research and Development Authority (BARDA) and Project BioShield. The Assistant Secretary for Preparedness and Response (ASPR) would also assume oversight over the Strategic National Stockpile from the Centers for Disease Control and Prevention (CDC), which totals over $500 million in discretionary resources. Finally, the Office of Management and Budget (OMB) addendum added $109 million originally removed from the **Public Health Emergency Preparedness (PHEP)** program for grant support.

**National Institutes of Health (NIH)**

As mentioned previously, the FY 2019 budget originally provided $25.38 billion for the NIH, representing a deep cut of $7.6 billion compared with the FY 2017 enacted level. However, due to the increase in the discretionary budget caps included in the *Bipartisan Budget Act of 2018*, NIH funding was bumped back up to slightly over the FY 2017 enacted level at $33.8 billion.

Despite the fact that the budget request moves NIH funding back to its original level, NIH program funding levels and oversight saw fairly significant changes. Many of the individual Institutes and Centers received cuts of between $15 million and $50 million, which then made room to incorporate two federal programs under NIH oversight: the Agency for Healthcare Research and Quality (AHRQ), which would be renamed the National Institute for Research on Safety and Quality (NIRSQ), and consolidates the CDC's National Institute for Occupational Safety and Health with the NIH's preexisting National Institute on Disability, Independent Living and Rehabilitation. The shift does not appear to significantly affect resources for AHRQ and does not affect its mandatory funding stream from the Patient-Centered Outcomes Research Trust Fund. The budget also includes $750 million to the NIH to combat the opioid crisis and to address serious mental illness. A total of $350 million of this initial funding would go toward opioid, mental illness and pain related research in FY 2019.

Finally, it should be noted that these types of funding reductions to the NIH and its Institutes and Centers, although less drastic than last year's cuts, flies in the face of strong bipartisan support in Congress for continued financial support and budget increases for the agency over the past several years.

**Centers for Disease Control and Prevention (CDC)**

The FY 2018 budget provides $5.6 billion in funding for the CDC, a cut of over $767 million from the FY 2017 enacted level. The budget makes several cuts of more than $100 million from accounts including Chronic Disease and Health Promotion and the mandatory Prevention and Public Health Fund, with the latter being largely shifted to a discretionary funding stream in the budget. The Public Health Fund, which has been a consistent target for cuts by Congress, already saw a cut of over $1.3 billion over a 10-year window in the *Bipartisan Budget Act*. Originally seeing a cut was the infectious disease prevention (HIV, Hepatitis, Sexually Transmitted Disease, and Tuberculosis) account. However, due to the passage of the *Bipartisan Budget Act* the OMB increased this account back to its FY 2017 enacted level. In addition, the budget provides a significant increase for the Vaccines for Children program of $326 million and provides $175 million to combat the opioid epidemic.

Finally, as mentioned previously, the budget reduces funding for the agency by shifting the Strategic National Stockpile to the Office of the Assistant Secretary for Preparedness and Response from the CDC, and reallocating $575 million of CDC funds to that office to maintain the stockpile.

**Other Health-Related Issues**

**Association Health Plans**

The administration is seeking increased funding through the Employee Benefits Security Administration to promote association health plans (AHPs). The funding request follows a proposed rule released earlier this year that seeks to increase the availability of AHPs.

**Healthcare Fraud and Abuse**

The administration is asking Congress to approve $770 million to fight healthcare fraud. The funding would go to the Health Care Fraud and Abuse Control program, which coordinates federal, state and local law enforcement activities related to healthcare fraud and abuse. The money is shared among CMS, the U.S. Department of Justice and the HHS Office of Inspector General.

**21st Century Cures Act Funding**

Finally, the budget preserved the discretionary funding authorized by the *21st Century Cures Act* for the NIH and FDA. This funding by law falls outside the discretionary budget caps and is directly appropriated for several provisions, such as the cancer moonshot, the Precision Medicine Initiative and the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative.

## President's FY 2019 Budget Blueprint Comparison

| | FY 2018 Enacted Level (CR) | President's FY 2018 Budget | President's FY 2019 Budget |
|---|---|---|---|
| **Centers for Medicare and Medicaid Services (CMS)** | | | |
| Health Care Fraud and Abuse Control (HCFAC) | $725 million | $751 million | $770 million |

| | | | |
|---|---|---|---|
| **Health Resources and Services Administration (HRSA)** | $6.164 billion | $5.5 billion | $9.569 billion |
| Health Workforce Programs | $1.221 billion | $771 million | $477 million |
| Children's Hospital Graduate Medical Education (CHGME) | $298 million | $295 million | $0 |
| Ryan White HIV/AIDS Program | $2.303 billion | $2.260 billion | $2.260 billion |
| Title X Family Planning Program | $286 million | $286 million | $286 million |
| 340B Drug Pricing Program | $10.2 million | $10.2 million | $26 million |
| Community Health Centers | $1.5 billion | $1.5 billion | N/A |
| **National Institutes of Health (NIH)** | $33.1 billion | $26.5 billion | $33.8 billion |
| *Eunice K. Shriver* National Institute of Child Health and Human Development (NICHD) | $1.371 billion | $1.032 billion | $1.340 billion |
| Agency for Healthcare Research and Quality (AHRQ)/National Institute for Research on Safety and Quality (NIRSQ) | $322 million | $272 million | $256 million |
| **Food and Drug Administration (FDA)** | $2.78 billion | $1.88 billion | $3.25 billion |
| **Centers for Disease Control and Prevention (CDC)** | $6.29 billion | $5.1 billion | $5.6 billion |
| ASPR Programs | $1.393 billion | $1.375 billion | $1.977 billion |

**Resources**

Trump Administration FY 2019 Budget Request
Trump Administration FY 2019 Budget Request HHS Budget in Brief
OMB Addendum to Trump Administration FY 2019 Budget

For more information or questions, please contact Public Affairs Advisor Ethan Jorgensen-Earp.