DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2019

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

MESSAGE FROM THE ADMINISTRATOR

I am pleased to present the FY 2019 Congressional Justification for the Health Resources and Services Administration (HRSA). HRSA is the primary Federal agency for improving access to health care for people who are geographically isolated, and economically or medically challenged. The FY 2019 Budget provides $9.6 billion to invest in programs that provide direct heath care services to individuals who are medically underserved or face barriers to health care. The Budget also proposes an additional opioid allocation of $550 million to HRSA to address the opioid epidemic. When accounting for these resources, the total for HRSA is $10.2 billion.

In FY 2019, the Health Center program supports nearly 1,400 health centers grantees, providing care to approximately 26 million patients. The Budget provides $5.1 billion for the Health Center Program. These resources will ensure that current health centers can continue to provide essential health care services to their patient populations.

The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals. HRSA is requesting $476.6 million for workforce programs. The Budget requests strategic investments in the National Health Service Corps, Nurse Corps Loan Repayment and Scholarships programs, Teaching Health Center Graduate Medical Education program, and Health Care Workforce Assessment. In addition, the Budget proposes to consolidate Federal graduate medical education spending from Medicare, Medicaid, and the Children's Hospitals Graduate Medical Education program into a single grant program for teaching hospitals.

The Budget requests $1.1 billion to improve the health of mothers and children. The Budget provides $627.7 million for the Maternal and Child Health Block Grant program, which works to improve the lives of America's children and families. The Block Grant serves more than 76 million people, including over 57 million children and 3 million pregnant women. These resources, in conjunction with $103.5 million for the Healthy Start program, and $405 million for the Maternal, Infant, and Early Childhood Home Visiting Program and the Family-to-Family Health Information Centers, will allow HRSA to focus on direct access to quality health care and services for mothers, children and families.

The Budget request also includes $74.9 million to support health care needs in rural areas. The request provides funding for direct service programs, including the Radiation Exposure Screening Program, Black Lung Clinics, and Rural Health Outreach Services; as well as for telehealth activities to promote the modernization of the health care infrastructure in rural areas. The Budget also includes funding for the Rural Health Policy program to support the Federal Office of Rural Health Policy's role to advise the Secretary on rural health issues, conduct and oversee research on rural health, and provide support for grant programs that enhance health care delivery in rural communities.

The FY 2019 Budget includes $2.3 billion for the Ryan White program to improve access to care for persons living with HIV/AIDS. Of this amount, $900.3 million is included for the AIDS

Drug Assistance Program. Over the last 27 years, the program has developed a comprehensive system of safety net providers who deliver high quality direct health care and support services. Viral suppression outcome measures demonstrate the success of the program because 85 percent of patients receiving medical care are virally suppressed. Furthermore, the AIDS Drug Assistance Program creates a major public health benefit by also reducing new infections. The Budget proposes to reauthorize the Ryan White program to make statutory changes to reduce recipient burden, standardize certain requirements and definitions, and effectively focus resources for HIV care, treatment, and support based on need, geography, data quality, and performance.

The FY 2019 Budget includes $116.5 million to support additional healthcare systems programs. These include programs to support organ and cell transplantation, Poison Control Centers, and the National Hansen's Disease Program. In addition, the Budget proposes reforms to the 340B Drug Pricing Program, which requires drug manufacturers to provide discounts on outpatient prescription drugs to certain safety net providers. These changes – including requirements to report on the use of 340B savings, a new user fee for covered entities and general regulatory authority – would strengthen program integrity and ensure patients benefit from the Program, as intended.

The Budget includes an initial opioid allocation of $550 million to address substance abuse, including opioid abuse, and the overdose crisis in highest risk communities. This funding will allow communities to develop plans to address local needs. This funding is part of the $10 billion proposal to combat the opioid epidemic and address mental health across HHS.

The Health Resources and Services Administration's FY 2019 Budget supports the Administration's commitment to prioritize direct health care services. This request supports the President's goal to put American families first while improving the efficiency and effectiveness of the Federal Government.

George Sigounas, MS, Ph.D.
Administrator

Organizational Chart

Health Resources and Services Administration

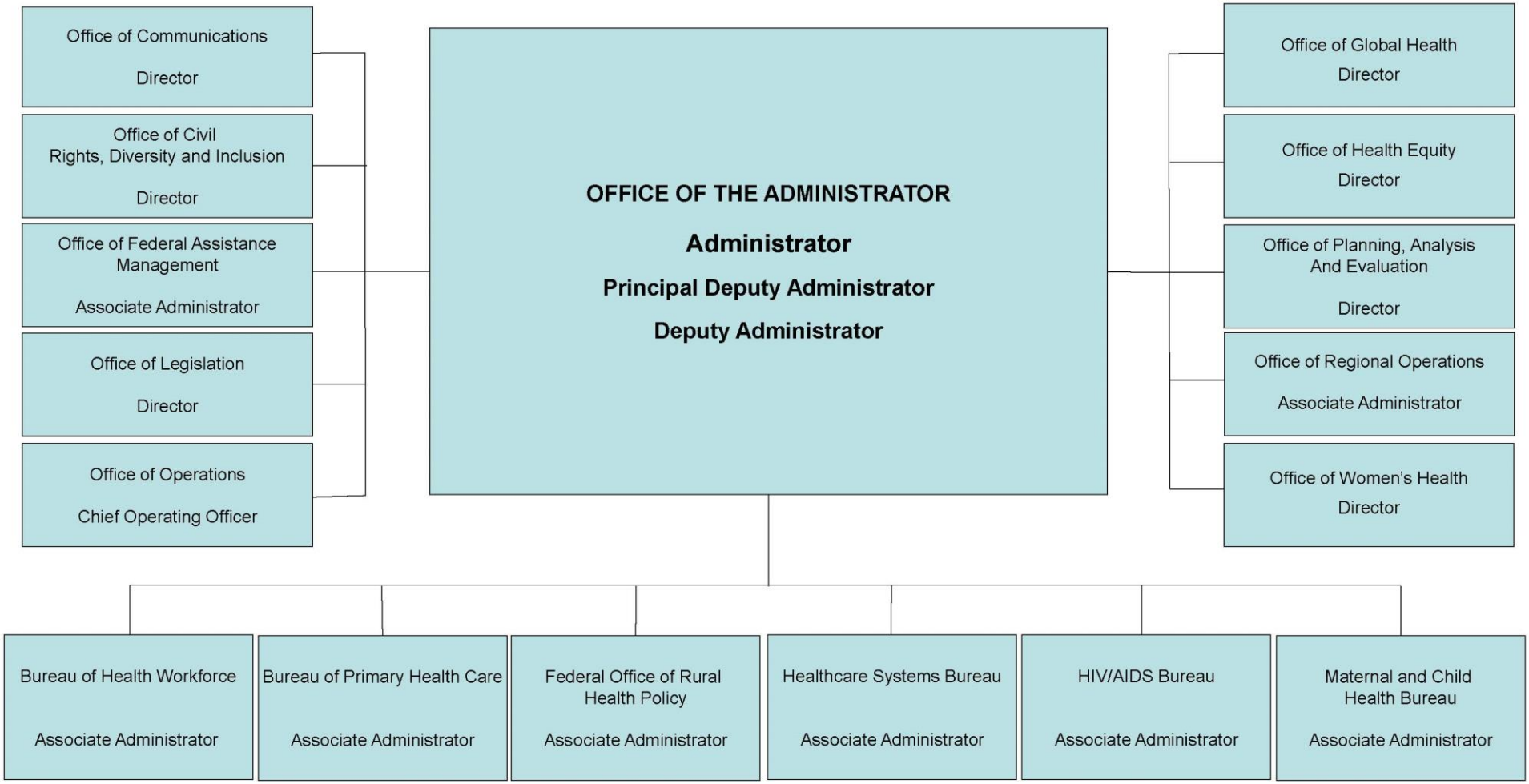

Table of Contents

Executive Summary

TAB

Introduction and Mission

The Health Resources and Services Administration (HRSA) is an agency of the U.S. Department of Health and Human Services. The Department's mission is, in part, to enhance the health and well-being of Americans by providing effective health and human services. In alignment with this mission, HRSA is the principal Federal agency charged with increasing access to effective and efficient basic health care for those individuals and families who are medically underserved due to barriers (e.g., economic, geographic, linguistic, cultural) they face in obtaining appropriate and quality care.

HRSA supports programs and services that target, for example:

- Underserved persons who live in rural and poor urban neighborhoods where health care providers and services are scarce,
- Individuals who lack health insurance--many of whom are racial and ethnic minorities,
- African American infants who still are 2.3 times as likely as white infants to die before their first birthday,
- The more than 1.1 million people living with HIV infection,
- Persons affected by the critical national problem of opioid abuse and overdose,
- The nearly 115,000 individuals who are waiting for an organ transplant.

By focusing on these and other underserved and at-risk groups, HRSA's leadership and programs promote the improvements in health care access and quality that are essential for a healthy nation.

Overview of Budget Request

The FY 2019 President's program level request is $9.6 billion for the Health Resources and Services Administration (HRSA). This is -$953.3 million below the FY 2018 Annualized Continuing Resolution (CR) level.

Highlights of the major programs are listed below:

Health Centers and Free Clinics: +$10.1 million; total program $5.1 billion – The Budget supports nearly 1,400 health centers, providing care to approximately 26 million patients. These resources will help ensure that current health centers can continue to provide essential primary health care services to their patient populations. The Budget proposes a shift from mandatory resources to discretionary resources for this program.

Health Workforce: -$744.4 million; total $476.6 million

- *National Health Service Corps (NHSC): total program $310 million.* The Budget proposes a shift from mandatory resources to discretionary resources for this program. This funding will support a field strength of 8,810 providers in FY 2019.

- *NURSE Corps: +$0.6 million; total program $83.1 million.* The Budget prioritizes nursing activities that provide nurse scholarships and nurse loan repayments in exchange for service in areas of the United States with health workforce shortages. This funding will allow the program to maintain its efforts to address the anticipated demand for access to services in Critical Shortage Facilities.

- *Children's Hospital Graduate Medical Education (GME) Program: -$298 million; total program $0.* The Budget proposes to consolidate Federal graduate medical education spending from Medicare, Medicaid, and the Children's Hospitals Graduate Medical Education program into a single grant program for teaching hospitals equal to the sum of Medicare and Medicaid's 2016 payments for graduate medical education, plus 2016 spending on children's hospitals graduate medical education, adjusted for inflation. This amount would then grow with inflation minus 1 percentage point each year. HRSA and the Centers for Medicare & Medicaid Services (CMS) would jointly determine program requirements and the formula for distribution. Payments 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. The Secretary would have authority to modify the amounts distributed based on the proportion of residents training in priority specialties or programs and based on other criteria identified by the Secretary, including addressing health care professional shortages and educational priorities. This grant program would be funded out of the general fund of the Treasury.

- *Teaching Health Centers Graduate Medical Education Program*: *total program $60 million.* The Budget includes $60 million for residency training in primary care

medicine and dentistry in community-based, ambulatory settings. The Budget proposes a shift from mandatory resources to discretionary resources for this program.

- *Workforce Training Programs: -$447.8 million; total program $4.7 million.* The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals and eliminates funding for other health professions and nursing training programs. As the nation's health care system continues to change, state and national level analysis of health care workforce needs will be critical to determining appropriate investments in the health workforce. To meet this need, the Budget provides $4.7 million for the Health Care Workforce Assessment program.

Maternal and Child Health (MCH): -$111.7 million; total $1.1 billion –The Budget provides $627.7 million for the MCH Block Grant program, a decrease of -$9.7 million. The Block Grant supports services for more than 76 million people, including 57 million children and 3 million pregnant women. The request also includes $103.5 million, an increase of +$0.7 million, for Healthy Start program, which serves approximately 69,000 participants annually. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs and eliminates funding related to Autism and Developmental Disorders, Sickle Cell, Universal Newborn Hearing, Heritable Disorders and Emergency Medical Services for Children.

The FY 2019 Budget includes $400 million in discretionary resources for the Maternal, Infant, and Early Childhood Home Visiting program. This funding will improve access for at-risk families to voluntary, evidence-based home visiting services where nurses, social workers, and other professionals provide support for their children's health, development, and ability to learn. The Budget also includes $5 million to extend the Family-to-Family Health Information Centers Program. The Budget proposes to change the source of funding for these two programs from mandatory to discretionary.

HIV/AIDS: -$42.9 million; total program $2.3 billion – The Budget provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people living with HIV. It includes $900.3 million for the AIDS Drug Assistance Programs (ADAP) to provide access to life saving HIV related medications and health care services to persons living with HIV in all 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and five Pacific jurisdictions. In an effort to more effectively target resources and reduce burden, the Budget proposes statutory changes to allow a data driven framework to distribute funding, and simplify and standardize certain requirements and definitions. The request eliminates funding for AIDS Educations and Training Centers and does not provide a direct appropriation for Special Programs of National Significance.

Healthcare Systems: -$3 million in discretionary funding; total programs $116.5 million – The Budget provides funding to support Poison Control Centers, organ and cell transplantation and the National Hansen's Disease Program. The Budget reduces National Hansen's Disease

Program funding to focus on direct patient care activities, while reflecting the declining beneficiary population. The Budget includes resources and proposes broad regulatory authority to support the 340B Drug Pricing Program, which requires drug manufacturers to provide discounts on outpatient prescription drugs to certain safety net providers. In addition, the Budget includes a new user fee on covered entities for the 340B program.

Rural Health: -$80.1 million; total program $74.9 million – The Budget prioritizes funding for direct service programs, including the Radiation Exposure Screening Program, Black Lung Clinics, and Rural Health Outreach Services, as well as Telehealth. The allocation includes funding for the Rural Health Policy program to support the Federal Office of Rural Health Policy's role to advise the Secretary on rural health issues, conduct and oversee research on rural health, and provide support for grant programs that enhance health care delivery in rural communities. This level eliminates funding for Rural Hospital Flexibility grants and State Offices of Rural Health.

Funding to Combat the Opioid Epidemic - The Budget includes an initial opioid allocation of $550 million to address substance abuse, including opioid abuse, and the overdose crisis. This funding is part of the HHS $10 billion proposal to combat the opioid epidemic and address mental health.

Program Management: -$1 million; total program $152 million – This request supports program management activities to effectively and efficiently support HRSA's operations, including investments in information technology and cybersecurity.

Vaccine Injury Compensation Program: +$1.5 million; total program $9.2 million – The Budget requests additional administrative funding to support the significant rise in the number of claims filed largely due to claims for injuries from the influenza vaccine. The funding will support the additional costs of medical reviewers dedicated to evaluating the increased claims.

Overview of Performance

HRSA and its partners work to achieve the vision of "Healthy Communities, Healthy People." In pursuing this vision, HRSA's strategic goals are to: improve access to quality health care and services, strengthen the health workforce, build healthy communities, improve health equity, and strengthen program management and operations. The anticipated performance in FY 2019 of key HRSA programs is highlighted below, categorized by goal to indicate the close alignment of specific programmatic activities with broader HRSA priorities. The examples illustrate ways HRSA will continue to help states, communities and organizations provide essential health care and related services to meet the needs of medically underserved individuals, special needs populations, and many other Americans.

Highlights of Performance Results and Targets

HRSA Goals: *Improve access to quality health care and services; Improve health equity*

HRSA programs support the direct delivery of health services and health system improvements that increase access to health care and help reduce health disparities.

- In 2016, the Health Center Program supported health centers' provision of affordable, accessible, quality and cost efficient care to 25.9 million patients. In FY 2019, the number is projected be 26 million.

- The Health Center Program projects that the low birthweight rate (LBW) among health center patients will be five percent below the national rate in FY 2019, an ambitious target given the many factors that predispose these patients to greater risk of LBW and adverse birth outcomes.

- HRSA expects to help states serve 51 million children through the Maternal and Child Health (MCH) Block Grant program in FY 2019, providing support to address states' highest MCH priorities.

- The MCH Block Grant program expects to contribute to the reduction of the national infant mortality rate from 5.9 per 1,000 in 2015 to 5.5 per 1,000 in 2019 by supporting state MCH activities to improve the health of mothers, children, and families, particularly those with low-income or limited availability of care.

- Grantees of the Maternal, Infant, and Early Childhood Home Visiting Program are expected to make 960,000 home visits to at-risk families in FY 2019, using evidence-based models of care to address children's health, development and well-being.

- By supporting the provision of HIV medications and related services to more than 259,500 persons in FY 2019 through the AIDS Drug Assistance Program, HRSA will continue its contribution to reducing AIDS-related mortality for low-income and uninsured people living with HIV/AIDS.

- In FY 2019, the Ryan White HIV Emergency Relief Grants (Part A) and HIV Care Grants to States (Part B) are projected to support, respectively, 3.6 million visits and 3.4 million visits for health-related care.

- To increase the number of patients from racially and ethnically diverse backgrounds able to find a suitably matched unrelated adult donor for their blood stem cell transplants, the C.W. Bill Young Cell Transplantation program projects that it will have more than 4.0 million adult volunteer potential donors of minority race and ethnicity listed on the donor registry in FY 2019. Approximately 3.5 million were listed on the registry in FY 2016.

- The Organ Transplantation program projects that it will facilitate the transplantation of nearly 27,000 deceased donor organs in FY 2019.

HRSA Goal: Strengthen the health workforce

HRSA works to improve the health care system by bolstering the healthcare workforce through the support of provider placement, retention, and training activities.

- In FY 2019, 8,810 primary care and other health practitioners will provide service in health professional shortage areas in rural, urban, and frontier communities in return for National Health Service Corps (NHSC) loan repayment or scholarship support.

- HRSA projects that in FY 2019 11,500 healthcare providers will be deemed eligible for Federal Tort Claims Act malpractice coverage through the Free Clinics Medical Malpractice program. The program encourages providers to volunteer their time at sponsoring free clinics, thereby expanding the capacity of the healthcare safety net.

In the ways highlighted above and others, HRSA will continue to help strengthen the Nation's healthcare safety net and improve Americans' health, health care, and quality-of-life.

Performance Management

Performance management is central to the agency's overall management approach and performance-related information is routinely used to improve HRSA's operations and those of its grantees. At the agency level, HRSA's performance management process includes setting priorities and goals that are linked to HRSA's Strategic Plan, action planning and execution, and regular monitoring and review with follow-up.

As the key element of the performance management process, priority setting is done each fiscal year in which annual goals, potentially covering a wide range of areas, and measures or other indicators of success are established as part of the development of performance plans for Senior Staff. Senior Staff oversee the planning, development, and implementation of the major actions that must be accomplished to achieve progress in the defined performance areas.

Regular reviews of performance take place several times a year between Senior Staff and the Administrator/Deputy Administrator, including during regularly scheduled one-on-one meetings,

mid-year and year-end Senior Staff performance reviews, and ad hoc meetings to address emerging issues and problems. Reviews focus on progress, challenges, and possible course corrections, with particular emphasis on root-causes of performance results.

These aspects of HRSA's performance management system promote accountability and transparency, support collaboration in problem solving, and help drive performance improvement at the HRSA level and among its grantees.

All-Purpose Table
Health Resources and Services Administration

(Dollars in Thousands)

Program	FY 2017 Final	FY 2018 Annualized CR[1]	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
PRIMARY CARE:				
Health Centers:				
Health Centers	1,387,036	1,381,185	4,990,629	+3,609,444
Health Centers Current Law Mandatory	3,510,661	550,000	-	-550,000
Health Centers Proposed Law Mandatory	-	3,050,000	-	-3,050,000
Health Center Tort Claims	99,893	99,215	99,893	+678
Subtotal, Health Centers	***4,997,590***	***5,080,400***	***5,090,522***	***+10,122***
Free Clinics Medical Malpractice	1,000	993	1,000	+7
Subtotal, Bureau of Primary Health Care (BPHC)	**4,998,590**	**5,081,393**	**5,091,522**	**+10,129**
Subtotal, Mandatory BPHC (non-add)	*3,510,661*	*3,600,000*	-	*-3,600,000*
Subtotal, Discretionary BPHC (non add)	*1,487,929*	*1,481,393*	*5,091,522*	*+3,610,129*
HEALTH WORKFORCE:				
National Health Service Corps (NHSC):				
NHSC	-	-	310,000	+310,000
NHSC Current Law Mandatory	288,610	65,000	-	-65,000
NHSC Proposed Law Mandatory	-	245,000	-	-245,000
Subtotal, NHSC	***288,610***	***310,000***	***310,000***	**-**
Loan Repayment/Faculty Fellowships	1,187	1,182	-	-1,182
Health Professions Training for Diversity:				
Centers of Excellence	21,659	21,564	-	-21,564
Scholarships for Disadvantaged Students	45,859	45,658	-	-45,658
Health Careers Opportunity Program	14,155	14,093	-	-14,093
Subtotal, Health Professions Training for Diversity	***81,673***	***81,315***	**-**	***-81,315***
Health Care Workforce Assessment	4,652	4,631	4,663	+32
Primary Care Training and Enhancement	38,830	38,660	-	-38,660
Oral Health Training Programs	36,587	36,424	-	-36,424

[1] Reflects the annualized level of the Continuing Resolution (P.L. 115-96), including any applicable funding anomalies and directed or permissive transfers (where applicable).

Program	FY 2017 Final	FY 2018 Annualized CR[1]	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Interdisciplinary, Community-Based Linkages:				
Area Health Education Centers	30,177	30,045	-	-30,045
Geriatric Programs	38,644	38,474	-	-38,474
Behavioral Health Workforce Education and Training	50,000	49,660	-	-49,660
Mental and Behavioral Health	9,892	9,849	-	-9,849
Subtotal, Interdisciplinary, Community-Based Linkages	***128,713***	***128,028***	***-***	***-128,028***
Public Health Workforce Development:				
Public Health/Preventive Medicine	16,949	16,885	-	-16,885
Nursing Workforce Development:				
Advanced Nursing Education	64,425	64,142	-	-64,142
Nursing Workforce Diversity	15,306	15,239	-	-15,239
Nurse Education, Practice and Retention	39,817	39,642	-	-39,642
Nurse Faculty Loan Program	26,436	26,320	-	-26,320
NURSE Corps Scholarship and Loan Repayment Program	82,935	82,570	83,135	+565
Subtotal, Nursing Workforce Development	***228,919***	***227,913***	***83,135***	***-144,778***
Children's Hospital Graduate Medical Education[2]	299,289	297,963	-	-297,963
Teaching Health Center Graduate Medical Education (THCGME):				
THCGME	-	-	60,000	+60,000
THCGME Current Law Mandatory	55,860	30,000	-	-30,000
THCGME Mandatory Proposed Law	-	30,000	-	-30,000
Subtotal, THCGME	***55,860***	***60,000***	***60,000***	***-***
National Practitioner Data Bank (User Fees)	*18,814*	*18,000*	*18,814*	*+814*
Subtotal, Bureau of Health Workforce (BHW)	**1,200,083**	**1,221,001**	**476,612**	**-744,389**
Subtotal, User Fees BHW (non-add)	*18,814*	*18,000*	*18,814*	*+814*
Subtotal, Discretionary BHW (non-add)	*836,799*	*833,001*	*457,798*	*-375,203*
Subtotal, Mandatory BHW (non-add)	*344,470*	*370,000*	*-*	*-370,000*

[2] Discretionary funding for CHGME is discontinued in FY 2019. The Budget proposes to consolidate Federal graduate medical education spending from Medicare, Medicaid, and the Children's Hospitals Graduate Medical Education program into a single grant program for teaching hospitals.

Program	FY 2017 Final	FY 2018 Annualized CR[1]	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant	640,163	637,342	627,700	-9,642
Autism and Other Developmental Disorders	46,985	46,779	-	-46,779
Sickle Cell Service Demonstrations	4,444	4,425	-	-4,425
James T. Walsh Universal Newborn Hearing Screening	17,775	17,697	-	-17,697
Emergency Medical Services for Children	20,113	20,025	-	-20,025
Healthy Start	118,251	102,797	103,500	+703
Heritable Disorders	13,850	13,789	-	-13,789
Family-to-Family Health Information Centers (F2F HICs):				
F2F HICs	-	-	5,000	+5,000
F2F HICs Current Law Mandatory	4,655	-	-	-
F2F HICs Proposed Law Mandatory	-	5,000	-	-5,000
Subtotal, F2F HICs	***4,655***	***5,000***	***5,000***	**-**
Maternal, Infant and Early Childhood Home Visiting Program (MIECHV):				
MIECHV	-	-	400,000	+400,000
MIECHV Current Law Mandatory	372,400	-	-	-
MIECHV Proposed Law Mandatory	-	400,000	-	-400,000
Subtotal, MIECHV	***372,400***	***400,000***	***400,000***	**-**
Subtotal, Maternal and Child Health Bureau (MCHB)	**1,238,636**	**1,247,854**	**1,136,200**	**-111,654**
Subtotal, Discretionary MCHB (non-add)	*861,581*	*842,854*	*1,136,200*	*293,346*
Subtotal, Mandatory MCHB (non-add)	*377,055*	*405,000*	-	*-405,000*
HIV/AIDS:				
Emergency Relief - Part A	654,296	651,422	655,876	+4,454
Comprehensive Care - Part B	1,311,837	1,306,075	1,315,005	+8,930
AIDS Drug Assistance Program (non-add)	*900,313*	*894,199*	*900,313*	*+6,114*
Early Intervention - Part C	200,585	199,713	201,079	+1,366
Children, Youth, Women & Families - Part D	74,907	74,578	75,088	+510
AIDS Education and Training Centers - Part F	33,530	33,383	-	-33,383
Dental Reimbursement Program Part F	13,090	13,033	13,122	+89
Special Projects of National Significance (SPNS)	24,940	24,830	-	-24,830
Subtotal, HIV/AIDS Bureau	**2,313,185**	**2,303,034**	**2,260,170**	**-42,864**

Program	FY 2017 Final	FY 2018 Annualized CR[1]	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
HEALTHCARE SYSTEMS:				
Organ Transplantation	23,492	23,389	23,549	+160
National Cord Blood Inventory	12,239	12,183	12,266	+83
C.W. Bill Young Cell Transplantation Program	22,056	21,959	22,109	+150
Poison Control Centers	18,801	18,718	18,846	+128
340B Drug Pricing Program/Office of Pharmacy Affairs	10,213	10,168	10,238	+70
340B Drug Pricing Program User Fees	-	-	*16,000*	*+16,000*
Hansen's Disease Center	15,169	15,103	11,653	-3,450
Payment to Hawaii	1,853	1,844	1,857	+13
National Hansen's Disease Program - Buildings and Facilities	122	121	-	-121
Subtotal, Healthcare Systems Bureau (HSB)	**103,945**	**103,485**	**116,518**	**+13,033**
Subtotal, Discretionary HSB (non-add)	*103,945*	*103,485*	*100,518*	*-2,967*
Subtotal, User Fees HSB (non-add)	-	-	*16,000*	*+16,000*
RURAL HEALTH:				
Rural Health Policy Development	9,328	9,287	5,000	-4,287
Rural Health Outreach Grants	65,347	65,055	50,811	-14,244
Rural Hospital Flexibility Grants	43,509	43,313	-	-43,313
State Offices of Rural Health	9,977	9,932	-	-9,932
Radiation Exposure Screening and Education Program	1,830	1,822	1,834	+12
Black Lung	7,250	7,217	7,266	+49
Telehealth	18,459	18,374	10,000	-8,374
Subtotal, Federal Office of Rural Health Policy	**155,700**	**155,000**	**74,911**	**-80,089**
PROGRAM MANAGEMENT	153,629	152,954	151,993	-961
FAMILY PLANNING	286,479	284,534	286,479	+1,945
Appropriation Table Match	**6,199,247**	**6,156,255**	**9,559,591**	**+3,403,336**
Funds Appropriated to Other HRSA Accounts:				
Vaccine Injury Compensation:				
Vaccine Injury Compensation Trust Fund (HRSA Claims)	282,000	308,000	308,000	-
VICTF Direct Operations - HRSA	7,750	7,697	9,200	+1,503
Subtotal, Vaccine Injury Compensation	**289,750**	**315,697**	**317,200**	**+1,503**

Program	FY 2017 Final	FY 2018 Annualized CR[1]	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Total, HRSA Discretionary Program Level	**6,225,811**	**6,181,952**	**9,603,605**	**+3,421,653**
Mandatory Programs:	**4,232,186**	**4,375,000**	**-**	**-4,375,000**
Total, HRSA Program Level	**10,457,997**	**10,556,952**	**9,603,605**	**-953,347**
Less Programs Funded from Other Sources:				
User Fees	*-18,814*	*-18,000*	*-34,814*	*-16,814*
Mandatory Programs	*-4,232,186*	*-4,375,000*	*-*	*+4,375,000*
Total, HRSA Discretionary Budget Authority	**6,206,997**	**6,163,952**	**9,568,791**	**+3,404,839**
Additional Opioids Allocation[3]	*-*	*-*	*550,000*	*+550,000*
Total, HRSA Program Level with Opioids	**10,457,997**	**10,556,952**	**10,153,605**	**-403,347**

[3] This funding is part of the HHS $10 billion proposal to combat the opioid epidemic and address mental health.

Budget Exhibits

TAB

Appropriations Language

PRIMARY HEALTH CARE

For carrying out titles II and III of the Public Health Service Act (referred to in this Act as the "PHS Act") with respect to primary health care and the Native Hawaiian Health Care Act of 1988, $5,091,522,000: Provided, That $4,990,629,000, to remain available until expended, shall be for the Health Centers program under section 330 of the PHS Act, of which $5,000,000 shall be transferred to and merged with the Domestic Trafficking Victims Fund established under section 3014(c) of title 18, United States Code: Provided further, That no more than $1,000,000 shall be available until expended for carrying out the provisions of section 224(o) of the PHS Act: Provided further, That no more than $99,893,000 shall be available until expended for carrying out subsections (g) through (n) and (q) of section 224 of the PHS Act, and for expenses incurred by the Department of Health and Human Services (referred to in this Act as "HHS") pertaining to administrative claims made under such law: Provided further, That the ninth provisos under the heading "Department of Health and Human Services—Health Resources and Services Administration—Health Resources and Services" in Public Laws 104-208 and 105-78 are amended by striking "$80,000,000" and inserting "$152,700,000" in each such ninth proviso and by adding at the end of each such ninth proviso the following new proviso: "Provided further, That such costs, including the cost of modifying such loans, shall be defined in section 502 of the Congressional Budget Act of 1974:".

HEALTH WORKFORCE

For carrying out titles III, VII, and VIII of the PHS Act with respect to the health workforce, sections 1128E and 1921(b) of the Social Security Act, and the Health Care Quality

Improvement Act of 1986, $457,798,000: Provided, That $310,000,000, to remain available until expended, shall be for the National Health Service Corps program under subparts II and III of part D of the PHS Act: Provided further, That $60,000,000, to remain available until expended, shall be for Teaching Health Center Graduate Medical Education under section 340H of the PHS Act: Provided further, That sections 751 and 762(k) of the PHS Act shall not apply to funds made available under this heading: Provided further, That fees collected for the disclosure of information under section 427(b) of the Health Care Quality Improvement Act of 1986 and sections 1128E(d)(2) and 1921 of the Social Security Act shall be sufficient to recover the full costs of operating the programs authorized by such sections and shall remain available until expended for the National Practitioner Data Bank: Provided further, That funds transferred to this account to carry out section 846 and subpart 3 of part D of title III of the PHS Act may be used to make prior year adjustments to awards made under such sections.

MATERNAL AND CHILD HEALTH

For carrying out titles III, XI, XII, and XIX of the PHS Act with respect to maternal and child health, title V of the Social Security Act, and section 712 of the American Jobs Creation Act of 2004, $1,136,200,000: Provided, That $5,000,000, to remain available until expended, shall be for the Family-to-Family Health Information Centers program under section 501 of the Social Security Act: Provided further, That $400,000,000, to remain available until expended, shall be for the Maternal, Infant, and Early Childhood Home Visiting program under section 511 of the Social Security Act: Provided further, That notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act, not more than $66,593,000 shall be available for carrying out special projects of regional and national significance pursuant to section 501(a)(2) of such Act and

$10,276,000 shall be available for projects described in subparagraphs (A) through (F) of section 501(a)(3) of such Act.

RYAN WHITE HIV/AIDS PROGRAM

For carrying out title XXVI of the PHS Act with respect to the Ryan White HIV/AIDS program, $2,260,170,000, of which $1,970,881,000 shall remain available to the Secretary of Health and Human Services (referred to in this title as the "Secretary") through September 30, 2021, for parts A and B of title XXVI of the PHS Act, and of which not less than $900,313,000 shall be for State AIDS Drug Assistance Programs under the authority of section 2616 or 311(c) of such Act; Provided, That section 2691 of the PHS Act shall not apply to funds appropriated under this heading.

HEALTH CARE SYSTEMS

For carrying out titles III and XII of the PHS Act with respect to health care systems, and the Stem Cell Therapeutic and Research Act of 2005, $100,518,000; Provided, That the Secretary may collect a fee of 0.1 percent of each purchase of 340B drugs from entities participating in the Drug Pricing Program pursuant to section 340B of the PHS Act to pay for the operating costs of such program: Provided further, That fees pursuant to the 340B Drug Pricing Program shall be collected by the Secretary based on sales data that shall be submitted by drug manufacturers and shall be credited to this account to remain available until expended.

RURAL HEALTH

For carrying out titles III and IV of the PHS Act with respect to rural health, section 427(a) of the Federal Coal Mine Health and Safety Act of 1969, and section 711 of the Social Security Act, $74,911,000.

FAMILY PLANNING

For carrying out the program under title X of the PHS Act to provide for voluntary family planning projects, $286,479,000: Provided, That amounts provided to said projects under such title shall not be expended for abortions, that all pregnancy counseling shall be nondirective, and that such amounts shall not be expended for any activity (including the publication or distribution of literature) that in any way tends to promote public support or opposition to any legislative proposal or candidate for public office.

PROGRAM MANAGEMENT

For program support in the Health Resources and Services Administration, $151,993,000: Provided, That funds made available under this heading may be used to supplement program support funding provided under the headings "Primary Health Care", "Health Workforce", "Maternal and Child Health", "Ryan White HIV/AIDS Program", "Health Care Systems", and "Rural Health".

GENERAL PROVISIONS

SEC. 222.

Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(a) in subsection (a)(5)(C)—

(1) by striking "A covered entity shall permit" and inserting "(i) DUPLICATE DISCOUNTS AND DRUG RESALE.—A covered entity shall permit"

(2) by inserting at the end the following:

"(ii) USE OF SAVINGS.—A covered entity shall permit the Secretary to audit [at the Secretary's expense] the records of the entity to determine how net income from purchases under this section are used by the covered entity.

"(iii) RECORDS RETENTION.— Covered entities shall retain such records and provide such records and reports as deemed necessary by the Secretary for carrying out this subparagraph.".

(b) by adding at the end the following new subsection:

"(f) REGULATIONS.—The Secretary may promulgate such regulations as the Secretary determines necessary or appropriate to carry out the provisions of this section.".

SEC. 205. In lieu of the timeframe specified in section 338E(c)(2) of the PHS Act, terminations described in such section may occur up to 60 days after the execution of a contract awarded in fiscal year 2019 under section 338B of such Act.

Language Analysis

LANGUAGE PROVISION	EXPLANATION
For carrying out titles II and III of the Public Health Service Act (referred to in this Act as the "PHS Act") with respect to primary health care and the Native Hawaiian Health Care Act of 1988, $5,091,522,000: Provided, That $4,990,629,000, to remain available until expended, shall be for the Health Centers program under section 330 of the PHS Act, of which $5,000,000 shall be transferred to and merged with the Domestic Trafficking Victims Fund established under section 3014(c) of title 18, United States Code:	Defines the authorization and amount appropriated for Health Centers program and continues current law transfers to the Domestic Trafficking Victims Fund. In addition to the appropriations language, changes in authorizing language are required to fully realize this discretionary proposal. Consistent with the Addendum, authorizing proposals are assumed to reclassify several programs within the Department of Health and Human Services from mandatory to discretionary and cancel any currently-enacted mandatory funding for these programs appropriated in FY 2019 and beyond.
Provided further, That no more than $1,000,000 shall be available until expended for carrying out the provisions of section 224(o) of the PHS Act:	Defines a subset appropriated for the Free Clinics Medical Malpractice program.
Provided further, That no more than $99,703,000 shall be available until expended for carrying out subsections (g) through (n) and (q) of section 224 of the PHS Act, and for expenses incurred by the Department of Health and Human Services (referred to in this Act as "HHS") pertaining to administrative claims made under such law.	Defines a subset appropriated for the Health Center Tort Claims program.
Provided further, That the ninth provisos under the heading "Department of Health and Human Services—Health Resources and Services Administration—Health Resources and Services" in Public Laws 104–208 and 105–78 are amended by striking "$80,000,000" and inserting "$152,700,000" in each such ninth proviso and by adding at the end of each such ninth proviso the following new proviso: "Provided further, That such costs, including the cost of	Provision to increase the loan limitation authorized for the Health Center Loan Guarantee Program.

LANGUAGE PROVISION	EXPLANATION
modifying such loans, shall be as defined in section 502 of the Congressional Budget Act of 1974:".	
For carrying out titles III, VII, and VIII of the PHS Act with respect to the health workforce, sections 1128E and 1921(b) of the Social Security Act, and the Health Care Quality Improvement Act of 1986, $457,798,000:	Defines the authorization and amount appropriated for the Health Workforce programs.
Provided, That $310,000,000, to remain available until expended, shall be for the National Health Service Corps program under subparts II and III of part D of the PHS Act:	Defines a subset appropriated for the National Health Service Corps program. In addition to the appropriations language, changes in authorizing language are required to fully realize this discretionary proposal. Consistent with the Addendum, authorizing proposals are assumed to reclassify several programs within the Department of Health and Human Services from mandatory to discretionary and cancel any currently-enacted mandatory funding for these programs appropriated in FY 2019 and beyond.
Provided further, That $60,000,000, to remain available until expended, shall be for Teaching Health Center Graduate Medical Education under section 340H of the PHS Act:	Defines a subset appropriated for Teaching Health Center Graduate Medical Education. In addition to the appropriations language, changes in authorizing language are required to fully realize this discretionary proposal. Consistent with the Addendum, authorizing proposals are assumed to reclassify several programs within the Department of Health and Human Services from mandatory to discretionary and cancel any currently-enacted mandatory funding for these programs appropriated in FY 2019 and beyond.
Provided further, That sections 751 and 762(k) of the PHS Act shall not apply to funds made available under this heading:	Provides that restrictions defined in sections 751 and 762(k) of the PHS Act shall not apply to the appropriations made.
Provided further, That fees collected for the disclosure of information under section 427(b) of the Health Care Quality Improvement Act of 1986 and sections	Provides the authorization and source of funds for the National Practitioner Data Bank program.

LANGUAGE PROVISION	EXPLANATION
1128E(d)(2) and 1921 of the Social Security Act shall be sufficient to recover the full costs of operating the programs authorized by such sections and shall remain available until expended for the National Practitioner Data Bank:	
Provided further, That funds transferred to this account to carry out section 846 and subpart 3 of part D of title III of the PHS Act may be used to make prior year adjustments to awards made under such sections.	Provides that funds transferred for the Loan Repayment and Scholarship programs may be used to make prior year adjustments.
For carrying out titles III, XI, XII, and XIX of the PHS Act with respect to maternal and child health, title V of the Social Security Act, and section 712 of the American Jobs Creation Act of 2004, $1,136,200,000:	Provides the authorization and appropriation amount for Maternal and Child Health programs.
Provided, That $5,000,000, to remain available until expended, shall be for the Family-to-Family Health Information Centers program:	Defines a subset appropriated for the Family-to-Family Health Information Centers program.
Provided, That $5,000,000, to remain available until expended, shall be for the Family-to-Family Health Information Centers program under section 501 of the Social Security Act	Defines a subset appropriated for the Family-to-Family Health Information Centers program. In addition to the appropriations language, changes in authorizing language are required to fully realize this discretionary proposal. Consistent with the Addendum, authorizing proposals are assumed to reclassify several programs within the Department of Health and Human Services from mandatory to discretionary and cancel any currently-enacted mandatory funding for these programs appropriated in FY 2019 and beyond.

LANGUAGE PROVISION	EXPLANATION
Provided further, That $400,000,000, to remain available until expended, shall be for the Maternal, Infant, and Early Childhood Home Visiting program under section 511 of the Social Security Act:	Defines a subset appropriated for the Maternal, Infant, and Early Childhood Home Visiting program. In addition to the appropriations language, changes in authorizing language are required to fully realize this discretionary proposal. Consistent with the Addendum, authorizing proposals are assumed to reclassify several programs within the Department of Health and Human Services from mandatory to discretionary and cancel any currently-enacted mandatory funding for these programs appropriated in FY 2019 and beyond.
Provided further, That notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act, not more than $66,593,000 shall be available for carrying out special projects of regional and national significance pursuant to section 501(a)(2) of such Act and $10,276,000 shall be available for projects described in subparagraphs (A) through (F) of section 501(a)(3) of such Act.	Provision overriding the set-aside requirements in the SSA Act and providing specific set-aside appropriated amounts for Special Projects of National Significance and Community Integrated Services and Supports activities.
For carrying out title XXVI of the PHS Act with respect to the Ryan White HIV/AIDS program, $2,260,170,000, of which $1,970,881,000 shall remain available to the Secretary of Health and Human Services (referred to in this title as the "Secretary") through September 30, 2021, for parts A and B of title XXVI of the PHS Act, and of which not less than $900,313,000 shall be for State AIDS Drug Assistance Programs under the authority of section 2616 or 311(c) of such Act;	Provides the authorization and appropriation for Ryan White HIV/AIDS activities and the set-aside amount for Parts A & B of the Ryan White HIV/AIDS program which are available for a three year period. Additionally provides a set-aside amount for State AIDS Drug Assistance Programs.
Provided, That section 2691 of the PHS Act shall not apply to funds appropriated under this heading.	Provision overriding set-aside funding for the Special Projects of National Significance program.
For carrying out titles III and XII of the PHS Act with respect to health care systems, and	Provides the authorization and appropriation for the Health Care Systems programs.

LANGUAGE PROVISION	EXPLANATION
the Stem Cell Therapeutic and Research Act of 2005, $100,518,000;	
Provided, That the Secretary may collect a fee of 0.1 percent of each purchase of 340B drugs from entities participating in the Drug Pricing Program pursuant to section 340B of the PHS Act to pay for the operating costs of such program: Provided further, That fees pursuant to the 340B Drug Pricing Program shall be collected by the Secretary based on sales data that shall be submitted by drug manufacturers and shall be credited to this account to remain available until expended.	Provision to authorize the Secretary to collect and spend user fees for the 340B Drug Pricing program.
For carrying out titles III and IV of the PHS Act with respect to rural health, section 427(a) of the Federal Coal Mine Health and Safety Act of 1969, and section 711 of the Social Security Act, $74,911,000.	Provides the authorization and appropriation for the Rural Health programs.
For carrying out the program under title X of the PHS Act to provide for voluntary family planning projects, $286,479,000:	Provides the authorization and appropriation for the Family Planning program.
Provided, That amounts provided to said projects under such title shall not be expended for abortions, that all pregnancy counseling shall be nondirective, and that such amounts shall not be expended for any activity (including the publication or distribution of literature) that in any way tends to promote public support or opposition to any legislative proposal or candidate for public office.	Restricts the purpose of the funding for the Family Planning program.
For program support in the Health Resources and Services Administration, $151,993,000:	Provides the authorization and appropriation for Program Management.
Provided, That funds made available under this heading may be used to supplement program support funding provided under the headings "Primary Health Care", "Health Workforce", "Maternal and Child Health", "Ryan White HIV/AIDS Program", "Health Care Systems", and "Rural Health	Provision permitting appropriations for Program Management to be used to provide program support to for programs appropriated under the Primary Health Care, Health Workforce, Maternal and Child Health, Ryan White HIV/AIDS Program, Health Care Systems, and Rural Health appropriations.

SEC. 222. *Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—* *(a) in subsection (a)(5)(C)—* *(1) by striking "A covered entity shall permit" and inserting "(i) DUPLICATE DISCOUNTS AND DRUG RESALE.—A covered entity shall permit"* *(2) by inserting at the end the following:* *"(ii) USE OF SAVINGS.—A covered entity shall permit the Secretary to audit [at the Secretary's expense] the records of the entity to determine how net income from purchases under this section are used by the covered entity.* *"(iii) RECORDS RETENTION.— Covered entities shall retain such records and provide such records and reports as deemed necessary by the Secretary for carrying out this subparagraph.".* *(b) by adding at the end the following new subsection:* *"(f) REGULATIONS.—The Secretary may promulgate such regulations as the Secretary determines necessary or appropriate*	Provision to permit the Secretary to issue regulations on all aspects of the 340B Program and to require covered entities to report on the use of savings to ensure that net income from purchases under the 340B Drug Pricing Program benefit low-income and uninsured patients of the covered entities.

LANGUAGE PROVISION	EXPLANATION
to carry out the provisions of this section.".	
SEC. 205. In lieu of the timeframe specified in section 338E(c)(2) of the PHS Act, terminations described in such section may occur up to 60 days after the execution of a contract awarded in fiscal year 2019 under section 338B of such Act.	Provision to amend timeframe specified in section 338E(c)(2).

Amounts Available for Obligation[4]

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
General Fund Discretionary Appropriation:			
Appropriation	$6,213,347,000	$6,156,255,000	$9,559,591,000
Real transfer to the Administration for Children and Families	-14,100,000	-	-
Subtotal, adjusted general fund discretionary appropriation	**6,199,247,000**	**6,156,255,000**	**9,559,591,000**
Mandatory Appropriation:[5]			
Family to Family Health Information Centers	+5,000,000	+5,000,000	-
Primary Health Care Access:			
Community Health Center Fund	+3,600,000,000	+3,600,000,000	-
National Health Service Corps	+310,000,000	+310,000,000	-
Subtotal Primary Health Care Access	**+3,910,000,000**	**+3,910,000,000**	**-**
Maternal, Infant and Early Childhood Home Visitation	+400,000,000	+400,000,000	-
Teaching Health Centers Graduate Medical Education	+60,000,000	+60,000,000	-
Transfer to the Department of Justice	-5,000,000	-	-5,000,000
Appropriations Permanently Reduced	-142,814,000	-	-
Subtotal, adjusted mandatory appropriation	**4,227,186,000**	**4,375,000,000**	**-5,000,000**
Offsetting Collections	**+16,902,000**	**+19,000,000**	**+35,000,000**
Unobligated balance, start of year	+519,437,000	+322,598,000	+223,000,000
Unobligated balance, end of year	-322,598,000	-223,000,000	-220,000,000
Recovery of prior year obligations	+ 84,000,000	-	-
Unobligated balance, lapsing	-4,497,000	-	-
Total obligations	**$10,719,677,000**	**$10,649,853,000**	**$9,592,591,000**

[4] Excludes the following amounts for reimbursable activities carried out by this account: FY 2017 - $12,178,000 and 26 FTE; FY 2018 - $12,194,000 and 26 FTE; FY 2019 $12,199,000 and 26 FTE.
[5] FY 2018 level includes proposed mandatory funding.

Summary of Changes

2018 Continuing Resolution	$6,156,255,000
(Obligations)	($6,156,255,000)
2019 Estimate	$9,559,591,000
(Obligations)	($9,559,591,000)
2018 Mandatory[6]	$4,375,000,000
(Obligations)	($4,375,000,000)
2019 Mandatory	-
(Obligations)	-
Net Change	**-$971,664,000**
(Obligations)	**+$971,664,000**

	FY 2018 Annualized CR		FY 2019 President's Budget		FY 2019 +/- FY 2018	
	FTE	**Budget Authority**	**FTE**	**Budget Authority**	**FTE**	**Budget Authority**
FTE	**2,074**		**1,993**		**-81**	
Pay Cost		$ 316,033,636		$ 303,264,411		$-12,769,225
Increases:						
A. Built in:						
1. January 2019 Civilian Pay Raise		3,712,418		-		-3,712,418
2. January 2019 Military Pay Raise		467,598		607,948		+140,350
3. Civilian Annualization of Jan. 2018		1,933,436		1,275,155		-658,281
4. Military Annualization of Jan. 2018		232,384		194,913		-37,471
Subtotal, built-in increases		**$6,345,836**		**$2,078,016**		**-4,267,820**

[6] FY 2018 level includes proposed mandatory funding.

	FY 2018 Annualized CR		FY 2019 President's Budget		FY 2019 +/- FY 2018	
B. Program:	**FTE**	**Budget Authority**	**FTE**	**Budget Authority**	**FTE**	**Budget Authority**
Discretionary Increases						
Health Centers	288	1,381,185,000	522	4,990,629,000	+234	+3,609,444,000
Health Center Tort Claims	-	99,215,000	-	99,893,000	-	+678,000
Free Clinics Medical Malpractice	-	993,000	-	1,000,000	-	+7,000
National Health Service Corps	-	-	225	310,000,000	+225	+310,000,000
Health Workforce Assessment	6	4,631,000	6	4,663,000	-	+32,000
NURSE Corps Scholarship and Loan Repayment	32	82,570,000	32	83,135,000	-	+565,000
Teaching Health Center Graduate Medical Education	-	-	8	60,000,000	+8	+60,000,000
Healthy Start	15	102,797,000	15	103,500,000	-	+703,000
Family-to-Family Health Information Centers	-	-	1	5,000,000	+1	+5,000,000
Maternal, Infant and Early Childhood Home Visiting	-	-	43	400,000,000	+43	+400,000,000
Emergency Relief - Part A	44	651,422,000	44	655,876,000	-	+4,454,000
Comprehensive Care - Part B	63	1,306,075,000	63	1,315,005,000	-	+8,930,000
Early Intervention - Part C	54	199,713,000	56	201,079,000	+2	+1,366,000
Children, Youth, Women & Families - Part D	10	74,578,000	10	75,088,000	-	+510,000
Dental Reimbursement Program Part F	1	13,033,000	1	13,122,000	-	+89,000
Organ Transplantation	2	23,389,000	2	23,549,000	-	+160,000
National Cord Blood Inventory	4	12,183,000	4	12,266,000	-	+83,000
C.W. Bill Young Cell Transplantation Program	7	21,959,000	7	22,109,000	-	+150,000
Poison Control Centers	2	18,718,000	2	18,846,000	-	+128,000
340B Drug Pricing Program/Office of Pharmacy Affairs	22	10,168,000	22	10,238,000	-	+70,000
Payment to Hawaii	-	1,844,000	-	1,857,000	-	+13,000
Radiation Exposure Screening and Education Program	1	1,822,000	1	1,834,000	-	+12,000
Black Lung	-	7,217,000	-	7,266,000	-	+49,000
Family Planning	12	284,534,000	35	286,479,000	+23	+1,945,000
Subtotal Discretionary Program Increases	**563**	**4,298,046,000**	**1,099**	**8,702,434,000**	**+536**	**+4,404,388,000**
Mandatory Increases						
Subtotal Mandatory Program Increases	**-**	**-**	**-**	**-**	**-**	**-**
Total Program Increases	**563**	**4,298,046,000**	**1,099**	**8,702,434,000**	**+ 536**	**+4,404,388,000**

	FY 2018 Annualized CR		FY 2019 President's Budget		FY 2019 +/- FY 2018	
	FTE	**Budget Authority**	**FTE**	**Budget Authority**	**FTE**	**Budget Authority**
Decreases:						
A. Built in:						
1. Pay Costs	**2,074**	**316,033,636**	**1,993**	**303,264,411**	**-81**	**-4,267,820**
B. Program:						
Discretionary Decreases						
Loan Repayment/Faculty Fellowships	-	1,182,000	-	-	-	-1,182,000
Centers of Excellence	1	21,564,000	-	-	-1	-21,564,000
Scholarships for Disadvantaged Students	5	45,658,000	-	-	-5	-45,658,000
Health Careers Opportunity Program	2	14,093,000	-	-	-2	-14,093,000
Primary Care Training and Enhancement	6	38,660,000	-	-	-6	-38,660,000
Oral Health Training Programs	6	36,424,000	-	-	-6	-36,424,000
Area Health Education Centers	4	30,045,000	-	-	-4	-30,045,000
Geriatric Programs	6	38,474,000	-	-	-6	-38,474,000
Behavioral Health Workforce Education and Training	6	49,660,000	-	-	-6	-49,660,000
Mental and Behavioral Health	2	9,849,000	-	-	-2	-9,849,000
Public Health/Preventive Medicine	4	16,885,000	-	-	-4	-16,885,000
Advanced Nursing Education	8	64,142,000	-	-	-8	-64,142,000
Nursing Workforce Diversity	-	15,239,000	-	-	-	-15,239,000
Nurse Education, Practice and Retention	5	39,642,000	-	-	-5	-39,642,000
Nurse Faculty Loan Program	5	26,320,000	-	-	-5	-26,320,000
Children's Hospital Graduate Medical Education	17	297,963,000	-	-	-17	-297,963,000
Maternal and Child Health Block Grant	42	637,342,000	42	627,700,000	-	-9,642,000
Autism and Other Developmental Disorders	6	46,779,000	-	-	-6	-46,779,000
Sickle Cell Service Demonstrations	2	4,425,000	-	-	-2	-4,425,000
James T. Walsh Universal Newborn Hearing Screening	4	17,697,000	-	-	-4	-17,697,000
Emergency Medical Services for Children	5	20,025,000	-	-	-5	-20,025,000
Heritable Disorders	3	13,789,000	-	-	-3	-13,789,000
AIDS Education and Training Centers - Part F	5	33,383,000	-	-	-5	-33,383,000
Special Projects of National Significance (SPNS)	2	24,830,000	-	-	-2	-24,830,000
Hansen's Disease Center	53	15,103,000	53	11,653,000	-	-3,450,000
Natl. Hansen's Disease Prog. - Buildings and Facilities	-	121,000	-	-	-	-121,000

	FY 2018 Annualized CR		FY 2019 President's Budget		FY 2019 +/- FY 2018	
	FTE	**Budget Authority**	**FTE**	**Budget Authority**	**FTE**	**Budget Authority**
Rural Health Policy Development	1	9,287,000	1	5,000,000	-	-4,287,000
Rural Health Outreach Grants	8	65,055,000	8	50,811,000	-	-14,244,000
Rural Hospital Flexibility Grants	2	43,313,000	-	-	-2	-43,313,000
State Offices of Rural Health	-	9,932,000	-	-	-	-9,932,000
Telehealth	1	18,374,000	1	10,000,000	-	-8,374,000
Program Management	789	152,954,000	789	151,993,000	-	-961,000
Subtotal Discretionary Program Decreases	**1,000**	**1,858,209,000**	**894**	**857,157,000**	**-106**	**-1,001,052,000**
Mandatory Decreases						
Health Centers	234	3,600,000,000	-	-	-234	-3,600,000,000
National Health Service Corps	225	310,000,000	-	-	-225	-310,000,000
Teaching Health Center Graduate Medical Education	8	60,000,000	-	-	-8	-60,000,000
Family-to-Family Health Information Centers	1	5,000,000	-	-	-1	-5,000,000
Maternal, Infant and Early Childhood Home Visiting	43	400,000,000	-	-	-43	-400,000,000
Subtotal Mandatory Program Decreases	**511**	**4,375,000,000**	-	-	**-511**	**-4,375,000,000**
Total Program Decreases	**1,511**	**6,233,209,000**	**894**	**857,157,000**	**-617**	**-5,376,052,000**
Net Change Discretionary	**1,563**	**6,156,255,000**	**1,993**	**9,559,591,000**	**+430**	**+3,403,336,000**
Net Change Mandatory	**511**	**4,375,000,000**	**-**	**-**	**-511**	**-4,375,000,000**
Net Change Discretionary and Mandatory	**2,074**	**10,531,255,000**	**1,993**	**9,559,591,000**	**-81**	**-971,664,000**

Budget Authority by Activity

(Dollars in Thousands)

Program	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
1. PRIMARY CARE:			
Health Centers:			
Health Centers	1,387,036	1,381,185	4,990,629
Health Centers Mandatory	3,510,661	550,000	-
Health Centers Proposed Mandatory	-	3,050,000	-
Health Center Tort Claims	99,893	99,215	99,893
Subtotal, Health Centers	***4,997,590***	***5,080,400***	***5,090,522***
Free Clinics Medical Malpractice	1,000	993	1,000
Subtotal, Bureau of Primary Health Care	**4,998,590**	**5,081,393**	**5,091,522**
2. HEALTH WORKFORCE:			
National Health Service Corps (NHSC):			
NHSC			310,000
NHSC Mandatory	288,610	65,000	-
NHSC Proposed Mandatory	-	245,000	-
Subtotal, NHSC	***288,610***	***310,000***	***310,000***
Loan Repayment/Faculty Fellowships	1,187	1,182	-
Health Professions Training for Diversity:			
Centers of Excellence	21,659	21,564	-
Scholarships for Disadvantaged Students	45,859	45,658	-
Health Careers Opportunity Program	14,155	14,093	-
Subtotal, Health Professions Training for Diversity	***81,673***	***81,315***	***-***
Health Care Workforce Assessment	4,652	4,631	4,663
Primary Care Training and Enhancement	38,830	38,660	-
Oral Health Training Programs	36,587	36,424	-
Interdisciplinary, Community-Based Linkages:			
Area Health Education Centers	30,177	30,045	-
Geriatric Programs	38,644	38,474	-
Behavioral Health Workforce Education and Training	50,000	49,660	-
Mental and Behavioral Health	9,892	9,849	-
Subtotal, Interdisciplinary, Community-Based Linkages	***128,713***	***128,028***	***-***

Program	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Public Health Workforce Development:			
Public Health/Preventive Medicine	16,949	16,885	-
Nursing Workforce Development:			
Advanced Nursing Education	64,425	64,142	-
Nursing Workforce Diversity	15,306	15,239	-
Nurse Education, Practice and Retention	39,817	39,642	-
Nurse Faculty Loan Program	26,436	26,320	-
NURSE Corps Scholarship and Loan Repayment Program	82,935	82,570	83,135
Subtotal, Nursing Workforce Development	***228,919***	***227,913***	***83,135***
Children's Hospital Graduate Medical Education	299,289	297,963	-
Teaching Health Center Graduate Medical Education (THCGME):			
THCGME	-	-	60,000
THCGME Current Law Mandatory	55,860	30,000	-
THCGME Proposed Mandatory	-	30,000	-
Subtotal. THCGME	***55,860***	***60,000***	***60,000***
National Practitioner Data Bank (User Fees)	*18,814*	*18,000*	*18,814*
Subtotal, Bureau of Health Workforce	**1,200,083**	**1,221,001**	**476,612**
3. MATERNAL & CHILD HEALTH:			
Maternal and Child Health Block Grant	640,163	637,342	627,700
Autism and Other Developmental Disorders	46,985	46,779	-
Sickle Cell Service Demonstrations	4,444	4,425	-
James T. Walsh Universal Newborn Hearing Screening	17,775	17,697	-
Emergency Medical Services for Children	20,113	20,025	-
Healthy Start	118,251	102,797	103,500
Heritable Disorders	13,850	13,789	-
Family-to-Family Health Information Centers (F2F HICs)			
F2F HICs	-	-	5,000
F2F HICs Current Law Mandatory	4,655	-	-
F2F HICs Proposed Mandatory	-	5,000	-
Subtotal, F2F HICs	***4,655***	***5,000***	***5,000***
Maternal, Infant and Early Childhood Home Visiting Program (MIECHV)			
MIECHV	-	-	400,000
MIECHV Current Law Mandatory	372,400	-	-

Program	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
MIECHV Proposed Mandatory	-	400,000	-
Subtotal, MIECHV	***372,400***	***400,000***	***400,000***
Subtotal, Maternal and Child Health Bureau	**1,238,636**	**1,247,854**	**1,136,200**
4. HIV/AIDS:			
Emergency Relief - Part A	654,296	651,422	655,876
Comprehensive Care - Part B	1,311,837	1,306,075	1,315,005
AIDS Drug Assistance Program (non-add)	*900,313*	*894,199*	*900,313*
Early Intervention - Part C	200,585	199,713	201,079
Children, Youth, Women & Families - Part D	74,907	74,578	75,088
AIDS Education and Training Centers - Part F	33,530	33,383	-
Dental Reimbursement Program Part F	13,090	13,033	13,122
Special Projects of National Significance (SPNS)	24,940	24,830	-
Subtotal, HIV/AIDS Bureau	**2,313,185**	**2,303,034**	**2,260,170**
5. HEALTHCARE SYSTEMS:			
Organ Transplantation	23,492	23,389	23,549
National Cord Blood Inventory	12,239	12,183	12,266
C.W. Bill Young Cell Transplantation Program	22,056	21,959	22,109
Poison Control Centers	18,801	18,718	18,846
340B Drug Pricing Program/Office of Pharmacy Affairs	10,213	10,168	10,238
340B Drug Pricing Program User Fees	-	-	*16,000*
Hansen's Disease Center	15,169	15,103	11,653
Payment to Hawaii	1,853	1,844	1,857
National Hansen's Disease Program - Buildings and Facilities	122	121	-
Subtotal, Healthcare Systems Bureau	**103,945**	**103,485**	**116,518**
6. RURAL HEALTH:			
Rural Health Policy Development	9,328	9,287	5,000
Rural Health Outreach Grants	65,347	65,055	50,811
Rural Hospital Flexibility Grants	43,509	43,313	-
State Offices of Rural Health	9,977	9,932	-
Radiation Exposure Screening and Education Program	1,830	1,822	1,834
Black Lung	7,250	7,217	7,266

Program	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Telehealth	18,459	18,374	10,000
Subtotal, Federal Office of Rural Health Policy	**155,700**	**155,000**	**74,911**
7. PROGRAM MANAGEMENT	153,629	152,954	151,993
8. FAMILY PLANNING	286,479	284,534	286,479
Total, Discretionary Budget Authority	**6,199,247**	**6,156,255**	**9,559,591**
FTE[7,8]	**2,141**	**2,141**	**2,060**

[7] Does not include the Vaccine Injury Compensation program
[8] Due to coding error in the Family Planning program, FTE is reporting lower than actual

Authorizing Legislation

	FY 2018 Amount Authorized	FY 2018 Annualized CR	FY 2019 Amount Authorized	FY 2019 President's Budget
PRIMARY HEALTH CARE:				
Health Centers: Public Health Service (PHS) Act, Section 330, as amended by P.L. 111-148, Section 5601	Authorized for FY 2018 (and each subsequent year), an amount equal to the previous year's funding adjusted for any increase in the number of patients served and the per-patient costs	1,381,185,000	Authorized for FY 2019 (and each subsequent year), an amount equal to the previous year's funding adjusted for any increase in the number of patients served and the per-patient costs	4,990,629,000
Health Centers (Mandatory): P.L. 111-148, Section 10503; as amended by P.L 111-152, Section 2303; as amended by P.L. 114-10, Section 221 [see 42 USC 254b-2 stand-alone provision—not in PHS Act], as amended by P.L. 115-96, Sec. 3101(a)(2)(F)	Expiring 3/31/2018 ($550,000,000 for the period of the first and second quarters of FY 2018)	3,600,000,000[9]	$0	--
Federal Tort Claims Act Coverage for Health Centers: PHS Act, Section 224, as added by P.L. 102-501; as amended by P.L. 103-183; P.L. 104-73; P.L. 108-163; and the 21st Century Cures Act, P.L. 114-255, Section 9025	$10,000,000 per fiscal year is authorized under Section 224; funding comes from the Health Center line	99,215,000	$10,000,000 per fiscal year is authorized under Section 224; funding comes from the Health Center line	99,893,000
Federal Tort Claims Act Coverage for Free Clinics: PHS Act, Section 224, as added to the PHS Act by P.L. 104-191, Section 194; as amended by P.L. 111-148, Section 10608	$10,000,000 per fiscal year is authorized	993,000	$10,000,000 per fiscal year is authorized	1,000,000
BUREAU OF HEALTH WORKFORCE:				
National Health Service Corps (NHSC): NHSC: PHS Act, Sections 331-338, and 338C-H as amended by the Health Care Safety Net Act of 2008, P.L. 110-355, Section 3(a)(1) and 3(c)-(d); as amended by P.L. 111-148, 10501(n)(1)-(3) and (5)	Authorized for FY 2018 (and each subsequent year), based on previous year's funding, subject to adjustment formula	--	Authorized for FY 2019 (and each subsequent year), based on previous year's funding, subject to adjustment formula	310,000,000

[9] FY 2018 level includes proposed mandatory funding.

	FY 2018 Amount Authorized	FY 2018 Annualized CR	FY 2019 Amount Authorized	FY 2019 President's Budget
NHSC (Mandatory): P.L. 111-148, Section 10503(b)(2), as amended by P.L. 114-10, Section 221 [see 42 USC 254b-2 stand-alone provision—not in PHS Act] , as amended by P.L. 115-96, Sec. 3101(b)(3)(F)	Expiring 3/31/2018 ($65,000,000 for the period of the first and second quarters of FY 2018)	310,000,000[10]	$0	--
NHSC Scholarship Program: PHS Act, Sections 338A and 338C-H, as amended by the Health Care Safety Net Act of 2008, P.L. 110-355, Section 3(a)(2); as amended by the Patient Protection and Affordable Care Act P.L. 111-148, Sections 5207 NHSC Loan Repayment Program: PHS Act, Sections 338B and 338C-H, as amended by the Health Care Safety Net Act of 2008, P.L. 110-355, Section 3(a)(2); as amended by the Patient Protection and Affordable Care Act , P.L. 111-148, Sections 5207 and 10501(n)(4)				
Students to Service Loan Repayment Program: PHS Act, Section 338B	Indefinite		Indefinite	
State Loan Repayment Program (SLRP): PHS Act, Section 338I(a)-(i), as amended by P.L. 107-251, Section 315; as further amended by the Health Care Safety Net Act of 2008, P.L. 110-355, Section 3(a)(2)	Expired (Note: The CHC/NHSC Fund (extended by MACRA) is used to make SLRP grants)		Expired (Note: The CHC/NHSC Fund (extended by MACRA) was used to make SLRP grants	
Loan Repayments and Fellowships Regarding Faculty Positions (Faculty Loan Repayment): PHS Act, Section 738(a) and 740(b), as amended by P.L. 111-148, Sections 5402 and 10501(d)	Expired	1,182,000	Expired	--
Centers of Excellence: Section 736, PHS Act, as amended by P.L. 111-148, Section 5401	SSAN	21,564,000	SSAN	--
Scholarships for Disadvantaged Students: PHS Act, Section 737, as amended by P.L. 111-148, Section 5402(b), authorization of appropriations in Section 740(a)	Expired	45,658,000	Expired	--
Health Careers Opportunity Program: PHS Act, Section 739, as amended by P.L. 111-148, Section 5402, authorization of appropriation in Section 740(c),	Expired	14,093,000	Expired	--

[10] FY 2018 level includes proposed mandatory funding.

	FY 2018 Amount Authorized	FY 2018 Annualized CR	FY 2019 Amount Authorized	FY 2019 President's Budget
National Center for Workforce Analysis: PHS Act, Section 761(b), as amended by P.L. 111-148, Section 5103	Expired	4,631,000	Expired	4,663,000
Primary Care Training and Enhancement: PHS Act, Section 747, as amended by P.L. 111-148, Section 5301	Expired	38,660,000	Expired	--
Oral Health Training Programs (Training in General, Pediatric, and Public Health Dentistry): PHS Act, Section 748, as added by P.L. 111-148, Section 5303	Expired (with provision for carryover funds for no more than 3 years)	36,424,000	Expired (with provision for carryover funds for no more than 3 years)	--
Interdisciplinary, Community-Based Linkages: Area Health Education Centers: PHS Act, Section 751, as amended by P.L. 111-148, Section 5403; as amended by P.L. 113-128, Section 512(z)(2)	Expired (with provision for carryover funds for no more than 3 years)	30,045,000	Expired (with provision for carryover funds for no more than 3 years)	--
Behavioral Health Workforce Education and Training (BHWET): PHS Act, Sections 755 and 756; as amended by the 21st Century Cures Act, P.L. 114-255, section 9021	$50,000,000 for each of fiscal years 2018 through 2022	49,660,000	$50,000,000	--
Education and Training Related to Geriatrics: PHS Act, Section 753, as amended by P.L. 111-148, Section 5305	Expired	38,474,000	Expired	--
Mental and Behavioral Health Education and Training Grants (MBHET): PHS Act, Section 756, as added by P.L. 111-148, Section 5306; as amended by the 21st Century Cures Act, P.L. 114-255, Section 9021	(through FY 2022) Subsection (a)(1) grants: $15,000,000 Subsection (a)(2) grants: $15,000,000 Subsection (a)(3) grants: $10,000,000 Subsection (a)(4) grants: $10,000,000	9,849,000	21st Century CURES Act, Section 9021Subsection (a)(1)-- $15,000,000 Subsection (a)(2) $15,000,000; Subsection (a)(3): $10,000,000; Subsection (a)(4): $10,000,000	--
Public Health /Preventive Medicine: PHS Act, Sections 765-768, as amended by P.L. 111-148, Section 10501	Expired	16,885,000	Expired	--
Nursing Workforce Development: Advanced Education Nursing: PHS Act, Section 811, as amended by P.L. 111-148, Section 5308	Expired	64,142,000	Expired	--

	FY 2018 Amount Authorized	FY 2018 Annualized CR	FY 2019 Amount Authorized	FY 2019 President's Budget
Nursing Workforce Diversity PHS Act, Section 821, as amended by P.L. 111-148, Sec. 5404	Expired	15,239,000	Expired	--
Nurse Education, Practice, Quality and Retention : PHS Act, Section 831 and 831A, as amended by P.L. 111-148, Section 5309	Expired	39,642,000	Expired	--
Nurse Faculty Loan Program: PHS Act, Section 846A, as amended by P.L. 111-148, Section 5311	Expired	26,320,000	Expired	--
Comprehensive Geriatric Education: PHS Act, Section 865, as re-designated by P.L. 111-148, Section 5310(b)	Expired	--	Expired	--
NURSE Corps (formerly Nursing Education Loan Repayment and Scholarship Programs): PHS Act, Section 846, as amended by P.L. 107-205, Section 103; and for NURSE Corps Loan Repayment only, as amended by P.L. 111-148, Section 5310(a)	Expired	82,570,000	Expired	83,135,000
Children's Hospitals Graduate Medical Education Program: PHS Act, Section 340E, as amended by P.L. 106-129, section 4; as amended by P.L. 106-310, section 2001; as amended by P.L. 108-490; as amended by P.L. 109-307; as amended by P.L. 113-98	Direct GME: $100,000,000 Indirect Medical Education: $200,000,000	297,963,000	Direct GME: $100,000,000 (through FY 2018) and Indirect Medical Education: $200,000,000 (through FY 2018)	--
Teaching Health Centers Graduate Medical Education Program: PHS Act, Section 340H, as added by P.L. 111-148, Section 5508; as amended by P.L. 114-10, Section 221; as amended by P.L. 115-63, Section 301(a) by the Disaster Tax Relief and Airport and Airway Extension Act of 2017 (included 3-month THCGME funding), as amended by P.L. 115-96 Sec. 3101(c)(2)	Expiring on 3/31/2018 ($30,000,000 for the period of the first and second quarters of FY 2018)	60,000,000[11]	$0	60,000,000

[11] FY 2018 level includes proposed mandatory funding.

	FY 2018 Amount Authorized	FY 2018 Annualized CR	FY 2019 Amount Authorized	FY 2019 President's Budget
National Practitioner Data Bank: (User Fees) *Title IV, P.L. 99-660, SSA, Section 1921; P.L. 100-508, SSA, Section 1128E* *(also includes: Health Care Integrity and Protection Data Bank (HIPDB), SSA, Section 1128E)*	*Not Specified*	*18,000,000*	*Not Specified*	*18,814,000*
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant: Social Security Act, Title V	Indefinite at $850,000,000	637,342,000	Indefinite at $850,000,000	627,700,000
Autism Education, Early Detection and Intervention: PHS Act, Section 399BB, as added by P.L. 109-416, Section 2; reauthorized: P.L. 112-32, Section 2; reauthorized: P.L. 113-157, Section 4	Not Specified (sunset at end of FY 2019)	46,779,000	Not Specified (sunset at the end of FY 2019)	--
Sickle Cell Service Demonstration Grants: American Jobs Creation Act of 2004, P.L. 108-357, Section 712(c)	Expired	4,425,000	Expired	--
Universal Newborn Hearing Screening: PHS Act, Section 399M, as amended by P.L. 106-310, Section 702; as amended by P.L. 111-337, Section 2	Expired	17,697,000	Expired	--
Emergency Medical Services for Children: PHS Act, Section 1910, as amended by P.L. 105-392, Section 415; as amended by P.L. 111-148, Section 5603; as amended by P.L. 113-180, Section 2	$20,213,000 (through FY 2019)	20,025,000	$20,213,000	--
Healthy Start: PHS Act, Section 330H(a)-(d), as amended by P.L. 106-310, Section 1501; as amended by P.L. 110-339, Section 2	Expired	102,797,000	Expired	103,500,000
Heritable Disorders: PHS Act, Section 1109-1112 and 1114, as amended by P.L. 106-310, Section 2601; as amended by P.L. 110-204, Section 2; as amended by P.L. 110-237, Section 1; as amended by P.L. 113-240, Section 10 (see PHS Act, Section 1117-authorization levels)	$11,900,000 (Sections 1109-1112); $8,000,000 (Section 1113) (through FY 2019)	13,789,000	$11,900,000 (Sections 1109-1112); $8,000,000 (Section 1113)	--

	FY 2018 Amount Authorized	FY 2018 Annualized CR	FY 2019 Amount Authorized	FY 2019 President's Budget
Family to Family Health Information Centers: Social Security Act, Section 501(c)(1)(A), as amended by P.L. 109-171, Section 6064; reauthorized by P.L. 111-148, Section 5507(b), as amended by P.L. 112-240, Section 624; as amended by P.L. 113-67, Section 1203; as amended by P.L. 113-93, Section 207; as amended by P.L. 114-10, Section 216	Expired	5,000,000[12]	$0	5,000,000
Maternal, Infant and Early Childhood Visiting Program: Social Security Act, Section 511, as added by P.L. 111-148, Section 2951; as amended by P.L. 113-93, Section 209; as amended by P.L. 114-10, Section 218	Expired	400,000,000[12]	$0	400,000,000
HIV/AIDS:[13]				
Emergency Relief - Part A PHS Act, Sections 2601-10, as amended by P.L. 106-345; as amended by P.L. 109-415; as amended by P.L. 111-87	Expired	651,422,000	Expired	655,876,000
Comprehensive Care - Part B: PHS Act, Sections 2611-31, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	1,306,075,000	Expired	1,315,005,000
AIDS Drug Assistance Program (Non-Add) PHS Act, Sections 2611-31 and 2616, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	*Expired*	*894,199,000*	*Expired*	*900,313,000*
Early Intervention Services – Part C: PHS Act, Sections 2651-67, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	199,713,000	Expired	201,079,000

[12] FY 2018 level includes proposed mandatory funding.

[13] The Ryan White Program was authorized through September 30, 2013. The Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87, October 30, 2009) removed the explicit sunset clause. In the absence of the sunset clause, the program will continue to operate without a Congressional reauthorization if funds are appropriated.

	FY 2018 Amount Authorized	FY 2018 Annualized CR	FY 2019 Amount Authorized	FY 2019 President's Budget
Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D: PHS Act, Section 2671, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	74,578,000	Expired	75,088,000
AIDS Education and Training Centers - Part F: PHS Act, Section 2692(a), as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	33,383,000	Expired	--
Dental Reimbursement Program - Part F: PHS Act, Section 2692(b), as amended by P.L. 106-345, as amended by P.L.109-415, as amended by P.L.111-87	Expired	13,033,000	Expired	13,122,000
Special Projects of National Significance - Part F: PHS Act, Section 2691, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	24,830,000	Expired	--
HEALTHCARE SYSTEMS:				
Organ Transplantation: 42 U.S.C. 273-274g, PHS Act, Sections 371-378, as amended by P.L. 108-216, P.L. 109-129, P.L. 110-144, P.L. 110-413, and P.L. 113-51	Expired	23,389,000	Expired	23,549,000
National Cord Blood Inventory: PHS Act, Section 379; as amended by P.L. 109-129, Section 3; as amended by P.L. 111-264; as amended by P.L. 114-104, Section 3	$23,000,000 (through FY 2020)	12,183,000	$23,000,000	12,266,000
C.W. Bill Young Cell Transplantation Program: PHS Act, Sections 379-379B, as amended by P.L. 109-129, Section 3; as amended by P.L. 111-264; as amended by P.L. 114-104, Section 2	$30,000,000 (through FY 2020)	21,959,000	$30,000,000	22,109,000
Poison Control: PHS Act, Sections 1271-1274, as amended by P.L. 108-194; as amended by P.L. 110-377; as amended by P.L. 113-77	Toll-free number: $700,000 Media campaign: $800,000 Grant program: $28,600,000	18,718,000	Toll-free number: $700,000; Media Campaign: $800,000; Grant program: $28,600,000	18,846,000

	FY 2018 Amount Authorized	FY 2018 Annualized CR	FY 2019 Amount Authorized	FY 2019 President's Budget
340B Drug Pricing Program: PHS Act, Section 340B, as added by P.L. 102-585, Section 602(a); as amended by P. L. 103-43, Section 2008(i)(1)(A); as amended by P.L. 111-148, Sections 2501(f)(1), 7101(a) –(d), 7102; as amended by P.L. 111-152, Section 2302; as amended by P.L. 111-309, Section 204(a)(1)	SSAN indefinitely	10,168,000	SSAN	10,238,000
National Hansen's Disease Program: PHS Act, Section 320, as amended by P.L. 105-78, Section 211; as amended by P.L. 107-220	Not Specified	15,103,000	Not Specified	11,653,000
Payment to Hawaii: PHS Act, Section 320(d), as amended by P.L. 105-78, Section 211	Not Specified	1,844,000	Not Specified	1,857,000
National Hansen's Disease - Buildings and Facilities: PHS Act, Section 320	Not Specified	122,000	Not Specified	--
Countermeasures Injury Compensation Program: PHS Act, Sections 319F-3 and 319F-4, as added by P.L. 109-148, as amended by P.L. 113-5 (to Section 319F-3)	Not Specified	--	Not Specified	--
RURAL HEALTH:				
Rural Health Policy Development: Social Security Act, Section 711, and PHS Act, Section 301	Indefinite	9,287,000	Indefinite	5,000,000
Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement: PHS Act, Section 330A, as amended by P.L. 107-251, Section 201; as amended by P.L. 110-355, Section 4	Expired	65,055,000	Expired	50,811,000
Rural Hospital Flexibility Grants: SSA, Section 1820(j), as amended by P.L. 105-33, Section 4201(a) and Section 4002(f), and P.L. 108-173, Section 405(f), as amended by P.L. 110-275, Section 121; as amended by P.L. 111-148, Section 3129(a)	Expired	43,313,000	Expired	--
State Offices of Rural Health: PHS Act, Section 338J, as amended by P.L. 105-392, Section 301	Expired	9,932,000	Expired	--
Radiogenic Diseases (Radiation Exposure Screening and Education Program): PHS Act, Section 417C, as amended by P.L. 106-245, Section 4, as amended by P.L. 109-482, Sections 103, 104	Not Specified	1,822,000	Not Specified	1,834,000

	FY 2018 Amount Authorized	FY 2018 Annualized CR	FY 2019 Amount Authorized	FY 2019 President's Budget
Black Lung: Federal Mine Safety and Health Act 1977, P.L. 91-173, Section 427(a)	Not Specified	7,217,000	$10,000,000	7,266,000
Telehealth: PHS Act, Section 330I, as amended by P.L. 107-251, as amended by P.L. 108-163; as amended by P.L. 113-55, Section 103	Expired	18,374,000	Expired	10,000,000
OTHER PROGRAMS:				
Family Planning: Grants: PHS Act Title X	Expired	284,534,000	Expired	286,479,000
Program Management	Indefinite	152,954,000	Indefinite	151,993,000
Vaccine Injury Compensation Program (VICP) (funded through the VICP Trust Fund): PHS Act, Title XXI, Subtitle 2, Sections 2110-34, as amended by P.L. 114-255, Section 3093(c).	Indefinite	315,697,000	Indefinite	317,200,000
UNFUNDED AUTHORIZATIONS:				
Health Center Demonstration Project for Individualized Wellness Plans PHS Act, Section 330(s), as added to PHS Act by P.L. 111-148, Section 4206	SSAN	--	SSAN	--
School Based Health Centers - Facilities Construction P.L. 111-148, Section 4101(a)	Expired (through FY 2013 and amounts remain available until expended)	--	Expired (through FY 2013 and amounts remain available until expended)	--
School Based Health Centers - Operations PHS Act, Section 399Z-1, as added by P.L. 111-148, Section 4101(b)	Expired	--	Expired	--
Health Information Technology Innovation Initiative PHS Act, Section 330(e)(1)(C), (Grants for Operation of Health Center Networks and Plans), as amended	SSAN	--	SSAN	--
Health Information Technology Planning Grants PHS Act, Section 330(c)(1)(B)-(C), as amended	SSAN	--	SSAN	--

	FY 2018 Amount Authorized	FY 2018 Annualized CR	FY 2019 Amount Authorized	FY 2019 President's Budget
Electronic Health Record Implementation Initiative PHS Act, Section 330(e)(1)(C), as amended	SSAN	--	SSAN	--
Native Hawaiian Health Scholarships: 42 USC 11709, as amended by P.L. 111-148, Section 10221 (incorporating Section 202(a) of title II of Senate Indian Affairs Committee-reported S. 1790)	SSAN (through FY 2019)	--	SSAN (through FY 2019)	--
Health Professions Education in Health Disparities and Cultural Competency PHS Act, Section 741, as amended by P.L. 111-148, Section 5307	Expired	--	Expired	--
Training Opportunities for Direct Care Workers PHS Act, Section 747A, as added by P.L. 111-148, Section 5302	Expired	--	Expired	--
Continuing Education Support for Health Professionals Serving in Underserved Communities PHS Act, Section 752, as amended by P.L. 111-148, Section 5403	SSAN	--	SSAN	--
Geriatric Career Incentive Awards PHS Act, Section 753(e), as amended by P.L. 111-148, Section 5305(a)	Expired	--	Expired	--
Geriatric Academic Career Awards PHS Act, Section 753(c), as amended by P.L. 111-148, Section 5305(b)	Not Specified	--	Not Specified	--
Rural Interdisciplinary Training (Burdick) PHS Act, Section 754	Not Specified	--	Not Specified	--
Grants for Pain Care Education & Training, PHS Act, Section 759, as added by P.L.111-148, Section 4305	Expired (through FY 2012 and amounts appropriated remain available until expended)	--	Expired (through FY 2012 and amounts appropriated remain available until expended)	--
Advisory Council on Graduate Medical Education PHS Act, Section 762, as amended by P.L. 111-148, Section 5103	Expired	--	Expired	--
Health Professions Education in Health Disparities and Cultural Competency PHS Act, Section 807, as amended by P.L. 111-148, Section 5307	Expired	--	Expired	--
Minority Faculty Fellowship Program PHS Act, Section 738 (authorized appropriation in PHS Act Section 740(b)), as amended by P.L.111-148, Sections 5402, 10501	Expired	--	Expired	--

	FY 2018 Amount Authorized	FY 2018 Annualized CR	FY 2019 Amount Authorized	FY 2019 President's Budget
State Health Care Workforce Development Grants and Implementation Grants [stand-alone 42 U.S.C. 294r (not as part of PHS Act)], as added by P.L. 111-148, Section 5102	SSAN	--	SSAN	--
Allied Health and Other Disciplines PHS Act, Section 755	Not Specified	--	Not Specified	--
Nurse Managed Health Clinics , PHS Act, Section 330A-1, as added by P.L. 111-148, Section 5208	Expired	--	Expired	--
Patient Navigator PHS Act, Section 340A, as added by P.L. 109-18, Section 2; as amended by P.L. 111-148, Section 3510	Expired	--	Expired	--
Teaching Health Centers Development Grants, PHS Act, Section 749A, as added by P.L. 111-148, Section 5508	SSAN	--	SSAN	--
Evaluation of Long Term Effects of Living Organ Donation, PHS Act, Section 371A, as added by P.L. 108-216, Section 7	Not Specified	--	Not Specified	--
Congenital Disabilities PHS Act, Section 399T, as added by P.L. 110-374, Section 3, as renumbered by P.L. 111-148, Section 4003	Not Specified	--	Not Specified	--
Pediatric Loan Repayment: PHS Act, Section 775, as added by P.L. 111-148, Section 5203	Expired	--	Expired	--
Clinical Training in Interprofessional Practice: PHS Act, Sections 755, 765, 831	Not Specified (Section 755) Expired (Sections 765 and 831)	--	Not Specified (Section 755) Expired (Sections 765 and 831)	--
Rural Access to Emergency Devices: PHS Act, Section 313 (Public Access Defibrillation Demo), and P.L. 106-505, Section 413 (Rural Access to Emergency Devices)	Expired	--	Expired	--
Training Demonstration Program: PHS Act, Section 760, as added by P.L. 114-255, the 21st Century Cures Act, Section 9022	$10,000,000 (for each of FY 2018-FY 2022)	--	$10,000,000 (for each of FY 2018-FY 2022)	--
Pediatric Mental Health Care Access Grants: PHS Act, Section 330M, as added by P.L. 114-255, the 21st Century Cures Act, Section 10002	$9,000,000 (for the period of fiscal years 2018-2022)	--	$9,000,000 (for the period of fiscal years 2018-2022)	--

	FY 2018 Amount Authorized	FY 2018 Annualized CR	FY 2019 Amount Authorized	FY 2019 President's Budget
Screening and Treatment for Maternal Depression Grants: PHS Act, Section 317L-1, as added by P.L. 114-255, the 21st Century Cures Act, Section 10005	$5,000,000 (for each of FY 2018-FY 2022)	--	$5,000,000 (for each of FY 2018-FY 2022)	--
Infant and Early Childhood Mental Health Promotion, Intervention, and Treatment Grants: PHS Act, Section 399Z-2, as added by P.L. 114-255, the 21st Century Cures Act, Section 10006	$20,000,000 (for the period of fiscal years 2018- 2022)	--	$20,000,000 (for the period of fiscal years 2018- 2022)	--
Liability Protections for Health Professional Volunteers at Community Health Centers: PHS Act, Section 224(q), as added by P.L. 114-255, the 21st Century Cures Act, Section 9025	Not Specified	--	Not Specified	--

Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2009				
General Fund Appropriation:				
Base	5,864,511,000	7,081,668,000	6,943,926,000	7,234,436,000
Mandatory Authority				5,000,000
Advance				
Supplemental				2,500,000,000
Rescission of Unobligated Funds				
Transfers				
Subtotal	5,864,511,000	7,081,668,000	6,943,926,000	9,739,436,000
FY 2010				
General Fund Appropriation:				
Base	7,126,700,000	7,306,817,000	7,238,799,000	7,473,522,000
Advance				
Supplemental				
Rescissions				
Transfers				9,472,000
Subtotal	7,126,700,000	7,306,817,000	7,238,799,000	7,482,994,000
FY 2011				
General Fund Appropriation:				
Base	7,473,522,000		7,491,063,000	6,274,790,000
Supplemental				
Transfers				
Across-the-board reductions				-12,549,000
American Recovery and Reinvestment Act				73,600,000
Subtotal	7,473,522,000		7,491,063,000	6,335,841,000
FY 2012				
General Fund Appropriation:				
Base	6,801,262,000			6,206,204,000
Advance				
Supplemental				
Rescissions				
Across-the-board reductions				-11,730,000
Transfers				11,277,000
Subtotal	6,801,262,000			6,205,751,000

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2013				
General Fund Appropriation:				
Base	6,067,862,000			6,194,474,000
Advance				
Supplemental				
Rescissions				-12,389,000
Transfers				-15,807,000
Sequestration				-311,619,000
Subtotal	6,067,862,000			5,854,664,000
FY 2014				
General Fund Appropriation:				
Base	6,015,039,000		6,309,896,000	6,054,378,000
Advance				
Supplemental				
Rescissions				
Transfers				-15,198,000
Subtotal	6,015,039,000		6,309,896,000	6,039,180,000
FY 2015				
General Fund Appropriation:				
Base	5,292,739,000		6,093,916,000	6,104,784,000
Advance				
Supplemental				
Rescissions				
Transfers				
Subtotal	5,292,739,000		6,093,916,000	6,104,784,000
FY 2016				
General Fund Appropriation:				
Base	6,217,677,000	5,804,254,000	5,987,562,000	6,139,558,000
Advance				
Supplemental				
Rescissions				
Transfers				
Subtotal	6,217,677,000	5,804,254,000	5,987,562,000	6,139,558,000

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2017				
General Fund Appropriation:				
Base	5,733,481,000	5,917,190,000	6,155,869,000	6,213,347,000
Advance				
Supplemental				
Rescissions				
Transfers				-14,100,000
Subtotal	5,733,481,000	5,917,190,000	6,155,869,000	6,199,247,000
FY 2018				
General Fund Appropriation:				
Base	5,538,834,000	5,839,777,000	6,217,794,000	6,156,255,000
Advance				
Supplemental				
Rescissions				
Transfers				
Subtotal	5,538,834,000	5,815,727,000	6,217,794,000	6,156,255,000
FY 2019				
General Fund Appropriation:	9,559,591,000			
Base				
Advance				
Supplemental				
Rescissions				
Transfers				
Subtotal	9,559,591,000			

Appropriations Not Authorized by Law[14]

HRSA Program	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2018
Health Centers (Mandatory): P.L. 111-148, Section 10503; as amended by P.L 111-152, Section 2303; as amended by P.L. 114-10, Section 221 [see 42 USC 254b-2 stand-alone provision—not in PHS Act]	2017	36,000,000,000	3,510,661,000	3,600,000,000[15]
School-Based Health Centers (facilities construction) –P.L. 111-148, Section 4101(a)	2013	$50,000,000	47,450,000	--
National Health Service Corps (NHSC) (Mandatory): P.L. 111-148, Section 10503(b)(2), as amended by P.L. 114-10, Section 221 [see 42 USC 254b-2 stand-alone provision—not in PHS Act]	2017	310,000,000	288,610,000	310,000,000
State Loan Repayment Program (SLRP) – Public Health Service (PHS) Act, Section 338I(a)-(i), as amended by P.L. 107-251, Section 315; as amended by P.L. 110-355, Section 3(a)(2) Authorization of appropriations: Section 338I(i)	2012	Such sums as necessary (SSAN)	--	--
NHSC – PHS Act, Sections 331-338 Authorization of appropriations ("Field"): Section 338(a)	2012	--	--	--
NURSE Corps (formerly Nursing Education Loan Repayment and Scholarship Programs) PHS Act, Section 846, as amended by P.L. 107-205, Section 103; and for NURSE Corps Loan Repayment only, as amended by P.L. 111-148, Section 5310(a) Authorization of appropriations: Section 846(i)(1)	2007	SSAN	31,055,000	82,570,000
Loan Repayments and Fellowships Regarding Faculty Positions (Faculty Loan Repayment) – PHS Act, Section 738(a) and 740(b), as amended by P.L. 111-148, Sections 5402 and 10501(d)	2014	5,000,000	1,187,000	1,182,000
Scholarships for Disadvantaged Students – PHS Act, program authorized by Section 737, authorization of appropriations in Section 740(a), as amended by P.L. 111-148, Section 5402(b)	2014	SSAN	44,857,000	45,658,000

[14] Please note that even where authorizations of appropriations ended in prior fiscal years, authority still exists for particular activities if the enabling authorities continue to exist and if current appropriations extend to the programmatic activities.

[15] FY 2018 level includes proposed mandatory funding.

HRSA Program	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2018
Health Careers Opportunity Program – PHS Act, program authorized by Section 739, authorization of appropriation in Section 740(c), as amended by P.L. 111-148, Section 5402	2014	SSAN	14,153,000	14,093,000
National Center for Workforce Analysis – PHS Act, Section 761(b), authorization of appropriation in Section 760(e)(1)(A), as amended by P.L. 111-148, Section 5103	2014	7,500,000	4,651,000	4,631,000
Primary Care Training and Enhancement -- PHS Act, Section 747, as amended by P.L. 111-148, Section 5301	2014	SSAN	36,831,000	38,660,000
Oral Health Training Programs (Grants for Innovative Programs for Dental Health) – PHS Act, Section 340G	2012	$25,000,000 Total (for FY 2008-12)	31,928,000	36,424,000
Area Health Education Centers PHS Act, Section 751, as amended by P.L. 111-148, Section 5403; as amended by P.L. 113-128, Section 512(z)(2)	2014	125,000,000	30,250,000	30,045,000
• Education and Training Relating to Geriatrics – PHS Act, Section 753, as amended by P.L. 111-148, Section 5305 • Geriatric Workforce Development (authorization of appropriation in Section 753(d) (9)) • Geriatric Career Incentive Awards (authorization of appropriation in Section 753(e)(4))	2014 2013	10,800,000 10,000,000	33,237,000	38,474,000
Nursing Workforce Development • Nurse Retention Grants – PHS Act, Section 831A	2012	SSAN	--	--
Nursing Workforce Development • Nurse Education, Practice, and Quality grants – PHS Act, Section 831	2016	SSAN	37,913,000	39,642,000
Nursing Workforce Development • Nurse Faculty Loan Program – PHS Act, Section 846A	2014	SSAN	24,500,000	26,320,000
Nursing Workforce Development • Comprehensive Geriatric Education – PHS Act, Section 865	2014	SSAN	4,350,000	--
Teaching Health Centers Graduate Medical Education (THCGME) Program: PHS Act, Section 340H, as added by P.L. 111-148, Section 5508; as amended by P.L. 114-10, Section 221; as amended by P.L. 115-63, Section 301(a) by the Disaster Tax Relief and Airport and Airway Extension Act of 2017 (included 3-month THCGME funding)	2018 (First Quarter only)	15,000,000	60,000,000	60,000,000[16]

[16] FY 2018 level includes proposed mandatory funding.

HRSA Program	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2018
Sickle Cell Service Demonstration Grants – American Jobs Creation Act of 2004, P.L. 108-357, Section 712(c)	2009	10,000,000	4,455,000	4,425,000
Healthy Start – PHS Act, Section 330H(a)-(d), as amended by P.L. 106-310, Section 1501; as amended by P.L. 110-339, Section 2	2013	Amount authorized for the preceding FY increased by formula	100,746,000	102,797,000
Family to Family Health Information Centers: Social Security Act, Section 501(c)(1)(A), as amended by P.L. 109-171, Section 6064; reauthorized by P.L. 111-148, Section 5507(b), as amended by P.L. 112-240, Section 624; as amended by P.L. 113-67, Section 1203; as amended by P.L. 113-93, Section 207; as amended by P.L. 114-10, Section 216	2017	5,000,000	4,655,000	5,000,000[17]
Maternal, Infant and Early Childhood Visiting Program: Social Security Act, Section 511, as added by P.L. 111-148, Section 2951; as amended by P.L. 113-93, Section 209; as amended by P.L. 114-10, Section 218	2017	400,000,000	372,400,000	400,000,000[17]
Emergency Relief - Part A – PHS Act, Sections 2601-10, as amended by P.L. 106-345; as amended by P.L. 109-415; as amended by P.L. 111-87	2013	789,471,000	649,373,000	651,422,000
Comprehensive Care - Part B – PHS Act, Sections 2611-31, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	1,562,169,000	1,314,446,000	1,306,075,000
Early Intervention Services – Part C – PHS Act, Sections 2651-67, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	285,766,000	205,544,000	199,713,000
Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D – PHS Act, Section 2671, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	87,273,000	72,395,000	74,578,000
Special Projects of National Significance - Part F – PHS Act, Section 2691, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	25,000,000	25,000,000	24,830,000

[17] FY 2018 level includes proposed mandatory funding.

HRSA Program	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2018
AIDS Education and Training Centers - Part F – PHS Act, Section 2692(a), as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	42,178,000	33,275,000	33,383,000
Dental Reimbursement Program - Part F – PHS Act, Section 2692(b), as amended by P.L. 106-345, as amended by P.L.109-415, as amended by P.L.111-87	2013	15,802,000	12,991,000	13,033,000
Organ Transplantation – 42 U.S.C. 273-274g, PHS Act, Sections 371-378, as amended by P.L. 108-216, P.L. 109-129, P.L. 110-144, P.L. 110-413, and P.L. 113-51	Annual appropriations constitute authorizations (Section-specific appropriations for sections 377, 377A, and 377B expired September 30, 2009)	Section 377— 5,000,000 Section 377A— SSAN Section 377B— SSAN	2,767,000	23,389,000
Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement – PHS Act, Section 330A, as amended by P.L. 107-251, Section 201; as amended by P.L. 110-355, Section 4	2012	45,000,000	55,553,000	65,055,000
Rural Hospital Flexibility Grants – SSA, Section 1820(j), as amended by P.L. 105-33, Section 4201(a) and Section 4002(f),, and P.L. 108-173, Section 405(f), as amended by, P.L. 110-275, Section 121; as amended by P.L. 111-148, Section 3129(a)	2012	SSAN	41,040,000	43,313,000
State Offices of Rural Health— PHS Act, Section 338J, as amended by P.L. 105-392, Section 301	2002	SSAN	4,000,000	9,932,000
Telehealth – PHS Act, Section 330I, as amended by P.L. 107-251, as amended by P.L. 108-163; as further amended by P.L. 113-55, Section 103	2006	SSAN	6,814,000	18,374,000
Family Planning Grants – PHS Act, Title X	1985	158,400,000	142,500,000	284,534,000

Primary Health Care
TAB

PRIMARY HEALTH CARE

Health Centers

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$1,387,036,000	$1,381,185,000	$4,990,629,000	+$3,609,444,000
Current Law Mandatory Funding	$3,510,661,000	$550,000,000	---	-$550,000,000
Proposed Law Mandatory Funding	---	$3,050,000,000	---	-$3,050,000,000
FTCA Program	$99,893,000	$99,215,000	$99,893,000	+$678,000
Total	**$4,997,590,000**	**$5,080,400,000**	**$5,090,522,000**	**+$10,122,000**
FTE	522	522	522	---

Authorizing Legislation: Public Health Service Act, Section 330, as amended by Public Law 111-148, Section 5601; Public Law 111-148, Section 10503, as amended by Public Law 114-10, Section 221; Public Health Service Act, Section 224, as added by Public Law 102-501 and amended by Public Law 104-73; Public Law 114-22.

FY 2019 Authorization: FY 2018 authorization level adjusted by the product of -
(i) one plus the average percentage increase in costs incurred per patient served; and
(ii) one plus the average percentage increase in the total number of patients served.

FY 2019 Community Health Center Fund Authorization.....$0

Allocation Method .....Competitive grants/cooperative agreements

Program Description and Accomplishments

For more than 50 years, health centers have delivered affordable, accessible, quality, and cost-effective primary health care to patients regardless of their ability to pay. During that time, health centers have become an essential primary care provider. Health centers advance a model of coordinated, comprehensive, and patient-centered primary health care, integrating a wide range of medical, dental, behavioral, and patient services. Today, nearly 1,400 health centers operate more than 11,000 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

In 2016, health centers served 25.9 million patients, one in every twelve people living in the United States, providing approximately 104 million patient visits, at an average cost of $890 per patient (including Federal and non-Federal sources of funding). In 2016, nearly half of all health centers served rural areas providing care to 8.6 million patients, about one in 6 people living in rural areas. Patient services are supported through Federal Health Center grants, Medicaid,

Medicare, Children's Health Insurance Program (CHIP), other third party payments, self-pay collections, other Federal grants, and State/local/other resources.

Health centers deliver high quality and cost-effective care by using key quality improvement practices, including health information technology. Approximately 66 percent of health centers are recognized by national accrediting organizations as Patient Centered Medical Homes– an advanced model of patient-centered primary care that emphasizes quality and care coordination through a team-based approach to care. Despite treating a sicker, poorer, and more diverse population than other health care providers, health centers exceeded numerous national averages and benchmarks in 2016 including Healthy People 2020 goals for low birth rate, hypertension control, and dental sealant services. Overall, 91 percent of health centers met or exceeded Healthy People 2020 goals for at least one clinical measure in 2016. Health centers also reduce costs to health systems; the health center model of care has been shown to reduce the use of costlier providers of care, such as emergency departments and hospitals.

Populations served: Health centers serve a diverse patient population. In 2016:

- People of all ages: Approximately 31 percent of patients were children (age 17 and younger); over 8 percent were 65 or older. Health centers provided primary care services for one in ten children nationwide.

- People in poverty: 92 percent of health center patients are individuals or families living at or below 200 percent of the Federal Poverty Guidelines as compared to approximately 34 percent of the U.S. population as a whole.

- People without and with health insurance: About one in 4 patients were without health insurance. Those patients that are insured are covered by Medicaid, Medicare, other public insurance, or private insurance.

- Special Populations: Some health centers receive specific funding to provide primary care services for certain special populations including individuals and families experiencing homelessness, agricultural workers, those living in public housing, and Native Hawaiians. Health centers served over 1.2 million individuals experiencing homelessness, over 950,000 agricultural workers and their families, almost 2.7 million residents of public housing and nearly 14,000 Native Hawaiians.

    - Health Care for the Homeless Program: Homelessness continues to affect rural as well as urban and suburban communities in the United States. According to the Department of Housing and Urban Development's 2015 Annual Homeless Assessment Report to Congress, approximately 1.5 million people were homeless. In 2016, HRSA-funded health centers provided primary care services for over 1.2 million persons experiencing homelessness. The Health Care for the Homeless Program supports coordinated, comprehensive, integrated primary care including substance abuse and mental health services for homeless persons in the United States, serving patients that live on the street, in shelters, or in transitional housing.

- Migrant Health Center Program: HRSA-funded health centers provided primary care services for over 950,000 migratory and seasonal agricultural workers and their families. It is estimated that there are approximately 2.8 million migratory and seasonal agricultural workers in the United States (2016 LSC Agricultural Worker Population Estimate Update). The Migrant Health Center Program supports comprehensive, integrated primary care services for agricultural workers and their families with a particular focus on occupational health and safety.

- Public Housing Primary Care Program: The Public Housing Primary Care Program increases access for residents of public housing to comprehensive, integrated primary care services. Health centers deliver care at locations on the premises of public housing developments or immediately accessible to residents. HRSA-funded health centers provided primary care services for nearly 2.7 million residents of public housing. The Public Housing Primary Care Program provides services that are responsive to identified needs of the residents and in coordination with public housing authorities.

- Native Hawaiian Health Care Program: The Native Hawaiian Health Care Program, funded within the Health Center appropriation, improves the health of Native Hawaiians by making health education, health promotion, and disease prevention services available through a combination of outreach, referral, and linkage mechanisms. Services provided include nutrition programs, screening and control of hypertension and diabetes, immunizations, and basic primary care services. Native Hawaiian Health Care Systems provided medical and enabling services to nearly 14,000 people.

Allocation Method: Public and non-profit private entities, including tribal, faith-based and community-based organizations are eligible to apply for funding under the Health Center Program. New health center grants are awarded based on a competitive process that includes an assessment of need and merit. In addition, health centers are required to compete for continued grant funding to serve their existing service areas at the completion of every project period (generally every 3 years). New Health Center Program grant opportunities are announced nationally and applications are reviewed and rated by objective review committees (ORC), composed of experts who are qualified by training and experience in particular fields related to the Program.

Funding decisions are made based on ORC assessments, announced funding preferences and program priorities. In making funding decisions, HRSA applies statutory awarding factors including funding priority for applications serving a sparsely-populated area; consideration of the rural and urban distribution of awards (no more than 60 percent and no fewer than 40 percent of projected patients come from either rural or urban areas); and continued proportionate distribution of funds to the special populations served under the Health Center Program.

Patient Care: Health centers continue to serve an increasing number of patients. The number of health center patients served in 2016 was 25.9 million; an increase of 10.9 million, or 73 percent, above the 15.0 million patients served in 2006. Of the 25.9 million patients served and for those

for whom income status is known, 92 percent were at or below 200 percent of the Federal poverty level and approximately 23 percent were uninsured. Success in increasing the number of patients served has been due in large part to the development of new health centers, new satellite sites, and expanded capacity at existing clinics.

Health centers focus on integrating care for their patients across the full range of services – not just medical but oral health, vision, behavioral health (mental health and substance use disorder services), and pharmacy. Health centers also deliver crucial services such as case management, transportation, and health education, which enable target populations to access care. Over 90 percent of health centers provide preventive dental services either directly or via contract. In 2016, health centers provided oral health services to about 5.7 million patients, an increase of 50 percent since 2010. In 2016, almost 1.8 million people received behavioral health services at health centers, an increase of 43 percent from 2014 to 2016 due to significant Health Center Program investments in behavioral health services beginning in 2014.

Improving Quality of Care and Health Outcomes: Health centers continue to provide quality primary and related health care services, improving the health of the Nation's underserved communities and populations. HRSA-funded health centers are evaluated on a set of performance measures emphasizing health outcomes and the value of care delivered. These measures provide a balanced, comprehensive look at a health center's services toward common conditions affecting underserved communities. Performance measures align with national standards and are commonly used by Medicare, Medicaid, and health insurance/managed care organizations. Benchmarking health center outcomes to national rates demonstrates how health center performance compares to the performance of the nation overall.

Timely entry into prenatal care is an indicator of both access to and quality of care. Identifying maternal disease and risks for complications of pregnancy or birth during the first trimester can also help improve birth outcomes. Results over the past few years demonstrate improved performance as the percentage of pregnant health center patients that began prenatal care in the first trimester grew from 57.8 percent in 2011 to 74.0 percent in 2016, exceeding the target of 67.0 percent.

Appropriate prenatal care management can also have a significant effect on the incidence of low birth weight (LBW), the risk factor most closely associated with neonatal mortality. Monitoring birth weight rates is one way to measure quality of care and health outcomes for health center female patients of childbearing age, approximately 29 percent of the total health center patient population served in 2016. In 2016, the health center rate was 7.8 percent, approximately 4 percentage points lower than the 2015 national rate of 8.1 percent, and has consistently been lower than the national rate during the past several years.

Health center patients, including low-income individuals, racial/ethnic minority groups, and persons who are uninsured, are more likely to suffer from chronic diseases such as hypertension and diabetes. Clinical evidence indicates that access to appropriate care can improve the health status of patients with chronic diseases and thus reduce or eliminate health disparities. The Health Center Program began reporting data from all grantees on the control of hypertension and diabetes via its Uniform Data System in 2008. In 2016, 62 percent of adult health center patients

with diagnosed hypertension had blood pressure under adequate control (less than 140/90) compared to 53 percent nationally. Additionally in 2016, 68 percent of adult health center patients with type 1 or 2 diabetes had their most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent) compared to 55 percent nationally.

HRSA recognizes that there are many opportunities to maintain and improve the quality and effectiveness of health center care. In FY 2015, HRSA established an annual Health Center Quality Improvement Fund to recognize the highest clinically-performing health centers nationwide as well as those health centers that have made significant quality improvement gains in the past year. Quality Improvement Fund awards are based on uniform clinical performance measures collected from all health centers, including measures on preventive health, perinatal/prenatal care, and chronic disease management, and designed to drive improvements in patient care and outcomes.

Health centers improve health outcomes by emphasizing the care management of patients with multiple health care needs and the use of key quality improvement practices, including health information technology. HRSA's Health Center Program Patient Centered Medical Home (PCMH) Initiative supports health centers to achieve national PCMH recognition, an advanced model of primary care using a team-based approach to improve quality through coordination of care and patient engagement. At the end of FY 2016, two-thirds of HRSA-funded health centers were recognized as PCMHs. In addition, health centers have advanced quality and accountability by adopting Health Information Technology (HIT), including the use of certified Electronic Health Records (EHRs), telehealth and other technologies that advance and enable quality improvement. Over 98 percent of all health centers reported having an EHR in 2016.

Promoting Efficiency: Health centers provide cost effective, affordable, quality primary health care services. The Program's efficiency measure focuses on maximizing the number of health center patients served per dollar as well as keeping cost increases below average annual national health care cost growth rate while maintaining access to high quality services. The annual growth in total cost per patient, reflects the full complement of services (e.g., medical, dental, mental health, substance abuse, pharmacy, outreach, translation) that make health centers a "health care home". In 2014, health center costs grew at a rate of 4.7 percent, compared to a national rate of 5.3 percent. In 2015, the health center cost growth rate was 5.4 percent, compared to a national rate of 5.8 percent. In 2016, the health center cost growth rate was 7.9 percent, slightly higher than the national rate of 4.3 percent, due to extensive investments in new health center services and capital improvement projects.

By keeping increases in the cost per individual served at health centers below than national per capita health care cost increases, the Program demonstrates that it delivers its high-quality services at a more cost-effective rate. Success in achieving cost-effectiveness may in part be related to the multi- and interdisciplinary team-based approach used under the PCMH model of care that not only increases access and reduces health disparities, but also promotes more effective care for health center patients with chronic conditions.

External Evaluation: In addition to internal monitoring of health center performance, peer reviewed literature and major reports continue to document that health centers successfully

increase access to care, promote quality and cost-effective care, and improve patient outcomes, especially for traditionally underserved populations.

- Health center Medicaid patients had lower use and spending than did non-health center patients across all services, with 22 percent fewer visits and 33 percent lower spending on specialty care, and 25 percent fewer admissions and 27 percent lower spending on inpatient care. Total spending was 24 percent lower for health center patients. (Nocon, Robert S. et al. "Health Care Use and Spending for Medicaid Enrollees in federally Qualified Health Centers Versus Other Primary Care Settings" American Journal of Public Health, Nov 2016).

- Health centers provide socially and medically disadvantaged patients with care that results in lower utilization and maintained or improved preventive care. (Neda Laiteerapong, James Kirby, Yue Gao, Tzy-Chyi Yu, Ravi Sharma, Robert Nocon, Sang Mee Lee, Marshall H. Chin, Aviva G. Nathan, Quyen Ngo-Metzger, and Elbert S. Huang; *Health Services Research* 2014).

- Health centers provide high-quality primary care and do not exhibit the extent of disparities that exist in other US health care settings. (Shi L, Lebrun-Harris L, Parasuraman S, Zhu J, Ngo-Metzger Q "The Quality of Primary Care Experienced by Health Center Patients" Journal of the American Board of Family Medicine, 2013; 26(6): 768-777).

- Health Centers and look-alikes demonstrated equal or better performance than private practice primary care providers on select quality measures despite serving patients who have more chronic disease and socioeconomic complexity (Goldman LE, Chu PW, Tran H, Romano MJ, Stafford RS; 2. American Journal of Preventive Medicine 2012 Aug; 43(2):142-9).

- Rural counties with a community health center site had 33 percent fewer uninsured emergency department (ED) visits per 10,000 uninsured populations than those rural counties without a health center site. Rural health center counties also had fewer ED visits for ambulatory care sensitive visits – those visits that could have been avoided through timely treatment in a primary care setting. (Rust George, et al. "Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties." Journal of Rural Health, Winter 2009 25(1):8-16.)

- Health centers providing enabling services that were linguistically appropriate helped patients obtain health care (Weir R, et al. Use of Enabling Services by Asian American, Native Hawaiian, and Other Pacific Islander Patients at 4 Community Health Centers. Am J Public Health 2010 Nov; 100(11): 2199 – 2205).

- ED visits are higher in counties with limited access to primary care (Hossain MM, Laditka JN. Using hospitalization for ambulatory care sensitive conditions to measure access to primary health care: an application of spatial structural equation modeling. Int J Health Geogr. 2009 Aug 28; 8:51).

Federal Tort Claims Act (FTCA) Program: The Health Center Program administers the FTCA Program, under which participating health centers, their employees and eligible contractors may be deemed to be Federal employees qualified for medical malpractice liability protection under the FTCA. As Federal employees, they are immune from suit for medical malpractice claims while acting within the scope of their employment. The Federal Government assumes responsibility for such claims. In addition, the FTCA Program supports risk mitigation activities, including reviews of risk management plans and sites visits as well as risk management technical assistance and resources to support health centers. The enactment of the 21st Century Cures Act in December of 2016 extended liability protections for volunteers at deemed health centers under the FTCA Program. In accordance with the statute, HRSA implemented FTCA coverage for volunteers in FY 2017. In FY 2014, 103 claims were paid totaling $72.2 million, in FY 2015, 111 claims were paid totaling $93.8 million, and in FY 2016, 134 claims were paid totaling $92.4 million. Currently, there are 868 FTCA Program claims outstanding. It is projected that the number of claims paid will continue to increase in FY 2019.

Funding History

FY	**Amount**
FY 2015	$1,491,422,000
FY 2015 Mandatory Funding[18]	$3,509,111,000
FY 2016	$1,491,422,000
FY 2016 Mandatory Funding	$3,600,000,000
FY 2017	$1,481,929,000
FY 2017 Mandatory Funding	$3,510,661,000
FY 2018 (annualized CR level)	$1,481,393,000
FY 2018 Current Law Mandatory Funding	$550,000,000
FY 2018 Proposed Law Mandatory Funding	$3,050,000,000
FY 2019	$4,990,629,000

Budget Request

The FY 2019 Budget requests $5.1 billion in discretionary resources, an increase of $10.1 million over the FY 2018 Annualized CR level. The Budget proposes a shift from mandatory resources to discretionary resources for this program. In FY 2019, the Health Center Program will provide care for approximately 26 million patients. This request will also support quality improvement and performance management activities at existing health center organizations, and ensure that current health centers can continue to provide essential primary health care services to their patient populations, including substance abuse services focusing on the treatment, prevention, and/or awareness of opioid abuse. The FY 2019 Request also supports $99.9 million for the FTCA Program, which is an increase of $678,000 over FY 2018 Annualized CR level.

[18] FY 2015 and 2017 reflect the post-sequestered amount.

The request also includes costs associated with the grant review and award process, operational site visits, information technology, and other program support costs.

To provide support for the improvement and expansion of health center facilities, the request includes a proposal to increase the loan limitation for the Health Center Loan Guarantee Program, allowing the use existing carryover Health Center Loan Guarantee Program funding to guarantee an addition $139 million in loans. This change will expand the capacity of health centers to provide quality health care to more patients.

Health centers continue to be a critical element of the health system, largely because they can provide an accessible and dependable source of primary health care services in underserved communities. In particular, health centers emphasize coordinated primary and preventive services that promote reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities and other underserved populations. Health centers place emphasis on the coordination and comprehensiveness of care, the ability to manage patients with multiple health care needs, and the use of key quality improvement practices, including HIT. The health center model also overcomes geographic, cultural, linguistic and other barriers through a team-based approach to care that includes physicians, nurse practitioners, physician assistants, nurses, dental providers, midwives, behavioral health care providers, social workers, health educators, and many others. Health centers also reduce costs to health systems; the health center model of care has been shown to reduce the use of costlier providers of care, such as EDs and hospitals.

The FY 2019 Request supports the Health Center Program's achievement of its performance targets and continues to enable the provision of access to primary health care services and the improvement of the quality of care in the health care safety net. The Health Center Program has established ambitious targets for FY 2019 and beyond. For low birth weight, the Program seeks to be at least 5 percent below the national rate. This is ambitious because health centers continue to serve a higher risk prenatal population than represented nationally in terms of socio-economic, health status and other factors that predispose health center patients to greater risk for LBW and adverse birth outcomes. The FY 2019 target for the program's hypertension measure is that 63 percent of adult patients with diagnosed hypertension will have blood pressure under adequate control. The FY 2019 target for the program's diabetes management measure is 69 percent of adult patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent).

The Health Center Program will also continue to promote efficiency and aims to keep the percentage increase in cost per patient below the average annual national growth rate in health care costs, as noted in the Center for Medicare & Medicaid Services' (CMS) National Health Expenditure Amounts and Projections. By benchmarking the health center efficiency to national per capita health care cost growth rate, the measure takes into account changes in the healthcare marketplace while demonstrating the Program's continued ability to deliver services at a more cost-effective rate. The FY 2019 target is to keep the program's cost per patient increase below the 2019 national health care cost growth rate. By restraining increases in the cost per individual served at health centers, the Health Center Program is able to demonstrate that it delivers its high-quality services at a more cost-effective rate.

The FY 2019 Request also supports efforts to improve quality and program integrity in all HRSA-funded programs that deliver direct health care. Health centers annually report on a core set of clinical performance measures that are consistent with Healthy People 2020, and include: immunizations; prenatal care; cancer screenings; cardiovascular disease/hypertension; diabetes; weight assessment and counseling for children and adolescents; adult weight screening and follow up; tobacco use assessment and counseling; depression screening and follow-up; dental sealants; asthma treatment; coronary artery disease/cholesterol; ischemic vascular disease/aspirin use; and colorectal cancer screening. In addition to tracking core clinical indicators, health centers report on health outcome measures (low birth weight, diabetes, and hypertension) by race/ethnicity in order to demonstrate progress towards eliminating health disparities in health outcomes.

To support quality improvement, the Program will continue to facilitate national and State-level technical assistance and training programs that promote quality improvements in health center data and quality reporting, clinical and quality improvement, and implementation of innovative quality activities. The Program continues to promote the integration of HIT into health centers to assure that key safety-net providers are able to advance with technology.

HRSA's efforts to strengthen evidence-building capacity in the Health Center Program include enhancements to the Uniform Data System (UDS). Beginning with 2013 UDS data, patients are reported by both zip code and primary medical insurance status within four insurance categories: Medicare; Medicaid/S-CHIP/and Other Public Insurance; Private insurance; and Uninsured. This data enhancement supports HRSA's efforts to better identify medically underserved populations. Comparing geocoded health center patient insurance information with the general U.S. population by insurance status (via the U.S. Census) facilitates identifying unmet medical need and geographical areas that would see improved healthcare access if there were health center presence. All UDS data continues to be aggregated at the health center/organizational level.

Funding would allow continued coordination and collaboration with related Federal, State, local, and private programs in order to further leverage and promote efforts to expand and improve health centers. The Health Center Program will continue to work with the CMS and the Office of the National Coordinator for Health Information Technology on HIT, and the Centers for Disease Control and Prevention to address HIV prevention and public health initiatives, and the National Institutes of Health on clinical practice issues, among others. In addition, the Health Center Program will continue to coordinate with CMS to jointly review section 1115 Medicaid Demonstration Waivers. The Program will continue to work closely with the Department of Justice on the FTCA Program. Additionally, the proposed Budget supports coordination with programs in the Departments of Housing and Urban Development, Education, and Justice.

The FY 2019 Budget also allocates new resources to the Health Center program to combat the opioid epidemic. Additional details can be found under the Opioid tab.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
1.I.A.1: Number of patients served by health centers (Output)	FY 2016: 25.9M Target: 25.5M (Target Exceeded)	26.0M	26.0M	Maintain
1.I.A.2.b: Percentage of grantees that provide the following services either on-site or by paid referral: (b) Preventive Dental Care (Output)	FY 2016: 91% Target: 89% (Target Exceeded)	90%	90%	Maintain
1.I.A.2.c: Percentage of grantees that provide the following services either on-site or by paid referral: (c) Mental Health/Substance Abuse (Output)	FY 2016: 88% Target: 75% (Target Exceeded)	86%	86%	Maintain
1.E: Percentage increase in cost per patient served at health centers compared to the national rate (Efficiency)	FY 2016: 7.9% Target: below national rate (4.3%) (Target not met)	Below national rate	Below national rate	Maintain
1.II.B.2: Rate of births less than 2500 grams (low birth weight) to prenatal Health Center patients compared to the national low birth weight rate (Outcome)	FY 2016: 7.8%, Target: 5% below national rate (not yet known)	5% below national rate	5% below national rate	Maintain
1.II.B.3: Percentage of adult health center patients with diagnosed hypertension whose blood pressure is under adequate control (less than 140/90) (Outcome)	FY 2016: 62% Target: 63% (Target Virtually Met)	63%	63%	Maintain
1.II.B.4: Percentage of adult health center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent) (Outcome)	FY 2016: 68% Target: 69% (Target Virtually Met)	69%	69%	Maintain
1.II.B.1: Percentage of pregnant health center patients beginning prenatal care in the first trimester (Output)	FY 2016: 74% Target: 67% (Target Exceeded)	70%	70%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
1.II.A.1: Percentage of Health Center patients who are at or below 200 percent of poverty (Output)	FY 2016: 92% Target: 91% (Target Exceeded)	91%	91%	Maintain
1.I.A.3: Percentage of health centers with at least one site recognized as a patient centered medical home (Outcome)	FY 2016: 66% Target: 65% (Target Exceeded)	65%	65%	Maintain

Grants Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	1,376	1,376	1,376
Average Award	$3.4 million	$3.4 million	$3.4 million
Range of Awards	$400,000 – $22.5 million	$400,000 – $22.5 million	$400,000 – $22.5 million

Free Clinics Medical Malpractice

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$1,000,000	$993,000	$1,000,000	+$7,000
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Section 224, as amended by Public Law 111-148, Section 10608

FY 2019 Authorization ..... Indefinite

Allocation Method ..... Other

Program Description and Accomplishments

The Free Clinics Medical Malpractice Program encourages health care providers to volunteer their time at qualified free clinics by providing medical malpractice protection at sponsoring health clinics, thus expanding the capacity of the health care safety net. In many communities, free clinics assist in meeting the health care needs of the uninsured and underserved. They provide a venue for providers to volunteer their services. Most free clinics are small organizations with annual budgets of less than $250,000.

In FY 2004, Congress provided first-time funding for payments of free clinic provider's claims under the Federal Tort Claims Act (FTCA). The appropriation established the Free Clinics Medical Malpractice Judgment Fund and extended FTCA coverage to medical professional volunteers in free clinics in order to expand access to health care services for low-income individuals in medically underserved areas.

Allocation Method: Qualifying free clinics submit applications to the Department of Health and Human Services to deem providers that they sponsor. Qualifying free clinics (or health care facilities operated by nonprofit private entities) must be licensed or certified in accordance with applicable law regarding the provision of health services. To qualify under the Free Clinics Medical Malpractice Program, the clinic cannot: accept reimbursements from any third-party payor (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program including Medicare or Medicaid); or impose charges on the individuals to whom the services are provided; or impose charges according to the ability of the individual involved to pay the charge.

Increasing Access: In FY 2016, 11,517 health care providers received Federal malpractice insurance through the Free Clinics Medical Malpractice Program, exceeding the Program target. In FY 2014, 232 clinics operated with FTCA deemed clinicians; in FY 2015, 237 clinics

participated; and in FY 2016, 243 clinics participated. The Free Clinics Medical Malpractice Program also examines the quality of services annually by monitoring the percentage of free clinic health professionals meeting licensing and certification requirements. Performance continues to meet the target with 100 percent of FTCA deemed clinicians meeting appropriate licensing and credentialing requirements.

Promoting Efficiency: The Free Clinics Medical Malpractice Program is committed to improving overall efficiency by controlling the Federal administrative costs necessary to deem each provider. By restraining these annual administrative costs, the Program is able to provide an increasing number of clinicians with malpractice coverage, thus building the free clinic workforce capacity nationwide and increasing access to care for the target populations served by these clinics. In FY 2014 the cost was $61 per provider; in FY 2015 the cost was $45 per provider; and in FY 2016 the cost was $50 per provider. In each year, the Program performance target has been exceeded.

To date, there have been no paid claims under the Free Clinics Medical Malpractice Program. There are 2 claims currently outstanding, and the Program Fund has a current balance of approximately $1,200,000.

Funding History

FY	Amount
FY 2015	$100,000
FY 2016	$100,000
FY 2017	$1,000,000
FY 2018	$993,000
FY 2019	$1,000,000

Budget Request

The FY 2019 Budget requests $1.0 million for the Free Clinics Medical Malpractice Program, which is an increase of $7,000 over the FY 2018 Annualized CR level. The request will support the Program's continued achievement of its performance targets addressing its goal of maintaining access and capacity in the health care safety net.

Targets for FY 2019 focus on maintaining FY 2018 target levels for the number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage at 11,500 while also maintaining the number of free clinics operating with FTCA deemed volunteer clinicians at 220. The Program will also continue to promote efficiency by restraining growth in the annual Federal administrative costs necessary to deem each provider, with a target of $75 administrative cost per provider in FY 2019.

The FY 2019 request will also support the Program's continued coordination and collaboration with related Federal programs in order to further leverage and promote efforts to increase the capacity of the health care safety net. Areas of collaboration include coordination with the Health Center FTCA Program, also administered by HRSA, to share program expertise. In

addition, the two programs control costs by sharing a contract to process future claims, and by providing technical support and outreach. The Program will coordinate with non-profit free clinic-related umbrella groups on issues related to program information dissemination and outreach and will continue to collaborate with the Department of Justice (DOJ) and the HHS Office of General Counsel (HHS/OGC) to assist in drafting items including deeming applications and related policies. The Program continues to work with the HHS/OGC to answer legal technical assistance issues raised by free clinics in the Program and clinics interested in joining the Program.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
2.I.A.1: Number of free clinic health care providers deemed eligible for FTCA malpractice coverage (Outcome)	FY 2016: 11,517 Target: 7,800 (Target Exceeded)	11,500	11,500	Maintain
2.1: Patient visits provided by free clinics sponsoring FTCA deemed clinicians (Outcome)	FY 2016: 533,423 Target: 500,000 (Target Exceeded)	475,000	475,000	Maintain
2.I.A.2: Number of free clinics operating with FTCA deemed clinicians (Output)	FY 2016: 243 Target: 240 (Target Exceeded)	220	220	Maintain
2.E: Administrative costs of the program per FTCA covered provider (Efficiency)	FY 2016: $50 Target: $89 (Target Exceeded)	$75	$75	Maintain

Health Workforce TAB

HEALTH WORKFORCE

National Health Service Corps (NHSC)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	---	---	$310,000,000	+$310,000,000
Current Law Mandatory	$288,610,000	$65,000,000	---	-$65,000,000
Proposed Law Mandatory	---	$245,000,000	---	-$245,000,000
Total	$288,610,000	$310,000,000	$310,000,000	---
FTE	225	225	225	---

Authorizing Legislation: Public Health Service Act, Sections 331-338H, as amended by Public Law 114-10

FY 2019 Authorization .....Expires at the end of second quarter FY 2018

Allocation Method ..... Other (Competitive Awards to Individuals)

Program Description and Accomplishments:

Since its inception in 1972, the National Health Service Corps (NHSC) has worked to support qualified health care providers dedicated to working underserved communities. Across the nation, NHSC clinicians serve patients in Health Professional Shortage Areas (HPSAs) – communities with limited access to health care. As of September 30, 2017, there were more than 72 million people living in primary care HPSAs, more than 54 million people living in dental HPSAs, and more than 111 million people living in mental health HPSAs.

The NHSC seeks clinicians who demonstrate a commitment to serve the Nation's medically underserved populations at NHSC-approved sites located in HPSAs. NHSC-approved sites provide care to individuals regardless of ability to pay; currently, there are over 16,000 NHSC-approved sites. Eligible sites include Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes, American Indian and Native Alaska health clinics, rural health clinics, critical access hospitals and hospitals managed or owned by the Indian Health Service (IHS), school-based clinics, mobile units, free clinics, community mental health centers, state or local health departments, community outpatient facilities, federal facilities such as the Bureau of Prisons, U.S. Immigration and Customs Enforcement, IHS, and private practices.

In particular, the NHSC has partnered closely with HRSA-supported FQHCs to help meet their staffing needs. Over 60 percent of NHSC clinicians serve in Health Centers around the nation, and 15 percent of clinical staff at FQHCs are NHSC clinicians. The NHSC also places clinicians in other community-based systems of care that serve underserved populations, targeting HPSAs of greatest need.

As of September 30, 2017, there are 10,179 primary care medical, dental, and mental and behavioral health practitioners were providing service nationwide in the following programs[19]:

NHSC Scholarship Program (SP): The NHSC SP provides financial support through scholarships, including tuition, other reasonable education expenses, and a monthly living stipend to health professions students committed to providing primary care in underserved communities of greatest need. Awards are targeted to individuals who demonstrate characteristics that are indicative of success in a career in primary care in underserved communities. The NHSC SP provides a supply of clinicians who will be available over the next one to eight years, depending on the length of their education and training programs. Upon completion of training, NHSC scholars become salaried employees of NHSC-approved sites in underserved communities.

NHSC Loan Repayment Program (LRP): The NHSC LRP offers fully trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service in a HPSA. In exchange for an initial two years of service, loan repayers receive up to $50,000 in loan repayment assistance. The NHSC LRP recruits clinicians as they complete training and are immediately available for service, as well as seasoned professionals seeking an opportunity to serve in the nation's underserved communities.

NHSC Students to Service (S2S) Loan Repayment Program (LRP): The NHSC S2S LRP provides loan repayment assistance of up to $120,000 to allopathic and osteopathic medical students and dental students in their last year of school in return for a commitment to provide primary health care in rural and urban HPSAs of greatest need for three years. This program was established with the goal to double the number of physicians in the NHSC pipeline and was expanded to dentists in FY 2017.

State Loan Repayment Program (SLRP): The SLRP is a federal-state partnership grant program that requires a dollar-for-dollar match from the state that enters into loan repayment contracts with clinicians who practice in a HPSA in that state. The program serves as a complement to the NHSC and provides flexibility to states to help meet their unique primary care workforce needs. States have the discretion to focus on one, some, or all of the eligible primary care disciplines eligible within the NHSC and may also include pharmacists and registered nurses. The program supported 37 states in FY 2017. In FY 2018, HRSA is opening a new SLRP competition, expanding approved disciplines to include substance use disorder counselors, and is considering opportunities to allow SLRP to expand to include different disciplines based on state needs or emergent health crises.

[19] NHSC field strength data include awards made from the FY 2017 Zika Supplemental, which supported providers in U.S. territories.

The combination of these programs serves the immediate needs (through loan repayers) of underserved communities and supports the development of a pipeline (through Scholars and Students to Service awardees) poised to meet the needs of these communities upon completion of their training. The tables below show the students in the NHSC pipeline that are training to serve the underserved and the number and type of primary care providers currently serving in the NHSC and providing care in underserved areas.

NHSC Student Pipeline by Program as of 09/30/2017

Programs	**Students**
Scholarship Program	1,049
Students to Service Program	387
Total	**1,436**

NHSC Student Pipeline by Discipline as of 09/30/2017

Disciplines	**Students**
Allopathic/Osteopathic Physicians	1,014
Dentists	226
Nurse Practitioners	57
Physician Assistants	123
Certified Nurse Midwives	16
Total	**1,436**

NHSC Field Strength[20] by Program as of 09/30/2017

Programs	**Clinicians**
Scholarship Program Clinicians	405
Loan Repayment Program Clinicians	8,362
State Loan Repayment Program Clinicians	1,233
Student to Service Loan Repayment Program	179
Total	**10,179**

NHSC Field Strength by Discipline as of 09/30/2017

Disciplines	**Clinicians**
Allopathic/Osteopathic Physicians[21]	2,058
Dentists	1,298
Dental Hygienists	311
Nurse Practitioners	2,150
Physician Assistants	1,111
Nurse Midwives	183
Mental and Behavioral Health Professionals	3,002
Other State Loan Repayment Program Clinicians	66
Total	**10,179**

[20] NHSC field strength data include awards made from the FY 2017 Zika Supplemental, which supported providers in U.S. territories.

[21] Includes psychiatrists.

Average NHSC Award by Program as of 09/30/2017

Program	Average Award Amount
Scholarship Program	$210,069
Students to Service Loan Repayment Program	$118,518
Loan Repayment Program	$30,902

NHSC is committed to continuous performance improvement. Based on the most recent Participant Satisfaction Survey results, the short-term retention rate among respondents who completed their NHSC service commitment in the past 2 years is 93 percent.[22] Applying the NHSC alumni retention rate among survey respondents to the 5,024 clinicians who successfully completed service in that period, NHSC estimates that more than 4,400 retained clinicians continue to provide primary care services to underserved communities within 2 years after completing their service commitment.

The experiences that NHSC providers have at their sites while completing their service obligations significantly influences retention among NHSC providers. The most common reasons given by participants for not remaining at their NHSC-approved site following their service commitment were financial considerations and site operations.

Eligible Entities: Eligible participants for the NHSC SP are U.S. citizens (either U.S. born or naturalized) or U.S. nationals enrolled or accepted for enrollment as a full-time student pursuing a degree in a NHSC-eligible discipline at an accredited health professions school or program located in a State, the District of Columbia, or a U.S. territory.

Eligible participants for the NHSC LRP are U.S. citizens (either U.S. born or naturalized) or U.S. nationals practicing in a NHSC-eligible discipline, maintaining a current, full, unencumbered, unrestricted health professional license, certificate, or registration to practice in the discipline and State in which the loan repayer is applying to serve, and currently working in a NHSC approved site in a HPSA.

Eligible participants for the NHSC Students to Service LRP are U.S. citizens (either U.S. born or naturalized) or U.S. nationals enrolled as a full-time student in the final year at a fully accredited medical school located in an eligible allopathic or osteopathic degree program or school of dentistry. Medical students must be planning to complete an accredited primary medical care residence in a NHSC-approved specialty.

[22] The 2016 National Health Service Corps Participant Satisfaction Survey found that 88 percent of those NHSC clinicians who had fulfilled their obligation within the past 2 years (957 of 1,089 survey respondents) and responded to this voluntary survey, met the program's definition of being retained; i.e., they were continuing to practice at their assigned site, were practicing at another NHSC site, or were practicing in a designated shortage area. HRSA uses survey information due to the efficiency of this method as well as a lack of authority to require individuals out of service to provide their current place of employment.

Eligible entities for the State Loan Repayment Program are the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, Palau, the Marshall Islands and the Commonwealth of the Northern Mariana Islands.

Funding History

FY	Amount
FY 2015	$287,370,000
FY 2016	$310,000,000
FY 2017	$288,610,000
FY 2018 Current Law Mandatory	$65,000,000
FY 2018 Proposed Law Mandatory	$245,000,000
FY 2019	$310,000,000

Budget Request

The FY 2019 Budget requests $310.0 million in discretionary resources for the NHSC program. The Budget proposes a shift from mandatory resources to discretionary resources for this program. The FY 2019 request will fund 2,527 new and 1,754 continuation Loan Repayment awards, 132 new and 11 continuation Scholarship awards, 625 State Loan Repayment awards, and 167 Students to Service Loan Repayment awards. The funding request also includes operational costs in the form of required Federal Insurance Contributions Act tax contributions on stipend payments for the NHSC SP, staffing, and acquisition contracts.

In FY 2019, the Department also is looking for opportunities to enhance the ability of the NHSC to address the opioid epidemic. The NHSC will award enhanced loan repayment to physicians, nurse practitioners and physician assistants (with a specialty in psychiatry) who have DATA 2000 waivers. As of September 2017, only two of the over 10,000 NHSC clinicians have DATA 2000 waivers. While enhanced awards would decrease the total number of NHSC new awards, HRSA anticipates the incentive awards would:

- Encourage behavioral health clinicians to obtain a DATA 2000 waiver;
- Increase participation in NHSC LRP by DATA 2000 waiver clinicians who can be placed in at-risk communities, and give NHSC-approved sites an added incentive to support their recruitment of behavioral health clinicians who are well-positioned to address the need for medication-assisted treatment. The Department is also assessing other changes in NHSC that can help address the opioid epidemic.

The FY 2019 Budget also provides additional loan payment awards to combat the opioid epidemic. Additional details can be found under the Opioid tab.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
4.I.C.1: Number of individuals served by NHSC clinicians *(Outcome)*	FY 2017: 10.7 Million Target: 9.7 Million (Target Exceeded)	9.1 million	9.2 million	+ 0.1 million
4.I.C.2: Support field strength of the NHSC through scholarship and loan repayment agreements. *(Outcome)*	FY 2017: 10,179[23] Target: 9,219 (Target Exceeded)	8,705	8,810	+105
4.I.C.4: Percent of NHSC clinicians retained in service to the underserved for at least one year beyond the completion of their NHSC service commitment. *(Outcome)*	FY 2016: 93% Target: 80% (Target Exceeded)	80%	80%	Maintain
4.E.1: Default rate of NHSC Scholarship and Loan Repayment Program participants. *(Efficiency)* (Baseline: FY 2007 = 0.8%)	FY 2017: 1.0 % Target: ≤2.0% (Target Exceeded)	≤ 2.0%	≤ 2.0%	Maintain
4.I.C.6: Number of NHSC sites *(Outcome)*	FY 2017: 16,568 Target: 14,000 (Target Exceeded)	14,000	14,000	Maintain

[23] NHSC field strength data include awards made from the FY 2017 Zika Supplemental, which supported providers in the U.S. territories.

Loan Repayments/Scholarships Awards Table

(whole dollars)	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Loan Repayments	$167,675,000	$167,000,000	$167,000,000
State Loan Repayments	$14,959,000	$15,000,000	$15,000,000
Scholarships	$48,849,000	$38,000,000	$38,000,000
Students to Service Loan Repayment	$15,146,000	$20,000,000	$20,000,000

NHSC Awards Table[24]

Program	2012	2013	2014	2015	2016	2017	2018	2019
Scholarships	212	180	190	196	205	181	139	132
Scholarship Continuation	10	16	7	11	8	7	10	11
Loan Repayment	2,342	2,106	2,775	2,934	3,079	2,554	2,384	2,527
Loan Repayment Continuations	1,925	2,399	2,105	1,841	2,111	2,259	2,111	1,754
State Loan Repayment	281	447	464	620	634	535	625	625
Students to Service Loan Repayment	69	78	79	96	92	175	167	167
Total Awards	**4,839**	**5,226**	**5,620**	**5,698**	**6,129**	**5,711**	**5,436**	**5,216**

[24] NHSC awards include those made from the FY 2017 Zika Supplemental.

NHSC Field Strength Table as of 9/30/2017

Program:	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Scholars	502	493	459	458	437	405	513	538
Loan Repayment	8,634	7,547	7,648	8,062	8,593	8,362	6,707	6,769
Students to Service Loan Repayment	625	753	1,135	1,136	1,378	179	226	253
State Loan Repayment	130	106	-	27	85	1,233	1,259	1,250
USPHS Commissioned Corps Ready Responders	17	-	-	-	-	-	-	-
Total Field Strength	**9,908**	**8,899**	**9,242**	**9,683**	**10,493**	**10,179**	**8,705**	**8,810**

Faculty Loan Repayment Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$1,187,000	$1,182,000	---	-$1,182,000
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 738 and 740

FY 2019 Authorization ..... Expired at the end of FY 2014

Allocation Method ..... Other (Competitive Awards to Individuals)

Program Description and Accomplishments:

The Faculty Loan Repayment Program provides loan repayment to health profession graduates from disadvantaged backgrounds who serve as faculty at eligible health professions colleges or universities for a minimum of two years. In return, the federal government agrees to pay up to $20,000 of the outstanding principal and interest on the individual's health professions education loans for each year of service. The employing institution must also make payments to the faculty member that match the amount paid by HRSA. In FY 2017, the Faculty Loan Repayment Program made 20 new loan repayment awards.

Funding History

FY	Amount
FY 2015	$1,190,000
FY 2016	$1,190,000
FY 2017	$1,187,000
FY 2018	$1,182,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Faculty Loan Repayment Program, which is $1.2 million below the FY 2018 Annualized CR level. At the annualized CR level, the program supports 22 individuals from disadvantaged backgrounds per year. At this level of funding, the program does not have a board impact on the health professions workforce. The Request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Loans Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	20	22	---

Health Professions Training for Diversity

Centers of Excellence

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$21,659,000	$21,564,000	---	-$21,564,000
FTE	1	1	---	-1

Authorizing Legislation: Public Health Service Act, Section 736

FY 2019 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

The Centers of Excellence (COE) Program provides grants to health professions schools and other public and nonprofit health or educational entities to serve as innovative resource and education centers for the recruitment, training and retention of underrepresented minority (URM) students and faculty.

In Academic Year 2016-2017, the COE Program supported 164 different training programs and activities designed to prepare individuals either to apply to a health professions training program or to maintain enrollment in such programs during the academic year. These programs supported 956 trainees across the country with stipend support. Over 93 percent of the trainees were considered underrepresented minorities (URMs) in the health professions. In addition, 74 percent of the trainees were from financially and/or educationally disadvantaged backgrounds. Despite an overall decrease in the number of students trained in Academic Year 2016-2017, COE Program outcomes related to retention and post-completion intentions remained relatively stable. Additional students participated in COE Programs throughout the academic year increasing total participation to 6,871 students of whom 2,798 completed their programs.

Grantees partnered with 185 health care delivery sites, to provide 3,379 clinical training experiences to health professions trainees. Nearly 46 percent of training sites used by COE grantees were primary care settings and 55 percent were in medically underserved communities.

Eligible Entities: Health professions schools and other public and nonprofit health or educational entities that operate programs of excellence for URM individuals and meet the required general conditions requirements in section 736(c)(1)(B)of the Public Health Service Act, including Historically Black Colleges and Universities; Hispanic COEs; Native American COEs; and other COEs.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Allopathic medicine • Dentistry • Graduate programs in mental health • Osteopathic medicine • Pharmacy	• Undergraduate • Graduate • Faculty development	• Increase outreach to URM students to enlarge the competitive applicant pool. • Develop academic enhancement programs for URM students and train, recruit, and retain URM faculty. • Improve information resources, clinical education, cultural competency, and curricula as they relate to minority health issues.

Funding History

FY	Amount
FY 2015	$21,711,000
FY 2016	$21,711,000
FY 2017	$21,659,000
FY 2018	$21,564,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Center of Excellence Program, which is $21.6 million below the FY 2018 Annualized CR level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [25]	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
6.I.C.20: Percent of program participants who completed pre-health professions preparation training and intend to apply to a health professions degree program	FY 2016: 22% Target: 22% (Target Met)	22%	N/A	N/A
6.I.C.21: Percent of program participants who received academic retention support and maintained enrollment in a health professions degree program	FY 2016: 41% Target: 43% (Target Not Met)	43%	N/A	N/A

[25] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.

Program Activity Data

COE Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Number of health professions students participating in research on minority health-related issues	FY 2016: 695	600	600	---
Number of faculty members participating in research on minority health-related issues	FY 2016: 568	500	500	---

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	17	17	---
Average Award	$1,203,780	$1,203,780	---
Range of Awards	$564,723-$3,499,317	$564,723-$3,499,317	---

Health Professions Training

Scholarships for Disadvantaged Students

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$45,859,000	$45,658,000	---	-$45,658,000
FTE	5	5	---	-5

Authorizing Legislation: Public Health Service Act, Sections 737 and 740

FY 2019 Authorization .....Expired at the end of FY 2014

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

The Scholarships for Disadvantaged Students (SDS) Program authorized in 1989, provides grants to eligible health professions and nursing schools for use in awarding scholarships to students from disadvantaged backgrounds who have financial need, many of whom are underrepresented minorities (URMs). The program also connects students to retention services and activities that support their progression through the health professions educational program.

In Academic Year 2016-2017, the SDS Program provided scholarships to 2,811 students from disadvantaged backgrounds, missing the FY 2016 target count by approximately 5 percent. This was due in large part to fewer grants being awarded in FY 2016 as well as a significant increase in the scholarship limit per student (increased from $15,000 to $30,000) resulting in more substantial investments in fewer individuals. The adjustment to the scholarship cap was made to reflect the increasing costs of health professions education programs. The majority of students were female (80 percent), and 64 percent of students were considered under-represented minorities (URMs) in their prospective professions.

Additionally, 621 students who received SDS-funded scholarships successfully graduated from their degree programs by the end of Academic Year 2016-2017. Upon graduation, 59 percent intended to work or pursue additional training in medically underserved communities, and 59 percent intended to work or pursue additional training in primary care settings.

Eligible Entities: Eligible entities are accredited schools of medicine, osteopathic medicine, dentistry, nursing, pharmacy, podiatric medicine, optometry, veterinary medicine, public health, chiropractic, allied health, and a school offering a graduate program in behavioral and mental health practice or an entity providing programs for the training of physician assistants.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Allied health • Behavioral and mental health • Chiropractic • Dentistry • Allopathic medicine • Nursing • Optometry • Osteopathic medicine • Pharmacy • Physical Therapy • Physician assistants • Podiatric medicine • Public health • Veterinary medicine	• Undergraduate • Graduate	• Provide scholarships to eligible full-time students. • Retain students from disadvantaged backgrounds including students who are members of racial and ethnic minority groups.

Funding History

FY	Amount
FY 2015	$45,970,000
FY 2016	$45,970,000
FY 2017	$45,859,000
FY 2018	$45,658,000
FY 2019	---

Budget Request

FY 2019 Budget requests $0 for the Scholarships for Disadvantaged Students Program, which is $45.7 million below the FY 2018 Annualized CR level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals. While the SDS Program exposes students from disadvantaged backgrounds who have financial need to careers in the health professions, there are private scholarships and other Federal loan programs that can support student education.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[26]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.22: Number of disadvantaged students with scholarships	FY 2016: 2,811 Target: 2,940 (Target Not Met)	2,900	N/A	N/A

Program Activity Data

SDS Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Number of URM students with scholarships	FY 2016: 1,794	2,000	1,800	---
Percent of students who are URMs	FY 2016: 64%	62%	62%	---

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	79	79	---
Average Award	$545,828	$542,828	---
Range of Awards	$26,615-$617,837	$26,615-$617,837	---

[26] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.

Health Professions Training for Diversity

Health Careers Opportunity Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$14,155,000	$14,093,000	---	-$14,093,000
FTE	2	2	---	-2

Authorizing Legislation: Public Health Service Act, Sections 739 and 740(c)

FY 2019 Authorization .....Expired at the end of FY 2014

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

The Health Careers Opportunity Program (HCOP) provides individuals from economically and educationally disadvantaged backgrounds an opportunity to develop the skills needed to successfully compete for, enter, and graduate from schools of health professions or allied health professions. The HCOP is comprised of two cohorts:

HCOP: In Academic Year 2016-2017, HCOP supported 169 different training programs and activities to promote interest in the health professions among prospective, disadvantaged students. In total, HCOP grantees reached 2,442 disadvantaged trainees across the country through structured programs. In AY 2016-2017, the program failed to reach its target of 3,500 disadvantaged students; however, the percentage of participants from disadvantaged backgrounds remained stable around 90 percent (as has been the case since FY 2013). HCOP grantees partnered with 110 sites to provide 2,736 clinical training experiences for HCOP student trainees (e.g., academic institutions, community-based organizations, and hospitals). Approximately 70 percent of these training sites were located in medically underserved communities and/or rural settings. Additional students participated in HCOP activities and programs as well bringing 5,044 total students into the health professions pipeline of whom 2,997 completed their training.

HCOP for Skills Training and Health Workforce Development of Paraprofessionals Program: In Academic Year 2016-2017, the Program provided stipend support for 862 certificate students, most commonly training to become nursing aids/assistants, medical assistants, and community health workers. Analyses of data showed that approximately 95 percent of students were from financially or educationally disadvantaged backgrounds and 77 percent were considered URMs in their prospective professions. By the end of the Academic Year, 696 of funded students graduated from these certificate-bearing programs in addition to other students who participated in the Program but were not funded. In total, 1,843 students participated of whom 975 graduated and earned certificates.

Eligible Entities: Accredited health professions schools and other public or private nonprofit health or educational institutions.

Funding History

FY	Amount
FY 2015	$14,189,000
FY 2016	$14,189,000
FY 2017	$14,155,000
FY 2018	$14,093,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Health Careers Opportunity Program, which is $14.1 million below the FY 2018 Annualized CR level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[27]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.23: Total number of disadvantaged students in structured programs	FY 2016: 2,442 Target: 3,500 (Target Not Met)	2,000	N/A	N/A

Program Activity Data

HCOP Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Total number of students participating in all HCOP programs	FY 2016: 5,044	9,000	5,000	---
Total number of URM students participating in all HCOP programs	FY 2016: 2,799	4,000	2,700	---

27 Most recent results are for Academic Year 2016-2017 and funded in FY 2016.

HCOP Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Total number of URM students in all HCOP-Skills Training programs	FY 2016: 1,449	1,000	N/A[28]	---
Total number of students graduating from HCOP-Skills Training programs	FY 2016: 975	800	N/A	---

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	17	17	---
Average Award	$752,607	$752,607	---
Range of Awards	$629,989-$797,450	$629,989-$797,450	---

[28] HCOP-Skills Training programs completed activities during FY 2017. Performance results will be available in the FY 2020 Congressional Justification.

Health Care Workforce Assessment

The National Center for Health Workforce Analysis

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$4,652,000	$4,631,000	$4,663,000	+$32,000
FTE	6	6	6	---

Authorizing Legislation: Public Health Service Act, Sections 761, 792, and 806(f)

FY 2019 Authorization ..... Expired as of FY 2014

Allocation Method .....Competitive Grant/Contract

Program Description and Accomplishments:

The United States spends billions of dollars in both public and private funds each year on education and training of the health workforce. Since the nation's health care system is constantly changing and preparing new providers requires long lead times, it is critical to have high quality projections to ensure a workforce of sufficient size and skills capable of meeting the nation's health care needs. Policymakers and other decision makers need high quality information about the health workforce that incorporates up-to-date research, modeling, and trends. This information can help inform how the nation spends billions of dollars each year on the education and training of the health workforce.

The National Center for Health Workforce Analysis (NCHWA) collects and analyzes health workforce data and information in order to provide national and state policy makers, researchers, and the public with information on health workforce supply and demand. NCHWA also evaluates the effectiveness of HRSA's workforce investments. NCHWA focuses on:

- Providing timely reports and data on the current state and trends of the U.S. health workforce;
- Building national capacity for health workforce data collection by working with federal agencies, professional associations, and others to develop and promote guidelines for data collection and analysis;
- Improving tools for data management, analysis, modeling and projection to support research, policy analysis, and decision making, as well as evaluation of the effectiveness of workforce programs and policies;
- Responding to information and data needs by translating data and findings to inform policies and programs; and
- Analyzing grantee performance data and evaluating Bureau of Health Workforce's programs.

NCHWA continues to model supply and demand of health professionals across a range of health occupations, and makes health workforce information available through reports and online databases. Several publications were released during Calendar Year 2017:

- Supply and Demand Projections of the Nursing Workforce: 2014-2030;
- National and Regional Projections of Supply and Demand for Geriatricians: 2013-2025
- Health Workforce Projections: General Pediatricians
- Health Workforce Projections: Neurology Physicians and Physician Assistants
- Health Workforce Projections: Physical Medicine and Rehabilitation Physicians and Physician Assistants
- Health Workforce Projections: Physicians and Physician Assistants in Emergency Medicine

NCHWA also annually updates county-, state-, and national-level data and works to improve the availability of online comparison and mapping tools for analyzing data. In addition, NCHWA oversees seven Health Workforce Research Centers that perform and disseminate research and data analysis on health workforce issues of national importance, and provide technical assistance to regional and local entities on workforce data collection, analysis, and reporting. Through an interagency agreement with the Substance Abuse and Mental Health Association (SAMHSA), NCHWA also funds a Behavioral Health Workforce Research Center, whose work is jointly overseen by both entities.

Funding History

FY	Amount
FY 2015	$4,663,000
FY 2016	$4,663,000
FY 2017	$4,652,000
FY 2018	$4,631,000
FY 2019	$4,663,000

Budget Request

The FY 2019 Budget requests $4.6 million for the National Center for Health Workforce Analysis, which is $0.03 million above the FY 2018 Annualized CR level. In FY 2019, NCHWA will continue to develop a projection model that allows a more sophisticated analysis and projection of health workforce supply and demand, taking into account changing national demographics, the demand for health care services, and the impact those changes have on the delivery of health care. In addition, the National Center is poised to comply with Section 10 of Executive Order 13801 to support efforts to evaluate and identify the most effective workforce training investments. The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Grants Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	7	7	7
Average Award	$469,108	$469,108	$469,108
Range of Awards	$134,000-$660,000	$134,000-$660,000	$134,000-$660,000

Primary Care Training and Enhancement Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$38,830,000	$38,660,000	---	-$38,660,000
FTE	6	6	---	-6

Authorizing Legislation: Public Health Service Act, Section 747

FY 2019 Authorization .....Expired at the end of FY 2014

Allocation Method. ..... Competitive Grant/Cooperative Agreement/Contract

Program Description and Accomplishments:

The Primary Care Training and Enhancement (PCTE) Program aims to strengthen the primary care workforce by supporting enhanced training for future primary care clinicians, teachers, and researchers and promoting primary care practice, particularly in rural and underserved areas. The focus is to produce primary care providers who will be well prepared to practice in, teach, and lead transforming health care systems aimed at improving access, quality of care, and cost effectiveness.

Program	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Primary Care Training and Enhancement[29]	$33,913,267	$33,774,806	---
Academic Units for Primary Care Training and Enhancement	$4,919,775	$4,898,236	---

The PCTE Program includes three cohorts:

PCTE: The PCTE Program is designed to strengthen the primary care workforce by supporting enhanced training for future primary care clinicians, teachers, and researchers. The PCTE Program is focused on training for transforming health care systems, particularly enhancing the clinical training experience of trainees. This Program also supports the Primary Care Medicine and Dentistry Clinician Educator Career Development Awards, which support the development of future clinician educator faculty and leaders in primary care medicine and dentistry while also supporting innovative projects that involve the transformation of health care delivery systems.

[29] The PCTE Program includes the Primary Care Medicine and Dentistry Clinician Educator Career Development Awards, which are jointly funded by PCTE and Oral Health Programs. The total is approximately $3.43 million, $2.17 million from PCTE and $1.26 million from Oral Health Programs.

Academic Units for Primary Care Training and Enhancement (AU-PCTE): The AU-PCTE Program establishes, maintains, or improves academic units or programs that improve clinical teaching and research in the fields of family medicine, general internal medicine, or general pediatrics in order to strengthen the primary care workforce. The Program established academic units to conduct systems-level research to inform primary care training; disseminate best practices and resources; and develop a community of practice to promote the widespread enhancement of primary care training to produce a high quality primary care workforce.

In Academic Year 2016-2017[30], PCTE grantees trained 2,098 primary care residents and fellows, 3,109 medical students, 1,138 students in physician assistant programs, 38 primary care medicine faculty, and 961 students from collaborating interprofessional disciplines (including pharmacy students, psychology students, dental and dental hygiene students, and nursing students) for a total of 7,344 trainees, 1,647 of whom completed their programs at the end of the academic year. PCTE grantees partnered with 707 health care delivery sites (e.g., physician's offices, hospitals, and ambulatory practice sites) to provide clinical training experiences to trainees. Approximately 64 percent of these sites were located in medically underserved communities, 30 percent were located in rural areas, and 62 percent were primary care settings.

With regard to the continuing education of the current workforce, PCTE grantees delivered 100 unique continuing education courses that focused on emerging issues in the field of primary care to 2,295 faculty members and current practicing providers. In addition, PCTE grantees developed or enhanced and implemented 592 different curricular activities, most of which were new academic courses, clinical rotations, and workshops for health professions students, residents and fellows that reached 16,138 trainees. PCTE grantees also supported 245 different faculty-focused training programs and activities during the academic year, reaching 4,217 faculty-level trainees.

Eligible Entities: Accredited public or nonprofit private hospitals, schools of allopathic or osteopathic medicine, academically affiliated physician assistant training programs, or public or private nonprofit entities determined eligible by the Secretary.

[30] This performance includes the PCTE program grantees. The other grantees will report performance in the FY 2020 Congressional Justification based on FY 2017 activities.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Physicians, including family medicine, general internal medicine, general pediatrics, and combinations of these specialties • Physician assistants	• Medical school • Graduate physician assistant education • Physician residency training • Academic and community faculty development	• Support innovations in primary care curriculum development, education, and practice for physicians and physician assistants. • Community-based training in medical schools, physician assistant education, and residencies. • Primary care academic and community faculty development. • Improve clinical teaching and research in primary care.

Funding History

FY	Amount
FY 2015	$38,924,000
FY 2016	$38,924,000
FY 2017	$38,830,000
FY 2018	$38,660,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the PCTE Program, which is $38.7 million below the FY 2018 Annualized CR level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table[31]

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[32]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.24: Number of physicians completing a Bureau of Health Workforce-funded residency or fellowship	FY 2016: 555 Target: 400 (Target Exceeded)	480	N/A	N/A
6.I.C.25: Number of physicians graduating from a Bureau of Health Workforce-funded medical school	FY 2016: 518 (Baseline)	400	N/A	N/A
6.I.C.26: Number of physician assistants graduating from a Bureau of Health Workforce-funded program	FY 2016: 357 Target: 120 (Target Exceeded)	200	N/A	N/A

Program Activity Data

PCTE Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Percent of physician and physician assistant trainees receiving at least a portion of their clinical training in an underserved area	FY 2016: 53%	50%	50%	---
Percent of physician and physician assistant graduates who practice in medically underserved areas	FY 2016: 50%	38%	38%	---

[31] The PCTE Program supports primary care workforce growth and diversification, curricular innovations, and development of academic *infrastructure*. The current outcome measures reflect these objectives. Awards emphasize new and evidence-based education strategies such as interprofessional education and care, community based practice experience, and education responsive to learners' and patients' needs, the evaluation and outcome measures are adjusted accordingly.

[32] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.

PCTE Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Percent of physician and physician assistant graduates and program completers who are minority and/or from disadvantaged backgrounds	FY 2016: 49%	24%	30%	---
Number of physicians training in a Bureau of Health Workforce-funded residency or fellowship	FY 2016: 2,098	1,200	1,650	---
Number of medical students training in a Bureau of Health Workforce-funded medical school	FY 2016: 3,109	800	2,000	---
Number of physician assistant students training in a Bureau of Health Workforce-funded program	FY 2016: 1,138	600	700	---

Grant Awards Table[33]

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	91	91	---
Average Award	$392,747	$392,747	---
Range of Awards	$194,813-$818,490	$194,813-$818,490	---

[33] This table includes the PCTE portion of the 20 awards for the Primary Care Medicine and Dentistry Clinician Educator Career Development Program, which is co-funded by the Oral Health Programs. The award amount is approximately $3.43 million, $2.17 million from PCTE and $1.26 million from Oral Health Programs. This table includes the $2.17 million in PCTE funds; the Oral Health Program funds are accounted for in the Grants Award Table below.

Oral Health Training Programs

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$36,587,000	$36,424,000	---	-$36,424,000
FTE	6	6	---	-6

Authorizing Legislation: Public Health Service Act, Sections 748 and 340G

FY 2019 Authorizations:.....Expired at the end of 2016

Allocation Method: .....Competitive Grant/Contract

Program Description and Accomplishments:

The Oral Health Training Programs increase access to high-quality dental health services in rural and other underserved communities by increasing the number of oral health care providers working in underserved areas and improving training programs for these providers.

Program	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene[34]	$21,147,273	$21,058,672	---
Dental Loan Repayment	$3,212,149	$3,197,839	---
State Oral Health Workforce Improvement Grant	$12,124,363	$12,070,347	---

Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program: The Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program aims to increase the number of dental students, residents, practicing dentists, dental faculty, dental hygienists, or other approved primary care dental trainees qualified to practice in general, pediatric and dental public health fields and thus increase access to oral health care. This Program also supports the Primary Care Medicine and Dentistry Clinician Educator Career Development Awards, which support the development of future clinician educator faculty and leaders in primary care medicine and dentistry while also supporting innovative projects that involve the transformation of health care delivery systems.

[34] The Primary Care Medicine and Dentistry Clinician Educator Career Development Awards are jointly funded by PCTE and Oral Health Programs. The total funding is approximately $3.43 million, $2.17 million from PCTE and $1.26 million from Oral Health Programs.

In Academic Year 2016-2017, grantees of the Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program trained 5,291 dental and dental hygiene students in pre-doctoral training degree programs; 460 dental residents and fellows in advanced primary care dental residency and fellowship training programs; and 1180 dental faculty members in faculty development activities.

Eligible Entities: Schools of dentistry and dental hygiene, public or non-profit private hospitals, and public or nonprofit private entities that have approved residency or advanced education programs.

Designated Health Professions	**Targeted Educational Levels**	**Grantee Activities**
• General dentists • Pediatric dentists • Public health dentists • Dental hygienists • Other approved primary care dental trainees	• Dental Hygiene Training Programs • Undergraduate • Graduate School (dental schools) • Predoctoral Dental Programs • Dental Residency Programs	• Funds to plan, develop, operate or participate in approved dental training programs in the fields of general, pediatric or public health dentistry. • Provide financial assistance to dental students, residents, dental hygiene students, and practicing dentists and dental hygienists who are in need and are participants in any such program and who plan to work in the practice of general, pediatric, or public health dentistry or dental hygiene. • Provide traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric or public health dentistry. • Partner with schools of public health to permit the education of dental students, residents, and dental hygiene students for a master's year in public health at a school of public health.

Dental Faculty Loan Repayment Program: The purpose of this program is to increase the number of dental and dental hygiene faculty in the workforce by assisting dental and dental hygiene training programs attract and retain dental and dental hygiene faculty through loan repayment and help fund development program to provide continuing education opportunities.

In Academic Year 2016-2017, the Dental Faculty Loan Repayment Program provided a median loan repayment of $12,526 to 14 dentists serving as teaching faculty. Females comprised 71 percent of supported faculty. Disciplines of dental faculty receiving loan repayments were General Dentistry (57 percent), Dental Hygiene (21 percent), Pediatric Dentistry (14 percent), and Public Health Dentistry (7 percent). With regard to background, 50 percent of teaching faculty members were from financially or educationally disadvantaged backgrounds and about

36 percent were underrepresented minorities. A total of 24 faculty members participated in structured faculty development programs through the academic year.

Faculty funded through the Dental Faculty Loan Repayment Program delivered 26 academic courses during the year to a total of 1,904 students and advanced trainees including general dentistry residents (70 percent), pediatric dentistry residents (16 percent), and public health dentistry residents (4 percent).

Eligible Entities: Schools of dentistry and dental hygiene, and public or nonprofit private entities that have approved residency or advanced education programs.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• General dentists • Pediatric dentists • Public health dentists • Dental hygienists • Other approved primary care dental trainees	• Dental Hygiene Training Programs • Graduate School (dental schools) • Predoctoral Dental Programs • Dental Residency Programs	• Provide loan repayment to dentistry faculty supervising residents at dental training institutions providing clinical services in dental clinics located in dental schools, hospitals, or community based affiliated sites.

State Oral Health Workforce Improvement Grant Program: The State Oral Health Workforce Improvement Grant Program aims to enhance dental workforce planning and development, through the support of innovative programs, to meet the individual needs of each state. The program focuses on supporting innovative projects including integrating oral and primary care medical delivery systems and supporting oral health providers who practice in advanced roles specifically designed to improve oral health access.

In Academic Year 2016-2017, the State Oral Health Workforce Improvement Grant Program continued carrying out a number of community-based prevention activities authorized under statute. Grantees established 6 new oral health facilities for children with unmet needs in dental HPSAs, and expanded 24 oral health facilities in dental HPSAs to provide education, prevention, and restoration services to 99,581 patients. Grantees also supported four tele-dentistry facilities; replaced 26 water fluoridation systems to provide optimally fluoridated water to 2,691,366 individuals; provided dental sealants to 31,273 children; provided topical fluoride to 85,383 individuals; provided diagnostic or preventive dental services to 85,764 persons; and oral health education to 170,931 persons.

The program provided direct financial support to 127 dental students and 7 residents. Of these 134 students and residents, approximately 31 percent of students and residents reported coming from a rural background, 18 percent reported coming from a disadvantaged background, and 19 percent comprised an underrepresented minority group. The program also provided loan repayment to 4 practicing dentists, all of whom were enrolled in the Medicaid program and had 2,592 Medicaid/CHIP patient encounters during the year.

Eligible Entities: Eligible applicants include Governor-appointed, state governmental entities. A 40 percent match by the state is required for this program.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Oral Health Service Providers	• Primary and Secondary Education • Pre- and Postdoctoral Programs • Residency Programs • Continuing Education	• Integration of oral and primary care medical delivery systems. • Supporting oral health providers practicing in advanced roles. • Teledentistry. • Expand or establish oral health services and facilities in Dental HPSAs. • Partnerships with dental training institutions. • Expand a state dental office.

Funding History

FY	Amount
FY 2015	$33,928,000
FY 2016	$35,873,000
FY 2017	$36,587,000
FY 2018	$36,424,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Oral Health Programs, which is $36.4 million under the FY 2018 Annualized CR level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[35]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.27: Number of dental students trained	FY 2016: 5,291 Target: 1,600 (Target Exceeded)	5,300	N/A	N/A
6.I.C.28: Number of dental residents trained	FY 2016: 460 Target: 311 (Target Exceeded)	350	N/A	N/A
6.I.C.29: Number of faculty trained	FY 2016: 1,180 Target: 1,200 (Target Not Met)	300[36]	N/A	N/A

Program Activity Data

Oral Health Training and Workforce Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Percent of students and residents trained who are URMs	FY 2016: 17%	17%	17%	---
Number of dentists completing a Bureau of Health Workforce-funded dental residency or fellowship	FY 2016: 259	270	250	---
Number of dentists graduating from a Bureau of Health Workforce-funded dental school	FY 2016: 1,366	900	1,300	---

[35] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.
[36] In FY 2016, HRSA discontinued the Faculty Development in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program, which accounted for the large number of faculty trained. In FY 2016, HRSA instead made awards to support the Dental Faculty Loan Repayment Program, which is a more modest investment with fewer faculty supported.

Grant Awards Table – Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene[37]

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	62	62	---
Average Award	$316,798	$316,798	---
Range of Awards	$10,461-$747,949	$10,461-$747,949	---

Grant Awards Table – Dental Loan Repayment Programs

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	19	19	---
Average Award	$156,260	$156,260	---
Range of Awards	$54,000-$250,000	$54,000-$250,000	---

Grant Awards Table – State Oral Health Workforce Improvement Grant Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	27	27	---
Average Award	$415,051	$415,051	---
Range of Awards	$198,132-$500,000	$198,132-$500,000	---

[37] The Primary Care Medicine and Dentistry Clinician Educator Career Development Awards are jointly funded by PCTE and Oral Health Programs. The total funding is approximately $3.43 million, $2.17 million from PCTE and $1.26 million from Oral Health Programs. This awards table accounts for the $1.26 million in Oral Health Program funds only.

Interdisciplinary, Community-Based Linkages

Area Health Education Centers Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$30,177,000	$30,045,000	---	-$30,045,000
FTE	4	4	---	-4

Authorizing Legislation: Public Health Service Act, Section 751

FY 2019 Authorization ..... Expired at the end of FY 2014

Allocation Method ..... Competitive Grant/Cooperative Agreement

Program Description and Accomplishments:

The purpose of the Area Health Education Centers (AHEC) Program is to develop and enhance education and training networks within communities, academic institutions, and community-based organizations. In turn, these networks develop the health care workforce, broaden the distribution of the health workforce, enhance health care quality, and improve health care delivery to rural and underserved areas and populations.

In Academic Year 2016-2017, the AHEC Program supported various types of pre-pipeline, pipeline, and continuing education training activities for thousands of trainees across the country. AHEC grantees implemented 3,307 unique continuing education courses that were delivered to 214,789 practicing professionals nationwide, 88,731 of whom were concurrently employed in medically underserved communities.

AHEC grantees partnered with 6,574 sites to provide 40,688 clinical training experiences to student trainees (e.g., ambulatory practice sites, physician offices, and hospitals). Approximately 63 percent of these training sites were primary care settings; 63 percent were located in medically underserved communities; and 42 percent were in rural areas.

In the past, AHEC Program awardees addressed the immediate needs of their service areas, which allowed for a high degree of individuality; however, the variation among programs made it challenging to measure the collective impact of the program nationally. In FY 2017, HRSA made new AHEC awards aligning investments around defined evidence-based practices established through previous AHEC awards aimed at achieving a more measurable, long-term impact on the communities and populations served.

Eligible Entities: Public or private non-profit accredited schools of allopathic and osteopathic medicine. Accredited schools of nursing are eligible applicants in states and territories in which no AHEC Program is in operation.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Allied health • Behavioral/Mental health • Community health workers • Dentists • Nurse midwives • Nurse practitioners • Optometrists • Pharmacists • Physicians • Physician assistants • Psychologists • Public health • Other health professions	All education levels are targeted to provide primary care workforce development for the following trainees: • Medical residents • Medical students • Health professions students • Continuing education (CE) for primary care providers in underserved areas	• Health professions recruitment, education, training and placement. • Clinical/community-based practice • Interprofessional education • Strengthening partnerships • Evaluation

Funding History

FY	Amount
FY 2015	$30,250,000
FY 2016	$30,250,000
FY 2017	$30,177,000
FY 2018	$30,045,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Area Health Education Centers Program, which is $30 million below the FY 2018 Annualized CR level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals. It is anticipated that the AHEC Program awardees can find other sources of funding to continue these activities.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[38]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.30: Percent of CE trainees who report being currently employed in medically underserved areas	FY 2016: 41% Target: 34% (Target Exceeded)	34%	N/A	N/A
6.I.C.31: Number of trainees receiving health career guidance and information from the AHEC Programs	FY 2016: 402,045 Target: 325,000 (Target Exceeded)	275,000[39]	N/A	N/A

Program Activity Data

AHEC Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Number of medical students who participated in community-based clinical training	FY 2016: 17,879	18,000	17,000	---
Number of other health professions trainees who participated in community-based clinical training	FY 2016: 17,343	18,000	17,000	---
Number of trainees who received CE on topics including cultural competence, women's health, diabetes, hypertension, obesity, and health disparities	FY 2016: 214,789	200,000	175,000	---

[38] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.

[39] In the past, AHEC Program awardees addressed the immediate needs of their service areas, which allowed for a high degree of individuality; however, the variation among programs made it challenging to measure the collective impact of the program nationally. In FY 2017, HRSA made new AHEC awards aligning investments around defined evidence-based practices that increase the level of support for individual trainees. This program will decrease the overall number of individuals served in FY 2018.

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	49	49	---
Average Award	$580,922	$580,922	---
Range of Awards	$105,739 - $1,411,968	$105,739 - $1,411,968	---

Interdisciplinary, Community-Based Linkages

Geriatrics Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$38,644,000	$38,474,000	---	-$38,474,000
FTE	6	6	---	-6

Authorizing Legislation: Public Health Service Act, Sections 750, 753 and 865

FY 2019 Authorizations:.....Expired at the end of FY 2014

Allocation Method ..... Cooperative Agreement

Program Description and Accomplishments:

The Geriatrics Workforce Enhancement Program (GWEP) improves health care for older people by fostering clinical training environments that integrate geriatrics and primary care delivery systems and by maximizing patient and family engagement in health care decisions. The Program provides training across the provider continuum (students, faculty, providers, direct service workers, patients, families, and lay and family caregivers) focusing on training in interprofessional and team-based care and on academic-community partnerships to address gaps in health care for older adults.

In Academic Year 2016-2017, GWEP grantees provided training for 30,082 students and fellows participating in a variety of geriatrics-focused degree programs, field placements, and fellowships. Of these trainees, 20,114 graduated or completed their training during the current academic year. GWEP grantees partnered with 265 health care delivery sites (e.g., hospitals, long-term care facilities, and academic institutions) to provide clinical training experiences to trainees. Approximately 49 percent of these sites were located in medically underserved communities, and 42 percent were situated in primary care settings.

With regard to the continuing education of the current workforce, 173,078 faculty and practicing professionals participated in 1,578 unique continuing education courses offered by GWEP grantees, 467 of which were specifically focused on Alzheimer's disease and related dementia. We expect grantees to meet the target for next year. In addition, GWEP grantees developed or enhanced and implemented 2,543 different curricular activities. Most of these were new continuing education courses, academic courses, and workshops which together reached 131,293 people. Finally, with regard to faculty development, results showed that GWEP grantees supported 307 different faculty-focused training programs and activities during the academic year, reaching 6,688 faculty-level trainees.

Eligible Entities: Accredited schools representing various health disciplines, healthcare facilities, and programs leading to certification as a certified nursing assistant.

Designated Health Professions	Targeted Educational Levels	Program Activities
• Allied health • Allopathic medicine • Behavioral and mental health • Chiropractic • Clinical psychology • Clinical social work • Dentistry • Health administration • Marriage and family therapy • Nursing • Optometry • Osteopathic medicine • Pharmacy • Physician assistant • Podiatric medicine • Professional counseling • Public health	• Undergraduate • Graduate • Post-graduate • Practicing health care providers • Faculty • Direct service workers • Lay and family caregivers	• Interprofessional geriatrics education and training to students, faculty, practitioners, and caregivers. • Curricula development relating to the treatment of the health problems of elderly individuals. • Faculty development in geriatrics. • Continuing education for health professionals who provide geriatric care. • Clinical training for students in geriatrics in nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers.

Funding History

FY	Amount
FY 2015	$34,237,000
FY 2016	$38,737,000
FY 2017	$38,644,000
FY 2018	$38,474,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Geriatrics Program, which is $38.5 million below the FY 2018 Annualized CR level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[40]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.12: Number of Bureau of Health Workforce-sponsored interprofessional continuing education sessions provided on Alzheimer's disease	FY 2016: 467 Target: 600 (Target Not Met)	500	N/A	N/A
6.I.C.13: Number of trainees participating in interprofessional continuing education on Alzheimer's disease	FY 2016: 55,640 Target: 51,000 (Target Exceeded)	51,000	N/A	N/A
6.I.C.32: Number of continuing education trainees in geriatrics programs	FY 2016: 173,078 Target: 100,000 (Target Exceeded)	125,000	N/A	N/A
6.I.C.33: Number of students who received geriatric-focused training in geriatric nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers	FY 2016: 29,444 Target: 17,000 (Target Exceeded)	23,000	N/A	N/A

Program Activity Data

Geriatrics Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Number of continuing education offerings delivered by grantees	FY 2016: 1,579	1,000	1,300	---
Number of faculty members participating in geriatrics trainings offered by grantees	FY 2016: 6,688	6,000	6,000	---
Number of individuals trained in new or enhanced curricula relating to the treatment of health problems of elderly individuals	FY 2016: 131,293	50,000	100,000	---

[40] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.

Geriatrics Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Number of individuals enrolled in geriatrics fellowships	FY 2016: 638	800	700	---
Number of advanced education nursing students enrolled in advanced practice adult-gerontology nursing programs	FY 2016: 136	65	75	---

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	44	44	---
Average Award	$816,000	$816,000	---
Range of Awards	$557,791 - $850,000	$557,791 - $850,000	---

Interdisciplinary, Community-Based Linkages

Behavioral Health Workforce Education and Training

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$50,000,000	$49,660,000	---	-$49,660,000
FTE	6	6	---	-6

Authorizing Legislation: Public Health Service Act, Section 755 and 756

FY 2019 Authorization .....$50,000,000[41]

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

The purpose of the Behavioral Health Workforce Education and Training (BHWET) Program is to develop and expand the behavioral health workforce serving populations across the lifespan, including in rural and medically underserved areas. The Program places special emphasis on establishing or expanding internships or field placement programs in behavioral health that include interdisciplinary training for students/interns, faculty, and field supervisors to provide quality behavioral health services to communities in need.

The Program increases the behavioral health workforce including: psychiatrists, psychologists (to include doctoral internships and post-doctoral residency programs), psychiatric nurse practitioners, social workers, substance use disorder prevention and treatment counselors, marriage and family therapists, occupational therapists, and professional counselors, as well as behavioral health-related paraprofessionals.

In Academic Year 2016-2017, the BHWET Program supported training for 3,876 individuals, missing the target for number of students trained. Due to timing of awards, many of the grantees were unable to recruit for the academic year; however, targets should be met for the next academic year (5,600 students in training; 3,600 graduates) as all awardees will have their programs established. Of the total students supported, 2,385 graduate-level social workers, psychologists, school and clinical counselors, psychiatric nurse practitioners, and marriage and family therapists were trained as well as 1,491 students training to become behavioral health paraprofessionals (such as community health workers, outreach workers, social services aides, mental health workers, substance abuse/addictions workers, youth workers, and peer paraprofessionals). By the end of the Academic Year, 2,947 students graduated from these degree and certificate-bearing programs and entered the behavioral health workforce. Upon

[41] The 21st Century Cures Act (P.L. 114-255) authorized $50 million in appropriations through FY 2022 for Section 756 of the Public Health Service Act, which authorizes the BHWET Program, the Graduate Psychology Education Program, and Leadership in Public Health and Social Work Education Program.

program completion, 62 percent of students intended to pursue training and/or employment to serve at-risk children, adolescents, and transitional-aged youth.

BHWET grantees partnered with 2,348 training sites to provide 5,431 clinical training experiences for BHWET student trainees (e.g., hospitals, ambulatory practice sites, and academic institutions). Over 76 percent of these training sites were located in rural and/or medically underserved communities where trainees provided over 1 million hours of behavioral health services to patients and clients. Training at partnered sites incorporated interdisciplinary team-based approaches, where 7,723 students, residents and/or fellows from a variety of professions and disciplines were trained on teams with BHWET students. Finally, BHWET grantees used grant funds to develop, enhance, and implement 900 behavioral health-related courses and training activities, reaching over 25,000 students and advanced trainees (i.e., psychology interns and fellows and psychiatry residents).

Eligible Entities:
Professionals: Accredited institutions of higher education or accredited behavioral health professional training programs in psychiatry, behavioral pediatrics, social work, school social work, substance use disorder prevention and treatment, marriage and family therapy, occupational therapy, school counseling, or professional counseling. Accredited schools of masters or doctoral level training in psychiatric nursing programs. American Psychological Association (APA)-accredited doctoral level schools and programs of health service psychology or school psychology.

Paraprofessionals: Behavioral paraprofessional certificate training programs and peer paraprofessional certificate training programs offered by States, political subdivisions of states, Indian tribes and tribal organizations, public or nonprofit private health professions schools, academic health centers, State or local governments, or other appropriate public or private nonprofit entities as determined appropriate by the Secretary.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
Professionals Paraprofessionals	• Graduate (doctoral) • Graduate (masters) • Undergraduate • Certificate	• Develop and support training programs • Support internships and field placement

Funding History

FY	Amount
FY 2015	$35,000,000
FY 2016	$50,000,000
FY 2017	$50,000,000
FY 2018	$49,660,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Behavioral Health Workforce Education and Training Program, which is $49.7 million below the FY 2018 Annualized CR level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result[42]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.34: Number of students currently receiving training in behavioral health degree and certificate programs	FY 2016: 3,876 Target: 5,000 (Target Not Met)	4,500	N/A	N/A
6.I.C.35: Number of graduates completing behavioral health programs and entering the behavioral health workforce	FY 2016: 2,947 Target: 3,000 (Target Not Met)	3,000	N/A	N/A

Grant Award Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	136	136	---
Average Award	$344,072	$344,072	---
Range of Awards	$83,320 - $480,000	$83,320 - $480,000	---

[42] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.

Interdisciplinary, Community-Based Linkages

Mental and Behavioral Health Education and Training Programs

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$9,892,000	$9,849,000	---	-$9,849,000
FTE	2	2	---	-2

Authorizing Legislation: Public Health Service Act, Sections 750, 756 and 791

FY 2019 Authorization .....$50,000,000[43]

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

The Mental and Behavioral Health Education and Training Programs work to close the gap in access to behavioral health services by increasing the number and distribution of adequately trained behavioral health professionals in integrated care settings, particularly within underserved and/or rural communities.

Graduate Psychology Education (GPE) Program: In Academic Year 2016-2017, the GPE Program provided stipend support to 189 students participating in practica or pre-degree internships in psychology. The majority of students who received a stipend were trained in medically underserved communities (96 percent) and/or a primary care setting (91 percent). Of the 89 students who completed GPE-supported programs, 84 percent intended to become employed or pursue further training in medically underserved communities and 56 percent intended to become employed or pursue further training in primary care settings. GPE grantees partnered with 139 sites to provide 428 clinical training experiences for psychology graduate students (e.g., hospitals, ambulatory practice sites, and academic institutions) as well as 2,642 interprofessional team-based care trainees who participated in clinical training along with the psychology graduate students. Approximately 87 percent of these training sites were located in medically underserved communities and 74 percent were primary care settings.

Leadership in Public Health Social Work Education (LPHSWE) Program: In Academic Year 2016-2017, the LPHSWE Program supported 20 graduate-level public health social work students most of whom were enrolled in dual degree Masters of Social Work and Masters of Public Health programs. By the end of the academic year, 17 students graduated from their dual degree programs, 76 percent of whom intended to pursue employment or further training in a

[43] The 21st Century Cures Act (P.L. 114-255) authorized $50 million in appropriations through FY 2022 for Section 756 of the Public Health Service Act under which LPHSWE, GPE, and the Behavioral Health Workforce Education Training Programs are all authorized.

medically underserved community and/or rural setting. LPHSWE grantees also partnered with 15 sites to provide clinical training experiences for supported students (e.g., community-based organizations, hospitals, and academic institutions). Approximately 67 percent of these training sites were located in medically underserved communities. HRSA awarded the final year of the LPHSWE awards in FY 2017; the LPSWE Program activities will be completed in June 2018.

Eligible Entities: Accredited doctoral level schools and programs of health service psychology, doctoral internships in professional psychology, and post-doctoral residency programs in practice psychology.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Psychologists	• Graduate (doctoral)	• Develop and support training programs. • Faculty development. • Model demonstration programs. • Provide stipends for fellowship trainees.

Funding History

FY	Amount
FY 2015	$8,916,000
FY 2016	$9,916,000
FY 2017	$9,892,000
FY 2018	$9,849,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Mental and Behavioral Health Education and Training Program, which is $9.8 million below the FY 2018 Annualized CR level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result[44]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.36: Number of graduate-level psychology students supported in GPE program	FY 2016: 189 Target: 170 (Target Exceeded)	170	N/A	N/A
6.I.C.37: Number of interprofessional students trained in GPE program	FY 2016: 2,642 Target: 1,900 (Target Exceeded)	1,900	N/A	N/A

Program Activity Data

Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Number of GPE clinical training experiences that incorporated interprofessional team-based care training	FY 2016: 428	500	425	---

Grant Award Table – Mental and Behavioral Health Education and Training

	FY 2017 Final	FY 2018 Annualized CR[45]	FY 2019 President's Budget
Number of Awards	34	31	---
Average Award	$253,459	$265,000	---
Range of Awards	$47,213 - 350,000	$47,213 - 350,000	---

[44] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.
[45] The decreased awards reflect the discontinuation of the Leadership in Public Health Social Work Education Program. Grantees received the final year of funding in FY 2017.

Public Health Workforce Development

Public Health and Preventive Medicine Training Grant Programs

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$16,949,000	$16,885,000	---	-$16,885,000
FTE	4	4	---	-4

Authorizing Legislation: Public Health Service Act, Sections 765-768 and 770

FY 2019 Authorization .....Expired at the end of FY 2015

Funding Allocation ..... Competitive Grant/Cooperative Agreement

Program Description and Accomplishments:

The Preventive Medicine and Public Health Training Grant Programs train the current and future workforce through the development of new training content and delivery and through the coordination of student placements and collaborative projects. The programs aim to improve the health of communities by increasing the number and quality of public health and preventive medicine personnel who can address public health needs and advance preventive medicine practices.

Program	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Public Health Training Centers Program	$9,887,030	$9,849,696	---
Preventive Medicine Residency Program	$7,061,970	$7,035,304	---

Public Health Training Centers (PHTC) Program: The PHTC Program, established in 1999 funds schools and programs of public health to expand and enhance training opportunities focused on the technical, scientific, managerial and leadership competencies and capabilities of the current and future public health workforce, including regional centers. The PHTC Program aims to strengthen the public health workforce through the provision of education, training and consultation to state, local, and tribal health departments to improve the capacity and quality of a broad range of public health personnel to carry out core public health functions by providing education, training and consultation to these public health personnel. The primary target for education and training through the PHTC Program are frontline public health workers, middle managers, and staff in other parts of the public health system. Beginning in Academic Year 2017-2018, the National Coordinating Center was discontinued.

In Academic Year 2016-2017, Regional PHTCs partnered with 170 sites to provide more than 208 clinical training experiences to student trainees (e.g., local health departments, academic institutions, and community-based organizations). Approximately 67 percent of these training sites were located in medically underserved communities and 28 percent were located in rural areas. With regard to the continuing education (CE) of the current workforce, PHTC grantees delivered 2,573 unique CE courses to 226,635 trainees during the academic year, approximately 25 percent of whom were practicing professionals concurrently employed in medically underserved communities. Due to timing of award allocation and changes in accreditation of continuing education the number of instructional hours for continuing education was 6,597 and missed the target of 9,320.

Eligible Entities: Health professions schools, including accredited schools or programs of public health, health administration, preventive medicine, or dental public health or schools providing health management programs; academic health centers; State or local governments; or any other appropriate public or private nonprofit entity that prepares and submits an application at such time, in such manner, and containing such information as the Secretary may require.

Designated Health Professions	**Targeted Educational Levels**	**Grantee Activities**
• Public health, health administration, preventive medicine, dental public health, health management. • Primary Target Audience: Frontline and Middle Managers in state, local, and tribal health departments • Public health workforce and staff in other parts of the public health system	• Public health students (graduate and undergraduate) • Existing public health professionals at all levels in the workforce	• Planning, developing, or operating demonstration training programs. • Faculty development. • Trainee support. • Technical assistance.

Preventive Medicine Residency (PMR) Program: The PMR Program provides support for residents in medical training in preventive medicine, including stipends for residents to defray the costs associated with living expenses, tuition, and fees. In FY 2018, PMR applicants are encouraged to address Department of Health and Human Services (HHS) clinical priorities of opioid abuse, mental health, and childhood obesity.

In Academic Year 2016-2017, the PMR Program supported 130 residents, the majority of which received clinical or experiential training in a primary care setting (88 percent) and/or a medically underserved community (82 percent). Of the 63 residents who completed their residency training programs during the academic year, 32 percent intended to pursue employment or further training in primary care. PMR grantees partnered with 232 sites to provide 671 clinical training experiences for PMR residents (e.g., academic institutions, ambulatory care sites, and hospitals). Approximately 44 percent of these training sites were located in medically underserved communities and 32 percent were primary care settings.
In Academic Year 2015-2016, the national center of excellence for integrative medicine in primary care continued to develop and disseminate guidelines and patient education for integrative health care in primary care, particularly for underserved communities, completed the

pilot period of the Foundations in Integrative Healthcare online course, and launched the revised online course. As of January 2017, 66 health professions education and training programs and eight community health centers had enrolled in the pilot online course.

Eligible Entities: Accredited schools of public health, allopathic or osteopathic medicine; accredited public or private non-profit hospitals; state, local or tribal health departments or a consortium of two or more of the above entities.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Preventive medicine physicians	• Residency training	• Plan and develop new residency training programs. • Maintain or improve existing residency programs. • Provide financial support to residency trainees. • Plan, develop, operate, and/or participate in an accredited residency program. • Establish, maintain or improve academic administrative units in preventive medicine and public health, or programs that improve clinical teaching in preventive medicine and public health.

Funding History

FY	Amount
FY 2015	$21,000,000
FY 2016	$21,000,000
FY 2017	$16,949,000
FY 2018	$16,885,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Preventive Medicine and Public Health Training Grant Programs, which is $16.9 million below the FY 2018 Annualized CR level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[46]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.9: Number of trainees participating in continuing education sessions delivered by PHTCs	FY 2016: 226,635 Target: 23,000 (Target Exceeded)	150,000	N/A	N/A
6.I.C.18: Number of instructional hours offered by PHTCs	FY 2016: 6,597 Target: 9,320 (Target Not Met)	6,000	N/A	N/A
6.I.C.19: Number of PHTC-sponsored public health students that completed field placement practicums in State, Local, and Tribal Health Departments	FY 2016: 144 Target: 150 (Target Not Met)	140	N/A	N/A

Program Activity Data

PMR Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Number of preventive medicine residents participating in residencies	FY 2016: 130	75[47]	75	---
Number of preventive medicine residents completing training	FY 2016: 63	40	40	---
Percent of program completers who are URMs	FY 2016: 32%	20%	20%	---
Percent of preventive medicine resident program completers who intend to practice in primary care settings	FY 2016: 32%	60%	60%	---

[46] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.
[47] The PMR targets for number of residents decreased significantly in FY 2017 due to a $4 million decrease in funding for Integrative Medicine residencies.

Grant Awards Table – Public Health Training Centers Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	11	10	---
Average Award	$824,261	$910,000	---
Range of Awards	$701,112-$1,005,000	$780,000-$1,105,000	---

Grant Awards Table – Preventive Medicine Residency Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	25	25	---
Average Award	$258,788	$257,810	---
Range of Awards	$120,484-500,847	$120,484-500,847	---

Nursing Workforce Development

Advanced Nursing Education Programs

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$64,425,000	$64,142,000	---	-$64,142,000
FTE	8	8	---	-8

Authorizing Legislation: Public Health Service Act, Section 811

FY 2019 Authorization .....Expired at the end of FY 2016

Allocation Method .....Formula Grant/Competitive Grant

Program Description and Accomplishments:

The Advanced Nursing Education Programs increase the number of qualified nurses in the primary care workforce by improving advanced nursing education through traineeships as well as curriculum and faculty development. The programs include a preference for supporting rural and underserved communities.

Advanced Nursing Education Workforce (ANEW) Program: In FY 2017, HRSA established the ANEW Program, which supports innovative academic-practice partnerships to prepare primary care advanced practice registered nursing students to practice in rural and underserved settings through academic and clinical training. The partnerships support traineeships as well as academic-practice program infrastructure funds to schools of nursing and their practice partners who deliver longitudinal primary care clinical training experiences with rural and/or underserved populations for selected students in primary care nurse practitioners (NP), primary care clinical nurse specialists (CNS), and/or nurse-midwives programs and facilitate program graduates' employment in those settings.

Advanced Nursing Education (ANE) Program: In Academic Year 2016-2017, grantees of the ANE Program trained 5,942 nursing students and produced 1,541 graduates. Although the number of students trained was lower than the projected target, this was primarily related to increased programmatic emphasis on faculty development and continuing education. Awardees offered 20 percent more faculty development activities and 36 percent more continuing education courses than the prior year, thereby training more than 5,400 individuals on topics in nursing and public health. The majority of ANE students were female (88 percent) and were most commonly between the ages of 30 and 39 (39 percent). Further analysis showed that ANE grantees partnered with 2,304 health care delivery sites to provide clinical and experiential training. Approximately 40 percent of sites used by ANE grantees were located in a medically underserved community, and 59 percent were primary care settings.

Nurse Anesthetist Traineeships (NAT) Program: In Academic Year 2016-2017, grantees of the NAT Program provided direct financial support to 2,429 nurse anesthetist students. Students received clinical training in medically underserved communities (75 percent) and/or primary care settings (46 percent) during the academic year. More than 1,000 of the supported students graduated from their degree programs and entered the workforce. At the time of graduation, 53 percent of graduates intended to pursue employment or further training in medically underserved communities, and 27 percent planned to pursue employment or further training in a primary care setting.

Advanced Education Nursing Traineeship (AENT) Program: In Academic Year 2016-2017, grantees of the AENT program provided direct financial support to 2,166 advanced nursing students. These individuals received training in primary care settings (80 percent), medically underserved communities (61 percent), and/or rural settings (41 percent) during the academic year. More than 1,200 supported students graduated from their degree programs and entered the workforce. At the time of graduation, graduates intended to pursue employment or further training in primary care settings (74 percent), medically underserved communities (50 percent), and/or rural settings (28 percent).

Eligible Entities: Schools of nursing, nursing centers, academic health centers, State or local governments, and other public or private, non-profit entities determined appropriate by the Secretary.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Nurse Practitioners • Nurse Midwives • Nurse Anesthetists • Nurse Educators	• Graduate (master's and doctoral)	• Enhance advanced nursing education and practice • Provide traineeships to students in advanced nursing education programs

Funding History

FY	Amount
FY 2015	$63,581,000
FY 2016	$64,581,000
FY 2017	$64,425,000
FY 2018	$64,142,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Advanced Nursing Education program, which is $64.1 million below the FY 2018 Annualized CR level. HRSA's nursing projections generally indicate that the supply of nurses will outpace demand at a national level in 2025. However, the distribution of nurses is estimated to be uneven with some areas of the country having an inadequate supply to meet the needs of their region, which is addressed by the NHSC, the NURSE Corps or other HRSA

investments. The Request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[48]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.38: Number of students trained in advanced nursing degree programs	FY 2016: 5,942 Target: 6,255 (Target Not Met)	350[49]	N/A	N/A
6.I.C.39: Percent of students trained who are URMs and/or from disadvantaged backgrounds	FY 2016: 32% Target: 24% (Target Exceeded)	24%	N/A	N/A
6.I.C.40: Number of graduates from advanced nursing degree programs	FY 2016: 1,541 Target: 1,485 (Target Exceeded)	75[50]	N/A	N/A

Program Activity Data

ANE Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Number of students supported in AENT program[51]	FY 2016: 2,166	---	---	---
Number of graduates from AENT program	FY 2016: 1,287	---	---	---
Number of students supported in NAT program	FY 2016: 2,429	3,000	2,200	---
Number of graduates from NAT program	FY 2016: 1,098	1,500	1,000	---

[48] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.
[49] Targets are adjusted as the ANE program grantees complete work in FY 2017 and shift to the ANEW program.
[50] Targets are adjusted as the ANE program grantees complete work in FY 2017 and shift to the ANEW program.
[51] Output measures for AENT were discontinued in FY 2017 as the AENT program was no longer active.

ANE Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Percent of NAT graduates who are minority and/or from disadvantaged backgrounds	FY 2016: 32%	30%	30%	---
Percent of graduates from NAT programs employed in underserved areas	FY 2016: 53%	40%	40%	---
Percent of AENT graduates who are minority and/or from disadvantaged backgrounds	FY 2016: 42%	---	---	---
Percent of graduates from AENT programs employed in underserved areas	FY 2016: 56%	---	---	---

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	176	176	---
Average Award	$338,406	$338,406	---
Range of Awards	$12,406-$700,000	$12,406-$700,000	---

Nursing Workforce Development

Nursing Workforce Diversity

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$15,306,000	$15,239,000	---	-$15,239,000
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 821

FY 2019 Authorization .....Expired at end of FY 2016

Allocation Method .....Competitive Grant/Contract

Program Description and Accomplishments:

The Nursing Workforce Diversity (NWD) Program increases nursing education opportunities for individuals from disadvantaged backgrounds, including racial and ethnic minorities who are underrepresented among registered nurses. The program supports disadvantaged students through student stipends and scholarships, and a variety of pre-entry preparation, advanced education preparation, and retention activities.

In Academic Year 2016-2017, the NWD Program supported 57 college-level degree programs as well as 38 training programs and activities designed to recruit and retain health professions students. These programs trained 4,416 students including 2,637 students who graduated or completed their programs. As project periods ended for the outgoing cohort of awardees, there was a shift in programmatic emphasis from recruitment of new students to graduation of existing trainees, resulting in an overall decrease in volume of trainees participating in academic support programs as well as nursing degree programs, causing targets to be missed. With a new cohort of awardees beginning in Academic Year 17-18, enrollment counts are expected to rebound to target levels.

In addition to providing support to students, NWD grantees partnered with 571 training sites during the academic year to provide 7,800 clinical training experiences to trainees across all programs. Approximately 49 percent of training sites were located in medically underserved communities and 37 percent were in primary care settings.

Eligible Entities: Accredited schools of nursing, nursing centers, academic health centers, state or local governments, and other private or public entities, including faith-based and community based organizations, tribes and tribal organizations.

Designated Health Professions	Targeted Educational Levels	Program Activities
• Baccalaureate-prepared Registered Nurses (RNs)	• RNs who matriculate into accredited bridge or degree completion program • Baccalaureate degree • Advanced nursing education preparation • PhD degree RNs	• Increase the recruitment, enrollment, retention, and graduation of students from disadvantaged backgrounds in schools of nursing. • Provide student scholarships or stipends. • Prepare diploma or associate degree RNs to become baccalaureate-prepared RNs.

Funding History

FY	Amount
FY 2015	$15,343,000
FY 2016	$15,343,000
FY 2017	$15,306,000
FY 2018	$15,239,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Nursing Workforce Diversity Program, which is $15.2 million below the FY 2018 Annualized CR level. HRSA's nursing projections generally indicate that the supply of nurses will outpace demand at a national level in 2025. However, the distribution of nurses is estimated to be uneven with some areas of the country having an inadequate supply to meet the needs of their region, which is addressed by the NHSC, the NURSE Corps or other HRSA investments. The Request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[52]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.41: Percent of program participants who are URMs and/or from disadvantaged backgrounds	FY 2016: 100% Target: 95% (Target Exceeded)	95%	N/A	N/A
6.I.C.42: Number of program participants who participated in academic support programs during the academic year	FY 2016: 1,878 Target: 2,900 (Target Not Met)	2,000	N/A	N/A
6.I.C.43: Number of program participants who are enrolled in a nursing degree program	FY 2016: 2,538 Target: 4,000 (Target Not Met)	2,500	N/A	N/A

Program Activity Data

NWD Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Percent of URM students	FY 2016: 46%	45%	45%	---
Number of nursing students graduating from nursing programs	FY 2016: 1,145	1,000	500	---

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	31	31	---
Average Award	$447,016	$447,016	---
Range of Awards	$195,574-$500,000	$195,574-$500,000	---

[52] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.

Nursing Workforce Development

Nurse Education, Practice, Quality and Retention Programs

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$39,817,000	39,642,000	---	-39,642,000
FTE	5	5	---	-5

Authorizing Legislation: Public Health Service Act, Sections 831 and 831A

FY 2019 Authorizations.....Expired at the end of FY 2016

Allocation Method .....Competitive Grant/Contract

Program Description and Accomplishments:

The Nurse Education, Practice, Quality and Retention (NEPQR) Programs address national nursing needs and strengthen the capacity for basic nurse education and practice under three priority areas: Education, Practice and Retention. The Programs support academic, service and continuing education projects to enhance nursing education, improve the quality of patient care, increase nurse retention, and strengthen the nursing workforce. The NEPQR Programs have a variety of legislative goals and purposes that support the development, distribution and retention of a diverse, culturally competent health workforce that can adapt to the population's changing health care needs and provide the highest quality of care for all. Woven throughout the Programs is the aim to increase the number of Bachelor of Science in Nursing (BSN) students exposed to enhanced curriculum and with meaningful clinical experience and training in medically underserved and rural communities, who will then be more likely to choose to work in these settings upon graduation.

Interprofessional Collaborative Practice (IPCP) Program: The IPCP Program was designed to create or expand practice environments comprised of nursing and other professional disciplines that are engaged in collaborative practice innovations. In Academic Year 2016-2017, IPCP grantees trained more than 6,430 individuals. In addition, IPCP grantees partnered with 148 clinical sites to provide interprofessional team-based training to 6,216 individuals, 19 percent of whom were nursing students and 763 trainees from other health care disciplines including medical, dental, and behavioral health students. Approximately 71 percent of the clinical training sites were located in medically underserved communities and 51 percent were in primary care settings.

BSN Practicums in Community-based Settings (BPCS) Program: The BPCS Program increases experiential training opportunities for senior-level BSN students in primary care community-based settings. In Academic Year 2016-2017, 11 BPCS awardees trained 681 students, 26 percent of whom reported coming from rural backgrounds. BPCS awardees partnered with 57 clinical sites to provide training experiences to students. Approximately 75

percent of sites were located in medically underserved communities, 65 percent were in primary care settings, and 44 percent were in rural areas. In addition, awardees offered 12 continuing education programs to 229 practicing professionals.

Veterans' Bachelor of Science in Nursing (VBSN) Program: The VBSN Program was designed to increase enrollment, progression, and graduation of veterans from BSN degree programs. In Academic Year 2016-2017, 953 veterans were enrolled in BSN degree programs, and 265 graduated with BSN degrees. Approximately 44 percent of veterans received clinical training in a primary care setting, and 57 percent received training in a medically underserved community during the academic year. Grantees also implemented 23 structured faculty development programs and 82 faculty development activities including conferences and workshops designed to enhance the teaching of veterans; 1,312 faculty were trained as a result. HRSA awarded the final year of the VBSN awards in FY 2017; the VBSN Program activities will be completed in June 2018.

Eligible Entities: Accredited schools of nursing, healthcare facilities, and partnerships of a nursing school and healthcare facility.

Designated Health Professions	**Targeted Educational Levels**	**Grantee Activities**
• Registered nurses • Advanced practice registered nurses	• Baccalaureate education • Advanced nursing education • Continuing professional training	• Expand enrollment in baccalaureate nursing programs. • Provide education in new technologies including simulation learning and distance learning methodologies. • Establish or expand nursing practice arrangements in non-institutional settings. • Provide care for underserved populations and other high-risk groups. • Provide coordinated care, and other skills needed to practice in existing and emerging organized health care systems. • Develop career ladder programs to promote career mobility in nursing. • Promote career advancement for nursing personnel. • Improve the retention of nurses and enhance patient care. • Develop internships and residency programs.

Funding History

FY	Amount
FY 2015	$39,913,000
FY 2016	$39,913,000
FY 2017	$39,817,000
FY 2018	$39,642,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Nurse Education, Practice, Quality and Retention Program, which is $39.6 million below the FY 2018 Annualized CR level. HRSA's nursing projections generally indicate that the supply of nurses will outpace demand at a national level in 2025. However, the distribution of nurses is estimated to be uneven with some areas of the country having an inadequate supply to meet the needs of their region, which is addressed by the NHSC, the NURSE Corps or other HRSA investments. The Request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[53]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.44: Number of trainees participating in interprofessional team-based care	FY 2016: 1,938 Target: 1,700 (Target Exceeded)	N/A[54]	N/A	N/A
6.I.C.45: Number of nurses and nursing students trained in interprofessional team-based care	FY 2016: 3,869 Target: 3,000 (Target Exceeded)	N/A	N/A	N/A

[53] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.
[54] Measures for the IPCP program will be discontinued in FY 2018 as grantees complete work, and the program will not be recompeted.

Program Activity Data

NEPQR Program Outputs	Year and Most Recent Result	FY 2017 Target	FY 2018 Target	FY 2019 Target
Total number of trainees and professionals participating in interprofessional team-based care	FY 2016: 6,216	7,000	N/A[55]	---
Number of veterans enrolled in baccalaureate (BSN) nursing programs	FY 2016: 953	350	N/A[56]	---
Number of veterans who graduate from baccalaureate (BSN) nursing programs	FY 2016: 265	150	N/A	---

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	87	85	---
Average Award	$410,588	$420,250	---
Range of Awards	$90,000-$557,500	$90,000-$557,5000	---

[55] Outputs for the IPCP and VBSN programs are discontinued in FY 2018 as these programs will complete work in FY 2017.
[56] This measure was discontinued in FY 2018 as the Veterans' Bachelor of Science in Nursing Program completed its activities.

Nursing Workforce Development

Nurse Faculty Loan Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$26,436,000	$26,320,000	---	-$26,320,000
FTE	5	5	---	-5

Authorizing Legislation: Public Health Service Act, Section 846A and 847(f)

FY 2019 Authorization .....Expired at the end of FY 16

Allocation Method .....Formula Grant

Program Description and Accomplishments:

The Nurse Faculty Loan Program (NFLP), which began in 2004, seeks to increase the number of qualified nurse faculty by awarding funds to schools of nursing who in turn provide student loans to graduate-level nursing students who are interested to serve as faculty. Upon graduation, student borrowers are eligible to receive partial loan cancellation (up to 85 percent of the loan principal and interest over four years) in exchange for serving as full-time faculty at an accredited school of nursing.

In Academic Year 2016-2017, 84 schools received new NFLP grant awards and supported 1,998 nursing students pursuing graduate level degrees as nurse faculty. This outcome is slightly below the FY16 target of 2,200 students, primarily as a result of fewer awards being made and more stringent criteria being used to ensure that loan support was provided to individuals with an expressed intent to pursue nursing faculty positions. The majority of students (83 percent) who received loans during the academic year were pursuing doctoral-level nursing degrees (e.g., PhD, DNP, DNSc/DNS, or EdD). By the end of the Academic Year, 568 trainees graduated; 92 percent of whom intend to teach nursing.

Eligible Entity: Accredited schools of nursing that offer advanced nursing education degree program(s) that prepare graduate students for roles as nurse educators.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
Nursing	Graduate (masters and doctoral)	• Provide funding to nursing schools to establish and operate revolving loan fund. • Match of at least 1/9 of the federal contribution to the loan fund. • Provide low interest rate loans to nursing students that may be used to pay costs of tuition, fees, books, laboratory expenses, and other education expenses. • Provides up to 85 percent loan cancellation upon completion of four years of service.

Funding History

FY	Amount
FY 2015	$26,500,000
FY 2016	$26,500,000
FY 2017	$26,436,000
FY 2018	$26,320,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Nurse Faculty Loan Program, which is $26.3 million below the FY 2018 Annualized CR level. HRSA's nursing projections generally indicate that the supply of nurses will outpace demand at a national level in 2025. However, the distribution of nurses is estimated to be uneven with some areas of the country having an inadequate supply to meet the needs of their region, which is addressed by the NHSC, the NURSE Corps or other HRSA investments. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[57]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.46: Number of graduate-level nursing students who received a loan	FY 2016: 1,998 Target: 2,200 (Target Not Met)	1,900	N/A	N/A

[57] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[57]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.47: Number of loan recipients who graduated from an advanced nursing degree program	FY 2016: 568 Target: 400 (Target Exceeded)	350	N/A	N/A

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	80	80	---
Average Award	$308,942	$308,942	---
Range of Awards	$14,842-$2,351,957	$14,842-$2,351,957	---

Nursing Workforce Development

NURSE Corps

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$82,935,000	$82,570,000	$83,135,000	+$565,000
FTE	32	32	32	---

Authorizing Legislation: Public Health Service Act, Section 846

FY 2019 Authorization ..... Expired at the end of FY 2007

Allocation Method .....Other (Competitive Awards to Individuals)

Program Description and Accomplishments:

HRSA's nursing and primary care projections generally indicate that the supply of nurses will outpace demand at a national level in 2025 and 2020, respectively. However, maldistribution of nurses is projected to be a continued problem. In addition, projections at the national-level mask a distributional imbalance of Registered Nurses (RN) at the state-level. Specifically, sixteen states are projected to experience a shortage of RNs by 2025.[58]

The NURSE Corps helps to improve the distribution of nurses by supporting nurses and nursing students committed to working in communities with inadequate access to care. In exchange for scholarships or educational loan repayment, NURSE Corps members fulfill their service obligation by working in Critical Shortage Facilities (CSFs) located in health professional shortage areas and medically underserved communities around the nation, which include rural communities and other identified geographic areas with populations that lack access to primary care services. The NURSE Corps Program includes:

NURSE Corps Loan Repayment Program (LRP): NURSE Corps LRP which began in 1988, aims to assist in the recruitment and retention of professional RNs, including advanced practice RNs, (i.e., nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, clinical nurse specialists) who are dedicated to working in CSFs or as faculty in schools of nursing. The NURSE Corps LRP decreases the economic barriers associated with pursuing careers in CSFs or in academic nursing by repaying 60 percent of the principal and interest on nursing education loans in exchange for two years of full-time service at a CSF or in academic nursing.

***The NURSE Corps Scholarship Program (SP)*:** NURSE Corps SP which began in 2002**,** awards scholarships to individuals who are enrolled or accepted for enrollment in an accredited school of

[58] DHHS (US), Health Resources and Services Administration, National Center for Health Workforce Analysis. (2017) Supply and Demand Projections of Nursing Workforce: 2014-2030.

nursing in exchange for a service commitment of at least two years in a CSF after graduation. The NURSE Corps SP awards reduce the financial barrier to nursing education for all levels of professional nursing students and increase the pipeline of nurses who will serve in CSFs.

The NURSE Corps performance measures gauge these programs' contribution towards improving access to health care and improving the health care systems through the recruitment and retention of nurses working in CSFs. In FY 2016, 55 percent of NURSE Corps LRP participants extended their service commitment for an additional year, exceeding the 52 percent target; and in FY 2016, 86 percent of NURSE Corps participants were retained in service at a CSF for up to two years beyond the completion of their NURSE Corps service commitment. In addition, in FY 2016, 95 percent of NURSE Corps SP awardees are pursuing their baccalaureate degree or advanced practice degree.

In FY 2017, HRSA began collecting National Provider Identifier (NPI) for NURSE Corps applicants. This process will support the Administration's efforts to evaluate and identify the most effective workforce training investments.[59] This will allow HRSA to conduct longitudinal tracking for NURSE Corps participants, thereby improving the quality and breadth of the data to drive HRSA policies and investments.

Eligible Entities: Eligible participants for the NURSE Corps LRP are U.S. citizens (either U.S. born or naturalized), U.S. Nationals or Lawful Permanent Residents with a current license to practice as a registered nurse who are employed full time (at least 32 hours per week) at a public or private nonprofit CSF or at an accredited, public or private non-profit school of nursing.

Eligible participants for the NURSE Corps SP are U.S. citizens (either U.S. born or naturalized), U.S. Nationals or Lawful Permanent Residents enrolled or accepted for enrollment in an accredited diploma, associate or collegiate (bachelors, master's, doctoral) school of nursing program.

Funding History

FY	Amount
FY 2015	$81,785,000
FY 2016	$83,135,000
FY 2017	$82,935,000
FY 2018	$82,570,000
FY 2019	$83,135,000

Budget Request

The FY 2019 Budget requests $83.1 million for the NURSE Corps Program, which is an increase of $0.56 million above the FY 2018 Annualized CR level. This request will fund an estimated 202 scholarship (new and continuation) and 1,015 loan repayment (new and continuation) awards. This request will allow the program to maintain its efforts to address the anticipated demand for nurses in CSF. In FY 2019, NURSE Corps will assess options to direct a higher

[59] See Section 10 of Executive Order 13801.

proportion of awards to community-based CSFs located in rural and underserved communities. The funding request also includes operational costs in the form of required Federal Insurance Contributions Act tax contributions, staffing, and acquisition contracts.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
5.I.C.4: Proportion of NURSE Corps LRP participants who extend their service contracts to commit to work at a critical shortage facility for an additional year. *(Outcome)*	FY 2017: 58% Target: 52% (Target Exceeded)	52%	52%	Maintain
5.I.C.5: Proportion of NURSE Corps LRP/SP participants retained in service at a critical shortage facility for at least one year beyond the completion of their NURSE Corps LRP/SP commitment.	FY 2016: 86% Target: 80% (Target Exceeded)	80%	80%	Maintain
5.I.C.7: Proportion of NURSE Corps SP awardees obtaining their baccalaureate degree or advanced practice degree in nursing. *(Outcome)*	FY 2017: 98% Target: 85% (Target Exceeded)	85%	85%	Maintain
5.E.1: Default rate of NURSE Corps LRP and SP participants. *(Efficiency)*	FY 2017: LRP: 2.7% Target: 3% (Target Exceeded) SP: 8.5% Target: 15% (Target Exceeded)	LRP: 3% SP: 15%	LRP: 3% SP: 15%	Maintain

NURSE Corps Loans/Scholarships Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Loans	$48,110,375	$48,452,829	$48,452,829
Scholarships	$23,696,155	$23,864,826	$23,864,826

NURSE Corps Awards

	2012	2013	2014	2015	2016	2017	2018	2019
Scholarships								
New Awards	233	239	242	257	230	198	203	183
Continuation Awards	31	21	13	12	12	14	22	19
Loan Repayment								
New Awards	720	580	667	590	518	501	671	645
Continuation Awards	732	606	412	319	365	340	326	370
Total	**1,716**	**1,446**	**1,334**	**1,178**	**1,125**	**1,053**	**1,222**	**1,217**

NURSE Corps Field Strength

	2012	2013	2014	2015	2016	2017	2018	2019
Scholarship	475	558	465	396	476	362	361	321
Loan Repayment	2,125	1,634	1,420	1,313	1,219	1,181	1,333	1,348
Loan Repayment Nurse Faculty	467	367	318	321	321	331	340	340
Total	**3,067**	**2,559**	**2,203**	**2,030**	**2,016**	**1,874**	**2,034**	**2,009**

Children's Hospitals Graduate Medical Education Payment Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$299,289,000	$297,963,000	---[60]	- $297,963,000
FTE	17	17	---	-17

Authorizing Legislation: Public Health Service Act, Section 340E

FY 2019 Authorization ..... Expired at the end of FY 2018

Allocation Method ..... Formula Based Payment

Program Description and Accomplishments:

The Children's Hospitals Graduate Medical Education (CHGME) Payment Program was first established in 1999 and it supports graduate medical education in freestanding children's teaching hospitals. CHGME helps eligible hospitals maintain GME programs to provide graduate training for physicians to provide quality care to children and enhance their ability to care for low-income patients. It supports the training of residents to care for the pediatric population and enhances the supply of primary care and pediatric medical and surgical subspecialties.

In FY 2017, 58 children's hospitals received CHGME funding. During Academic Year 2016-2017, the most recent year for which FTE information was reported, the CHGME hospitals trained 7,164 resident full-time equivalents (FTEs).[61] Among these FTEs, 41 percent were pediatric residents, 33 percent were pediatric subspecialty residents, and 26 percent were residents training in other primary disciplines such as family medicine.

During Academic Year 2015-2016, the most recent year for which performance information is available, CHGME-funded hospitals served as sponsoring institutions for 32 residency programs and 251 fellowship programs. In addition, they served as major participating rotation sites for 598 additional residency and fellowship programs. CHGME supported the training of 5,017 pediatric residents that included general pediatrics residents, as well as residents from five types of combined pediatrics programs (e.g., internal medicine/ pediatrics). Additionally, 2,713 pediatric medical subspecialty residents, 285 pediatric surgical subspecialty residents, and 365 pediatric dentistry residents were trained. CHGME funding was also responsible for the training of 3,120 adult medical and surgical specialty residents such as family medicine residents who rotate through children's hospitals for pediatrics training. During their training, these medical residents and fellows provided care during more than 2 million patient encounters in primary

[60] Discretionary funding for CHGME is discontinued in FY 2019. The Budget proposes to consolidate Federal graduate medical education spending from Medicare, Medicaid, and the Children's Hospitals Graduate Medical Education program into a single grant program for teaching hospitals.

[61] Each of the children's hospitals report the number of full-time equivalent residents trained during the latest filed (completed) Medicare Cost Report period.

care settings in addition to providing 4.7 million patient contact hours in medically underserved communities. Of the full-time residents and fellows who completed their training during this Academic Year, approximately 62 percent of these CHGME-funded physicians chose to remain and practice in the state where they completed their residency training.

Eligible Entities: Freestanding children's teaching hospitals.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Pediatric • Pediatric medical subspecialties • Pediatric surgical Subspecialties • Other primary care, medical, and surgical specialties	• Graduate medical education	• Operate accredited graduate medical education programs for residents and fellows. • Submit an annual report on the status and expansion of GME in their institutions.

Funding History

FY	Amount
FY 2015	$265,000,000
FY 2016	$295,000,000
FY 2017	$299,289,000
FY 2018	$297,963,000
FY 2019	---

Budget Request

The FY 2019 Budget request discontinues the discretionary CHGME program, which is $297.96 million below the FY 2018 Annualized CR level. The Budget proposes to consolidate Federal graduate medical education spending from Medicare, Medicaid, and the Children's Hospitals Graduate Medical Education program into a single grant program for teaching hospitals equal to the sum of Medicare and Medicaid's 2016 payments for graduate medical education, plus 2016 spending on children's hospitals graduate medical education, adjusted for inflation. This amount would then grow with inflation minus 1 percentage point each year. HRSA and the Centers for Medicare & Medicaid Services (CMS) would jointly determine program requirements and the formula for distribution. Payments 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. The Secretary would have authority to modify the amounts distributed based on the proportion of residents training in priority specialties or programs and based on other criteria identified by the Secretary, including addressing health care professional shortages and educational priorities. This grant program would be funded out of the general fund of the Treasury.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[62]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
7.I.A.1: Maintain the number of FTE residents training in eligible children's teaching hospitals	FY 2016: 7,164 Target: 6,300 (Target Exceeded)	6,300	N/A	N/A
7.VII.C.1: Percent of hospitals with verified FTE residents counts and caps	FY 2016: 100% Target: 100% (Target Met)	100%	N/A	N/A
7.E: Percent of payments made on time	FY 2016: 100% Target: 100% (Target Met)	100%	N/A	N/A

Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	58	58	---
Average Award	$4,838,475	$4,838,475	---
Range of Awards	$31,808-$21,117,097	$31,808-$21,117,097	---

[62] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.

Teaching Health Center Graduate Medical Education Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	---	---	$60,000,000	+$60,000,000
Current Law Mandatory	$55,860,000	$30,000,000	---	-$30,000,000
Proposed Law Mandatory	---	$30,000,000	---	-$30,000,000
TOTAL	$55,860,000	$60,000,000	$60,000,000	---
FTE	8	8	8	---

Authorizing Legislation: Section 340H of the Public Health Service Act

FY 2019 Authorization .....Expires end of the second quarter FY 2018

Allocation Method ..... Formula Based Payment

Program Description and Accomplishments:

Primary care physician shortages persist, particularly in rural and other underserved communities.[63] Access to high quality primary care is associated with improved health outcomes and lower costs.[64, 65] The Teaching Health Center Graduate Medical Education (THCGME) Program, established in 2010, increases the number of primary care physician and dental residents, increasing the overall number of these primary care providers. There is also evidence that physicians who receive training in community and underserved settings are more likely to practice in similar settings, such as health centers.[66, 67] Unlike most Federal funding for GME, payments support training based in community-based ambulatory care settings, as opposed to in-patient care settings in hospitals.

[63] U.S. Department of Health and Human Services, Health Resources and Services Administration. HRSA, 2015. "National and Regional Projections of Supply and Demand for Primary Care Practitioners: 2013-2025. November 2016. https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-national-projections2013-2025.pdf.

[64] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Quarterly. 2005; 83(3):457-502.

[65] Chang CH, O'Malley AJ, Goodman DC. Association between Temporal Changes in Primary Care Workforce and Patient Outcomes. Health Services Research 2017; 52:634–55.

[66] Phillips, RL; Petterson,S; Bazemore, A. Do Residents Who Train in Safety Net Settings Return for Practice? Academic Medicine: 2013; 88(12): 1934–1940.

[67] Goodfellow A, Ulloa J, Dowling P, Talamantes E, Chheda Somil, Bone C, Moreno G. Predictors of Primary Care Physician Practice Location in Underserved Urban or Rural Areas in the United States: A Systematic Literature Review. 2016, Academic Medicine.

Although health centers receive federal funding to improve access to care, they often have difficulty recruiting and retaining primary care professionals.[68] The THCGME Program is uniquely positioned to meet these recruitment and retention needs by providing funding to support residents training in underserved communities. As community health centers are generally smaller organizations than teaching hospitals with smaller operating margins, these organizations are unable to offset the additional costs of GME training without significantly affecting the patient and community services provided. Without THCGME funding, these additional residency positions will cease to exist and the additional primary care physicians and dentists will not be available to rural and underserved communities.

In addition to increasing the number of primary care residents training in these community-based patient care settings, the THCGME Program seeks to increase health care quality and improve overall access to care. Program funds support the educational costs incurred by new and expanded residency programs. In addition to supporting the salaries and benefits of residents and faculty, THCGME funds are used to foster innovation and support curriculum concepts aimed at improving patient care, such as the Patient-Centered Medical Home model, Electronic Health Record utilization, population health, telemedicine, and healthcare leadership. These activities ensure residents receive high quality training and are well prepared to practice in community-based setting after graduation.

In Academic Year 2016-2017, the THCGME Program awarded 742 resident FTE slots that provided funding to 771 primary care medical and dental residents. Nearly all residents (over 99 percent) received training in a primary care setting, providing care during more than half a million patient encounters and accruing nearly 600,000 contact hours with these primary care patients. Additionally, most THCGME residents (83 percent) spent part of their training in medically underserved and/or rural communities, providing over 795,000 hours of patient care. Approximately 20 percent of residents reported coming from a financially or educationally disadvantaged background, and 23 percent reported coming from a rural background.

In addition to supporting training of individual residents, THCGME recipients also used funding to develop or enhance curricula on topics related to primary care. Programs developed or enhanced and implemented 1,157 courses and training activities during the academic year, impacting over 8,800 healthcare trainees. More than 12,000 students, residents, and other health care professionals from a variety of professions and disciplines trained alongside THCGME residents while participating in interprofessional team-based care.

Of the 248 residents who completed the program in Academic Year 2016-2017, approximately 61 percent reported intentions to practice in a primary care setting, while 51 percent intended to practice in a medically underserved and/or rural area. Employment status will be assessed for these individuals one year after program completion (during Academic Year 2017-2018). Of the 172 program completers from the prior academic year for whom employment data was available, most currently practice in a primary care setting (68 percent) and/or in a medically underserved community (30 percent).

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[68] National Association of Community Health Centers. Staffing the Safety Net: Building the Primary Care Workforce at America's Health Centers.2016: http://www.nachc.org/wp-content/uploads/2015/10/NACHC_Workforce_Report_2016.pdf.

Since the THCGME Program began, 632 new primary care physicians and dentists have graduated and entered the workforce. As the national average of physicians practicing primary care is approximately 33 percent, [69] the THCGME Program has evidenced much stronger results. Cumulative follow-up data indicates that 69 percent of graduates are currently practicing in a primary setting and approximately 55 percent of the graduating physicians and dentists are currently practicing in a medically underserved community and/or rural setting.

Eligible Entities: Community-based ambulatory patient care centers identified in statute.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Family medicine • General dentistry • Geriatrics • Internal medicine • Internal medicine-pediatrics • Obstetrics and gynecology • Pediatrics • Psychiatry • Pediatric dentistry	• Post graduate medical and dental education	• Operate an accredited residency program. • Medical and dental residents will provide patient care services during their training under supervision of program faculty.

Funding History

FY	Amount
FY 2015	---
FY 2016	$60,000,000
FY 2017	$55,860,000
FY 2018 Current Law Mandatory	$30,000,000
FY 2018 Proposed law Mandatory	$30,000,000
FY 2019	$60,000,000

Budget Request

The FY 2019 Budget requests $60 million in discretionary resources for the THCGME Program. The Budget proposes a shift from mandatory resources to discretionary resources for this program. With this funding, HRSA will support the existing 57 THC recipients at their approved FTE level for Academic Year 2018-2019.

[69] Agency for Healthcare Research and Quality. Primary care workforce facts and stats no. 1. AHRQ Pub. No. 12-P001-2-EF. Rockville, MD. 2011.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[70]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.C.5: Number of resident positions supported by Teaching Health Centers (Cumulative)[71]	FY 2016: 742 Target: 660 (Target Exceeded)	800	800	Maintain
6.I.C.48: Percent of THCGME-supported residents training in rural and/or underserved communities	FY 2016: 83% (Baseline)	80%	80%	Maintain

Program Activity Data

THCGME Program Outputs	Year and Most Recent Result
Number of primary care residents funded by THCGME residencies[72]	FY 2016: 771
Number of primary care residents completing training	FY 2016: 248
Percent of residents who are from a disadvantaged and/or rural background	FY 2016: 35%
Percent of primary care resident program completers who intend to practice in primary care settings	FY 2016: 61%

[70] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.

[71] Measure captures the number FTEs resident slots supported and not the number of individuals receiving direct financial support through the program. Awardees may use 1 FTE slot to fund two residents at 50 percent time, thus the FTE slot is not a one to one correspondence with number of individuals trained. Number of residents also does not equal the number of graduates as primary care residency programs require one year (Dental and Geriatrics), three years (Family Medicine, Internal Medicine, and Pediatrics), or four years (Ob-Gyn and Psychiatry) of training.

[72] Measure captures the number of individual residents supported, which is different than the FTE slots.

Awards Table

	FY 2017 Final	FY 2018 Annualized Level	FY 2019 President's Budget
Number of Awards	59	57	57
Average Award	$993,789	$1,028,658	$1,028,658
Range of Awards	$48,285-$4,210,799	$48,285-$4,210,799	$48,285-$4,210,799

National Practitioner Data Bank

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Discretionary Collections	$18,814,000	$18,000,000	$18,814,000	+$814,000
FTE	35	35	35	---

Authorizing Legislation: Section 6403 of the Patient Protection and Affordable Care Act (P.L. 111-148); Title IV of the Health Care Quality Improvement Act of 1986 (P.L. 99-660); Section 1921 of the Social Security Act (Section 5(b) of P.L. 100-93, the Medicare and Medicaid Patient and Program Protection Act of 1987, as amended); and Section 1128E of the Social Security Act (P.L. 104-191, the Health Insurance Portability and Accountability Act of 1996).

FY 2019 Authorization ..... Indefinite

Allocation Method ..... User Fee Program

Program Description and Accomplishments:

The National Practitioner Data Bank (NPDB) is a workforce tool that improves health care quality, promotes patient safety, and deters fraud and abuse in the health care system by providing information about past adverse actions of practitioners, providers, and suppliers to authorized health care entities and agencies. With approximately 1.3 million reports, the NPDB helps reduce health care fraud and abuse by collecting and disclosing information to authorized entities on health care-related civil judgments and criminal convictions, adverse licensure and certification actions, exclusions from health care programs, and other adjudicated actions taken against health care providers, suppliers, and practitioners. Authorized health care entities then use this information to make informed hiring, credentialing, and privileging decisions to ultimately determine whether, or under what conditions, it is appropriate for health care practitioners, providers, and suppliers to provide health care services.

Prior to NPDB's inception, health care providers who lost their licenses or had serious unprofessional conduct moved from state to state with impunity, making it difficult for employers and licensing boards to learn about their prior acts. Through the use of the NPDB, employers and other authorized health care entities are able to receive reliable information on health care practitioners, providers, and suppliers.

- In FY 2017, the NPDB facilitated over 7 million queries from the NPDB to authorized health care providers.
- In FY 2017, the program implemented more user self-service features than ever before (most notably for Self-Query). While NPDB customer transactions increase by 60 percent, there was no appreciable increase in calls to the NPDB call center. In June 2017, the

transaction-to-call center case ratio of was 81 NPDB transactions to 1 Customer Service Center case; one year later, it was 130 to 1.

- In August 2017, the program launched attestation for HRSA's community health centers. Health center attestation marks the beginning of a multi-year compliance initiative to reach health centers, hospitals, medical malpractice payers, and health plans.

Funding History

The table below shows the user fees (revenue) collected (or expected to be collected):

FY	Amount
FY 2015	$20,159,152
FY 2016	$22,436,863
FY 2017	$18,814,000
FY 2018	$18,000,000
FY 2019	$18,814,000

Budget Request

The FY 2019 Budget requests $18.8 million for the National Practitioner Databank in user fees, which is an increase of $0.8 million above the FY 2018 Annualized CR level. This is based on HRSA's projections of 8.5 million queries on practitioners and organizations, and 250,000 self-queries, which yields estimated FY 2019 revenue projections similar to the level in FYs 2017 and 2018.

As mandated by the Health Care Quality Improvement Act, the NPDB does not receive appropriated funds and is financed by the collection of user fees. Annual Appropriations Act language since FY 1993 requires that user fee collections cover the full cost of NPDB operations; therefore, there is no request for appropriation for operating the NPDB. User fees are established at a level to cover all program costs to allow the NPDB to meet annual and long term program performance goals. Fees are established based on forecasts of query volume to result in adequate, but not excessive, revenues to pay all program costs to meet program performance goals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[73]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
8.III.B.5: Increase the number of practitioners enrolled in Continuous Query (which is a subscription service for Data Bank queries that notifies them of new information on enrolled practitioners within one business day)	FY 2017: 2,778,496 Enrolled Practitioners Target: 2,155,000 Enrolled Practitioners (Target Exceeded)	2,928,500	3,078,500	+150,000
8.III.B.7: Increase annually the number of reports disclosed to health care organizations	FY 2017: 1,730,116 Disclosures Target: 1,265,000 (Target Exceeded)	1,750,000	1,770,000	+20,000

[73] The NPDB modified the calculation method for continuous query disclosures in order to make it more consistent with the calculation method for one-time disclosures. As a result, the targets have been updated to reflect this change.

Health Workforce Cross-Cutting Performance Measures

The Bureau of Health Workforce (BHW) has tracked and reported on four cross-cutting measures for 33 of its programs that reported performance data during Academic Year 2016-2017. The cross-cutting measures focus specifically on the diversity of individuals completing specific types of health professions training programs;[74] the rate in which individuals participating in specific types of health professions training programs are trained in medically underserved communities;[75] the rate in which individuals who complete specific types of health professions training programs report being employed in a medically underserved community; and the rate in which clinical training sites provide interprofessional team-based care to patients. These measures do not currently include data from the Faculty Loan Repayment Program or the National Practitioner Data Bank.[76]

During Academic Year 2016-2017, results showed that 49 percent of graduates and program completers participating in BHW-supported health professions training and loan programs were underrepresented minorities (URMs) in the health professions and/or from disadvantaged backgrounds.[77]

With regard to the types of settings used to provide training, results showed that 56 percent of individuals participating in BHW-supported health professions training programs received at least a portion of their training in a medically underserved community just surpassing the performance target of 55 percent. Generally across all programs, more health professions trainees are being exposed to training and patient care in medically underserved communities than in prior years as a result of the Bureau's programmatic changes aimed at increasing service and training in rural and underserved areas.

Results showed that 46 percent of individuals who graduated from or completed specific types of BHW-supported training programs by June 30, 2016[78], reported working in medically underserved communities across the nation one year after graduation/completion.

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[74] BHW currently funds more than 35 health professions training and loan programs that have varying types of data reporting requirements based on the program's authorizing legislation. For the purposes of the cross-cutting measures, only programs that are required to report individual-level data are included in the calculation, as this ensures a higher level of accuracy and data quality, as well as consistency in the types of programs that are included in the calculation. Currently, 33 of the BHW-funded programs are required to report individual-level data and are included in these calculations. These programs are representative of the health professions and include oral health programs, behavioral health programs, medicine programs, nursing programs, geriatrics programs, and physician assistant programs, among others.

[75] A medically underserved community is a geographic location or population of individuals that is eligible for designation by a state and/or the federal government as a medically underserved area, a health professions shortage area, and/or medically underserved population.

[76] Nearly all grant programs are reporting performance data that is utilized in the cross-cutting measures. Only two programs do not currently report data as they have specific reporting requirements unique to their legislation.

[77] This measure includes individuals who graduated from or completed a specific type of HRSA-supported health professions training or loan program and identified as Hispanic (all races); Non-Hispanic Black or African American; Non-Hispanic American Indian or Alaska Native; Non-Hispanic Native Hawaiian or Other Pacific Islander; and/or identified as coming from a financially and/or educationally disadvantaged background (regardless of race).

[78] Measure based on data reported about graduates and program completers from Academic Year 2015-2016.

Lastly, the percent of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program was 30 percent, exceeding the target of 19 percent. This result is 9 percentage points higher than last year's result due to the programmatic emphasis of interprofessional training across programs in the Bureau.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [79]	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
6.I.B.1. Percentage of graduates and program completers of Bureau of Health Workforce-supported health professions training programs who are underrepresented minorities and/or from disadvantaged backgrounds.	FY 2016: 49% Target: 46% (Target Exceeded)	46%	TBD	TBD
6.I.C.1. Percentage of trainees in Bureau of Health Workforce-supported health professions training programs who receive training in medically underserved communities.	FY 2016: 56% Target: 55% (Target Exceeded)	55%	TBD	TBD
6.I.C.2. Percentage of individuals supported by the Bureau of Health Workforce who completed a primary care training program and are currently employed in underserved areas.[80]	FY 2016: 46% Target: 34% (Target Exceeded)	40%	TBD	TBD
6.I.1. Percent of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program.	FY 2016: 30% Target: 19% (Target Exceeded)	24%	TBD	TBD

[79] Most recent results are for Academic Year 2016-2017 and funded in FY 2016.

[80] Service location data are collected on students who have been out of the HRSA program for one year. The results are from programs that have the ability to produce clinicians with one-year post program graduation. Results are from Academic Year 2016-2017 based on graduates from Academic Year 2015-2016.

Maternal and Child Health

TAB

MATERNAL AND CHILD HEALTH

Maternal and Child Health Block Grant

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$640,163,000	$637,342,000	$627,700,000	-$9,642,000
FTE	42	42	42	---

Authorizing Legislation - Social Security Act, Title V

FY 2019 Authorization $638,200,000

Allocation Methods:
- Direct federal/intramural
- Contract
- Formula grant/cooperative agreement
- Competitive grant/cooperative agreement

Program Description and Accomplishments

The Maternal and Child Health (MCH) Block Grant program, authorized under Title V of the Social Security Act, seeks to improve the health of all mothers, children, and their families. The activities authorized as part of the MCH Block Grant program include:

- The **State MCH Block Grant program**, which awards formula grants to 59 states and jurisdictions to address the health needs of mothers, infants, and children, as well as children with special health care needs (CSHCN) in their state or jurisdiction;
- **Special Projects of Regional and National Significance (SPRANS)** that address national or regional needs, priorities, or emerging issues (such as opioids and Zika)and demonstrate methods for improving care and outcomes for mothers and children; and
- **Community Integrated Service Systems (CISS)** grants, which help increase local service delivery capacity and form state and local comprehensive care systems for mothers and children, including children with special health care needs.

The MCH Block Grant program funding, combined with state investments, provides a significant funding source to improve access to and the quality of health care for mothers, children, and their families in all 50 states, the District of Columbia and the territories. The MCH Block Grant program enables each state to:
- Assure mothers and children access to quality maternal and child health services, especially for those with low-incomes or limited availability of care;

- Reduce infant mortality;
- Provide access to prenatal, delivery, and postnatal care to women (especially low-income and at risk pregnant women);
- Increase the number of low-income children who receive regular health assessments and, follow-up diagnostic and treatment services;
- Provide access to preventive and primary care services for low income children as well as rehabilitative services for children with special health needs;
- Implement family-centered, community-based, systems of coordinated care for CSHCN; and
- Provide toll-free hotlines and assistance with applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

State MCH Block Grant Program

The State MCH Block Grant Program awards formula grants to improve care and outcomes for mothers, children, and families in all 50 states, the District of Columbia and the territories. A federal-state partnership, the State MCH Block Grant program gives states control and flexibility in meeting the unique health needs of their children and families, while HRSA assures accountability and impact through performance measurement and technical assistance.

In part, HRSA distributes funding based on a legislative funding formula tied to a state's level of child poverty compared to the overall level of child poverty in the United States. States report progress annually on key MCH performance/outcome measures and indicators. To assist states in improving their performance, HRSA provides technical assistance to states on request, as specified in Section 509(a)(4) of the Social Security Act. Each state conducts a comprehensive Needs Assessment, as mandated by law, every five years. This assessment helps each state to determine its highest MCH priorities, target funds to address them, and report annually on its progress. Federal funds, combined with statutorily required state matching investments, support activities that address individual state MCH needs.

The State MCH Block Grant continues to play an important role as payer of last resort to address gaps in coverage and services not reimbursed by Medicaid/CHIP and other third-party payers. In addition to gap-filling direct and enabling services, state MCH programs promote the access and quality of comprehensive public health services and systems of care, including quality improvement initiatives, workforce training, program outreach and population-based disease prevention and health promotion education campaigns.

Consistent with the block grant structure and driven by a commitment to improving the health and well-being of the nation's mothers, infants, children and families, HRSA continues to implement efforts to:

- **Reduce state burden** by streamlining the narrative reporting structure of the Five-Year Needs Assessment and Application/Annual Report, by reducing duplication in narrative reporting across multiple sections of the Application/Annual Report, and by pre-populating performance and outcome measure data, as available, using national data sources.

- **Maintain state flexibility** through a comprehensive needs assessment process where state needs and priorities drive the selection of national performance measures and state-specific performance measures and inform the development of a state action plan that responds to individual state MCH needs. The action plan includes evidence-based/informed strategy measures that assess the outputs of State Title V strategies and activities that drive improvement in performance measures.
- **Improve accountability** through a performance measurement framework that enables the states to describe their program efforts and demonstrate the impact of Title V on the health of mothers, children, and families, at both state and national levels.

MCHB works in partnership with the State MCH Block Grant programs to provide technical support, as requested by the state, for addressing their MCH priority needs as well as other performance and programmatic requirements of the MCH Block Grant program. HRSA makes key financial, program, performance, and health indicator data, as reported by states, available to the public at https://mchb.tvisdata.hrsa.gov/.

As a longstanding source of funding for MCH populations, the State MCH Block Grant supports a wide range of services for millions of women and children, including low-income children and children with special health care needs. Program achievements include:

- Over 76 million individuals benefitted from a service supported by the State MCH Block Grant in FY 2016. More than 3 million pregnant women and 57 million infants, children and children with special health care needs were served.
- Access to health services for mothers has improved with support of the State Block Grant program. The percentage of women who received early prenatal care in the first trimester of pregnancy increased from 71 percent in 2007 to 77 percent in 2016. Recognizing that improving maternal and child health in the United States will require, first of all, improving women's health before pregnancy, a total of 50 states and jurisdictions are now working to improve access to preventive and primary care for all women of childbearing age.
- The infant mortality rate is a widely used indicator of the nation's health. The State Block Grant program has played a lead role in the 18 percent decline in U.S. infant mortality from 7.2 infant deaths per 1,000 live births in 1997 to 5.9 infant deaths per 1,000 in 2016. Efforts to reduce the overall infant mortality rate and its contributing factors continue.
- States are also working to reduce maternal mortality, which has been rising over the past two decades, through a range of approaches. For example, many State Title V programs support comprehensive maternal mortality reviews to identify contributing factors, monitor trends, and initiate appropriate action to reduce such events in the future. In Kentucky, for example, the maternal mortality review team's findings led to the development of a patient "safety bundle" for obstetrical hemorrhage that provides standardized treatment protocols. California's MCH Block Grant program supported the development and implementation of several maternal safety bundles to improve the quality and safety of maternity care in birthing hospitals, which resulted in a 60 percent reduction in maternal deaths in California between 2006 and 2012. New York is focusing on the "pre-hospital" antecedents of maternal mortality, which include promotion of women's health and wellness across the reproductive life course and early identification and coordinated management of high-risk pregnancies.

- State MCH Block Grant programs work to achieve improved health outcomes among their individual MCH populations by removing barriers to receiving comprehensive, timely, and appropriate health care.

Below, selected National Outcome and National Performance Measures in effect from 1997 to 2015 illustrate the program's successes.

National Outcome Measures	Percent Improvement (1997 – 2015) Source: National Vital Statistics System
Infant Mortality Rate per 1,000 live births	18%
Neonatal mortality rate per 1,000 live births	19%
Post neonatal mortality rate per 1,000 live births	20%
Perinatal mortality rate per 1,000 live births plus fetal deaths	18%
Child mortality rate, ages 1 through 9 per 100,000	32%

National Performance Measures	Percent Change (1997 – 2015 unless otherwise noted)	Source
Percent of 19-35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, & Hepatitis B	63% increase (2009-2015)	National Immunization Survey (NIS)
The rate of birth (per 1000) for teenagers age 15-17 years	68% decrease	National Vital Statistics System (NVSS)
Percent of third grade children who have received protective sealants on at least one permanent molar tooth	47% increase (2000-2012)	National Health and Nutrition Examination Survey
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children	58% decrease	NVSS
The percent of mothers who breastfeed their infants at 6 months of age	50% increase (2000-2013)	NIS
Percentage of newborns who have been screened for hearing before hospital discharge	31% increase (2005-2014)	Early Hearing Detection and Intervention (EHDI)
Percent of children without health insurance	68% decrease	National Health Interview Survey

National Performance Measures	Percent Change (1997 – 2015 unless otherwise noted)	Source
Percent of children, ages 2-5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile	7% decrease (2008-2012)	Supplemental Nutrition Program for Women, Infants, and Children (WIC)
Percentage of women who smoke in the last 3 months of pregnancy	25% decrease (2000-2013)	Pregnancy Risk Assessment Monitoring System
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates	12% increase (1997-2013)	Title V Information System
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	8% increase (2007-2015)	NVSS

Special Projects of Regional and National Significance (SPRANS)

HRSA awards SPRANS grants to 1) respond to legislative set-asides and directives, 2) address critical and emerging issues of regional and national significance in maternal and child health, and 3) support collaborative and innovative learning across states so programs can utilize existing best-practices and evidence. Of the $80 million for SPRANS in FY 2017, Congress set aside approximately 15 percent to address four specific priorities: oral health, epilepsy, sickle cell disease, and Fetal Alcohol Syndrome. In addition, approximately 55 percent of the total SPRANS budget supports specific directives highlighted in the authorizing language, including genetics, hemophilia, training, and research. The remaining approximately 30 percent addresses critical and emerging issues in maternal and child health such as maternal mortality, child obesity, adolescent mental health, and opioid abuse prevention, and supports collaborative learning across states.

<u>Legislative Set-Asides</u>
In FY 2017 Congressional appropriations directed approximately $12.4 million of SPRANS funding to four areas:

- Oral health—to improve perinatal and infant oral health;
- Epilepsy—to improve access to quality services for children and youth with epilepsy in underserved areas;
- Sickle cell disease—to improve care coordination for children and families affected by sickle cell disease; and
- Fetal Alcohol Syndrome—to decrease the prevalence of alcohol use during pregnancy through provider and consumer education.

<u>Legislative Directives</u>
Topics outlined in the authorizing legislation for SPRANS include.

- *Genetics*—projects to improve access to genetic counseling and services for those at-risk of having a genetic condition and their families;
- *Hemophilia*—projects to improve the quality of care in 135 hemophilia treatment centers serving 33,000 patients with hemophilia and related blood disorders per year;
- *Training*—projects to support targeted interdisciplinary professional training in areas such as behavioral health, nutrition, public health, and adolescent health. In FY 2015, SPRANS projects trained 17,171 individuals across the country and provided continuing education to 77,297 practicing MCH professionals to improve care and outcomes for MCH populations, including state and local MCH professionals such as Title V leaders and staff, school nurses, and childcare providers;
- *Research and Data*— projects to support 1) translational research to advance MCH science and practice; 2) capacity-building in state Title V MCH programs to use data to drive improvements in programs and outcomes; and 3) a national survey (the National Survey of Children's Health). The survey is the only data source for annual national and state-by-state data on how our children and families are doing. As such, it is the only data source for many Title V outcome and performance measures to track how state MCH programs are performing (and allows them to learn from each other and improve their services in real time), as well as for 15 Healthy People Objectives.

Critical and Emerging Issues in Maternal and Child Health

SPRANS also supports projects that address critical and emerging issues in maternal and child health. For example:

- *Maternal mortality* - SPRANS supports the Alliance for Innovation in Maternal Health (AIM) to reduce maternal mortality in the United States. Building on the early successes in California, AIM is now working with 13 states and has implemented maternal safety bundles in more than 667 birthing hospitals across the country reaching 1,780,000 annual births or 45 percent of all annual births in the United States.
- *Opioids* – SPRANS supports a pilot project working with two states (Kentucky and West Virginia) to prevent HIV and Hepatitis C infections from injectable opioid abuse. SPRANS also supported AIM to develop a safety bundle on the prevention and treatment of opioid abuse during pregnancy as well as neonatal abstinence syndrome.

Collaborative Learning across the States

SPRANS improves the efficiency and effectiveness of the state MCH Block Grant program by supporting collaborative learning across the states. For example, SPRANS supported a collaborative improvement and innovation network (CoIIN) of 13 southern states to address infant mortality. The CoIIN:

- Provided a platform for the 13 states to share best practices and lessons learned with each other, and to learn from national content, methods, and data experts serving as improvement coaches for the states.
- Provided a virtual shared workspace for the states, as well as a data dashboard that provided real-time data to drive real-time improvements.
- Contributed, between 2011 and 2014, to a 30 percent reduction in early elective delivery across the 13 states, averting more than 85,000 early elective deliveries and saving state Medicaid programs hundreds of millions of dollars in unnecessary neonatal intensive care

unit (NICU) stays; and a 12 percent reduction in smoking during pregnancy, translating to approximately 18,000 fewer pregnant women smoking across the South.

Building on the successes of this CoIIN, SPRANS now supports several other CoIINs in areas such as child safety and pediatric obesity to accelerate collaborative improvement and innovation across the states.

Community Integrated Service Systems (CISS)

CISS grants are awarded on a competitive basis and support states and communities in building comprehensive, integrated system of care to improve care and outcomes for all children, including children with special healthcare needs. For example, CISS funding supports Early Childhood Comprehensive Systems (ECCS) to establish CoIIN partnerships at the community level that work together to enhance early childhood systems building and demonstrate improved outcomes in population-based children's developmental health and family well-being indicators. ECCS works with 12 states and 27 communities to improve care coordination and systems integration so that more children are healthy at birth, thriving at age three, and school ready by age five.

Table 1. MCH Block Grant Activities ($ in thousands)

MCH Activities	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
State MCH Block Grant Awards	$549,511	$547,090	$550,831
SPRANS	$80,400	$80,046	$66,593
CISS	$10,252	$10,206	$10,276
Total	**$640,163**	**$637,342**	**$627,700**

Table 2. MCH Block Grant SPRANS Set-Aside Grants ($ in thousands)

MCH SPRANS Set-Aside Programs	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
SPRANS - Other	$68,061	$67,761	$63,593
SPRANS - Oral Health	$5,237	$5,214	---
SPRANS - Epilepsy	$3,633	$3,617	---

MCH SPRANS Set-Aside Programs	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
SPRANS - Sickle Cell	$2,993	$2,980	$3,000
SPRANS - Fetal Alcohol Syndrome Demo	$476	$474	---
Total SPRANS	**$80,400**	**$80,046**	**$66,593**
CISS	**$10,252**	**$10,206**	**$10,276**

Funding History

FY	Amount
FY 2015	$637,000,000
FY 2016	$638,200,000
FY 2017	$640,163,000
FY 2018	$637,342,000
FY 2019	$627,700,000

Budget Request

The FY 2019 Budget requests $627.7 million for the MCH Block Grant program, which is a decrease of $9.6 million from the FY 2018 Annualized CR. The request prioritizes support for State MCH Block Grant formula awards, CISS projects, and SPRANS continuation awards. HRSA will not fund new SPRANS grants or re-compete SPRANS awards that are due for renewal in FY 2019. This will affect SPRANS activities in some areas including, oral health, epilepsy, fetal alcohol syndrome, and maternal and child health workforce development.

HRSA will continue to:

- Partner with states through the State MCH Block Grant program to improve the health of all mothers, adolescents, and children, particularly under-served and at-risk populations such as CYSHCN and low-income mothers and families, through a broad array of public health and community-based programs.
- Provide gap-filling services to assure access to quality health care services for all MCH populations
- Provide technical assistance to states as they address emerging issues, such as opioid abuse and Zika virus infection, as needed.
- Fund continuations of existing SPRANS awards to respond to emerging issues of regional and national significance and support collaborative learning across the states.
- Support CISS grants to improve care and outcomes for all children, including children with special healthcare needs, through service coordination and systems integration.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
10.I.A.1: The number of children served by the Maternal and Child Health Block Grant[81] *(Output)*	FY 2016:[82] 50.7M Target: 34M (Target Exceeded)	48M	51M	+3M
10.I.A.2: The number of children receiving Maternal and Child Health Block Grant services who are enrolled in and have Medicaid and CHIP coverage[83] *(Output)*	FY 2016:[84] 5.6M[85] Target: 15M (Target Not Met)	5.6M[86]	5.6M	Maintain
10.IV.B.1: Decrease the ratio of the Black infant mortality rate to the White infant mortality rate *(Output)*	FY 2016: 2.2 to 1[87,88] Target: 2.0 to 1 (Target Not Met)	2.0 to 1	2.0 to 1	Maintain

[81] The definition of "children" includes those with special healthcare needs. The definition of "served" is receiving direct, enabling, and population based services.
[82] Source: State FY 2018 MCH Block Grant Applications/FY 2016 Annual Reports, Title V Information System, HRSA/MCHB
[83] The definition of "children" includes those with special healthcare needs. The methodology for reporting this measure changed in FY 2014 to include only direct and enabling services. Prior to that time states reported on children receiving population based services as well as children receiving direct and enabling services. This change in methodology resulted in states reporting a smaller number of children served relative to the target that had been set before the methodology changed. This is because population based services reach a larger number of children per dollar spent than do individually delivered services.
[84] Source: State FY 2018 MCH Block Grant Applications/FY 2016 Annual Reports, Title V Information System, HRSA/MCHB
[85] FY 2016 results may appear low because of the changes in reporting direct and enabling services. The above table reflects the target for FY 2016 that was established prior to the change in reporting methodology.
[86] The target for FY 2018 was revised to reflect the change in methodology for reporting direct and enabling services.
[87] Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2016 on CDC WONDER Online Database, released December 2016. Data are from the Compressed Mortality File 1999-2016 Series 20 No. 2U, 2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/cmf-icd10.html
[88] National Center for Health Statistics. Natality Public Use File, 2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
10.III.A.1: Reduce the infant mortality rate *(Outcome)*	FY 2016: 5.9 per 1,000[87] Target: 5.8 per 1,000 (Target Not Met)	5.5 per 1,000	5.5 per 1,000	Maintain
10.III.A.2: Reduce the incidence of low birth weight births *(Outcome)*	FY 2016: 8.2%[88] Target: 7.8% (Target Not Met)	7.8%	7.8%	Maintain
10.III.A.3: Increase percent of pregnant women who received prenatal care in the first trimester *(Outcome)*	FY 2016: 77%[88] Target: 76% (Target Exceeded)	79%	79%	Maintain
10.3: Reduce the maternal mortality rate. (deaths/100,000 live births) *(Outcome)*[89]	FY 2014: 22.2 per 100,000 (baseline)[90] (Target Not in Place)	21.6	N/A[91]	N/A

Grant Awards Table – Maternal and Child Health Block Grant

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	59	59	59
Average Award	$9,131,524	$9,080,694	$ 9,151,082
Range of Awards	$145,466- $39,113,905	$144,656 - $38,541,369	$145,777 - $38,857,412

[89] This is a long-term measure with no annual targets. The most recent target was set for FY2018 and will be updated every 5 years.

[90] A revised baseline was established based for FY2014 using the Centers for Disease Control and Prevention, National Center for Health Statistics Compressed Mortality File 2014;including 45 states and the District of Columbia that had implemented the 2003 revision of the U.S. Standard Certificate of death or a comparable pregnancy checkbox as of January 1, 2014. File may be accessed at http://wonder.cdc.gov/cmf-icd10.html

[91] This is a long-term measure with no annual targets. The most recent target was set for FY2018 and will be updated every 5 years.

Grant Awards Table – SPRANS

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	249	249	207
Average Award	$272,508	$272,508	$261,584
Range of Awards	$14,952 - $3,500,000	$14,952 - $3,500,000	$14,952 - $3,500,000

Grant Awards Table – CISS

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	14	14	14
Average Award	$676,084	$676,084	$676,084
Range of Awards	$404,843 - $2,700,000	$404,843 - $2,700,000	$404,843 - $2,700,000

State Table

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2017[92] Final	FY 2018[93] Annualized CR	FY 2019[94] President's Budget	FY 2019 +/- FY 2018
Alabama	11,264,929	11,237,479	11,328,587	91,108
Alaska	1,057,450	1,063,094	1,087,333	24,239
Arizona	7,242,332	7,168,853	7,296,839	127,986
Arkansas	6,883,968	6,860,682	6,876,413	15,731
California	39,113,905	38,541,369	38,857,412	316,043

[92] MCH Block Grant allocations are determined by a formula, as cited in Section 502 (c) (2) of Title V of the Social Security Act, in which each state receive a base amount established from 1983 funding levels with any excess funding distributed according to each state's share of all U.S. children living in poverty. The poverty-based allocation for FY17 uses 3-year poverty data calculated from the American Community Survey, 2012-2014.
[93] The poverty-based allocation for FY18 uses 3-year poverty data from the American Community Survey, 2013-2015
[94] The poverty-based allocation for FY19 uses 3-year poverty data from the American Community Survey, 2014-2016

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2017[92] Final	FY 2018[93] Annualized CR	FY 2019[94] President's Budget	FY 2019 +/- FY 2018
Colorado	7,382,930	7,290,807	7,299,734	8,927
Connecticut	4,620,209	4,605,962	4,627,137	21,175
Delaware	1,961,971	1,972,412	1,990,992	18,580
District of Columbia	6,890,080	6,893,366	6,912,601	19,235
Florida	19,186,417	19,047,608	19,316,689	269,081
Georgia	16,928,422	16,783,140	16,933,460	150,320
Hawaii	2,153,135	2,135,954	2,135,802	-152
Idaho	3,252,956	3,229,388	3,263,675	34,287
Illinois	21,035,682	20,896,819	20,972,361	75,542
Indiana	12,140,583	12,085,479	12,166,755	81,276
Iowa	6,458,264	6,444,459	6,482,111	37,652
Kansas	4,729,794	4,703,220	4,692,491	-10,729
Kentucky	10,963,089	10,951,165	11,089,913	138,748
Louisiana	12,054,384	12,067,905	12,270,038	202,133
Maine	3,310,719	3,286,771	3,306,933	20,162
Maryland	11,673,326	11,659,029	11,731,502	72,473
Massachusetts	11,038,348	11,018,409	11,042,121	23,712
Michigan	18,725,742	18,578,367	18,669,724	91,357
Minnesota	9,039,369	9,000,707	9,062,034	61,327
Mississippi	9,170,542	9,102,262	9,145,227	42,965
Missouri	12,107,084	12,033,376	12,091,607	58,231
Montana	2,277,159	2,276,100	2,268,237	-7,863
Nebraska	3,986,203	3,981,428	3,988,735	7,307
Nevada	2,083,713	2,042,348	2,072,033	29,685
New Hampshire	1,989,264	1,956,175	1,955,635	-540
New Jersey	11,460,935	11,463,882	11,526,613	62,731
New Mexico	4,060,131	4,044,153	4,100,787	56,634
New York	37,781,882	37,690,629	37,968,161	277,532
North Carolina	17,222,472	17,103,681	17,226,213	122,532
North Dakota	1,725,639	1,727,233	1,744,875	17,642

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2017[92] Final	**FY 2018[93] Annualized CR**	**FY 2019[94] President's Budget**	**FY 2019 +/- FY 2018**
Ohio	21,917,021	21,765,846	21,930,711	164,865
Oklahoma	6,956,304	6,931,897	7,038,872	106,975
Oregon	6,217,387	6,164,584	6,171,771	7,187
Pennsylvania	23,480,555	23,447,566	23,667,534	219,968
Rhode Island	1,624,486	1,622,998	1,622,569	-429
South Carolina	11,408,634	11,341,765	11,393,105	51,340
South Dakota	2,147,032	2,153,398	2,169,188	15,790
Tennessee	11,714,889	11,667,474	11,744,454	76,980
Texas	33,822,318	33,537,482	34,211,850	674,368
Utah	6,127,189	6,092,917	6,088,271	-4,646
Vermont	1,646,665	1,639,272	1,645,587	6,315
Virginia	12,128,653	12,121,239	12,218,466	97,227
Washington	8,834,688	8,742,953	8,709,035	-33,918
West Virginia	6,055,641	6,061,535	6,086,827	25,292
Wisconsin	10,851,318	10,791,346	10,825,111	33,765
Wyoming	1,194,729	1,185,070	1,188,247	3,177
SUBTOTAL	**519,100,537**	**516,211,053**	**520,212,378**	**4,001,325**
American Samoa[95]	484,884	482,185	485,922	3,737
Guam	748,877	744,708	750,481	5,773
Marshalls	226,278	225,018	226,763	1,745
Micronesia	511,823	508,974	512,919	3,945
Northern Marianas	457,947	455,397	458,927	3,530
Palau	145,466	144,656	145,777	1,121
Puerto Rico	15,613,262	15,526,353	15,646,703	120,350
Virgin Islands[96]	1,470,815	1,462,628	1,473,965	11,337
SUBTOTAL	**19,659,352**	**19,549,919**	**19,701,457**	**151,538**
TOTAL Resources	**538,759,889**	**535,760,972**	**539,913,835**	**4,152,863**

[95] Funds provided in the Zika Supplemental are not included in this table
[96] Funds provided in the Zika Supplemental are not included in this table

Autism and Other Developmental Disabilities

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$46,985,000	$46,779,000	---	-$46,779,000
FTE	6	6	---	-6

Authorizing Legislation - Public Health Service Act, Section 399BB, reauthorized by Public Law 113-157, Section 4

FY 2019 Authorization ..... Not Specified

Allocation Methods:

- Direct federal/intramural
- Contract
- Competitive grant/cooperative agreement
- Other

Program Description and Accomplishments

The Autism and Other Developmental Disabilities program improves care and outcomes for children and adolescents with autism spectrum disorder (ASD) and other developmental disabilities (DDs) through training, advancing best practices, and service. The Autism and Other Developmental Disabilities program began in 2008 as authorized by the Combating Autism Act of 2006. The Autism Collaboration, Accountability, Research, Education and Support, or Autism CARES Act reauthorized the program in 2014. The program supports training programs, research, and state systems grants to:

- Improve access to early screening, diagnosis and intervention for children with ASD or other DDs;
- Increase the number of professionals able to diagnose ASD and other DDs;
- Promote the use of evidence-based interventions for individuals at higher risk for ASD and other DDs as early as possible;
- Increase the number of professionals able to provide evidence-based interventions for individuals diagnosed with ASD or other DDs;
- Provide information and education on ASD and other DDs to increase public awareness;
- Promote research and information distribution on the development and validation of reliable screening tools and interventions for ASD and other DDs; and
- Promote early screening of individuals at higher risk for ASD and other DDs.

Training Programs: The program has two main training components, the Leadership Education in Neurodevelopmental and Other Related Disabilities (LEND) program and the Developmental-

Behavioral Pediatrics (DBP) Training program. LEND programs provide interdisciplinary training to enhance the clinical expertise and leadership skills of professionals dedicated to caring for children with neurodevelopmental and other related disabilities including autism. DBP trains the next generation of leaders in developmental-behavioral pediatrics and provides pediatric practitioners, residents, and medical students with essential biopsychosocial knowledge and clinical expertise. For the most recent evaluation period, FY 2011-2014, the LEND and DBP programs collectively:

- Provided diagnostic evaluations for ASD and other DDs to more than 224,000 children.
- Provided training to nearly 16,000 pediatricians, developmental-behavioral pediatrics specialists, and other health professionals.
- Provided more than 3,000 continuing education events on early screening, diagnosis, and intervention that reached over 214,000 pediatricians and other health professionals.

Research: To improve the health and well-being of children with ASD, HRSA supports five research networks and investigator-initiated autism intervention research projects. HRSA supports research and development of reliable screening tools for ASD and other developmental disabilities and research to advance the evidence base on the effectiveness of interventions to improve the physical and behavioral health of individuals with ASD and other DDs, develop guidelines for those interventions, and disseminate information regarding these research findings, tools, and guidelines. These research investments address the Interagency Autism Coordinating Committee Strategic Plan research questions around improving early identification and advancing effectiveness of interventions and services for children with ASD and other developmental disabilities. Recent accomplishments include:

- From 2011-2014, the research programs funded 57 studies on physical and behavioral health issues related to ASD and other DDs, screening and diagnostic measures, early intervention, and transition to adulthood.
- Collectively, the research programs developed 42 new measures and tools, including diagnostic and screening tools and outcome measures that are helping to guide provider practice.
- From 2011-2014, research grantees prepared 209 publications for peer reviewed journals, of which 105 were published, and the remainder were in progress. HRSA autism research helps underserved populations overcome barriers to diagnosis and access needed services.

State Systems grants: The Autism and Other Developmental Disabilities program supports state systems grants to improve access to comprehensive, coordinated health care and related services for children and youth with ASD and other DDs.

Funding History

FY	Amount
FY 2015	$47,099,000
FY 2016	$47,099,000
FY 2017	$46,985,000
FY 2018	$46,779,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0, which is a decrease of $46.8 million from the FY 2018 Annualized CR. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
50.I.A.1 Percent of long-term trainees (LEND, DBP) working with underserved populations, 5 years post-training.	FY 2015[97]: LEND 75.3% DBP 85.7% (baseline Target: NA)	Maintain FY 2017 Result[98]	N/A	N/A
50.I.A.2 Percent of LEND long-term trainees who at 1, 5, and 10 years post-training, work in an interdisciplinary manner to serve the MCH population	FY 2015 Result: 1 year = 78 % 5 years = 80.6% (baseline Target: NA)	Maintain FY 2017 Result[99]	N/A	N/A

[97] The data source for this measure is the Discretionary Grants Information System.
[98] The FY2017 target for this measure is set at a 0.5 percentage point increase in the prior year. A continued increase is not anticipated in in FY 2018 and therefore the target has been set to maintain the results that will be reported in FY2017.
[99] The FY2017 target for this measure is set at a 0.25 percentage point increase in the prior year. A continued increase is not anticipated in in FY 2018 and therefore the target has been set to maintain the results that will be reported in FY2017.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
50.I.A.3 Percent of MCHB Autism research programs supporting the production of scientific publications (*Developmental*)	Baseline data for FY 2017 will be available in 2019	N/A	N/A	N/A

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
LEND	$31,655,250	$31,892,453	---
DBP	$1,848,853	$1,906,150	---
Research	$7,123,654	$7,124,950	---
State Systems	$1,680,000	$1,680,000	---
Resource Centers	$1,076,000	$1,076,000	---
Number of Awards	**76**	**76**	**---**
Average Award	**$570,839**	**$574,731**	**---**

Sickle Cell Disease Treatment Demonstration Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$4,444,000	$4,425,000	---	-$4,425,000
FTE	2	2	---	-2

Authorizing Legislation - American Jobs Creation Act of 2004, Public Law 108-357, Section 712(c)

FY 2019 Authorization .....Expired

Allocation Methods:

- Competitive cooperative agreement
- Contract

Program Description and Accomplishments

The Sickle Cell Disease Treatment Demonstration Program (SCDTDP) improves access to care and health outcomes for individuals with sickle cell disease, a genetic condition that results in abnormal red blood cells that can block blood flow to organs and tissues, causing anemia, periodic pain episodes, damage to tissues and vital organs, and increased susceptibility to infections and early death. While life expectancy of individuals with sickle cell disease has increased, affected populations have not benefitted equally from therapies. Specifically, until July 2017 hydroxyurea was the only FDA approved therapy for sickle cell disease; however many patients who could benefit from hydroxyurea do not have access to it. Barriers to access include a lack of knowledge of the benefits and a limited number of providers prescribing hydroxyurea. SCDTDP grantees work to address these barriers and improve the prevention and treatment of the complications of sickle cell disease by:

- Coordinating service delivery;
- Assessing patient need for genetic counseling and testing, and providing referral as appropriate;
- Providing guidance and technical assistance;
- Training health professionals on evidence-based treatment of sickle cell disease, such as hydroxyurea; and
- Expanding and coordinating patient education, treatment, and care continuity.

In FY 2014-2016, the four SCDTDP grantees developed regional clinical networks, covering 25 states, Washington, DC, and 2 territories, to improve the delivery of care for patients with sickle cell disease, primarily by training health professionals and supporting regional coordination for service delivery through telementoring, and improve data collection to inform the delivery of

care. As a result, almost 11,000 patients with sickle cell disease received care through the four regional clinical networks. In FY 2017, the program was recompeted and five organizations received grants to develop Regional Coordinating Centers that cover the United States. The program aims to support at least 25 states where about 50% of the 100,000 individuals live with sickle cell disease in the United States.

Efforts have improved sickle cell disease patients' access to appropriate sickle cell care. Each Sickle Cell Regional Coordinating Center grantee collects data to monitor the progress of these activities and evaluate program outcomes. Grantee performance will be demonstrated by the number of patients served and the number of patients on hydroxyurea.

Funding History

FY	Amount
FY 2015	$4,455,000
FY 2016	$4,455,000
FY 2017	$4,444,000
FY 2018	$4,425,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0, which is a decrease of $4.4 million from the FY 2018 Annualized CR. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	5	5	---
Average Award	$691,404	$691,404	---
Range of Awards	$345,703-$1,037,105	$345,703-$1,037,105	---

James T. Walsh Universal Newborn Hearing Screening

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$17,775,000	$17,697,000	---	-$17,697,000
FTE	4	4	---	-4

Authorizing Legislation - Public Health Service Act, Section 399M, as amended by Public Law 111-337, Section 2, and Public Law 115-71, Section 2

FY 2019 Authorization $18,173,800

Allocation Methods:

- Competitive grant
- Cooperative agreement

Program Description and Accomplishments

The James T. Walsh Universal Newborn Hearing Screening Program (UNHS Program) enables states and territories to develop statewide comprehensive and coordinated systems of care to ensure that newborns/infants receive hearing screenings and those who are diagnosed as deaf or hard of hearing receive appropriate and timely services. The Children's Health Act of 2000 (P.L. 106-310) authorized the UNHS Program in FY 2000. The Early Hearing Detection and Intervention Act of 2017 (P.L. 115-71) recently amended and reauthorized the program. The UNHS Program supports state and territorial efforts to:

- Develop statewide early hearing detection and intervention (EHDI) programs and systems;
- Recruit, retain, educate, and train qualified personnel and health care providers; and
- Establish and foster family-to-family support mechanisms after a child is identified with hearing loss.

The UNHS Program funds 59 competitive grants to states and territories to develop comprehensive and coordinated statewide EHDI systems of care as well as two technical resource centers that support these efforts in addition to empowering families to serve as leaders in the EHDI system. Funding also supports supplemental awards to 12 Leadership Education in Neurodevelopmental and Related Disabilities training programs supported by the Autism and Developmental Disabilities program to train future leaders in pediatric audiology. Since the program's inception, states and territories have had significant success in identifying newborns and infants with permanent hearing loss. In 2015, 98.2 percent of infants were screened for hearing loss and 60.7 percent were diagnosed appropriately, compared to 97.9 percent and 57.6 percent respectively in FY 2014. Additionally, the UNHS program continues to work with states to meet the Healthy People 2020 objectives of screening no later than one month of age,

conducting audiologic evaluations no later than 3 months of age, and enrollment in early intervention services no later than 6 months of age (1-3-6 objectives). A lack of comprehensive data reporting requirements for service providers and variability across states in timely access to such providers, among other factors, continues to be a challenge.

The UNHS program continues to focus on supporting early screening and diagnosis as recommended by Healthy People 2020. Although the program did not meet the ambitious targets set for the 1-3-6 objectives for FY 2015, overall system improvements have led to more infants being screened and identified as deaf or hard of hearing and fewer infants being lost to follow-up (when an infant does not receive the recommended follow-up services) or lost to documentation (when an infant has received services, but results have not been reported to the EHDI program and, therefore, cannot be documented). In addition, the UNHS Program encourages grantees to develop an integrated EHDI health information system that allows communication and protected data sharing among health care providers to ensure that newborns and infants receive pertinent screenings and follow-up services.

Funding History

FY	Amount
FY 2015	$17,818,000
FY 2016	$17,818,000
FY 2017	$17,775,000
FY 2018	$17,697,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0, which is a decrease of $17.7 million from the FY 2018 Annualized CR. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
13.2: Increase the percentage of infants with hearing loss enrolled in early intervention before six months of age. *(Output)*	FY 2015: 65.3%[100, 101] Target: 72% (Target Not Met)	72%	N/A	N/A
13.III.A.1: Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by three months of age. *(Output)*	FY 2015: 58.7%[100] Target: 77% (Target Not Met)	77%	N/A	N/A
13.III.A.3: Percentage of infants screened for hearing loss prior to one month of age. *(Output)*	FY 2015: 95.5%[100] Target 98% (Target Not Met)	95%	N/A	N/A
13.III.A.4 Percentage of families with deaf or hard of hearing newborns and infants that are active participants and leaders within their state/territory UNHS program and policy activities. (*Developmental*)	Baseline data for FY 2018 will be available in 2019	N/A	N/A	N/A

[100] 2015 CDC EHDI Hearing Screening & Follow-up Survey (HSFS); ((https://www.cdc.gov/ncbddd/hearingloss/2015-data/01-2015-HSFS-Data-Summary-508.pdf). The CDC has been collecting data annually since 2005. Baseline updated to reflect annual data collection. Previously, data was collected by the National Center for Hearing Assessment and Management.

[101] This measure is to be tracked annually in light of new Part C of the Individuals with Disabilities Act (IDEA) regulations that mandate collaboration with Title V programs and newborn hearing screening programs.

Grant Awards Table[102]

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	59	59	---
Average Award	$225,787	$225,787	---
Range of Awards	$68,740-$250,000	$68,740-$250,000	---

[102] Does not include $1.2 million for Universal Newborn Hearing & Screening cooperative agreement, ~$940,000 for LEND supplements, $500,000 for Family Leadership in Language and Learning, $200,000 for medical home capacity building (FY 2017), and approximately $150,000 each for Advancing Systems of Services for Children and Youth with Special Health Care Needs: medical home capacity building and technical assistance to LEND Audiology grantees (FY 2018).

Emergency Medical Services for Children

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$20,113,000	$20,025,000	---	-$20,025,000
FTE	5	5	---	-5

Authorizing Legislation – Public Health Service Act, Section 1910, as amended by Public Law 113-180, Section 2

FY 2019 Authorization $20,213,000

Allocation Method

- Competitive grant/cooperative agreement
- Contract

Program Description and Accomplishments

The Emergency Medical Services for Children (EMSC) program is the only federal grant program specifically focused on addressing the distinct needs of pediatric patients in emergency medical services. The EMSC program, authorized under the EMSC Reauthorization Act of 2014, works to ensure that seriously sick or injured children have access to the same high-quality pediatric emergency care, no matter where they live in the United States. Children make up 25 percent of hospital emergency department visits and 10 percent of emergency transports. Critically needed pediatric skills are often not available when needed in emergency care settings. It is also difficult to ensure that practitioners in these settings remain current on issues affecting children.

Additionally, EMS agencies and hospital emergency departments often do not have the necessary equipment to treat children adequately. The EMSC program works to ensure that ambulances and emergency rooms are equipped to deal with pediatric medical emergencies and trauma; emergency medical services personnel receive the appropriate training for pediatric emergencies; and guidelines and agreements are in place, which ensure the safe and effective transfer of children from one hospital to another as necessary.

In tribal and rural areas, EMSC State Partnership Regionalization of Care grantees are testing innovative models to address challenges such as fewer pediatric specialists and greater distances to critical care. Improvements in technology and care coordination help to reduce costs by

minimizing transports and expanding pediatric access to specialty care through virtual services.[103]

In recent years, the EMSC program has invested in activities that have improved the pediatric readiness of prehospital services (EMS agencies) and emergency departments as demonstrated through the data below:

- By 2013, greater than 95 percent of EMS agencies carried at least 75 percent of recommended equipment, 90 percent of EMS agencies had access to medical consultation, and 85 percent of EMS agencies had protocols for pediatric patients.
- Between 2003 and 2013, the national median pediatric readiness score improved from 55 (out of 100) to 69.[104] This score represents the degree to which an emergency department has implemented the essential components for pediatric readiness.

The EMSC program also supports the Pediatric Emergency Care Applied Research Network (PECARN), a research network that has advanced EMSC science and clinical practice, and Targeted Issue grants to EMS practitioners to research ways to improve emergency pediatric care. A specific example of how PECARN research has improved pediatric emergency care is the enrollment of 42,000 children to study the appropriate use of radiographic studies (CT scans) in children with traumatic brain injury, resulting in a clinical decision rule that has reduced children's exposure to unnecessary radiation and medical cost savings.[105]

Funding History

FY	Amount
FY 2015	$20,162,000
FY 2016	$20,162,000
FY 2017	$20,113,000
FY 2018	$20,025,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0, which is a decrease of $20.0 million from the FY 2018 Annualized CR. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

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[103] Yang, N. H., Dharmar, M., Yoo, B. K., Leigh, J. P., Kuppermann, N., Romano, P. S., ... & Marcin, J. P. (2015). Economic evaluation of pediatric telemedicine consultations to rural emergency departments. *Medical Decision Making*, *35*(6), 773-783.

[104] https://emscimprovement.center/projects/pediatricreadiness/results-and-findings The response rate for the 2003 survey was 29% (N=1,489) while the response rate for the 2013 was 82% (N=4,164).

[105] Kuppermann, N., Holmes, J. F., Dayan, P. S., Hoyle, J. D., Atabaki, S. M., Holubkov, R., ... & Badawy, M. K. (2009). Identification of children at very low risk of clinically-important brain injuries after head trauma: a prospective cohort study. *The Lancet*, *374*(9696), 1160-1170.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
14.1.A: Percent reduction in mortality rate for children with an injury severity score greater than 15. *(Outcome)*	CY 2014[106]: 9.7% decrease Target: 0.5 percentage point reduction from prior year (Target Met)	N/A[107]	N/A	N/A
14.V.B.4A: Number of awardees that have made progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric medical emergencies.[108] *(Output)*	FY 2016[109] Result: 25 Target: 26 (Target Not Met)	27	N/A	N/A
14.V.B.4B: Number of awardees that have made progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric traumatic emergencies.[110] *(Output)*	FY 2016 Result: 43 Target: 46 (Target Not Met)	44	N/A	N/A

[106] The 2014 result has been retained because this metric is no longer calculable as of CY 2015 due to changes in the data source elements. The data source for this measure is the National Emergency Department Sample, using the most currently available pediatric mortality data. Source: Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality.

[107] A FY 2018 target cannot be established for this measure because this metric is no longer calculable as of CY 2015 due to changes in the data source elements. .

[108] An organized, coordinated system that recognizes the readiness and capability of a hospital and its staff to triage and provide care appropriately, based upon the severity of illness/injury of the child. The system designates/verifies hospitals as providers of a certain level of emergency care within a specified geographic area (e.g., region).

[109] Twenty-five grantees made significant progress in implementing a pediatric medical recognition system, with a subset of 11 grantees having fully developed tiered system.

[110] An organized, coordinated trauma system that recognizes the readiness and capability of a hospital and its staff to triage and provide care appropriately, based upon the severity of injury of the child. The system designates/verifies hospitals as providers of a certain level of trauma care within a specified geographic area (e.g., region).

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
14.V.B.5: The percentage of EMS agencies in the state/territory that have a designated individual who coordinates pediatric emergency care. *(Developmental)*	Baseline data for FY 2017 will be available in 2018	N/A	N/A	N/A
14.V.B.6 The number of awardees that monitor EMS provider skill retention and performance in the use of pediatric equipment. *(Developmental)*	Baseline data for FY 2017 will be available in 2018[111]	N/A	N/A	N/A

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	74	75	---
Average Award	$235,053	$238,761	---
Range of Awards	$130,000-$3,000,000	$130,000-$3,000,000	---

[111] This is a new performance measure that launched on March 1, 2017. Baseline data collection is underway during the EMSC grant year (3/1/2017 to 2/28/2018). A baseline will be established in 2018 following data collection and analysis.

Healthy Start

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$118,251,000[112]	$102,797,000	$103,500,000	+$703,000
FTE	15	15	15	---

Authorizing Legislation - Public Health Service Act, Section 330H, as amended by Public Law 110-339, Section 2

FY 2019 Authorization .....Expired

Allocation Method ..... Competitive grant/cooperative agreement

Program Description

HRSA's Healthy Start program provides grants to support community-based strategies to reduce disparities in infant mortality and improve perinatal outcomes for women and children in high-risk communities throughout the nation. Major and persistent racial and ethnic disparities exist for infant mortality, maternal mortality, and other adverse outcomes such as preterm birth and low birth weight. In 2015, the preterm birth rate for non-Hispanic White infants was 8.9 percent compared to 13.4 percent for non-Hispanic Black infants.[113] Similarly, in 2013 the preterm-related infant mortality rate for non-Hispanic Black infants was three times higher than for non-Hispanic White infants.[114] Healthy Start aims to reduce these disparities by empowering high-risk women and their families to identify and access needed services to improve the health of mothers and children before, during, and after pregnancy. The program began in 1991 as an initiative and was authorized and expanded under the Children's Health Act of 2000 (P.L. 106-310). Healthy Start was reauthorized under the Healthy Start Reauthorization Act of 2007 (P. L. 110-339).

Healthy Start funds 100 competitive grants that reach 127 counties in 37 States and the District of Columbia. Healthy Start targets communities with infant mortality rates that are at least 1½ times the U.S. national average and/or with high indicators of poor perinatal outcomes, particularly among non-Hispanic Black and other disproportionately affected populations.

[112] Includes one-time funding of $15 million provided for lead poisoning prevention services in Flint, Michigan.
[114] Martin JA, Hamilton BE, Osterman MJK. Births in the United States, 2015. NCHS data brief, no 258. Hyattsville, MD: National Center for Health Statistics. 2016.
[114] Mathews TJ, MacDorman MF, Thoma ME. Infant mortality statistics from the 2013 period linked birth/infant death data set. National vital statistics reports; vol 64 no 9. Hyattsville, MD: National Center for Health Statistics. 2015.

Grantees use five approaches to reduce infant mortality through individual services and community support to women, infants, and families:

1) Improve women's health before, during, and between pregnancies;
2) Promote quality services;
3) Strengthen family resilience;
4) Achieve collective impact, as a result of organizations from different sectors agreeing to solve a specific social problem using a common agenda, alignment of efforts, and use of common measures of success[115]; and
5) Increase accountability through ongoing quality improvement, performance monitoring, and evaluation.

Healthy Start implements community-based interventions and ensures a well-prepared quality workforce; establishes an information system for client services coordination; and supports ongoing evaluation and quality improvement at the local and national levels. The Healthy Start service delivery model engages the entire family, working with women and their families before, during, and after pregnancy, and through the baby's second birthday. Service provision begins with direct outreach by Healthy Start community health workers to high-risk women. Each enrolled Healthy Start family receives a standardized, comprehensive assessment that considers physical and behavioral health, employment, housing, domestic violence risks, and more. Case managers link women and families to appropriate services and a medical home. Healthy Start delivers services using a range of approaches, including on-site provider/program locations, home visits, and community locations/events. Services incorporate:

- Referrals and ongoing health care coordination for well-woman, prenatal, postpartum, and well-child care;
- Case management and linkage to social services;
- Alcohol, tobacco, and other drug use counseling;
- Nutritional counseling and breastfeeding support;
- Perinatal depression screening and linkage to behavioral health services;
- Inter-conception education and reproductive life planning; and
- Child development education and parenting support.

Healthy Start works with individual communities to build upon their existing resources to improve the quality of, and access to, healthcare for women and infants. Every Healthy Start project has a Community Action Network (CAN) composed of neighborhood residents, key community leaders, perinatal care clients or consumers, medical and social service providers, as well as faith-based and business community representatives. Together they identify and address barriers in their community, including fragmented service delivery, lack of culturally appropriate health and social services, and barriers to accessing care. The CAN also coordinates care and helps ensure the maximum and non-duplicated use of resources and services.

Healthy Start projects collaborate with federal, state, and local programs, including but not limited to, the Maternal, Infant, and Early Childhood Home Visiting Program; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); Early Head Start;

[115] Kania J and Kramer M. Collective Impact. *Stanford Social Innovation Review*. 2011; 60. http://www.ssireview.org/articles/entry/collective_impact

Title V Maternal and Child Health Block Grant; Medicaid; Children's Health Insurance Program; and local perinatal systems such as those in community health centers. These collaborations strengthen the services provided and help reduce risk factors, such as substance abuse during pregnancy, while promoting healthy behaviors that can lead to improved outcomes for women and their families. Healthy Start may also provide home visiting services, but in communities where there is a home visiting program, programs are expected to collaborate in order to maximize coordination and minimize duplication.

Regular collection of program data using the Healthy Start Monitoring and Evaluation Data System enables HRSA and grantees to monitor and evaluate ongoing activities, as well as to identify technical assistance needs. HRSA supports ongoing technical assistance, training, and education for grantees through the Healthy Start EPIC Center (www.healthystartepic.org). EPIC Center services include strengthening staff skills to implement evidence-based practices in maternal and child health; facilitating grantee-to-grantee sharing of expertise and lessons from the field; and sharing resources for effective program delivery. Additionally, Healthy Start supports the Healthy Start Collaborative Improvement and Innovation Network (HS CoIIN), a collaborative learning partnership of 20 experienced grantees. This initiative strengthens the program by providing feedback to HRSA on how to effectively support Healthy Start grantees.

In FY 2017, the Water Infrastructure Improvements for the Nation Act (P.L. 114-322) authorized $15,000,000 for Healthy Start, and the Further Continuing and Security Assistance Appropriations Act of 2017 (P.L. 114-254) provided this one-time funding to address lead exposure in Genesee County, Michigan. These funds will assure that children with increased risk to lead poisoning due to the Flint water crisis receive all recommended services to minimize developmental delays.

Program Accomplishments

- HRSA transformed Healthy Start in 2014 to apply lessons from emerging research, act on national recommendations, and improve accountability. In 2016, grantees reported an overall infant mortality of 5.35 deaths per 1,000 live births, below the national average despite serving communities that historically had very high rates of infant mortality.
- An important risk factor for infant mortality is the adequacy of prenatal care. Healthy Start facilitates access to prenatal care for disadvantaged and high-risk women. In 2016, 89 percent of Healthy Start participants initiated prenatal care during the first trimester, a notable increase from 68.3 percent in 2015.
- Low birth weight, or birth weight less than 2,500 grams, is a major contributor to infant mortality and has been reduced among Healthy Start participants. In 2016, 9.9 percent of infants born to Healthy Start participants were low birth weight, compared to 10.4 percent of births to Healthy Start participants in 2015.

Consistent with the commitment to data-driven and evidence-based decision-making, in 2017 the Healthy Start program initiated a rigorous impact evaluation plan to determine the effect of the program on changes in participant-level characteristics, including behaviors, service use, and health outcomes. By collaborating with the Centers for Disease Control and Prevention (CDC) and state vital records offices, the evaluation includes non-participant comparison groups

through linked Vital Statistics and CDC Pregnancy Risk Assessment Monitoring System (PRAMS) data that will allow for rigorous assessments of program impact. Final results are expected in the Fall of 2019.

Funding History

FY	Amount
FY 2015	$102,000,000
FY 2016	$103,500,000
FY 2017	$118,251,000[116]
FY 2018	$102,797,000
FY 2019	$103,500,000

Budget Request

The FY 2019 Budget requests $103.5 million for the Healthy Start program, which is an increase of $703,000 above the FY 2018 Annualized CR. In FY 2019, the program will be recompeted and will serve women and families across the Nation through approximately 100 new grants. Healthy Start expects to serve at least 69,000 participants in FY 2019 with case managed services. Recognizing that improving birth outcomes begins with improving women's health before, during, and between pregnancies, funding will continue to strengthen services and supports to improve women's health.

The Healthy Start program will continue to support the HS CoIIN to support collaborative learning among grantees. HRSA will continue to collect program data through the Healthy Start Monitoring and Evaluation Data System in order to strengthen performance monitoring and program evaluation.

Funding also includes costs associated with the grant review and award process, follow-up performance reviews, and other program support costs.

[116] Includes one-time funding of $15 million provided for lead poisoning prevention services in Flint, Michigan.

Outcomes and Outputs Tables[117]

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
12.1: The infant mortality rate (IMR) per 1,000 live births among Healthy Start Program clients.[118] *(Outcome)*	FY 2013: 5.48 per 1,000 live births	N/A	N/A	N/A
12. III.A.1: The percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester. *(Outcome)*	FY 2016: 89%[119] Target: 75% (Target Exceeded)	75%	80%	+5% points
12.III.A.2. Percent of singleton births weighing less than 2,500 grams (low birth weight) (*Outcome*)	FY 2016: 9.9%[120] Target: 9.6% (Target not Met)	9.6%	9.6%	Maintain
12.E.2 The number of persons case managed in the Healthy Start Program with a (relatively) constant level of funding.[121] (*Efficiency*)	FY 2015: 60,000 (baseline)	69,000[122]	69,000	Maintain

[117] There are limitations that should be considered when interpreting the estimates, such as these data are obtained by self-report and may be underreported or over reported.
[118] This is a long term measure with no annual targets. The last target was set in FY 2013. The next long term target will be set for 2020 and every 5 years thereafter.
[119] Note that the FY2016 result was reported as 80% in the FY2018 Congressional Justification. HRSA has updated this result to 89% based on more recent data.
[120] Note that the FY2016 result was reported as 10% in the FY2018 Congressional Justification. HRSA has updated this result to 9.9% to be more precise.
[121] This measure does not include clients served through Addressing and Preventing Lead Exposure through Healthy Start, the program to address lead exposure in Flint, MI.
[122] Target adjusted from 74,000 as set in the FY 2018 Congressional Justification to reflect FY 2018 Annualized CR funding levels.

Grant Awards Table[123]

	FY 2017 Final[124]	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	100 / 1	100	100
Average Award	$920,737 / $14,975,000	$920,737	$920,737
Range of Awards	$372,768-1,814,000 / $14,975,000	$372,768-$1,814,000	$372,768-$1,814,000

[123] Does not include grant offsets. Does not include amounts awarded for two technical assistance awards that are both approximately $2 million, the HS CoIIN and Supporting Healthy Start Performance Project. .
[124] Column represents Healthy Start grants/Healthy Start Addressing and Preventing Lead Exposure through Healthy Start grant. FY 2017 Final does not include the $15 million provided for lead poisoning prevention services in Flint, Michigan.

Heritable Disorders in Newborns and Children

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$13,850,000	$13,789,000	---	-$13,789,000
FTE	3	3	---	-3

Authorizing Legislation – Public Health Service Act, Section 1109-1112 and 1114, as amended by Public Law 113-240, Section 10

FY 2019 Authorization……$11,900,000

Allocation Methods:

- Contract
- Competitive grant/cooperative agreement

Program Description and Accomplishments

The Heritable Disorders in Newborns and Children program focuses on reducing the morbidity and mortality caused by heritable disorders in newborns and children by supporting state and local public health agencies' ability to provide screening, counseling, and health care services. Four million newborns each year are screened for at least 29 of the 34 conditions on the Recommended Uniform Screening Panel (RUSP), a list of conditions recommended by the Secretary of HHS for state newborn screening programs. Babies testing positive for one of these conditions receive early intervention and treatment to prevent serious problems such as brain damage, organ damage, and even death. Newborn screening saves or improves the lives of more than 12,000 babies in the United States each year. The Heritable Disorders in Newborns and Children program was authorized in 2000 and was reauthorized by the Newborn Screening Saves Lives Reauthorization Act of 2014.

The program is composed of six different projects.

- The **Newborn Screening Data Repository and Technical Assistance Center** (the Center) seeks to enhance, improve and expand the newborn screening system by supporting state public health newborn screening programs, public health professionals, and primary and specialty care providers. The Center also tracks and estimates the incidence of screened conditions. These data help the Center assist states and territories to implement quality improvement activities, evaluate newborn screening program impact, and address gaps in newborn screening follow-up. In addition, the Center supports states with implementing conditions recently added to the RUSP.

- The **Quality Improvement in Newborn Screening Program** supports states to improve the outcomes of newborns with conditions identified through newborn screening by improving: the amount of time it takes to identify infants at high risk for having one of these conditions; the processes used for detecting out-of-range results; improving the procedures for reporting out-of-range results to providers; and the methods state newborn screening programs use to confirm diagnoses. In addition, the program addresses emerging issues, or any other NBS process or procedure that could negatively affect the quality, accuracy, or timeliness of NBS. The program supports 30 states to use quality improvement methodology to improve the newborn screening system.
- The **Newborn Screening Family Education Program** seeks to increase awareness, knowledge, and understanding of newborn screening for parents, families, patient advocacy and support groups, as well as the public at large.
- The **Regional Genetics Networks** address the challenges of enhancing, improving, or expanding access to screening, counseling, and health care services for newborns and children having or at risk for genetic disorders. The networks link patients to genetic services and provide resources to genetic service providers, public health officials and families.
- **Severe Combined Immunodeficiency (SCID) Implementation Program**: SCID is a primary immune deficiency characterized by the lack of a functioning immune system that, if untreated, leads to death in infancy. The program works to increase awareness and knowledge about SCID and newborn screening for SCID among parents, families, health care providers, public health professionals, and the public; provide education, training, and support for newborn screening programs; link children with SCID and their families to clinical services; and improve clinical care through education and training for providers caring for individuals with SCID.
- Since 2009, the **Clearinghouse of Newborn Screening Information** serves as a central source of current educational and family support information, materials, resources, research, and data on newborn screening. The Clearinghouse is interactive and contains links to various resources including government-sponsored, non-profit organizations, laboratories, and other organizations with expertise in newborn screening; research-based information on newborn screening tests currently available throughout the United States; and information about newborn conditions and screening services available in each state.

The Heritable Disorders in Newborns and Children program also supports the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (the Committee), which was re-chartered in FY 2015 as part of the Newborn Screening Saves Lives Reauthorization Act of 2014. The Committee advises the Secretary on reducing mortality or morbidity from heritable disorders, conducts evidence-based reviews of conditions to recommend updates to the RUSP, and considers ways to ensure state and territory capacity to screen for RUSP conditions.

Funding History

FY	Amount
FY 2015	$13,883,000
FY 2016	$13,883,000
FY 2017	$13,850,000
FY 2018	$13,789,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0, which is a decrease of $13.8 million from the FY 2018 Annualized CR. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	12	11	---
Average Award	$972,917	$1,072,727	---
Range of Awards	$599,999-2,000,000	$599,999-2,000,000	---

Family-To-Family Health Information Centers

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	---	---	$5,000,000	+$5,000,000
Current Law Mandatory Funding	$4,655,000	---	---	---
Proposed Law Mandatory Funding	---	$5,000,000	---	-$5,000,000
Total	$4,655,000	$5,000,000	$5,000,000	---
FTE	1	1	1	---

Authorizing Legislation - Social Security Act, Section 501(c)(1)(A) as amended by Public Law 114-10, Section 216

FY 2019 Authorization……Expired

Allocation Method ..... Competitive grants

Program Description and Accomplishments

The Family-to-Family Health Information Centers (F2F HICs) Program assists families of children and youth with special health care needs (CYSHCN) to be partners in health care decision making. Staffed by family members who have first-hand experience using health care services and programs for CYSHCN, F2F HICs promote cost-effective, quality health care by providing patient-centered information, education, technical assistance, and peer support to families of CYSHCN and health professionals. Authorized by the Deficit Reduction Act of 2005, the program funds one health information center in each of the 50 states and the District of Columbia. It was most recently reauthorized through the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015.

The 51 F2F HICs empower families of CYSHCN to be partners in health care decision making by:

- Helping families gain the knowledge and skills to make informed health care choices that promote good treatment decisions, cost effectiveness, and improved health outcomes;

- Developing models for building working relationships between families and health professionals to assist in providing appropriate services and information;
- Providing training and guidance to health professionals on the care of CYSHCN;
- Conducting outreach activities to families, health professionals, schools, and other appropriate entities to increase their knowledge of F2F HICs and the resources available for CYSHCN and their families; and
- Enlisting families of CYSHCN and health professionals to staff these efforts.

Research supports the effectiveness of the F2F HIC strategy.[125] Evidence shows CYSHCN experience improved health outcomes and cost-savings when families are empowered to make informed choices about their care and partner with health professionals.[126] Documented outcomes include:

- Improved transition from pediatric to adult health care systems;
- Fewer unmet health needs, better community-based systems;
- Fewer problems with specialty referrals;
- Lowered out-of-pocket costs;
- Improved physical and behavioral functions; and
- Increased access to preventive health care in a medical home.

In FY 2017 F2F HICs provided services to approximately 184,000 families, which exceeded the target of 166,000 families. In addition, in FY 2017, F2F HICs trained and provided information, resources, and referrals to approximately 85,500 health professionals who serve CYSHCN and their families within community and state public health agencies, managed care and insurance organizations, medical practices, children's hospitals, universities, Federally Qualified Health Centers, and more.

FY 2018 data will be collected and reported in the fall of 2018.

Funding History

FY	**Amount**
FY 2015	$5,000,000
FY 2016	$5,000,000
FY 2017	$4,655,000[127]
FY 2018 Current Law Mandatory Funding	---
FY 2018 Proposed law Mandatory Funding	$5,000,000
FY 2019	$5,000,000

[125] Perrin JM, Romm D, Bloom SR, Homer CJ, Kuhlthau KA, Cooley C, Duncan P, Roberts R, Sloyer P, Wells N, Newacheck P. A Family-Centered, Community-Based System of Services for Children and Youth With Special Health Care Needs. *Arch Pediatr Adolesc Med.* 2007;161(10):933-936. doi:10.1001/archpedi.161.10.933

[126] Smalley, L.P., Kenney, M.K., Denboba, D.D., & Strickland, B. (2013). Family perceptions of shared decision-making with health care providers: Results of the National Survey of Children with Special Health Care Needs, 2009-2010. *Maternal and Child Health Journal*.

[127] FY 2017 reflects the post-sequestration funding amount.

Budget Request

The FY 2019 Budget requests $5.0 million for the Family-to-Family Health Information Centers (F2F HICs). FY 2019 funding will support 51 F2F HIC grants to enable families of CYSHCN to partner in health care decision making at all levels to improve health outcomes for CYSHCN and achieve cost-savings for families. The FY 2019 funding will help ensure continued delivery of patient-centered information, education, technical assistance, and peer support to families of CYSHCN. These family-staffed centers will provide other enabling support to families and health professionals serving them including training and guidance to health professionals on the care of CYSHCN and building joint working relationships between families and health professionals to improve delivery of appropriate care.

Funding also includes costs associated with the grant review and award process, follow-up performance reviews, and other program support costs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
15.III.C.1: Number of families with CSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers (Output).	FY 2017: 184,002 Target: 166,000 (Target Exceeded)	174,300	174,300	Maintain

Grant Awards Table [128]

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	51	51	51
Average Award	$89,643	$91,845	$91,845
Range of Awards	$76,987-$90,030	$91,845	$91,845

[128] Does not include carryover funding.

Maternal, Infant, and Early Childhood Home Visiting Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	---	---	$400,000,000	+$400,000,000
Current Law Mandatory Funding	$372,400,000	---	---	---
Proposed Law Mandatory Funding	---	$400,000,000	---	-$400,000,000
Total	$372,400,000	$400,000,000	$400,000,000	---
FTE	43	43	43	---

Authorizing Legislation - Social Security Act, Section 511(j), as amended by Public Law 114-10, Section 218

FY 2019 Authorization .....Expired
Allocation Methods:

- Direct federal/intramural
- Contract
- Formula grant/cooperative agreement
- Competitive grant/cooperative agreement

Program Description
The Maternal, Infant, and Early Childhood Home Visiting Program, (MIECHV), supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry. The MIECHV Program builds upon decades of scientific research showing that home visits by a nurse, social worker, or early childhood educator during pregnancy and in the first years of life have the potential to improve the lives of children and families by:

- Helping to prevent child abuse and neglect;
- Encouraging positive parenting;
- Improving maternal and child health; and
- Promoting child development and school readiness.

By providing necessary resources and supports, home visiting empowers families. As research[129,130] shows, home visiting services provide a positive return on investment to society through savings in public expenditures such as emergency room visits, public benefits, and child protective services, as well as increased tax revenues from working parents.

States, territories, and tribal entities participating in MIECHV direct their home visiting efforts to at-risk communities. The statute defines at-risk communities as those with concentrations of:

- Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;
- Poverty;
- Crime;
- Domestic violence;
- High rates of high school drop-outs;
- Substance abuse;
- Unemployment; or
- Child maltreatment.[131]

Grantees deliver services by implementing one or more of 18 evidence-based home visiting models, selected by the grantee, which meet established evidence of effectiveness criteria, as required by statute. Administered by the Administration for Children and Families (ACF), the Home Visiting Evidence of Effectiveness review (HomVEE) assesses the research literature to determine which home visiting models meet the HHS criteria for evidence of effectiveness. While there is some variation across the 18 evidence-based home visiting models from which grantees may select (e.g., some programs serve expectant mothers as well as parents with young children, while others only serve families after the birth of a child), all models share some common characteristics. In these voluntary programs, trained professionals meet regularly with expectant parents or families with young children in their homes, building strong, positive relationships with families who want and need support. Home visitors work with families to determine their specific needs and provide services tailored to those needs, such as:

- Teaching parenting skills and modeling effective parenting techniques;
- Promoting early learning in the home with an emphasis on positive interactions between parents and children and the creation of a language-rich environment that stimulates early language development;
- Providing information and guidance on a wide range of topics including breastfeeding, safe sleep position, injury prevention, and nutrition;
- Conducting screenings and providing referrals to address caregiver depression, substance abuse, and family violence;
- Screening children for developmental delays and facilitating early diagnosis and intervention for autism and other developmental disabilities; and
- Connecting families to other services and resources as appropriate.

[129] Karoly, L, et al. (2005). Early Childhood Interventions: Proven Results, Future Promise. RAND Corporation. Santa Monica, California. Available at: http://www.rand.org/pubs/monographs/MG341.html
[130] Washington State Institute of Public Policy. Benefit-Cost Results. Available at: http://www.wsipp.wa.gov/BenefitCost
[131] 42 U.S.C. § 711(b)(1)(A).

MIECHV grantees have the flexibility to tailor the program to serve the specific needs of their states and at-risk communities. In order to meet those needs, grantees conduct needs assessments to identify eligible at-risk communities, determine priority populations, and choose which approved evidence-based models or promising approaches for home visiting will be used. Grantees work with local implementing agencies to:

- Build infrastructure for implementation of home visiting programs;
- Train a high-quality home visiting workforce;
- Provide home visiting services to eligible families;
- Establish data reporting, performance measurement, continuous quality improvement, and financial accountability systems; and
- Develop referral networks to enroll families and facilitate service coordination in local communities.

MIECHV distributes funds for delivery of services under early childhood home visiting programs through three types of awards:

1) Formula Grants to states, territories, and nonprofit organizations
2) Competitive Cooperative Agreements to Indian tribes (or a consortium of Indian tribes), tribal organizations, and urban Indian organizations, as defined in section 4 of the Indian Health Care Improvement Act.
3) Competitive Innovation Awards to states, territories, and nonprofit organizations

Additionally, three percent is set aside for research, evaluation, and corrective action technical assistance to grantees.

Formula grants to states and territories

In FY 2017, HRSA awarded $342 million in MIECHV formula grants to 56 states, territories, and nonprofit organizations. Grants are generally administered by the lead state agency for home visiting designated by the Governor or can be competitively awarded to a nonprofit organization in those states or territories that opted not to participate in the grant program.

By law, state and territory grantees must spend the majority of their MIECHV funds to implement evidence-based home visiting models, with up to 25 percent of funding available to implement promising approaches for home visiting that undergo rigorous evaluation. In FY 2017, three states implemented and evaluated three promising approaches to better address the needs of their communities.

Cooperative agreements to Indian tribes, tribal organizations, and urban Indian organizations

Three percent of funding is set aside for five-year competitive awards available to tribal entities. As of FY 2017, 29 tribal entities had received funding through the Tribal Home Visiting program, administered by ACF. There are currently 25 Tribal Home Visiting program grantees. The Tribal Home Visiting Program is designed to:

- Develop and strengthen tribal capacity to support and promote the health and well-being of American Indian and Alaska Native families through home visiting programs;
- Expand the evidence base around home visiting in tribal communities; and

- Support and strengthen cooperation and linkages between programs that serve Native children and their families.

Grantees may choose to implement either Family Spirit, the one evidence-based home visiting model with evidence of effectiveness in tribal communities, or a promising approach for home visiting (which includes any model that meets the evidence of effectiveness criteria for the formula grants but does not have specific evidence of effectiveness in American Indian and Alaska Native populations).

The Tribal Home Visiting Program also supports the Tribal Early Learning Initiative, a partnership between ACF and tribal communities that have Tribal Home Visiting, AI/AN Head Start, and Tribal Child Care and Development Fund programs. The eight tribal communities participating in the Tribal Early Learning Initiative work to strengthen early childhood systems by coordinating and collaborating across the three programs, breaking down traditional silos to improve program efficiency and outcomes for young children and their families. Grantee accomplishments include developing a single enrollment form across programs, agreeing on common assessment tools to be used by all tribal early learning and development programs, investing in a data system to allow for better coordination and sharing of relevant data across programs, and implementing joint professional development and training activities for all early childhood staff.

Competitive Innovation Awards

Beginning in FY 2016, HRSA revised the approach for distributing competitive funds to states. Under the new approach, HRSA awarded competitive grants in FY 2017 to support innovations that strengthen and improve the delivery of voluntary early childhood home visiting services to eligible families, specifically related to four areas:

1. Recruitment, engagement, and retention of eligible families;
2. Development and retention of a trained, highly skilled home visiting workforce;
3. Coordination of MIECHV-funded home visiting programs with community resources and supports, including high-quality, comprehensive statewide and/or local early childhood systems, such as child health, behavioral health, and human services systems; and
4. Implementation of effective continuous quality improvement processes.

Program Accomplishments

MIECHV state and territory grantees provided nearly 4.2 million visits from FY 2012 through FY 2017. In FY 2017 states reported serving more than 156,000 parents and children in 893 counties across all 50 states, the District of Columbia, and five territories.[132] This is a 350 percent increase in the number of participants served since FY 2012 (see Tables 1 and 2 below). The program exceeded the FY 2017 targets for the number of participants and home visits. There was a slight decrease in participants and home visits from FY 2016. This reduction may be due, in part, to a change in the reporting definitions as well as not receiving data from Puerto Rico and the U.S. Virgin Islands following reporting delays due to Hurricane Maria and Irma. In

[132] FY 2017 data does not include figures for Puerto Rico and the U.S. Virgin Islands due to reporting delays related to the impact of Hurricanes Maria and Irma.

addition, data from grantees indicate reductions in staffing over the past year. Staffing reductions in turn reduce the number of participants home visiting programs are able to serve. Tribal grantees provided over 72,000 home visits from FY 2012 to FY 2017 and served over 3,500 parents and children in FY 2017.

Table 1: Number of State/Territory Participants (FY 2012 – FY 2017)[133]

Fiscal Year	Number of Participants
2012	34,180
2013	75,970
2014	115,545
2015	145,561
2016	160,374
2017[134,135]	156,297

Table 2: Number of Home Visits by State/Territory Grantees (FY 2012 – FY 2017)

Fiscal Year	Number of Home Visits
2012	174,257
2013	489,363
2014	746,303
2015	894,347
2016	979,521
2017[136,137]	942,676

MIECHV currently serves 42 percent of the highest risk counties in the country as defined by the following indicators: low birth weight, teen birth rate, percent living in poverty and infant mortality rates.

MIECHV serves many low-income families. In FY 2017:

- 72 percent of participating families had household incomes at or below 100 percent of the federal poverty guidelines ($24,300 for a family of four), and 42 percent were at or below 50 percent of those guidelines;
- 28 percent of adult program participants had less than a high school education, and 38 percent had only a high school degree or equivalent; and

[133] Data in Tables 1 and 2 represent the number of participants and home visits provided by state and territory grantees (does not include tribal data).
[134] Reflects changes HRSA made to reporting definitions beginning in FY 2017clarifying that only participants whose services were directly supported with federal funds should be included in MIECHV reports.
[135] Does not include data from Puerto Rico and the U.S. Virgin Islands due to reporting delays caused by Hurricanes Maria and Irma.
[136] Reflects changes HRSA made to reporting definitions beginning in FY 2017 clarifying that only participants whose services were directly supported with federal funds should be included in MIECHV reports.
[137] Does not include data from Puerto Rico and the U.S. Virgin Islands due to reporting delays caused by Hurricanes Maria and Irma.

- 15 percent of households included pregnant teens; 22 percent of households reported a history of child abuse and maltreatment; and 12 percent of households reported substance abuse.

Performance data from state, territory, and non-profit grantees shows that 98 percent demonstrated improvement in at least four of the six benchmark areas for demonstrating program improvements as outlined in the legislation: improving maternal and newborn health; preventing child injuries, maltreatment, and emergency department visits; improving school readiness and achievement; reducing crime or domestic violence; improving family economic self-sufficiency; and improving service coordination and referrals for other community resources and supports. In FY 2018, state and territory grantees will report for the first time on 19 standardized performance indicators and systems outcome measures. The new performance measures will allow grantees to more effectively monitor and understand program performance, and implement continuous quality improvements in home visiting.

The statute requires an evaluation of the MIECHV Program. To fulfill this requirement, the Mother and Infant Home Visiting Program Evaluation (MIHOPE) was initiated in 2011. In February 2015, HHS delivered a Report to Congress that presented the first findings from the study, including an analysis of the states' needs assessments and baseline characteristics of families, staff, local programs, and models participating in the study. MIHOPE found that women enrolled in the evaluation face multiple risk factors that can lead to adverse outcomes for themselves and their children. The study also found that local programs' infrastructure aligns with MIECHV Program expectations and supports quality service delivery for these families. Final reports on program implementation, impacts, and cost effectiveness will be available in 2018.

Funding History

FY	Amount
FY 2015	$400,000,000
FY 2016	$400,000,000
FY 2017	$372,400,000[138]
FY 2018 Current Law Mandatory Funding	---
FY 2018 Proposed Mandatory Funding	$400,000,000
FY 2019	$400,000,000

Budget Request

The FY 2019 Budget requests $400.0 million for the Maternal, Infant, and Early Childhood Home Visiting Program. FY 2019 funding will support the state, territory, and tribal administration of locally run voluntary, evidence-based home visiting services for at-risk

[138] FY 2017 reflects the post-sequestration funding amount.

families that have been proven to prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. This level of funding will provide:

- Awards to 53 state and territory grantees and three non-profit organizations;
- 25 awards to tribal entities; and
- Support for research, evaluation, and technical assistance for both corrective action and program improvement for state, territory, and tribal MIECHV grantees.

Early childhood systems-building supplements have been provided to some tribal grantees since 2012 (under the Tribal Early Learning Initiative) and may continue in FY 2019.

Funds will continue to support the statutory directive for an ongoing portfolio of research and evaluation on home visiting, which includes the MIHOPE Long-Term Follow-Up evaluation, the Home Visiting Research and Development Platform, the Home Visiting Collaborative Improvement and Innovation Network, a study of the home visiting workforce, and a tribal early childhood research center.

Technical assistance to grantees is of vital importance to ensure that home visiting services are provided with quality and fidelity to evidence-based and promising approach home visiting service delivery models. The funding will support contracts for technical assistance to state, territory, and tribal grantees for performance measurement, implementation, data systems, quality improvement, and research and evaluation to help grantees enhance the efficiency and effectiveness of their home visiting programs.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
37.1: Number of home visits to families receiving services under the MIECHV Program.[139] (*Output*)	State/ Territory/ Tribal: FY 2017: 960,180 Target: 912,000 (Target Exceeded)	State/ Territory/ Tribal: 960,000[140]	State/ Territory/ Tribal: 960,000	Maintain

[139] A home visit is the service provided by qualified professionals, delivered over time within the home to build relationships with the enrolled caregiver and the index child to achieve improved child and family outcomes. The number of "home visits" demonstrates the level of effort and service utilization for all enrollees and index children participating in the MIECHV Program.

[140] FY2018 target adjusted to reflect trends in recent data

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 Target +/- FY 2019 Target
37.2: Number and percent of grantees that meet benchmark area data requirements for demonstrating improvement. (*Outcome)*	State/Territory: FY 2016: 55 (98%) Target: 53 (95%) (Target Exceeded) Tribal: FY 2016: 22 (88%) Target: 20 (80%) (Target Exceeded)	State/ Territory: 53 (95%) Tribal: 20 (80%)	State/Territory: 55 (98%) Tribal: 22 (88%)	State/Territory: +2 (+3% points) Tribal: +2 (+8% points)
37.3: Number of participants served by the MIECHV Program (*Output)*	State/ Territory/Tribal: FY 2017: 159,844 Target: 145,000 (Target Exceeded)	State/ Territory/ Tribal: 160,000[140]	State/ Territory/ Tribal: 160,000	Maintain

Grant Awards Tables[141]

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	81	81	81
Average Award	$4,228,467	$4,407,407	$4,407,407
Range of Awards	$300,000-$22,024,005	$300,000-$23,000,000	$300,000-$23,000,000

[141] Does not include carryover funding.

Ryan White
HIV/AIDS
TAB

RYAN WHITE HIV/AIDS

Ryan White HIV/AIDS Overview

The Ryan White HIV/AIDS Program (RWHAP) supports direct health care and support services for over half a million people living with HIV (PLWH)[142] – more than 50 percent of all people living with diagnosed HIV in the United States.[143] RWHAP has a history of creating effective patient-centered services that support strong provider and patient relationships. Nearly two-thirds of clients (patients) live at or below 100 percent of the Federal poverty level. Approximately three-quarters of RWHAP clients are racial/ethnic minorities. Viral suppression outcome measures demonstrate the success of the RWHAP as 85 percent of patients receiving medical care are virally suppressed[144] - this creates a major public health benefit by also reducing new infections.

Administered by HRSA's HIV/AIDS Bureau (HAB), the RWHAP funds and coordinates with cities, states, and local clinics/community-based organizations to deliver efficient and effective HIV care, treatment, and support to low-income PLWH. The RWHAP statute indicates that the program is the "payor of last resort" which means that RWHAP funds can only be used for services not covered by other Federal or state programs, or private insurance.

During the past 27 years, RWHAP has developed a comprehensive system of safety net providers who deliver high quality direct health care and support services. This system is the foundation for reaching the public health goal of ending the HIV epidemic in the United States. The RWHAP is critical to ensuring that individuals with HIV are linked and retained in care, are able to adhere to medication regimens, and ultimately, remain virally suppressed. These steps are not only crucial to ensuring the health outcomes of PLWH but to preventing further transmission of the virus and, ultimately, ending the HIV epidemic.[145]

Research studies demonstrate a 96 percent reduction of HIV transmission to others among PLWH on antiretroviral medications who achieve viral suppression.[146] According to a *Clinical Infectious Diseases* study, clients receiving care and support at RWHAP-funded facilities are

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[142] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2015. http://hab.hrsa.gov/data/data-reports. Published December 2016. Accessed December 9, 2016.
[143] Table 18a. Persons living with diagnosed HIV infection, by year and selected characteristics, 2010–2013 - United States. CDC HIV Surveillance Report, 2014; vol. 26. http://www.cdc.gov/hiv/library/reports/surveillance/. Published November 2015.
[144] HIV viral suppression was based on data for RWHAP clients who had at least 1 outpatient ambulatory medical care visit during the measurement year and one viral load measurement and whose most recent viral load test result was <200 copies/mL.
[145] The goal of HIV treatment is to decrease viral load in PLWH, ideally to an undetectable level, known as viral suppression. When viral suppression is achieved and maintained, the risk of transmitting HIV is reduced.
[146] National Institute of Allergy and Infectious Disease (NIAID). Preventing Sexual Transmission of HIV with Anti-HIV Drugs. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000- [cited 2016 Mar 29]. Available from: http://clinicaltrials.gov/show/ NCT00074581 NLM Identifier: NCT00074581.

associated with improved outcomes (such as viral suppression), compared to others.[147] Eighty-five (85) percent of RWHAP patients are virally suppressed compared to the 58 percent of all people living with diagnosed HIV in the United States who may be in or out of care.[148,149] Furthermore, RWHAP patients are more likely to reach viral suppression regardless of other health care coverage (e.g., uninsured, Medicaid, Medicare, or private insurance). Improved viral suppression rates reduce the transmission of HIV and result in significant cost-savings to the health care system.[150]

According to recent data, the RWHAP has made tremendous progress toward ending the HIV epidemic in the United States. From 2010 to 2016, HIV viral suppression among RWHAP patients has increased from 70 percent to 85 percent, and racial/ethnic, age-based, and regional disparities have decreased.[151] These improved outcomes mean more PLWH in the United States will live near normal lifespans and have a reduced risk of transmitting HIV to others. Even with these positive outcomes, fully addressing the HIV epidemic domestically continues to be a challenge. The CDC estimates that more than 1.1 million people in the United States are living with HIV infection, and almost 1 in 6 (15 percent) of those are unaware of their HIV infection.[152] In addition, approximately 40,000 new HIV infections occur each year.[153]

Through targeted funding, the RWHAP provides opportunities for innovations to improve HIV services to low-income PLWH within the context of their health care coverage status. At local and state levels, RWHAP recipients assess unmet need and then structure their program to fill the most critical gaps to provide a comprehensive system of HIV care in their jurisdiction.

To ensure effective use of resources and a coordinated and focused public health response, HRSA works closely with the CDC and other Federal partners to provide effective services that address underlying medical, public health, and social service needs, with the ultimate goal of ending the HIV epidemic in the United States. In FY 2019, the RWHAP will continue to coordinate and collaborate with other Federal, State, and local entities as well as national AIDS organizations in order to further leverage and promote efforts to address the unmet care and treatment needs of PLWH who are uninsured and underserved. HAB's work in collaboration with other programs has bolstered the success of the RWHAP's efforts through the alignment of

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[147] Bradley H, Viall AH, Wortley PM, Dempsey A, Hauck H, Skarbinski J. Ryan White HIV/AIDS Program Assistance and HIV Treatment Outcomes. *Clin Infect Dis.* (2016) 62 (1): 90-98.
[148] Table 5a. Viral suppression during 2014 among persons aged >=13 years. Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2015. HIV Surveillance Supplemental Report 2017;22(No. 2). http://www.cdc.gov/hiv/library/reports/hivsurveillance.html. Published July 2017. Accessed December 29, 2017.
[149] Based on data reported by 32 States and the District of Columbia.
[150]The lifetime cost of medical care and medications for a PLWH is $380,000. Schackman et al. The lifetime cost of current human immunodeficiency virus care in the United States. Med Care 2006; 44(11):990-997.
[151] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2015. http://hab.hrsa.gov/data/data-reports. Published December 2016. Accessed December 9, 2016.
[152] Table 9a. Est. HIV prevalence among persons aged >= 13 years and percentages of persons living with undiagnosed HIV infection, 2014. CDC HIV Surveillance Supplemental Report 2017; Volume 22, No. 2. Available at http://www.cdc.gov/hiv/library/reports/ surveillance/. Published July 2017. Accessed December 29, 2017.
[153] Table 1a. Diagnoses of HIV infection by year of diagnosis and selected characteristics, 2011 – 2016 – United States. CDC HIV Surveillance Report 2017; Volume 28. Available at http://www.cdc.gov/hiv/library/reports/ surveillance/. Published November 2017. Accessed December 29, 2017.

the priorities, policies, and activities of the multi-faceted and comprehensive Federal response to the HIV epidemic. Federal partners include the Office of the Assistant Secretary for Health (OASH), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS), the Indian Health Service (IHS), the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), the Department of Housing and Urban Development (HUD), the Department of Veterans Affairs (VA), and the Department of Justice (DOJ) as well as other HRSA-funded programs, such as the Health Center Program.

The Administration looks forward to working with Congress to reauthorize the RWHAP to ensure that Federal funds are allocated to address the changing landscape of HIV across the United States.

The Budget request proposes statutory changes through Ryan White HIV/AIDS Program authorization to the RWHAP Part A and B funding methodologies. These changes would allow HRSA to utilize a data driven framework to distribute RWHAP Part A and B funding to ensure that funds are allocated to populations experiencing high or increasing levels of HIV infections/diagnoses, such as minority populations, while continuing to support Americans that are already living with HIV across the nation. This approach would reduce burden for recipients and increase HHS's ability to effectively focus resources for HIV care, treatment, and support needs in funded cities and states based on need, geography, data quality, and performance.

The Budget request also proposes statutory changes to the Ryan White authorization intended to simplify, modernize and standardize certain statutory requirements and definitions to be consistent across the RWHAP Parts and to reduce burden when an organization receives funding from multiple RWHAP Parts. These changes would align and consolidate the slightly differing provisions and eliminate those provisions that are no longer current.

RWHAP Part A - Emergency Relief Grants

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$654,296,000	$651,422,000	$655,876,000	+$4,454,000
MAI (non add)	$54,105,000	$54,105,000	$54,105,000	---
Total Funding	$654,296,000	$651,422,000	$655,876,000	+$4,454,000
FTE	44	44	44	---

Authorizing Legislation: Public Health Service Act, Section 2601, as amended by Public Law 111-87

FY 2019 Authorization…….……..……Expired

Allocation Method:

- Formula Grants
- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

Ryan White HIV/AIDS Program (RWHAP) Part A provides grants to cities with a population of at least 50,000, which are severely affected by the HIV epidemic. These jurisdictions are funded as either an Eligible Metropolitan Area (EMA) or a Transitional Grant Area (TGA), depending on the severity of the epidemic in their jurisdiction. Formula and supplemental grants assist eligible areas in developing and enhancing access to a comprehensive continuum of high quality, community-based care for low-income people living with HIV (PLWH). The RWHAP requires EMAs and TGAs to develop coordinated systems of HIV care in order to improve health outcomes for low-income PLWH, thereby reducing transmission of HIV. Seventy-two percent of all people living with diagnosed HIV reside in a RWHAP Part A EMA or TGA.[154,155]

RWHAP Part A prioritizes primary medical care, access to antiretroviral treatment, and other core medical and supportive services in order to engage and retain PLWH in care. The grants fund systems of care to provide services for PLWH in 24 EMAs, which are jurisdictions with

[154] Table 20a. Persons living with diagnosed HIV infection, by year and selected characteristics, 2011–2015 - United States. CDC HIV Surveillance Report, 2016; vol. 28. http://www.cdc.gov/hiv/library/reports/surveillance/. Published November 2017.

[155] Centers for Disease Control and Prevention. HIV/AIDS data through December 2015 provided for the Ryan White HIV/AIDS Program, for fiscal year 2017. HIV Surveillance Supplemental Report 2017;22(No. 5). http://www.cdc.gov/hiv/library/reports/surveillance/. Published November 2017.

2,000 or more AIDS cases over the last five years, and 28 TGAs, which are jurisdictions with at least 1,000 but fewer than 2,000 AIDS cases over the last five years as reported to the Centers for Disease Control and Prevention. Two-thirds of the funds available for EMAs and TGAs are awarded according to a formula, based on the number of living cases of HIV in the EMAs and TGAs. The remaining funds are awarded as discretionary supplemental grants based on the demonstration of additional need by the eligible EMAs and TGAs, and as Minority AIDS Initiative (MAI) grants. The MAI funds are a statutory set-aside funding component for Parts A – D, and Part F AIDS Education and Training Center programs to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. MAI funds are also awarded based on a formula utilizing the number of minorities living with HIV and AIDS in a jurisdiction and support HIV care, treatment, and support services to racial/ethnic minorities.

The RWHAP Part A funds are awarded to the Chief Elected Official who is required to establish a local Planning Council/Body that determines the allocation of RWHAP resources based on local needs assessments. Eligible sub-recipients are community health centers, health departments, ambulatory care facilities, and other non-profit organizations providing services for PLWH.

In 2016, 77 percent of RWHAP Part A clients were racial/ethnic minorities and 26 percent were women. In 2016, RWHAP Part A funded sites provided 3.6million core medical service visits for health-related care utilizing a combination of Parts A, B, C, and D funding. The number of visits for health-related services demonstrates the scope of Part A in delivering primary care and related services for PLWH by increasing the availability and accessibility of care.

RWHAP Part A Funding History

FY	Amount
FY 2010	$678,074,000
FY 2011	$672,529,000
FY 2012	$666,071,000
FY 2013	$624,262,000
FY 2014	$649,373,000
FY 2015	$655,220,000
FY 2016	$655,876,000
FY 2017	$654,296,000
FY 2018	$651,422,000
FY 2019	$655,876,000

Budget Request

The FY 2019 Budget requests $655.9 million for the Ryan White HIV/AIDS Program (RWHAP) Part A, which is $4.5 million above the FY 2018 Annualized CR level. The request will fund RWHAP activities and services for PLWH in the 24 EMAs and 28 TGAs. The FY 2019 Request proposes statutory changes through Ryan White HIV/AIDS Program authorization to the RWHAP Part A funding methodology. These changes would allow HRSA to utilize a data driven framework to distribute RWHAP Part A funding to ensure that funds are allocated to

populations experiencing high or increasing levels of HIV infections/diagnoses, such as minority populations, while continuing to support Americans that are already living with HIV across the nation. This approach would reduce burden for recipients and increase HHS's ability to effectively focus resources for HIV care, treatment, and support needs in funded cities based on need, geography, data quality, and performance.

Nearly 68 percent of all clients served by the RWHAP in 2016 were served in one of the 52 metropolitan areas funded under the RWHAP Part A. Approximately 72 percent of all PLWH reside within these metropolitan areas. The RWHAP serves populations that are increasingly diverse and challenging in terms of service delivery (e.g., PLWH at or below 100 percent Federal Poverty Level and/or those who are homeless). The clinical paradigm has changed significantly such that ongoing and effective treatment can not only enhance the quality and length of life but also can suppress the virus and reduce new infections. Thus, the RWHAP Part A has a significant public health impact on HIV incidence. These factors outline the context and role of the RWHAP Part A Program, which focuses on areas with concentrated cases of HIV, which must further develop and sustain a comprehensive system of HIV care to improve health outcomes and address the HIV epidemic.

In FY 2019, Part A grant recipients will continue to provide services not covered by private or public health care plans but which are essential to:

1. Providing quality comprehensive HIV care, such as intensive case management and care coordination services, and
2. Linking individuals living with HIV into care in a timely manner, initiating antiretroviral treatment as early as possible, and retaining them in ongoing care.

Supporting interventions that get people linked into care and on medications is critical to prevent the spread of the epidemic as studies have found that treatment reduces HIV transmission by more than 96 percent. RWHAP Part A jurisdictions are experienced in data-driven, community-based needs assessment, responsive procurement of a variety of direct medical and supportive services, working with a set of providers to weave together a constellation of services, serving diverse populations and continuing to make improvements that positively affect the HIV care continuum.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, information technology, and other program support costs.

Measuring Ryan White HIV/AIDS Program Performance

Direct Service Provision: The FY 2019 performance target for the service utilization measure is that RWHAP Part A will provide 3.6 million core medical service visits for health-related care.

RWHAP Part A funding will contribute to achieving the FY 2019 targets for the RWHAP's over-arching performance measures including: percentage of racial/ethnic minorities and women served, percentage of clients who achieved viral suppression, and percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive antiretroviral medications (in Part B Section).

Improving Access to Health Care: The RWHAP works to improve access to health care by addressing the disparities in access, treatment, and care for populations disproportionately affected by HIV, including low-income racial/ethnic minorities. Through targeted investments, the RWHAP has consistently provided HIV care and treatment services to a significantly higher proportion of HIV-positive racial/ethnic minorities than their representation in the epidemic nationally. According to the most recent CDC data (2015), 70 percent of PLWH in the United States are racial/ethnic minorities, while 73 percent of RWHAP clients are racial/ethnic minorities.[156]

The RWHAP also serves a higher proportion of women living with HIV relative to the number of HIV cases reported nationally by the CDC and has maintained this higher percentage for the past five years. In 2015, 27 percent of RWHAP clients living with HIV were women, compared to 24 percent of CDC-reported women living with diagnosed HIV infection in the United States.

Improving Health Outcomes: The RWHAP works to improve health outcomes by preventing transmission or slowing disease progression for disproportionately impacted communities. One way RWHAP accomplishes this is through the provision of medications that help patients reach HIV viral suppression. From 2010 to 2016, HIV viral suppression among RWHAP clients has increased from 70 percent to 85 percent, and racial/ethnic, age-based, and regional disparities have decreased.

PLWH who are on the appropriate medications and virally suppressed are less infectious, reducing the risk of transmitting HIV to others. The importance of helping PLWH reach viral suppression through antiretroviral medications and other medical and support services has been highlighted by studies which show antiretroviral treatment reduces HIV transmission by more than 96 percent. The RWHAP will continue to support activities that help low-income PLWH reach viral suppression until the goal of an AIDS-free generation is achieved. Two targets have been set for FY 2019 to measure progress related to antiretroviral treatment and viral suppression across the RWHAP Parts A – D:

- At least 90 percent of pregnant women living with HIV will receive antiretroviral medications through the RWHAP (in Part B section)
- At least 83 percent of all patients receiving HIV medical care and at least one viral load test will be virally suppressed.

HRSA will continue to set goals for those disproportionately impacted by HIV. At some point in their lifetimes, 1 in 16 black men will be diagnosed with HIV infection, as will 1 in 32 black women. The estimated rate of newly diagnosed HIV infections for black women was more than

[156] Table 20b. Persons living with diagnosed HIV infection, by year and selected characteristics, 2011-2015 – United States and 6 dependent areas. Centers for Disease Control and Prevention. *HIV Surveillance Report, 2016*; vol. 28. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published November 2017. Accessed December 29, 2017.

15 times that of white women and almost 5 times that of Hispanic/Latina women.[157] Black and Hispanic/Latina women accounted for 78 percent of the estimated total of all women diagnosed with HIV infection.[158] Youth (ages 13-24) make up an estimated 22 percent of all new HIV diagnoses in the United States in 2016.[159] Two performance targets have been set for FY 2019 to measure progress related to HIV care, treatment, and support of racial/ethnic minorities and women:

- The RWHAP will serve racial/ethnic minorities at a proportion that is not lower than 3 percentage points of national HIV prevalence data as reported by CDC.
- The RWHAP will serve women at a proportion that is not lower than 3 percentage points of national HIV prevalence data as reported by CDC.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 +/- FY 2019
17.I.A.2: Number of RWHAP Part A visits for health-related care.[160] *(Output)*	2016: 3.6M (Target not in place) 2015 Baseline: 3.7 M	3.7M	3.6M	-.1M
16.I.A.1: Percentage of people living with HIV served by the Ryan White HIV/AIDS Program who are racial/ethnic minorities.[161] *(Outcome)*	2016: 73.2% Target: Within 3 percentage points of CDC data (CDC data not available) 2015: 73.1% Target: Within 3 percentage points of	Not lower than 3 percentage points of CDC data	Not lower than 3 percentage points of CDC data	Maintain

[157] Table 3a. Diagnoses of HIV infection by race/ethnicity and selected characteristics, 2016 – United States. CDC HIV Surveillance Supplemental Report 2017; Volume 28. http://www.cdc.gov/hiv/library/reports/ surveillance/. Published November 2017. Accessed December 29, 2017.

[158] Table 22a. Persons living with diagnosed HIV infection by race/ethnicity and selected characteristics, year-end 2015 – United States. Centers for Disease Control and Prevention. HIV Surveillance Report, 2016; vol. 28. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published November 2017. Accessed December 29, 2017.

[159]Table 1a. Diagnoses of HIV infection by year of diagnosis and selected characteristics, 2011 – 2016 – United States. Centers for Disease Control and Prevention. HIV Surveillance Report, 2016; vol. 28. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published November 2017. Accessed December 29, 2017.

[160] This measure reports on core medical services. It replaces measure 17.I.A.1 that reported on only a subset of core medical services.

[161] A RWHAP overarching performance measure that applies to Parts A, B, C, and D and is not Part A specific.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 +/- FY 2019
	CDC data or 69.8% (Target Met)			
16.I.A.2: Percentage of people living with HIV served by the Ryan White HIV/AIDS Program who are women.[162] *(Outcome)*	2016: 26.95% Target: Within 3 percentage points of CDC data (CDC data not available) 2015: 27.0% Target: Within 3 percentage points of CDC data or 24% (Target Met)	Not lower than 3 percentage points of CDC data	Not lower than 3 percentage points of CDC data	Maintain
16.III.A.4: Percentage of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test who are virally suppressed.[163]	2016: 85% (Target not in place) 2015 Baseline: 83%	83%	83%	Maintain

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	52	52	52
Average Award	$12,109,576	$12,109,576	$12,195,230
Range of Awards	$2,841,355 - $98,869,770	$2,841,355 - $98,869,770	$2,841,355 - $98,869,770

[162] A RWHAP overarching performance measure that applies to Parts A, B, C, and D and is not Part A specific. The first target is set for 2018.
[163] This is a RWHAP overarching performance measure that applies to Parts A, B, C, and D and is not Part A specific.

RWHAP Part A – FY 2017 Formula, Supplemental & MAI Grants[164]

Table 1. Eligible Metropolitan Areas

EMAs	Formula[165]	Supplemental	MAI	Total
Atlanta, GA	$15,388,141	$7,765,662	$2,376,116	$25,529,919
Baltimore, MD	9,836,906	5,540,990	1,631,100	17,008,996
Boston, MA	9,102,632	4,782,459	1,000,465	14,885,556
Chicago, IL	16,607,645	8,472,441	2,370,449	27,450,535
Dallas, TX	10,641,875	5,370,448	1,353,909	17,366,232
Detroit, MI	5,633,713	3,279,350	814,056	9,727,119
Ft. Lauderdale, FL	9,740,502	4,824,699	1,266,527	15,831,728
Houston, TX	14,088,300	6,567,876	2,117,885	22,774,061
Los Angeles, CA	26,409,738	13,626,878	3,509,303	43,545,919
Miami, FL	15,528,997	8,457,806	2,644,652	26,631,455
Nassau-Suffolk, NY	3,356,448	1,811,951	446,803	5,615,202
New Haven, CT	3,342,523	1,898,644	456,593	5,697,760
New Orleans, LA	4,618,263	2,658,091	632,594	7,908,948
New York, NY	57,774,082	31,888,924	9,206,764	98,869,770
Newark, NJ	7,385,043	4,175,063	1,265,600	12,825,706
Orlando, FL	6,090,559	2,834,567	779,948	9,705,074
Philadelphia, PA	13,405,442	7,479,766	1,994,128	22,879,336
Phoenix, AZ	5,802,955	2,870,083	542,120	9,215,158
San Diego, CA	7,109,758	3,584,211	707,817	11,401,786
San Francisco, CA	9,579,294	5,463,505	768,201	15,811,000
San Juan, PR	6,495,989	3,561,222	1,249,112	11,306,323
Tampa-St. Petersburg, FL	6,258,729	3,371,799	663,301	10,293,829
Washington, DC-MD-VA-WV	18,878,483	10,681,106	2,957,703	32,517,292
West Palm Beach, FL	4,462,946	2,512,504	662,683	7,638,133
Subtotal EMAs	**$287,538,963**	**$153,480,045**	**$41,417,829**	**$482,436,837**

[164] Awards to EMAs and TGAs include prior year unobligated balances.

[165] Hold Harmless expired in FY 2014.

Table 2. Transitional Grant Areas

TGAs	Formula	Supplemental	MAI	Total
Austin, TX	$3,034,191	$1,468,780	$328,199	$4,831,170
Baton Rouge, LA	2,765,539	1,394,005	443,918	4,603,462
Bergen-Passaic, NJ	2,485,988	1,291,393	349,323	4,126,704
Charlotte-Gastonia, NC-SC	3,831,974	1,842,270	559,741	6,233,985
Cleveland, OH	2,886,514	1,424,794	365,398	4,676,706
Columbus, OH	2,937,738	1,320,479	276,161	4,534,378
Denver, CO	4,976,335	2,480,300	369,107	7,825,742
Fort Worth, TX	2,808,044	1,332,555	343,346	4,483,945
Hartford, CT	1,991,188	993,222	266,371	3,250,781
Indianapolis, IN	2,706,686	1,380,177	274,203	4,361,066
Jacksonville, FL	3,662,500	1,867,559	503,478	6,033,537
Jersey City, NJ	3,045,635	1,659,069	465,661	5,170,365
Kansas City, MO	2,691,428	1,363,059	264,105	4,318,592
Las Vegas, NV	3,871,754	1,857,385	408,677	6,137,816
Memphis, TN	4,203,619	1,904,279	688,650	6,796,548
Middlesex-Somerset-Hunterdon, NJ	1,690,384	919,326	231,645	2,841,355
Minneapolis-St. Paul, MN	3,684,842	1,865,596	352,620	5,903,058
Nashville, TN	2,878,340	1,401,384	306,147	4,585,871
Norfolk, VA	3,635,253	1,767,646	532,228	5,935,127
Oakland, CA	4,398,705	2,218,135	548,509	7,165,349
Orange County, CA	3,955,129	1,952,880	419,187	6,327,196
Portland, OR	2,612,957	1,320,071	131,692	4,064,720
Riverside-San Bernardino, CA	4,896,230	2,408,938	486,167	7,791,335
Sacramento, CA	2,110,528	1,072,691	182,802	3,366,021
Saint Louis, MO	3,913,714	1,903,048	459,066	6,275,828
San Antonio, TX	3,251,075	1,582,354	481,736	5,315,165
San Jose, CA	1,927,431	988,811	219,383	3,135,625
Seattle, WA	4,546,382	2,305,080	318,203	7,169,665
Subtotal TGAs	**$91,400,103**	**$45,285,286**	**$10,575,723**	**$147,261,112**
Subtotal EMAs/TGAs	**$378,939,066**	**$198,765,331**	**$51,993,552**	**$629,697,949**

RWHAP Part B - HIV Care Grants to States

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$1,311,837,000	$1,306,075,000	$1,315,005,000	+$8,930,000
MAI (non add)	$10,145,000	$10,145,000	$10,145,000	---
ADAP (non add)	$900,313,000	$894,199,000	$900,313,000	+$6,114,000
Total Funding	$1,311,837,000	$1,306,075,000	$1,315,005,000	+$8,930,000
FTE	63	63	63	---

Authorizing Legislation: Public Health Service Act, Section 2611, as amended by Public Law 111-87

FY 2019 Authorization……Expired

Allocation Method:

- Formula Grants
- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part B is the largest RWHAP Part providing grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and five Associated Jurisdictions to provide services for people living with HIV (PLWH). RWHAP Part B grants support outpatient ambulatory medical care, HIV-related prescription medications, case management, oral health care, health insurance premium and cost-sharing assistance, mental health and substance abuse services, and support services.

Seventy-five percent of RWHAP Part B funds must be used to support core medical services. RWHAP Part B funds are distributed through base and supplemental grants, AIDS Drug Assistance Program (ADAP) base and ADAP supplemental grants, Emerging Communities (ECs) grants, and Minority AIDS Initiative (MAI) grants. The base awards are distributed by a formula based on a state or territory's living HIV/AIDS cases weighted for cases outside of the jurisdictions that receive RWHAP Part A funding. The ECs are metropolitan areas that do not qualify as RWHAP Part A EMAs or TGAs but have 500-999 cumulative reported AIDS cases over the last five years. States apply on behalf of the ECs for funding through the Part B base grant application. RWHAP Part B Supplemental grants are available through a competitive process to eligible states with demonstrated need.

A portion of the RWHAP Part B appropriation supports ADAP, which supports the provision of HIV medications and related services, including health insurance premium and cost-sharing assistance. These funds are distributed by a formula based on living HIV/AIDS cases. In addition, ADAP supplemental funds are a five percent set aside for states with severe need. ADAP provides FDA-approved prescription medications for PLWH who cannot afford HIV medications. ADAP is instrumental in efforts to end the HIV epidemic across the nation. ADAP provides the access to medications and insurance necessary for PWLH to achieve optimal health outcomes and viral suppression. . Individual ADAPs operate in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, the Republic of Palau, and the Republic of the Marshall Islands.

The MAI funds are a statutory set-aside funding component for RWHAP Parts A – D, and Part F AIDS Education and Training Center programs to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. The RWHAP Part B MAI funding is statutorily required to specifically support education and outreach services to increase the number of eligible racial/ethnic minorities who have access to the RWHAP ADAP.

Over half of diagnosed PLWH in the United States who are in regular care receive antiretroviral medications or medication assistance through RWHAP ADAPs. According to the RWHAP ADAP Data Report, the demand for ADAP services has increased over the last six years from 208,809 clients in 2010, to 259,531 clients in 2015, a growth of 24 percent. In FY 2015, 67 percent of the clients served by ADAPs were racial/ethnic minorities. Nationally, more than 78 percent of ADAP clients had incomes at or below 200 percent of the Federal poverty level.

Increased demand for RWHAP Part B services in recent years has led a number of States to implement cost-containment measures for their Part B ADAPs. Cost-containment measures include reducing ADAP formularies, capping enrollment, lowering financial eligibility levels, and implementing waiting lists for people to enroll in their ADAP. In addition, states implemented cost-savings strategies such as recovering costs when another payor was primary, coordinating benefits with Medicare Part D, and improving drug-purchasing models. In particular, State ADAPs reported savings by participating in manufacturer rebate programs and recovering costs through insurance reimbursement of $1.17 billion in 2015.

Since FY 2010, HHS has taken several actions to stabilize the RWHAP ADAP:

- In FY 2010, HHS used emergency authority to redistribute and transfer $25 million to provide direct assistance to help State ADAPs eliminate their waiting lists and to address cost containment measures;
- The FY 2011 appropriation provided an increase of $50 million for State ADAPs, including $40 million in emergency relief funding;

- In FY 2012, $75 million in emergency funding was provided for ADAPs, including $35 million in redirected funding and $40 million in continuation emergency funding first appropriated in FY 2011;
- In FY 2013, HHS redirected an additional $35 million above the FY 2013 appropriations for State ADAPs, bringing the total for ADAP emergency relief funding to $75 million;
- In FY 2014, HRSA leveraged $73 million from the ADAP appropriation to support emergency relief efforts to help State ADAPs eliminate their waiting lists and to address cost containment measures;
- In FY 2015 and FY 2016, HRSA leveraged $75 million from the ADAP appropriation to support emergency relief efforts to help State ADAP eliminate their waiting lists and to address cost containment measures; and
- In FY 2017, HRSA leveraged $65 million from the ADAP appropriation to support emergency relief efforts to help State ADAP maintain elimination of their waiting lists and to address cost containment measures.

Because of investments in RWHAP ADAP and the increased technical assistance activities for cost-containment measures, the program was able to serve 146,106 clients with HIV-related medications or medication assistance in FY 2015. ADAP waiting lists decreased from a peak of 9,310 in September 2011, to zero in August 2015 because of these directed efforts. In FY 2018 and FY 2019, HRSA will continue the use of ADAP Emergency Relief Funds (ERF) through "311 authority" in order to maintain infrastructure in the states and territories that had previously imposed waiting lists and to ensure that no new waiting lists are established. This funding is also required to address the gaps in access created by ongoing cost-containment measures in many state ADAPs such as HIV medication formulary reductions, lower client financial eligibility levels, and capped enrollment. However, with no individuals on the RWHAP ADAP waiting lists in FY 2017, HRSA distributed $47.3 million in ERF funding, $18 million less than it had planned for FY 2017 and allocated these remaining funds to the RWHAP ADAP Base Award. These funds are required to be used for RWHAP ADAP services, including the purchase of medications, insurance premium assistance, and medication copay assistance. States that developed need through unforeseen events had the ability to request Part B supplemental funds to assist in meeting shortfalls.

The RWHAP Part B has been successful in helping to ensure that PLWH have access to the care and treatment services they need to live longer, healthier lives. Recent studies have demonstrated that individuals with HIV on antiretroviral medications who achieve viral suppression are not at risk to transmit HIV to others. The RWHAP provides the care and treatment services that support the achievement of viral suppression and therefore, has a significant public health impact on HIV incidence as well. These efforts demonstrate the central role of the RWHAP in ending the HIV epidemic by ensuring that PLWH have access to regular care, are started on, and adhere to, their antiretroviral medications.

In 2016, 70 percent of RWHAP Part B clients were racial/ethnic minorities, and 27 percent were women. The number of visits for health-related services demonstrates the scope of Part B in delivering primary care and related services for PLWH by increasing the availability and

accessibility of care. In 2016, Part B funded sites provided 3.4 million core medical service visits for health-related care utilizing Parts A, B, C, and D funding.

Funding History

FY	Amount	ADAP (Non-Add)
FY 2010	$1,276,791,000	($858,000,000)
FY 2011	$1,308,141,000	($885,000,000)
FY 2012	$1,360,827,000	($933,299,000)
FY 2013	$1,287,535,000	($886,313,000)
FY 2014	$1,314,446,000	($900,313,000)
FY 2015	$1,315,005,000	($900,313,000)
FY 2016	$1,315,005,000	($900,313,000)
FY 2017	$1,311,837,000	($900,313,000)
FY 2018	$1,306,075,000	($894,199,000)
FY 2019	$1,315,005,000	($900,313,000)

Budget Request

The FY 2019 Budget requests $1.3 billion for the Ryan White HIV/AIDS Program (RWHAP) Part B, which is $8.9 million above the FY 2018 Annualized CR level. The request includes $900.3 million for ADAPs to provide access to life saving HIV related medications and direct health care services to people living with HIV (PLWH) in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam and five Pacific jurisdictions. The 311 authority will be utilized to implement the Emergency Relief Fund to minimize RWHAP ADAP waiting lists.

The FY 2019 Request proposes statutory changes through Ryan White HIV/AIDS Program authorization to the RWHAP Part B funding methodology. These changes would allow HRSA to utilize a data driven framework developed by the Secretary to distribute RWHAP Part B funding to ensure that funds are allocated to populations experiencing high or increasing levels of HIV infections/diagnoses, such as minority populations, while continuing to support Americans that are already living with HIV across the nation. This approach would reduce burden for recipients and increase HHS's ability to effectively focus resources for HIV care, treatment, and support needs based on need, geography, data quality, and performance.

In FY 2019, the RWHAP ADAP will continue to serve more than 259,000 clients. An important contributing factor to the demand for services for ADAP continues to be access to HIV medications and high cost-sharing requirements for these medications. The RWHAP will continue to provide access to life-saving medications and related services for PLWH.

In FY 2019, RWHAP Part B/ADAP grant recipients will continue to work directly with uninsured PLWH to ensure access to health care coverage and will continue to support HIV medications not on health plan formularies and the cost sharing required by health coverage plans. RWHAP ADAP resources will also support:

- The continued increase in RWHAP clients as more PLWH are diagnosed, linked to care, and retained in care;
- The continued increase in RWHAP growth as more people enter the health care system with coverage who require assistance with insurance premiums and cost-sharing; and,
- The continued need for ADAP for clients who remain uninsured.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, information technology, and other program support costs.

Measuring Ryan White HIV/AIDS Program Performance

Direct Service Provision: The FY 2019 performance target for the service utilization measure is that RWHAP Part B will provide 3.4 million core medical service visits for health-related care.

According to the RWHAP ADAP Report, State ADAP Programs continue to provide robust formularies of antiretroviral medications to treat HIV infection, prevent and treat opportunistic infections, manage side effects, and treat co-morbidities. From 2010 through 2014, State ADAPs served 59,827 additional clients, an increase of 28.7 percent. In 2015, State ADAP programs served 268,636 clients, exceeding the FY 2015 performance target by 32,406 clients.

Cost Containment: Across the RWHAP, grant recipients are encouraged to maximize resources and leverage efficiencies. One example of this is within RWHAP Part B, where State ADAPs use a variety of strategies to maximize resources, which result in effective funds management, enabling ADAPs to serve more people. Cost-containment approaches used by ADAPs include using drug-purchasing strategies such as cost recovery through drug rebates and third party billing; directly negotiating pharmaceutical pricing; reducing ADAP formularies; capping enrollment; and lowering financial eligibility levels. In 2015, State ADAPs participating in cost-savings strategies on medications saved $1.12 billion, exceeding the FY 2015 performance target by $60.2 million. Over the last 5 years, ADAPs participating in medication cost-savings strategies saved $4.7 billion.

RWHAP will continue to provide access to life-saving medications and related services for low-income PLWH. While the number of RWHAP ADAP clients is projected to remain constant in future years with anticipated steady funding, health care coverage and costs related to co-pays, co-insurance, premiums, etc., are difficult to anticipate. The increased demand for ADAP services in recent years has required many states to recover costs when possible by coordinating benefits with Medicare Part D or exhausting all coverage options, participating in rebate programs, and improving drug-purchasing models. Two performance targets have been set for FY 2019 to measure RWHAP ADAP performance:

- The RWHAP ADAP will continue to be able to serve 259,531 clients in 2019. This target is based on anticipated steady funding and not demand.
- The RWHAP ADAP will maintain prior year results of State ADAP's participation in cost-savings strategies on medications.

RWHAP Part B/ADAP funding will contribute to achieving the FY 2019 targets for the RWHAP's over-arching performance measures including: percentage of racial/ethnic minorities

and women served (in Part A section), percentage of clients who achieved viral suppression (in Part A Section), and percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive antiretroviral medications

Antiretroviral Therapy to Pregnant Women: Mother-to-child transmission in the United States has decreased dramatically since its peak in 1992 due to 1) the implementation of opt-out testing for HIV for all pregnant women; and 2) the use of antiretroviral therapy, which significantly reduces the risk of HIV transmission from the mother to her baby. In 2016, 96 percent of HIV-positive pregnant women served by the RWHAP were prescribed antiretroviral therapy to prevent maternal-to-child transmission of HIV, exceeding the FY 2016 performance target of 90 percent. In 2019, HRSA and the Centers for Disease Control and Prevention will collaborate to accelerate the elimination of perinatal HIV transmission in the United States.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 +/- FY 2019
18.I.A.2: Number of RWHAP Part B visits for health-related care.[166] *(Output)*	2016: 3.4M (Target not in place) 2015 Baseline: 3.6M	3.6M	3.4M	-.2M
16.II.A.1: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. *(Output)*	2015: 259,531 Target: 212,107 (Target Exceeded)	259,531	259,531	Maintain
16.E: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. *(Containing Costs)*	2015: $1.12B Target: $1.02B (Target Exceeded)	Sustain Prior Year Results	Sustain Prior Year Results	Maintain
16.II.A.3: Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive antiretroviral medications.[167] *(Output)*	2016: 96% Target: 90% (Target Exceeded)	90%	96%	+6%

[166] This measure reports on core medical services. It replaces measure 18.I.A.1 that reported on only a subset of core medical services. The first target is set for 2018.
[167] This RWHAP overarching performance measure applies to Parts A, B, C, and D and is not Part B specific.

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	59	59	59
Average Award	$23,856,579	$23,856,579	$24,007,935
Range of Awards	$50,000 - $181,550,889	$50,000 - $181,550,889	$50,000 - $181,550,889

RWHAP Part B – FY 2017 State Table[168]

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Alabama	$7,891,622	$4,000,000	$10,081,565	$309,234	$154,750	$22,437,171
Alaska	500,000	152,453	567,987	0	0	1,220,440
American Samoa	23,734	0	143	0	0	23,877
Arizona	4,079,902	0	11,586,446	0	120,556	15,786,904
Arkansas	3,324,876	0	4,368,380	0	51,239	7,744,495
California	33,146,827	35,000,000	111,954,339	164,048	1,285,675	181,550,889
Colorado	3,402,181	0	9,644,402	0	79,499	13,126,082
Connecticut	2,794,701	0	8,848,895	0	0	11,643,596
Delaware	2,055,117	0	2,625,416	196,874	40,128	4,917,535
District of Columbia	3,828,733	0	12,905,249	0	229,604	16,963,586
F. States Micronesia	50,000	0	0	0	0	50,000
Florida	30,743,307	0	88,224,056	481,611	1,342,005	120,790,979
Georgia	13,448,517	700,000	49,467,718	167,886	599,252	64,383,373
Guam	200,000	0	60,943	0	0	260,943
Hawaii	1,628,955	0	2,080,994	0	22,360	3,732,309
Idaho	573,728	1,809,207	1,740,507	0	0	4,123,442
Illinois	9,567,609	0	32,275,155	0	448,304	42,291,068
Indiana	3,609,959	26,365,550	11,126,249	0	0	41,101,758
Iowa	1,404,425	12,286,473	1,794,156	0	0	15,485,054
Kansas	1,104,957	0	2,490,529	0	0	3,595,486
Kentucky	4,072,706	0	5,202,891	270,120	47,644	9,593,361

[168] Awards include prior year unobligated balances.

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Louisiana	6,402,181	0	16,799,088	0	266,998	23,468,267
Maine	796,350	1,776,038	1,017,339	0	0	3,589,727
Marshall Islands	47,623	0	813	0	0	48,436
Maryland	7,965,275	0	25,998,201	0	475,222	34,438,698
Massachusetts	4,989,140	0	14,460,547	0	0	19,449,687
Michigan	4,994,196	0	13,040,135	0	185,847	18,220,178
Minnesota	2,040,110	900,000	6,262,483	0	66,668	9,269,261
Mississippi	5,904,190	6,375,000	10,278,657	280,981	133,301	22,972,129
Missouri	3,508,508	8,700,000	10,064,501	0	0	22,273,009
Montana	500,000	1,087,718	1,272,607	0	0	2,860,325
N. Marianas	50,000	42,576	1,625	0	0	94,201
Nebraska	1,268,944	3,416,000	1,621,079	0	0	6,306,023
Nevada	2,147,677	1,902,971	6,541,195	0	0	10,591,843
New Hampshire	500,000	0	963,709	0	0	1,463,709
New Jersey	10,286,108	1,097,877	30,213,006	0	511,067	42,108,058
New Mexico	1,876,383	0	2,397,084	0	0	4,273,467
New York	35,252,036	35,000,000	107,486,859	616,508	1,824,537	180,179,940
North Carolina	11,497,540	7,300,000	26,192,394	301,803	371,591	45,663,328
North Dakota	500,000	0	213,706	0	0	713,706
Ohio	5,555,550	0	16,796,650	323,524	0	22,675,724
Oklahoma	3,630,642	0	4,638,154	227,985	0	8,496,781
Oregon	1,728,496	0	4,749,476	0	0	6,477,972
Pennsylvania	10,822,830	0	27,850,050	273,060	411,857	39,357,797
Puerto Rico	5,972,511	18,214,030	28,392,459	0	326,114	52,905,114
Republic of Palau	50,000	0	3,250	0	0	53,250
Rhode Island	1,496,654	2,460,384	1,911,979	188,137	22,188	6,079,342
South Carolina	10,208,283	0	13,282,281	558,531	216,120	24,265,215
South Dakota	500,000	0	415,224	0	0	915,224
Tennessee	5,215,284	0	23,135,481	0	193,536	28,544,301
Texas	23,234,672	2,800,000	87,441,727	0	1,007,480	114,483,879
Utah	1,718,640	2,710,676	3,686,275	0	15,859	8,131,450
Vermont	500,000	0	407,098	0	0	907,098
Virgin Islands	500,000	946,025	498,918	0	9,735	1,954,678
Virginia	7,180,931	0	27,410,415	381,500	275,942	35,248,788

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Washington	3,617,896	0	9,936,928	0	76,799	13,631,623
West Virginia	1,037,285	0	1,443,938	0	0	2,481,223
Wisconsin	3,610,212	2,824,500	4,636,529	258,198	54,886	11,384,325
Wyoming	500,000	0	238,083	0	0	738,083
Total	**$315,058,003**	**$177,867,478**	**$898,745,963**	**$5,000,000**	**$10,866,763**	**$1,407,538,207**

RWHAP Part C - Early Intervention Services

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$200,585,000	$199,713,000	$201,079,000	+$1,366,000
MAI (non add)	$71,012,000	$71,012,000	$71,012,000	---
Total Funding	$200,585,000	$199,713,000	$201,079,000	+$1,366,000
FTE	54	54	56	+2

Authorizing Legislation: Public Health Service Act, Section 2651, as amended by Public Law 111-87

FY 2019 Authorization……..……..…….…...Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part C provides grants directly to community and faith-based organizations, community health centers, health departments, and university or hospital-based clinics in 49 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. RWHAP Part C supports comprehensive primary health care and support services in an outpatient setting for low-income, uninsured, and underserved people living with HIV (PLWH). The MAI funds are a statutory set-aside funding component for Parts A – D, and Part F AIDS Education and Training Center programs to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. Part C Minority AIDS Initiative funding supports HIV care, treatment, and support services to racial/ethnic minorities. Part C is also authorized to fund capacity development grants that strengthen organizational development and infrastructure, resulting in a more effective delivery of HIV care and services.

The RWHAP Part C provides services for PLWH who are disproportionately affected by the HIV epidemic and have poor health outcomes, including ethnic and minority populations and youth. In 2016, Part C funded sites served over 300,000 clients utilizing a combination of Parts A, B, C, and D funding. Of the total clients served, 72 percent were racial/ethnic minorities and 27 percent were female. Part C providers have the clinical expertise and cultural competency to provide quality care and treatment to low-income, diverse people living with HIV. In 2016, RWHAP Part C funded sites provided 3.5 million core medical service visits for health-related care utilizing a combination of Parts A, B, C, and D funding. The number of visits for health-

related services demonstrates the scope of Part C in delivering primary care and related services for PLWH by increasing the availability and accessibility of care.

Funding History

FY	Amount
FY 2010	$206,383,000
FY 2011	$205,564,000
FY 2012[169]	$215,086,000
FY 2013	$194,444,000
FY 2014	$205,544,000
FY 2015	$204,179,000
FY 2016	$205,079,000
FY 2017	$200,585,000
FY 2018	$199,713,000
FY 2019	$201,079,000

Budget Request

The FY 2019 Budget requests $201.1 million for the Ryan White HIV/AIDS Program (RWHAP) Part C, which is $1.4 million above the FY 2018 Annualized CR level. In FY 2019, RWHAP Part C grant recipients' clients will continue to achieve improved health outcomes resulting from the comprehensive array of direct medical and supports services that are essential in addressing the HIV epidemic. Part C supports direct health care services for low income PLWH who may not be fully covered by public or private health care plans. These services are considered essential to improving health outcomes and are a crucial part of the care network that links and retains PLWH into health care. Such critical health care services include intensive case management and care coordination services, linking and retaining PLWH into care and getting them on antiretroviral medications as early as possible.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, information technology, and other program support costs.

Measuring Ryan White HIV/AIDS Program Performance

Direct Service Provision: The FY 2019 performance target for the service utilization measure is that RWHAP Part C will provide 3.5 million visits for health-related care.

RWHAP Part C funding will contribute to achieving the FY 2019 targets for the RWHAP's over-arching performance measures including: percentage of racial/ethnic minorities and women served (in Part A section), percentage of clients who achieved viral suppression (in Part A Section), and percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive antiretroviral medications (in Part B Section).

[169] Reflects Ryan White Budget Authority only (does not include $5.089 million in Health Center Program Budget Authority for Part C grant recipients in FY 2012).

Improving the Quality of Health Care: A major focus of the RWHAP is improving the quality of care that participating clients receive. Grant recipients are required to develop, implement, and monitor clinical quality management programs to ensure that service providers adhere to established HIV clinical practices and implement quality improvement strategies. The statute also requires that demographic, clinical, and health care utilization information be used to monitor trends in the spectrum of HIV-related illnesses. The RWHAP will continue to assist grant recipients in developing or maintaining a clinical quality management program.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 +/- FY 2019
19.II.A.3: Number of RWHAP Part C visits for health-related care.[170] *(Output)*	2016: 3.5M (Target not in place) 2015 Baseline: 3.8M	3.8M	3.5M	-.3M

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	344	358	358
Average Award	$528,334	$525,382	$525,382
Range of Awards	$92,720 - $1,540,565	$94,676 - $1,534,196	$94,676 - $1,534,196

[170] This measure reports on core medical services. It replaces measure 19.II.A.2 that reported on only a subset of core medical services. The first target is set for 2018.

RWHAP Part D - Women, Infants, Children and Youth

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$74,907,000	$74,578,000	$75,088,000	+$510,000
MAI (non add)	$23,671,000	$23,671,000	$23,671,000	---
Total Funding	$74,907,000	$74,578,000	$75,088,000	+$510,000
FTE	10	10	10	---

Authorizing Legislation: Public Health Service Act, Section 2671, as amended by Public Law 111-87

FY 2019 Authorization……Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part D provides grants directly to public or private community-based organizations, hospitals, and State and local governments. Currently, there are 116 Part D grant recipients located in 40 states, the District of Columbia, and Puerto Rico. The RWHAP Part D focuses on providing access to coordinated, comprehensive, culturally and linguistically competent, family-centered HIV primary medical care and support services. RWHAP services focus on low-income, uninsured, and underserved HIV-positive women, infants, children, and youth living with HIV and their affected[171] family members. Part D also funds essential support services, such as case management and transportation that help clients' access medical care and stay in care. The MAI funds are a statutory set-aside funding component for Parts A – D, and Part F AIDS Education and Training Center programs to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. Part D Minority AIDS Initiative funding supports HIV care, treatment, and support services to racial/ethnic minorities. In 2016, Part D funded sites provided over 220,000 visits for health-related care and support services utilizing a combination of Parts A, B, C, and D funding.

The RWHAP Part D serves women, infant, children, and youth – populations disproportionately affected by HIV epidemic that have poor health outcomes. In 2016, RWHAP Part D funded sites served 217,665 clients utilizing a combination of Parts A, B, C, and D funding. Of the total

[171] Support services are available for family members not living with HIV. Some examples are family-centered case management, childcare services during medical appointment attendance, and psychosocial support services that focus on equipping affected family members, and caregivers, to manage the stress associated with HIV.

clients served, 75 percent were racial/ethnic minorities and 29 percent were female. Part D providers have the clinical expertise and cultural competency to provide quality care and treatment to low-income, diverse women, infant, children, and youth living with HIV.

Funding History

FY	Amount
FY 2009	$76,845,000
FY 2010	$77,621,000
FY 2011	$77,313,000
FY 2012	$77,167,000
FY 2013	$72,361,000
FY 2014	$72,395,000
FY 2015	$73,008,000
FY 2016	$75,088,000
FY 2017	$74,907,000
FY 2018	$74,578,000
FY 2019	$75,088,000

Budget Request

The FY 2019 Budget requests $75.1 million for the Ryan White HIV/AIDS Program (RWHAP) Part D, which is $0.5 million above the FY 2018 Annualized CR level. In FY 2019, RWHAP Part D grant recipients' clients will continue to achieve improved health outcomes resulting from the comprehensive array of medical and supports services that are essential in addressing the HIV epidemic. Part D supports health care services for low income PLWH who may not be fully covered by public or private health care plans. These services are considered essential to improving health outcomes and are a crucial part of the care network that links and retains PLWH into health care, especially for women, infants and children and youth. Such critical health care services include intensive case management and care coordination services, linking and retaining PLWH into care and getting them on antiretroviral medications as early as possible.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, information technology, and other program support costs.

Measuring Ryan White HIV/AIDS Program Performance

Direct Service Provision: The FY 2019 performance target for the service utilization measure is that RWHAP Part D will provide 221,737 health-related care and support service visits.

RWHAP Part D funding will contribute to achieving the FY 2019 targets for the RWHAP's over-arching performance measures including: percentage of racial/ethnic minorities and women served (in Part A section), percentage of clients who achieved viral suppression (in Part A Section), and percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive antiretroviral medications (in Part B Section).

To achieve the elimination of mother-to-child (perinatal) HIV transmission goal, the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) will accelerate efforts by continuing to invest in eliminating mother-to-child HIV transmission efforts (EMCT), primarily through o-going collaborations with health departments and the Ryan White HIV/AIDS Program Part D programs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 +/- FY 2019
20.II.A.2 Number of RWHAP Part D visits for health-related care and support services	2016: 221,737 (Target not in place) 2015 Baseline: 220,713	220,713	221,737	+1,024

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	116	116	116
Average Award	$580,068	$580,068	$580,068
Range of Awards	$113,823 - $2,185,691	$113,823 - $2,185,691	$113,823 - $2,185,691

RWHAP Part F - AIDS Education and Training Programs

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$33,530,000	$33,383,000	---	-$33,383,000
MAI (non add)	$10,144,000	$10,144,000	---	-$10,144,000
Total Funding	$33,530,000	$33,383,000	---	-$33,383,000
FTE	5	5	---	-5

Authorizing Legislation: Public Health Service Act, Sec. 2692(a), as amended by Public Law 111-87.

FY 2019 Authorization……...….Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part F AIDS Education and Training Center (AETC) Program supports a network of regional centers and two national centers that conduct targeted, multidisciplinary education and training programs for health care providers serving people living with HIV (PLWH) in all states, DC, Puerto Rico, the U.S. Virgin Islands, and the Associated Jurisdictions. The RWHAP AETC improves the quality of life of persons living with or at-risk of HIV through the provision of specialized professional education and training. The program uses a strategy of implementation of multidisciplinary education and training programs for health care providers in the prevention and treatment of HIV.

RWHAP AETC-trained providers are more experienced with regard to HIV clinical care and treat more PLWH patients than other primary care providers.[172] The RWHAP AETCs target training to health care providers who serve minority populations, the homeless, rural communities, incarcerated persons, federally qualified community and migrant health centers, and RWHAP sites. In addition, nearly half the providers themselves are racial/ethnic minorities. In 2015-2016, the proportion of racial/ethnic minority health care providers participating in AETC training intervention programs was 47 percent, exceeding the FY 2016 performance target by 4 percent.

[172] Devin McBrayer. "Treatment Cascade" presentation, July 7, 2014. https://prezi.com/p6biexvknarb/addressing-hiv-stigma-in-health-care-workers/

AETCs currently train providers through a variety of training modalities, including didactics, clinical preceptorships, self-study, clinical consultation, communities of practice and distance-based technologies. A variety of educational formats are used such as including skills building workshops, hands-on preceptorships and mini-residencies, on-site training, tele-education, and technical assistance. Clinical faculty also provides timely clinical consultation in person or via the telephone or internet.

Funding History

FY	Amount
FY 2010	$34,745,000
FY 2011	$34,607,000
FY 2012	$34,542,000
FY 2013	$32,390,000
FY 2014	$33,275,000
FY 2015	$33,349,000
FY 2016	$33,611,000
FY 2017	$33,530,000
FY 2018	$33,383,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Ryan White HIV/AIDS Program (RWHAP) Part F-AETC, which is $33.4 million below the FY 2018 Annualized CR level. The Budget prioritizes programs that provide direct healthcare services.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 +/- FY 2019
21.V.B.1: Proportion of RWHAP AETC training intervention participants that are racial/ethnic minorities. *(Output)*	FY 2015: 47% Target: 43% (Target Exceeded)	43%	N/A	N/A

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	16	13	---
Average Award	$2,029,605	$2,547,385	---
Range of Awards	$175,460 - $4,278,600	$750,000 - $4,278,600	---

RWHAP Part F - Dental Programs

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$13,090,000	$13,033,000	$13,122,000	+$89,000
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 2692(b) as amended by Public Law 111-87

FY 2019 Authorization……..……..Expired

Allocation Method:

- Competitive Grants
- Formula Grants
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part F funding supports two dental programs: 1) HIV/AIDS Dental Reimbursement Program (DRP); and 2) Community-Based Dental Partnership Program (CBDPP).

The RWHAP DRP ensures access to oral health care for low-income people living with HIV (PLWH) by reimbursing dental education programs for the non-reimbursed costs they incur providing such care. By offsetting the costs of non-reimbursed HIV care in accredited dental education institutions, the DRP improves access to oral health care for low-income, PLWH and ensures quality services by dental students, dental hygiene students, and dental residents for providing oral health care services to PLWH. The care provided through the program includes a full range of diagnostic, preventive, and treatment services, including oral surgery, as well as oral health education and health promotion. Dental schools, post-doctoral dental education programs, and dental hygiene education programs accredited by the Commission on Dental Accreditation that have documented non-reimbursed costs for providing oral health care to PLWH are eligible to apply for reimbursement. Funds are then distributed to eligible organizations taking into account the number of people served and the cost of providing care.

In FY 2016, the RWHAP DRP awards were able to provide 27 percent of the total non-reimbursed costs requested by 52 participating institutions in support of oral health care. These institutions reported providing care to 36,232 HIV-positive individuals, 18,644 for whom no other funded source was available, missing the FY 2016 performance target by 3,578 individuals or 10 percent. In FY 2016, the demographic characteristics of patients who were cared for by institutions participating in the DRP were 54 percent minority and 31 percent women.

The RWHAP CBDPP supports collaborations between dental education programs and community-based partners to deliver oral health services in community settings while supporting students and residents enrolled in accredited dental educations programs. In FY 2016, CBDPP funded 11 partnership grants to support collaboration and coordination between the dental education programs and the community-based partners in the delivery of oral health services.

Programs	FY 2017	FY 2018	FY 2019
Dental Reimbursement Program	$8,721,326	$9,042,411	$9,042,411
Community-Based Dental Partnership Program	$3,189,991	$3,489,991	$3,489,991

Funding History

FY	Amount
FY 2010	$13,565,000
FY 2011	$13,511,000
FY 2012	$13,485,000
FY 2013	$12,646,000
FY 2014	$12,991,000
FY 2015	$13,020,000
FY 2016	$13,122,000
FY 2017	$13,090,000
FY 2018	$13,033,000
FY 2019	$13,122,000

Budget Request

The FY 2019 Budget requests $13.1 million for the Ryan White HIV/AIDS (RWHAP) Part F Dental Programs, which is $89,000 above the FY 2018 Annualized CR level. The request will support oral health care for PLWH. This Request supports the reimbursement of applicant institutions through the RWHAP DRP and funding of the RWHAP CBDPP.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, information technology, and other program support costs.

Measuring Ryan White HIV/AIDS Program Performance

Direct Service Provision: The FY 2019 target for the dental health care measure is that institutions will be reimbursed for a portion of their unreimbursed oral health costs for provision of uncompensated care to 36,232 people.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 +/- FY 2019
22. I.D.1: Number of persons for whom a portion/percentage of their unreimbursed oral health costs were reimbursed. *(Output)*	2016: 36,232 Target: 39,810 (Target Not Met)	38,436	36,232	-2,204

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	67	68	68
Average Award	$177,781	$184,300	$184,300
Range of Awards	$1,901 - $1,134,333	$1,901 - $1,134,333	$1,901 - $1,134,333

RWHAP Part F - Special Projects of National Significance

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$24,940,000	$24,830,000	---	-$24,830,000
FTE	2	2	---	-2

Authorizing Legislation: Public Health Service Act, Section 2691, as amended by Public Law 111-87

FY 2019 Authorization……..……..Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part F Special Projects of National Significance (SPNS) supports the development, evaluation, and dissemination of innovative models of HIV care to improve the retention and health outcomes of RWHAP clients. The RWHAP SPNS evaluates the effectiveness of the models' design, implementation, utilization, cost, and health related outcomes, while promoting the dissemination and replication of successful models. Through these special projects, SPNS grant recipients implement a variety of promising interventions gathering evidence-informed practices and lessons learned to improve treatment outcomes and avert new HIV infections. SPNS initiatives address the emerging needs of the most disproportionately impacted populations living with HIV.

The RWHAP SPNS program provides opportunities for the development, implementation, and assessment of system, community, and individual-level innovations designed to meet RWHAP goals as well as the demands of changing health care delivery systems. Through its demonstration projects, SPNS models contribute to the advancement of public health knowledge and help move toward the elimination of HIV in the United States by promoting models that focus on expanding linkage to HIV medical care, improving lifelong retention in HIV medical care, the delivery of ART, and ultimately achieving HIV viral suppression among people living with HIV.

Of the 64 currently funded FY 2016 RWHAP SPNS grant recipients: 15 percent are community-based organizations/AIDS service organizations, 22 percent are state/county/local departments of health, 36 percent are community health centers, 10 percent are academic-based clinics, and 11 percent are evaluation and technical assistance centers.

Funding History

FY	Amount
FY 2008	$25,000,000
FY 2009	$25,000,000
FY 2010	$25,000,000
FY 2011	$25,000,000
FY 2012	$25,000,000
FY 2013	$25,000,000
FY 2014	$25,000,000
FY 2015	$25,000,000
FY 2016	$25,000,000
FY 2017	$24,940,000
FY 2018	$24,830,000
FY 2019	---

Budget Request

The FY 2019 Budget requests $0 for the Ryan White HIV/AIDS Program (RWHAP) Part F Special Projects of National Significance (SPNS), which is $24.8 million below the FY 2018 Annualized CR level. The Budget prioritizes programs that provide direct healthcare services.

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	54	37	---
Average Award	$420,468	$602,596	---
Range of Awards	$200,000 - $5,324,429	$200,000 - $5,469,458	---

Healthcare Systems

TAB

HEALTHCARE SYSTEMS

Organ Transplantation

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$23,492,000	$23,389,000	$23,549,000	+$160,000
FTE	2	2	2	---

Authorizing Legislation: Public Health Service Act, Sections 371-378, as amended by Public Law 113-51

FY 2019 Authorization……..……..……..……...……..……..…..... Expired

Allocation Method:
- Contracts
- Competitive Grants/Co-operative Agreements
- Other (Interagency Support)

Program Description and Accomplishments

The National Organ Transplant Act of 1984 (NOTA), as amended, provides the authorities for the Organ Transplantation Program (Program). The primary purpose of the Program is to extend and enhance the lives of individuals with end-stage organ failure for whom an organ transplant is the most appropriate therapeutic treatment. The Program oversees a national system, the Organ Procurement and Transplantation Network (OPTN), to allocate and distribute donor organs to individuals waiting for an organ transplant. Organ allocation is guided by OPTN policies informed by analytic support from the Scientific Registry of Transplant Recipients (SRTR), which is also supported by the Program. In addition to the efficient and effective allocation of donor organs through OPTN, the Program also supports public education and outreach efforts to increase the supply of deceased donor organs made available for transplant and other efforts to ensure the safety of living organ donation.

<u>Program Activities</u>

- Organ Procurement and Transplantation Network — OPTN is a critical system that facilitates matching donor organs to individuals needing an organ transplant. Given the great demand for and limited supply of organs, OPTN policies are under continual review and refinement to achieve the best outcomes for patients, to attain the maximum benefit for the maximum number of waitlist candidates, to make the best use of donor organs, and to align with policy development requirements of the OPTN final rule (42 CFR 121).

OPTN operating costs are covered by appropriated funds and revenues generated by registration fees paid by transplant centers for each transplant candidate placed on the waiting list and collected by the contractor under authority of 42 CFR 121.5(c).

- Scientific Registry of Transplant Recipients — SRTR provides analytic support to OPTN in the development of organ allocation policies and program performance evaluations. Additionally, the SRTR provides analytic support to HHS, including the Advisory Committee on Organ Transplantation (described below). SRTR makes information about the performance of transplant programs and organ procurement organizations more widely available to the public. It publishes online transplant program risk-adjusted patient and graft outcomes data as well as organ procurement organization risk-adjusted organs transplanted per donor figures. SRTR also publishes online a comprehensive Annual Data Report that includes the most current ten years of data on waitlist, transplant, and deceased donor organ donation.

- Advisory Committee on Organ Transplantation (ACOT) and Interagency Activities to Support Donation and Transplantation — The OPTN final rule (42 CFR §121.12) established the Advisory Committee on Organ Transplantation to provide recommendations to the Secretary on issues related to organ donation and transplantation. The Program supports ACOT activities including logistics for periodic meetings and analytic requirements. These funds also support interagency activities in support of the Program's mission.

- Public and Professional Education Activities — The Program, independently and in collaboration with the organ donation and transplantation community and other stakeholders, supports a variety of public and professional education and outreach efforts designed to increase organ donation. The Program supports public education and outreach initiatives to (1) increase donor registrations, (2) enhance public awareness of the need for organs, (3) encourage family discussion about organ donation, and (4) improve public trust in the organ transplantation system. Communication channels include downloadable print, radio, television, Internet (organdonor.gov and donaciondeorganos.gov), print media, and social media platforms. The Program also collaborates and partners with stakeholders including hospitals, faith leaders, and post-secondary institutions.

- Grants to Support Projects to Increase Organ Donation — Through a competitive process, the Program awards grants to public and non-profit private entities: (1) to test new and replicate effective approaches for increasing registration in donor registries and (2) to promote public awareness of the need for deceased organ donation and the opportunities, risks, and benefits of living donation.

- Cooperative Agreement to Provide Support for Reimbursement of Travel and Subsistence Expenses toward Living Organ Donation — This cooperative agreement provides reimbursement of travel and subsistence expenses to living organ donors who are not able to receive such support: (1) under any state compensation program, insurance policy, or

under any Federal or state health benefits program; (2) by an entity that provides health services on a prepaid basis; or (3) by organ recipient.

Funding History

FY	Amount
FY 2015	$23,549,000
FY 2016	$23,549,000
FY 2017	$23,492,000
FY 2018	$23,389,000
FY 2019	$23,549,000

Budget Request

The FY 2019 Budget requests $23.5 million for the Organ Transplantation Program, which is $160,000 above the FY 2018 Annualized CR level. The request provides $14.6 million for contracts to operate OPTN and SRTR and to support public and professional education. The funding level will support $6.6 million for grants and cooperative agreements to fund efforts to increase organ donation, to provide reimbursement of travel and subsistence expenses to living organ donors who do not qualify for other means of support, and to explore the feasibility of further reducing financial disincentives to living organ donation. The Budget request also provides $2.3 million for activities related to the Advisory Committee, interagency agreements, and other internal support and Program-related activities.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, information technology and other program support costs. Additionally, the request covers IT investment costs to support the strategic and performance outcomes of the Program and to provide a mechanism for sharing data and conducting business in a more efficient manner.

Performance Measures

The first of three Program goals is to increase the annual number of deceased donor organs transplanted. In 2016, the number of deceased donor organs transplanted was 29,497, which is a 7.11 percent increase over the 2015 total of 27,539 and a 44.65 percent increase over the 2003 baseline of 20,392 deceased organs transplanted.

The second Program goal is to increase the number of expected “life-years” gained by kidney and kidney/pancreas transplant recipients as a result of receiving the transplants. This measure compares the life-years gained by these recipients in the first five years following the transplants against anticipated “life-years” had these transplant recipients remained on the waiting list.

Table 1. Life-Years Gained in First Five Years after Kidney/Pancreas Transplant

Fiscal Year	Avg. No. Life-Years Gained	Total Life-Years Gained	Target Life-Years Gained
2014	.28	3,466	4,433
2015	.34	3,801	4,502
2016	.32	4,510	4,572

The increase in total life-years gained in Table 1 reflects the record-breaking number of transplants in 2015 and 2016. Prior to 2015, there was a continuing decrease in the average and total "life-years" gained by transplant recipients. The decrease was attributable to increasing "life-years" gained by patients while on the transplant waiting list prior to receiving the transplant, due to improvements in dialysis management and clinical care of waitlist patients. Even with these increases in "life-years" gained by candidates pre-transplant, the number of "life-years" gained as a result of transplantation is still greater.

The third Program goal, increasing the organ donor conversion rate, is a measure of the rate at which potential organ donors become actual organ donors after death. The conversion rate has been a key performance metric for the organ transplantation program since 2003. Improving national performance in this metric was a primary focus during a series of Breakthrough Collaboratives sponsored by the Program from 2003 to 2008. Through concerted efforts of HHS and the transplant community to promote best practices, the conversion rate increased from a baseline of 52 percent in 2003 to 75 percent during this period. The conversion rate, however, has remained steady at approximately 72 percent since 2010, indicating a possible natural peak in this measure. The Program will continue to monitor conversion rates and assess potential next steps.

The conversion rate is dependent on a denominator of potential "eligible deaths," which by definition includes only those potential donors aged 75 or below who are legally declared dead by neurologic criteria (brain death) and not excluded for other reasons related to the potential donor's risk factors, including positive results on tests indicating the presence of several potentially transmissible infectious diseases. Number of "eligible deaths" does not include: (1) donors declared dead by circulatory determination of death (cardiac death) rather than neurologic criteria and (2) donors whose organs were transplanted despite donor ages or other risk factors that may have excluded them from being counted as "eligible deaths."

The total number of transplantable organs has increased in part due to an increase in the number of reported "eligible deaths." The slight conversion rate changes recorded in 2015 and 2016 reflect increased numbers of "eligible deaths" reported in those years (Table 2). Since 2013, the annual number of "eligible deaths" has been increasing, perhaps linked to increases in motor vehicle fatalities.

Table 2. Eligible Deaths 2008-2016

Year	Number of Donors	Number of Eligible Deaths	Conversion Rate (%)	Change in Eligible Deaths (%)
2008	6,574	9,845	66.8%	Baseline Year
2009	6,551	9,420	69.5%	-4.3%
2010	6,503	9,061	71.8%	-3.8%
2011	6,540	8,946	73.1%	-1.3%
2012	6,503	8,947	72.7%	0.0%
2013	6,530	9,173	71.2%	2.5%
2014	6,821	9,259	73.7%	0.9%
2015	7,053	9,781	72.1%	5.6%
2016	7,753	10,706	72.4%	9.5%

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
23.II.A.1: Increase the annual number of deceased donor organs transplanted.	FY 2016: 29,497 Target: 25,796 (Target Exceeded)	26,378	26,555	+177
23.II.A.7: Increase the total number of expected life-years gained in the first 5 years after the transplant for all deceased kidney and kidney/pancreas transplant recipients compared to what would be expected for these patients had they remained on the waiting list.	FY 2016: 4,510 Target: 4,572 (Target Not Met)	4,675	4,706	+31
23.II.A.8: Increase the annual conversion rate of eligible donors.	FY 2016: 72.20% Target: 73.75% (Target Not Met)	74.25%	74.50%	+0.25% points

Grants Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	10	12	8
Average Award	$629,906	$646,665	$824,812
Range of Awards	$184,192-$2,790,204	$250,000-$3,500,000	$250,000-$3,500,000

National Cord Blood Inventory

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$12,239,000	$12,183,000	$12,266,000	+$83,000
FTE	4	4	4	---

Authorizing Legislation: Public Health Service Act, Section 379, as amended by Public Law 111-264

FY 2019 Authorization…….....$23,000,000

Allocation Method…….……..……Contract

Program Description

The National Cord Blood Inventory (NCBI) Program, established through the Stem Cell Therapeutic and Research Act of 2005 and reauthorized by the Stem Cell Therapeutic and Research Reauthorization Act of 2015, is charged with building a genetically and ethnically diverse inventory of at least 150,000 new units of high-quality umbilical cord blood for transplantation. These cord blood units (CBUs), as well as other units in the inventories of participating cord blood banks, are made available to physicians, working on behalf of patients, for blood stem cell transplants through the C.W. Bill Young Cell Transplantation Program, which is authorized by the same law. Cord blood banks participating in the NCBI Program also make cord blood units available for preclinical and clinical research focusing on cord blood stem cell biology and the use of cord blood stem cells for human transplantation and cellular therapies.

Blood stem cell transplantation is potentially a curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year, nearly 18,000 people in the U.S. are diagnosed with illnesses for which blood stem cell transplantation from a matched donor is their best treatment option. Often, the first-choice donor is a sibling, but only 30 percent of people have a fully tissue-matched brother or sister. For the other 70 percent, or approximately 12,600 people, they often search for a matched, unrelated adult donor or a matched umbilical cord blood unit.

The tissue types of blood stem cell donors must closely match their recipients for the transplant to be successful. Since tissue types are inherited, patients are more likely to find a closely matched donor within their racial and ethnic group. Due to the high rate of diversity in tissue types of racial and ethnic minorities, especially African-Americans, racial and ethnic minorities are less likely to find a suitably matched adult marrow donor on the Program Registry. Because umbilical cord blood can be used with a less than perfect match in tissue type between donor and recipient than is the case for adult marrow donors, umbilical cord blood offers a chance of survival for patients who lack a suitably tissue-matched relative and who cannot find an

adequately matched unrelated adult donor through the Program. Patients from racially and ethnically diverse populations, especially African-American patients, are particularly likely to benefit from additional CBUs. For these reasons, HRSA's NCBI policy continues to emphasize increasing the number of CBUs collected from diverse populations.

The NCBI provides funds through competitive contracts for the collection and storage of qualified CBUs by a network of cord blood banks in the U.S. The NCBI program selects cord blood banks based on assessment of technical merit, overall quality, ability to collect from diverse populations, geographic dispersion of storage sites, evaluation of past performance, and evaluation of proposed costs. Additionally, HRSA prioritizes demonstrated ability of cord blood banks to collect and bank significant numbers of CBUs from racially and ethnically diverse populations.

Program Accomplishments

Currently, thirteen cord blood banks hold NCBI contracts. As of September 30, 2017, the cumulative number of NCBI CBUs available through the Program was 92,546 (Table 1). HRSA estimates that approximately 5,000 additional units will be collected with FY 2019 funds.

Table 1. Cord Blood Collections

Fiscal Year	Number of Units Contracted	Cumulative Units Made Available[173]
2007[174]	23,049	2,017
2008	8,938	11,870
2009	10,207	22,920
2010	9,900	34,744
2011	10,571	43,340
2012	9,162	53,609
2013	7,900	63,960
2014	7,469	74,650
2015	6,469	79,276
2016	5,840	85,443
2017	6,369	92,546

The availability of umbilical cord blood has significantly increased access to blood stem cell transplantation, particularly for patients who would not otherwise have a well-matched adult donor. Additionally, cord blood has accounted for growth in blood stem cell transplants over the

[173] Due to the lag between when cord blood units are collected and when they have been fully tested and qualified for listing on the public registry, all of the units collected with funds from a given fiscal year will not be made available on the registry during that same fiscal year.

[174] Units contracted during FY 2007 used funds from no-year appropriations in FY 2004 – FY 2006 and from FY 2007 annual appropriations. The lag from time of collection of contracted units to when they were made available was significant during the early years of the program (2004-2007).

life of the NCBI Program (Table 2). The NCBI further increases access to transplantation compared to non-NCBI CBUs, because NCBI CBUs are more genetically diverse and contain higher cell counts. Higher cell counts reflect more blood stem cells available for infusion into a transplant patient, which can benefit larger patients and assist with improving outcomes. NCBI units released for transplantation have cell counts well above the levels generally available prior to implementation of the NCBI Program.

Table 2. Cord Blood Units Released for Transplantation

Fiscal Year	NCBI Units Released for Transplantation	Total Cord Blood Units (NCBI and Non-NCBI) released for Transplantation through the C.W. Bill Young Cell Transplantation Program
2007	4	648
2008	104	898
2009	458	1,056
2010	530	1,153
2011	690	1,180
2012	714	1,191
2013	714	1,102
2014	544	1,359
2015	609	1,393
2016	529	1,154
2017	494	1,050
Total	**5,390**	**12,184**

The number of NCBI cord blood units released for transplants fell below the FY 2016 target set due to the increasing use of alternative therapies. In particular, haploidentical transplants, use of blood stem cells from a donor who is biologically related to the recipient-patient, are on the rise. Despite this recent trend, NCBI units remain key in servicing a diverse population. As the NCBI's diverse inventory of cord blood units grows, it will continue to serve an increasing number of patients. Racial and ethnic minorities represent over 60 percent of the cord blood units collected with funds awarded from FY 2007 to FY 2016. HRSA will continue to monitor and assess trends in cord blood transplantation and will adjust collection targets accordingly.

In addition to directly growing the NCBI inventory, the support provided to NCBI-contracted banks has played an important role in stimulating the collection and banking of many other non-NCBI units. These CBUs may not meet the minimum cell content threshold established for the NCBI, but may be a suitable source of blood stem cells for smaller patients where an acceptable cell dose can still be achieved using smaller units. Additionally, NCBI banks have provided researchers more than 53,025 non-NCBI units for a wide variety of research purposes.

Funding History

FY	Amount
FY 2015	$11,266,000
FY 2016	$11,266,000
FY 2017	$12,239,000
FY 2018	$12,183,000
FY 2019	$12,266,000

Budget Request

The FY 2019 Budget requests $12.3 million for the National Cord Blood Inventory program, which is $83,000 above the FY 2018 Annualized CR level. This funding supports continued progress toward the statutory goal of building a genetically diverse inventory of at least 150,000 new units of high-quality cord blood for transplantation. This request will also increase the number of patients in all population groups who are able to obtain life-saving transplants. Cell dose and degree of match between patient and cord blood unit are both strongly associated with positive transplant outcomes. Therefore, a larger inventory of publicly available CBUs will contribute to improved patient survival after transplant because a growing inventory of high cell count CBUs will allow better tissue matches between patients and CBUs.

The FY 2019 Budget request supports collecting and banking approximately 5,000 additional CBUs, assuming an average price to HRSA of $2,000 per cord blood unit, which includes an anticipated price increase of $400 per cord blood unit. HRSA anticipates the NCBI CBUs price increase since cord blood banks are no longer financially positioned to offer the government significant discounts as provided previously. However, HRSA will continue to seek substantial discounts for each cord blood unit through competitive contracting.

The funding request also includes costs associated with the contract review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
40.II.A.1: The cumulative number of minority cord blood units available through the C.W. Bill Young Cell Transplantation Program (NCBI & non-NCBI)[175]	FY 2016: 135,287 Target: 86,720 (Target Exceeded)	80,809	83,809	+3,000
40.II.A.2: The size of the National Cord Blood Inventory (cumulative # of units banked and available through the C.W. Bill Young Cell Transplantation Program)	FY 2016: 85,443 Target: 76,000 (Target Exceeded)	91,000	96,000	+5,000
40.II.A.3: The annual number of NCBI cord blood units released for transplant[176]	FY 2016: 529 Target: 700 (Target Not Met)	535	500	-35

Contracts Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Contracts	5	6	6
Average Contract	$2,265,827	$1,718,833	$1,718,833
Range of Contracts	$498,700-5,290,755	$500,000-5,000,000	$500,000-$5,000,000

[175] Data shows there are close to 19,000 cord blood units designated as "unknown race/ethnicity" as not every cord blood bank require donors to provide the information. Inability to properly categorize these units subsequently impacts tracked data.

[176] Due to advances in the field, the number of unrelated blood stem cell transplants using cord blood has been on the decline, which may impact established targets.

C.W Bill Young Cell Transplantation Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$22,056,000	$21,959,000	$22,109,000	+$150,000
FTE	7	7	7	---

Authorizing Legislation: Public Health Service Act, Sections 379-379B, as amended by Public Law 114-104

FY 2019 Authorization…….$30,000,000

Allocation Method……..…….……Contract

Program Description

The primary goal of the C.W. Bill Young Cell Transplantation Program (Program) is to increase the number of transplants for recipients suitably matched to biologically unrelated bone marrow[177] and umbilical cord blood donors. The Program achieves this goal by: (1) providing a national system for recruiting potential bone marrow donors; (2) tissue typing potential donors; (3) coordinating the procurement of bone marrow and umbilical cord blood units for transplantation; (4) offering patient and donor advocacy services; (5) providing public and professional education; and (6) collecting, analyzing, and reporting data on transplant outcomes.

Blood stem cell transplantation, which includes bone marrow and cord blood, is a potentially curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year nearly 18,000 people in the U.S. are diagnosed with life-threatening illnesses where blood stem cell transplantation from a matched donor is the best treatment option. Often, the ideal donor is a suitably matched family member, but only 30 percent of people have a fully matched relative. The other 70 percent, or approximately 12,600 people, often search for a matched unrelated adult donor or umbilical cord blood unit.

The C.W. Bill Young Cell Transplantation Program is the successor to the National Bone Marrow Donor Registry. While the current scope of the program is similar to that of its predecessor, the Program has expanded responsibility for collecting, analyzing, and reporting data on transplant outcomes, to include all allogeneic (from a genetically similar, but not identical, donor) blood stem cell transplants as well as other therapeutic uses of blood stem cells. The Program operates through four major contracts that require close coordination and oversight.

[177] Public Health Service Act, Sections 379-379B, as amended by P.L. 114-104 states that the term 'bone marrow' means the cells found in the adult bone marrow and peripheral blood.

The authorizing legislation also requires the establishment of an Advisory Council to provide recommendations to the HHS Secretary and to HRSA on activities related to the Program.

The major components of the Program are:

- The combined Single Point of Access – Coordinating Center (SPA-CC) maintains a system for health care professionals and physicians, searching on behalf of patients, to search electronically for cells derived from adult marrow donors and cord blood units through a single point of access and supports coordination activities for bone marrow and cord blood.

- The Office of Patient Advocacy (OPA) maintains a system for patient advocacy, which serves the patient by directly providing to the patient (or family members, physicians, or other individuals acting on behalf of the patient) individualized services with respect to efficiently utilizing the system to conduct an ongoing search for a bone marrow donor or cord blood unit and assists with information regarding treatment options and third party payer matters.

- The Stem Cell Therapeutic Outcomes Database (SCTOD) provides an electronic outcomes blood stem cell transplantation database for use by researchers and health care professionals. The SCTOD also provides a repository that stores donor and recipient samples for research and the collection and analysis of data on the clinical outcomes of blood stem cell transplants.

Performance measures are incorporated into contracts and monitored quarterly to ensure the Program meets its long-term goals in terms of: (1) number of blood stem cell transplants facilitated annually; (2) number of transplants facilitated annually for minority patients; (3) number of domestic transplants facilitated annually; and (4) one-year post-transplant patient survival. The Program also relies on two annual performance measures: (1) number of adult volunteer potential donors of minority race and ethnicity on the Program's registry; and (2) per unit cost for human leukocyte antigen (HLA) tissue typing needed to match patients and donors. Additional performance standards are developed and monitored under each contract.

Program Accomplishments

The Program continues to serve a diverse patient population, with umbilical cord blood playing a vital role in expanding access to transplants for minority patients. Increasing the number of blood stem cell transplants facilitated for patients from racially and ethnically diverse backgrounds addresses the statutory aim of ensuring comparable access to transplantation for patients from all populations. Adding to the pool of potential adult volunteer blood stem cell donors also helps achieve this aim. As of the end of FY 2016, more than 14.8 million potential adult volunteer donors were listed on the Program's registry. More than 3.5 million, or 24 percent, self-identify as belonging to a racial/ethnic minority group, meeting the Program goal of 3.49 million. Program expects the registry will list 4.08 million adult donors who self-identify as belonging to a racial or ethnic minority population in FY 2019.

The cost of tissue typing per donor strongly influences the number of potential volunteer donors recruited for the Program's registry. The FY 2019 cost for each donor's tissue typing will remain at $58.00, the same cost as in FY 2016. The cost of tissue typing increased from $40.81 in FY 2014 to $58.00 in FY 2016 due to advances in typing technology: from an allele-based, high-resolution method to a DNA-based sequencing platform. In addition, newer techniques identify more genetic markers to assist physicians in conducting donor searches on behalf of patients. These advances in tissue typing technology will facilitate more efficient matching between potential donors and searching patients and allow patients to more rapidly move toward transplantation.

Funding History

FY	Amount
FY 2015	$22,109,000
FY 2016	$22,109,000
FY 2017	$22,056,000
FY 2018	$21,959,000
FY 2019	$22,109,000

Budget Request

The FY 2019 Budget requests $22.1 million for the C.W Bill Young Cell Transplantation program, which is $150,000 above the FY 2018 Annualized CR level. This request supports the Program's performance target of 4,080,000 adult volunteer donors from racially/ethnically diverse minority population groups listed on the Program's registry and funds the major Program components.

The majority of funds will be used to recruit and tissue-type new donors. The Program will also continue: (1) collecting comprehensive outcomes data on both related and unrelated-donor blood stem cell transplants; (2) assessing quality of life for transplant recipients; (3) working with foreign transplant centers to obtain data on U.S. stem cell products provided to them for transplant; and (4) collecting data on emerging therapies using cells derived from bone marrow and umbilical cord blood. Additionally, the FY 2019 Budget request allows the Program to continue critical planning in collaboration with HHS on a response to a national radiation or chemical emergency that could leave casualties with temporary or permanent marrow failure and to facilitate emergency transplants for those casualties who would not otherwise recover marrow function.

The funding request also includes costs associated with information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
24.II.A.2: The number of adult volunteer potential donors of blood stem cells from minority race and ethnic groups (Outcomes)	FY 2016: 3.5M Target: 3.49M (Target Met)	3.94M	4.08M	+0.14M
24.1: The number of blood stem cell transplants facilitated by the Program [178] (Outcome)	FY 2013: 6,283 Target: 5,513 (Target Exceeded)	N/A	N/A	N/A
24.2: The number of blood stem cell transplants facilitated for minority patients by the Program [179] (Outcome)	FY 2013: 992 Target: 845 (Target Exceeded)	N/A	N/A	N/A
24.3: The rate of patient survival at one year, post- transplant [180] (Outcome)	FY 2013: 71% Target: 69% (Target Exceeded)	N/A	N/A	N/A
24.4: The number of blood stem cell transplants facilitated for domestic patients by the Program [181] (Outcome)	FY 2013: 3,918 (Baseline) (Target Not in Place)	N/A	N/A	N/A
24.E: The unit cost of human leukocyte antigen (HLA) typing of potential donors (Efficiency)	FY 2016: $58.00 Target: $58.00 (Target Met)	$58.00	$58.00	Maintain

Contracts Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	3	4	4
Average Award	$6,585,737	$4,939,303	$4,939,303
Range of Awards	$800,000-$14,801,102	$800,000-$14,700,000	$800,000-$14,700,000

[178] "This is a long-term measure. The 2017 target for this measure, set at 6,960, will be compared to actuals once available. There is no set schedule for establishing new long-term measures."
[179] "This is a long-term measure. The 2017 target for this measure, set at 845, will be compared to actuals once available. There is no set schedule for establishing new long-term measures."
[180] "This is a long-term measure. The 2017 target for this measure, set at 69%, will be compared to actuals once available. There is no set schedule for establishing new long-term measures."
[181] "This is a new long-term measure. The 2017 target for this measure, set at 5,135, will be compared to actuals once available. There is no set schedule for establishing new long-term measures."

Poison Control Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$18,801,000	$18,718,000	$18,846,000	+$128,000
FTE	2	2	2	---

Authorizing Legislation: Public Health Service Act, Sections 1271-1274, as amended by Public Law 113-77

FY 2019 Authorization ..... National Toll-Free Number - $700,000

FY 2019 Authorization .....Nationwide Media Campaign - $800,000

FY 2019 Authorization .....Poison Control Center Grant Program – $28,600,000

Allocation Method:

- Contracts
- Competitive Grants/Co-operative Agreements

Program Description and Accomplishments

The Poison Control Program (PCP) is authorized through Public Law 113-77, the Poison Center Network Act. The Program is legislatively mandated to fund poison centers; establish and maintain a single, national toll-free number (800-222-1222) to ensure universal access to poison center services and connect callers to the poison centers serving their areas; and implement a nationwide media campaign to educate the public and health care providers about poison prevention, poison center services, and the 800 number.

The grant program supports poison control centers' (PCCs) efforts to: 1) prevent and provide treatment recommendations for poisonings; 2) comply with operational requirements needed to sustain accreditation and or achieve accreditation; and 3) improve and enhance communications and response capability and capacity. Funds may also be used to improve the quality of data uploaded from poison centers to the National Poison Data System (NPDS) in support of national toxic surveillance activities conducted by the Centers for Disease Control and Prevention (CDC).

The Poison Help Line was established in 2001 to ensure universal access to PCC services. Individuals can call from anywhere in the United States (U.S.) and will be connected to the poison center that serves their respective areas. The PCP maintains the number, provides translation services in over 150 languages, and offers services for the hearing impaired.

For over 50 years, PCCs have been our Nation's primary defense against injury and death from poisonings. Today, a network of 55 PCCs provides cost effective, quality health care advice to the general public and health care providers across the entire U.S. including American Samoa, the District of Columbia, the Federated States of Micronesia, Guam, Puerto Rico, and the U.S. Virgin Islands. Twenty-four hours a day, seven days a week, health care providers and other specially trained poison experts provide poisoning triage and treatment recommendations at no cost to the caller. A hallmark of poison center case management is the use of follow up calls to monitor case progress and medical outcomes. Poison centers are not only consulted when children get into household products, but also when seniors and people of all ages take too much medicine or when workers are exposed to harmful substances on the job. Emergency 911 operators refer poison-related calls to PCCs, and health care professionals regularly consult PCCs for expert advice on complex cases. PCCs are a critical resource for emergency preparedness and response as well as for other public health emergencies.

According to the American Association of Poison Control Centers (AAPCC), poison centers managed 2.7 million calls in 2016, an average of 7,446 calls per day. Of the approximate 2.1 million human exposure poisonings reported in FY 2016, PCCs managed 66.6 percent at the site of exposure, avoiding unnecessary visits to emergency departments and reducing health care costs. Health care facilities represented less than one percent of exposures but made approximately 23 percent of poison control calls.[182]

Multiple studies have demonstrated that accurate assessment and triage of poison exposures by poison centers save dollars by reducing severity of illness and death, and eliminating or reducing the expense of unnecessary trips to an emergency department. Poison center consultations also significantly decrease patients' lengths of stay in hospitals and decrease hospital costs.[183,184,185,186] Health care facilities' utilization of poison centers continues to increase, indicating an increase in severity of poisonings and the need for toxicological expertise in clinical settings.[187] Every dollar invested in the poison center system is estimated to save $13.39 in medical costs and lost productivity, for a total savings of more than $1.8 billion every year. Of the $1.8 billion saved, the Federal Government saves approximately $662.8 million in medical care costs and lost productivity.[188]

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[182] David D. Gummin, James B. Mowry, Daniel A. Spyker, Daniel E. Brooks, Michael O. Fraser & William Banner: 2016 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 34th Annual Report, Clinical Toxicology.

[183] Vassilev ZP, Marcus SM. Impact of a Poison Control Center on the Length of Hospital Stay for patients with Poisoning. J Toxicol Environ Health Part A. 2007; 70(2): 107-110

[184] Zaloshnja, E., Miller, T.R., Jones, P., Litovitz, T.; Coben, J.; Steiner, C.; Sheppard, M. (2006). The potential impact of poison control centers on rural hospitalization rates for poisonings. Pediatrics. 118(5), 2094-2100.

[185] Healthcare Cost and Utilization Project [HCUP] (2007). 2005 National Inpatient Sample. Rockville, MD: Agency for Healthcare Research and Quality, Department of Health and Human Services.

[186] Zaloshnja, E., Miller, T.R., Jones, P., Litovitz, T.; Coben, J.; Steiner, C.; Sheppard, M. The impact of poison control cents on poisoning-related visits to emergency departments, U.S. 2003. Am J Emerg Med. 2008.

[187] Bronstein AC, Spyker DA, Cantilena LR Jr, et al. 2011 annual report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 29th annual report. Clin Toxicol (Phila). 2012;50:911-1164.

[188] Value of the Poison Center System: Lewin Group Report for the American Association of Poison Control Centers. 2011.

Through the nationwide Poison Help media campaign, the PCP has been educating the public about the toll-free number and increasing awareness of poison center services. In FY 2017, the Poison Help media campaign included an initial investment of $320,442. Based on over 300 million media impressions through television, radio, and social media, the PCP was able to leverage an advertising return on investment of nearly $5 million.

In addition to providing the public and health care providers with treatment advice on poisonings, a second critical function of the PCCs is the collection of poison exposure and surveillance data. Multiple Federal agencies, including the CDC, Consumer Product Safety Commission, Environmental Protection Agency, Food and Drug Administration, and Substance Abuse and Mental Health Services Administration, use these data for public health surveillance, including timely identification, characterization, or ongoing tracking of outbreaks and other public health threats. In addition, many state health departments collaborate directly with poison centers within their jurisdictions. For example, states and Federal agencies use data from PCCs to monitor exposures to e-cigarette devices and liquid nicotine, synthetic cathinones and cannabinoids, opioids, and laundry detergent packets.

According to the CDC, in 2015, the most recent year for which data are available, unintentional poisoning continues to be the leading cause of unintentional injury deaths. Prescription drugs, primarily opioid analgesics, were responsible for 91 percent of unintentional poisonings. The rate of drug poisoning deaths involving opioid analgesics nearly quadrupled over a 14-year period. PCCs play a critical role in combatting opioid drug-related abuse and misuse, from helping to define and trace the problem within a local and national context to responding to calls from health care providers seeking treatment advice for substance abuse patients.

PCCs also provide public and health care provider education and actively seek to change behaviors to reduce poisonings and promote awareness and utilization of poison center services. Education efforts include: partnering with health departments, education departments, and other state agencies; promoting safe prescription medication use and storage; messaging at health fairs and community events; and collaborating to develop media campaigns focused on preventing injuries. Additionally, PCCs participate in National Prescription Drug Take Back events sponsored by the Drug Enforcement Agency to provide a safe, convenient, and responsible means of prescription drug disposal, while also educating the public about potential medication abuses.

Funding History

FY	Amount
FY 2015	$18,846,000
FY 2016	$18,846,000
FY 2017	$18,801,000
FY 2018	$18,718,000
FY 2019	$18,846,000

Budget Request

The FY 2019 Budget requests $18.8 million for the Poison Control Program, which is an increase of $128,000 above the FY 2018 Annualized CR level. This request will support the PCCs' infrastructure and core triage and treatment services. PCCs predominantly rely on state and local funding, as Federal funding accounts for approximately 13 percent of total PCC funding. While PCCs have innovatively secured funding from a variety of local sources, including philanthropic organizations, their financial stability is tenuous. Federal funding helps reinforce the nationwide PCC infrastructure, enabling PCCs to sustain their public health and toxicosurveillance efforts.

The FY 2019 Request will also support the following activities:

National Toll-Free Hotline Services and Promotion of Number and Services will ensure access to PCCs through the national toll-free Poison Help hotline, 24 hours a day, every day of the year and will also support translation services for non-English speaking callers.

Nationwide Media Campaign will continue to educate the public and health care providers about the national toll-free number and to build upon the existing national public awareness campaign, to highlight the role of PCCs in the public health system with a focus on Medicare and Medicaid beneficiaries. In FY 2019, the PCP will continue to build upon the existing national public awareness campaign, Poison Help. The goals of the campaign include, increasing public awareness of the national Poison Help toll-free number; educating Medicare and Medicaid beneficiaries about poisoning risk and prevention; and showcasing the role of the national network of PCCs and the services they provide. The PCP will also continue to promote the hotline to the public and health care providers as well as engage other Federal partners including community health centers, 340B Drug Pricing Program participants, geriatric education centers, rural health associations, Ryan White Program providers, and Head Start programs.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
25.III.D.3: Percent of inbound volume on the toll-free number. (Output)	FY 2017: 85.5% Target: 83.0% (Target Exceeded)	83%	83%	Maintain

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
25. III.D.4: Percent of national survey respondents who are aware that calls to poison control centers are handled by health care professionals. (Outcome)[189]	FY 2012: 25% (Target Expected in FY2018)	25%	N/A	N/A
25. III.D.5: Percent of human poison exposure calls made to PCCs that were managed by poison centers outside of a healthcare facility. (Output)	FY 2016: 66.6% Target: 71% (Target Not Met)	65%	65%	Maintain

Grants Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards[190]	52	52	52
Average Awards	$323,762	$327,275	$329,635
Range of Award	$12,466-$1,974,902	$12,466-$2,006,384	$12,466-$2,013,447
Range of Contracts	$10,168-$320,443	$10,168-$320,443	$10,168-$320,443

[189] This is a long-term measure based on periodic survey data, reported about every 5 years.
[190] There are 55 PCCs across the Nation. Fifty-two awards were made in FY 2017 and are anticipated in FY 2018 and FY 2019 under the Poison Center Network Grant Program, representing all of the poison centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, while it encompasses four California poison centers.

Office of Pharmacy Affairs/340B Drug Pricing Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$10,213,000	$10,168,000	$10,238,000	+$70,000
User Fees	---	---	$16,000,000	+$16,000,000
TOTAL	$10,213,000	$10,168,000	$26,238,000	+$16,070,000
FTE	22	22	22	---

Authorizing Legislation: Public Health Service Act, Section 340B, as amended by Public Law 111-309, Section 204

FY 2019 Authorization…….…….…….…….....SSAN

Allocation Method……...…….……..….Contract

Program Description and Accomplishments

Section 602 of Public Law 102-585, the "Veterans Health Care Act of 1992," enacted section 340B of the Public Health Service Act (PHSA), "Limitation on Prices of Drugs Purchased by Covered Entities." Administered by HRSA's Office of Pharmacy Affairs, the 340B Program requires drug manufacturers to provide discounts on outpatient prescription drugs to certain safety net health care providers specified in statute, known as covered entities. This includes Federally Qualified Health Centers, AIDS Drug Assistance Programs, and certain disproportionate share hospitals. The 340B Program can help these designated hospitals and clinics provide more care to additional patients. A 2011 Government Accountability Office (GAO) study found that entities participating in the 340B Program are able to expand the type and volume of care they provide to target patient populations as a result of access to these lower cost medications.

The 340B ceiling price – the maximum amount a drug manufacturer can charge a covered entity for a given drug – is equal to the Average Manufacturer Price (AMP) minus the Unit Rebate Amount, both set by the Centers for Medicare & Medicaid Services (CMS). Covered entities purchase 340B drugs that are at least 23.1 percent below AMP for brand name drugs; 13 percent below AMP for generic drugs; and 17.1 percent below AMP for clotting factor and pediatric drugs. In 2016, total sales in the 340B Program were approximately $16 billion. Covered entities saved between 25 to 50 percent on what they would have otherwise paid for covered outpatient drugs. HRSA estimates 340B sales are approximately 3.6 percent of the total U.S. drug market.

HRSA places a high priority on the integrity of the 340B Program and continually works to improve its oversight of the Program. HRSA conducts the following activities to ensure both covered entities and manufacturers are in compliance with program requirements:

- Performs initial eligibility checks of all entities seeking to register with the Program.
- Recertifies covered entities annually including an attestation to compliance with all Program requirements.
- Performs audits of covered entities to assure compliance within the Program. Since FY 2012 HRSA has completed 814 covered entity audits which included review of 11,057 offsite outpatient facilities and 18,063 contract pharmacies. Final audit results, including statuses of corrective actions, are available on HRSA's website. As of July 1, 2017, HRSA has closed out and finalized 642 of the 814 audits conducted with 48 percent of findings related to diversion and 28 percent related to duplicate discount.
- Reviews every non-compliance allegation received through targeted communication and, if necessary, on-site audits.
- Performs audits of manufacturers.
- Provides assistance to covered entities that self-disclose compliance issues, including developing corrective action plans and working with affected manufacturers.
- Supports an integrated system of compliance tracking for covered entities and manufacturers, enabling enhanced communication across the Office of Pharmacy Affairs to ensure that all covered entities and manufacturers are in compliance with 340B program requirements.

HRSA uses the results of these program integrity efforts to develop and refine a proactive strategy to promote best practices for complying with Program requirements.

Section 340B(a)(8) of the Public Health Service Act required the establishment of a 340B Prime Vendor Program (PVP). The purpose of PVP is to develop, maintain, and coordinate a program capable of facilitating distribution in support of the 340B Program. By the end of 2017, PVP had nearly 7,800 products available to participating entities below the 340B ceiling price, including 3,760 covered outpatient drugs with an estimated average savings of 10 percent below 340B ceiling price. From 2009 to 2017, the PVP contracts provided over $723 million in additional sub-ceiling savings for covered entities.

HRSA continues to strengthen the program, including implementation of recommendations made by the Office of the Inspector General (OIG) and GAO. For example, OIG recommended that HRSA provide covered entities access to ceiling price information and improve oversight of 340B pricing. The following activities are priorities in FY 2018:

- Price Verification – Compute the 340B ceiling prices using data that manufacturers supplied to CMS, based on an agreement with HRSA.
- Refunds and Credits – Facilitate the process for refunds and credits to entities who were overcharged by participating manufacturers.
- Pricing System – Continue to develop a system whereby covered entities can access 340B ceiling price information via a secure website. The system will allow manufacturers

to submit 340B price information, allowing regular spot checks of prices and any necessary follow up on pricing errors.

Funding History

FY	Budget Authority	User Fees
FY 2015	$10,238,000	---
FY 2016	$10,238,000	---
FY 2017	$10,213,000	---
FY 2018	$10,168,000	---
FY 2019	$10,238,000	$16,000,000

Budget Request

The FY 2019 Budget requests $10.2 million in budget authority for the 340B Program, which is $70,000 above the FY 2018 Annualized CR level, and $16.0 million from user fees, as a new revenue source. In FY 2019, HRSA will begin the development of a multi-functional web-based user fee system that will calculate user fees based on required manufacturer and covered entity sales data, collect user fees from covered entities, and verify payments. HRSA bases revenue projections on collecting a 0.1 percent (or one dollar for every thousand dollars) of the total 340B drug purchases paid by participating covered entities. Funding from both sources will support implementation of 340B Program statutory obligations, oversight of participating manufacturers and covered entities, operational improvements, and increased efficiencies using information technology.

General regulatory authority over the 340B Program would allow HHS to set clear enforceable standards on participation on all aspects of 340B program and will help ensure compliance with 340B Program requirements. Hospitals participating in 340B are not required to report on 340B savings or how these savings are used to benefit patient populations. The FY 2019 Request also proposes to reform the 340B Program through a General Provision in the L/HHS Appropriations Act that would require covered entities to report both the savings and their uses to HRSA, and provide HRSA with general regulatory authority. In addition, the Budget includes a legislative proposal to amend the 340B statute to improve program integrity and ensure that the program benefits patients, especially low-income and uninsured patients. These reforms would ensure low income and uninsured patients benefit from the Program, as intended, and strengthen program integrity and oversight activities.

FY 2019 Budget Authority

The FY 2019 Budget request provides resources for the 340B Program to educate participating covered entities and prospective sites on compliance with statutory requirements. For participating covered entities, HRSA will continue to expand its oversight activities, producing a sentinel effect of increased compliance. PVP data shows education based on oversight measures reduces the risk of future compliance issues. Finally, HRSA will conduct audits of manufacturers, which should not only increase compliance, but also provide greater insight into the tools and mechanisms used by companies to comply with 340B statutory requirements and

guide future technical assistance. HRSA will continue to strengthen the program, including implementation of recommendations made by the Office of the Inspector General (OIG) and GAO. The following activities are priorities in FY 2019:

- Price Verification – Compute the 340B ceiling prices using data that manufacturers supplied to CMS, based on an agreement with HRSA. Conduct random spot checks of these prices with information submitted voluntarily by a small group of manufacturers.
- Price Submission – Maintain a secure system for all manufacturers to submit 340B price information, allowing regular spot checks of prices and any necessary follow up on pricing errors.
- Refunds and Credits – Facilitate refunds and credits to entities that are overcharged by participating manufacturers.
- Pricing System – Continue to develop a system whereby covered entities can access 340B ceiling price information via a secure website. Implementation is expected once the Civil Monetary Penalty and Ceiling Price calculation regulation has been finalized and any necessary changes to the system have been implemented.

In addition, GAO recommended that HRSA clarify the definition of a patient eligible to receive 340B drugs, as well as eligibility of certain hospitals that participate as covered entities. HRSA prioritizes developing and providing clear policies to stakeholders through regulations and guidance.

The FY 2019 Request for budget authority includes costs associated with contract award process, follow-up reviews, and information technology and other program support costs.

FY 2019 User Fees

In FY 2019, HRSA will began user fee implementation. Revenue collected from user fees, once fully implemented, will support improvements to the 340B public database, program audits, and improve the Program's automated compliance management tool.

- Improvement of 340B Public Database – The Office of Pharmacy Affairs Information System (OPAIS) is a multi-function web-based database system that provides information on covered entities, contract pharmacy arrangements, and participating manufacturers. External stakeholders use the database to verify eligible entities and their associated sites, confirm manufacturer participation, and prevent statutorily prohibited duplicate discounts. Integrity of the 340B database requires ongoing maintenance and development. The user fee request would provide the additional resources needed to improve the integrity, transparency, security, and reliability of the OPAIS and ensure that the database continues to meet the needs of external stakeholders.

- Program Audits of Covered Entities – HRSA plans to continue random and targeted audits of covered entities, as well as publish audit report summaries on the HRSA website to expand the program's compliance reach while managing program risk. The user fee request would provide the additional funding needed to hire and train staff to

conduct an additional 100 on-site covered entity audits, write reports, work with entities through the notice and hearing process, and finalize information for public dissemination.

- Program Audits of Manufacturers – HRSA plans to continue random and targeted audits of manufacturers, as well as publish audit report summaries on the HRSA website to expand the program's compliance reach while managing program risk. The user fee request would provide additional funding to hire and train staff to conduct an additional five manufacturer audits, write reports, work with manufacturers through the notice and hearing process, and finalize information for public dissemination.

Performance Measures

HRSA measures 340B Program performance by two key metrics. HRSA tracks participation levels of eligible providers and ensures quality through oversight and audits of covered entities and manufacturers.

As of January 1, 2018, there were 12,823 covered entities and 29,663 associated sites participating in the 340B Program, for a total 42,486 registered sites. Twenty-seven percent of the 42,486 covered entity sites have contract pharmacy arrangements that support 20,757 unique pharmacy locations registered in the 340B database.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
39.I.A.1: Covered Entity Audits Conducted	FY 2017: 200 Target: 200 (Target Met)	200	200	Maintain
39.I.A.2: Manufacturer Audits Conducted	FY 2017: 5 Target: 5 (Target Met)	5	5	Maintain

Contracts Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Contracts	3	3	3
Average Contract	$2,766,666	$3,000,000	$3,000,000
Range of Contracts	$1,500,000 - $3,900,000	$1,000,000 - $4,000,000	$1,000,000 - $4,000,000

National Hansen's Disease Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$15,169,000	$15,103,000	$11,653,000	-$3,450,000
FTE	56	56	52	-4

Authorizing Legislation: Public Health Service Act, Section 320, as amended by Public Law 105-78, Section 211

FY 2019 Authorization ..... Indefinite

Allocation Methods:
- Direct Federal/Intramural
- Contract

Program Description and Accomplishments

The National Hansen's Disease Program (NHDP) provides medical care, education, and research for Hansen's disease (HD, leprosy) and related conditions as authorized since 1921. Medical care includes providing direct patient care (diagnosis, treatment and rehabilitation), HD drug regimens at no cost to patients, consultations, laboratory services and outpatient referral services to any patient living in the United States (U.S.) or its territories. The Program strengthens the safety net infrastructure for patients with this rare disease by focusing on case management, patient compliance, and training on the diagnosis and management of Hansen's disease, with specific outreach efforts to health care providers who are likely to encounter and treat patients in geographic areas most impacted by the disease. The more complicated HD cases are treated as short-term referrals in the NHDP clinic in Baton Rouge, Louisiana.

Ninety-five percent of the human population is not susceptible to infection with *M. leprae*, the bacteria that causes leprosy. Hansen's disease is also not highly transmissible, is very treatable, and, with early diagnosis and treatment, is not disabling. Treatment with standard antibiotic drugs is very effective, and patients become noninfectious after taking only a few doses of medication and need not be isolated from family and friends. However, diagnosis in the U.S. is often delayed because health care providers are unaware of Hansen's disease and its symptoms. Early diagnosis and treatment prevents nerve involvement, the hallmark of Hansen's disease, and the disability it causes. People with leprosy can generally continue their normal work and other activities uninterrupted while they are under treatment, which may last several years.

Increasing Quality of Care: Increasing health care provider knowledge about Hansen's disease will lead to earlier diagnosis and treatment, which are key to blocking or arresting the trajectory

of Hansen's disease-related disability and deformity. The Program facilitates outpatient management of leprosy by providing additional laboratory, diagnostic, consultation, and referral services to private sector physicians. NHDP increases U.S. health care providers' knowledge by serving as an education and referral center.

Improving Health Outcomes: Hansen's disease is a life-long chronic condition, which left untreated and unmanaged usually progresses to severe deformity. Through a focus on early diagnosis and treatment, NHDP measures its impact on improving health outcomes for Hansen's disease patients in terms of reducing the percentage of patients with grades 1 or 2 disability/deformity.[191] The percentage of patients presenting with disability fluctuates due to several variables, including migration, immigration, and disease stigma. However, fluctuations in disability are primarily attributed to delays in diagnosis

The Program has also been improving health outcomes through research. With advanced scientific knowledge and breakthroughs in genomics and molecular biology, the Program has been advancing the standard-of-care for leprosy with rapid assessment of drug resistance and strain typing of leprosy bacilli to determine the origins of individual infections and the likelihood of severe pathological reactions.

Promoting Efficiency: The NHDP outpatient care is comprehensive and includes treatment protocols for multi-drug therapy, diagnostic studies, provider consultations, ancillary medical services, clinical laboratory analysis, hand and foot rehabilitation, leprosy surveillance, and patient transportation for indigent patients.

Fostering Collaboration: NHDP is the sole worldwide provider of reagent grade viable leprosy bacilli and collaborates with researchers across the globe to further scientific investigations and advances related to the disease. NHDP coordinates and collaborates with Federal, state, local, and private programs to further leverage and promote efforts to improve quality of care and health outcomes related to Hansen's disease. Areas of collaboration include a partnership with the Food and Drug Administration (FDA) Drug Shortage Program to distribute the drug Clofazimine to over 500 providers nationally. The Program manages the investigational new drug (IND) application that makes Clofazimine available in the U.S. for treatment of leprosy. .

[191] Disability/deformity is measured based on the World Health Organization scale, which ranges from 0-2. Patients graded at 0 have protective sensation and no visible deformities. Patients graded at 1 have loss of protective sensation and no visible deformity. Patients graded at 2 have visible deformities secondary to muscle paralysis and loss of protective sensation.

Funding History

FY	Amount
FY 2015	$15,206,000
FY 2016	$15,206,000
FY 2017	$15,169,000
FY 2018	$15,103,000
FY 2019	$11,653,000

Budget Request

The FY 2019 Budget requests $11.7 million for the National Hansen's Disease Program, which is $3.5 million below the FY 2018 Annualized CR level. This request supports the Program's primary focus on direct patient care activities and improving health outcomes for Hansen's disease patients. The reduced funding level also reflects a declining inpatient beneficiary population and improvements in health outcomes through research and health care provider education.

NHDP continues to evaluate ways to optimize resources to provide the most effective and efficient health care services to leprosy patients across the nation. As part of this effort, in FY 2018, NHDP expects to reduce the number of ambulatory care clinics to align resources with levels of care. Hansen's disease patients with severe complications, either who are advanced on the HD spectrum or who have HD related disabilities, may be referred to the primary clinic in Baton Rouge free of charge. The National Hansen's Disease Program provides HD medication free of charge to all providers upon request for the care and treatment of HD patients.

NHDP is assessing ways to reduce the overall footprint occupied by clinical and administrative branches and the Gillis W. Long Hansen's Disease Center, located in Carville, Louisiana. Currently, the branches are located in separate facilities in Baton Rouge. NHDP is working with the General Services Administration to locate a new facility, accommodate the structure to NHDP special needs (patient rooms, pharmacy, rehab therapy, medical records, etc.) and complete a lease agreement before January 2020.

The funding request also includes costs associated with the contract review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Table

Measure	Year and Most Recent Result/Target for Recent Result/ (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
3.E.: Maintain the increase in the cost per outpatient served below the medical inflation rate (Efficiency)	FY 2016: -6.59% Target: Below national medical inflation rate Target: 4.11 % (Target Met)	Maintain below national medical inflation rate	Maintain below national medical inflation rate	Maintain
3.II.A.4.: Number of health care providers who have received training from NHDP (Output)	FY 2017: 682 Target 550 (Target Exceeded)	550	550	Maintain
3.II.A.1.: Percentage of patients at Grade 1 or 2 disability [192] (Outcome)	FY 2016: 42% Target: Less than or equal to 50% (Target Met)	Less than or equal to 50%	Less than or equal to 50%	Maintain

Program Indicators

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Resident Population: Inpatients	6	4	4
Baton Rouge Clinic: Outpatients	177	177	177
Baton Rouge Clinic: Outpatient Visits	20,859	20,859	20,859
Ambulatory Care Program (ACP) Clinics	16	3-8	3-8
ACP Clinic: Outpatients	3,394	2919	2919
ACP Clinic: Outpatient Visits	5,754	4948	4948

[192] World Health Organization scale: Grade 0 = no disability; Grade 1 = sensory loss; Grade 2 = visible deformity

National Hansen's Disease Program – Buildings and Facilities

	FY 2017 Enacted	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$122,000	$121,000	---	-$121,000
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 320 and 321(a)

FY 2019 Authorization ..... Indefinite

Allocation Method ..... Direct Federal

Program Description and Accomplishments

This activity provides for renovation and modernization of buildings at the Gillis W. Long Hansen's Disease Center at Carville, Louisiana, to eliminate structural deficiencies under applicable laws in keeping with accepted standards of safety, comfort, human dignity, efficiency, and effectiveness. Projects assure a safe facility and functional environment for the delivery of patient care and training activities, while meeting requirements to preserve the Carville historic district under the National Historic Preservation Act.

Funding History

FY	Amount
FY 2015	$122,000
FY 2016	$122,000
FY 2017	$122,000
FY 2018	$121,000
FY 2019	$---

Budget Request

There is no request in FY 2019 for Building and Facilities. There are sufficient funds available to continue renovation and repair work on patient and clinic areas and to complete minor renovation work at the Carville facilities.

Payment to Hawaii

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$1,853,000	$1,844,000	$1,857,000	+$13,000
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Section 320(d), as amended by Public Law 105-78, Section 211

FY 2019 Authorization ..... Indefinite

Allocation Method .....Direct Federal

Program Description and Accomplishments

Payments are made to the State of Hawaii for the medical care and treatment of persons with Hansen's disease (HD) in its hospital and clinic facilities at Kalaupapa, Molokai, and Honolulu. Expenses above the level of the Federal funds appropriated for the support of medical care are borne by the State of Hawaii.

Funding History

FY	Amount
FY 2015	$1,857,000
FY 2016	$1,857,000
FY 2017	$1,853,000
FY 2018	$1,844,000
FY 2019	$1,857,000

Budget Request

The FY 2019 Budget requests $1.9 million, which is an increase of $13,000 over the FY 2018 Annualized CR level. In addition to the payment made to the State of Hawaii for the medical care and treatment of person with HD, the funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology, and other program support costs.

Rural Health Policy TAB

FEDERAL OFFICE OF RURAL HEALTH POLICY

Rural Health Policy Development

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$9,328,000	$9,287,000	$5,000,00	-$4,287,000
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 301 and Social Security Act, Section 711

FY 2019 Authorization ..... Indefinite

Allocation Method ..... Competitive Grant

Program Description and Accomplishments

The Federal Office of Rural Health Policy (FORHP) is charged with advising the HHS Secretary on how rural health care is impacted by current policies as well as proposed statutory, regulatory, administrative, and budgetary changes in the Medicare and Medicaid programs. The authorizing legislation requires FORHP to advise on: (1) the financial viability of small rural hospitals; (2) the ability of rural areas (particularly rural hospitals) to attract and retain physicians and other health professionals; and (3) access to and quality of health care in rural areas. FORHP is also charged with overseeing compliance, per the requirements of section 1102(b) of the Social Security Act, related to assessing the impact of key regulations affecting a substantial number of small rural hospitals. To support these advisory and compliance roles, FORHP maintains clearinghouses for collecting and disseminating information on rural health care issues, promising approaches to improving and enhancing health care delivery in rural communities, and policy-relevant research findings addressing rural health care delivery.

Rural Health Policy Development supports a range of activities including policy analysis, research, and information dissemination. The Rural Health Research Center and Rapid Response Research Programs are the only Federal research programs specifically designed to provide both short and long-term policy relevant studies on rural health issues. The Research Center program awards seven research center grants to conduct policy-oriented health services research, while the Rapid Response Research Program awards one grantee to conduct rapid data analyses and short-term, issue-specific rural research studies. Rural Health Research Centers publish in policy briefs, academic journals, research papers, and other venues, and their publications are available

to policy makers at both the Federal and State levels. Research Center briefs also align with Administration priorities, such as addressing opioid abuse and other clinical priorities. For example, the Research Centers Program is developing a number of research briefs for release in FY 2018 that analyze rural-urban differences in opioid-affected pregnancies and births, variations in family physicians' prescribing of Buprenorphine, and best practices for providing Buprenorphine Maintenance Treatment.

Rural Health Policy Development supports cooperative agreements, including the Research Gateway, which are public clearinghouses for rural health policy research and provide general information on HRSA's rural health programs. In FY 2017, these clearinghouses disseminated 61 research reports, including policy briefs, full reports posted on the Rural Health Research Gateway website, and documents published in peer-reviewed journals.

Rural Health Policy Development also supports the staffing for the National Advisory Committee on Rural Health and Human Services (NACRHHS), which advises the HHS Secretary on rural health and human service programs and policies, produces policy briefs, and makes recommendations on emerging rural policy issues. In addition, HRSA continues to monitor and track the number of rural hospitals that have closed across the country and funds a number of grants that focus on addressing hospital closures or mitigating the loss of services due to hospitals facing financial distress.

Funding History

FY	Amount
FY 2015	$9,351,000
FY 2016	$9,351,000
FY 2017	$9,328,000
FY 2018	$9,287,000
FY 2019	$5,000,000

Budget Request

The FY 2019 Budget requests $5.0 million for Rural Health Policy Development, which is $4.3 million below the FY 2018 Annualized CR level. This request will maintain base-level support for the following activities: Rural Health Research Centers; Rapid Response Program; Rural Health Research Gateway; rural health information dissemination; and the National Advisory Committee on Rural Health and Human Services. The Rural Health Research Center program will produce 14 rural policy briefs in FY 2019.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Outcome)	FY 2017 : 61 Target: 39 (Target Exceeded)	35	14	-21

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 Annualized CR
Number of Awards	13	13	9
Average Award	$656,662	$639,867	$298,000
Range of Awards	$120,000-$1,548,632	$120,000-$1,540,889	$100,000-$350,000

Rural Health Care Services Outreach, Network and Quality Improvement Grants

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$65,347,000	$65,055,000	$50,811,000	-$14,244,000
FTE	8	8	8	---

Authorizing Legislation: Public Health Service Act, Section 330A, as amended by Public Law 110-355, Section 4

FY 2019 Authorization .....Expired

Allocation Method ..... Competitive Grants and Cooperative Agreements

Program Description and Accomplishments

The Rural Health Care Services Outreach, Network and Quality Improvement Grants (Outreach programs) improve rural community health by focusing on quality improvement, increasing health care access, coordination of care, and integration of services.

All Outreach grant programs support collaborative models to deliver basic health care services to rural areas and are uniquely designed to meet rural needs. The grants allow rural communities to compete for funding against other rural communities, rather than competing against larger metropolitan communities with greater resources. The Outreach programs are among the only non-categorical grants within HHS, allowing grantees to determine the best ways to meet local needs. This flexibility responds to the unique health care challenges in rural communities and enables communities to determine the best approaches for addressing needs. Rural Health Care Services Outreach, Network and Quality Improvement Grants Programs include:

- Rural Health Care Services Outreach Grants focus on improving access to care in rural communities through the work of community coalitions and partnerships. These grants often focus on disease prevention and health promotion but can also support expansion of services such as primary care, opioid abuse treatment and prevention, mental and behavioral health, and oral health care services. Grantees are required to submit and track baseline data throughout their project periods and to develop their programs based on promising practices or evidence-based models. The program expects to fund 55 awards in FY 2019.

  The Outreach Services grant funding also supports the Rural Health Opioid Program. This program promotes rural health care services outreach by expanding the delivery of

opioid related health care services to rural communities through broad community consortiums focused on treatment, care coordination practices to organize patient care activities, and support to individuals in recovery through behavioral counselling and peer support activities. The program brings together non-profit entities such as hospitals, primary care practices, substance abuse treatment centers, social service organizations, and other community groups to respond with a multifaceted approach to the opioid epidemic in a rural community. The program expects to continue 10 awards in FY 2019.

The FY 2019 Budget also allocates new resources to HRSA to combat the opioid epidemic. Additional details can be found under the Opioid tab.

- Rural Network Development Grants support building regional or local partnerships among local hospitals, physician groups, long-term care facilities, and public health agencies to improve management of scarce health care resources. The program focuses on demonstrating the health outcomes made by the network as well as positioning networks to be successful in the current health care landscape. Grantees under this program are likely to focus on improving health outcomes and enhancing health care quality. The program expects to continue 51 awards in FY 2019.

- Rural Network Development Planning Grants bring together key parts of a rural health care delivery system (hospitals, clinics, public health, etc.) so they can work together to address local health care challenges. The Network Planning provides an opportunity for grantees to work on priority and emerging public health issues, such as opioid abuse. The program plans to award 20 new grants in FY 2019.

- Small Health Care Provider Quality Improvement Grants help improve patient care and chronic disease outcomes by assisting rural primary care providers with the implementation of quality improvement activities. Specifically, program objectives include developing more coordinated delivery of care, enhanced chronic disease management, and improved health outcomes for patients. An additional program goal is to prepare rural health care providers for quality reporting and pay-for-performance programs. The program expects to award 15 new grants in FY 2019.

- The Delta States Network Grant Program provides network development grants to the eight states in the Mississippi Delta for network and rural health infrastructure development. In addition, the program supports chronic disease management, oral health services, and recruitment and retention efforts. Unlike the programs mentioned above, this program is geographically targeted, given the health care disparities across this eight-state region. The program also requires all grantees to focus on diabetes, cardiovascular disease, and obesity and to develop programs based on promising practices or evidence-based models. The program expects to award 12 new grants in FY 2019.

In FY 2017, the Outreach program received an additional $2 million to enhance health care delivery in the Delta region. As a result, a three-year Delta Region Community Health Systems Development Cooperative Agreement was developed and awarded. This program will help

underserved rural communities identify and better address their health care needs and will help small rural hospitals and clinics improve their financial and operational performances. These efforts will be coordinated with the Delta Regional Authority (DRA), particularly in the selection of the communities to receive assistance. The program expects to continue the Delta Region Community Health Systems Development award in FY 2019.

The Outreach programs continue to conduct program evaluations and build evidence-based models for new ways to improve health care in rural communities. Evaluations focus on measuring program impact on the health status of rural residents with chronic conditions and economic impact of the Federal investment in rural communities. Grantees use the Rural Health Information (RHI) Hub's Economic Impact Analysis[193] tool to assess the economic impact of the Federal investment. The tool translates project impacts into community-wide benefits, such as number of jobs created, new spending, and impacts of new and expanded services.

Grantees are also required to demonstrate program impact through outcome-focused measures. Grantees track and submit to HRSA baseline data throughout their project periods and implement programs that are adapted from promising practices or evidence-based models. The programs support innovative models that offer rural communities the tools and resources to enhance health care services and ease the transition to health care models focusing on improved quality and value.

While making the initial Federal investment in a rural area, each of the grant programs expects the communities to continue providing the services at the conclusion of the grant funding. As project periods end, the Outreach programs continually assess program sustainability. While sustainability rates may vary across grantee cohorts, the majority of projects are expected to continue after Federal funding. The most recent cohort of community-based grantees that completed Federal funding is the Rural Health Network Development. The FY 2016 results showed that 98 percent of the Rural Health Network Development grantees continued to sustain either all or some of their programs, exceeding the target of 70 percent.

Across the programmatic investments made in the Outreach programs, findings and key lessons learned from evaluations and case studies are gathered and made available on the RHI Hub's Community Health Gateway[194] so that rural communities from across the country can benefit from Outreach program investments and results.

Funding History

FY	Amount
FY 2015	$59,000,000
FY 2016	$63,500,000
FY 2017	$65,347,000
FY 2018	$65,055,000
FY 2019	$50,811,000

[193] https://www.ruralhealthinfo.org/econtool
[194] https://www.ruralhealthinfo.org/community-health

Budget Request

The FY 2019 Budget requests $50.8 million for the Rural Health Care Services Outreach, Network, and Quality Improvement Grants, which is $14.7 million below the FY 2018 Annualized CR level. The budget will support 87 existing grantees and 66 new grant awards that will positively affect health care service delivery for 230,000 people.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
29.IV.A.3. Track number of unique individuals who received direct services through FORHP Outreach grants, subject to availability of resources. (Outcome)	FY 2016: 993,187 Target: 410,000 (Target Exceeded)	420,000	230,000	-190,000
29.IV.A.4: Percent of Outreach Authority grantees that will continue to offer services after the Federal grant funding ends.[195] (Outcome)	FY 2016: 98% Target: 70% (Target Exceeded)	75%	75%	Maintain

[195] Outreach programs have varying three-year project periods. When sustainability data is captured at the end of a program project period, sustainability rates may vary based on the nature of the program ending.

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	197	186	164
Average Award	$278,758	$264,883	$285,615
Range of Awards	$74,515 - $2,000,000	$100,000 - $ 2,000,000	$100,000 - $2,000,000

Rural Hospital Flexibility Grants

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$43,509,000	$43,313,000	---	-$43,313,000
FTE	2	2	---	-2

Authorizing Legislation: Social Security Act, Section 1820(j), as amended by Public Law 105-33, Section 4201(a), and Public Law 108-173, Section 405 (f), as amended by Section 121, Public Law 110-275

FY 2019 Authorization .....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments

The Rural Hospital Flexibility Grants are offered through three grant programs:

- Medicare Rural Hospital Flexibility Grant (Flex) Program supports a partnership between 45 states and over 1,300 Critical Access Hospitals (CAHs) to work on quality and performance improvement activities, as well as help eligible rural hospitals convert to CAH status and enhance CAH-related emergency medical services. The Flex Program's goal is to help CAHs maintain high-quality and economically viable facilities to ensure that rural community residents, particularly Medicare beneficiaries, have access to high-quality health care services. States use Flex resources to address identified CAH needs and to achieve improved and measurable outcomes in each selected program area. In FY 2017, the Flex program received an additional $2 million that was provided to 40 hospitals as supplemental awards to serve rural communities with high rates of poverty, unemployment and substance abuse.

  The Flex Program plays a key role in ensuring that CAHs are aligned with certain Medicare Program quality initiatives. All prospective payment system hospitals (PPS) are required to submit quality data to the Centers for Medicare & Medicaid Services (CMS) to receive a full Medicare payment update. While not subject to this CMS requirement, CAHs elect to submit quality data to CMS to demonstrate areas of high quality while also identifying areas for improvement. As a result of the Flex Program's Medicare Beneficiary Quality Improvement Project (MBQIP), ninety-six percent[196] of CAH's are reporting quality data to CMS.

[196] Results based on the Flex Monitoring Team analysis of the 2016 CMS data.

- Small Rural Hospital Improvement Program (SHIP) provides support to rural hospitals with fewer than 50 beds to enhance their administrative capabilities in meeting information technology and reporting requirements under value-based care through awards to 46 states with eligible hospitals, SHIP provides funding for equipment and training to upgrade billing requirements, such as incorporating new ICD-10 standards, and for software that captures patient satisfaction data.

- Flex Rural Veterans Health Access Program provides grants to Alaska, Missouri, and South Carolina, states with high percentages of veterans relative to their total populations. This program focuses on increasing the delivery of mental health services or other health care services to meet the needs of Operation Iraqi Freedom and Operation Enduring Freedom veterans living in rural areas. Administered in collaboration with the Department of Veterans Affairs (VA) Office of Rural Health, this program enhances health care for veterans living in isolated rural areas and who receive care both at their local facilities and at more distant VA facilities. Grantees focus on investments in telehealth and health information exchange technologies to improve veteran access to needed services and to provide veterans greater continuity of care.

Funding History

FY	Amount
FY 2015	$41,609,000
FY 2016	$41,609,000
FY 2017	$43,509,000
FY 2018	$43,313,000
FY 2019	$---

Budget Request

The FY 2019 Budget requests $0 for Rural Hospital Flexibility Grants, which is $43.3 million below the FY 2018 Annualized CR level. The Budget prioritizes programs that provide direct health care services.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
30.V.B.6: Increase the percent of Critical Access Hospitals participating in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey	FY 2015: 75.8% Target: 70% (Target Exceeded)	76%	N/A	N/A
30. V.B.7a: Percent of CAHs participating in one or more Flex-funded required quality improvement initiatives that showed improvement in one or more specified quality domains.[197] *(Developmental)*	FY15: 65% (Target Not in Place)	N/A	N/A	N/A
30. V.B.7b: Percent of CAHs participating in one or more Flex-funded optional quality improvement initiatives that showed improvement in one or more specified quality domains.[198] *(Developmental)*	FY15: 44% (Target Not in Place)	N/A	N/A	N/A

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	94	94	---
Average Award	$565,000	$565,000	---
Range of Awards	$18,000-$945,000	$18,000-$945,000	---

[197] FY 2015 was the first year of data for this measure. Targets will be set after two years of results.

[198] The initial baseline is from FY 2015 data. Targets will be set after two years of results.

State Offices of Rural Health

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$9,977,000	$9,932,000	---	-$9,932,000
FTE	---	---	---	----

Authorizing Legislation: Section 338J of the Public Health Service Act, as amended by Public Law 105-392, Section 301

FY 2019 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

This grant program provides funding to establish and maintain a State Office of Rural Health (SORH) to strengthen each state's rural health care delivery system, with every dollar of Federal support matched by three state dollars. SORHs serve as focal points and clearinghouses for the collection and dissemination of information on rural health issues, research findings, innovative approaches, and best-practices pertaining to the delivery of health care in rural areas.

As the state's rural institutional framework, SORHs help link rural communities with state and Federal resources to develop long-term solutions to rural health problems. SORHs form collaborative partnerships to better coordinate rural health activities, maximize limited resources, and avoid duplication of effort and activities. SORHs facilitate clinical placements through recruitment initiatives and help rural constituents meet recruitment challenges by sharing information. SORHs identify Federal, state, and nongovernmental programs and funding opportunities and provide technical assistance to public and nonprofit private entities regarding participation in rural health programs. In FY 2016, SORHs provided 63,160 technical assistance encounters directly to clients. The number of technical assistance (TA) encounters declined compared to FY 2015 (71,868), due to programmatic changes in several states to better target information and educational resources. FORHP continues to work with grantees, especially engaging with new SORH program directors to provide additional support and guidance.

Funding History

FY	Amount
FY 2015	$9,511,000
FY 2016	$9,511,000
FY 2017	$9,977,000
FY 2018	$9,932,000
FY 2019	$---

Budget Request

The FY 2019 Budget requests $0 for State Office of Rural Health, which is $9.9 million below the FY 2018 Annualized CR level. The Budget prioritizes programs that provide direct health care services.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. (Outcome)	FY 2016: 63,160 Target: 68,960 (Target Not Met)	63,791	N/A	N/A
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. (Outcome)	FY 2016: 22,618 Target: 22,858 (Target Not Met)	22,844	N/A	N/A
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment initiatives. (Outcome)	FY 2015: 1,984 Target: 1,260 (Target Exceeded)	1,260	N/A	N/A

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	50	50	---
Average Award	$179,871	$179,871	---
Range of Awards	$165,521-$179,871	$165,521-$179,871	---

Radiation Exposure Screening and Education Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$1,830,000	$1,822,000	$1,834,000	+$12,000
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 417C, as amended by Public Law 109-482, Sections 103 and 104

FY 2019 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Radiation Exposure Screening and Education Program (RESEP) provides grants to states, local governments, and appropriate health care organizations to support programs for cancer screening for individuals adversely affected by the mining, transport and processing of uranium and the testing of nuclear weapons for the Nation's weapons arsenal. The RESEP grantees also help clients with appropriate medical referrals, engage in public information development and dissemination, and facilitate claims documentation to aid individuals who may wish to apply for support under the Radiation Exposure Compensation Act. In FY 2016, the number of individuals screened at RESEP was 1,453 and the average screening cost per individual was $1,184.

Funding History

FY	Amount
FY 2015	$1,834,000
FY 2016	$1,834,000
FY 2017	$1,830,000
FY 2018	$1,822,000
FY 2019	$1,834,000

Budget Request

The FY 2019 Budget requests $1.8 million for Radiation Exposure Screening and Education, which is $12,000 above the FY 2018 Annualized CR level. This request will continue to support activities such as: implementing cancer screening programs; developing education programs;

disseminating information on radiogenic diseases and the importance of early detection; screening eligible individuals for cancer and other radiogenic diseases; providing appropriate referrals for medical treatment; and facilitating documentation of Radiation Exposure Compensation Act (RECA) claims.

Funding also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
32.1: Percent of RECA successful claimants screened at RESEP centers. (Outcome)	FY 2016: 21.1 % Target: 8.8% (Target Exceeded)	13%	13%	Maintain
32.2: Percent of patients screened at RESEP clinics who file RECA claims that receive RECA benefits. (Outcome)	FY 2016: 85.9% Target: 72% (Target Exceeded)	72%	77%	+5% points
32.I.A.1: Total number of individuals screened per year. (Output)	FY 2016: 1,453 Target: 1,400 (Target Exceeded)	1,200	1,300	+100

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	8	8	8
Average Award	$244,791	$244,791	$244,791
Range of Awards	$123,696-$232,776	$123,630-$300,000	$123,630-$300,000

Black Lung

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$7,250,000	$7,217,000	$7,266,000	+$49,000
FTE	---	---	---	---

Authorizing Legislation: Federal Mine, Health, and Safety Act of 1977, Public Law 91-173, Section 427(a), as amended by Public Law 95-239, Section 9

FY 2019 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants and Cooperative Agreement

Program Description and Accomplishments

The Black Lung Clinics Program (BLCP) funds eligible public, private, and state entities that provide medical, outreach, educational, and benefits counseling services to active, inactive, retired, and disabled coal miners throughout the United States with the goal of reducing the morbidity and mortality associated with occupationally related coal-mine dust lung disease. To support the longer-term need faced by miners with severe disability due to black lung disease, grantees may also assist coal miners and their families in preparing the detailed application for Federal Black Lung benefits from the Department of Labor (DOL).

In FY 2016, the program served 13,122 miners, exceeding a key target program measure of 12,836. An equally important measure is the number of medical encounters BLCP awardees had with miners with black lung disease, or coal workers' pneumoconiosis (CWP). The program supported 18,684 medical encounters with black lung disease patients in FY 2016, which fell below the target of 19,880 medical encounters. Several factors may have contributed to this gap, including HRSA's implementation of a new approach to more effectively respond to the growing prevalence and incidence of black lung disease across the country. This resulted in funding a new grantee currently in the early stages of building its capacity to screen, diagnose, and treat miners in its state's service area. Staff turnover at black lung clinics also remains an issue, and there continue to be shortages in the number of clinicians able to perform exams related to new DOL standards for x-rays, pulmonary testing, and medical documentation.

Recent data highlights the continued need for black lung services. The National Institute of Occupational Safety and Health (NIOSH) identified a cluster of 56 progressive massive fibrosis (PMF) cases among Kentucky residents who were current and former coal miners at a single eastern Kentucky radiology practice from January 2015 to August 2016. This figure exceeded

the 19 PMF cases in Kentucky detected by NIOSH's National Coal Workers' Health Surveillance Program between August 2011 to July 2016.[199] The current prevalence of PMF among underground coal miners with 25 years or more of underground mining tenure in Virginia and West Virginia, as reported by NIOSH's Coal Workers' Health Surveillance Program, is around 5 percent, up from 3 percent in 2012.[200]

Funding History

FY	Amount
FY 2015	$6,766,000
FY 2016	$6,766,000
FY 2017	$7,250,000
FY 2018	$7,217,000
FY 2019	$7,266,000

Budget Request

The FY 2019 Budget requests $7.3 million for the Black Lung Clinics Program, which is $49,000 above the FY 2018 Annualized CR level. HRSA will continue to fund 15 Black Lung Clinic Program awards that provide primary care and other services to coal miners and a cooperative agreement with one Black Lung Center of Excellence (BLCE) to enhance the quality of services provided by BLCP grantees. The BLCE cooperative agreement recipient will work closely with HRSA to strengthen the quality of data collection and analysis.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
33.I.A.1: Number of miners served each year. (Output)	FY 2016: 13,122 Target: 12,836 (Target Exceeded)	13,800	13,800	Maintain

[199] PMF cluster in eastern KY: Blackley, et al., "Resurgence of Progressive Massive Fibrosis in Coal Miners—Eastern Kentucky, 2016," *CDC Morbidity and Mortality Weekly Report* Vol. 65, No. 49, Dec. 2016, pg. 1386.
[200] Ibid., 1387.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
33.I.A.2: Number of medical encounters from Black Lung each year. (Output)	FY 2016: 18,684 Target: 19,880 (Target Not Met)	19,000	19,000	Maintain
33.E.1:The number of miners served per $1 million in HRSA Black Lung Clinics Program funding.(Efficiency)	FY 2016: 1,986 (Baseline)	1,900	1,900	Maintain

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	16	16	16
Average Award	$446,317	$420,716	$444,755
Range of Awards	$150,000-$1,291,213	$125,000- $1,265,572	$125,000-$1,291,213

Telehealth

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$18,459,000	$18,374,000	$10,000,000	-$8,374,000
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 330I

FY 2019 Authorization .....Expired

Allocation Method .....Competitive Grants/Cooperative Agreements

Program Description and Accomplishments

The Office for the Advancement of Telehealth (OAT) promotes the use of telehealth technologies for health care delivery, education, and health information services. OAT administers the following grant programs listed below.

The Telehealth Network Grant Program (TNGP) supports the use of telehealth networks to improve health care services for medically underserved populations in urban, rural, and frontier communities. More specifically, the networks: (a) expand access to, coordinate, and improve the quality of health care services; (b) improve and expand the training of health care providers; and/or (c) expand and improve the quality of health information available to health care providers, patients, and their families. For the most recent year data is available, TNGP grantees provided 82 clinical services across 135 sites in underserved rural communities in FY 2015. Of these 135 telehealth sites, 87 sites offered pediatric mental health services and 119 sites offered adult mental health services. In FY 2019, FORHP will support two TNGP cohorts:

- School-Based Telehealth Network Grant focuses on providing telehealth services to rural communities through school-based health centers. Grantees are focused on five clinical areas, including chronic disease reduction and prevention and behavioral health. Twenty-one grants will continue in FY 2019.

- Substance Abuse Treatment Telehealth Network Grant focuses on increasing access to substance abuse treatment services in rural, frontier, and underserved communities. Three grantees will continue in FY 2019.

Evidence-Based Telehealth Network Grant has a two-fold purpose of increasing access to care in rural and frontier communities by using telehealth technologies and to conduct evaluations of those efforts to establish an evidence-base assessing the effectiveness of telehealth care for patients, providers, and payers. The emphasis on data collection and research to further the

telehealth evidence base separates this program from other Telehealth Network Grants in OAT. OAT will continue to support six grantees in FY 2019.

Telehealth Resource Center (TRC) Program provides expert and customizable telehealth technical assistance across the country. The TRCs provide training and support, disseminate information and research findings, promote effective collaboration, and foster the use of telehealth technologies to provide health care information and education for providers who serve rural and medically underserved areas and populations. In FY 2019, OAT will continue to fund twelve regional and two national TRCs.

Telehealth Centers of Excellence examine the efficacy of telehealth services in rural and urban areas and serve as a national clearinghouse for telehealth research and resources. OAT anticipates two grantees will continue in FY 2019.

Telehealth Focused Rural Health Research Center conducts policy-relevant and clinically-informed telehealth research. OAT does not anticipate making new awards in FY 2019.

Licensure Portability Grant Program provides support to state professional licensing boards to carry out programs under which the boards cooperate to develop and implement state policies that will reduce statutory and regulatory barriers to telemedicine. OAT does not anticipate making new awards in FY 2019.

Funding History

FY	Amount
FY 2015	$14,900,000
FY 2016	$17,000,000
FY 2017	$18,459,000
FY 2018	$18,374,000
FY 2019	$10,000,000

Budget Request

The FY 2019 Budget requests $10 million for the Telehealth program, which is $8.4 million below the FY 2018 Annualized CR level. This request allows a reduced level of support for the current Telehealth Network Grants, the Telehealth Resource Centers, and the Telehealth Centers of Excellence. It does not provide for new grant awards in FY 2019.

Funding also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure[201]	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
34.II.A.1: Increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program with ideal glycemic control (defined as hemoglobin A1c at or below 7%). (Outcome)	FY 2015: 43% Target: 30% (Target Exceeded)	25%	25%	Maintain
34.1: The percent of TNGP grantees that continue to offer services after the TNGP funding has ended. [202](Baseline – FY 2005: 100%) (Outcome)	FY 2017: N/A	N/A	N/A	N/A
34.III.D.2: Expand the number of telehealth services (e.g., dermatology, cardiology) and the number of sites where services are available as a result of the TNGP program. (Outcome)	FY 2015: 3,187 Target: 2,675 (Target Exceeded)	2,725	2,750	+25
34.III.D.1: Increase the number of communities that have access to pediatric and adolescent mental health services where access did not exist in the community prior to the TNGP grant.[203] (Outcome)	FY 2015: 488 Target: 320 (Target Exceeded)	330	335	+5

[201] The Telehealth Network Grant Program (TNGP) is a demonstration program. Every three to four years, each cohort of TNGP grantees completes its project period, while a new cohort of grantees commences a new cycle of grant-supported Telehealth activities. The data is calculated as a cumulative number, and with each new cohort, the distribution of these services is uncertain. Therefore, the targets may need to be revised if there is evidence of a significant increase in grantees that are providing mental health services.

[202] This is a long-term measure based on the end date of the current cohort of grantees. The target data for this measure is FY 2020.

[203] This is a demonstration program. Every three years to four years each cohort of TNGP grantees "graduates" from the grant program while a new cohort of grantees commences a new multi-year cycle of grant-supported Telehealth activities. The data is calculated as a cumulative number. However, with each new cohort, the

Measure[201]	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
34.III.D.1.1: Increase the number of communities that have access to adult mental health services where access did not exist in the community prior to the TNGP grant.[204] (Outcome)	FY 2015: 554 Target: 315 (Target Exceeded)	330	340	+10
34.E: Expand the number of services and/or sites providing access to health care as a result of the TNGP program per Federal program dollars expended.[205] (Efficiency)	FY 2015: 43 per Million $ Target: 105 per Million $ (Target Not Met)	60 per Million $	65 per Million $	+ 5 per Million $

Grant Awards Table

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	53	49	46
Average Award	$329,280	$353,061	$217,391
Range of Awards	$170,424 - $900,000	$250,000 - $1,000,000	$154,799 – 634,675

distribution of these services is uncertain. Therefore, the targets may need to be revised if there is evidence of a significant increase in grantees that are providing mental health services.

[204] This is a demonstration program. Every three years to four years each cohort of TNGP grantees "graduates" from the grant program while a new cohort of grantees commences a new multi-year cycle of grant-supported Telehealth activities. The data is calculated as a cumulative number. However, with each new cohort, the distribution of these services is uncertain. Therefore, the targets may need to be revised if there is evidence of a significant increase in grantees that are providing mental health services.

[205] This measure provides the number of sites and services made available to people who otherwise would not have access to them per million dollars of program funds spent. Every three years a new cohort of grantee commences with a new three-year cycle of grant supported activities, gradually expanding sites and services per dollar invested. With each new cohort, there is a start-up period where services are being put in place but are not yet implemented.

Opioids

TAB

Opioids Allocation Funding

The Budget provides $10 billion in new resources across HHS to combat the opioid epidemic and address mental health. This national crisis is a top priority at HHS. As part of this effort, the Budget provides an initial allocation totaling $550 million in HRSA to address substance abuse, including opioid abuse, and the overdose crisis in highest risk rural communities. This funding will go directly to communities that are best situated to address this crisis.

Community Health Centers: To date, Community Health Centers have played a vital role in helping millions of Americans who struggled with substance abuse and mental health issues. The Budget allocates $400 million to community health centers to address this crisis, of which $200 million is included to provide quality improvement incentive payments to community health centers that implement evidence-based models to address behavioral health issues, with a focus on opioid addiction, to meet the health needs of the population served by the health center. This funding will support and enhance the capacity of health centers to treat substance use disorders, which includes expanding evidence-based substance abuse prevention and education programs for patients, families, communities, and personnel to increase awareness of patient access to, and patient retention in substance use disorder treatment programs.

Investing in Rural Communities. The request includes $150 million to address substance abuse, including opioid abuse, and the overdose crisis in high risk rural communities. This funding will allow communities to develop plans to address local needs. Additionally, this funding will provide additional loan repayment awards through the National Health Service Corps to support the recruitment and retention of health professionals needed in rural areas to provide evidence-based substance abuse treatment and prevent overdose deaths.

The program will support multi-sector, county-level teams located in communities identified at the highest risk for substance abuse by the Centers for Disease Control and Prevention (CDC).[206] Approximately 98 percent of these communities are completely or partially rural, 61 percent are completely rural, and 63 percent are located in counties designated as part of the Appalachian region by the Appalachian Regional Commission. While the opioid epidemic has devastated both urban and rural counties, the burden in rural areas is significantly higher. Rural communities face a number of challenges in gaining access to health care in general, and substance abuse treatment in particular. These challenges include lack of specialized health services, health workforce shortages, and potentially greater stigma related to substance abuse due to living in smaller communities. Research shows that rural opioid users are more likely to have socioeconomic vulnerabilities including limited educational attainment, poor health status, being uninsured, and low-income.[207] In addition, the CDC has found that drug-related deaths are 45 percent higher in rural communities, and that rural states are more likely to have higher rates

[206] Van Handel MM, Rose CE, Hallisey EJ, Kolling JL, Zibbell JE, Lewis B, et al. County-level vulnerability assessment for rapid dissemination of HIV or HCV infections among persons who inject drugs, United States. J Acquir Immune Defic Syndr (2016) 73:323–31.10.1097

[207] Maine Rural Health Research Center. "Rural Opioid Abuse: Prevalence and User Characteristics". February, 2016.

of overdose death.[208] Furthermore, 53.4 percent of U.S. counties do not have a physician who can prescribe buprenorphine for opioid dependency treatment. Of those counties that have no physician to prescribe buprenorphine, 82.1 percent were in rural areas.[209]

HRSA's expertise in working directly with rural communities and diverse and medically underserved population groups, including people living with HIV/AIDS, children and pregnant women, uniquely positions HRSA to make a significant impact on the nation's opioid crisis. To effectively address the opioid abuse crisis, communities must be able to implement comprehensive strategies that address prevention, treatment, and other health and community support services. This can be achieved through the following activities:

- Recruitment of new substance abuse providers on-site at community health centers and/or other community health services providers *to increase access to services*.
- Increased use of telehealth *to increase access to services in rural communities*.
- Training and support for existing providers *to expand and enhance services*.
- Implementation of new models of care, including integrated behavioral health and primary care, and expanded team-based care, *to achieve coordinated care*.
- Establishment of cross-sector community partnerships that support comprehensive systems of care and support *to address the immediate treatment and recovery needs of individuals and families*. Collaborative partnerships would also actively work *to reduce the prevalence of substance misuse county-wide*.
- Emphasis on the needs of special populations, including individuals with HIV/AIDS, perinatal women and infants, children, adolescents and their families, individuals who are homeless, and veterans, *to help overcome their multiple and unique barriers to care.*

[208] Faul, M., et al. "Disparity in Naloxone Administration by Emergency Medical Service Providers and the Burden of Drug Overdose in Us Rural Communities." Am J Public Health 105 Suppl 3 (2015): e26-32.
[209] WWAMI Rural Health Research Center. "Geographic and Specialty Distribution of US Physicians Trained to Treat Opioid Use Disorder." December, 2014.

Program Management TAB

Program Management

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$153,629,000	$152,954,000	$151,993,000	-$961,000
FTE	789	789	789	---

Authorizing Legislation: Public Health Service Act, Section 301

FY 2019 Authorization……...……Indefinite

Allocation Method……...Other

To achieve its mission, HRSA requires qualified staff to operate at maximum efficiency. One of HRSA's goals is to strengthen program management and operations by improving program customer satisfaction, increasing employee engagement, and implementing organizational improvements and innovative projects. Program Management is the primary means of support for staff, business operations and processes, information technology and overhead expenses such as rent, utilities, and miscellaneous charges, for HRSA.

Improving Processes and Business Operations

HRSA continues to improve operational planning processes to foster cross-agency collaboration. HRSA has automated its contracting process to operate in a totally paperless environment, including the receipt of committed funds, the obligation of funds, and the generation and storage of contract documents. Over the past five years, HRSA has reduced travel costs and supported telework participation by increasing the agency-wide utilization of real-time web collaboration tools. Real-time collaboration is accomplished using automated tools that support a full range of requirements from one-on-one for teleworkers to web-based meetings supporting as many as 500 participants. In FY 2016 HRSA used 12.7 million virtual meeting minutes, which is 2.6 million more minutes than FY 2014.

Improving Data Transparency, Services, and Cybersecurity

Program Management supports the continued development, operations and maintenance of enterprise functionality of the HRSA Electronic Handbooks (EHBs). The EHBs is an IT Investment that provides the strategic and performance outcomes of the HRSA Programs and contributes to their success by providing a mechanism for sharing data and conducting business in a more efficient manner, while improving program integrity. The EHBs supports HRSA with program administration, grants administration and monitoring, management reporting, and performance measurement and analysis. In FY 2016, HRSA re-engineered the EHBs resulting in increased 508-compliance from 52 percent to 92 percent, making the HRSA system available to visually impaired individuals. HRSA also improved the efficiency of the system with a 50

percent reduction in response time and an 84 percent increase in grantee satisfaction, particularly related to improvements in navigation, search, help videos, and screen sharing; HRSA also supports a secure and trusted IT infrastructure. In FY 2016, HRSA patched approximately 500 servers monthly and 2,000 desktops weekly with the latest software and security updates. The agency also investigated 222 malware detection alerts and implemented a new intrusion detection system that blocked 18,735 intrusion events. These efforts help HRSA meet its business needs in a safe and secure manner.

Creating a Culture of Program Integrity

Program Management also supports program integrity activities that align with performance and strategic planning activities to reduce programmatic risk and improve performance. HRSA's Program Integrity Initiative includes an agency-wide workgroup that develops, monitors, and oversees the agency's program integrity activities; training for federal staff and grantees; and the hiring of program integrity analysts and auditors. HRSA has established a HRSA-wide governance structure for enterprise-wide business operations and program integrity activities to ensure a customer-focused suite of business operation services and functions. HRSA is currently evolving its Program Integrity Initiative to focus on Enterprise Risk Management (ERM) and the development of a risk-aware organizational culture.

Utilizing feedback from GAO studies, OIG reports, and issues identified through members of the HRSA Program Integrity Workgroup, HRSA has developed a series of program integrity training, webcasts, and reference materials. For example, HRSA developed an online program integrity toolkit that provides HRSA staff with a single source of information, resources, templates, policies, procedures, and manuals. Additionally, HRSA collaborated with the HHS Inspector General to provide OIG-led grant fraud training to HRSA project officers. HRSA has also submitted its mission critical support functions—such as time and attendance, property management, research integrity, and FOIA—to operational reviews to assess compliance with laws and regulations, and Departmental and HRSA policies.

Funding History

FY	Amount
FY 2015	$154,000,000
FY 2016	$154,000,000
FY 2017	$153,629,000
FY 2018	$152,954,000
FY 2019	$151,993,000

Budget Request

The FY 2019 Budget requests $152.0 million, which is a decrease of $961,000 below the FY 2018 Annualized CR. This funding level supports program management activities to effectively and efficiently support HRSA's operations.

HRSA is committed to improving quality at a lower cost and improving the effectiveness and efficiency of government operations. HRSA continues to reduce travel costs and support

telework participation by increasing the agency-wide utilization of web collaboration tools, which have led to greater business productivity.

HRSA also continues to enhance its program integrity activities by supporting analytical tools using HRSA's electronic grants system, program data, Office of Federal Assistance Management data sources, HHS sources, and government-wide sources. The goal is for HRSA to identify potential issues in the pre- and post-award processes and to address issues before they become audit findings. HRSA plans to focus on a risk-based approach to grantee monitoring using the information and corresponding analysis to help staff spend their time on grantees at risk of noncompliance. HRSA will also continue to provide training for grants management and program staff to support the alignment of program integrity initiatives with planning and performance activities. These efforts will enhance HRSA grantees awareness and ability to avoid potential financial integrity issues.

IT Investments
Significant progress has been made in a range of program management activities. Some highlights include:

- Improve cybersecurity efforts through the implementation of state of the art security tools and robust reporting. These integrated tools not only improve and secure the Information Technology infrastructure, but will also reduce the number of physical servers as part of the ongoing virtualization and consolidation initiative.

- Continue implementation of the Enterprise Architecture, Capital Planning and Investment Control (CPIC) and Enterprise Performance Life Cycle (EPLC) processes.

- Support the Federal Information Technology Shared Services Strategy by consuming more than 35 shared services offered by other HHS Operating Divisions. Shared services enables HRSA to drive down operating costs in support and commodity areas, improve return on investment, and eliminate waste and duplication.

- Continue development, operations and maintenance of the Electronic Handbooks (EHBs).

- Release of a redesigned Data Warehouse site that has increased mobile and tablet device usage by 20 percent. The Data Warehouse is the official repository for current enterprise HRSA data and promotes maximum operating efficiency through centralization, reconciliation, and standardization of data across HRSA's various transactional business systems. The Data Warehouse also promotes "Open Data" by providing HRSA and the general public with a single source of HRSA programmatic information, related health resources, demographic, and statistical data for analyzing and reporting on HRSA activities with easily accessible, readily-available charts, maps, reports, data portal, dashboards, tools, downloadable files and data feeds.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY2019 Target +/- FY2018 Target
35.VII.B.1.: Ensure Critical Infrastructure Protection: Security Awareness Training (Output)	FY 2017: Full participation in Security and Privacy Awareness training by 100% of HRSA staff. Specialized role-based training for 100% of HRSA staff identified to have significant security and privacy responsibilities. (Target Met)	Full participation in Security and Privacy Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities, and participation in Executive Awareness training by 100% of HRSA executive staff	Full participation in Security and Privacy Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities, and participation in Executive Awareness training by 100% of HRSA executive staff	Maintain
35.VII.B.2: Ensure Critical Infrastructure Protection: Security Authorization to Operate (Output)	FY 2017: 100% of HRSA information systems will be assessed and authorized to operate (ATO). In addition, all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner. (Target Met)	100% of HRSA information systems will be assessed and authorized to operate (ATO). In addition all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner	100% of HRSA information systems will be assessed and authorized to operate (ATO). In addition all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY2019 Target +/- FY2018 Target
35.VII.B.2a: Ensure Critical Infrastructure Protection: Security HSPD-12 Privilege and Non-Privilege	FY 2017: Privacy - 100% of HRSA staff (federal and contractor) accessing the HRSA network with Privileged accounts must use PIV cards or other 2-factor authentication (Target Met)	Privacy - 100% of HRSA staff (federal and contractor) accessing the HRSA network with Privileged accounts must use PIV cards or other 2-factor authentication	Privacy - 100% of HRSA staff (federal and contractor) accessing the HRSA network with Privileged accounts must use PIV cards or other 2-factor authentication	Maintain
35.VII.B.2b: Ensure Critical Infrastructure Protection: Security Cyber Sprint	FY 2017: Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 Days (Target Met)	Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 Days	Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 Days	Maintain
35.VII.B.2c: Ensure Critical Infrastructure Protection: Security Privacy Impact Assessment (PIA) Or Privacy Threshold Assessment (PTA)	FY 2017: Identify 85% of systems that require a PIA or a Privacy Threshold Assessment (PTA) (Target Met)	Identify 90% of systems that require a PIA or a Privacy Threshold Assessment (PTA)	Identify 90% of systems that require a PIA or a Privacy Threshold Assessment (PTA)	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY2019 Target +/- FY2018 Target
35.VII.B.2d: Ensure Critical Infrastructure Protection: Security Phishing	FY 2017: 10 Phishing Campaigns completed (Target Met)	6 Phishing Campaigns completed	6 Phishing Campaigns completed	Maintain
35.VII.B.3: Capital Planning and Investment Control (Output)	FY 2017: 1) 100% of major investments received an IT Dashboard Overall Rating of "Green", which indicates an acceptable cost, schedule and Agency CIO Rating; **(**Target Met) 2) 100% of major Investment Managers are in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM). (Target Met)	1) Receiving FITARA score of "A" for IT Portfolio; 2) 75% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	1) Receiving FITARA score of "A" for IT Portfolio; 2) 75% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY2019 Target +/- FY2018 Target
35.VII.B.4: Enterprise Architecture	FY 2017: Enterprise Architecture: 95% of IT investments reported to OMB with mapping to at least one HHS segment and domain. (Target Met)	Enterprise Architecture: 90% of IT investments reported to OMB with mapping to at least one HHS segment and domain.	Enterprise Architecture: 90% of IT investments reported to OMB with mapping to at least one HHS segment and domain.	Maintain
35.VII.A.4: Implement Enterprise Risk Management (ERM)	FY 2017: Began to implement ERM efforts, including participation in HHS Risk Profile development and integration of the revised OMB Circular A-123 (Target Met)	Continue to implement Enterprise Risk Management, including developing a risk aware culture at HRSA	Assess HRSA's ERM implementation efforts, including alignment with HHS and OMB Circular A-123 ERM guidance	NA

Family Planning

TAB

Family Planning

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$286,479,000	$284,534,000	$286,479,000	+$1,945,000
FTE	12[210]	12[2102]	35	---

Authorizing Legislation: …….Title X of the Public Health Service Act

FY 2017 Authorization…….Indefinite

Allocation Method…….Direct Federal, Contract, Competitive Grant

Program Description and Accomplishments

The Title X Family Planning Program is the only federal grant program dedicated to providing individuals with comprehensive family planning and related health services. Enacted in 1970 as part of the Public Health Service Act, the mission of the Title X Program is to aid individuals and families in determining the number and spacing of children and to provide access to voluntary family planning methods, and services (including natural family planning methods, infertility services, and services for adolescents), and information to all who want and need them. By law, priority is given to persons from low-income families.

The Title X Program fulfills its mission through awarding competitive grants to public and private nonprofit organizations to support the provision of voluntary family planning services, information, and education. According to the 2016 Family Planning Annual Report (FPAR) data, services were provided through 91 family planning service grants that supported a nationwide network of 3,898 community-based sites that provided clinical and educational services to more than 4,007,500 persons. There is at least one Title X services grantee in every state, the District of Columbia, and in each of the U.S. territories, including the six Pacific jurisdictions. Title X family planning program regulations and authorizing legislation require that projects provide a broad range of effective and acceptable family planning methods and services, including natural family planning methods, infertility services and services for adolescents.

In addition to clinical services, the Title X Family Planning program supports the US Government response to Zika as well as three key functions aimed at assisting clinics in responding to clients' needs: (1) training for all levels of family planning agency personnel through a national training program; (2) information dissemination and community-based education and outreach activities; and (3) data collection and research to improve the delivery of family planning services. The OPA provided support for the US response to Zika through

[210] Due to coding error, FTE is reporting lower than actual 35 FTE

creation of a "Zika toolkit," entitled "Providing Family Planning Care for Non-Pregnant Women and Men of Reproductive Age in the Context of Zika," based on Centers for Disease and Control Prevention (CDC) guidance that addresses the educational, counseling, and testing advice for providers serving individuals of child-bearing age, with guidance and patient education tools specific to areas with and without local transmission of Zika. The toolkit is available in Spanish as well as English. In addition, in 2016 OPA conducted extensive training and provided supplemental funds to Title X recipients in Puerto Rico, the US Virgin Islands, Texas, Arizona, Mississippi, and California to assist with Zika response. Each year the program establishes a set of program-wide priorities that provide guidance to grantees. The 2019 priorities include promoting the overall health of individuals by offering core family-planning services which include a sexual health assessment and tools for family planning such as a family planning or reproductive life plan, health screenings and information as well as education and counseling and referral services. An important part of family planning includes supporting the overall health of clients who may seek to become parents in the future. Therefore, each Title X project should ensure that family planning is contextualized within a holistic conversation of health, with the project optimally offering primary health services onsite, or having robust referral linkages to primary health providers in close proximity to the Title X site. The FY 2019 priorities also seek to promote positive family relationships for the purpose of healthy decision-making and optimal health and life outcomes for every individual and couple. An additional focus has been placed on implementing electronic health record and administrative management systems, increasing the number and types of contracts with health insurance plans, and recovering more costs through reimbursements and billing third-party payers to ensure the financial sustainability of service sites.

In order to improve overall program performance, the program is increasing the emphasis on financial and program management by providing training around billing practices, including billing all appropriate third-party payers, and other cost recovery methods through the Title X National Training Center. In addition, grantees are being urged to implement more efficient administrative systems, such as health information technologies, electronic health records, and payment management systems.

Another trend, which the program believes will improve program performance, is increased competition and diversity in the types of grantees funded. Increased competition has led to more diversified grantees, leading to improved cost recovery methods and different administrative structures, which, it is anticipated, will ultimately improve quality and service delivery.

Funding History

FY	Amount
FY 2015	$286,749,000
FY 2016	$286,479,000
FY 2017	$286,479,000
FY 2018	$284,534,000
FY 2019	$286,479,000

Budget Request

The FY 2019 Budget request of $286.5 million is $1.9 million above the FY 2018 Annualized CR. The budget request provides funding for family planning methods and related health services, as well as related training, information, education, counseling, and research to improve family planning awareness and service delivery.

The FY 2019 Budget request is expected to support family planning for approximately 3,991,000 persons, with approximately 90 percent having family incomes at or below 200 percent of the federal poverty level.

As indicated in the Program Description, OPA currently funds at least one Title X family planning service grantee in each state throughout the U.S. as well as in the territories and most of the Pacific Basin jurisdictions. The FY 2019 request provides funding for family planning methods and related health services as well as related training, education, and research.

The FY 2019 request will also allow the program to continue supporting the operation of a Family Planning National Delivery System Improvement Center. The program will likely need to continue addressing the impact of the Zika virus or other conditions which affect non-pregnant individuals of child-bearing age, including but not limited to the population which receives services at Title X family planning service sites. This will include dissemination of the Zika Toolkit, developed by OPA to incorporate CDC guidance that addresses the educational, counseling, and testing advice for providers serving individuals of child-bearing age, with guidance and patient education tools specific to areas with and without local transmission of Zika.

OPA clinics and grantees were also involved in the Chlamydia screening of approximately 1,218,000 females ages 15-24, and the prevention of approximately 360 cases of invasive cervical cancer through cervical cancer screening; they will also be involved in the prevention of approximately 903,000 unintended pregnancies.

The targets for FY 2019 assume other sources of revenue that contribute to the family planning program at the grantee level will continue at approximately the same levels, including Medicaid, state and local government programs, other federal, state, and private grants, and private insurance .

OPA's clinical grantees will continue to include recommended chlamydia screening, screening for undiagnosed cervical tissue abnormalities, preconception care and counseling, basic infertility services, pregnancy testing and counseling, natural family planning methods, contraceptives, adolescent services and related education and counseling. These services, along with community-based education and outreach, assist individuals and families with pregnancy leading to healthy birth outcomes and prevention of unintended pregnancy. To the extent practicable, Title X clinics also encourage family participation when delivering such services.

OPA will also coordinate with other federal agencies, and with other data collection efforts reflecting performance and impact. The program is anticipating that additional investment in

third party billing, an increase in the proportion of clients who have health insurance, and better adoption of electronic health records and related health IT systems, will increase revenue and allow the Title X program to reach more of the population it is intended by law to serve.

Outputs and Outcomes Tables

Long Term Objective: Increase awareness of voluntary family planning resources and methods by providing Title X family planning services, education and research, with priority for services to low-income individuals.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 +/- FY 2019
36.II.A.1: Total number of unduplicated clients served in Title X service sites. *(Outcome)*	FY 2016: 4,018,000 Target: 4,672,000 (Target Not Met)	4,000,000	3,991,000	(9,000)
36.II.A.2: Maintain the proportion of clients served who are at or below 200% of the Federal poverty level at 90% of total unduplicated family planning users. *(Outcome)*	FY 2016: 88.9 Target: 90% (Target Not Met)	90%	90%	Maintain
36.II.A.3: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals. *(Outcome)*	FY 2016: 901,838 Target: 832,000 (Target Exceeded)	905,000	903,000	(2,000)
36.II.B.1: Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24. *(Outcome)*	FY 2016: 939,224 Target: 1,195,000 (Target Not Met)	1,195,000	1,218,000	+23,000
36.II.C.3: Increase the proportion of females ages 15 – 24 attending Title X family planning clinics screened for Chlamydia infection. *(Outcome)*	FY 2016: 61.54% Target: 64.4% (Target Not Met)	64.4%	64.4%	Maintain

Efficiency Measure

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 +/- FY 2017
36.E: Maintain the actual cost per Title X client below the medical care inflation rate. *(Efficiency)*	FY 2016: $325.76 Target: $301.14 (Target Not Met)	$336.69	$345.11	+$8.43

Grant Awards Tables

	FY 2017 Actual	FY 2018 Annualized CR	FY 2019 President's Level
Number of Awards	84	90	90
Average Award	$3,079,500	$2,867,000	$2,867,000
Range of Awards	$131,000 - $20,500,000	$130,000 - $20,000,000	$130,000 - $20,000,000

Supplementary Tables
TAB

Budget Authority by Object Class

(Dollars in Thousands)

DISCRETIONARY

OBJECT CLASS	2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Full-time permanent (11.1)	149,468	152,730	194,094	+41,364
Other than full-time permanent (11.3)	6,173	6,308	7,609	+1,301
Other personnel compensation (11.5)	3,118	3,186	3,896	+710
Military personnel (11.7)	17,251	17,647	21,688	+4,041
Special personnel services payments (11.8)	20	5	-	-5
Subtotal personnel compensation	**176,031**	**179,876**	**227,287**	**+47,411**
Civilian benefits (12.1)	49,484	50,564	64,429	+13,865
Military benefits (12.2)	9,178	9,388	11,548	+2,160
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**234,693**	**239,828**	**303,264**	**+63,436**
Travel and transportation of persons (21.0)	2,612	2,614	2,727	+113
Transportation of things (22.0)	163	163	146	-17
Rental payments to GSA (23.1)	14,859	14,990	18,318	+3,328
Rental payments to Others (23.2)	704	704	722	+18
Communication, utilities, and misc. charges (23.3)	7,918	7,782	8,431	+649
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	84	84	84	-
Other Contractual Services: 25.0	**-**	**-**	-	-
Advisory and assistance services (25.1)	13,569	13,569	29,785	+16,216
Other services (25.2)	194,577	197,108	212,396	+15,288
Purchase of goods and services from government accounts (25.3)	179,471	176,349	256,110	+79,761
Operation and maintenance of facilities (25.4)	944	975	854	-121
Research and Development Contracts (25.5)	16	16	16	-
Medical care (25.6)	2,964	2,964	2,964	-
Operation and maintenance of equipment (25.7)	4,927	4,801	7,077	+2,276
Subsistence and support of persons (25.8)	30	30	30	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	1,187	1,182	687	-495
Subtotal Other Contractual Services	**397,684**	**396,994**	**509,919**	**+112,925**
Equipment (31.0)	9,120	9,112	7,828	-1,284
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	5,411,327	5,396,289	8,619,788	+3,223,499
Insurance Claims and Indemnities (42.0)	120,083	87,695	88,364	+669
Total Non-Pay Costs	**$ 5,964,554**	**$ 5,916,426**	**$ 9,256,327**	**+$3,339,901**
Total Budget Authority by Object Class	**$ 6,199,247**	**$ 6,156,255**	**$ 9,559,591**	**+$3,403,336**

PRIMARY HEALTH CARE

OBJECT CLASS	2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Full-time permanent (11.1)	24,202	24,731	49,224	+24,493
Other than full-time permanent (11.3)	1,303	1,331	1,986	+655
Other personnel compensation (11.5)	386	394	831	+437
Military personnel (11.7)	5,262	5,382	6,502	+1,120
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**31,152**	**31,838**	**58,543**	**+26,705**
Civilian benefits (12.1)	8,206	8,385	16,503	+8,118
Military benefits (12.2)	2,824	2,888	3,483	+595
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**42,182**	**43,112**	**78,529**	**+35,417**
Travel and transportation of persons (21.0)	842	842	887	+45
Transportation of things (22.0)	9	9	9	-
Rental payments to GSA (23.1)	2,436	2,436	3,676	+1,240
Rental payments to Others (23.2)	2	2	2	-
Communication, utilities, and misc. charges (23.3)	1,169	1,169	1,902	+733
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	86,179	87,102	94,385	+7,283
Purchase of goods and services from government accounts (25.3)	42,189	42,189	134,268	+92,079
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	655	655	3,896	+3,241
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	178	178	178	-
Subtotal Other Contractual Services	**129,201**	**130,124**	**232,727**	**+102,603**
Equipment (31.0)	2,022	2,022	2,024	+2
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	1,190,230	1,213,982	4,683,402	+3,469,420
Insurance Claims and Indemnities (42.0)	119,837	87,695	88,364	+669
Total Non-Pay Costs	**$ 1,445,748**	**$ 1,438,281**	**$ 5,012,993**	**+$3,574,712**
Total Budget Authority by Object Class	**$ 1,487,929**	**$ 1,481,393**	**$ 5,091,522**	**+$3,610,129**

HEALTH WORKFORCE

OBJECT CLASS	2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Full-time permanent (11.1)	10,221	10,444	24,492	+14,048
Other than full-time permanent (11.3)	405	414	878	+464
Other personnel compensation (11.5)	196	200	379	+179
Military personnel (11.7)	1,026	1,050	3,437	+2,387
Special personnel services payments (11.8)	5	5	-	-5
Subtotal personnel compensation	**11,853**	**12,113**	**29,186**	**+17,073**
Civilian benefits (12.1)	3,367	3,441	8,143	+4,702
Military benefits (12.2)	569	582	1,774	+1,192
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**15,790**	**16,136**	**39,103**	**+22,967**
Travel and transportation of persons (21.0)	148	148	247	+99
Transportation of things (22.0)	41	41	23	-18
Rental payments to GSA (23.1)	798	869	2,533	+1,664
Rental payments to Others (23.2)	-	-	18	+18
Communication, utilities, and misc. charges (23.3)	2,399	2,328	2,717	+389
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	14,902	14,902	23,635	+8,733
Purchase of goods and services from government accounts (25.3)	26,560	26,560	18,957	-7,603
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	862	862	140	-722
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	-	-	2	+2
Subtotal Other Contractual Services	**42,324**	**42,324**	**42,734**	**+410**
Equipment (31.0)	675	675	59	-616
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	774,624	770,480	370,364	-400,116
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**$ 821,009**	**$ 816,865**	**$ 418,695**	**-$398,170**
Total Budget Authority by Object Class	**$ 836,799**	**$ 833,001**	**$ 457,798**	**-$375,203**

MATERNAL AND CHILD HEALTH

OBJECT CLASS	2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Full-time permanent (11.1)	7,368	7,529	10,063	+2,534
Other than full-time permanent (11.3)	371	379	584	+205
Other personnel compensation (11.5)	152	155	244	+89
Military personnel (11.7)	506	518	779	+261
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**8,397**	**8,581**	**11,670**	**+3,089**
Civilian benefits (12.1)	2,415	2,468	3,421	+953
Military benefits (12.2)	252	258	486	+228
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**11,064**	**11,307**	**15,577**	**+4,270**
Travel and transportation of persons (21.0)	438	434	472	+38
Transportation of things (22.0)	10	10	11	+1
Rental payments to GSA (23.1)	640	640	1,137	+497
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	580	580	367	-213
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	8,665	8,665	24,880	+16,215
Other services (25.2)	4,525	4,525	6,242	+1,717
Purchase of goods and services from government accounts (25.3)	15,324	15,324	15,262	-62
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	423	423	278	-145
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	6	6	11	+5
Subtotal Other Contractual Services	**28,942**	**28,943**	**46,673**	**+17,730**
Equipment (31.0)	440	440	387	-53
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	819,468	800,500	1,071,576	+271,076
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**$850,517**	**$831,547**	**$1,120,623**	**+$289,076**
Total Budget Authority by Object Class	**$861,581**	**$842,854**	**$1,136,200**	**+$293,346**

HIV/AIDS

OBJECT CLASS	2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Full-time permanent (11.1)	15,813	16,158	16,178	+20
Other than full-time permanent (11.3)	129	132	124	-8
Other personnel compensation (11.5)	252	257	255	-2
Military personnel (11.7)	2,978	3,046	3,124	+78
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**19,171**	**19,593**	**19,681**	**+88**
Civilian benefits (12.1)	5,182	5,295	5,310	+15
Military benefits (12.2)	1,607	1,644	1,686	+42
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**25,960**	**26,532**	**26,677**	**+145**
Travel and transportation of persons (21.0)	556	556	518	-37
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	1,171	1,229	1,170	-59
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	1,711	1,653	1,550	-103
Commercial Reimbursement (23.6)	0	-	-	-
Network use data transmission service (23.8)	0	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	**-**	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	24,989	24,989	23,899	-1,091
Purchase of goods and services from government accounts (25.3)	58,833	58,833	56,984	-1,849
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	1,861	1,861	1,861	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	38	38	38	-
Subtotal Other Contractual Services	**85,721**	**85,721**	**82,782**	**-2,939**
Equipment (31.0)	2,003	2,003	1,868	-135
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	2,196,062	2,185,340	2,145,606	-39,734
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**$ 2,287,224**	**$ 2,276,502**	**$ 2,233,493**	**-$43,008**
Total Budget Authority by Object Class	**$ 2,313,185**	**$ 2,303,034**	**$ 2,260,170**	**-$42,864**

HEALTHCARE SYSTEMS

OBJECT CLASS	2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Full-time permanent (11.1)	6,608	6,752	6,784	+32
Other than full-time permanent (11.3)	453	463	465	+2
Other personnel compensation (11.5)	230	235	236	+1
Military personnel (11.7)	1,382	1,414	1,450	+36
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**8,673**	**8,864**	**8,935**	**+72**
Civilian benefits (12.1)	2,322	2,373	2,384	+11
Military benefits (12.2)	583	596	612	+16
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**11,578**	**11,833**	**11,932**	**+99**
Travel and transportation of persons (21.0)	244	245	245	-
Transportation of things (22.0)	78	78	78	-
Rental payments to GSA (23.1)	392	392	392	-
Rental payments to Others (23.2)	687	687	687	-
Communication, utilities, and misc. charges (23.3)	1,097	1,097	1,097	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	0	0	0	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	462	463	463	-
Other services (25.2)	52,791	52,510	51,710	-800
Purchase of goods and services from government accounts (25.3)	4,798	4,748	3,964	-784
Operation and maintenance of facilities (25.4)	159	190	69	-121
Research and Development Contracts (25.5)	16	16	16	-
Medical care (25.6)	2,964	2,964	2,964	-
Operation and maintenance of equipment (25.7)	325	329	329	+
Subsistence and support of persons (25.8)	30	30	30	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	693	688	186	-502
Subtotal Other Contractual Services	**62,237**	**61,938**	**59,730**	**-2,208**
Equipment (31.0)	413	406	78	-327
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	27,217	26,808	26,277	-531
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**$92,366**	**$91,652**	**$88,586**	**-$3,066**
Total Budget Authority by Object Class	**$103,945**	**$103,485**	**$100,518**	**-$2,967**

RURAL HEALTH POLICY

OBJECT CLASS	2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Full-time permanent (11.1)	$ 951	$ 972	$ 799	$-173
Other than full-time permanent (11.3)	70	71	37	-34
Other personnel compensation (11.5)	16	16	14	-2
Military personnel (11.7)	69	70	72	+2
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**1,106**	**1,130**	**922**	**-208**
Civilian benefits (12.1)	321	328	259	-68
Military benefits (12.2)	41	42	43	+1
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**1,467**	**1,499**	**1,224**	**-275**
Travel and transportation of persons (21.0)	171	176	145	-31
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	102	103	89	-15
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	207	200	42	-158
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	7,427	9,316	8,760	-555
Purchase of goods and services from government accounts (25.3)	2,971	2,876	2,411	-466
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	254	124	27	-97
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	-	-	-	-
Subtotal Other Contractual Services	**10,653**	**12,316**	**11,198**	**-1,118**
Equipment (31.0)	21	21	21	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	143,080	140,685	62,192	-78,493
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**$154,234**	**$153,501**	**$73,687**	**-$79,814**
Total Budget Authority by Object Class	**$155,700**	**$155,000**	**$74,911**	**-$80,089**

PROGRAM MANAGEMENT

OBJECT CLASS	2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Full-time permanent (11.1)	79,063	80,788	81,172	+384
Other than full-time permanent (11.3)	3,379	3,453	3,469	+16
Other personnel compensation (11.5)	1,790	1,829	1,838	+9
Military personnel (11.7)	5,221	5,341	5,477	+136
Special personnel services payments (11.8)	9	-	-	-
Subtotal personnel compensation	**89,462**	**91,411**	**91,956**	**+545**
Civilian benefits (12.1)	26,027	26,595	26,722	+126
Military benefits (12.2)	2,877	2,943	3,018	+75
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**118,366**	**120,949**	**121,696**	**+746**
Travel and transportation of persons (21.0)	95	95	95	-
Transportation of things (22.0)	23	23	23	-
Rental payments to GSA (23.1)	8,798	8,798	8,798	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	703	703	703	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	82	82	82	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	3,713	3,713	3,713	-
Purchase of goods and services from government accounts (25.3)	16,515	13,503	11,949	-1,554
Operation and maintenance of facilities (25.4)	735	735	735	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	547	547	547	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	266	266	266	-
Subtotal Other Contractual Services	**21,775**	**18,764**	**17,210**	**-1,554**
Equipment (31.0)	3,540	3,540	3,387	-153
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	-	-	-	-
Insurance Claims and Indemnities (42.0)	246	-	-	-
Total Non-Pay Costs	**$35,263**	**$32,005**	**$30,297**	**-$1,707**
Total Budget Authority by Object Class	**$153,629**	**$152,954**	**$151,993**	**-$961**

FAMILY PLANNING

OBJECT CLASS	2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Full-time permanent (11.1)	5,242	$,357	5,382	+25
Other than full-time permanent (11.3)	64	65	65	+
Other personnel compensation (11.5)	97	99	100	+
Military personnel (11.7)	808	826	847	+21
Special personnel services payments (11.8)	6	-	-	-
Subtotal personnel compensation	**6,217**	**6,347**	**6,394**	**+47**
Civilian benefits (12.1)	1,644	1,679	1,687	+8
Military benefits (12.2)	425	435	446	+11
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**8,286**	**8,462**	**8,528**	**+66**
Travel and transportation of persons (21.0)	117	117	117	-
Transportation of things (22.0)	1	1	1	-
Rental payments to GSA (23.1)	523	523	523	-
Rental payments to Others (23.2)	15	15	15	-
Communication, utilities, and misc. charges (23.3)	53	53	53	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	2	2	2	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	4,442	4,442	4,442	-
Other services (25.2)	51	51	51	-
Purchase of goods and services from government accounts (25.3)	12,315	12,315	12,315	-
Operation and maintenance of facilities (25.4)	50	50	50	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	-	-	-	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	6	6	6	-
Subtotal Other Contractual Services	**16,865**	**16,865**	**16,865**	**-**
Equipment (31.0)	4	4	4	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	260,612	258,492	260,371	+1,879
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**$278,193**	**$276,072**	**$277,952**	**+$1,879**
Total Budget Authority by Object Class	**$286,479**	**$284,534**	**$286,479**	**+$1,945**

MANDATORY

OBJECT CLASS	2017 Final	FY 2018 Annualized CR[211]	FY 2019 President's Budget	FY 2019 +/- FY 2018
Full-time permanent (11.1)	48,649	50,237	-	-50,237
Other than full-time permanent (11.3)	1,559	1,605	-	-1,605
Other personnel compensation (11.5)	870	898	-	-898
Military personnel (11.7)	4,080	4,204	-	-4,204
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**55,158**	**56,945**	**-**	**-56,945**
Civilian benefits (12.1)	16,210	16,738	-	-16,738
Military benefits (12.2)	2,489	2,521	-	-2,521
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**73,857**	**76,205**	**-**	**-76,205**
Travel and transportation of persons (21.0)	403	403	-	-403
Transportation of things (22.0)	24	24	-	-24
Rental payments to GSA (23.1)	4,144	4,144	-	-4,144
Rental payments to Others (23.2)	18	18	-	-18
Communication, utilities, and misc. charges (23.3)	2,390	2,390	-	-2,390
GSA Reimbursement Transaction Charge (23.5)	-	-	-	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	18,903	18,903	-	-18,903
Other services (25.2)	30,210	30,210	-	-30,210
Purchase of goods and services from government accounts (25.3)	111,241	111,241	-	-111,241
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	3,249	3,249	-	-3,249
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	8	8	-	-8
Subtotal Other Contractual Services	**163,612**	**163,612**	**-**	**-163,612**
Equipment (31.0)	84	84	-	-84
Grants, subsidies, and contributions (41.0)	3,987,654	4,128,121	-	-4,128,121
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**$4,158,329**	**$4,298,795**	**$0**	**-$4,298,795**
Total Budget Authority by Object Class	**$4,232,186**	**$4,375,000**	**$0**	**-$4,375,000**

[211] FY 2018 level includes proposed mandatory funding.

Salaries and Expenses

(Dollars in Thousands)

DISCRETIONARY

OBJECT CLASS	2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Full-time permanent (11.1)	149,468	152,730	194,094	+41,364
Other than full-time permanent (11.3)	6,173	6,308	7,609	+1,301
Other personnel compensation (11.5)	3,118	3,186	3,896	+710
Military personnel (11.7)	17,251	17,647	21,688	+4,041
Special personnel services payments (11.8)	20	5	-	-5
Subtotal personnel compensation	**176,031**	**179,876**	**227,288**	**+47,412**
Civilian benefits (12.1)	49,484	50,564	64,429	+13,865
Military benefits (12.2)	9,178	9,388	11,548	+2,160
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**234,693**	**239,829**	**303,265**	**+63,436**
Travel and transportation of persons (21.0)	2,612	2,614	2,728	+114
Transportation of things (22.0)	163	163	146	-17
Rental payments to Others (23.2)	704	704	722	+18
Communication, utilities, and misc. charges (23.3)	7,918	7,782	8,431	+649
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	84	84	84	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	13,569	13,569	29,785	+16,216
Other services (25.2)	194,577	197,108	212,396	+15,288
Purchase of goods and services from government accounts (25.3)	179,471	176,349	256,130	+79,781
Operation and maintenance of facilities (25.4)	944	975	854	-121
Medical care (25.6)	2,964	2,964	2,964	-
Operation and maintenance of equipment (25.7)	4,927	4,801	7,077	+2,276
Subsistence and support of persons (25.8)	30	30	30	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	1,187	1,182	688	-494
Subtotal Other Contractual Services	**397,669**	**396,978**	**509,924**	**+112,946**
Total Non-Pay Costs	**$409,149**	**$408,324**	**$522,035**	**+$113,711**
Total Budget Authority by Object Class	**$643,842**	**$648,153**	**$825,299**	**+$177,146**

MANDATORY

OBJECT CLASS	2017 Final	FY 2018 Annualized CR[212]	FY 2019 President's Budget	FY 2019 +/- FY 2018
Full-time permanent (11.1)	48,649	50,237	-	-50,237
Other than full-time permanent (11.3)	1,559	1,605	-	-1,605
Other personnel compensation (11.5)	870	898	-	-898
Military personnel (11.7)	4,080	4,204	-	-4,204
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**55,158**	**56,945**	**-**	**-56,945**
Civilian benefits (12.1)	16,210	16,738	-	-16,738
Military benefits (12.2)	2,489	2,521	-	-2,521
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**73,857**	**76,205**	**-**	**-76,205**
Travel and transportation of persons (21.0)	403	403	-	-403
Transportation of things (22.0)	24	24	-	-24
Rental payments to Others (23.2)	18	18	-	-18
Communication, utilities, and misc. charges (23.3)	2,390	2,390	-	-2,390
GSA Reimbursement Transaction Charge (23.5)	-	-	-	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	18,903	18,903	-	-18,903
Other services (25.2)	30,210	30,210	-	-30,210
Purchase of goods and services from government accounts (25.3)	111,241	111,241	-	-111,241
Operation and maintenance of facilities (25.4)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	3,249	3,249	-	-3,249
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-		-
Supplies and materials (26.0)	8	8	-	-8
Subtotal Other Contractual Services	**163,612**	**163,612**	**-**	-163,612
Total Non-Pay Costs	**$166,447**	**$166,447**	**$0**	**-$166,447**
Total Budget Authority by Object Class	**$240,304**	**$242,651**	**$0**	**-$242,651**

[212] FY 2018 level includes proposed mandatory funding.

Detail of Full-Time Equivalent Employment

Programs	FY 2017			FY 2018			FY 2019		
	Civilian	Military	Total	Civilian	Military	Estimate	Civilian	Military	Estimate
Bureau of Primary Health Care:									
Direct:									
Health Centers/Tort	235	53	288	235	53	288	456	66	522
Free Clinics Medical Malpractice	-	-	-	-	-	-	-	-	-
Total, Direct:	**235**	**53**	**288**	**235**	**53**	**288**	**456**	**66**	**522**
Mandatory:									
Health Centers	212	13	225	212	13	225	-	-	-
School-based Health Centers- Facilities (ACA)	9	-	9	9	-	9	-	-	-
Total, Mandatory	**221**	**13**	**234**	**221**	**13**	**234**	**-**	**-**	**-**
Total FTE, BPHC	**456**	**66**	**522**	**456**	**66**	**522**	**456**	**66**	**522**
Health Workforce:									
Direct:									
National Health Service Corps	-	-	-	-	-	-	200	25	225
NURSE Corps Loan Repayment & Scholarship	28	4	32	28	4	32	28	4	32
Centers for Excellence	1	-	1	1	-	1	-	-	-
Scholarships for Disadvantaged Students	5	-	5	5	-	5	-	-	-
Health Careers Opportunity Program	1	1	2	1	1	2	-	-	-
Health Care Workforce Assessment	6	-	6	6	-	6	6	-	6
Primary Care Training and Enhancement	6	-	6	6	-	6	-	-	-
Oral Health Training	5	1	6	5	1	6	-	-	-
Area Health Education Centers	4	-	4	4	-	4	-	-	-
Geriatric Programs	5	1	6	5	1	6	-	-	-
Behavioral Health Workforce Education and Training	5	1	6	5	1	6	-	-	-
Mental and Behavioral Health	2	-	2	2	-	2	-	-	-

Programs	FY 2017			FY 2018			FY 2019		
	Civilian	Military	Total	Civilian	Military	Estimate	Civilian	Military	Estimate
Public Health/Preventive Medicine	4	-	4	4	-	4	-	-	-
Advanced Education Nursing Program	7	1	8	7	1	8	-	-	-
Nurse Workforce Diversity	-	-	-	-	-	-	-	-	-
Nurse Education, Practice & Retention	4	1	5	4	1	5	-	-	-
Nurse Faculty Loan Program	4	1	5	4	1	5	-	-	-
Children's Hospitals GME Program	16	1	17	16	1	17	-	-	-
Teaching Health Center Graduate Medical Education	-	-	-	-	-	-	7	1	8
Total, Direct	**103**	**12**	**115**	**103**	**12**	**115**	**241**	**30**	**271**
Reimbursable:									
National Practitioner Data Bank	34	1	35	34	1	35	34	1	35
Total, Reimbursable:	**34**	**1**	**35**	**34**	**1**	**35**	**34**	**1**	**35**
Mandatory:									
National Health Service Corps	200	25	225	200	25	225	-	-	-
Teaching Health Center Graduate Medical Education	7	1	8	7	1	8	-	-	-
Total, Mandatory	**207**	**26**	**233**	**207**	**26**	**233**	**-**	**-**	**-**
Total FTE, Health Workforce	**344**	**39**	**383**	**344**	**39**	**383**	**275**	**31**	**306**
Maternal and Child Health Bureau:									
Direct:									
Maternal & Child Health Block Grant	41	1	42	41	1	42	41	1	42
Autism and Other Developmental Disorders	5	1	6	5	1	6	-	-	-
Sickle Cell Service Demonstrations	2	-	2	2	-	2	-	-	-
James T. Walsh Universal Newborn Hearing Screening	4	-	4	4	-	4	-	-	-
Emergency Medical Services for Children	5	-	5	5	-	5	-	-	-
Healthy Start	12	3	15	12	3	15	12	3	15
Heritable Disorders	3	-	3	3	-	3	-	-	-

Programs	FY 2017			FY 2018			FY 2019		
	Civilian	Military	Total	Civilian	Military	Estimate	Civilian	Military	Estimate
Family-to-Family Health Information Centers	-	-	-	-	-	-	-	1	1
Maternal, Infant, and Early Childhood Home Visiting	-	-	-	-	-	-	40	3	43
Total, Direct:	**72**	**5**	**77**	**72**	**5**	**77**	**93**	**8**	**101**
Mandatory									
Family-to-Family Health Information Centers	-	1	1	-	1	1	-	-	-
Maternal, Infant, and Early Childhood Home Visiting	40	3	43	40	3	43	-	-	-
Total, Mandatory	**40**	**4**	**44**	**40**	**4**	**44**	**-**	**-**	**-**
Total FTE, MCHB	**112**	**9**	**121**	**112**	**9**	**121**	**93**	**8**	**101**
HIV/AIDS Bureau:									
Direct:									
Ryan White Part A	39	5	44	39	5	44	39	5	44
Ryan White Part B	54	9	63	54	9	63	54	9	63
Ryan White Part C	39	15	54	39	15	54	41	15	56
Ryan White Part D	7	3	10	7	3	10	7	3	10
Ryan White Part F	4	1	5	4	1	5	-	-	-
Ryan White Part F Dental	1	-	1	1	-	1	1	-	1
Special Project of National Significance (SPNS)	2	-	2	2	-	2	-	-	-
Total, Direct:	**146**	**33**	**179**	**146**	**33**	**179**	**142**	**32**	**174**
Reimbursable:									
OGAC Global AIDS	20	3	23	20	3	23	20	3	23
Secretary's Minority AIDS Initiative	-	-	-	-	-	-	-	-	-
Total, Reimbursable	**20**	**3**	**23**	**20**	**3**	**23**	**20**	**3**	**23**
Total FTE, HAB	**166**	**36**	**202**	**166**	**36**	**202**	**162**	**35**	**197**

Programs	FY 2017			FY 2018			FY 2019		
	Civilian	Military	Total	Civilian	Military	Estimate	Civilian	Military	Estimate
Healthcare Systems Bureau:									
Direct:									
Organ Transplantation	2	-	2	2	-	2	2	-	2
National Cord Blood Inventory	3	1	4	3	1	4	3	1	4
C.W.Bill Young Cell Transplantation Program	7	-	7	7	-	7	7	-	7
Poison Control Centers	2	-	2	2	-	2	2	-	2
340B Drug Pricing Program/Office of Pharmacy Affairs	16	6	22	16	6	22	16	6	22
Hansen's Disease Center	48	5	53	48	5	53	48	5	53
Covered Countermeasures Compensation	4	2	6	4	2	6	4	2	6
Vaccine	14	6	20	14	6	20	16	6	22
Total, Direct:	**96**	**20**	**116**	**96**	**20**	**116**	**98**	**20**	**118**
Reimbursable:									
Hansen's Disease Center	3	-	3	3	-	3	3	-	3
Total, Reimbursable	**3**	**-**	**3**	**3**	**-**	**3**	**3**	**-**	**3**
				-	-	-	-	-	
Total FTE, HSB	**99**	**20**	**119**	**99**	**20**	**119**	**101**	**20**	**121**
Federal Office of Rural Health Policy:									
Direct:									
Rural Health Policy Development	1	-	1	1	-	1	1	-	1
Rural Health Outreach Grants	7	1	8	7	1	8	7	1	8
Rural Hospital Flexibility Grants	2	-	2	2	-	2	-	-	-
State Offices of Rural Health	-	-	-	-	-	-	-	-	-
Radiation Exposure Screening & Education Program	1	-	1	1	-	1	1	-	1
Black Lung	-	-	-	-	-	-	-	-	-
Telehealth	1		1	1	-	1	1	-	1
Total FTE, FORHP	**12**	**1**	**13**	**12**	**1**	**13**	**10**	**1**	**11**

Programs	FY 2017			FY 2018			FY 2019		
	Civilian	Military	Total	Civilian	Military	Estimate	Civilian	Military	Estimate
Family Planning (Direct)[213]	11	1	12	11	1	12	34	1	35
Program Management (Direct)	741	48	789	741	48	789	741	48	789
Subtotal Direct (non add)	1,416	173	1,589	1,416	173	1,589	1,815	206	2,021
Subtotal Reimbursable (non add)	57	4	61	57	4	61	57	4	61
Subtotal Mandatory (non add)	468	43	511	468	43	511	-	-	-
Total, Ceiling FTE	**1,941**	**220**	**2,161**	**1,941**	**220**	**2,161**	**1,872**	**210**	**2,082**

Average GS Grade

FY 2017	12.9
FY 2018	12.9
FY 2019	12.9

[213] Due to coding error, FTE is reporting lower than actual 35 FTE in FY 2017 and FY 2018.

FTEs Funded by P.L. 111-148 and Any Supplementals

(Dollars in Thousands)

		FY 2011		FY 2012		FY 2013		FY 2014		FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
Program	**Section**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**
Community Health Center Fund:																			
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(1)	1,000,000	56	1,200,000	47	1,500,000	60	2,144,716	95	3,509,111	122	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	-	-	-	-	3,600,000	240	3,510,661	225	3,600,000	225	-	-
Health Centers - Facilities Construction	H.R. 3590, Section 10503(c)	1,500,000	20	-	19	-	-	-	-	-	-	-	-	-	-	-	-	-	-
School-Based Health Centers-Facilities	H.R. 3590, Section 4101	50,000	9	50,000	5	47,500	8	-	9	-	7	-	7	-	9	-	9	-	-
National Health Service Corps:																			
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(2)	290,000	190	295,000	248	300,000	229	283,040	219	287,370	214	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	-	-	-	-	310,000	226	288,610	225	310,000	225	-	-
GME Payments Teaching Health Centers:	H.R. 3590, Section 5508																		
P.L. 111-148 Mandatory		230,000	4	-	4	-	6	-	5	-	4	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	-	-	-	-	60,000	8	55,860	8	60,000	8	-	-
Family to Family Health Information Centers:																			
Non-P.L. 111-148 Mandatory	H.R. 3590, Section 5507	5,000	1	5,000	1	5,000	-	5,000	1	5,000	1	5,000	1	4,655	1	5,000	1	-	-
Home Visiting Program:																			
P.L. 111-148 Mandatory	H.R. 3590, Section 2951	250,000	19	350,000	23	379,600	22	-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	371,200	22	400,000	25	400,000	37	372,400	44	400,000	44	-	-
Total		**3,325,000**	**299**	**1,900,000**	**347**	**2,232,100**	**325**	**2,803,956**	**351**	**4,201,481**	**373**	**4,375,000**	**519**	**4,232,186**	**512**	**4,375,000**	**512**	**-**	**-**

Programs Proposed for Elimination

The following list shows the programs proposed for elimination in the FY 2019 Budget request. Termination of these programs totals approximately $960.0 million in discretionary resources. Following each program is a brief summary and the rationale for its elimination.

Program	FY 2018 Annualized CR
Loan Repayment/Faculty Fellowships	$1.2
Centers of Excellence	$21.6
Scholarships for Disadvantaged Students	$45.7
Health Career Opportunity Program	$14.1
Primary Care Training and Enhancement	$38.7
Oral Health Training Programs	$36.4
Area Health Education Centers	$ 30.0
Geriatric Programs	$38.5
Behavioral Health Workforce Education and Training	$49.7
Mental and Behavioral Health	$9.8
Public Health/Preventative Medicine	$16.9
Advanced Nursing Education	$64.1
Nursing Workforce Diversity	$15.2
Nurse Education, Practice and Retention	$39.6
Nurse Faculty Loan Program	$26.3
Children's Hospital Graduate Medical Education	$298.0
Autism and Other Developmental Disorders	$46.8
Sickle Cell Service Demonstrations	$4.4
James T. Walsh Universal Newborn Hearing Screening	$17.7
Emergency Medical Services for Children	$20.0
Heritable Disorders	$13.8
AIDS Education and Training Centers – Part F	$33.4
HIV/AIDS Special Programs of National Significance	$24.8
Rural Hospital Flexibility Grants	$43.3
State Offices of Rural Health	$9.9
National Hansen's Disease – Building and Facilities	$0.1
Total Programs Proposed for Elimination	**$ 960.0**

Loan Repayment/Faculty Fellowships (-$1.2 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Centers of Excellence (-$21.6 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Scholarships for Disadvantaged Students (-$45.7 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Health Career Opportunity Program (-$14.1 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Primary Career Training and Enhancement (-$38.7 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Oral Health Training Programs (-$36.4 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Area Health Education Centers (-$30.0 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Geriatric Programs (-$38.5 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Behavioral Health Workforce Education and Training (-$49.7 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Mental and Behavioral Health (-$9.8 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Public Health/Preventative Medicine (-$16.9 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Advanced Nursing Education (-$64.1 million)
The Budget eliminates funding for Nurse training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Nursing Workforce Diversity (-$15.2 million)
The Budget eliminates funding for Nurse training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Nurse Education, Practice and Retention (-$39.6 million)
The Budget eliminates funding for Nurse training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Nurse Faculty Loan Program (-$26.3 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Children's Hospital Graduate Medical Education (-$298.0 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Autism and Other Developmental Disorders (-$46.8 million)
No funding is requested for this program. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs.

Sickle Cell Service Demonstrations (-$4.4 million)
No funding is provided for this program. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs.

James T. Walsh Universal Newborn Hearing Screening (-$17.7 million)
No funding is provided for this program. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs.

Emergency Medical Services for Children (-$20.0 million)
No funding is provided for this program. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs.

Heritable Disorders (-$13.8 million)
No funding is provided for this program. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs.

AIDS Education and Training Centers – Part F (-$33.4 million)
The Budget eliminates funding for training programs, and prioritizes program that provide direct health care services.

Special Programs of National Significance (-$24.8 million)
The Budget does not include a separate funding line for these projects. As required by Statute, SPNS will be funded from budget authority of Ryan White HIV/AIDS Parts A-D programs.

Rural Hospital Flexibility Grants (-$43.3 million)
No funding is provided for these programs, due to a shift in program priorities that emphasize direct health care services.

State Offices of Rural Health (-$9.9 million)
No funding is provided for this program, due to a shift in program priorities that emphasize direct health care services.

National Hansen's Disease – Building and Facilities (-$0.1 million)
No new funding is provided for buildings and facilities. There are sufficient funds available to continue the renovation and repair work on patient and clinic areas, and to complete minor renovation work on the Carville museum and cemetery.

Physicians' Comparability Allowance (PCA) Worksheet

Table 1

		FY2017	FY 2018* Estimate	FY 2019 Request
1) Number of Physicians Receiving PCAs		37	36	36
2) Number of Physicians with One-Year PCA Agreements		1	1	1
3) Number of Physicians with Multi-Year PCA Agreements		36	35	35
4) Average Annual PCA Physician Pay (without PCA payment)		$145,266	$157,524	$157,524
5) Average Annual PCA Payment		$22,457	$21,692	$22,692
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	2	2	2
	Category II Research Position	1	1	1
	Category III Occupational Health	0	0	0
	Category IV-A Disability Evaluation	0	0	0
	Category IV-B Health and Medical Admin.	34	33	33

*FY 2018 data will be approved during the FY 2019 Budget cycle.

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

n/a

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

For each category, the amount of PCA given is to retain highly qualified medical officers that could potentially be compensated more in the private sector.
Category I - $28,000
Category II - $6,500
Category IV – B - $30,000

Compensation reflects physician longevity and board certification. Physicians are also selecting multi-year contracts, which also reflect compensation for mission specific factors. Compensating at these levels has allowed HRSA to compete with the private sector and to increase retention of HRSA physicians. Most private sector physician salaries exceed the base salary HRSA is able to offer. Hence, PCA provides the mechanism to get close to what they are currently receiving.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

PCA is used to recruit and retain highly qualified medical officers. It is difficult to compete with private industry salaries. If HRSA did not offer PCA, HRSA would not be able to attract potential candidates or maintain current HRSA medical officers who enhance HRSA mission and goals. In FY17, there were (2) retirements and (3) resignations. The (3) resignations were as a result of private industry job offers.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

Three vacancies were filled at the highest salary rate with PCA.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

N/A

Significant Items TAB

SIGNIFICANT ITEMS FOR INCLUSION IN L-HHS APPROPRIATIONS COMMITTEE FY 2019 CONGRESSIONAL JUSTIFICATION

HOUSE REPORT 115-244 (July 24, 2017)

1. **Update on GAO Report. —** The Committee requests HRSA include an update in the fiscal year 2019 Congressional justification on the agency's efforts to implement the recommendations described in GAO Report (GAO–12– 546) Health Center Program: Improved Oversight Needed to Ensure Grantee Compliance with Requirements. **(Page 20)**

   Action to be Taken
   HRSA has completed implementation of actions in response to the recommendations included in the GAO Report (GAO-12-546). The status of each implementation response is acknowledged by GAO as "Closed – Implemented".

2. **Establishment of a Health Center Audit, Compliance, and Oversight Office. —** The Committee allocates not less than $15,000,000 for the establishment of a Health Center Audit, Compliance, and Oversight Office within the Bureau of Primary Health Care. The Committee expects the office to perform periodic audits and compliance reviews of all health center access points, with a goal of conducting a compliance or audit review for every access point location every five years. The office shall oversee Federally Qualified Health Centers, Health Center Program Look-Alikes, and Health Centers receiving a grant under section 330 of the Public Health Service Act. The office should provide uniform guidance to health center project officers, monitor project officer adherence to program guidance, and periodically assess whether program guidance is meeting program objectives. The office will also conduct independent compliance reviews, ensuring all health center access points have policies, procedures, and training to comply with applicable Federal laws. The office shall submit quarterly reports to the Committees on Appropriations of the House of Representatives and the Senate containing the results of all audits and compliance reviews of health center access points and oversight of health center project officers. The Committees directs HRSA to provide a briefing within 45 days of enactment of this Act on efforts to establish this office. **(Page 21)**

   Action to be Taken
   HRSA expects to provide the requested briefing, consistent with funding levels and direction included in the final enacted FY 2019 appropriation.

3. **Tuberculosis. —** The Committee encourages HRSA to continue to implement the recommendations of the Tuberculosis Action Plan and recommends that the agency include an update of its progress in the fiscal year 2019 Congressional Justification. **(Page 21)**

Action to be Taken
HRSA is collaborating with the National Association for City and County Health Officials (NACCHO) to provide technical assistance to support coordination between health centers and State and local TB control programs to help ensure appropriate identification, treatment, and prevention of TB among target populations. NACCHO is conducting an environmental scan and reaching out to stakeholders to inform their technical assistance plan.

4. **Centers of Excellence. —** The Committee directs HRSA to provide continuation grants for activities authorized under section 736 of the Public Health Service Act. **(Page 22)**

Action to be Taken
HRSA will follow this directive assuming funds are appropriated for these activities in FY 2018.

5. **Integration of Primary Care and Oral Health Practice. —** The Committee encourages HRSA to address the impact of medication on oral health as part of its ongoing efforts to promote oral health and primary care integration across the patient lifespan, additional focus would feature diabetic patients as a population of interest for primary care integration. **(Page 22)**

Action to be Taken
In FY 2018, HRSA will work to address the impact of medication on oral health, prioritizing opioids and their impact on oral health.

6. **Rare Diseases. —** The Committee encourages HRSA to examine programs to increase primary care physician's preparedness in the diagnosis of rare diseases. **(Page 23)**

Action to be Taken
If funds are appropriated in FY 2018, HRSA will consult with the advisory committees supporting our physician training program including Advisory Committee on Training in Primary Care Medicine and Dentistry and Council on Graduate Medical Education to determine opportunities under the currently authority to increase primary care physicians' preparedness in the diagnosis of rare diseases through technical assistance to grantees or dissemination of curricula.

7. **Oral Health Training. —** The Committee directs HRSA to provide continuation funding for pre-doctoral and postdoctoral training grants initially awarded in fiscal year 2015. The Committee directs HRSA to provide continuation funding for grants initially awarded in fiscal years 2016 and 2017. **(Page 23)**

Action to be Taken
In FY 2017, HRSA awarded non-competing continuations to the Pre-doctoral and Post-doctoral training grants, as well as making awards to a new cohort under the Pre-doctoral program. In FY 2017, HRSA also awarded non-competing continuations to the Dental

Faculty Development and Loan Repayment Program, as well as making awards to a new cohort under the Dental Faculty Loan Repayment Program.

8. **Area Health Education Centers. —** The Committee is aware that some State dental associations have already initiated programs to refer emergency room patients to dental networks. HRSA is encouraged to work with these programs. The Committee encourages HRSA to engage additional Federal partners, external stakeholders, including current and former grantees of the program, to determine how the AHEC network can be used to continually educate primary care health professionals, especially concerning infectious diseases. **(Page 23)**

   Action to be Taken
   In FY 2018, HRSA will continue to work with our Federal partners and external stakeholders to bolster our education efforts for health professionals around dental networks and infectious diseases. Specifically, HRSA will offer targeted technical assistance to support current AHEC grantees to develop partnerships with (1) State dental associations to support dental health networks and (2) the National AHEC Association to enhance training for health professionals concerning infectious diseases.

9. **Mental and Behavioral Health. —** The Committee encourages HRSA to invest in geropsychology training programs and to help integrate health service psychology trainees at Federally Qualified Health Centers. HRSA should build on recent efforts to expand training to increase mental, behavioral health services for returning service members, veterans, and their families, with an emphasis on veterans reintegrating into rural civilian communities. **(Page 23)**

   Action to be Taken
   HRSA continues to emphasize the integration of behavioral health into primary care settings, including Federally Qualified Health Centers. HRSA will consider other methods to integrate geropsychology and FQHCs in future funding opportunities.

10. **Behavioral Health Workforce Education and Training. —** The Committee directs HRSA to share information concerning pending grant opportunity announcements with State licensing organizations and all the relevant professional associations. **(Page 24)**

    Action to be Taken
    HRSA shared the FY 2017 BHWET Notice of Funding Opportunity with more than 123,000 individuals, including individuals working in mental and behavioral health organizations (i.e., American Psychiatric Association, American Academy of Pediatrics, American Occupational Therapist Association, etc.).

11. **Nursing Workforce Development. —** The Committee requests HRSA include in the fiscal year 2019 Congressional Justification information on the impact of Title VIII programs on workforce diversity. **(Page 24)**

Action to be Taken

Of the Title VIII programs, only the Nursing Workforce Diversity (NWD) Program is statutorily mandated to address diversity by increasing nursing education opportunities for individuals from disadvantaged backgrounds.

A recent review of 72 peer-reviewed research studies determined that the factors most strongly associated with primary care physicians working in underserved areas (both urban and rural) include: (1) being a racial/ethnic underrepresented minority (URM); and (2) growing up in inner city or rural area.

In Academic Year 2016-2017, the NWD program trained 4,416 students, 100 percent of whom were either underrepresented minorities and/or from disadvantaged backgrounds. In addition, 19 percent of trainees were from rural areas.

The follow up employment data shows that 45 percent of NWD graduates (from FY 2016) are currently practicing in Critical Access Hospitals and 52 percent were working in Medically Underserved Communities.

12. **Neonatal Abstinence Syndrome Effects on Maternal and Child Health. —** The Committee is alarmed by the prevalence of Neonatal Abstinence Syndrome (NAS) and the resulting health and developmental impacts on children. The Committee requests an update in the fiscal year 2019 Congressional Justification on efforts undertaken by HRSA to address NAS. **(Page 25)**

Action to be Taken

HRSA addresses the opioid crisis, including Neonatal Abstinence Syndrome (NAS), on several fronts, including the following:

- Grantees in programs such as the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program and Healthy Start use evidence-based approaches to screen, intervene, and refer perinatal women and parents of young children to treatment and recovery support services. Front-line staff also provide health education and guidance for parents of young children, including caring for babies born with neonatal abstinence syndrome.

    - The MIECHV Program supports voluntary, evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry.

    - The Healthy Start program supports organizations across the country to help reduce racial and ethnic disparities in maternal and infant health status in high-risk communities. Healthy Start supports women before, during, and after pregnancy through the baby's second birthday, by providing care coordination and linkage to comprehensive health and social services, health education, strengthening family resilience, and engaging community partners to enhance systems of care.

- States and territories use Title V Maternal and Child Health (MCH) Services Block Grant funds to support a range of activities at the state's discretion, which may include addressing NAS. In the MCH block grant FY 2018 Applications and FY 2016 Annual Reports, 21 of 59 states/jurisdictions reported activities to address NAS; and five states established an NAS-related State Performance Measure including measures to assess the rates of NAS diagnosis and early intervention for NAS-affected infants. As one of the block grant program's National Outcome Measures, and in response to legislation, HRSA annually compiles and makes available to states, national and state-level data on the proportion of infants born with NAS.

- HRSA funds the national *Alliance for Innovation in Maternal Health, or AIM,* that developed a maternal safety bundle in CY 2017 for hospitals to help obstetricians and others appropriately manage care for women with opioid dependence. In FY 2018, the AIM National Collaborative on Maternal Opioid Use Disorder has engaged 14 states to implement the bundle and raise awareness about the need for treatment and services for women.

13. Set-aside for Oral Health. — The Committee has included $250,000 to continue demonstration projects to increase the implementation of integrating oral health and primary care practice. The projects should model the core clinical oral health competencies for non-dental providers that HRSA published and initially tested in its 2014 report, Integration of Oral Health and Primary Care Practice. The Committee expects the Chief Dental Officer to play a key role in the design, monitoring, oversight, and implementation of these projects. **(Page 26)**

Action to be Taken

In FY 2017, HRSA provided $250,000 to the National Network of Oral Health Access (NNOHA) to support ten Health Centers in integrating oral health and primary care, using the User's Guide for Implementation of Interprofessional Oral Health Care Clinical Competencies: Results of a Pilot Project. The overall goal of the program is to increase use of dental care services by the population receiving health services at the selected Health Centers. The Chief Dental Officer was involved in the selection of the approach and design of the demonstration project. Plans for FY 2018 are in development, pending the final FY 2018 appropriation.

14. Thalassemia. — HRSA has a long history of supporting thalassemia services. The thalassemia program has been instrumental in aiding patients with this inherited blood disorder, especially as treatments and best practices have evolved over time. The Committee encourages HRSA to reconstitute this program in order to ensure the continued improvement of care and treatment options for patients with this complex and debilitating blood disorder. **(Page 26)**

Action to be Taken

HRSA continues to support programs that bring lifesaving medical care to individuals with thalassemia. HRSA released a notice of funding opportunity, HRSA-18-079 Thalassemia Program, to improve the quality of care delivered to individuals with

clinically significant thalassemia, especially those who are transfusion-dependent. Awardees will establish collaborative regional networks that use collective impact strategies and telehealth to (1) promote the use of expert recommended and evidence-informed care, and (2) improve capacity of primary and subspecialty care clinicians to manage thalassemia, particularly in remote and/or medically underserved communities.

15. **Birthplace and Seamless Systems for Transfer of Care. —** The Committee encourages HRSA to work with its partners, including National organizations representing professionals who attend home, birthing center, and hospital births, to develop a strategy for facilitating ongoing inter-professional dialogue and cooperation and universal adoption of the Best Practice Guidelines for Transfer from Planned Home Birth to Hospital. The goal of this effort should be to achieve optimal mother-baby outcomes in all settings and with all providers. The Committee requests HRSA include information on this effort in the fiscal year 2019 Congressional Justification. **(Page 27)**

    Action to be Taken

    HRSA is aware that the rates for out of hospital births have been increasing over time. Safe, timely transport of a woman and infant to a hospital is critical to saving lives in the event of unanticipated complications during a home birth. Inter-professional communication and cooperation are key components in improving quality of care and safety during transfer from a home or birth center to a hospital. In FY 2016, HRSA shared with all of its Healthy Start grantees "The Best Practice Guidelines for Transfer from Planned Home Birth to Hospital."

    In addition to providing the guidelines to all Healthy Start grantees, HRSA has and will continue to work with its technical assistance (TA) provider to use these materials in their work with local Healthy Start programs and in the delivery of ongoing TA wherever appropriate. HRSA notes that Healthy Start grantees do not provide delivery services.

    HRSA will continue to engage with partners, including the Centers for Disease Control and Prevention, the American Congress of Obstetricians and Gynecologists, and the American Academy of Pediatrics, as well as other HRSA programs, such as the Title V Maternal and Child Health Services Block Grant Program, in order to review and further disseminate best practices for planned home births to best assure the health and safety of the mother and infant.

16. **Breastfeeding Support and Safe Sleep Promotion. —** The Committee is aware that 49 jurisdictions have selected the Title V National Performance Measure 4 on Breastfeeding and encourages HRSA to ensure incorporation and coordination of breastfeeding support within and among the Title V Maternal and Child Health Block Grant, the Healthy Start program, and the Maternal, Infant and Early Childhood Home Visiting Program. The Committee further encourages the integration of breastfeeding support and safe sleep promotion activities within these programs. **(Page 27)**

Action to be Taken

HRSA encourages the integration of breastfeeding support and safe infant sleep promotion activities through the National Action Partnership to Promote Safe Sleep (NAPPSS) cooperative agreement program. NAPPSS is a partnership of organizations that work to assure that safe infant sleep and breastfeeding are jointly addressed in the delivery of health care, public health, and social services to families. The Title V Maternal and Child Health Block Grant; Healthy Start; and Maternal, Infant and Early Childhood Home Visiting Programs are each represented within NAPPSS, and have helped the program develop a training module, that was released in June 2017, for how health care and human service providers can use an individualized "conversations approach" to help infant caregivers overcome barriers to both safe sleep and breastfeeding. HRSA also is incorporating breastfeeding support within the Healthy Start program through the Breastfeeding Training Initiative (Initiative) launched in June 2016. The Initiative promotes and supports breastfeeding among the families served by Healthy Start grantees by providing Healthy Start staff community training opportunities on how to encourage, promote, and support breastfeeding, as well as up to 100 scholarships for Certified Lactation Counselor training. This Initiative will continue through May 2018.

17. **Recommended Uniform Screening Panel. —** The Committee encourages HRSA to expand the Heritable Disorders program to support States with the implementation, education, and awareness of newborn screening for new conditions recently added to the Recommended Uniform Screening Panel, including Pompe, Mucopolysaccharidosis I, and X-linked adrenoleukodystrophy. The program will also disseminate National, regional and State education and training resources for parents, families and providers. **(Page 28)**

Action to be Taken

HRSA is committed to supporting state efforts to screen newborns for conditions on the Recommended Uniform Screening Panel (RUSP), and developing and disseminating education and training resources. HRSA funds the Newborn Screening Data Repository and Technical Assistance Center to provide technical assistance on the implementation of state-based public health newborn screening through resource development, state education and training, policy initiatives, disorder surveillance, evidence-based data collection, evaluation, collaborative efforts with stakeholders, and technical assistance to state newborn screening programs to implement conditions added to the RUSP including Pompe, Mucopolysaccharidosis I, X-linked adrenoleukodystrophy or any new condition added to the RUSP by the Secretary. HRSA is also supporting the Newborn Screening Family Education Program to develop and deliver educational programs at appropriate literacy levels about newborn screening counseling, testing, follow-up, treatment, and specialty services to parents, families, patient advocacy and support groups, and the public. These educational programs will also include information on all conditions including the recently added conditions on the RUSP.

18. **Fetal Infant Mortality Review. —** The Fetal Infant Mortality Review (FIMR) program is an important component of many Healthy Start and local health department initiatives

that provide evidence-based interventions crucial to improving infant health in high risk communities. HRSA is encouraged to continue to support the FIMR program with Healthy Start funding while educating Healthy Start Programs on the successes of the FIMR. **(Page 29)**

Action to be Taken

Fetal and Infant Mortality Review (FIMR) is a community-based, action-oriented process to review fetal and infant deaths and make recommendations to facilitate systemic changes to prevent future similar deaths. Healthy Start grantees may use funds to support involvement in local FIMR programs or to start their own FIMR program. In addition, HRSA funds the National Center for Fatality Review and Prevention to train and provide technical support to approximately 1,350 Child Death Review (CDR) and 179 FIMR programs across the country, some of which are supported by Healthy Start programs. Information from these reviews can be used at the local, state, and federal levels for planning and policy development, quality improvement and health systems development, and enhancing efforts to develop and maintain risk reduction and prevention programs for healthy pregnancies, infants, children, and adolescents.

19. **Organ Distribution Proposal. —** The Committee recognizes that OPTN expects to release for public comment an amended proposal in 2017. The Committee urges HRSA to ensure that any proposals see a robust and transparent public debate on the merits of the proposal. Furthermore, the Committee believes that an extended process will allow the transplant community and its stakeholders to assess fully the use of appropriate supply and demand metrics and the protection of programs serving rural and underserved communities. The Committee encourages HRSA to ensure that liver redistribution proposals go through a transparent process and receive support from the transplant community prior to final action. **(Page 30)**

Action to be Taken

The development of the current liver allocation and distribution policy began in 2012 when the OPTN Board of Directors (OPTN Board) determined that geographic disparities in liver allocation were unacceptably high. Following were several years of policy discussion, modeling of numerous potential approaches, a series of public meetings, and public comment on a draft policy proposal in 2016. Subsequently, HRSA encouraged the OPTN leadership and leaders in the transplant community to consider options to address the OPTN Final Rule requirements while taking into account the concerns of stakeholders, including patients, liver transplant programs, and organ procurement organizations. On December 4, 2017, the OPTN Board of Directors approved a proposal by the OPTN Liver Committee modifying the OPTN Liver Allocation Policy (36 in favor, 3 opposed, 1 abstention). The approved policy will be implemented once updates to the OPTN organ matching and allocation system have been completed for incorporation in the new policy. An implementation date has yet to be determined.

20. **Costs of Liver Distribution Proposals. —** The Committee is aware that OPTN is preparing a revised proposal for redesigning the distribution of livers for transplant in the

United States. The Committee encourages the proposal to include the scope of financial costs associated with the proposal, including estimates of the direct and indirect costs imposed on the Federal government, State governments, local governments, and public and private health insurers. **(Page 30)**

Action to be Taken

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21. **Positions at Organ Procurement and Transplantation Network. —** The Committee appreciates the valuable role played by individuals in leadership positions and other voting positions at OPTN. The Committee expects HRSA to ensure OPTN policymaking committees and subcommittees are selected in a manner that provides equal representation with unbiased selection. **(Page 30)**

Action to be Taken

The process for appointments to the OPTN Board and committees is based on the requirements of the National Organ Transplant Act and the OPTN final rule. This well-established process is outlined in the OPTN Bylaws. The selection process includes guidelines to ensure inclusion of various stakeholders within the transplant community along with balanced regional and professional representation.

22. **Office of Pharmacy Affairs. —** The Committee is aware that the 340B statute requires HRSA to make 340B ceiling prices available to covered entities through a secure website and continues to be concerned that OPA has failed to meet deadlines to complete work on the secure website. The Committee urges OPA to complete the development of a secure website. The Committee directs OPA to include an update on the status of the secure website in the fiscal year 2019 Budget request. **(Page 31)**

Action to be Taken

The 340B statute mandates the creation of a system to allow covered entity authorized users access to view verified 340B ceiling prices for covered outpatient drugs. HRSA developed the *340B Pricing System* to calculate and verify 340B ceiling prices. Using this secure web-based system, drug manufacturers participating in the 340B Program will

submit to HRSA their quarterly pricing data for their portfolio of covered outpatient drugs, and validate their prices against HRSA-calculated 340B ceiling prices. Covered entities will be able to use the *340B Pricing System* as a mechanism to verify that they are not paying more than the posted 340B ceiling prices for covered outpatient drugs. To this end, HRSA has developed a new, integrated information system that focuses on three key priorities: security, user accessibility, and data accuracy.

In the process of developing the secure pricing system, HRSA also made security updates and enhancements to the current 340B Database used for covered entity and manufacturer registrations to strengthen the integrity and effectiveness of all 340B stakeholder information. It was critical to enhance the security of the registration system, as it verifies the identity of users that would have access to the secure pricing system. The new 340B Office of Pharmacy Affairs Information System (OPAIS) will have two separate components – a new registration system and a new secure pricing system. The registration component of the new 340B OPAIS was publicly launched on September 18, 2017.

The pricing component of the new 340B OPAIS has not been publicly released as HRSA is working to align pricing policy with a methodology included in a final rule on 340B Ceiling Prices and Civil Monetary Penalties, published in the Federal Register on January 5, 2017 (82 FR 1210, January 5, 2017). HRSA proposed delays to the effective date, which is currently July 1, 2018, to ensure responsiveness to public comment. The pricing component of the system was available for internal use during September 2017, allowing HRSA to input pricing data from CMS and pricing data from a third party to calculate the 340B ceiling prices. With this information, HRSA can respond to stakeholder inquiries about potential overcharges or participation in the 340B Program.

23. **Healthcare Professional Shortages. —** The Committee requests an update in the fiscal year 2019 Congressional Justification information on the best practices and strategies to attract healthcare practitioners to rural clinics and hospitals in areas with healthcare professional shortages. **(Page 32)**

Action to be Taken

Recruitment and retention of health care providers continues to be a challenge in rural communities. HRSA programs and resources can play a key role in helping Rural Health Clinics (RHCs) and rural hospitals attract health care practitioners. The National Health Service Corps (NHSC) plays an important role in supporting clinicians in underserved rural areas through its scholarship and loan repayment programs for providers in Health Professional Shortage Areas (HPSAs). Designed to maintain essential health care services in rural communities, Critical Access Hospitals (CAHs) are eligible service sites under the NHSC program. The Nurse Corps Loan Repayment program also offers support to nurses who practice at eligible sites, including CAHs.

HRSA's Federal Office of Rural Health Policy (FORHP) provides support to the National Rural Recruitment and Retention Network (3RNet), a 50-state consortium of state-level entities that link practitioners with an interest in rural practice to rural communities in need of clinicians. In 2016, the most recent reporting period, 3RNet supported the

placement of 1,984 clinicians in rural practice. FORHP also administers the grant-based Rural Health Outreach programs that rural communities may utilize to focus on addressing workforce issues.

FORHP continues to promote physician residency training in rural communities, playing a key role in promoting the Rural Training Track Program (RTT). This program supports family medicine residencies in which a resident serves one-year in academic health center and two-years in a rural area. Studies have proven that physicians who practice in rural communities are likely to stay in rural locations. There are currently 42 RTTs across the country, and data shows that graduates from 2008 through 2014, who initially chose rural practices, tended to remain in rural communities. One third of RTT graduates practiced in rural areas one year post graduation. Research shows that RTT graduates are twice as likely as non-rural residents to choose to practice in rural communities.

24. Telehealth. — The Committee encourages the Secretary to establish a Telehealth Center of Excellence to test the efficacy of telehealth services in both urban and rural geographic locations. **(Page 32)**

Action to be Taken

In FY 2017, HRSA awarded grants to two centers of excellence – the Medical University of South Carolina and the University of Mississippi Medical Center to examine the efficacy of telehealth in urban and rural areas. The grantees will coordinate with other HRSA-funded telehealth entities such as the Rural Telehealth Research Center and the Telehealth Resource Centers.

25. Chief Dental Officer. — The Committee is pleased that HRSA has restored the position of Chief Dental Officer (CDO) and looks forward to learning how the agency has ensured that the CDO is functioning with executive level authority with resources to oversee and lead HRSA oral health programs and initiatives. The Committee would like an update in the fiscal year 2019 Congressional Justification on how the CDO is serving as the agency representative on oral health issues to international, National, State, and/or local government agencies, universities, and oral health stakeholder organizations. **(Page 32)**

Action to be Taken

The CDO position at HRSA is responsible for: coordinating oral health activities across all HRSA programs; counseling program officials throughout HRSA on the recruitment, assignment, deployment, retention, and career development of dentists and other oral health professionals within the agency; and advising HRSA oral health investments throughout the various oral health programs in the agency. Over the past year, specific activities have included: reviewing and advising on all proposed oral health-related investments across the agency; leading a variety of cross-agency activities in recognition of Oral Health Month; serving as featured speaker in agency-wide All-Hands meeting on Oral Health; representing the agency at professional conferences and meetings; providing presentations on the agency's oral health portfolio to a variety of stakeholders; overseeing developmental opportunities for dental residents interested in federal public health

careers; and serving as advisor in HRSA's emergency response to affected areas during and after hurricanes Harvey, Irma, and Maria.

SENATE REPORT 115-150 (September 7, 2017)

1. **National Health Service Corps. —** The Committee encourages HRSA to increase the proportion of clinicians serving at health centers to improve alignment between these two programs and to best leverage investments in Corps health professionals. The Committee recognizes that the Secretary retains the authority to include additional disciplines in the Corps. As such, the Committee urges the Secretary to include pharmacists and pediatric subspecialists as eligible recipients of scholarships and loan repayments through the program. **(Page 43)**

   Action to be Taken

   The NHSC has partnered closely with HRSA-supported Federally Qualified Health Centers (FQHCs) to help meet their staffing needs; over 60 percent of NHSC clinicians serve in Health Centers around the nation, and 15 percent of clinical staff at FQHCs are NHSC clinicians.

   While there is flexibility to add other health professionals, such as pharmacists, to the NHSC, there are two considerations that the program must make before taking such action: (1) HRSA must demonstrate that there is a need in the NHSC and the communities it serves for the additional discipline; and (2) the discipline in question must meet the definition of "primary health services." It should be noted that State Loan Repayment Program (SLRP) grantees are allowed to include pharmacists among their eligible disciplines.

   Proposals that aim to include pediatric subspecialists in the NHSC represent an expansion of the NHSC into sub-specialty care; and therefore, would not be considered primary care providers.

2. **National Health Service Corps. —** The Committee encourages HRSA to ensure that States with fewer than ten Corps awardees in the most recent fiscal year, will receive at least five awards in that State this fiscal year, prioritizing awards to individuals for whom that is their home State or to those that received their education in that State. **(Page 43)**

   Action to be Taken

   The NHSC statute directs the Secretary to assign Corps members to HPSAs of greatest shortage, without regard for equal distribution among the States. In addition, NHSC Scholarship Program (SP) participants are not obligated to serve in the State in which they reside or attend health professions school at the time of award; as a result, making NHSC SP awards to individuals in each State would not guarantee that each State would have an NHSC scholar serving there upon completion of their training. Finally, by statute, the NHSC prioritizes both SP and Loan Repayment Program (LRP) awards based on the training and characteristics of the individual applicant, and whether they are from a disadvantaged background. LRP applications are also ranked based on the based on

HPSA scores which represents the degree of health professions short. The current statutory funding preferences do not allow the allocation of SP and LRP awards using the proposed criteria.

3. **Training in Oral Health Care. —** The Committee directs HRSA to provide an update on how the CDO is serving as the agency representative on oral health issues to international, national, State, and local government agencies, universities, and oral health stakeholder organizations in the fiscal year 2019 CJ. **(Page 44)**

   Action to be Taken
   The CDO position at HRSA is responsible for: coordinating oral health activities across all HRSA programs; counseling program officials throughout HRSA on the recruitment, assignment, deployment, retention, and career development of dentists and other oral health professionals within the agency; and advising HRSA oral health investments throughout the various oral health programs in the agency. Over the past year, specific activities have included: reviewing and advising on all proposed oral health-related investments across the agency; leading a variety of cross-agency activities in recognition of Oral Health Month; serving as featured speaker in agency-wide All-Hands meeting on Oral Health; representing the agency at professional conferences and meetings; providing presentations on the agency's oral health portfolio to a variety of stakeholders; overseeing developmental opportunities for dental residents interested in federal public health careers; and serving as advisor in HRSA's emergency response to affected areas during and after hurricanes Harvey, Irma, and Maria.

4. **Training in Oral Health Care. —** The Committee urges HRSA to convene a stakeholder meeting in order to determine how best to create new entry points into the oral health care delivery system for rural and other underserved populations, better utilization of existing dental personnel, and exploration of new types of dental providers. **(Page 44)**

   Action to be Taken
   HRSA has various mechanisms to ensure stakeholders are engaged around improving access to dental care for underserved and rural populations including the Advisory Committee on Training in Primary Care Medicine and Dentistry, quarterly calls with grantees, and informal conversations with stakeholders. Through these conversations, stakeholders have made clear that there are various approaches to address dental shortages.

   To that end, HRSA has afforded flexibility under the Grants to States to Support Oral Health Workforce Activities program to support various activities that are intended to drive innovation at the state level including:

   - Exposing dental and dental hygiene students to underserved rural clinical sites;
   - Targeting specific underserved populations such as those with substance use disorders and their families;
   - Leveraging dental hygienists' expanded scopes of practice in new care models;
   - Testing new models of care using new types of oral health professionals;

- Delivering care via teledentistry or mobile care models;
- Testing new payment models; and
- Assisting dentists in establishing or taking over rural practices.

5. **Training in Oral Health Care. —** The agency is directed to provide continuation funding for predoctoral and postdoctoral training grants initially awarded in fiscal year 2015, and for Section 748 Dental Faculty Loan Program grants initially awarded in fiscal year 2016 with preference for pediatric dentistry faculty supervising dental students or residents and providing clinical services in dental clinics located in dental schools, hospitals, and community-based affiliated sites. **(Page 44)**

   Action to be Taken
   In FY 2017, HRSA awarded non-competing continuations to the Pre-doctoral and Post-doctoral training grants, as well as making awards to a new cohort under the Pre-doctoral program. In FY 2017, HRSA also awarded non-competing continuations to the Dental Faculty Development and Loan Repayment Program, as well as making awards to a new cohort under the Dental Faculty Loan Repayment Program. The grant periods of these programs would extend to FY 2018, pending the final appropriation.

6. **Behavioral Health Workforce Education and Training Program. —** The Committee continues to direct that eligible entities for this program shall include, but is not limited to, accredited programs that train masters and clinical doctoral level social workers, psychologists, counselors, marriage and family therapists, psychiatric mental health nurse practitioners, occupational therapists; psychology interns; and behavioral health paraprofessionals. **(Page 45)**

   Action to be Taken
   Eligible applicants for the FY 2017 BHWET competition programs included psychiatry, behavioral pediatrics, social work, school social work, substance use disorder prevention and treatment, marriage and family therapy, occupational therapy, school counseling, or professional counseling, masters or doctoral level psychiatric nursing and American Psychological Association-accredited doctoral level programs of health service psychology or school psychology. Behavioral Health Paraprofessionals were also included as eligible applicants.

7. **Graduate Psychology Education Program. —** The Committee urges HRSA to explore evidence-based approaches to leverage workforce capacity through this program, to invest in geropsychology training programs, and to help integrate health service psychology trainees at Federally Qualified Health Centers. **(Page 46)**

   Action to be Taken
   HRSA continues to emphasize the integration of behavioral health into primary care settings, including Federally Qualified Health Centers. HRSA will consider other methods to integrate geropsychology and FQHCs in future funding opportunities.

8. **Screening and Treatment for Maternal Depression. —** The Committee provides $5,000,000 for a new Screening and Treatment for Maternal Depression program as authorized in Section 10005 of the 21st Century Cures Act (Public Law 114-255). HRSA is directed to make grants to States to establish, improve, or maintain programs to train professionals to screen, assess, and treat for maternal depression in women who are pregnant or who have given birth within the preceding 12 months. **(Page 46)**

   Action to be Taken
   If those funds are made available, HRSA will implement an initiative to focus on the areas identified.

9. **Advanced Education Nursing. —** The Committee provides an increase of $5,000,000 to award grants for the clinical training of sexual assault nurse examiners to administer medical forensic examinations and treatments to victims of sexual assault in hospitals, health centers, and other emergency health care service provider settings, including Federally qualified health centers, clinics receiving funding under title X, and other health care providers as determined appropriate by the Secretary. **(Page 47)**

   Action to be Taken
   If those funds are made available, HRSA will implement an initiative to focus on the areas identified.

10. **Children's Hospital Graduate Medical Education. —** The Committee notes the Secretary's use of the authority provided under the current authorization to make funding available for hospitals previously ineligible for the program, and urges the Secretary to continue to make such funding available in future CHGME application and funding cycles. **(Page 47)**

    Action to be Taken
    HRSA continues to utilize the expanded eligibility for "Newly Qualified Hospitals". The 2013 reauthorization permits the Secretary, "to make available up to 25 percent of the total amounts in excess of $245,000,000 …but not to exceed $7,000,000" for the purpose of making CHGME payments to these Newly Qualified Hospitals. The Notice of Funding Opportunity, most recently for FY2018, specifies the eligible applicants for the CHGME program as the following: There are two categories of children's hospitals that may be eligible for CHGME payments in FY 2018, depending on the funding appropriated to the program – "Currently Eligible Hospitals" or "Newly Qualified Hospitals." Hospitals that are applying for the first time for the CHGME program may be hospitals that are eligible as a "Newly Qualified Hospital" or hospitals that are new to the CHGME program but qualify under the "Currently Eligible Hospitals" requirements.

    Newly Qualified Hospitals: As per the Children's Hospital GME Support Reauthorization Act of 2013, a freestanding hospital may be eligible for CHGME payments depending on the level of funding appropriated to the program if it meets the following criteria:

1. Has a Medicare payment agreement and is excluded from Medicare IPPS pursuant to section 1886(d)(1)(B) of the SSA and its accompanying regulations;
2. Its inpatients are predominantly individuals under 18 years of age;
3. Has an approved medical residency training program as defined in section 1886(h)(5)(A) of the SSA;
4. Is not otherwise qualified to receive payments under this section or section 1886(h) of the SSA.

11. Children's Hospital Graduate Medical Education. — The Committee encourages HRSA to continue its work with the Children's Hospitals on the development and collection of enhanced program performance measures. **(Page 47)**

Action to be Taken

The CHGME statute allows the Secretary of Health and Human Services to establish a quality bonus system whereby the Secretary distributes bonus payments to participating children's hospitals that meet standards specified by the Secretary. A proposal for public comment was published in the Federal Register on October 16, 2017, with written comments due December 15, 2017.

12. Virtual Pediatric Trauma Center. — The Committee acknowledges the work that HRSA has undertaken with the Uniformed Services University of the Health Sciences to cooperatively introduce and develop the concept of a Virtual Pediatric Trauma Center. Recognizing the value of the concept and the established conceptual framework, the Committee requests that HRSA provide an update on the status of the Virtual Pediatric Trauma Center model in the fiscal year 2019 CJ. **(Page 48)**

Action to be Taken

Currently, access to pediatric trauma care for children is limited in many regions of the United States, particularly in rural areas. As a result, injured children receive care from health professionals with limited experience in pediatric medicine. In 2015, the HRSA MCHB Emergency Medical Services for Children (EMSC) Program collaborated with the Uniformed Services University of the Health Sciences (USUHS) to develop a conceptual framework for a Global Virtual Pediatric Trauma Center (VPTC) to address this need. The VPTC would use telehealth/telemedicine to increase access to pediatric trauma care for children in geographically isolated areas.

13. Children's Health and Development. — The Committee provides $3,500,000 within the Special Projects of Regional and National Significance program for the HRSA-funded study focused on improving child health through a statewide system of early childhood developmental screenings and interventions. This funding shall be used to extend the currently funded project for another year. **(Page 48)**

Action to be Taken

In FY 2017, HRSA awarded $3.5 million to the University of Mississippi Medical Center to support the Early Childhood Developmental Health System Program. The project will continue with annual funding of $3.5 million per year for three years, from September 30,

2017 to September 29, 2020, pending satisfactory performance and availability of future funds. The aim of the Early Childhood Developmental Health System Program is to improve population-level early childhood developmental health outcomes in a state with significant risk factors for poor child health status. Through this activity, HRSA aims to develop and promote best practices that can be applied to all states and communities, and particularly those with the highest rates of child poverty.

14. **Maternal, Infant and Early Childhood Home Visiting Program. —** The Committee encourages HRSA and the Administration for Children and Families to continue their collaboration and partnerships to improve health and development outcomes for at-risk pregnant women, parents, and young children through evidence-based home visiting programs. **(Page 49)**

    Action to be Taken
    HRSA is developing plans for continuation of the Maternal, Infant and Early Childhood Home Visiting Program in partnership with the Administration for Children and Families, pending continued appropriations for the program.

15. **Screening for Sexually Transmitted Diseases. —** The Committee encourages HRSA to continue to work with CDC's Division of STD Prevention to establish appropriate protocols and standards to assure that these screenings are fully integrated into grant recipients comprehensive clinical care plan. **(Page 50)**

    Action to be Taken
    There are many mechanisms that the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) uses to address the screening and treatment of sexually transmitted diseases (STDs). Examples include:

    - HRSA is currently working collaboratively with the Centers for Disease Control and Prevention's Division of STD Prevention:
        - To develop new activities to promote and demonstrate clinical service and system-level interventions that support improvements in the screening and treatment of STDs among low-income people living with HIV or at risk for HIV who are served by HRSA's RWHAP and/or the Health Center Program.
        - To review and update performance measures for STDs (chlamydia, gonorrhea, and syphilis screenings), which RWHAP providers utilize to assess the quality of services provided.
    - HRSA's RWHAP Part C program specifically outlines in their notice of funding opportunity the following programmatic expectations for recipients: *Recipients must also be able to diagnose, provide prophylaxis, and treat or refer clients co-infected with tuberculosis, hepatitis B and C, and sexually transmitted infections.*
    - All Ryan White HIV/AIDS Program Parts A, B, C, and D recipients must adhere to the legislative requirement to establish a clinical quality management program. The HRSA RWHAP expectations for clinical quality management are outlined in Policy Clarification Notice 15-02, Clinical Quality Management Policy Clarification Notice

(http://hab.hrsa.gov/manageyourgrant/clinicalqualitymanagementpcn.pdf). These expectations state that RWHAP recipients must assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines, (otherwise known as the HHS guidelines) for the treatment of HIV disease and related opportunistic infections. Specifically, the *Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents* includes screening and treatment of STDs.

16. **Office of Pharmacy Affairs. —** The Committee is aware that the 340B statute requires HRSA to make 340B ceiling prices available to covered entities through a secure Web site and continues to be concerned that OPA has failed to meet deadlines to complete work on the secure Web site. The Committee urges OPA to complete the development of a transparent system to verify the accuracy of the 340B discount or ceiling prices. **(Page 53)**

Action to be Taken

The 340B statute mandates the creation of a system to allow covered entity authorized users access to view verified 340B ceiling prices for covered outpatient drugs. HRSA developed the *340B Pricing System* to calculate and verify 340B ceiling prices. Using this secure web-based system, drug manufacturers participating in the 340B Program will submit to HRSA their quarterly pricing data for their portfolio of covered outpatient drugs, and validate their prices against HRSA-calculated 340B ceiling prices. Covered entities will be able to use the *340B Pricing System* as a mechanism to verify that they are not paying more than the posted 340B ceiling prices for covered outpatient drugs. To this end, HRSA has developed a new, integrated information system that focuses on three key priorities: security, user accessibility, and data accuracy.

In the process of developing the secure pricing system, HRSA also made security updates and enhancements to the current 340B Database used for covered entity and manufacturer registrations to strengthen the integrity and effectiveness of all 340B stakeholder information. It was critical to enhance the security of the registration system, as it verifies the identity of users that would have access to the secure pricing system. The new 340B Office of Pharmacy Affairs Information System (OPAIS) will have two separate components – a new registration system and a new secure pricing system. The registration component of the new 340B OPAIS was publicly launched on September 18, 2017.

The pricing component of the new 340B OPAIS has not been publicly released, as HRSA is working to align pricing policy with a methodology included in a final rule on 340B Ceiling Prices and Civil Monetary Penalties, published in the Federal Register on January 5, 2017 (82 FR 1210, January 5, 2017). HRSA proposed delays to the effective date, which is currently July 1, 2018, to ensure responsiveness to public comment. The pricing component of the system was available for internal use during September 2017, allowing HRSA to input pricing data from CMS and pricing data from a third party to calculate the 340B ceiling prices. With this information, HRSA can respond to stakeholder inquiries about potential overcharges or participation in the 340B Program.

17. **Delta States Rural Development Network Grant Program. —** The Committee encourages HRSA to continue to consult with the Delta Regional Authority [DRA] on the awarding, implementing, administering, and monitoring grants under the Delta States Network Grant Program in fiscal year 2018. The Committee continues to encourage HRSA to align its awards as closely as possible with the DRA's strategic plan and with DRA economic and community development plans. In addition, of the funds provided, the Committee provides $4,000,000 to support HRSA's collaboration with the DRA to continue DRA's program to help underserved rural communities identify and better address their health care needs and to help small rural hospitals improve their financial and operational performance. Finally, the Committee encourages HRSA to participate and collaborate on DRA's Next Health strategic plan for the Delta Region. The Committee believes that the information the DRA collects in the development of that plan will be of substantial value to HRSA, and encourages HRSA to provide support to DRA for the provision of that information. Within 90 days of enactment of this act, the Committee directs HRSA and DRA to jointly brief the Committee on this program's progress. **(Page 54)**

Action to be Taken

HRSA continues to collaborate with the DRA on the Delta States Network Program. In FY 2017, HRSA and DRA worked together to develop the Delta Region Community Health Systems Program which provides technical assistance to six hospitals located in the Delta region in the areas of financial operations, quality improvement, and telehealth. HRSA will continue its collaboration with DRA and engage in discussions on the development of DRA's Next Health Strategic Plan and other activities as requested to ensure that individuals in the Delta region receive high-quality health care.

18. **Expanding Capacity for Health Outcomes. —** The Committee notes there is increasing demand for technical training on Project ECHO and encourages HRSA to support a national resource center focused on Project ECHO technical training. **(Page 54)**

Action to be Taken

The Project ECHO model has proven to be a viable tool for enhancing rural patient outcomes by expanding rural clinicians' training. A broad range of HRSA programs use the Project ECHO model to support clinicians in community health centers, and similar efforts are underway to support Ryan White Care Act grantees as well as state-level efforts supported through Title V Maternal and Child Health Funding. HRSA's Telehealth Resource Centers are also using the Project ECHO model to support a broad range of clinical training in rural communities. As directed by the ECHO Act (PL 114-270), HHS is developing a report for Congress that examines technology-enabled collaborative learning and capacity building models used by health care providers. The report findings will inform HHS about Project ECHO and other methods of using technology to support clinical learning. HHS will continue to assess this model and how it can support broader workforce goals.

19. Black Lung Clinics. — The Committee continues to direct the Secretary to evaluate funding levels for applicants based on the needs of the populations those applicants will serve and the ability of those applicants to provide health care services to miners with respiratory illnesses, with preference given to State agency applications over other applicants in that State, without regard to the funding tiers and overall per-applicant funding cap established by the Secretary in fiscal year 2014. **(Page 55)**

Action to be Taken

The FY 2017 Black Lung Notice of Funding Opportunity removed the funding tiers and cap on individual applicants. The State preference remains since it is directly aligned with program regulations.

20. Telehealth Network Grant Program. — The Committee encourages HRSA to support telestroke initiatives in the Telehealth Network Grant Program. **(Page 56)**

Action to be Taken

HRSA currently administers the Evidence-Based Tele-Emergency Network Grant Program that supports the use of telehealth networks to deliver Emergency Department consultation services via telehealth to rural communities and providers without emergency care specialists. Several grantees in this program have developed and implemented telestroke initiatives in their networks.

21. Telehealth Resource Centers Grant Program. — The Committee recommends that part of OAT funding should be used to support increased outreach to providers and communities regarding the benefits of telehealth and the availability of technical assistance to support its further adoption. The Committee supports continued funding of the current 12 regional centers and two National centers in fiscal year 2018. **(Page 56)**

Action to be Taken

HRSA continues to fund the Telehealth Resource Center Program, which was competitive in FY 2017 and supports twelve regional and two national resource centers. The centers are responsible for providing assistance, education and information to organizations actively providing or interested in providing medical care in remote areas. The most recent funding announcement increased outreach to providers and communities regarding the benefits of telehealth and availability of technical assistance to support its further adoption.

Vaccine Injury Compensation Program

TAB

Vaccine Injury Compensation Program
Table of Contents

FY 2019 Budget

Appropriation Language

VACCINE INJURY COMPENSATION PROGRAM TRUST FUND

For payments from the Vaccine Injury Compensation Program Trust Fund (the ''Trust Fund''), such sums as may be necessary for claims associated with vaccine-related injury or death with respect to vaccines administered after September 30, 1988, pursuant to subtitle 2 of title XXI of the PHS Act, to remain available until expended: Provided, That for necessary administrative expenses, not to exceed $9,200,000 shall be available from the Trust Fund to the Secretary.

Note.—A full-year 2018 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Continuing Appropriations Act, 2018 (Division D of P.L. 115-56, as amended). The amounts included for 2018 reflect the annualized level provided by the continuing resolution.

Amounts Available for Obligation

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Discretionary Appropriation:	$ 24,260,000	$24,207,000	$27,015,000
Transfer to Other Accounts	-$7,750,000		
Transfer from Other Accounts	$7,750,000		
Subtotal, adjusted Discretionary Appropriation	**$ 24,260,000**	**$ 24,207,000**	**$ 27,015,000**
Mandatory Appropriation	$ 279,303,000	$308,000,000	$308,000,000
Transfer to Other Accounts	-$282,945,000		
Transfer from Other Accounts	$282,945,000		
Subtotal, adjusted Mandatory Appropriation	**$279,303,000**	**$308,000,000**	**$308,000,000**
Spending Auth Offsets	$ 5,549,000		
Administrative Expenses	24,260,000	24,207,000	27,015,000
Total HRSA Claims	282,945,000	308,000,000	308,000,000
Total New Obligations	**307,205,000**	**332,207,000**	**335,015,000**

Budget Authority by Activity

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Trust Fund Obligations: Post-10/1/88 claims	$282,000,000	$308,000,000	$308,000,000
Administrative Expenses: HRSA Direct Operations	$7,750,000	$7,697,000	$9,200,000
Total Obligations	$289,750,000	$315,697,000	$317,200,000

Budget Authority by Object

	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Insurance claims and indemnities	$308,000,000	$308,000,000	---
Salaries & Expenses/Other Services	$7,697,000	$9,200,000	+$1,503,000
Total	$315,697,000	$317,200,000	+$1,503,000

Authorizing Legislation

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
(a) PHS Act, Title XXI, Subtitle 2, Parts A and D:			
Pre-FY 1989 Claims	---	---	---
Post-FY 1989 Claims	$282,000,000	$308,000,000	$308,000,000
(b) Sec. 6601 (r)d ORBA of 1989 (P.L. 101-239):			
HRSA Operations	$7,750,000	$7,697,000	$9,200,000

Appropriation History Table

(Pre-1988 Claims Appropriation)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1996	110,000,000	110,000,000	110,000,000	110,000,000
1997	110,000,000	110,000,000	110,000,000	110,000,000
1998	---	---	---	---
1999	---	---	100,000,000	100,000,000
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2019	---	---	---	---

Vaccine Injury Compensation Program

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Claims BA	$282,000,000	$308,000,000	$308,000,000	---
Admin BA	$7,750,000	$7,697,000	$9,200,000	+$1,503,000
Total BA	**$289,750,000**	**$315,697,000**	**$317,200,000**	**+$1,503,000**
FTE	20	20	22	+2

Authorizing Legislation – Public Health Service Act, Title XXI, Subtitle 2, Parts A and D, Sections 2110-19 and 2131-34, as amended by Public Law 114-255, Section 3093(c).

FY 2019 Authorization ..... .Indefinite

Allocation Method ..... Other

Program Description and Accomplishments

The National Childhood Vaccine Injury Act of 1986 (the Act) established the National Vaccine Injury Compensation Program (VICP) to compensate individuals, or families of individuals, who have been injured by vaccines recommended by the Centers for Disease Control and Prevention (CDC) for routine administration to children and pregnant women, and to serve as a viable alternative to the traditional tort system. HRSA administers the VICP, and the Department of Justice (DOJ) represents HHS in the U.S. Court of Federal Claims (Court) which ultimately decides to provide compensation or dismiss claims.

HRSA receives claims requesting compensation for vaccine injuries or deaths, which the petitioner has served against the HHS Secretary and filed with the Court. HRSA medical officers with special expertise in pediatrics and adult medicine review these claims along with supporting documentation. HRSA also contracts with health care professionals for claims review and with other medical specialists to provide independent claim reviews and to testify in Court. HRSA medical officers develop preliminary recommendations regarding petitioner eligibility for claim compensation, based on medical reviews that DOJ incorporates in its Rule 4(b) report submitted to the Court. Lastly, HRSA processes payments to petitioners and their attorneys based on judgments entered by the Court.

HRSA also publishes notices in the Federal Register listing each claim received and promulgates regulations to modify the Vaccine Injury Table that lists injuries and/or conditions associated with covered vaccines. HRSA provides administrative support to the Advisory Commission on Childhood Vaccines (ACCV), which is responsible for advising the HHS Secretary on issues related to VICP operations. The ACCV is composed of nine voting members, including HHS officials, health professionals, attorneys, and parents or legal representatives of children who have suffered vaccine-related injuries or death.

Vaccine Injury Compensation Trust Fund

With a current balance of nearly $3.7 billion, the Vaccine Injury Compensation Trust Fund (Trust Fund) provides funding to compensate vaccine-related injury or death claims for covered vaccines administered on or after October 1, 1988. The Department of Treasury maintains the Trust Fund through a $.75 excise tax on vaccines recommended by the CDC for routine administration to children and pregnant women. The excise tax applies to each disease prevented per vaccine dose. For example, influenza vaccine is taxed $.75 because it prevents one disease while measles-mumps-rubella vaccine, which prevents three diseases, is taxed $2.25. The Department of Treasury collects the excise taxes and manages Trust Fund investments.

Petitioners include individuals, parents, or legal representatives applying on behalf of others. The number of petitioners receiving compensation nearly doubled from 375 in FY 2013 to 706 in FY 2017. The data in Table 1 reveals a steady rise in the number of petitioners and Court-ordered compensation since FY 2014.

Table 1. Growth in Families and Individuals Receiving Compensation

Fiscal Year	No. of Petitioners	Compensation ($ in millions)
2013	375	$277
2014	365	$214
2015	508	$226
2016	689	$253
2017	706	$282

VICP Administration

The number of claims filed has more than doubled from 504 claims filed in FY 2013 to 1,243 claims filed in FY 2017, primarily due to the increase in the number of seasonal influenza vaccine claims filed. With the CDC recommending an annual influenza vaccine for adults in addition to children, many more people receive influenza vaccines each year. This vaccine now accounts for approximately 60 percent of claims filed annually.

HRSA anticipates 1,720 claims filed in FY 2019, a 25% increase over the FY 2018 level of 1,380 claims filed. The Final Rule modifying the Vaccine Injury Table (Table) was published on March 21, 2017, and petitioners have two years from the effective date of Table changes to file claims for injuries or deaths that occurred up to eight years preceding the Table modification date. The FY 2019 claims filed increase is based on a projected bolus of claims filed by March 21, 2019, the deadline for filing claims related to specific changes to the Vaccine Injury Table.

Becoming law in December 2016, the 21st Century Cures Act (Cures Act) requires the Secretary to revise the Vaccine Injury Table to include vaccines recommended by the CDC for routine administration in pregnant women (and subject to an excise tax by Federal law). It also permits both a woman who received a covered vaccine while pregnant and any live-born child who was in utero at the time such woman received the vaccine to be considered persons to whom the

covered vaccine was administered. The Cures Act also mandates that a covered vaccine administered to a pregnant woman constitutes more than one vaccine administration—one to the mother and one to each live-born child who was in utero at the time the woman received the vaccine.

While the number of claims filed has more than doubled over the last five years, administrative funding has increased by only 19 percent from $6.5 million to $7.75 million from FY 2013 to FY 2017, as shown in Table 2. In FY 2017, the VICP initiated a backlog of claims because the increased number of claims filed exceeded the level of funding available to conduct medical reviews in FY 2017. This backlog results in delays in compensating petitioners since claims remain in backlog status for more than six months awaiting review.

Table 2. Five-Year Trend in Number of Claims Filed versus Administrative Costs

Fiscal Year (FY)	No. of Claims Filed	Administrative Funding *($ in millions)*
2013	504	$6.48
2014	633	$6.46
2015	803	$7.50
2016	1,120	$7.50
2017	1,243	$7.75

Funding History – VICP Claims Compensation

FY	Amount
FY 2015	$225,908,764
FY 2016	$252,884,049
FY 2017	$282,945,120
FY 2018	$308,000,000
FY 2019	$308,000,000

Funding History – VICP Administration

FY	Amount
FY 2015	$7,500,000
FY 2016	$7,500,000
FY 2017	$7,750,000
FY 2018	$7,697,000
FY 2019	$9,200,000

Budget Request

VICP Claims Compensation - The FY 2019 Budget request for VICP claims compensation of $308.0 million is the same as the FY 2018 Annualized CR level.

The FY 2019 Budget request will ensure adequate funds are available to compensate petitioners and pay their attorneys' fees and costs. These funds will also allow the VICP to continue to meet its zero percent target for the percentage of eligible claimants who opt to reject awards and elect to pursue civil action. Prior to the existence of the VICP, civil actions against vaccine manufacturers threatened to cause vaccine shortages and reduce vaccination rates.

VICP Administration - The FY 2019 Budget request for VICP administration of $9.2 million is $1.5 million above the FY 2018 Annualized CR level. This funding level will support administrative expenses to process FY 2019 claims filed, including costs associated with medical expert reviews and expert testimony to the Court. The increase in funds is needed to process the continued growth in claims filed annually. The backlog of claims awaiting review, which was 394 claims at the end of FY 2017, will continue to grow.

In addition, the VICP will continue to provide professional and administrative support to the ACCV, meet specific administrative requirements of the Act, process compensation awards, maintain necessary records securely, and inform the public of the availability of the VICP. The funding request also covers costs associated with the claims award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
26.II.A.1: Percentage of cases in which judgment awarding compensation is rejected and an election to pursue a civil action is filed. *(Outcome)*	FY 2017: 0% Target: 0% (Target Met)	0%	0%	Maintain
26.II.A.4: Average time settlements are approved from the date of receipt of the DOJ settlement proposal. *(Outcome)*	FY 2017:3.9 days Target: 10 days (Target Exceeded)	10 days	10 days	Maintain

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
26.II.A.5: Average time that lump sum only awards are paid from the receipt of all required documentation to make a payment. *(Outcome)*	FY 2017: 2.4days Target: 7 days (Target Exceeded)	7 days	7 days	Maintain
26.II.A.6: Percentage of cases in which court-ordered annuities are funded within the carrier's established underwriting deadline. *(Outcome)*	FY 2017: 100% (Baseline) (Target Exceeded)	98%	98%	Maintain
26.II.A.7: Percentage of medical reports that are completed within 90 days of receipt of complete medical records. *(Outcome)*	FY 2017: 90% (Baseline) (Results Not Available)	90%	90%	Maintain