DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2021

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Rockville, MD 20857

MESSAGE FROM THE ADMINISTRATOR

As the Administrator of the Health Resources and Services Administration (HRSA), I present the fiscal year (FY) 2021 Budget for 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 2021 Budget provides $11.2 billion to invest in programs that support direct heath care services to individuals who are medically underserved or face barriers to health care, and makes strategic investments in important health issues facing our country.

The FY 2021 Budget request:

- Accelerates efforts in the second year of the HHS wide initiative to end the HIV Epidemic, expanding funding to approximately 500 health centers. It is estimated that a total of 43,000 people with HIV will be served in the first two years of this 10-year initiative

- Supports the *Improving Maternal Health in America Initiative* by implementing evidence-based interventions to address critical gaps in maternity care service delivery and improve maternal health outcomes

- Maintains critical resources to help communities combat the opioid crisis and substance use disorders through funding for Health Centers and the National Health Service Corps, and investments in rural communities

- Expands financial support to living organ donors and increases awareness about living organ donation

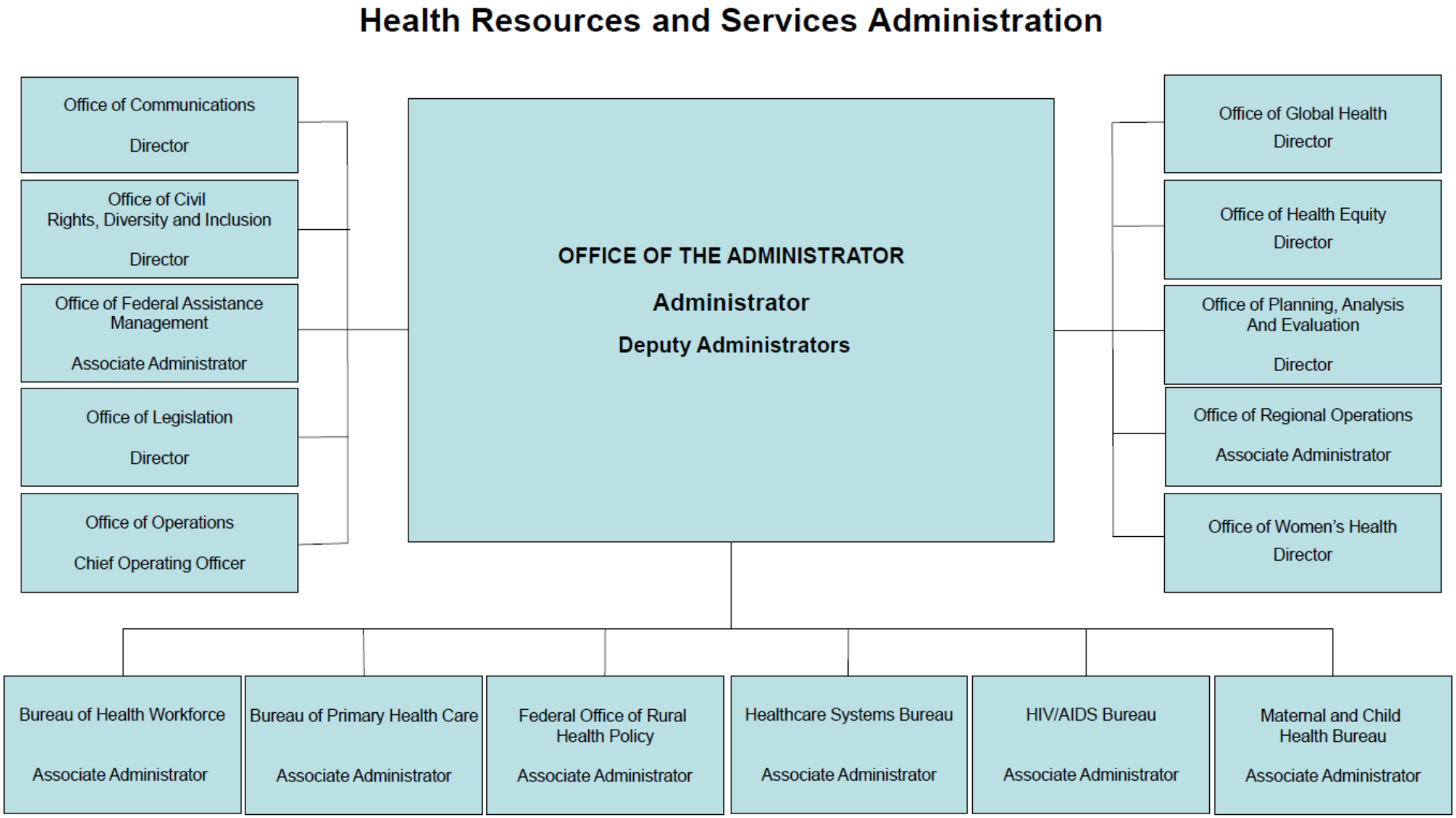
- Extends mandatory funding for Health Centers, National Health Service Corps, and Teaching Health Centers Graduate Medical Education

These investments will protect the health and well-being of the American people, while addressing the opioid crisis, reducing the number of new HIV infections, promoting value-based care, and focusing on programs that provide direct health care. HRSA is committed to maximizing its funding to support critical health issues.

/Thomas J. Engels/

Thomas J. Engels
Administrator

Organizational Chart



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Executive Summary

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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;[1,2]
- The more than 1.1 million people living with HIV infection;[3]
- Persons affected by the growing national problem of opioid abuse and overdose; and
- The more than 113,000 individuals who are waiting for an organ transplant.[4]

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

[1] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018.Data are from the Multiple Cause of Death Files, 1999-2017,as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html

[2] Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, Drake P. Births: Final data for 2017. National Vital Statistics Reports; vol 67 no 8. Hyattsville, MD: National Center for Health Statistics. 2018.

[3] Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2010–2015. HIV Surveillance Supplemental Report 2018;23 (No. 1). http://www.cdc.gov/hiv/library/reports/hivsurveillance.html. Published March 2018. Accessed November 18, 2018.

[4] Organ Procurement and Transplantation Network http://optn.transplant.hrsa.gov

Overview of Budget Request

The FY 2021 President's program level request is $11.2 billion for the Health Resources and Services Administration (HRSA). This level is $705[5] million below the FY 2020 enacted level, and provides investments to protect the health and well-being of the American people, while accelerating efforts in the second year of the HHS-wide initiative to end the HIV Epidemic, improving maternal health, transforming rural health in America, and reforming the organ transplantation system. The Budget also extends mandatory funding for three critical programs.

Highlights of the major changes to programs are listed below:

Health Centers and Free Clinics: +$102.0[6] million; total program $5.7 billion – The Budget provides resources for Health Centers to serve approximately 28.6 million patients in FY 2021. The Budget includes $137 million for approximately 500 health centers in the Phase 1 targeted areas to provide prevention and treatment services to people at high risk for HIV transmission, including Pre-Exposure Prophylaxis (PrEP)-related services, outreach, and care coordination. This will expand the initiative to all health centers in the Phase 1 targeted areas. The Budget also includes an additional $15 million to provide health care services to the unsheltered homeless and $4 billion in mandatory funding in FY 2021.

HIV/AIDS: +$95.0 million; total program $2.5 billion –The Budget provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people living with HIV. The request includes $165 million for the second year of the Ending HIV Epidemic Initiative. The additional resources will support HIV care and treatment services in the identified jurisdictions. Funding will also support evidence informed practices to link, engage, and retain people with HIV in care. The Budget provides funding for capacity building, technical assistance, and resources for program implementation and oversight. HRSA estimates 43,000 clients will be served by this initiative through FY 2021.

Health Workforce: -$824[7] million; total program $826 million

- *Behavioral Health Training Programs: total program level $138.9 million*
  The Budget prioritizes investments in the behavioral health workforce to expand integrated behavioral health care and treatment services in underserved communities. The request includes $29.5 million to support the Addiction Medicine Fellowship Program. This program seeks to increase the number of board certified addiction medicine and addiction psychiatry specialists trained in providing interprofessional behavioral health services, including substance use disorder prevention, treatment, and recovery services, in underserved, community-based settings.

[5] Total includes FY 2020 annualized funding amount for Health Centers, National Health Service Corps, and Teaching Health Center Graduate Medical Education mandatory programs.
[6] Total includes FY 2020 annualized funding amount for Health Centers mandatory program.
[7] Total includes FY 2020 annualized funding amount for National Health Service Corps and Teaching Health Center Graduate Medical Education mandatory programs.

- *National Health Service Corps (NHSC): total program $430 million*
  The Budget supports scholarships and loan repayment to improve access to quality primary care, dental, and behavioral health in underserved urban, rural, and tribal areas. The Budget includes $120 million specifically for loan repayment for clinicians to provide opioid and substance use disorder treatment. The Budget also proposes to extend mandatory funding at $310 million in FY 2021.

- *NURSE Corps: -$5.5 million; total program $83.1 million*
  The Budget addresses the anticipated demand for nurses in Critical Shortage Facilities. The Budget includes a legislative proposal to expand tax-exempt status to include all components of the NURSE Corps Scholarship Program, Native Hawaiian Health Scholarship Program, and NURSE Corps Loan Repayment Program.

- *Teaching Health Centers Graduate Medical Education Program: total program $126.5 million*
  The Budget includes $126.5 million in mandatory resources for residency training in primary care medicine and dentistry in community-based, ambulatory settings. In FY 2021, the program expects to support expects to support a maximum resident FTE cap of up to 801 resident FTE.

- *Children's Hospital Graduate Medical Education (GME) Program: -$340 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 2017 payments for graduate medical education, plus 2017 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.

- *Workforce Training Programs: -$478.6 million; total program $47.2 million*
  The Budget invests $4.7 million in the Health Care Workforce Assessment program to analyze health workforce data. HRSA is the primary Federal entity responsible for monitoring and analyzing the nation's health care workforce. The Budget also includes $18.8 million for the National Practitioner Data Bank (NPDB), 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. The request includes $23.7 million for the Centers of Excellence program to prepare health professions students provide quality health care to diverse populations. 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.

Maternal and Child Health (MCH): -$24.8 million; total program $1.3 billion – The Budget provides $760.7 million for the MCH Block Grant program, an increase of $73 million from the FY 2020 enacted level. The Block Grant serves an estimated 55 million people, including 91 percent of pregnant women, 99 percent of infants, and 54 percent of children nationwide. In FY 2021, HRSA will provide $68 million through Special Projects of Regional and National Significance for the HHS-wide *Improving Maternal Health in America Initiative*. FY 2021 resources will fund an additional State Maternal Health Innovation Grants and support the implementation and expansion of evidence-based models of maternity care, including the maternal safety bundles implemented through the Alliance for Innovation on Maternal Health to community based care settings including Health Centers and IHS and Tribal health care facilities. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs.

Rural Health: -$71.5 million; total programs $246.8 million – As part of the HHS-wide *Improving Maternal Health in America Initiative*, the Budget requests $12 million for the Rural Maternity and Obstetrics Management Strategies (RMOMS) program to support maternal health needs in rural communities. FY 2021 resources will support new awards to develop and test models that improve access to and continuity of maternal obstetrics care in rural communities. This program focuses on Healthy Pregnancies and Births by improving the quality of obstetrics care in rural areas.

The Budget provides $110 million for the Rural Communities Opioid Response Program to strengthen infrastructure and capacity within rural communities at high risk for substance abuse disorders. These funds will also support activities that combat methamphetamine, stimulant, alcohol, and other substance misuse in rural communities. The Budget prioritizes funding for Telehealth, the Radiation Exposure Screening Program, Black Lung Clinics, and Rural Health Outreach Services. The request 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.

Healthcare Systems: +$15.8 million; total programs $139.4 million – In support of the Administration's Advancing American Kidney Health Initiative, the Budget includes an increase of $3 million to expand HRSA's financial support to living organ donors and increase awareness about living organ donation. With these resources, HRSA will reimburse for donor support travel reimbursement, lost wages, child care, elder care, and subsistence expenses to reduce financial barriers to living organ donation. In FY 2020, HRSA proposed a new rule to expand the scope of reimbursable expenses for living donors to include child care and elder care expenses, to remove financial disincentives to living organ donation. HRSA also will propose to increase the income threshold for living donors eligible for reimbursements. The Budget also includes resources and 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.

Program Management: -$3.3 million; total program $152.0 million –The Budget supports program management activities that effectively and efficiently support HRSA's operations, including investments in information technology and cybersecurity. These investments are aligned with the President's Management Agenda.

Vaccine Injury Compensation Program: +$6 million; total program $16.2 million – The Budget requests additional administrative funding to address the significant rise in the number of claims filed largely due to increased claims for injuries from the influenza vaccine. The funding will support the additional costs of medical reviewers dedicated to evaluating the increased claims and reduce the current backlog of 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, foster a health workforce able to address current and emerging needs, enhance population health and address health disparities though community partnerships, maximize the value and impact of HRSA programs, and optimize HRSA operations to enhance efficiency, effectiveness, innovation, and accountability. The anticipated performance in FY 2021 of key HRSA programs is highlighted below, categorized by goal to indicate the close alignment of specific programmatic activities with broader HRSA priorities. In collaboration with states, communities, and organizations, the highlighted examples illustrate ways HRSA will continue to improve health outcomes and address disparities through access to quality services, a skilled health workforce, and innovative, high-value programs for millions of Americans who are geographically isolated and economically or medically vulnerable.

Highlights

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

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 FY 2021, the Health Center Program expects to support health centers' provision of affordable, accessible, quality, and cost efficient care to 28.6 million patients.

- 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 2021, 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 58 percent of children through the Maternal and Child Health (MCH) Block Grant program in FY 2021, 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 5.8 per 1,000 in 2017 to 5.5 per 1,000 in 2021 by supporting state MCH activities to improve the health of mothers, children, and families, particularly among low-income mothers and families or those with limited availability of care.

- Grantees of the Maternal, Infant, and Early Childhood Home Visiting Program are expected to make 1,033,000 home visits to at-risk families in FY 2021, using evidence-based models of care to address children's health, development, and well-being.

- In FY 2021, HRSA expects to serve 43,000 new clients under the Ending the HIV Epidemic: *A Plan for America* initiative.

- By supporting the provision of HIV medications and related services to more than 285,000 persons in FY 2021 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 2021, 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 3.0 million visits for health-related care.

- In FY 2021, 83% of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test are expected to be virally suppressed.

- 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 nearly 4.08 million adults on the donor registry in FY 2021 who self-identify as belonging to an underrepresented racial or ethnic group.

- The Organ Transplantation program projects that it will facilitate the transplantation of more than 32,600 deceased donor organs in FY 2021.

HRSA Goal: Foster a Health Care Workforce Able to Address Current and Emerging Needs

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

- In FY 2021, more than 14,600 primary care and other health practitioners will provide services in health professional shortage areas in rural, urban, and frontier communities in return for National Health Service Corps (NHSC) loan repayment or scholarship support.

- In FY 2021, 11,000 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.

HRSA Goal: Enhance Population Health and Address Health Disparities through Community Partnerships

HRSA efforts will include activities such as leveraging advisory councils to better understand community requirements, integrating public health and primary care services, using evidence-based research to address health disparities, and promoting illness prevention and healthy behaviors.

- In FY 2021, 200,000 unique individuals will receive direct services through Federal Office of Rural Health Policy (FORHP) Outreach grants, which improve rural health through community coalitions and evidence-based models by focusing on quality

improvement, increasing health care access, coordination of care, and integration of services.

- The Graduate Psychology Education Program (GPE) will train 200 students in FY 2021 through innovative doctoral-level health psychology programs that foster an integrated and interprofessional approach to addressing access of behavioral health and substance use prevention and treatment services in high need areas through academic and community partnerships. The GPE Program is focused on providing specialized training to doctoral health psychology students, interns, and post-doctoral residents in the provision of Opioid Use Disorder and other Substance Use Disorder prevention and treatment services.

- In FY 2021, HRSA expects to have 148,721 cord blood units from underrepresented racial and ethnic minorities available through the C.W. Young Cell Transplantation Program, increasing the likelihood of finding suitably matched donors among these populations with a high rate of diversity in tissue types.

- Recognizing that the adequacy of prenatal care is an important risk factor for infant mortality, HRSA projects that 80% of women participating in Healthy Start will have a prenatal care visit in the first trimester.

- The MCH Block Grant program expects to decrease the ratio of the Black infant mortality rate to 2.0 to 1 in FY 2021.

In the ways highlighted above and others, HRSA will continue to help strengthen the health care safety net, improve health outcomes, and increase access to quality services for millions of Americans.

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. HRSA's Strategic Plan includes three goals focused on health access, the health workforce, and population health, each of which gives direction to HRSA as it administers its external programs (described above). HRSA's Strategic Plan also includes two goals focused on internal HRSA performance management that drives improved used of data and evidence to support decision-making.

As the key element of the performance management process, HRSA Senior Staff establish annual fiscal year performance plans, including metrics and indicators of success, directly linked to implementation of the HRSA Strategic Plan and additional priorities, as appropriate.

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. 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. Ultimately, HRSA holds itself to high standards by ensuring all programs maximize the investments and contribute to improved health outcomes.

All-Purpose Table
Health Resources and Services Administration

(Dollars in Thousands)

	FY 2019	FY 2020	FY 2021	
	Final[8]	Enacted[9]	President's Budget	FY 2021 PB +/- FY 2020 Enacted
PRIMARY CARE:				
Health Centers:				
Health Centers	1,496,720	1,505,522	1,607,522	+102,000
Health Centers Mandatory	4,000,000	2,575,342	-	-2,575,342
Health Centers Proposed Mandatory	-	1,424,658	4,000,000	+2,575,342
Health Center Tort Claims	120,000	120,000	120,000	-
Subtotal, Health Centers	***5,616,720***	***5,625,522***	***5,727,522***	***+102,000***
Free Clinics Medical Malpractice	1,000	1,000	1,000	-
Subtotal, Bureau of Primary Health Care (BPHC)	**5,617,720**	**5,626,522**	**5,728,522**	**+102,000**
Subtotal, Mandatory BPHC (non-add)	*4,000,000*	*4,000,000*	*4,000,000*	*-*
Subtotal, Discretionary BPHC (non-add)	*1,617,720*	*1,626,522*	*1,728,522*	*+102,000*
HEALTH WORKFORCE:				
National Health Service Corps (NHSC):				
NHSC	120,000	120,000	120,000	-
NHSC Mandatory	310,000	199,589	-	-199,589
NHSC Proposed Mandatory	-	110,411	310,000	+199,589
Subtotal, NHSC	***430,000***	***430,000***	***430,000***	***-***
Loan Repayment/Faculty Fellowships	1,184	1,190		-1,190
Health Professions Training for Diversity:				
Centers of Excellence	23,593	23,711	23,711	-
Scholarships for Disadvantaged Students	48,726	51,470	-	-51,470
Health Careers Opportunity Program	14,118	15,000	-	-15,000
Subtotal, Health Professions Training for Diversity	***86,437***	***90,181***	***23,711***	***-66,470***
Health Care Workforce Assessment	5,635	5,663	4,663	-1,000
Primary Care Training and Enhancement	48,680	48,924	-	-48,924
Oral Health Training Programs	40,471	40,673	-	-40,673

[8] Funding levels displayed may not add to totals due to rounding.

[9] The Further Consolidated Appropriations Act of FY 2020, P.L. 116-94, provides mandatory funding for Health Centers, National Health Service Corps, and Teaching Health Centers through May 22, 2020. The amount appropriated is displayed with an adjustment so that it may be compared to the President's Budget. This adjustment displays the annualized amount for this program if extended by Congress through the end of the fiscal year.

	FY 2019	FY 2020	FY 2021	
	Final[8]	Enacted[9]	President's Budget	FY 2021 PB +/- FY 2020 Enacted
Medical Student Education	25,000	50,000	-	-50,000
Interdisciplinary, Community-Based Linkages:				
Area Health Education Centers	39,055	41,250	-	-41,250
Geriatric Programs	40,534	40,737	-	-40,737
Behavioral Health Workforce Development Programs	111,916	138,916	138,916	-
Subtotal, Interdisciplinary, Community-Based Linkages	***191,505***	***220,903***	***138,916***	***-81,987***
Public Health Workforce Development:				
Public Health/Preventive Medicine	16,915	17,000	-	-17,000
Nursing Workforce Development:				
Advanced Nursing Education	74,210	80,581	-	-80,581
Nursing Workforce Diversity	17,257	18,343	-	-18,343
Nurse Education, Practice and Retention	41,704	43,913	-	-43,913
Nurse Faculty Loan Program	13,433	28,500	-	-28,500
NURSE Corps Scholarship and Loan Repayment Program	86,701	88,635	83,135	-5,500
Subtotal, Nursing Workforce Development	***233,305***	***259,972***	***83,135***	***-176,837***
Children's Hospital Graduate Medical Education	323,382	340,000	-	-340,000
Teaching Health Center Graduate Medical Education (THCGME):				
THCGME Mandatory	126,500	81,445	-	-81,145
THCGME Mandatory Proposed	-	45,055	126,500	+81,445
Subtotal, THCGME	***126,500***	***126,500***	***126,500***	**-**
National Practitioner Data Bank (User Fees)	*18,814*	*18,814*	*18,814*	-
Subtotal, Bureau of Health Workforce (BHW)	**1,547,828**	**1,649,820**	**825,739**	**-824,081**
Subtotal, User Fees BHW (non-add)	*18,814*	*18,814*	*18,814*	-
Subtotal, Discretionary BHW (non-add)	*1,092,514*	*1,194,506*	*370,425*	*-824,081*
Subtotal, Mandatory BHW (non-add)	*436,500*	*436,500*	*436,500*	-
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant	674,723	687,700	760,700	+73,000
Autism and Other Developmental Disorders	50,377	52,344	-	-52,344
Sickle Cell Service Demonstrations	4,435	5,205	-	-5,205
Early Hearing Detection and Intervention	17,740	17,818	17,818	-
Emergency Medical Services for Children	22,236	22,334	-	-22,334
Healthy Start	121,962	125,500	125,500	-
Heritable Disorders	16,311	17,883	-	-17,883
Pediatric Mental Health Care Access Grants	9,956	10,000	10,000	-
Screening and Treatment for Maternal Depression	4,978	5,000	5,000	-

	FY 2019	FY 2020	FY 2021	
	Final[8]	Enacted[9]	President's Budget	FY 2021 PB +/- FY 2020 Enacted
Family-to-Family Health Information Centers Mandatory	6,000	6,000	6,000	-
Maternal, Infant and Early Childhood Home Visiting Program Mandatory	400,000	400,000	400,000	-
Subtotal, Maternal and Child Health Bureau (MCHB)	**1,328,717**	**1,349,784**	**1,325,018**	**-24,766**
Subtotal, Discretionary MCHB (non-add)	*922,717*	*943,784*	*919,018*	*-24,766*
Subtotal, Mandatory MCHB (non-add)	*406,000*	*406,000*	*406,000*	-
HIV/AIDS:				
Emergency Relief - Part A	655,876	655,876	655,876	-
Comprehensive Care - Part B	1,315,005	1,315,005	1,315,005	-
AIDS Drug Assistance Program (non-add)	*900,313*	*900,313*	*900,313*	-
Early Intervention - Part C	201,079	201,079	201,079	-
Children, Youth, Women & Families - Part D	75,088	75,088	75,088	-
AIDS Education and Training Centers - Part F	33,611	33,611	33,611	-
Dental Reimbursement Program Part F	13,122	13,122	13,122	-
Special Projects of National Significance (SPNS)	25,000	25,000	25,000	-
Ending HIV/AIDS Epidemic Initiative	-	70,000	165,000	+95,000
Subtotal, HIV/AIDS Bureau	**2,318,781**	**2,388,781**	**2,483,781**	**+95,000**
HEALTHCARE SYSTEMS:				
Organ Transplantation	25,437	27,549	30,549	+3,000
Discretionary (non-add)	*25,437*	*27,549*	*17,164*	*-10,385*
PHS Evaluation Funds (non-add)	-	-	*13,385*	*+13,385*
National Cord Blood Inventory	16,195	17,266	8,266	-9,000
C.W. Bill Young Cell Transplantation Program	24,501	30,009	30,009	-
Poison Control Centers	22,746	22,846	22,846	-
340B Drug Pricing Program/Office of Pharmacy Affairs	10,193	10,238	10,238	-
340B Drug Pricing Program User Fees	-	-	*24,000*	*+24,000*
Hansen's Disease Center	13,646	13,706	11,653	-2,053
Payment to Hawaii	1,849	1,857	1,857	-
National Hansen's Disease Program - Buildings and Facilities	122	122	-	-122
Subtotal, Healthcare Systems Bureau (HSB)	**114,689**	**123,593**	**139,418**	**15,825**
Subtotal, Discretionary HSB (non-add)	*114,689*	*123,593*	*102,033*	*-21,560*
Subtotal, User Fees HSB (non-add)	-	-	*24,000*	*+24,000*
Subtotal, Evaluation HSB (non-add)			*13,385*	*+13,385*

	FY 2019	FY 2020	FY 2021	
	Final[8]	Enacted[9]	President's Budget	FY 2021 PB +/- FY 2020 Enacted
RURAL HEALTH:				
Rural Health Policy Development	9,284	10,351	5,000	-5,351
Rural Health Outreach Grants	76,942	79,500	89,500	+10,000
Rural Hospital Flexibility Grants	53,223	53,609	-	-53,609
State Offices of Rural Health	9,928	12,500	-	-12,500
Radiation Exposure Screening and Education Program	1,821	1,834	1,834	-
Black Lung	10,921	11,500	11,500	-
Telehealth	24,324	29,000	29,000	-
Rural Communities Opioid Response	120,000	110,000	110,000	-
Rural Residency Planning and Development	9,956	10,000	-	-10,000
Subtotal, Federal Office of Rural Health Policy	**316,399**	**318,294**	**246,834**	**-71,460**
PROGRAM MANAGEMENT	154,568	155,300	151,993	-3,307
FAMILY PLANNING	285,220	286,479	286,479	-
Appropriation Table Match	**6,822,606**	**7,037,259**	**6,289,085**	**-748,174**
Funds Appropriated to Other HRSA Accounts:				
Vaccine Injury Compensation:				
Vaccine Injury Compensation Trust Fund (HRSA Claims)	225,900	260,400	265,600	+5,200
VICTF Direct Operations - HRSA	9,200	10,200	16,200	+6,000
Subtotal, Vaccine Injury Compensation	**235,100**	**270,600**	**281,800**	**+11,200**
Discretionary Program Level:				
HRSA	**6,841,420**	**7,056,073**	**6,345,284**	**-710,789**
Vaccine Direct Operations Budget Authority	9,200	10,200	16,200	+6,000
Total, HRSA Discretionary Program Level	**6,850,620**	**7,066,273**	**6,361,484**	**-704,789**
Mandatory Programs:	**4,842,500**	**4,842,500**	**4,842,500**	**-**
Total, HRSA Program Level	**11,693,120**	**11,908,773**	**11,203,984**	**-704,789**
Less Programs Funded from Other Sources:				
Evaluation Funds	-	-	*-13,385*	*-13,385*
User Fees	*-18,814*	*-18,814*	*-42,814*	*-24,000*
Mandatory Programs	*-4,842,500*	*-4,842,500*	*-4,842,500*	-
Total, HRSA Discretionary Budget Authority	**6,831,806**	**7,047,459**	**6,305,285**	**-742,174**
Nonrecurring Expense Fund (notification amount)	*13,000*	-	-	-

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, **[**$1,626,522,000**]** *$1,728,522,000*: Provided, 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 $120,000,000 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.

HEALTH WORKFORCE

For carrying out titles III, VII, and VIII of the PHS Act with respect to the health workforce, sections 1128E and 1921 of the Social Security Act, and the Health Care Quality Improvement Act of 1986, **[**$1,194,506,000, of which $138,916,000 shall remain available through September 30, 2021 to carry out sections 750, 755, 756, 760, 781, and 791 of the PHS Act**]***$370,425,000*: Provided, That sections 751**[**(j)(2)**]** and 762(k) of the PHS Act and the proportional funding amounts in paragraphs (1) through (4) of section 756(f) of the PHS Act shall not apply to funds made available under this heading**[:***Provided further*, That for any program operating under section 751 of the PHS Act on or before January 1, 2009, the Secretary of Health and Human Services (referred to in this title as the ‘‘Secretary’’) may hereafter waive any of the requirements contained in sections 751(d)(2)(A) and 751(d)(2)(B) of such Act for the full project period of a grant under such section: *Provided further*, That no funds shall be available for section 340G–1 of the PHS Act:**]** *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 section and subpart: *Provided further*, That $120,000,000 shall remain available until expended for the purposes of providing primary health services, assigning National Health Service Corps (''NHSC'') members to expand the delivery of substance use disorder treatment services, notwithstanding the assignment priorities and limitations under sections 333(a)(1)(D), 333(b), and 333A(a)(1)(B)(ii) of the PHS Act, and making payments under the NHSC Loan Repayment Program under section 338B of such Act: **[***Provided further*, That, within the amount made available in the previous proviso, $15,000,000 shall remain available until expended for the purposes of making payments under the NHSC Loan Repayment Program under section 338B of the PHS Act to individuals participating in such program who provide primary health services in Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs (as those terms are defined by the Secretary), notwithstanding the assignment priorities and limitations under section 333(b) of such Act**[**: *Provided further*, That for purposes of the previous **[**two provisos**]** *proviso*, section 331(a)(3)(D) of the PHS Act shall be applied as if the term ''primary health services'' includes clinical substance use disorder treatment services, including those provided by masters level, licensed substance use disorder treatment counselors**[**:*Provided further*, That of the funds made available under this heading, $5,000,000 shall be available to make grants to establish or expand optional community-based nurse practitioner fellowship

programs that are accredited or in the accreditation process, with a preference for those in Federally Qualified Health Centers, for practicing postgraduate nurse practitioners in primary care or behavioral health**]**.

[Of the funds made available under this heading, $50,000,000 shall remain available until expended for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions: Provided, That, in awarding such grants, the Secretary shall give priority to public institutions of higher education located in States with a projected primary care provider shortage in 2025, as determined by the Secretary: *Provided further*, That grants so awarded are limited to such public institutions of higher education in States in the top quintile of States with a projected primary care provider shortage in 2025, as determined by the Secretary: *Provided further*, That the minimum amount of a grant so awarded to such an institution shall be not less than $1,000,000 per year: *Provided further*, That such a grant may be awarded for a period not to exceed 5 years: *Provided further*, That such a grant awarded with respect to a year to such an institution shall be subject to a matching requirement of non-Federal funds in an amount that is not less than 10 percent of the total amount of Federal funds provided in the grant to such institution with respect to such year.**]**

MATERNAL AND CHILD HEALTH

For carrying out titles III, XI, XII, and XIX of the PHS Act with respect to maternal and child health and title V of the Social Security Act, **[**$943,784,000**]***$919,018,000*: Provided, That notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act, not more than **[**$119,116,000**]***$132,593,000* 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, **[**$2,388,781,000**]***$2,483,781,000*, of which $1,970,881,000 shall remain available to the Secretary through September 30, **[**2022**]** *2023*, 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; and of which **[**$70,000,000**]***$165,000,000*, to remain available until expended, shall be available to the Secretary for carrying out a program of grants and contracts under title XXVI or section 311(c) of such Act focused on ending the nationwide HIV/AIDS epidemic, with any grants issued under such section 311(c) administered in conjunction with title XXVI of the PHS Act, including the limitation on administrative expenses.

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, **[**$123,593,000, of which $122,000 shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center**]***$102,033,000: Provided, That in addition to amounts provided herein, $13,385,000 shall be from funds available under section 241 of the PHS Act to supplement funding for organ transplantation activities; Provided further, 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 sections 711 and 1820 of the Social Security Act, **[**$318,294,000 of which $53,609,000 from general revenues, notwithstanding section 1820(j) of the Social Security Act, shall be available for carrying out the Medicare rural hospital flexibility grants program: Provided, That of the funds made available under this heading for Medicare rural hospital flexibility grants, $19,942,000 shall be available for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of health information technology and up to $1,000,000 shall be to carryout section 1820(g)(6) of the Social Security Act, with funds provided for grants under section 1820(g)(6) available for the purchase and implementation of telehealth services, including pilots and demonstrations on the use of electronic health records to coordinate rural veterans care between rural providers and the Department of Veterans Affairs electronic health record system: *Provided further,* That notwithstanding section 338J(k) of the PHS Act, $12,500,000 shall be available for State Offices of Rural Health: *Provided further,* That $10,000,000 shall remain available through September 30, 2022, to support the Rural Residency Development Program: *Provided further,* That $110,000,000 shall be for the Rural Communities Opioids Response Program**]***$246,834,000*.

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, **[**$155,300,000**]***$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. 228 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"; and

(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 to carry out the provisions of this section.".

Language Analysis

LANGUAGE PROVISION	EXPLANATION
Provided, That sections 751**[(**j)(2)**]** and 762(k) of the PHS Act and the proportional funding amounts in paragraphs (1) through (4) of section 756(f) of the PHS Act shall not apply to funds made available under this heading:**[***Provided further*, That for any program operating under section 751 of the PHS Act on or before January 1, 2009, the Secretary of Health and Human Services (referred to in this title as the "Secretary") may hereafter waive any of the requirements contained in sections 751(d)(2)(A) and 751(d)(2)(B) of such Act for the full project period of a grant under such section: *Provided further*, That no funds shall be available for section 340G-1 of the PHS Act**]:**	Language and citation regarding the Area Health Education Centers is removed because funding is not requested for this program.
[of which $138,916,000 shall remain available through September 30, 2021 to carry out sections 750, 755, 756, 760, 781, and 791 of the PHS Act]:	Language specific to FY 2020 removed.
[*Provided further*, That, in addition to amounts otherwise made available in the previous proviso, $15,000,000 shall remain available until expended for the purposes of making payments under the NHSC Loan Repayment Program under section 338B of the PHS Act to individuals participating in such program who provide primary health services in Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs (as those terms are defined by the Secretary), notwithstanding the assignment priorities and limitations under section 333(b) of such Act**]**:	Specific set-aside language not necessary.
Provided further, That for purposes of the previous **[**two provisos**]** *proviso*, section 331(a)(3)(D) of the PHS Act shall be applied as if the term "primary health services"	Language amended to reflect removal of previous proviso.

LANGUAGE PROVISION	EXPLANATION
includes clinical substance use disorder treatment services, including those provided by masters level, licensed substance use disorder treatment counselors.	
[Provided further, That of the funds made available under this heading, $5,000,000 shall be available to make grants to establish or expand optional community-based nurse practitioner fellowship programs that are accredited or in the accreditation process, with a preference for those in Federally Qualified Health Centers, for practicing postgraduate nurse practitioners in primary care or behavioral health**]**.	Language specific to FY 2020 removed.
[Of the funds made available under this heading, $50,000,000 shall remain available until expended for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions: Provided, That, in awarding such grants, the Secretary shall give priority to public institutions of higher education located in States with a projected primary care provider shortage in 2025, as determined by the Secretary: Provided further, That grants so awarded are limited to such public institutions of higher education in States in the top quintile of States with a projected primary care provider shortage in 2025, as determined by the Secretary: Provided further, That the minimum amount of a grant so awarded to such an institution shall be not less than $1,000,000 per year: Provided further, That such a grant may be awarded for a period not to exceed 5 years: Provided further, That such a grant awarded with respect to a year to such an institution shall be subject to a matching requirement of non-Federal funds in an amount that is not less than 10 percent of the total amount of Federal funds provided in the grant to such institution with respect to such year.**]**	Language regarding the Graduate Medical Education for Health Care Professionals program removed because funding is not requested for this program.

LANGUAGE PROVISION	EXPLANATION
[of which $122,000 shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center**]**	Language removed because funding is not requested for this program.
Provided, That in addition to amounts provided herein, $13,385,000 shall be from funds available under section 241 of the PHS Act to supplement funding for organ transplantation activities;	Provision to authorize use of PHS evaluation funding to supplement funding for organ transplantation activities.
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 appropriation and remain available until expended.	Provision to authorize the Secretary to collect and spend user fees for the 340B Drug Pricing Program.
[of which $53,609,000 from general revenues, notwithstanding section 1820(j) of the Social Security Act, shall be available for carrying out the Medicare rural hospital flexibility grants program: Provided, That of the funds made available under this heading for Medicare rural hospital flexibility grants, $19,942,000 shall be available for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of health information technology and up to $1,000,000 shall be to carryout section 1820(g)(6) of the Social Security Act, with funds provided for grants under section 1820(g)(6) available for the purchase and implementation of telehealth services, including pilots and demonstrations on the use of electronic health records to coordinate rural veterans care between rural providers and the Department of Veterans Affairs electronic health record system: Provided	Language removed because funding is not requested for these programs.

LANGUAGE PROVISION	EXPLANATION
further, That notwithstanding section 338J(k) of the PHS Act, $12,500,000 shall be available for State Offices of Rural Health: Provided further, That $10,000,000 shall remain available through September 30, 2022, to support the Rural Residency Development Program**]**	
[*Provided further*, That $110,000,000 shall be for the Rural Communities Opioids Response Program.]	Language regarding the Rural Communities Opioids Response Program is removed because a separate funding proviso is unnecessary and duplicative.
Sec. 228 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;" and* *(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.".*	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.

Amounts Available for Obligation [10]

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
General Fund Discretionary Appropriation:			
Appropriation	6,843,503,000	7,037,259,000	6,289,085,000
Real transfer to the Administration for Children and Families	-20,897,000	-	-
Health Center Supplemental	+80,000,000	-	-
Subtotal, adjusted general fund discretionary appropriation	**$6,902,606,000**	**$7,037,259,000**	**$6,289,085,000**
Mandatory Appropriation: [11]			
Family to Family Health Information Centers	+6,000,000	+6,000,000	+6,000,000
Primary Health Care Access:			
Community Health Center Fund	+4,000,000,000	+4,000,000,000	+4,000,000,000
National Health Service Corps	+310,000,000	+310,000,000	+310,000,000
Subtotal Primary Health Care Access	**+4,310,000,000**	**+4,310,000,000**	**+4,310,000,000**
Early Childhood Visitation	+400,000,000	+400,000,000	+400,000,000
Teaching Health Centers Graduate Medical Education	+126,500,000	+126,500,000	+126,500,000
Subtotal, adjusted mandatory appropriation	**4,842,500,000**	**4,842,500,000[12]**	**4,842,500,000**
Subtotal, adjusted appropriation	**$11,745,106,000**	**$11,879,759,000**	**$11,131,585,000**
Offsetting Collections	+18,814,000	+18,814,000	+42,814,000
Subtotal Spending Authority from offsetting collections	**+18,814,000**	**+18,814,000**	**+42,814,000**
Unobligated balance, start of year	+473,568,000	+ 484,401,000	+ 228,000,000
Unobligated balanced end of year	-484,401,000	-228,000,000	-198,000,000
Recoveries from prior year unpaid obligations	-80,098,000	-	-
Unobligated balance, lapsing	-2,359,000	-	-
Total obligations	**$11,670,630,000**	**$12,154,974,000**	**$11,204,399,000**

[10] Excludes the following amounts for reimbursable activities carried out by this account: FY 2019 - 12,088,000 and 18 FTE; FY 2020 - $12,088,000 and 18 FTE; FY 2020 $25,474,000 and 18 FTE.

[11] FY 2020 and FY 2021 level includes proposed mandatory funding for Community Health Center Fund, National Health Service Corps, and Teaching Health Centers Graduate Medical Education.

[12] Total includes FY 2020 annualized funding amount for Health Centers, National Health Service Corps, and Teaching Health Center Graduate Medical Education mandatory programs.

Authorizing Legislation

	FY 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
PRIMARY HEALTH CARE:				
Health Centers (Discretionary): Public Health Service (PHS) Act, Section 330, as amended by P.L. 111-148, Section 5601;	Authorized for FY 2020 (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	$1,505,522,000	Authorized for FY 2021 (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	$1,607,522,000
Health Centers (Mandatory) (CHC Fund): P.L. 111-148, Section 10503 (b)(1)(F); as amended by P.L 111-152, Section 2303; as amended by P.L. 114-10, Section 221 P.L. 115-96, Sec. 3101(a); P.L. 115-123, Section 50901, and P.L. 116-59, Division B, Title I, Section 1101, as amended by P.L. 116-69, Division B, Title I, Section 1101, as amended by P.L. 116-94, Division N, Title I, Subtitle D, Section 401 (see 42 U.S.C. 254b-2)	(FY 2020 through 5/22/2020): $2,575,342,466	$4,000,000,000[13]	Expired	$4,000,000,000
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. Note: This program is funded through annual appropriations that are typically made "available until expended" (i.e., no-year) appropriations.	$120,000,000	$10,000,000 per fiscal year is authorized under Section 224; funding comes from the Health Center line. Note: This program is funded through annual appropriations that are typically made "available until expended" (i.e., no-year) appropriations.	$120,000,000

[13] Total includes FY 2020 annualized funding amount for Health Centers mandatory program.

	FY 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
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. Note: This program is funded through annual appropriations that are typically made "available until expended" (i.e., no-year) appropriations.	$1,000,000	$10,000,000 per fiscal year is authorized. Note: This program is funded through annual appropriations that are typically made "available until expended" (i.e., no-year) appropriations.	$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 2020 (and each subsequent year), based on previous year's funding, subject to adjustment formula	$120,000,000	Authorized for FY 2021 (and each subsequent year), based on previous year's funding, subject to adjustment formula	$120,000,000
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); as amended by P.L. 115-123, Section 50901, as amended by P.L. 116-59, Division B, Title I, Section 1101, as amended by P.L. 116-69, Division B, Title I, Section 1101, as amended by P.L. 116-94, Division N, Title I, Subtitle D, Section 401 (see 42 U.S.C. 254b-2)	(FY 2020 through 5/22/2020): $199,589,041	$310,000,000[14]	Expired	$310,000,000
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	---	---	---	---

[14] Total includes FY 2020 annualized funding amount for National Health Service Corps mandatory program.

	FY 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
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) is 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	$1,190,000	Expired	---
Centers of Excellence: Section 736, PHS Act, as amended by P.L. 111-148, Section 5401	SSAN	$23,711,000	SSAN	$23,711,000
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	$51,470,000	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	$15,000,000	Expired	---
National Center for Workforce Analysis: PHS Act, Section 761(b), as amended by P.L. 111-148, Section 5103	Expired	$5,663,000	Expired	$4,663,000
Primary Care Training and Enhancement: PHS Act, Section 747, as amended by P.L. 111-148, Section 5301	Expired	$48,924,000	Expired	---

	FY 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
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)	$40,673,000	Expired (with provision for carryover funds for no more than 3 years)	---
Graduate Medical Education for Physicians: as added by P.L. 115-245, Title II	$25,000,000 (until expended)	$50,000,000	$25,000,000 (until expended)	---
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)	$41,250,000	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 and the SUPPORT for Patients and Communities Act P.L. 115-271, section 7073	$50,000,000 for each of fiscal years 2020 through 2023	$102,000,000	$50,000,000 for each of fiscal years 2021 through 2023	$102,000,000
Education and Training Related to Geriatrics: PHS Act, Section 753, as amended by P.L. 111-148, Section 5305	Expired	$40,737,000	Expired	---
Geriatric Academic Career Awards PHS Act, Section 753(c), as amended by P.L. 111-148, Section 5305(b)	Not Specified	---	Not Specified	---
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 and the SUPPORT for Patients and Communities Act P.L. 115-271, section 7073	21st Century CURES Act, 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	$36,916,000	SUPPORT Act (through FY 2023): Subsection (a)(1)-- $15,000,000 Subsection (a)(2) $15,000,000; Subsection (a)(3): $10,000,000; Subsection (a)(4): $10,000,000	$36,916,000

	FY 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
Public Health /Preventive Medicine: PHS Act, Sections 765-768, as amended by P.L. 111-148, Section 10501. Note: PHS Act Section 770 provides the authorization of appropriations for subpart 2 of Part E of Title VII, which includes sections 765-768	Expired	$17,000,000	Expired	---
Nursing Workforce Development: Advanced Education Nursing: PHS Act, Section 811, as amended by P.L. 111-148, Section 5308	Expired	$75,581,000	Expired	---
Nursing Workforce Diversity PHS Act, Section 821, as amended by P.L. 111-148, Sec. 5404	Expired	$18,343,000	Expired	----
Nurse Education, Practice, Quality and Retention : PHS Act, Section 831 and 831A, as amended by P.L. 111-148, Section 5309	Expired	$43,913,000	Expired	---
Nurse Faculty Loan Program: PHS Act, Section 846A, as amended by P.L. 111-148, Section 5311	Expired	$28,500,000	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	$88,635,000	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, as amended by P.L. 115-241, section 2	Direct GME: $105,000,000 Indirect Medical Education: $220,000,000	$340,000,000	Direct GME: $105,000,000 Indirect Medical Education: $220,000,000	---

	FY 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
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); as amended by P.L. 115-123, Section 50901, as amended by P.L. 116-69, Division B, Title I, Section 1101, as amended by P.L. 116-94, Division N, Title I, Subtitle D, Section 401	(FY 2020 through 5/22/2020): $81,445,205	$126,500,000[15]	Expired	$126,5000,000
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*	*$18,814,000*	*Not Specified*	*$18,814,000*
Health Professional Shortage Areas PHS Act Section 332 as amended by the Improving Access to Maternity Care Act, Public Law 115-320, section 2—*added a new subsection (k) authority for "Maternity Care Health Professional Target Areas"*	----	---	----	---
Grants for Innovative Programs PHS Act Section 340G, as amended by the Action for Dental Health Act of 2018 P.L. 115-302, section 3	FY 2019-2023 $13,903,000	---	FY 2019-2023 $13,903,000	---
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant: Social Security Act, Title V	Indefinite at $850,000,000	$687,700,000	Indefinite at $850,000,000	$760,700,000

[15] Total includes FY 2020 annualized funding amount for Teaching Health Center Graduate Medical Education mandatory program.

	FY 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
Autism Education, Early Detection and Intervention: PHS Act, Section 399BB, as added by P.L. 109-416, Section 3; reauthorized: P.L. 112-32, Section 2; reauthorized: P.L. 113-157, Section 4; reauthorized by P.L. 116-60, Section 3	$50,599,000 (through FY 2024)	$52,344,000	$50,599,000 (through FY 2024)	---
Sickle Cell Service Demonstration Grants: American Jobs Creation Act of 2004, P.L. 108-357, Section 712(c), as amended by the Sickle Cell Disease and Other Heritable Blood Disorders Research, Surveillance, Prevention, and Other Treatment Act of 2018, P.L. 115-327, section 3(b) (which transferred section 712(c) of Pub. L. 108–357 section and redesignated it as 42 U.S.C. 300b-5)	$4,455,000 (each of FY 2020 through FY 2023)	$5,205,000	$4,455,000 (each of FY 2021 through FY 2023)	---
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	$17,818,000	Expired	$17,818,000
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(1); as amended by P.L. 113-180, Section 2; as amended by the Emergency Medical Services for Children Program Reauthorization Act of 2019, P.L. 116-49, Section 2	$22,334,000 (through FY 2024)	$22,334,000	334,000 (through FY 2024)	---
Healthy Start: PHS Act, Section 330H, as added by P.L. 106-310, Section 1501; as amended by P.L. 110-339, Section 2	Expired	$125,500,000	Expired	$125,500,000
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-relating to authorization of appropriations for fiscal years 2015 through 2019)	Expired	$17,883,000	Expired	---
Pediatric Mental Health Care Access Grants: PHS Act, Section 330M, as added by P.L. 114-255, Section 10002	$9,000,000 (each of FY 2020 through FY 2022)	$10,000,000	$9,000,000 (each of FY 2021 through FY 2022)	$10,000,000

	FY 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
Screening and Treatment for Maternal Depression: PHS Act, Section 317L-1, as added by P.L. 114-255, Section 10005	$5,000,000 (each of FY 2020 through FY 2022)	$5,000,000	$5,000,000 (each of FY 2021 through FY 2022)	$5,000,000
Family to Family Health Information Centers: Social Security Act, Section 501(c)(1)(A), as added 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; as amended by P.L. 115-123, Section 50501; as amended by P.L. 116-39, Section 5	$6,000,000 (each of fiscal years 2020 through 2024)	$6,000,000	$6,000,000 (each of fiscal years 2021 through 2024)	$6,000,000
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; as amended by the Bipartisan Budget Act of 2018, P.L. 115-123, Section 50601-50607(see 42 U.S.C. 711)	$400,000,000 (each of FY 2020 through FY 2022) [Note: P.L. 115-123, Section 50606, adds subsection (h)(5) language on "data exchange standards for improved interoperability" at the end of Social Security Act, Section 511(h)(4)—effective on 02/09/2020.]	$400,000,000	$400,000,000 (each of FY 2021 through FY 2022)	$400,000,000
HIV/AIDS:[16]				
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	$655,876,000	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	$1,315,005,000	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*	*$900,313,000*	*Expired*	*$900,313,000*

[16] The Ryan White Program was authorized through September 30, 2013. The Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87, enacted 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 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
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	$201,079,000	Expired	$201,079,000
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	Expired	$75,088,000	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	$33,611,000	Expired	$33,611,000
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	Expired	$13,122,000	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	$25,000,000	Expired	$25,000,000
Ending HIV Epidemic Initiative: Section 311 of the Public Health Service Act and Title XXVI of the Public Health Service Act	Expired	$70,000,000	Expired	$165,000,000
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	$27,549,000	Expired	$30,549,000
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)	$17,266,000	Expired	$8,266,000

	FY 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
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)	$30,009,000	Expired	$30,009,000
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, as amended by P.L. 116-94, Division N, Title I, Subtitle D, Section 403	Toll-free number: $700,000 Media campaign: $800,000 Grant program: $28,600,000 Note: The amounts are authorized through fiscal year 2024	$22,846,000	Toll-free number: $700,000 Media campaign: $800,000 Grant program: $28,600,000 Note: The amounts are authorized through fiscal year 2024	$22,846,000
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	$10,238,000	SSAN indefinitely	$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, Section 1	Not Specified	$13,706,000	Not Specified	$11,653,000
Payment to Hawaii: PHS Act, Section 320(d), as amended by P.L. 105-78, Section 211	Not Specified	$1,857,000	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:				

	FY 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
Rural Health Policy Development: Social Security Act, Section 711, and PHS Act, Section 301	Indefinite	$10,351,000	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	$79,500,000	Expired	$89,500,000
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	$53,609,000	Expired	---
State Offices of Rural Health: PHS Act, Section 338J, as amended by P.L. 105-392, Section 301, and the State Offices of Rural Health Reauthorization Act of 2018, P.L. 115-408, Section 2	$12,500,000 (each of fiscal years 2020 through 2022)	$12,500,000	$12,500,000 (each of fiscal years 2021 through 2022)	---
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	$1,834,000	Not Specified	$1,834,000
Black Lung: Federal Mine Safety and Health Act 1977, P.L. 91-173, Section 427(a)	Not Specified	$11,500,000	Not Specified	$11,500,000
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	$29,000,000	Expired	$29,000,000
Rural Communities Opioid Response: SSA Section 711, as added by P.L. 100-203, Section 4401; as amended by P.L. 100-360, Section 411(m)(1); as amended by P.L. 101-239, Section 6213(g); as amended by P.L. 108-173, Section 432	Not Specified	$110,000,000	Not Specified	$110,000,000

	FY 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
Rural Residency: SSA Section 711(b)(5), as added by P.L. 100-203, Section 4401; as amended by P.L. 100-360, Section 411(m)(1); as amended by P.L. 101-239, Section 6213(g); as amended by P.L. 108-173, Section 432	Not Specified	$10,000,000	Not Specified	---
Rural Emergency Medical Services Training and Equipment Assistance Program: PHS Act Section 330J as amended by the Agriculture Improvement Act of 2018, P.L. 115-334, Section 12608	SSAN (each of fiscal years 2020 through 2023)	---	SSAN (each of fiscal years 2021 through 2023)	---
OTHER PROGRAMS:				
Family Planning: Grants: PHS Act Title X	Expired	$286,479,000	Expired	$286,479,000
Program Management	Indefinite	$155,300,000	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	$270,600,000	Indefinite	$281,800,000
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 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 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)	Expired	---	Expired	---
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	---
Comprehensive Geriatric Education: PHS Act, Section 865, as re-designated by P.L. 111-148, Section 5310(b)	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	---
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 and the SUPPORT for Patients and Communities Act P.L. 115-271, section 7073	Expired (through FY 2012 and amounts appropriated remain available until expended)	---	SSAN 2019-2023	---
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	---

	FY 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
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	---
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 (each of FY 2020-FY 2022)	---	$10,000,000 (each of FY 2021-FY 2022)	---
Liability Protections for Health Professional Volunteers at Community	Not Specified	---	Not Specified	---

	FY 2020 Amount Authorized	FY 2020 Amount Appropriated	FY 2021 Amount Authorized	FY 2021 President's Budget
Health Centers: PHS Act, Section 224(q), as added by P.L. 114-255, the 21st Century Cures Act, Section 9025				

Summary of Changes

2020 Enacted	$7,037,259,000
(Obligations)	($7,037,259,000)
2021 Estimate	$6,289,085,000
(Obligations)	($6,289,085,000)
2020 Mandatory	$4,842,500,000
(Obligations)	($4,842,500,000)
2021 Mandatory	$4,842,500,000
(Obligations)	($4,842,500,000)
Net Change	-$748,174,000

	FY 2020 Enacted		FY 2021 President's Budget	FY 20201+/- FY 2020	
	FTE	**Budget Authority**	**Budget Authority**	**FTE**	**Budget Authority**
	2,090			**-85**	
		$338,504,686	$330,618,222		-$7,886,464
Increases:					
A. Built in:					
1. January 2021 Civilian Pay Raise		+6,734,553	+2,168,902		-4,565,651
2. January 2021 Military Pay Raise		+730,383	+708,262		-22,121
3. Civilian Annualization of Jan. 2020		+1,382,486	+2,242,962		+860,476
4. Military Annualization of Jan. 2020		+204,193	+243,957		+39,764
Subtotal, built-in increases		**+9,051,615**	**+5,364,083**		**-3,687,532**
B. Program:					
Discretionary Increases					
Health Centers	319	1,505,522,000	1,607,522,000	-	+102,000,000
National Health Service Corps	5	120,000,000	120,000,000	+ 1	-

	FY 2020 Enacted		FY 2021 President's Budget	FY 20201+/- FY 2020	
Maternal and Child Health Block Grant	44	687,700,000	760,700,000	-	+73,000,000
Ending HIV/AIDS Epidemic Initiative	30	70,000,000	165,000,000	-	+95,000,000
Rural Communities Opioid Response	7	110,000,000	110,000,000	+ 5	-
Rural Health Outreach Grants	9	79,500,000	89,500,000	-	+10,000,000
Subtotal Discretionary Program Increases	**414**	**2,572,722,000**	**2,852,722,000**	+6	**+280,000,000**
Mandatory Increases					
Subtotal Mandatory Program Increases	-	-	-	-	-
Total Program Increases	**414**	**2,572,722,000**	**2,852,722,000**	+ 6	**+280,000,000**
Decreases:					
A. Built in:					
1. Pay Costs	**2,090**	**338,504,686**	**330,618,222**	-85	**-7,886,464**
B. Program:					
Discretionary Decreases					
Loan Repayment/Faculty Fellowships	-	1,190,000	-	-	-1,190,000
Scholarships for Disadvantaged Students	5	51,470,000	-	-5	-51,470,000
Health Careers Opportunity Program	2	15,000,000	-	-2	-15,000,000
Health Care Workforce Assessment	6	5,663,000	4,663,000	-	-1,000,000
Primary Care Training and Enhancement	7	48,924,000	-	-7	-48,924,000
Oral Health Training Programs	6	40,673,000	-	-6	-40,673,000
Graduate Medical Education for Health Care Professionals	-	50,000,000	-	-	-50,000,000
Area Health Education Centers	4	41,250,000	-	-4	-41,250,000
Geriatric Programs	5	40,737,000	-	-5	-40,737,000
Public Health/Preventive Medicine	5	17,000,000	-	-5	-17,000,000
Advanced Nursing Education	9	75,581,000	-	-9	-75,581,000
Nursing Workforce Diversity	3	18,343,000	-	-3	-18,343,000
Nurse Education, Practice and Retention	4	43,913,000	-	-4	-43,913,000
Nurse Faculty Loan Program	3	28,500,000	-	-3	-28,500,000
NURSE Corps Scholarship and Loan Repayment Program	30	88,635,000	83,135,000	+ 2	-5,500,000
Nurse Practitioner Residency Program	-	5,000,000			-5,000,000
Children's Hospital Graduate Medical Education	20	340,000,000	-	-20	-340,000,000
Autism and Other Developmental Disorders	7	52,344,000	-	-7	-52,344,000
Sickle Cell Service Demonstrations	2	5,205,000	-	-2	-5,205,000
Emergency Medical Services for Children	5	22,334,000	-	-5	-22,334,000
Heritable Disorders	3	17,883,000	-	-3	-17,883,000

	FY 2020 Enacted		FY 2021 President's Budget	FY 20201+/- FY 2020	
Organ Transplantation	4	27,549,000	17,164,000	-	-10,385,000
National Cord Blood Inventory	4	17,266,000	8,266,000	-	-9,000,000
Hansen's Disease Center	49	13,706,000	11,653,000	-	-2,053,000
National Hansen's Disease Program - Buildings and Facilities	-	122,000	-	-	-122,000
Rural Health Policy Development	3	10,351,000	5,000,000	-	-5,351,000
Rural Hospital Flexibility Grants	2	53,609,000	-	-2	-53,609,000
State Offices of Rural Health	-	12,500,000	-	-	-12,500,000
Rural Residency	**1**	10,000,000	-	-1	-10,000,000
Program Management	**770**	155,300,000	151,993,000	-	-3,307,000
Subtotal Discretionary Program Decreases	**959**	**1,310,048,000**	**281,874,000**	**-91**	**-1,028,174,000**
Mandatory Decreases					
Subtotal Mandatory Program Decreases	**-**	**-**	**-**		**-**
Total Program Decreases	**959**	**$1,310,048,000**	**$281,874,000**	**-91**	**-$1,028,174,000**
Net Change Discretionary	**1,373**	**$3,882,770,000**	**$3,134,596,000**	**-85**	**-$748,174,000**
Net Change Mandatory	-	-	-	-	-
Net Change Discretionary and Mandatory	**1,373**	**$3,882,770,000**	**$3,134,596,000**	**-85**	**-$748,174,000**

Budget Authority by Activity
(Dollars in Thousands)

	FY 2019	FY 2020	FY 2021
	Final[17]	Enacted[18]	President's Budget
1. PRIMARY CARE:			
Health Centers:			
Health Centers	1,496,720	1,505,522	1,607,522
Health Centers Mandatory	4,000,000	2,575,342	-
Health Centers Proposed Mandatory	-	1,424,658	4,000,000
Health Center Tort Claims	120,000	120,000	120,000
Subtotal, Health Centers	***5,616,720***	***5,625,522***	***5,727,522***
Free Clinics Medical Malpractice	1,000	1,000	1,000
Subtotal, Bureau of Primary Health Care	**5,617,720**	**5,626,522**	**5,728,522**
2. HEALTH WORKFORCE:			
National Health Service Corps (NHSC):			
NHSC	120,000	120,000	120,000
NHSC Mandatory	310,000	199,589	-
NHSC Proposed Mandatory	-	110,411	310,000
Subtotal, NHSC	***430,000***	***430,000***	***430,000***
Loan Repayment/Faculty Fellowships	1,184	1,190	
Health Professions Training for Diversity:	-	-	
Centers of Excellence	23,593	23,711	23,711
Scholarships for Disadvantaged Students	48,726	51,470	-
Health Careers Opportunity Program	14,118	15,000	-
Subtotal, Health Professions Training for Diversity	***86,437***	***90,181***	***23,711***
Health Care Workforce Assessment	5,635	5,663	4,663
Primary Care Training and Enhancement	48,680	48,924	-
Oral Health Training Programs	40,471	40,673	-
Medical Student Education	25,000	50,000	-

[17] Funding levels displayed may not add to totals due to rounding

[18] The Further Consolidated Appropriations Act of FY 2020, P.L. 116-94, provides mandatory funding for Health Centers, National Health Service Corps, and Teaching Health Centers through May 22, 2020 at a pro-rated level. The amount appropriated is displayed with an adjustment so that it may be compared to the President's Budget. This adjustment displays the annualized amount for this program if extended by Congress through the end of the fiscal year.

	FY 2019	FY 2020	FY 2021
	Final[17]	Enacted[18]	President's Budget
Interdisciplinary, Community-Based Linkages:			
Area Health Education Centers	39,055	41,250	-
Geriatric Programs	40,534	40,737	-
Behavioral Health Workforce Development Programs	111,916	138,916	138,916
Subtotal, Interdisciplinary, Community-Based Linkages	***191,505***	***220,903***	***138,916***
Public Health Workforce Development:			
Public Health/Preventive Medicine	16,915	17,000	-
Nursing Workforce Development:			
Advanced Nursing Education	74,210	75,581	-
Nursing Workforce Diversity	17,257	18,343	-
Nurse Education, Practice and Retention	41,704	43,913	-
Nurse Faculty Loan Program	13,433	28,500	-
NURSE Corps Scholarship and Loan Repayment Program	86,701	88,635	83,135
Nurse Practitioner Residency Program	-	5,000	-
Subtotal, Nursing Workforce Development	***233,305***	***259,972***	***83,135***
Children's Hospital Graduate Medical Education	323,382	340,000	-
Teaching Health Center Graduate Medical Education:			
THCGME Mandatory	126,500	81,445	-
THCGME Mandatory Proposed	-	45,055	126,500
Subtotal, THCGME	***126,500***	***126,500***	***126,500***
National Practitioner Data Bank (User Fees)	*18,814*	*18,814*	*18,814*
Subtotal, Bureau of Health Workforce	**1,547,828**	**1,649,820**	**825,739**
3. MATERNAL & CHILD HEALTH:			
Maternal and Child Health Block Grant	674,723	687,700	760,700
Autism and Other Developmental Disorders	50,377	52,344	-
Sickle Cell Service Demonstrations	4,435	5,205	-
Early Hearing Detection and Intervention	17,740	17,818	17,818
Emergency Medical Services for Children	22,236	22,334	-
Healthy Start	121,962	125,500	125,500
Heritable Disorders	16,311	17,883	-
Pediatric Mental Health Care Access Grants	9,956	10,000	10,000
Screening and Treatment for Maternal Depression	4,978	5,000	5,000
Family-to-Family Health Information Centers Mandatory	6,000	6,000	6,000
Maternal, Infant and Early Childhood Home Visiting Program Mandatory	400,000	400,000	400,000
Subtotal, Maternal and Child Health Bureau	**1,328,717**	**1,349,784**	**1,325,018**

	FY 2019	FY 2020	FY 2021
	Final[17]	Enacted[18]	President's Budget
4. HIV/AIDS:			
Emergency Relief - Part A	655,876	655,876	655,876
Comprehensive Care - Part B	1,315,005	1,315,005	1,315,005
AIDS Drug Assistance Program (non-add)	*900,313*	*900,313*	*900,313*
Early Intervention - Part C	201,079	201,079	201,079
Children, Youth, Women & Families - Part D	75,088	75,088	75,088
AIDS Education and Training Centers - Part F	33,611	33,611	33,611
Dental Reimbursement Program Part F	13,122	13,122	13,122
Special Projects of National Significance (SPNS)	25,000	25,000	25,000
Ending HIV/AIDS Epidemic Initiative	-	70,000	165,000
Subtotal, HIV/AIDS Bureau	**2,318,781**	**2,388,781**	**2,483,781**
5. HEALTHCARE SYSTEMS:			
Organ Transplantation	25,437	27,549	30,549
Discretionary (non-add)	*25,437*	*27,549*	*17,164*
PHS Evaluation Funds (non-add)	-	-	*13,385*
National Cord Blood Inventory	16,195	17,266	8,266
C.W. Bill Young Cell Transplantation Program	24,501	30,009	30,009
Poison Control Centers	22,746	22,846	22,846
340B Drug Pricing Program/Office of Pharmacy Affairs	10,193	10,238	10,238
340B Drug Pricing Program User Fees	-	-	*24,000*
Hansen's Disease Center	13,646	13,706	11,653
Payment to Hawaii	1,849	1,857	1,857
National Hansen's Disease Program - Buildings and Facilities	122	122	-
Subtotal, Healthcare Systems Bureau	**114,689**	**123,593**	**418**
6. RURAL HEALTH:			
Rural Health Policy Development	9,284	10,351	5,000
Rural Health Outreach Grants	76,942	79,500	89,500
Rural Hospital Flexibility Grants	53,223	53,609	-
State Offices of Rural Health	9,928	12,500	-
Radiation Exposure Screening and Education Program	1,821	1,834	1,834
Black Lung	10,921	11,500	11,500
Telehealth	24,324	29,000	29,000
Rural Communities Opioid Response	120,000	110,000	110,000
Rural Residency Planning and Development	9,956	10,000	-
Subtotal, Federal Office of Rural Health Policy	**316,399**	**318,294**	**246,834**

	FY 2019	FY 2020	FY 2021
	Final[17]	Enacted[18]	President's Budget
7. PROGRAM MANAGEMENT	154,568	155,300	151,993
8. FAMILY PLANNING	285,220	286,479	286,479
Total, HRSA Discretionary Budget Authority	**6,822,606**	**7,037,259**	**6,289,085**
FTE (excludes Vaccine)	2,095	2,152	2,083

Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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
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

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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
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	6,736,753,000
Advance				
Supplemental				
Rescissions				
Transfers				-15,857,000
Subtotal	5,538,834,000	5,815,727,000	6,217,794,000	6,720,897,000
FY 2019				
General Fund Appropriation:				
Base	9,559,591,000	6,540,385,000	6,816,753,000	6,843,503,000
Advance				
Supplemental				60,000,000
Rescissions				
Transfers				-20,897,087
Subtotal	9,559,591,000	6,540,385,000	6,816,753,000	6,882,605,973

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2020				
General Fund Appropriation:				
Base	5,841,352,000	7,326,109,000	6,928,714,000	7,037,259,000
Advance				
Supplemental				
Rescissions				
Transfers				
Subtotal	5,841,352,000	7,326,109,000	6,928,714,000	7,037,259,000
FY 2021				
General Fund Appropriation:				
Base	6,289,085,000			
Advance				
Supplemental				
Rescissions				
Transfers				
Subtotal	6,289,085,000			

Appropriations Not Authorized by Law[19]

HRSA Program	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2020
School-Based Health Centers (Facilities Construction) –P.L. 111-148, Section 4101(a) School Based Health Centers - Operations PHS Act, Section 399Z-1, as added by P.L. 111-148, Section 4101(b)	2013	50,000,000	47,450,000	---
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	88,635,000
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	1,190,000
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	51,470,000
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	15,000,000
National Center for Workforce Analysis – PHS Act, Section 761(b), authorization of appropriation in Section 761(e)(1)(A), as amended by P.L. 111-148, Section 5103	2014	7,500,000	4,651,000	5,663,000
Primary Care Training and Enhancement -- PHS Act, Section 747, as amended by P.L. 111-148, Section 5301	2014	SSAN	36,831,000	48,924,000
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	41,250,000

[19] 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.

HRSA Program	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2020
Education and Training Relating to Geriatrics – PHS Act, Section 753, as amended by P.L. 111-148, Section 5305; as amended by P.L. 111-256, Section 2(f)(5) • Geriatric Workforce Development (authorization of appropriation in Section 753(d) (9)) • Geriatric Career Incentive Awards (authorization of appropriation in Section 753(e)(4)) • Geriatric Academic Career Awards PHS Act, Section 753(c), as amended by P.L. 111-148, Section 5305(b)	2014 2013	10,800,000 10,000,000	33,237,000	40,737,000
Nursing Workforce Development • Nurse Retention Grants – PHS Act, Section 831A; as amended by P.L. 111-148, Section 5309(a)	2012	SSAN	---	---
Nursing Workforce Development • Nurse Education, Practice, and Quality grants – PHS Act, Section 831; as amended by P.L. 111-148, Section 5311(a)	2016	SSAN	37,913,000	43,913,000
Nursing Workforce Development • Nurse Faculty Loan Program – PHS Act, Section 846A; as amended by P.L. 111-148, Sections 5305(c), 5310(b)(10)(A)	2014	SSAN	24,500,000	28,500,000
Nursing Workforce Development • Comprehensive Geriatric Education – PHS Act, Section 865	2014	SSAN	4,350,000	---
Healthy Start – PHS Act, Section 330H, as added 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	125,500,000
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	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	2013	1,562,169,000	1,314,446,000	1,315,005,000
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	201,079,000
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	75,088,000

HRSA Program	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2020
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	25,000,000
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	2013	42,178,000	33,275,000	33,611,000
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	13,122,000
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	27,549,000
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	79,500,000
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	53,609,000
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	29,000,000
Family Planning Grants – PHS Act, Title X	1985	158,400,000	142,500,000	286,479,000

Primary Health Care

TAB

PRIMARY HEALTH CARE

Health Centers

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$1,496,720,000	$1,505,522,000	$1,607,522,000	+$102,000,000
Current Law Mandatory Funding	$4,000,000,000	$2,575,342,000	---	-$2,575,342,000
Proposed Law Mandatory Funding	---	$1,424,658,000	$4,000,000,000	+$2,575,342,000
FTCA Program	$120,000,000	$120,000,000	$120,000,000	---
Total	**$5,616,720,000**	**$5,625,522,000**	**$5,727,522,000**	**+$102,000,000**
FTE	504	504	504	---

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 2021 Authorization: FY 2020 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 2021 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 for millions of people across the country. Health centers advance a model of coordinated, comprehensive, and patient-centered primary health care, integrating a wide range of medical, dental, mental health, substance use disorder, and patient services. Today, approximately 1,400 health centers operate over 12,000 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 2018, health centers served 28.4 million patients, one in every twelve people living in the United States, providing approximately 116 million patient visits, at an average cost of $990 per

patient (including Federal and non-Federal sources of funding). In 2018, nearly half of all health centers served rural areas providing care to 8.9 million patients, one in 5 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 value-based care by using key quality improvement practices, including health information technology. More than 77 percent of health centers are currently 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 2018 including Healthy People 2020 goals for hypertension control and dental sealant services. Overall, 93 percent of health centers met or exceeded Healthy People 2020 goals for at least one clinical measure in 2018, and 99% of health centers improved in one or more clinical quality measures. 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[20].

Populations served: Health centers serve a diverse patient population. In 2018:

- People of all ages: Approximately 31 percent of patients were children (age 17 and younger); over 9 percent were 65 or older. Health centers provided primary care services for one in nine children nationwide.

- People in poverty: Over 91 percent of health center patients are individuals or families living at or below 200 percent of the Federal Poverty Guidelines as compared to approximately 33 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 1.4 million individuals experiencing homelessness, nearly 1 million agricultural workers and their families, 4.4 million people living in or near public housing and nearly 13,000 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 2017 Annual Homeless Assessment Report to Congress, over 1.4 million people experienced sheltered

[20] 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

homelessness. In 2018, HRSA-funded health centers provided primary care services for nearly 1.4 million persons in supportive housing and/or 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 nearly 1 million 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 4.4 million people living in or near 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 13,000 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 2018 was 28.4 million; an increase of 11.3 million, or 66 percent, above the 17.1 million patients served in 2008. Of the 28.4 million patients served and for those for whom income status is known, over 91 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 91 percent of health centers provide preventive dental services either directly or via contract. In 2018, health centers provided oral health services to over 6.4 million patients, an increase of 86 percent since 2010. In 2018, nearly 2.5 million people received behavioral health services at health centers, an increase of 83 percent from 2014 to 2018 due to significant Health Center Program investments in behavioral health services beginning in 2014.

From FY 2016 through FY 2019, HRSA has invested $545 million in targeted, ongoing annual grant funding for the expansion of substance use disorder (SUD) and mental health (MH) services in health centers. An additional $300 million has been invested in one-time health center infrastructure costs that support the expansion of services. These investments support health centers in implementing and advancing evidence-based strategies to expand access to quality integrated SUD prevention and treatment services, including those addressing opioid use disorder (OUD) and other emerging SUD issues, to best meet the health needs of the population served by each health center; and/or to expand access to quality integrated mental health services, with a focus on conditions that increase risk for, or co-occur with SUD, including OUD. Screening for substance use disorders has increased 53 percent since 2016 with the number of patients receiving screening, brief intervention, referral and treatment (SBIRT) increasing from 716,677 in 2016 to 1,099,001 in 2018. From 2016–2018, the number of health center providers eligible to prescribe MAT increased nearly 190 percent (from 1,700 in 2016 to 4,897 in 2018) and the number of patients receiving MAT increased 142 percent (from 39,075 in 2016 to 94,528 in 2018).

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 2018, exceeding the target of 70.0 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 28 percent of the total health center patient population served in 2018. In 2018, the health center rate was 8.0 percent, lower than the 2018 national rate of 8.3 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 2018, 63 percent of adult health center patients with diagnosed hypertension had blood pressure under adequate control (less than 140/90) compared to 57 percent nationally. Additionally in 2018, 67 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 60 percent nationally.

HRSA recognizes that there are many opportunities to maintain and improve the quality, value, 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 2019, more than three-fourths 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 99 percent of all health centers reported having an EHR in 2018.

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 patient visits provided per dollar as well as keeping medical cost per medical visit below average annual national health care medical cost per medical visit while maintaining access to the full complement of high quality services (e.g., medical, dental, mental health, substance use disorder, pharmacy and patient support services) that make health centers a "health care home". In 2015, the medical cost per medical visit at health centers was $177, compared to the national cost of $187. In 2016, the medical cost per medical visit at health centers was $185, compared to the national figure of $187. In 2017, the medical cost per medical visit at health centers was $192, and in 2018 it was $200.

By keeping the cost per medical visit at health centers below comparable national costs, 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 centers' support for ambulatory care accreditation improve quality of care and reduce health disparities in underserved communities across the United States. (Nair S, Chen J; "Improving Quality of Care in Federally Qualified Health Centers Through Ambulatory Care Accreditation" Journal of Healthcare Quality 2018 Oct; 40(5):301-309).

- The availability of health centers' services is positively associated with having a usual source of care among those with no insurance coverage. (Kirby JB, Sharma R. "The Availability of Community Health Center Services and Access to Medical Care" Healthcare, 2017 December; 5(4): 174-182).

- Health centers with longer periods of PCMH recognition were more likely to have improved their clinical quality on 9 of 11 measures, than health centers with fewer years of PCMH recognition. (Ruwei Hu, Leiyu Shi, Alek Sripipatana, Hailun Liang, Ravi Sharma, Suma Nair, Michelle Chung, De-Chih Lee; "The Association of Patient-Centered Medical Home Designation with Quality of Care of HRSA-Funded Health Centers: A Longitudinal Analysis of 2012 - 2015" Medical Care, 2018 Feb; 56(2): 130-138).

- 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 demonstrate lower total costs for Medicare beneficiaries. Total median annual costs (at $2,370) for health center Medicare patients were lower by 10 percent compared to patients in physician offices ($2,667) and by 30 percent compared to patients in outpatient clinics ($3,580). (Dana B. Mukamel, Laura M. White, Robert S. Nocon, Elbert S. Huang, Ravi Sharma, Leiyu Shi and Quyen Ngo-Metzger; "Comparing the Cost of Caring for Medicare Beneficiaries in Federally Funded Health Centers to Other Care Settings" *Health Services Research*, Volume 51, No. 2, April 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).

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 2018. More than 220 volunteers were covered under the FTCA Program in FY 2018. Overall, in FY 2017, 127 claims were paid totaling $119.7 million, in FY 2018, 110 claims were paid totaling $109.3 million, and in FY 2019, 150 claims were paid totaling $135 million. Currently, there are over 840 FTCA Program claims outstanding. As the number of

health center patients continues to grow, it is projected that the amount of annual claims paid will continue to increase through FY 2021.

Funding History

FY	Amount
FY 2017	$1,481,929,000
FY 2017 Mandatory[21]	$3,510,661,000
FY 2018	$1,621,709,000
FY 2018 Mandatory	$3,825,000,000
FY 2019	$1,616,720,000
FY 2019 Mandatory	$4,000,000,000
FY 2020	$1,625,522,000
FY 2020 Mandatory	$4,000,000,000[22]
FY 2021	$1,727,522,000
FY 2021 Mandatory	$4,000,000,000

Budget Request

The FY 2021 Budget Request for the Health Center Program is $1.7 billion in discretionary resources and includes $4 billion in mandatory funding, for a total request of $5.7 billion, which is an increase of $102 million over the FY 2020 Enacted level. In FY 2021, the Health Center Program will provide care for approximately 28.6 million patients. This request will also support quality improvement and value-based 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 use disorder services focusing on the treatment, prevention, and/or awareness of opioid abuse. The request also supports costs associated with the grant review and award process, operational site visits, information technology, and other program support costs. The FY 2021 Request also supports $120 million for the FTCA Program, which is equal to the FY 2020 Enacted level. In addition, HHS is seeking to establish statutory confidentiality and privilege protections for medical quality assurance and peer review activities conducted by and on behalf of HHS components and HHS grantees and contractors that are applying for or acting within the scope of deemed Public Health Service (PHS) employment.

The Budget also supports a strategic initiative of the Administration to address the unsheltered homelessness in the United States. Specifically, the Budget would support a Commissioned Corps led public health efforts that could include health assessments, treatment of acute and chronic illness, and medical stabilization for transitioning to long term health care services – all of which would be coordinated with a larger program of human services such as housing and training. Included in the Budget Request level is an additional $15 million for health centers to provide primary care services to individuals experiencing homelessness in geographic areas with

[21] FY 2017 reflects the post-sequestered amount.
[22] Includes FY 2020 annualized funding amount for Health Centers mandatory program.

large numbers of unsheltered homeless individuals as part of the Administration's FY 2021 efforts in this area.

In February 2019, the Administration announced a new initiative, Ending the HIV Epidemic: A Plan for America. This ten-year initiative beginning in FY 2020 seeks to achieve the important goal of reducing new HIV infections in the United States to less than 3,000 per year by 2030. The first phase of the Ending the HIV Epidemic (EHE) initiative will focus on 48 counties, Washington, D.C., San Juan (PR), and seven states that have a substantial rural HIV burden. By focusing on these jurisdictions in the first phase of the EHE initiative, HHS plans to reduce new HIV infections by 75% within five years.

The HRSA Health Center Program will provide HIV testing and prevention services, HIV care and treatment where appropriate, and also assist with responding quickly to HIV cluster detection efforts. The HRSA Health Center Programs' primary focus in the Ending the HIV Epidemic initiative will be on expanding outreach, care coordination, and access to Pre-Exposure Prophylaxis (PrEP)-related services to people at high risk for HIV transmission through selected health centers in the identified jurisdictions. In FY 2020, the first year of the Initiative, HRSA will target resources to nearly 200 health centers that receive Health Center/Ryan White Program funding and/or are located in close proximity to a Ryan White Program where no jointly funded health center currently exists in the target jurisdiction.

In FY 2021, the second year of the EHE initiative, the Budget Request level includes $137 million which will support the participation of approximately 500 health centers in the phase I targeted Initiative areas. This will add all health centers located in the targeted areas to the Imitative. The Health Centers Program will continue to provide prevention and treatment services to people at high risk for HIV transmission, including Pre-Exposure Prophylaxis (PrEP)-related services, outreach, and care coordination through new grant awards in targeted areas currently served by health centers. The Health Center program will continue to provide resources to support the expansion of patient access and adherence to PrEP, with an increased emphasis on outreach and care coordination.

Health centers continue to be a critical element of the health system, largely because they can provide an accessible and dependable source of value-based 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, and health educators.

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. In 2016, a study published in the American Journal of Public Health evaluated the total annual health care use and total health care spending of Medicaid (fee-for-service) patients seen at health centers versus

those seen at non-health center settings.[23] This study found that patients seen at a health center had lower health care utilization and spending across all services when compared to non-health center patients. This included 33% lower spending on specialty care, 25% fewer inpatient admissions, and 24% lower total spending overall. Specifically, Medicaid FFS patients seen at a health center saved nearly $2,400 in total health care spending per year when compared to those seen in a non-health center setting. Health centers serve 4.4 million Medicaid FFS patients.

The FY 2021 Request supports the Health Center Program's achievement of its performance targets, including goals on access to affordable, accessible, quality, and cost-effective primary health care services, and the improvement of health outcomes and quality of care. The Health Center Program has established ambitious targets for FY 2021 and beyond. For low birth weight, the Program seeks to be 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 2021 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 2021 target for the program's diabetes management measure is 67 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 efficient, value-based care, and aims to keep the medical cost per medical visit below the average annual national medical visit costs. By benchmarking the health center efficiency to national per capita medical visit costs, 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 2021 target is to keep the program's medical cost per medical visit below the 2021 national cost figure. By restraining increases in the medical cost per medical visit 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 2021 Request also supports efforts to improve the value, 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

[23] 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

data and quality reporting, clinical and quality improvement, and implementation of innovative value-based, quality activities. The Program continues to promote the integration of HIT into health centers through the Health Center Controlled Network Program to assure that key safety-net providers are able to advance their operations through enhanced technology and tele-health systems.

HRSA also utilizes a variety of methods to oversee the Health Center Program and to monitor Health Center Program grantees to identify potential issues, including non-compliance with program requirements and areas where technical assistance might be beneficial. HRSA accomplishes this monitoring through a variety of available resources, including the review of health center data reports, independent annual financial audits reports, routine conference calls, and site visits.

HRSA's efforts to strengthen evidence-building capacity in the Health Center Program include recent enhancements and modernization to the Uniform Data System (UDS). Patient visits are now reported for both in-person and virtual visits. This data enhancement supports HRSA's efforts to better identify medically underserved population service needs and utilize new technology to improve access to care in medically underserved communities nationwide.

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 and precision medicine, 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.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
1.I.A.1: Number of patients served by health centers (Output)	FY 2018: 28.4M Target: 26.0M (Target Exceeded)	28.6M	28.6M	Maintain

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
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 2018: 91% Target: 90% (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 2018: 93% Target: 86% (Target Exceeded)	88%	88%	Maintain
1.I.A.2.d: Number of HIV tests conducted (Output)	FY 2018: 2.4M Target: 2.0M (Target Exceeded)	2.8M	3.2M	+0.4M
1.E.1: Medical cost per medical visit at health centers compared to the national cost (Efficiency)	FY 2018: $200 Target: below national cost (not yet known)	Below national cost	Below national cost	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 2018: 8.0%, Target: 5% below national rate of 8.3% (Target Virtually Met)	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 2018: 63% Target: 63% (Target Met)	63%	63%	Maintain

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
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 2018: 67% Target: 69% (Target Not Met)	67%	67%	Maintain
1.II.B.1: Percentage of pregnant health center patients beginning prenatal care in the first trimester (Output)	FY 2018: 74% Target: 70% (Target Exceeded)	73%	73%	Maintain
1.II.A.1: Percentage of Health Center patients who are at or below 200 percent of poverty (Output)	FY 2018: 91% Target: 91% (Target Met)	91%	91%	Maintain
1.I.A.3: Percentage of health centers with at least one site recognized as a patient centered medical home (Output)	FY 2018: 75% Target: 65% (Target Exceeded)	70%	70%	Maintain

Grants Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	1,395	1,395	1,395
Average Award	$3.7 million	$3.7 million	$3.7 million
Range of Awards	$400,000 – $23 million	$400,000 – $23 million	$400,000 – $23 million

Free Clinics Medical Malpractice

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$1,000,000	$1,000,000	$1,000,000	---
FTE	---	---	---	---

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

FY 2021 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 2018, 11,338 health care providers received Federal malpractice insurance through the Free Clinics Medical Malpractice Program, slightly less than the Program target. In FY 2016, 243 clinics operated with FTCA deemed clinicians; in FY 2017, 237 clinics participated, and in FY 2018, 239 clinics participated, exceeding the program target in each year.

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 2016 the cost was $50 per provider, and in FY 2017 the cost was $7 per provider, which was unusually low due to no need to support system enhancement costs in FY 2017. Costs in FY 2018 were $38 per provider and are expected to remain similar through FY 2021. In each year, the Program performance target has been exceeded.

To date, there has been 1 paid claim under the Free Clinics Medical Malpractice Program. There is 1 claim currently outstanding, and the Program Fund has a current balance of approximately $2.46 million.

Funding History

FY	Amount
FY 2017	$1,000,000
FY 2018	$1,000,000
FY 2019	$1,000,000
FY 2020	$1,000,000
FY 2021	$1,000,000

Budget Request

The FY 2021 Budget request for the Free Clinics Medical Malpractice Program is $1 million, which is equal to the FY 2020 Enacted 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. The funding request also includes costs associated with information technology and other program support costs.

Targets for FY 2021 focus on maintaining FY 2020 target levels for the number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage at 11,000, 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 2021.

The FY 2021 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 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
2.I.A.1: Number of free clinic health care providers deemed eligible for FTCA malpractice coverage (Output)	FY 2018: 11,338 Target: 11,500 (Target Not Met)	11,000	11,000	Maintain
2.1: Patient visits provided by free clinics sponsoring FTCA deemed clinicians (Output)	FY 2017: 474,701 Target: 475,000 (Target Virtually Met)	475,000	475,000	Maintain
2.I.A.2: Number of free clinics operating with FTCA deemed clinicians (Output)	FY 2018: 239 Target: 220 (Target Exceeded)	220	220	Maintain
2.E: Administrative costs of the program per FTCA covered provider (Efficiency)	FY 2018: $85 Target: $75 (Target Not Met)	$75	$75	Maintain

Health Workforce

TAB

HEALTH WORKFORCE

National Health Service Corps (NHSC)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$120,000,000	$120,000,000	$120,000,000	---
Current Law Mandatory Funding	$310,000,000	$199,589,000	---	-$199,589,000
Proposed Law Mandatory Funding	---	$110,411,000	$310,000,000	+$199,589,000
Total	$430,000,000	$430,000,000	$430,000,000	---
FTE	214	214	215	+1

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

FY 2021 Authorization ..... Expires FY 2019

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 in underserved communities in urban, rural, and tribal areas. Across the nation, NHSC clinicians serve patients in Health Professional Shortage Areas (HPSAs) – communities with limited access to health care. As of September 30, 2019, there were 7,578 primary care HPSAs, 6,782 dental HPSAs, and 6,069 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 17,740 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, 2019, there are 13,053 primary care medical, dental, and mental and behavioral health practitioners providing service nationwide in the following programs[24]:

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. In FY 2018, the NHSC LRP added flexibility for NHSC clinicians to better utilize telemedicine. Currently, less than 10 percent of NHSC applicants indicate that their site uses telemedicine.

In addition, the NHSC and Primary Care Training and Enhancement (PCTE) are coordinating to increase the number of PCTE graduates serving in HPSAs through the PCTE: Training Primary Care Champions program. The purpose of this program is to strengthen primary care and the workforce by establishing fellowship programs to train community-based practicing primary care physicians and/or physician assistant champions to lead health care transformation and enhance teaching in community–based settings. HRSA made awards in FY 2018 to support the PCTE: Training Primary Care Champions program to give PCTE fellows experience and competency in areas that make them more likely to serve in underserved areas. Physicians and physician assistants who have completed PCTE fellowships will be afforded priority status when applying for NHSC LRP awards and continuation awards in FY 2020.

NHSC Substance Use Disorder (SUD) Workforce LRP: The Consolidated Appropriations Act of 2018 and the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Further Consolidated Appropriations Act, 2020 appropriated funding to the NHSC for the express purpose of expanding and improving access to quality opioid and SUD treatment in rural and underserved areas nationwide. The primary purpose of

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

this dedicated funding is to expand the availability of substance use disorder (SUD) treatment providers to include the SUD workforce and categories for outpatient services, including Opioid Treatment Programs, Office-based Opioid Treatment Facilities and Non-opioid Outpatient SUD facilities. The funding supports the recruitment and retention of health professionals needed in underserved areas to provide evidence-based SUD treatment and prevent overdose deaths. Providers receive loan repayment assistance to reduce their educational financial debt in exchange for service at SUD Treatment Facilities.

SUD Providers include:

- MDs/DOs, NPs, PAs with Drug Addiction Treatment Act 2000 Waivers
- Licensed or certified Health professionals providing SUD services; and
- Licensed primary care and mental & behavioral health professionals.

NHSC Rural Community LRP: A portion of the FY 2018 and FY 2019 appropriations provided funding for the NHSC Rural Community LRP, a new program for providers working to combat the opioid epidemic in the nation's rural communities. The NHSC Rural Community LRP will make FY 2020 loan repayment awards in coordination with the Rural Communities Opioid Response Program (RCORP) initiative within the Federal Office of Rural Health Policy (FORHP) to provide evidence-based substance use treatment, assist in recovery, and to prevent overdose deaths across the nation.

NHSC and the Indian Health Service (IHS:) The FY 2020 appropriation directed funding to support loan repayment awards to both fully trained medical, nursing, dental and behavioral/mental health clinicians, and SUD providers, to deliver health care services in Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs. Federal Indian Health Service Clinics, Tribal Health Clinics, Urban Indian Health Clinics, and dually-funded Tribal Health Clinics/Community Health Centers are automatically designated as HPSAs. Without directed funding, these entities are still eligible to receive providers that are supported through NHSC scholarship and loan repayment activities.

NHSC Students to Service (S2S) 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 increase the number of physicians and dentists in the NHSC pipeline.

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. In FY 2018, HRSA opened a new SLRP competition, expanding approved disciplines to include substance use disorder counselors, an additional 5 states and one territory received awards, for a total of 43 grantees.

The combination of these programs serve 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. States receiving funding from this opportunity are encouraged to allow health professionals to practice to the full extent of their license.

NHSC Student Pipeline by Program as of 09/30/2019

Programs	**Students**
Scholarship Program	1,081
Students to Service Program	398
Total	**1,479**

NHSC Student Pipeline by Discipline as of 09/30/2019

Disciplines	**Students**
Allopathic/Osteopathic Physicians	971
Dentists	266
Nurse Practitioners	72
Physician Assistants	149
Certified Nurse Midwives	21
Total	**1,479**

NHSC Field Strength[25] by Program as of 09/30/2019

Programs	**Clinicians**
Scholarship Program Clinicians	506
Loan Repayment Program Clinicians	8,973
State Loan Repayment Program Clinicians	1,957
SUD Workforce Loan Repayment Program	1,074
Rural Community Loan Repayment Program	174
Student to Service Loan Repayment Program	369
Total	**13,053**

NHSC Field Strength by Discipline as of 09/30/2019

Disciplines	**Clinicians**
Allopathic/Osteopathic Physicians[26]	2,418
Dentists	1,473
Dental Hygienists	363
Nurse Practitioners	3,150
Physician Assistants	1,255

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

Disciplines	Clinicians
Nurse Midwives	175
Mental and Behavioral Health Professionals	4,074
Other State Loan Repayment Program Clinicians	145
Total	**13,053**

Average NHSC Award by Program as of 09/30/2019

Program	Average Award Amount
Scholarship Program	$225,393
Students to Service Loan Repayment Program	$119,904
Loan Repayment Program	$37,020

NHSC is committed to continuous performance improvement. The short-term retention rate among NHSC participants who completed their service obligation in FY 2018 is 81 percent, meaning that more than 2,000 clinicians continue to provide primary care services to underserved communities 1-2 years after completing their service commitment. In FY 2019, HRSA began using a newly-developed Clinician Dashboard to calculate retention rate for NHSC providers. The Clinician Dashboard uses National Provider Identifier numbers from CMS as a baseline in conjunction with other data sources to assist in determining the current practice locations of providers who previously served in the National Health Service Corps. It allows HRSA to calculate a more accurate retention rate that is not dependent on survey response rates.

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:

General Eligibility: Participants for all the NHSC programs are U.S. citizens (either U.S. born or naturalized) or U.S. nationals.

Program Specific Eligibility: For NHSC SP, participants must be 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.

For all NHSC LRPs participants must be practicing in a NHSC-eligible discipline with qualified student loan debt for education that led to their degree; 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 either have accepted a position to work or are currently working in a NHSC approved site in a HPSA.

For the NHSC SUD Workforce LRP participants must be working, or have accepted a position to work, at an NHSC-approved SUD treatment facility. For the NHSC Rural Community LRP participants must be working, or have accepted a position to work, at a rural NHSC-approved SUD treatment facility.

For the NHSC Students to Service LRP participants must be 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.

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 2018 Discretionary	$105,000,000
FY 2018 Current Law Mandatory	$310,000,000
FY 2019 Discretionary	$120,000,000
FY 2019 Current Law Mandatory	$310,000,000
FY 2020 Enacted Discretionary	$120,000,000
FY 2020 Current Law Mandatory	$310,000,000
FY 2021 Discretionary Request	$120,000,000
FY 2021 Proposed Law Mandatory	$310,000,000

Budget Request

The FY 2021 Budget Request for the NHSC program of $430 million is equal to the FY 2020 Enacted level and includes $310 million in mandatory funding. This request will fund an estimated 4,160 new and 2,350 continuation Loan Repayment awards, 149 new and 12 continuation scholarship awards, 594 State Loan Repayment awards, and 158 Students to Service Loan Repayment awards.

The FY 2021 Discretionary Request of $120 million, combined with any carryover of Discretionary funds from FY 2020 will enable HRSA to continue to enhance the ability of the NHSC to combat the opioid epidemic by making as many as 2,360 new awards (of the 4,160 noted above) through the NHSC LRP, NHSC SUD Workforce LRP and the NHSC RCLRP in this year. In coordination with both IHS and FORHP, these additional primary care and SUD-treatment clinicians may be placed in Indian and rural NHSC-approved SUD treatment facilities to address the needs of these communities in the face of the opioid epidemic.

The FY 2021 funding request includes operational costs in the form of Federal Insurance Contributions Act tax contributions, staffing, and acquisition contracts and also includes costs associated with the award process, follow-up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
4.I.C.1: Number of individuals served by NHSC clinicians *(Outcome)*	FY 2019: 13.05 Million Target: 11.9 Million (Target Exceeded)	14.8 million	15.7 million	+.9 million
4.I.C.2: Support field strength (participants in service) of the NHSC *(Outcome)*	FY 2019: 13,053 [27] Target: 11,410 (Target Exceeded)	14,133	14,964	+831
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[28]. *(Outcome)*	FY 2019: 81% 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 2019: 1.3% Target: ≤2.0% (Target Exceeded)	≤ 2.0%	≤ 2.0%	Maintain
4.I.C.6: Number of NHSC sites *(Outcome)*	FY 2019: 17,744 Target: 16,000 (Target Exceeded)	18,000	18,000	Maintain

[27] This measure reports on the number of people who received assistance through the NHSC scholarship and loan repayment programs who are currently in the field. 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

	FY 2019 Final	FY 2020 Enacted[29]	FY 2021 President's Budget[30]
Loan Repayments	$236,821,423	$355,000,000	$311,000,000
State Loan Repayments	$19,785,850	$15,000,000	$19,000,000
Scholarships	$47,558,840	$38,000,000	$37,000,000
Students to Service Loan Repayment	$15,277,840	$20,000,000	$19,000,000

NHSC Awards Table[3132]

Program	2014	2015	2016	2017	2018	2019	2020	2021
Scholarships	190	196	205	181	222	200	150	149
Scholarship Continuation	7	11	8	7	7	11	12	12
Loan Repayment	2,775	2,934	3,079	2,554	3,262	4,012	4,899	4,160
Loan Repayment Continuations	2,105	1,841	2,111	2,259	2,384	2,385	2,350	2,350
State Loan Repayment	464	620	634	535	625	812	625	594
Students to Service Loan Repayment	79	96	92	175	162	127	167	158
Total Awards	**5,620**	**5,698**	**6,129**	**5,711**	**6,662**	**7,547**	**8,203**	**7,423**

[29] FY 2020 Enacted level assumes annualized mandatory funding. Loan Repayment Funding includes planned carry-over FY 2018 and FY 2019 Discretionary funds for NHSC SUD LRP and NHSC RC LRP
[30] Loan Repayment Funding includes possible carry-over of FY 2020 Discretionary funds for NHSC RC LRP
[31] NHSC awards include those made from the FY 2017 Zika Supplemental.
[32] NHSC LRP awards include those made from the FY 2018 and FY 2020 BA appropriations

NHSC Field Strength Table as of 9/30/2019[33]

Program:	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Scholars	459	458	437	405	463	506	513	540
Loan Repayment	7,648	8,062	8,593	8,362	8,849	10,221	11,361	12,657
Students to Service Loan Repayment	1,135	1,136	1,378	179	277	369	434	517
State Loan Repayment	-	27	85	1,233	1,350	1,957	1,825	1,250
Total Field Strength	**9,242**	**9,683**	**10,493**	**10,179**	**10,939**	**13,053**	**14,133**	**14,964**

[33] Field Strength numbers for FY 2020- FY 2021 are projections.

Faculty Loan Repayment Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$1,184,000	$1,190,000	---	-$1,190,000
FTE	4	4	---	-4

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

FY 2021 Authorization ..... Expired at the end of FY 2014

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

Program Description and Accomplishments:

The Faculty Loan Repayment Program (FLRP) 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 2019, FLRP made 22 new loan repayment awards. In FY 2020, FLRP anticipates making 21 new loan repayment awards.

Funding History

FY	Amount
FY 2017	$1,187,000
FY 2018	$1,187,000
FY 2019	$1,184,000
FY 2020	$1,190,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Faculty Loan Repayment Program of $0 is $1.1 million below the FY 2020 Enacted 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.

Loans Table

	FY 2019 Final Level	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	22	21	---

Health Professions Training for Diversity

Centers of Excellence

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$23,593,000	$23,711,000	$23,711,000	---
FTE	2	2	2	---

Authorizing Legislation: Public Health Service Act, Section 736

FY 2021 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. These award recipients also focus on facilitating faculty and student research on health issues particularly affecting URM groups.

In Academic Year 2018-2019, the COE Program supported 159 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. Award recipients develop programming focused on mentorship and academic support, and faculty recruitment and development. These programs supported 1,357 trainees across the country with stipend support of whom 99 percent were considered underrepresented minorities (URMs) in the health professions. In addition, 64 percent of the trainees were from financially and/or educationally disadvantaged backgrounds. Additional students participated in COE Programs throughout the academic year increasing total participation to 5,631 students of whom 3,107 completed their programs.

Grantees partnered with 239 health care delivery sites, to provide 3,894 clinical training experiences to health professions trainees. The clinical experiences are designed to help prepare health professions students to provide quality health care to diverse populations. The training emphasizes the importance of cultural competency and the impact of health disparities on overall health outcomes. Nearly 42 percent of training sites used by COE grantees were primary care settings and 56 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 (HBCUs); 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 • 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 2017	$21,659,000
FY 2018	$23,652,000
FY 2019	$23,593,000
FY 2020	$23,711,000
FY 2021	$23,711,000

Budget Request

The FY 2021 Budget Request for the Centers of Excellence program of $23,711,000 is the same as the FY 2020 Enacted level. In FY 2020 and FY 2021, the COE program anticipates making 19 awards and plans to continue supporting health workforce activities that strengthen the national capacity to produce a high quality, diverse healthcare workforce. These funds support HBCUs and other minority serving intuitions.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [34]	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
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 2018: 13% Target: 22% (Target Not Met)	18%	18%	Maintain
6.I.C.21: Percent of program participants who received academic retention support and maintained enrollment in a health professions degree program	FY 2018: 27% Target: 43% (Target Not Met)	40%	40%	Maintain

Program Activity Data

COE Program Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target	FY 2021
Number of health professions students participating in research on minority health-related issues	FY 2018: 414	600	600	600
Number of faculty members participating in research on minority health-related issues	FY 2018: 359	500	500	500

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	19	19	19
Average Award	$1,165,025	$1,170,883	---
Range of Awards	$465,860-$3,177,641	$604,971-$3,177,641	---

[34] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.

Scholarships for Disadvantaged Students

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$48,726,000	$51,470,000	---	-$51,470,000
FTE	5	5	---	-5

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

FY 2021 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 pipeline program.

In Academic Year 2018-2019, the SDS Program provided scholarships to 3,155 students from disadvantaged backgrounds, slightly above the FY 2018 target. The majority of students were considered under-represented minorities (URMs) in their prospective professions (64 percent). Additionally, 1,392 students who received SDS-funded scholarships successfully graduated from their degree programs by the end of Academic Year 2018-2019. Upon graduation, 69 percent intended to work or pursue additional training in medically underserved communities, and 50 percent intended to work or pursue additional training in primary care settings. In FY 2020, SDS will direct funds to educate midwives to address the national shortage of maternity care providers, and specifically to address the lack of diversity in the maternity care workforce

Eligible Entities: Eligible entities are accredited schools of medicine, osteopathic medicine, dentistry, nursing, pharmacy, physical therapy, 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 • Allopathic medicine • Behavioral and mental health • Chiropractic • Dentistry • Nursing • Certified Nurse-Midwife • 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 2016	$45,970,000
FY 2017	$45,859,000
FY 2018	$48,705,000
FY 2019	$48,726,000
FY 2020	$51,470,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Scholarships for Disadvantaged Students Program of $0 is $51.5 million below the FY 2020 Enacted 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 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
6.I.C.22: Number of disadvantaged students with scholarships	FY 2018: 3,155 Target: 2,930 (Target Exceeded)	2,930	N/A	-2,930

Program Activity Data

SDS Program Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target	FY 2021
Number of URM students with scholarships	FY 2018: 2,024	1,800	1,869	---
Percent of students who are URMs	FY 2018: 64%	62%	62%	---

Grant Awards Table

	FY 2019 Level	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	79	79	---
Average Award	$578,780	$600,000	---
Range of Awards	$28,000-$650,000	$28,000-$650,000	---

[35] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.

Health Careers Opportunity Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$14,118,000	$15,000,000	---	-$15,000,000
FTE	2	2	---	-2

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

FY 2021 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 National HCOP Academies provide a variety of academic and social supports to individuals from disadvantaged backgrounds through formal academic and research training, programming, and student enhancement or support services that can include tailored academic counseling and highly-focused mentoring services, student financial assistance in the form of scholarships and stipends, financial planning resources, and health care careers and training information. These HCOP activities are an integral part of structured programming for students throughout the academic year. Exemplary activities of HCOP grantees include post-baccalaureate, summer, and other programs that provide disadvantaged students with often previously unheard of knowledge, experiences, and opportunities to participate in individualized and tailored academic coursework and community work in the health professions school areas. In addition, the HCOP National Ambassador Program, a longitudinal, integrated curriculum-based program, provides assist to students from disadvantaged backgrounds with matriculating through the educational pipeline.

In Academic Year 2018-2019, HCOP supported 232 training programs and activities to promote interest in the health professions among prospective, disadvantaged students. In total, HCOP grantees reached 4,082 disadvantaged trainees across the country through structured programs. The establishment of National HCOP Academies is aimed at increasing the numbers of students in formal-structured programs in order to meet established targets.

HCOP grantees partnered with 168 sites to provide 3,437 clinical health profession trainings in primary care, emphasizing experiences in rural and underserved communities for HCOP student trainees (e.g., academic institutions, community-based organizations, and hospitals). Approximately 65 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 5,616 total students into the health professions pipeline of whom 3,794 completed their training.

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

Funding History

FY	Amount
FY 2017	$14,155,000
FY 2018	$14,154,000
FY 2019	$14,118,000
FY 2020	$15,000,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Health Careers Opportunity Program of $0 is $15 million below the FY 2020 Enacted 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)[36]	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
6.I.C.23: Total number of disadvantaged students in structured programs	FY 2018: 4,082 Target: 2,000 (Target Exceeded)	N/A[37]	N/A	N/A
6.I.C.51: Number of HCOP trainees from disadvantaged backgrounds participating in academic programming, clinical training and/or student support services	---[38]	TBD	N/A	N/A

36 Most recent results are for Academic Year 2018-2019 and funded in FY 2018.
[37] This measure will be discontinued in FY 2019 as new measures will account for programmatic changes.
[38] Baseline will be set for this measure in FY 2019 and reported in the FY 2022 Congressional Justification.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[36]	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
6.I.C.52: Percent of HCOP health professions program completers who intend to work in primary care settings	---[39]	TBD	N/A	N/A

Program Activity Data

HCOP Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target	FY 2021
Total number of students participating in all HCOP programs	FY 2018: 5,616	5,000	5,000	---
Total number of URM students participating in all HCOP programs	FY 2018: 3,638	2,700	3,000	---

Grant Awards Table

	FY 2019 Final Level	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	21	21	---
Average Award	$633,384	$672,003	---
Range of Awards	$583,464 – $645,101	$620,083-$683,720	---

[39] Baseline will be set for this measure in FY 2019 and reported in the FY 2022 Congressional Justification.

Health Care Workforce Assessment

The National Center for Health Workforce Analysis

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$5,635,000	$5,663,000	$4,663,000	-$1,000,000
FTE	6	6	6	---

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

FY 2021 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 have been released during Calendar Years 2018 and 2019:

- Long-Term Services and Supports: Direct Care Worker Demand Projections 2015-2030
- Long-Term Services and Supports: Nursing Workforce Demand Projections 2015-2030
- Behavioral Health Workforce Projections, 2016 – 2030
- Allied Health Workforce Projections, 2016-2030

NCHWA also oversees nine 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.[40] NCHWA funded two new Health Workforce Research Centers (HWRCs) that began work in FY 2019. Together, these two Centers examine a broad range of issues related to health equity in health workforce education and training. Research conducted by these two HWRCs aims to strengthen the evidence base for effective education and training programs that can enable and empower a health workforce capable of fostering and ensuring health equity for all populations. Examples of research areas related to this topic include:

- Looking across a range of health care professions and providers to develop a comprehensive picture of how current health workforce education and training programs incorporate consideration of health equity, including social needs, social determinants of health, and related elements, into their programs.
- Developing measures to assess and track consideration of health equity and related elements into health workforce education and training programs.
- Evaluating health workforce education and training programs to understand whether and how a program's incorporation of health equity considerations, including consideration of social needs and social determinants of health, may improve health care delivery, with respect to factors such as: increasing access to primary care; mitigating provider shortages in underserved areas; delivering integrated primary, behavioral, and oral health care; addressing health workforce diversity; and strengthening community/provider partnerships.

Funding History

FY	Amount
FY 2017	$4,652,000
FY 2018	$5,663,000
FY 2019	$5,635,000
FY 2020	$5,663,000
FY 2021	$4,663,000

[40] In FY 2019, one Health Workforce Resource Center administered by NCHWA was funded from the Bureau of Primary Health Care.

Budget Request

The FY 2021 Budget Request for NCHWA of $4.7 million is $1 million below the FY 2020 Enacted level.

In FY 2020, NCHWA continued 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 FY 2021, NCHWA will continue to deliver reports and evaluation that support the Administration's goal of improving access to behavioral health services, including substance use treatment and prevention services. This includes collecting data and conducting studies on models of

Grants Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	5	5	5
Average Award	$449,951	$449,951	$449,951
Range of Awards	$449,795-$450,000	$449,795-$450,000	$449,795-$450,000

Primary Care Training and Enhancement Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$48,680,000	$48,924,000	---	-$48,924,000
FTE	7	7	---	-7

Authorizing Legislation: Public Health Service Act, Section 747

FY 2021 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 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 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Primary Care Training and Enhancement[41]	$31,395,619	$21,201,184	---
Training Primary Care Champions	$7,363,001	$7,513,767	---
Academic Units for Primary Care Training and Enhancement	$4,766,677	$4,467,071	---

[41] 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 $4,063,148 million, $2,977,396 million from PCTE and $1,085,752 million from Oral Health Programs.

Program	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Primary Care Training and Enhancement: Integrating Behavioral Health and Primary Care (PCTE-IBHPC) Program	$3,544,703	$3,598,770	---
Primary Care Training and Enhancement (PCTE) - Physician Assistant (PA) Program	$1,610,000	$3,081,542	---
Primary Care Training and Enhancement: Residency Training in Primary Care (PCTE-RTPC)	---	$9,061,666	---

The PCTE Program includes seven cohorts:

Primary Care Training and Enhancement (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.

Primary Care Medicine and Dentistry Clinician Educator Career Development Award: 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.

In Academic Year 2018-2019, the Primary Care Medicine and Dentistry Clinician Educator Career Development Award program supported 22 faculty, including 15 individuals from the field of medicine, 5 in dentistry, and 2 physician assistants. In addition, grantees developed or enhanced 90 curricula activities offered to 6,153 individuals. Grantees also sponsored 2,432 faculty development activities to 824 faculty members, and grant-funded faculty taught 49 courses to 1,926 students and advanced trainees.

Primary Care Training and Enhancement (PCTE): Training Primary Care Champions (TPCC): The PCTE-TPCC Program strengthens the primary care and the workforce by establishing fellowship programs to train community-based practicing primary care physician and/or physician assistant champions to lead health care transformation and enhance teaching in community-based settings. Awardees are encouraged to partner with National Health Service Corps-approved sites and to address the Administration's clinical priorities of opioid abuse and mental health through their training and fellows' health care transformation projects.

In Academic Year 2018-2019, PCTE-TPCC provided fellowships to 81 physicians and 18 physician assistants, of which 26 were from an underrepresented minority background and 46 reported coming from a rural or disadvantaged background. Among the physicians, 46 were from Family Medicine, 17 were from Internal Medicine, 15 were from Pediatrics, and the remainder from Internal Medicine/Pediatrics. PCTE-TPCC fellows developed or enhanced and implemented 194 different curricular activities, most of which were new academic courses, continuing education courses, and workshops for students that reached 629 trainees. PCTE-TPCC fellows also participated in 28 different faculty-focused training programs and activities during the academic year. Approximately 41 percent of fellows received training in substance use treatment, and 54 percent received specific training in medication-assisted treatment (MAT) for opioid use leading to 14 percent receiving a DATA waiver to prescribe MAT.

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 FY 2019, HRSA provided $300,000 in supplemental funding to continue to support collaborative activities that are intended to enable joint research, development of a common community of practice that will assist with dissemination and application of the research into education and practice, and develop plans for sustaining the scope of work after federal funding.

Primary Care Training and Enhancement (PCTE): Integrating Behavioral Health and Primary Care (IBHPC) Program: In FY 2019, HRSA established the PCTE-IBHPC Program to fund innovative training programs that integrate behavioral health care into primary care, particularly in rural and underserved settings with a special emphasis on the treatment of opioid use disorder.

Primary Care Training and Enhancement (PCTE) - Physician Assistant (PA) Program: In FY 2019, HRSA established the PCTE-PA Program to increase the number of primary care physician assistants, particularly in rural and underserved settings, and improve primary care training in order to strengthen access to and delivery of primary care services nationally.

Primary Care Training and Enhancement (PCTE) – Residency Training in Primary Care: In FY 2020, HRSA established the PCTE-Residency Training in Primary Care to enhance accredited residency training programs in family medicine, general internal medicine, general pediatrics or combined internal medicine and pediatrics (med-peds) in rural and/or underserved areas, and encourage program graduates to choose primary care careers in these areas.

In Academic Year 2018-2019, PCTE grantees trained 2,566 primary care residents and fellows, 6,482 medical students, 1,922 students in physician assistant programs, 107 primary care medicine faculty, and 2,017 students from collaborating interprofessional disciplines (including pharmacy students, psychology students, dental and dental hygiene students, and nursing students) for a total of 13,094 trainees, 3,593 of whom completed their programs at the end of the

academic year. PCTE grantees partnered with 997 health care delivery sites (e.g., physician's offices, hospitals, and ambulatory practice sites) to provide clinical training experiences to trainees. Over a third of the sites offered substance use treatment services. Approximately 61 percent of these sites were located in medically underserved communities, 30 percent were located in rural areas, and 63 percent were primary care settings.

With regard to the continuing education of the current workforce, PCTE grantees delivered 197 unique continuing education courses that focused on emerging issues in the field of primary care to 7,177 faculty members and current practicing providers. In addition, PCTE grantees developed or enhanced and implemented 1,220 different curricular activities, most of which were new academic courses, clinical rotations, and workshops for health professions students, residents and fellows that reached 35,086 trainees. PCTE grantees also supported 404 different faculty-focused training programs and activities during the academic year, reaching 7,427 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.

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 2017	$38,830,000
FY 2018	$48,802,000
FY 2019	$48,680,000
FY 2020	$48,924,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Primary Care Training and Enhancement program of $0 is $48.9 million below the FY 2020 Enacted 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[42]

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[43]	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
6.I.C.24: Number of physicians completing a Bureau of Health Workforce-funded residency or fellowship	FY 2018: 825 Target: 480 (Target Exceeded)	700	N/A	-700
6.I.C.25: Number of physicians graduating from a Bureau of Health Workforce-funded medical school	FY 2018: 1,622 Target: 400 (Target Exceeded)	1,000	N/A	-1,000
6.I.C.26: Number of physician assistants graduating from a Bureau of Health Workforce-funded program	FY 2018: 577 Target: 200 (Target Exceeded)	300	N/A	-300

[42] 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.

[43] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.

Program Activity Data

PCTE Program Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target	FY 2021 Target
Percent of physician and physician assistant trainees receiving at least a portion of their clinical training in an underserved area	FY 2018: 37%	50%	50%	---
Percent of physician and physician assistant graduates and program completers who are minority and/or from disadvantaged backgrounds	FY 2018: 35%	30%	30%	---
Number of physicians training in a Bureau of Health Workforce-funded residency or fellowship	FY 2018: 2,566	2,000	2,000	---
Number of medical students training in a Bureau of Health Workforce-funded medical school	FY 2018: 6,482	4,000	4,000	---
Number of physician assistant students training in a Bureau of Health Workforce-funded program	FY 2018: 1,922	1,000	1,000	---

Grant Awards Table[44]

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	108	109	---
Average Award	$389,331	$391,282	---
Range of Awards	$176,562-$799,802	$177,447-$803,811	---

[44] This table includes the PCTE portion of the 22 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 $4.4 million, $3.2 million from PCTE and $1.2 million from Oral Health Programs. This table includes the $3.2 million in PCTE funds; the Oral Health Program funds are accounted for in the Grants Award Table below.

Oral Health Training Programs

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$40,471,000	$40,673,000	---	- $40,673,000
FTE	6	6	---	- 6

Authorizing Legislation: Public Health Service Act, Sections 748 and 340G[45]

FY 2021 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 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene[46] and Dental Faculty Loan Repayment	$27,925,000	$26,675,000	---
State Oral Health Workforce Improvement Grant	$12,546,000	$13,998,000	---

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.

[45] Public Law No: 115-302 extended the authorization for Section 340G until FY 2023.
[46] 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 $4.0 million, $2.9 million from PCTE and $1.1 million from Oral Health Programs.

Dentists, in particular, are in a position to meet the Administration's goal of addressing the opioid epidemic through better pain management, identifying substance abuse and referring patients for treatment, and providing quality oral health care that meets the needs of this vulnerable population.

In Academic Year 2018-2019, grantees of the Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program trained 10,356 dental and dental hygiene students in pre-doctoral training degree programs; 494 dental residents and fellows in advanced primary care dental residency and fellowship training programs; and 261 dental faculty members in faculty development activities and programs.

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 faculty through loan repayment and help fund development programs to provide continuing education opportunities.

In Academic Year 2018-2019, the Dental Faculty Development and Loan Repayment Program provided financial support to 36 dental faculty and 1 dental resident with a median award of

$18,450 in direct financial support. Grantees developed or enhanced 77 curricula that were offered to 2,743 individuals. In addition, grantees sponsored 38 faculty development programs to 261 dental faculty, just missing the FY 2018 target of 300 due to a programmatic change where faculty development funding was capped, and the focus of the program was shifted to loan repayment. Faculty funded through the Dental Faculty Development and Loan Repayment Program offered 61 courses to 2,958 advanced trainees from general dentistry (85 percent) and pediatric dentistry (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 students and 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 funded 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 2018-2019, the State Oral Health Workforce Improvement Grant Program continued to carry out community-based prevention activities authorized under statute. Grantees established 6 new oral health facilities for children with unmet needs in dental HPSAs, and expanded 6 oral health facilities in dental HPSAs to provide education, prevention, and restoration services to 13,834 patients.

Grantees also supported 45 tele-dentistry facilities; replaced 7 water fluoridation systems to provide optimally fluoridated water to 1,358,663 individuals; provided dental sealants to 5,060 children; provided topical fluoride to 19,682 individuals; provided diagnostic or preventive dental services to 7,866 persons; and oral health education to 39,674 persons. The program provided direct financial support to 9 dental students and 1 dental resident. Of these 10 students and resident, approximately 30 percent reported coming from a rural background, 20 percent reported coming from a disadvantaged background, and 40 percent from an underrepresented minority group.

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. • Placement of dental trainees. • Partnerships with dental training institutions. • Expand a state dental office. • Advancing pain management and improving access to opioid treatment services.

Funding History

FY	Amount
FY 2016	$35,873,000
FY 2017	$36,587,000
FY 2018	$40,571,000
FY 2019	$40,471,000
FY 2020	$40,673,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Oral Health Training programs of $0 is $40.7 million below the FY 2020 Enacted 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)[47]	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
6.I.C.27: Number of dental students trained	FY 2018: 10,356 Target: 5,300 (Target Exceeded)	5,000[48]	N/A	-5,000
6.I.C.28: Number of dental residents trained	FY 2018: 494 Target: 350 (Target Exceeded)	650[49]	N/A	-650
6.I.C.29: Number of faculty trained	FY 2018: 261 Target: 300 (Target Not Met)	200	N/A	-200

Program Activity Data

Oral Health Training and Workforce Program Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target	FY 2021 Target
Percent of students and residents trained who are URMs	FY 2018: 24%	20%	20%	---
Number of dentists completing a Bureau of Health Workforce-funded dental residency or fellowship	FY 2018: 258	250	350	---
Number of dentists graduating from a Bureau of Health Workforce-funded dental school	FY 2018: 2,518	2,000	1,200	---

[47] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.
[48] One of two cohorts of grantees will not be funded beginning in FY 2020 resulting in a decline of dental students trained. Instead, funding will be utilized to fund additional advanced dental residencies.
[49] Additional funding for advanced dental residencies will be utilized beginning in FY 2020 resulting in an increase in dental residents trained.

Grant Awards Table – Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene[50]

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	52	47	---
Average Award	$414,250	$378,189	---
Range of Awards	$27,969-$812,803	$142,144-$650,000	---

Grant Awards Table – Dental Faculty Loan Repayment Programs

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	30	30	---
Average Award	$158,665	230,739	---
Range of Awards	$40,500-$300,000	$81,000-$350,000	---

Grant Awards Table – State Oral Health Workforce Improvement Grant Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	33	35	---
Average Award	$338,100	$375,719	---
Range of Awards	$181,698-$407,722	$209,904-$400,000	---

[50] 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 $4.0 million, $2.9 million from PCTE and $1.1 million from Oral Health Programs. This awards table accounts for the $1.1 million in Oral Health Program funds only.

Medical Student Education Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$25,000,000	$50,000,000	---	-$50,000,000
FTE	---	---	---	---

Authorizing Legislation: Department of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2019 and Further Consolidated Appropriations Act, 2020(P.L. 116-69)

FY 2021 Authorization .....Not Specified[51]

Allocation Method .....Grants

Program Description and Accomplishments:

The purpose of the Medical Student Education (MSE) Program is to provide grants to public institutions of higher education to expand or support graduate education for medical students preparing to become physicians in the top quintile of states with a projected primary care provider shortage in 2025[52]. The program is designed to prepare and encourage medical students who are training in the most underserved states to choose residencies and careers in primary care that serve tribal communities, rural communities, and/or medically underserved communities (MUCs) after they graduate. The MSE Program supports the development of medical school curricula, clinical training site partnerships, and faculty training programs, with the goal of educating medical students who are likely to choose career paths in primary care, especially for tribal communities, rural communities, and/or MUCs.

In FY 2019, HRSA awarded five institutions to develop new and expand medical school curricula and training focused on the primary care needs of rural and tribal communities. All awardees expanded their community-based partnerships to incorporate experiential training opportunities in rural communities. These grants were fully funded for the four-year project period.

In FY 2020, HRSA will fund the unfunded applications from the FY 2019 MSE Notice of Funding Opportunity. The remaining funds will be used to supplement the FY 2019 awardees. These grants will be fully funded for the four-year project period.

[51] The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245) authorized $25 million in appropriations, to remain available until expended, funding for the Medical School Education Program.
[52] 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-state-projections2013-2025.pdf.

Eligible Entities:
Eligible entities are limited to public institutions of higher education in states in the top quintile of states with projected primary care provider shortages in 2025.

Funding History

FY	Amount
FY 2017	---
FY 2018	---
FY 2019	$25,000,000
FY 2020	$50,000,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Medical Student Education program of $0 is $50 million below the FY 2020 Enacted level. As FY 2019 and FY 2020 grantees are fully funded for the four year project periods, these activities will still continue in 2021. 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)**	**FY 2020 Target**	**FY 2021 Target**	**FY 2021 +/- FY 2020**
6.I.C.59: Number of medical students trained in underserved states	---[53]	TBD	N/A	TBD
6.I.C.60: Number of medical students matched to primary care residencies	---[54]	TBD	N/A	TBD

[53] Baseline for this measure will be set for the FY 2019 and reported in the FY 2022 Congressional Justification.
[54] Baseline for this measure will be set for the FY 2019 and reported in the FY 2022 Congressional Justification.

Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	5	10	---
Average Award	$1,148,966	$1,695,048	---
Range of Awards	$1,101,010- $1,177,247	$1,119,468- $2,257,088	---

Interdisciplinary, Community-Based Linkages

Area Health Education Centers Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$39,055,000	$41,250,000	---	-$41,250,000
FTE	4	4	---	-4

Authorizing Legislation: Public Health Service Act, Section 751
FY 2021 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. AHECs develop and maintain a diverse health care workforce and broaden the distribution of the health workforce. The redesigned AHEC Program invests in interprofessional networks that address social determinants of health and incorporate field placement programs for rural and medically-underserved populations

In Academic Year 2018-2019, 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 2,238 unique continuing education courses that were delivered to 192,070 practicing professionals nationwide, 92,682 of whom (48 percent) were concurrently employed in medically underserved communities.

AHEC grantees partnered with 5,513 training sites to provide 34,663 clinical training experiences to student trainees (e.g., ambulatory practice sites, physician offices, and hospitals). Approximately 60 percent of these training sites were primary care settings; 69 percent were located in medically underserved communities; and 44 percent were in rural areas.

The new AHEC Scholars Program began in Academic Year 2018-2019 supporting 2,751 AHEC Scholars. The AHEC Scholars Program is an interprofessional educational and training program targeted towards health professions students and consists of a specialized curriculum focused on six core topic areas and health care delivery within rural/underserved areas and populations. The six core topic areas include: (a) interprofessional education, (b) social determinants of health, (c) behavioral health integration, (d) cultural competency, (e) practice transformation, and (f) current and emergent health issues. Approximately 36 percent of these AHEC Scholars came from a

rural background and nearly 45 percent came from a disadvantaged background. Over half of AHEC scholars received training in a rural setting and 87 percent received training a medically underserved community. Over a quarter of c Scholars received training on integrating behavioral health in primary care and 12 percent received training in substance use treatment. Since the AHEC Scholars program is a two-year commitment, there were no program completers during the first year.

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 2016	$30,250,000
FY 2017	$30,177,000
FY 2018	$38,154,000
FY 2019	$39,055,000
FY 2020	$41,250,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Area Health Education Centers (AHEC) Program of $0 is $41.3 million less than the FY 2020 Enacted 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)[55]	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
6.I.C.30: Percent of CE trainees who report being currently employed in medically underserved areas	FY 2018: 48% Target: 34% (Target Exceeded)	N/A[56]	N/A	N/A
6.I.C.31: Number of trainees receiving health career guidance and information from the AHEC Programs	FY 2018: 282,408 Target: 275,000 (Target Exceeded)	N/A[57]	N/A	N/A
6.I.C.49: Number of AHEC scholars trained in medically underserved communities and/or rural areas.	---[58]	TBD	N/A	N/A
6.I.C.50: Percent of AHEC program completers practicing in medically underserved communities and/or rural areas.	---[59]	TBD	N/A	N/A

Program Activity Data

AHEC Program Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target	FY 2021 Target
Number of medical students who participated in community-based clinical training	FY 2018: 11,739	13,000	11,500	N/A
Number of other health professions trainees who participated in community-based clinical training	FY 2018: 12,385	13,000	11,000	N/A

[55] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.
[56] Measure discontinued in FY 2019 as new measures will account for programmatic changes.
[57] Measure discontinued in FY 2019 as new measures will account for programmatic changes.
[58] Baseline will be set for this measure in FY 2019 and reported in the FY 2022 Congressional Justification.
[59] Baseline will be set for this measure in FY 2019 and reported in the FY 2022 Congressional Justification.

AHEC Program Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target	FY 2021 Target
Number of trainees who received CE on topics including cultural competence, women's health, diabetes, hypertension, obesity, and health disparities	FY 2018: 192,070	130,000	140,000	N/A

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	49	49	---
Average Award	$735,056	$773,009	---
Range of Awards	$255,600-$1,912,000	$249,967-$1,813,760	---

Geriatrics Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$40,534,000	$40,737,000	---	-$40,737,000
FTE	5	5	---	-5

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

FY 2021 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 adults by developing a health care workforce to provide value-based care that improves health outcomes for older adults by integrating geriatrics and primary care delivery sites/systems. . The Program maximizes patient and family engagement in health care decisions and provides training focusing on interprofessional and team-based care across the educational continuum (students, faculty, providers, direct service workers, patients, families, and lay and family caregivers).

An essential component of the program is developing academic-primary care-community-based partnerships to address gaps in health care for older adults, and transforming clinical training environments into integrated geriatrics and primary care sites/systems to become age-friendly health systems and dementia-friendly communities.

Program	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Geriatrics Workforce Enhancement Program	$38,534,000	$38,737,000	---
Geriatrics Academic Career Awards (GACA) Program	$2,000,000	$2,000,000	---

In Academic Year 2018-2019, GWEP grantees provided training for 39,585 students and fellows participating in a variety of geriatrics-focused degree programs, field placements, and fellowships. Of these trainees, 31,522 graduated or completed their training during the current academic year. GWEP grantees partnered with 307 health care delivery sites (e.g., hospitals, long-term care facilities, and academic institutions) to provide clinical training experiences to

trainees. Approximately 56 percent of these sites were located in medically underserved communities, and 54 percent were primary care settings.
With regard to the continuing education of the current workforce, 187,955 faculty and practicing professionals participated in 1,342 unique continuing education courses offered by GWEP grantees, 445 of which were specifically focused on Alzheimer's disease and related dementia, just missing the target of 500.

The redesign of the GWEP program in FY 2019 shifts its focus to transforming clinical training environments into integrated geriatrics and primary care systems to become age-friendly health systems that incorporate the principles of value-based care and alternative-payment models (e.g., Advanced Alternative Payment Models [AAPMs], bundled payment, Comprehensive Primary Care Plus [CPC+], etc.). The number of continuing education trainings decreased slightly (a 14 percent reduction in the number of courses offered in FY 2018), which explains the small decrease in professionals participating in these trainings (12 percent reduction those participating in continuing education trainings from the prior year). These targets were still exceeded, however.

In addition, GWEP grantees developed or enhanced and implemented 4,313 different curricular activities. Most of these were new continuing education courses, academic courses, and workshops, which together reached 142,022 people. Finally, with regard to faculty development, results showed that GWEP grantees supported 372 different faculty-focused training programs and activities during the academic year, reaching 11,406 faculty-level trainees.

The National and Regional Projections of Supply and Demand for Geriatricians: 2013-2025 report by HRSA's National Center for Health Workforce Analysis projected demand for geriatricians will exceed supply, resulting in a national shortage of 26,980 full time equivalent positions in 2025.[60] The report states all regions of the U.S. are projected to have a 2025 shortage of geriatricians, although the degree of shortage in each region is variable.[61] The education and training of health professionals in the area of geriatrics are hindered by a shortage of faculty, inadequate and variable academic curricula and clinical experiences, and a lack of opportunities for advanced training. In order to address these issues, faculty with expertise in geriatrics are needed to train the workforce to provide specialized care to improve health outcomes for older adults.

Consequently, in FY 2019, HRSA funded the Geriatrics Academic Career Awards (GACA) Program to support the career development of junior faculty in geriatrics at accredited schools of allopathic medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, or allied health. Faculty with expertise in geriatrics are needed to train the workforce and provide specialized care to improve health outcomes for older adults. Under the GACA program, career development awards were made to support individual junior faculty who will provide interprofessional clinical training and become leaders in academic geriatrics. The goals of the program are for the GACA candidate to develop the necessary skills to lead health care

[60] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2017. National and Regional Projections of Supply and Demand for Geriatricians: 2013-2025. Rockville, Maryland.
[61] Id.

transformation in a variety of settings. These settings include rural and/or medically underserved settings, as well as age-friendly settings that provide interprofessional training in clinical geriatrics.

GWEP 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.

GACA Eligible Entities: Accredited health professions schools of allopathic medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, or allied health who apply on behalf of individuals to HRSA for a Geriatrics Academic Career Award where the individuals have a full-time junior faculty appointment.

Designated Health Professions	Targeted Educational Levels	Program Activities
• Allied health • Allopathic medicine • Dentistry • Nursing • Osteopathic medicine • Pharmacy • Psychology • Social Work	• Practicing health care providers	• Develop and implement a faculty career development plan to develop the necessary knowledge and skills as a clinician educator in geriatrics to transform and lead age-friendly health systems • Meet the statutory service requirement that 75% of time will be devoted to provide training in clinical geriatrics, including the training of interprofessional teams of health care professionals • Disseminate reports, products, and/or project outputs so project information is provided to key target audiences

Funding History

FY	Amount
FY 2016	$38,737,000
FY 2017	$38,737,000
FY 2018	$40,635,000
FY 2019	$40,534,000
FY 2020	$40,737,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Geriatrics programs of $0 is $40.7 million less than the FY 2020 Enacted 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 Measures

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[62]	FY 2020 Target[63]	FY 2021 Target	FY 2021 +/- FY 2020
6.I.C.12: Number of Bureau of Health Workforce-sponsored interprofessional continuing education sessions provided on Alzheimer's disease	FY 2018: 445 Target: 500 (Target Not Met)	150	N/A	-150
6.I.C.13: Number of trainees participating in interprofessional continuing education on Alzheimer's disease	FY 2018: 73,115 Target: 51,000 (Target Exceeded)	10,000	N/A	-10,000
6.I.C.32: Number of continuing education trainees in geriatrics programs	FY 2018: 187,955 Target: 125,000 (Target Exceeded)	50,000	N/A	-50,000
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 2018: 38,916 Target: 23,000 (Target Exceeded)	10,000	N/A	-10,000

Program Activity Data

Geriatrics Program Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target[64]	FY 2021 Target
Number of continuing education offerings delivered by grantees	FY 2018: 1,342	1,500	1,000	---
Number of faculty members participating in geriatrics trainings offered by grantees	FY 2018: 11,406	8,000	8,000	---

[62] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.
[63] Reduction in targets reflect programmatic changes and shift to new priorities. New measures will be established in FY 2021.
[64] Reduction in targets reflect programmatic changes and shift to new priorities. New measures will be established in FY 2021.

Geriatrics Program Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target[64]	FY 2021 Target
Number of individuals trained in new or enhanced curricula relating to the treatment of health problems of elderly individuals	FY 2018: 142,022	140,000	140,000	---
Number of individuals enrolled in geriatrics fellowships	FY 2018: 669	560	560	---
Number of advanced education nursing students enrolled in advanced practice adult-gerontology nursing programs	FY 2018: 97	80	80	---

GWEP Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	48	48	---
Average Award	$740,384	$742,780	---
Range of Awards	$537,408-750,000	$537,408-750,000	---

GACA Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	26	26	---
Average Award	$75,000	$75,000	---
Range of Awards	$75,000	$75,000	---

Behavioral Health Workforce Development Programs

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA[1]	$111,916,000	$138,916,000	$138,916,000	---
FTE	13	13	13	---

1/ Funding combines appropriations for Mental and Behavioral Health Workforce ($36.916 million) and Training and Behavioral Health Workforce Education and Training ($102 million). Both appropriations support funding for the same authorizations and have been merged to streamline and eliminate confusion.

Authorizing Legislation: Public Health Service Act, Sections 755, 756 and 760

FY 2021 Authorization ..... $50,000,000[65]

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

Program Description and Accomplishments:

The purpose of the Behavioral Health Workforce Development Programs is to develop and expand the behavioral health workforce serving populations across the lifespan, including in rural and medically underserved areas. Opioid use and its resulting deaths have impacted the lives of individuals and families, crippled communities, and depleted limited resources. The rate of opioid-related Emergency Department visits continues to increase. Analysis of data from 52 jurisdictions in 45 states, which covers over 60 percent of ED visits in the U.S., found that from July 2016 through September 2017:

- All five U.S. regions experienced rate increases; the largest was in the Midwest (70 percent), followed by the West (40 percent), Northeast (21 percent), Southwest (20 percent), and Southeast (14 percent).
- Every demographic group experienced substantial rate increases, including men (30 percent) and women (24 percent) and people ages 25-34 (31 percent), 35-54 (36 percent), and 55 or older (32 percent)[66].

[65] The 21st Century Cures Act (P.L. 114-255) authorized $50 million through FY 2022.
[66] Vivolo-Kantor AM, Seth P, Gladden RM, et al. Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses — United States, July 2016–September 2017. MMWR Morb Mortal Wkly Rep 2018;67:279–285. DOI: http://dx.doi.org/10.15585/mmwr.mm6709e1

From 2013 to 2017, synthetic opioid-involved overdose death rates increased 45.2% in the U.S.[67] This effect is especially evident in geographical areas of the U.S. with large rural concentrations, where nonmedical prescription opioid misuse remains a growing public problem.[68]

HRSA uses projections data and other information about the behavioral health workforce to develop and adjust programs to ensure that they are responsive to the Nation's emerging needs. For example, HRSA's 2018 Behavioral Health Workforce Projections Report estimated national-level health workforce needs for several behavioral health occupations between 2016 and 2030. The report estimated the demand for addiction counselors is expected to increase 21 percent by 2030, with demand exceeding supply and leading to a deficit of addiction counselors of approximately 13,600 FTE.

Also, the report estimated that by 2030, the supply of psychiatrists is expected to decrease by approximately 27 percent. The report also highlighted that under certain scenarios, there could be an estimated shortage of 14,300 FTE psychologists by 2030.[69] However, by 2025, HRSA's BHWET program is projected to eliminate over 40% of the projected shortfall of behavioral health providers, and provide thousands of new paraprofessionals to enhance the nation's health workforce capacity in critical areas of need. Since the program began, 3,293 new paraprofessionals have begun work as community health workers, peer paraprofessionals, and substance use/addictions workers.

Since HRSA's workforce projection models are based on observed trends in production of new entrants to the workforce, HRSA's 2018 Behavioral Health Workforce Projections assume continued, stable discretionary appropriations levels and programmatic outputs for the BHWET program. As a result, HRSA's new behavioral health projections for the year 2030 demonstrate significant reductions in (or abatement of) 2016 (baseline) health workforce shortages projected across four BHWET-supported behavioral health professions: psychologists, social workers, school counselors, and marriage and family therapists.[70]

The Behavioral Health Workforce Development budget line supports the Behavioral Health Workforce Education and Training (BHWET) Program, the Graduate Psychology Education (GPE) Program, the Opioid Workforce Expansion Programs (OWEP), Addiction Medicine Fellowship (AMF) Program, a new loan repayment program for the Substance Use Disorder

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[67] Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;67:1419–1427. DOI: http://dx.doi.org/10.15585/mmwr.mm675152e1

[68] Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. MMWR Surveillance Summaries 2017;66(No. SS-19):1–12. DOI: http://dx.doi.org/10.15585/mmwr.ss6619a1

[69] Health Resources and Services Administration/National Center for Health Workforce Analysis; Substance Abuse and Mental Health Services Administration/Office of Policy, Planning, and Innovation.2019.Behavioral Health Workforce Projections, 2016-2030. Rockville, Maryland. DOI: https://bhw.hrsa.gov/health-workforce-analysis/research/projections/behavioral-health-workforce-projections

[70] Health Resources and Services Administration/National Center for Health Workforce Analysis. Behavioral Health Workforce Education and Training Program, Academic Years 2014-2018. Rockville, Maryland. DOI: https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/program-highlights/2018/behavioral-health-workforce-education-training-program-2018.pdf

Treatment Workforce, the Opioid-Impacted Family Support Program (OIFSP) and Peer Support Specialists program providing new training opportunities for paraprofessionals.

	FY 2019 Final (Dollars in Millions)	**FY 2020 Enacted** (Dollars in Millions)	**FY 2021 President's Budget** (Dollars in Millions)
Behavioral Health Workforce Development	$93.9	$120.9	$120.9
Graduate Psychology Education	$18.0	$18.0	$18.0
Total Behavioral Health Workforce Development Programs[1]	**$111.9**	**$138.9**	**$138.9**

1/ Includes appropriations from both MBHET and BWHET lines.

Behavioral Health Workforce Development: The Behavioral Health Workforce Development programs support a number of activities to increase the behavioral workforce. In Fiscal Year 2020, Behavioral Health Workforce Development (BHWD) will support a number of activities which are described below.

- ***BHWET Program:*** In 2020 HRSA anticipates making $51 million in continuation awards for BHWET. This program increases the number of behavioral health providers entering and continuing practice, with special emphasis on prevention and clinical intervention and treatment for those at risk of developing mental and substance use disorders, and the involvement of families in the prevention and treatment of behavioral health conditions. In FY 2018, HRSA made an additional $8 million in awards to current BHWET grantees for a two-year project to increase training in behavioral health and primary care services for Opioid Use Disorder (OUD) in HRSA-supported health centers.

  In Academic Year 2018-2019, the BHWET Program supported training for 6,209 individuals. Of the total students supported, 3,213 graduate-level social workers, psychologists, school and clinical counselors, psychiatric nurse practitioners, and marriage and family therapists were trained as well as 2,996 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).

  Over fifty percent of the BHWET trainees received training in substance use treatment. By the end of the Academic Year, 3,940 students graduated from these degree and certificate-bearing programs and entered the behavioral health workforce. Upon program

completion, 28 percent of students intended to pursue training and/or employment to serve at-risk children, adolescents, and transitional-aged youth. Further, 63 percent of students intended to pursue training and/or employment in a medically underserved area and/or primary care setting.

BHWET grantees partnered with 2,355 training sites (e.g., hospitals, ambulatory practice sites, and academic institutions) to provide 7,985 clinical training experiences for BHWET student trainees. Approximately 70 percent of these training sites were located in medically underserved communities where trainees provided over 1.3 million hours of behavioral health services to patients and clients. Over 20 percent of the sites offered opioid use treatment services and 49 percent of the sites offered substance use treatment services. Training at partnered sites incorporated interdisciplinary team-based approaches, where 17,345 students, residents and/or fellows from a variety of professions and disciplines were trained on teams with BHWET students. BHWET grantees used grant funds to develop, enhance, and implement nearly 1,500 behavioral health-related courses and training activities, reaching over 43,000 students and advanced trainees (i.e., psychology interns and fellows and psychiatry residents).

- ***Addiction Medicine Fellowship (AMF) Program:*** In FY 2020, HRSA anticipates making $26.7 million in awards for the AMF program. The AMF program seeks to increase the number of board certified addiction medicine and addiction psychiatry specialists trained in providing interprofessional behavioral health services, including OUD and SUD prevention, treatment, and recovery services, in underserved, community-based settings. HRSA anticipates making $3 million in additional awards above those made in FY 2020 to support Mental Health and Substance Use Disorder (SUD) Workforce Training Demonstration to expand the number of fellows trained as addiction medicine specialists and to increase the number of providers that serve in underserved, community-based settings.

- ***Opioid-Impacted Family Support Program (OIFSP):*** In FY 2020, HRSA anticipates making $11.5 million in awards for OIFSP**.** OIFSP seeks to train paraprofessionals to support children and families impacted by OUD and other SUD in underserved areas. The program will also provide professional development opportunities and educational support to increase the number of paraprofessional trainees receiving a certificate upon completion of the program. In FY 2021, HRSA anticipates supporting the FY 2020 awardees.

- ***Loan Repayment Program for Substance Use Disorder Treatment Workforce***: In FY 2020, HRSA anticipates developing Application and Program Guidance that would make available roughly $12 million to address shortages in the substance use disorder workforce by providing for the repayment of education loans for individuals working in a full-time SUD treatment job that involves direct patient care in either a Mental Health Professional Shortage Area or a county where the overdose death rate exceeds the national average. HRSA anticipates making awards in FY 2021.

The GPE Program: This program supports innovative doctoral-level health psychology programs that foster an interprofessional approach to providing behavioral health and substance use prevention and treatment services in high need and high demand areas through academic and community partnerships. Through these efforts, the GPE Program transforms clinical training environments and aligns with HRSA's mission to improve health outcomes and address health disparities through access to quality services, a skilled health workforce, and innovative, high-value programs.

- In Academic Year 2018-2019, the GPE Program provided stipend support to 267 students participating in practica, internships, or post-doctoral residency programs in psychology. The majority of students who received a stipend were trained in medically underserved communities (97 percent) and/or a primary care setting (87 percent). Of the 150 students who completed GPE-supported programs, 76 percent intended to become employed or pursue further training in medically underserved communities and 57 percent intended to become employed or pursue further training in primary care settings.

- GPE grantees partnered with 184 sites (e.g., hospitals, ambulatory practice sites, and academic institutions) to provide 1,003 clinical training experiences for psychology graduate students as well as 2,631 interprofessional team-based care trainees who participated in clinical training along with the psychology graduate students. Approximately 88 percent of these training sites were located in medically underserved communities and 85 percent were primary care and/or rural settings. Approximately 48 percent of the sites offered substance use treatment services and 38 percent offered telehealth services.

- The future targets for the GPE program take into account the timing of the psychology internship match and GPE funding. Because the annual psychology match for the next academic year occurs in early spring and grant funds are allocated in September, GPE grantees would have already had interns match prior to funding; therefore, almost a one-year delay occurs between the start of the next academic year and this program's funding cycle.

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: State-licensed mental health non-profit and for-profit organizations, including but not limited to Federally Qualified Health Centers, universities, community colleges and technical schools.

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

Funding History

FY	Amount
FY 2017	$ 69,784,000
FY 2018	$111,766,000
FY 2019	$111,916,000
FY 2020	$138,916,000
FY 2021	$138,916,000

Budget Request

The FY 2021 Budget Request for the Behavioral Health Workforce Development Programs (BHWD) of $138.9 million is the same as the FY 2020 Enacted level. The request continues to fund priorities authorized under section 760 of the PHSA including $29.5 million for the Addiction Medicine Fellowship (AMF) program. HRSA anticipates making new awards in the BHWET program and providing additional support to the AMF program to help ensure the behavioral health workforce has the skills and training necessary to address our nation's evolving behavioral health needs. HRSA anticipates making awards for the Loan Repayment for Substance Use Disorder Treatment Workforce program as well as continuing to support Opioid-Impacted Family Support Program grantees. HRSA will continue to fund the Graduate Psychology Education Program at the current levels with a slight decrease to the Behavioral Health Workforce programs due to an increase in the Addiction Medicine Fellowship program within BHWET.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result[71]	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
6.I.C.34: Number of students currently receiving training in behavioral health degree and certificate programs	FY 2018: 6,209 Target: 4,500 (Target Exceeded)	4,500	4,500	Maintain
6.I.C.35: Number of graduates completing behavioral health programs and entering the behavioral health workforce	FY 2018: 3,940 Target: 3,000 (Target Exceeded)	3,000	3,000	Maintain
6.I.C.53: Number of OWEP trainees currently receiving training in opioid-related behavioral health degree and certificate programs	---[72]	TBD	TBD	Maintain
6.I.C.54: Number of OWEP graduates completing opioid-related behavioral health programs and entering the behavioral health workforce	---[73]	TBD	TBD	Maintain
6.I.C.36: Number of graduate-level psychology students supported in GPE program	FY 2018: 267 Target: 170 (Target Exceeded)	200	200	Maintain
6.I.C.37: Number of interprofessional students trained in GPE program	FY 2018: 2,631 Target: 1,900 (Target Exceeded)	1,900	1,900	Maintain
6.I.C.61: Number of new addiction medicine and addiction psychiatry fellowship graduates entering workforce	---[74]	TBD	TBD	TBD
6.I.C.62: Number of substance use disorder treatment providers receiving loan repayment	---[75]	TBD	TBD	TBD

[71] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.

[72] Baseline for this measure will be set for FY 2019 and will be reported in the FY 2022 Congressional Justification.
[73] Baseline for this measure will be set for FY 2019 and will be reported in the FY 2022 Congressional Justification.
[74] Baseline for this measure will be set for FY 2020 and reported in the FY 2023 Congressional Justification.
[75] Baseline for this measure will be set for FY 2020 and reported in the FY 2023 Congressional Justification.

Program Activity Data

Program Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target	FY 2021 Target
Number of GPE clinical training experiences that incorporated interprofessional team-based care training	FY 2018: 1,003	500	400	400

Behavioral Health Workforce Development Programs Grant Award Table

	FY 2019 Final[76]	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	201	219	219
Average Award	$606,942	$498,330	$498,330
Range of Awards	$83,324- $1,350,000	$83,320- $800,000	$83,320-$800,000

Loan Repayment Program for Substance Use Disorder Treatment Workforce

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	---	42	42
Average Award	---	$250,000	$250,000
Range of Awards	---	$75,000 – 250,000	$75,000 – 250,000

GPE Grant Award Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	49	49	49
Average Award	$355,353	$355,353	$355,353
Range of Awards	$112,104-$450,000	$112,104-$450,000	$112,104-$450,000

[76] FY 2019 funding includes funds appropriated in FY 2018.

Public Health Workforce Development

Public Health and Preventive Medicine Training Grant Programs

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$16,915,000	$17,000,000	---	-$17,000,000
FTE	5	5	---	-5

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

FY 2021 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 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Public Health Training Centers Program	$9,651,757	$9,700,258	---
Preventive Medicine Residency Program	$7,263,243	$7,299,742	---

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.

The NCC's purpose was to provide national coordination and technical assistance to the 10 Regional PHTCs. Instead of developing a new iteration of the NCC, HRSA redesigned the Regional PHTC program. HRSA has funded 10 PHTCs, one for each HHS region, to ensure that the United States and its territories and jurisdictions have access to quality public health workforce education and training. Each Regional PHTC encompasses a designated geographic area or medically underserved population that provides specialized technical assistance reflective of that Region's unique needs.

In Academic Year 2018-2019, Regional PHTCs partnered with 241 sites to provide more than 304 clinical training experiences to student trainees (e.g., local health departments, academic institutions, and community-based organizations). Approximately 75 percent of these training sites were located in medically underserved communities and 25 percent were located in rural areas. With regard to the continuing education (CE) of the current workforce, PHTC grantees delivered 2,360 unique CE courses to 169,935 trainees during the academic year, approximately 22 percent of whom were practicing professionals concurrently employed in medically underserved communities. Nearly 6,000 instructional hours for continuing education were offered in the current academic year, slightly missing the target.

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. The program aims to increase the

number and quality of preventive medicine residents and physicians to support access to preventive medicine to improve the health of communities.

In Academic Year 2018-2019, the PMR Program financially supported 128 residents, the majority of whom received clinical or experiential training in a primary care setting (82 percent) and/or a medically underserved community (61 percent). Approximately 30 percent of residents received training in substance use treatment. Of the 76 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 293 sites to provide 839 clinical training experiences for PMR residents (e.g., academic institutions, ambulatory care sites, State and local health departments, and hospitals).

Approximately 35 percent of these training sites were located in medically underserved communities and 32 percent were primary care settings. Nearly 27 percent of these training sites offered substance use treatment services. The intent of the Preventive Medicine Residency Program is to prepare physicians for positions in public health. Physicians completing the residency program are prepared to work in a variety of settings including state and local health departments, health systems, companies, and government.

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 2017	$16,949,000
FY 2018	$17,000,000
FY 2019	$16,915,000
FY 2020	$17,000,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Preventive Medicine and Public Health Training Grant Programs of $0 is $17.0 million below the FY 2020 Enacted 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)[77]	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
6.I.C.9: Number of trainees participating in continuing education sessions delivered by PHTCs	FY 2018: 169,935 Target: 150,000 (Target Exceeded)	160,000	N/A	-160,000
6.I.C.18: Number of instructional hours offered by PHTCs	FY 2018: 5,972 Target: 6,000 (Target Not Met)	6,000	N/A	-6,000
6.I.C.19: Number of PHTC-sponsored public health students that completed field placement practicums in State, Local, and Tribal Health Departments	FY 2018: 189 Target: 140 (Target Exceeded)	180	N/A	-180

Program Activity Data

PMR Program Outputs	Year and Most Recent Result	FY 2019 Target[78]	FY 2020 Target	FY 2021 Target
Number of preventive medicine residents participating in residencies	FY 2018: 128	75	75	N/A
Number of preventive medicine residents completing training	FY 2018: 76	40	40	N/A
Percent of program completers who are URMs	FY 2018: 32%	20%	20%	N/A

[77] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.
[78] Reduced targets for PMR program reflects a $4 million decrease in funding for Preventive Medicine residencies and the completion of one program cohort that will not be re-competed.

PMR Program Outputs	Year and Most Recent Result	FY 2019 Target[78]	FY 2020 Target	FY 2021 Target
Percent of preventive medicine resident program completers who intend to practice in primary care settings	FY 2018: 32%	40%	30%	N/A

Grant Awards Table – Public Health Training Centers Program

	FY 2019 Operating Level	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	10	10	---
Average Award	$895,381	$899,880	---
Range of Awards	$767,470-$1,087,248	$771,326-$1,092,711	---

Grant Awards Table – Preventive Medicine Residency Program

	FY 2019 Operating Level	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	17	17	---
Average Award	$386,194	$388,135	---
Range of Awards	$347,399-$400,000	$349,145-$402,010	---

Nursing Workforce Development

Advanced Nursing Education Programs[79]

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$74,210,000	$80,581,000	---	-$80,581,000
FTE	9	9	---	-9

Authorizing Legislation: Public Health Service Act, Section 811

FY 2021 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.

Program	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Advanced Nursing Education Program	$74,210,000	$75,581,000	---
Nurse Optional Fellowship Program	--	$5,000,000	---

Advanced Nursing Education Workforce (ANEW) Program: In FY 2019, HRSA established a new funding opportunity for the ANEW Program to continue to support 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.

[79] Includes funding for Advanced Nursing Education and Nurse Practitioner Optional Fellowship Programs

In Academic Year 2018-2019, grantees of the ANEW Program trained 3,658 nursing students of which more than thirty percent were underrepresented minorities and/or from disadvantaged backgrounds. The ANEW program produced 1,256 graduates who were ready to enter the health care workforce. Of the 1,857 students who were directly funded by ANEW, the majority trained in rural and/or medically underserved settings and received training in substance use treatment (51 percent) and/or opioid use treatment (49 percent).

In addition, ANEW grantees supported 65 faculty and 32 preceptors. To provide clinical training experiences to nursing students, grantees partnered with 2,642 clinical training sites in primary care settings (73 percent), medically underserved communities (62 percent), and/or rural areas (32 percent). ANEW grantees offered 474 curricula, provided 168 continuing education courses to practicing professionals, and offered 156 faculty and preceptor development programs. HRSA anticipates $39 million in continuation awards in FY 2020.

Advanced Nursing Education Nurse Practitioner Residency (ANE-NPR) Program: In FY 2019, HRSA established the ANE-NPR program to prepare new nurse practitioners (NPs) in primary care for transition to practice in community-based settings through clinical and academic focused 12-month Nurse Practitioner Residency (NPR) programs with a preference for those projects that benefit rural or underserved populations. The program seeks to increase primary care providers in community-based settings and the program encourages eligible entities to develop training programs supporting the placement and retention of NPs in rural and underserved settings. HRSA anticipates $25 million in continuation awards in FY 2020.

Advanced Nursing Education-Sexual Assault Nurse Examiners (ANE-SANE) Program: In FY 2019, HRSA provided continuation funding for the ANE-SANE Program which supports partnerships that recruit, train and retain nurses to conduct sexual assault forensic examinations which provide better physical and mental health care for survivors, better evidence collection, and leads to higher prosecution rates. The partnerships have an infrastructure to provide didactic and clinical training, monitor and track experiential learning hours and SANE certificate completion. They also provide support and resources to help improve the practice and retention of sexual assault nurse examiners.

In Academic Year 2018-2019, Grantees from the ANE-SANE program trained 563 students and produced 59 graduates. The majority of trainees were from a rural and/or disadvantaged background (51 percent). The ANE-SANE grantees partnered with 95 clinical training sites in primary care settings (18 percent), medically underserved communities (64 percent), and/or rural areas (21 percent). HRSA anticipates $9 million in continuation awards in FY 2020.

Advanced Nursing Education (ANE)*:* In Academic Year 2018-2019, grantees of the ANE Program trained 2,324 nursing students and produced 642 graduates. Further analysis showed that ANE grantees partnered with 1,193 health care delivery sites to provide clinical and experiential training to students. Approximately 46 percent of these sites were located in medically underserved communities, and 62 percent were in primary care settings. This is the final year of reporting for the ANE program grants as this program was recompeted as the ANEW program.

Nurse Anesthetist Traineeships (NAT) Program: In Academic Year 2018-2019, grantees of the NAT Program provided direct financial support to 2,647 nurse anesthetist students and 1,168 students graduated. Students received clinical training in medically underserved communities (78 percent) and/or primary care settings (39 percent) during the academic year. More than 1,100 students graduated from their degree programs and entered the workforce. At the time of graduation, 58 percent of graduates intended to pursue employment or further training in medically underserved communities, and 19 percent planned to pursue employment or further training in a primary care setting. HRSA anticipates $2.3 million in new awards in FY 2020.

***Advanced Nursing Education- Primary Care/ Behavioral Health Nurse Practitioner Residency Program*:** In FY 2020, HRSA established the Advanced Nursing Education- Primary Care/ Behavioral Health Nurse Practitioner Residency Program with Nurse Practitioner Optional Fellowship, (NPOF) funds to establish or expand optional community-based nurse practitioner and nurse midwife fellowship programs that are accredited or in the accreditation process for practicing postgraduate nurse practitioners in primary care or behavioral health. This program gives preference to Federally Qualified Health Centers (FQHCs). HRSA anticipates $5 million in new awards in FY 2020.

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 • Sexual Assault Nurse Examiners • Registered Nurses • Forensic Nurses • Clinical Nurse Specialists	• Graduate (master's and doctoral) • Advanced education	• Enhance advanced nursing education and practice • Provide traineeships to students in advanced nursing education programs • Provide post graduate Nurse Practitioner and Nurse Midwife transition-to-practice periods through residency programs

Funding History

FY	Amount
FY 2017	$64,425,000
FY 2018	$74,311,000
FY 2019	$74,210,000
FY 2020	$80,581,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Advanced Nursing Education and Nurse Optional Fellowship programs of $0 is $80.6 million less than the FY 2020 Enacted 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)[80]	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
6.I.C.38: Number of students trained in advanced nursing degree programs	FY 2018: 3,658 Target: 350 (Target Exceeded)	3,700	N/A	-3,700
6.I.C.39: Percent of students trained who are URMs and/or from disadvantaged backgrounds	FY 2018: 36% Target: 24% (Target Exceeded)	36%	N/A	-36%
6.I.C.40: Number of graduates from advanced nursing degree programs	FY 2018: 1,256 Target: 75 (Target Exceeded)	1,000	N/A	-1,000

Program Activity Data

ANE Program Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target	FY 2021 Target
Number of students supported in NAT program	FY 2018: 2,647	2,200	2,400	---
Number of graduates from NAT program	FY 2018: 1,168	1,000	1,050	---
Percent of NAT graduates who are minority and/or from disadvantaged backgrounds	FY 2018: 29%	30%	30%	---

[80] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.

ANE Program Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target	FY 2021 Target
Percent of graduates from NAT programs employed in underserved areas	FY 2018: 48%	45%	45%	---

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	179	199	---
Average Award	$400,000	$388,510	---
Range of Awards	$10,000-$1,000,000	$4,229-$992,690	---

ANE- Primary Care/ Behavioral Health Nurse Practitioner Residency Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	---	Up to 10	---
Average Award	---	$450,000	---
Range of Awards	---	$250,000-$500,000	---

Nursing Workforce Development

Nursing Workforce Diversity

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$17,257,000	$18,343,000	---	-$18,343,000
FTE	3	3	---	-3

Authorizing Legislation: Public Health Service Act, Sections 821

FY 2021 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 2018-2019, the NWD Program supported 67 college-level degree programs as well as 174 training programs and activities designed to recruit and retain health professions students. These programs trained 11,067 students, including 5,405 students who graduated or completed their programs. Degree programs had 5,508 enrolled students and academic support programs had 5,559 participants this academic year.

In addition to providing support to students, NWD grantees partnered with 789 training sites during the academic year to provide 7,371 clinical training experiences to trainees across all programs. Approximately 46 percent of training sites were located in medically underserved communities and 37 percent were in primary care settings.

In FY 2020, HRSA will support a new Nursing Workforce Diversity program with an emphasis of increasing on increasing the eldercare workforce and increasing access to care in rural and underserved areas.

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 and Master's 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 2016	$15,343,000
FY 2017	$15,306,000
FY 2018	$17,300,000
FY 2019	$17,257,000
FY 2020	$18,343,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Nursing Workforce Diversity program of $0 is $18.3 million below the FY 2020 Enacted 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)[81]	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
6.I.C.41: Percent of program participants who are URMs and/or from disadvantaged backgrounds	FY 2018: 100% Target: 95% (Target Exceeded)	98%	N/A	-98 percentage points
6.I.C.42: Number of program participants who participated in academic support programs during the academic year	FY 2018: 5,559 Target: 2,000 (Target Exceeded)	4,500	N/A	-4,500
6.I.C.43: Number of program participants who are enrolled in a nursing degree program	FY 2018: 5,808 Target: 2,500 (Target Exceeded)	3,000	N/A	-3,000

Program Activity Data

NWD Program Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target	FY 2021 Target
Percent of URM students	FY 2018: 51%	65%	60%	---
Number of nursing students graduating from nursing programs	FY 2018: 1,650	2,500	2,500	---

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	34	35	---
Average Award	$475,458	$524,085	---
Range of Awards	$250,000-$500,000	$250,000-$1,000,000	---

[81] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.

Nursing Workforce Development

Nurse Education, Practice, Quality and Retention Programs

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$41,704,000	$43,913,000	---	-$43,913,000
FTE	4	4	---	-4

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

FY 2021 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 statutory 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.

In FY20 HRSA will support the use of simulation to enhance nurse education and expand experimental learning opportunities.

Interprofessional Collaborative Practice (IPCP): Behavioral Health Integration (BHI) Program: The IPCP: BHI Program was initiated in July 2016 to address the significant unmet need for behavioral health services in community-based primary care settings. The IPCP: BHI program expands evidence-based practices into nurse-led primary care teams to increase access to care, enhance care coordination and improve patient, family, and community outcomes in rural and underserved communities.

In Academic Year 2018-2019, IPCP grantees trained 1,680 individuals. Grantees partnered with 65 clinical sites to provide interprofessional team-based training to 1,381 individuals.

Approximately 77 percent of the clinical training sites were located in medically underserved communities, and 77 percent were in primary care settings. More than 56 percent of interprofessional trainees were nurses and nursing students, while 597 were trainees from other health care disciplines, including medical, dental, and behavioral health. HRSA anticipates approximately $9 million in new awards in FY 2020.

Registered Nurses in Primary Care (RNPC) Training Program: The purpose of this four-year training program is to recruit and train nursing students and current registered nurses (RNs) to practice to the full scope of their license in community-based primary care teams to increase access to care, with an emphasis on chronic disease prevention and control, including mental health and substance use conditions. The program aims to achieve a sustainable primary care nursing workforce equipped with the competencies necessary to address pressing national public health issues, even the distribution of the nursing workforce, improve access to care and improve population health outcomes.

In Academic Year 2018-2019, the RNPC program trained 831 individuals in primary care nursing programs and produced 174 graduates. Over one third of nursing students received training in substance use treatment (37 percent) and/or opioid use treatment (39 percent). RNPC grantees partnered with 307 training sites to provide experiential training. These training sites were located in primary care settings (70 percent), medically underserved communities (85 percent), or rural areas (44 percent). HRSA anticipates approximately $27 million in continuation awards in FY 2020.

Veteran Registered Nurses in Primary Care (VNPC) Training Program: The purpose of this three-year training program is to recruit and train veteran nursing students and current registered nurses (RNs) to practice to the full scope of their license in community-based primary care teams to increase access to care, with an emphasis on veteran care, chronic disease prevention and control, including mental health and substance use conditions. The program aims to achieve a sustainable primary care nursing workforce equipped with the competencies necessary to address pressing veteran public health issues, as well as the distribution of the nursing workforce, improve access to care and improve population health outcomes. HRSA anticipates approximately $3.5 million in continuation awards in FY 2020.

Simulation Education Training (SET) Program*:* This program aims to enhance public health nursing education and practice with the use of simulation-based technology to advance the health of patients, families, and communities in rural and medically underserved areas experiencing diseases and conditions that affect public health including high burden of stroke, heart disease, behavioral and mental health, maternal mortality, HIV/AIDS and or obesity. HRSA anticipates $2 million in new awards in FY 2020.

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	• Baccalaureate education • Continuing professional training • Advanced practice nursing education	• 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. • Promote career advancement for nursing personnel. • Improve the retention of nurses and enhance patient care.

Funding History

FY	Amount
FY 2017	$39,817,000
FY 2018	$41,733,000
FY 2019	$41,704,000
FY 2020	$43,913,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Nurse Education, Practice, Quality and Retention (NEPQR) Program of $0 is $43.9 million below the FY 2020 Enacted 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)[82]	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
6.I.C.44: Number of trainees participating in interprofessional team-based care	FY 2018: 368 Target: 250 (Target Exceeded)	N/A[83]	N/A	N/A
6.I.C.45: Number of nurses and nursing students trained in interprofessional team-based care	FY 2018: 784 Target: 300 (Target Exceeded)	N/A[84]	N/A	N/A
6.I.C.57: Number of NEPQR nursing students trained in primary care	---[85]	TBD	N/A	N/A
6.I.C.58: Number of NEPQR trainees and professionals participating in interprofessional team-based care	---[86]	TBD	N/A	N/A

Program Activity Data

NEPQR Program Outputs	Year and Most Recent Result	FY 2019 Target	FY 2020 Target	FY 2021 Target
Total number of trainees and professionals participating in interprofessional team-based care	FY 2018: 1,381	N/A[87]	N/A	N/A

[82] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.
[83] Measure discontinued as program was restructured.
[84] Measure discontinued as program was restructured.
[85] Baseline for this measure will be set for FY 2019 and reported in the FY 2022 Congressional Justification.
[86] Baseline for this measure will be set for FY 2019 and reported in the FY 2022 Congressional Justification.
[87] Measure discontinued as program was restructured.

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	73	72	---
Average Award	$530,665	$609,902	---
Range of Awards	$131,830-$700,000	$291,004-$700,000	---

Nursing Workforce Development

Nurse Faculty Loan Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$13,433,000	$28,500,000	---	-$28,500,000
FTE	3	3	---	-3

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

FY 2021 Authorization .....Expired at the end of FY 2016

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 2018-2019, 80 schools received new NFLP awards. Awardees supported 2,277 nursing students pursuing graduate level degrees as nurse faculty. By the end of the Academic Year, 699 trainees graduated, 65 percent of whom intended to teach nursing.

The number of schools receiving a new NFLP award does not equate to the number of schools providing NFLP loans to graduate-level nursing students. In order to receive a new NFLP award, schools must meet certain criteria with regard to available fund balances. However, even schools that do not receive new awards may continue giving out loans with the accounts they have already established.

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 2017	$26,436,000
FY 2018	$28,500,000
FY 2019	$13,433,000
FY 2020	$28,500,000
FY 2021	---

Budget Request

The FY 2021 Budget Request of $0 is $28.5 million below the FY 2020 Enacted 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)[88]	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
6.I.C.46: Number of graduate-level nursing students who received a loan	FY 2018: 2,277 Target: 1,900 (Target Exceeded)	1,900	N/A	-1,900
6.I.C.47: Number of loan recipients who graduated from an advanced nursing degree program	FY 2018: 699 Target: 350 (Target Exceeded)	400	N/A	-400

[88] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	80	45	---
Average Award	$159,000	$259,189	---
Range of Awards	$7,750-$1,014,000	$64,620-$1,113,268	---

Nursing Workforce Development

Nurse Corps

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$86,701,000	$88,635,000	$83,135,000	-$5,500,000
FTE	30	30	32	+2

Authorizing Legislation: Public Health Service Act, Section 846

FY 2021 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 2030. 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, seven states are projected to experience a shortage of RNs by 2030.[89] Furthermore, as the Administration seeks to continue to address the opioid epidemic and other substance use disorders across the nation, the Nurse Corp program is critical to ensure access to high quality adequate behavioral health nursing workforce.

The Nurse Corps addresses (1) the distribution of nurses by supporting nurses and nursing students committed to working in communities with inadequate access to care; and (2) limited access to behavioral health services by increasing funding for scholarships for behavioral health training for Nurse Practitioners (NPs). 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 and behavioral health services. As of September 30, 2019, over three-quarters of the Nurse Corps providers were serving in community-based settings and 22 percent served in rural communities.

The Nurse Corps Program includes:

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

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 (APRNs), (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 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 2019, 58 percent of Nurse Corps LRP participants extended their service commitment for an additional year, exceeding the 52 percent target; and in FY 2019, 84 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.[90] In addition, in FY 2019, 96 percent of Nurse Corps SP awardees are pursuing their baccalaureate degree or advanced practice degree.

In FY 2021, HRSA plans to continue directing up to 20 percent of scholarship awards to NPs specializing in Psychiatric-Mental Health with the goal of leveraging HRSA funding to address the opioid crisis.

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.

[90] In FY 2020, HRSA began using the "Clinician Dashboard" to calculate the retention rate. The Clinician Dashboard is a data visualization tool that includes data on clinicians with NPI numbers supported by the National Health Service Corps and Nurse Corps.

Funding History

FY	Amount
FY 2017	$82,935,000
FY 2018	$87,107,000
FY 2019	$86,701,000
FY 2020	$88,635,000
FY 2021	$83,135,000

Budget Request

The FY 2021 Budget Request for the Nurse Corps Program of $83.1 million is $5.5 million below the FY 2020 Enacted level. This request will fund an estimated 224 scholarship (new and continuation) and 799 loan repayment (new and continuation) awards. This request will allow the program to maintain its efforts to address the anticipated demand for nurses in Critical Shortage Facilities (CSF). Additionally, the funds will help increase the number of well-trained nurses available to provide mental/behavioral health services in communities experiencing a shortage in nurses. In FY 2021, Nurse Corps will continue to drive funding to support the Administration's priorities to improve access to opioid treatment and prevention services through the Scholarship and LRP.

In FY 2021, HRSA proposes to expand tax-exempt status under (1) 26 USC 117(c)(2) to the Nurse Corps Scholarship Program (SP) and Native Hawaiian Health Scholarship Program (NHHSP); and (2) 26 USC 108(f)(4) to the Nurse Corps Loan Repayment Program (LRP). The funding request includes operational, staffing, acquisition contracts, and costs associated with the award process, follow-up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 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 2019: 58% Target: 52% (Target Exceeded)	52%	52%	Maintain

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
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 2019: 84% 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 2019: 96% Target: 85% (Target Exceeded)	85%	85%	Maintain
5.E.1: Default rate of Nurse Corps LRP and SP participants. *(Efficiency)*	FY 2018: LRP: 2.8% Target: 3% (Target Exceeded) SP: 10.3% Target: 15% (Target Exceeded)	LRP: 3% SP: 15%	LRP: 3% SP: 15%	Maintain

Nurse Corps Loans/Scholarships Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Loans	$52,583,040	$53,719,072	$50,377,158
Scholarships	$24,295,434	$24,837,380	$23,296,166

Nurse Corps Awards

	2015	2016	2017	2018	2019	2020	2021
Scholarships							
New Awards	257	230	198	215	220	223	219
Continuation Awards	12	12	14	4	6	6	5
Loan Repayment							
New Awards	590	518	501	544	561	566	507
Continuation Awards	319	365	340	279	292	293	292
Total	**1,178**	**1,125**	**1,053**	**1,042**	**1,079**	**1,088**	**1,023**

Nurse Corps Field Strength

	2015	2016	2017	2018	2019	2020	2021
Scholarship	396	476	362	465	450	453	400
Loan Repayment	1,313	1,219	1,181	1,129	1,279	1,284	1,210
Loan Repayment Nurse Faculty	321	321	331	271	199	200	123
Total	**2,030**	**2,016**	**1,874**	**1,865**	**1,928**	**1,937**	**1,733**

Children's Hospitals Graduate Medical Education Payment Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$323,382,000	$340,000,000	---	-$340,000,000
FTE	20	20	---	-20

Authorizing Legislation: Public Health Service Act, Section 340E
FY 2021 Authorization $340,000.000

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. 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.

A sufficient and appropriate health workforce, efficient organization of health care teams, and training in value-based models of care are all critical components to supporting new models of care that drive value and quality throughout the entire system. In FY 2020, the CHGME program implemented the second year of the Quality Bonus System (QBS), authorized by statute to allow the Secretary of HHS to distribute bonus payments to participating CHGME hospitals that meet quality standards specified by the Secretary. The goal of the QBS is to recognize and incentivize CHGME Payment Program awardees with high quality training to meet the pediatric workforce needs of the nation. The CHGME QBS is the first of its kind for any federal GME payment program and responds to changes occurring in the larger health care arena. The CHGME QBS is the only flexibility allowed in the legislation in the CHGME Payment Program in how payments can be distributed.

In FY 2019, HRSA implemented the first phase of the CHGME QBS which included a pay-for-reporting CHGME QBS payment by requesting children's hospitals submit information on their hospital's initiatives, resident curriculum, and direct resident involvement in five areas: (1) integrated care models, (2) telehealth and/or health information technology, (3) population health, (4) social determinants of health, and (5) additional initiatives to improve access and quality of care to rural and/or underserved communities.

The FY 2020 CHGME QBS payment aims to incentivize complete individual level reporting for all residents supported by the CHGME Payment Program. In order to qualify for the QBS payment in FY 2020, CHGME awardees must complete individual level documentation for all residents supported by the CHGME Payment Program in the FY 2020 Annual Performance Report (AY 2019-2020). In FY 2021, HRSA will continue to collect baseline information to establish QBS standards in the future.

HRSA awarded an evaluation contract in FY 2019, to conduct an environmental scan of GME quality measures, develop quality measures for GME programs in the identified priority areas, and manage an organized stakeholder engagement process on potential QBS standards and measures. Recommendations from the QBS contract and data collected will help support HRSA's plan to implement a full Pay-for-Performance QBS.

In FY 2019, 58 children's hospitals received CHGME funding. During FY 2018 (AY 2018-2019), the most recent year for which FTE information was reported, the CHGME hospitals trained 7,522 resident full-time equivalents (FTEs).[91] Among these FTEs, 40 percent were pediatric residents, 34 percent were pediatric subspecialty residents, and 26 percent were residents training in other primary disciplines such as family medicine.

During Academic Year 2018-2019, the most recent year for which performance information is available, CHGME-funded hospitals served as sponsoring institutions for 39 residency programs and 257 fellowship programs. In addition, they served as major participating rotation sites for 666 additional residency and fellowship programs. CHGME supported the training of 4,634 pediatric residents that included general pediatrics residents, as well as residents from seven types of combined pediatrics programs (e.g., internal medicine/ pediatrics).

Additionally, 2,933 pediatric medical subspecialty residents, 331 pediatric surgical subspecialty residents, and 402 adult and pediatric dentistry residents were trained. CHGME funding was also responsible for the training of 3,349 adult medical and surgical specialty residents such as family medicine residents who rotate through children's hospitals for pediatrics training. The total number of funded residents and fellows during Academic Year 2018-2019 was 11,649. During their training, these medical residents and fellows provided care during more than 1.4 million patient encounters in primary care settings in addition to providing over 4 million patient contact hours in medically underserved communities. Of the full-time residents and fellows who completed their training during this Academic Year, approximately 59 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.

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

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 2016	$295,000,000
FY 2017	$299,289,000
FY 2018	$314,213,000
FY 2019	$323,382,000
FY 2020	$340,000,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Children's Hospitals Graduate Medical Education program of $0 is $340.0 million below the FY 2020 Enacted level.

The Request 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 2017 payments for graduate medical education, plus 2017 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)[92]	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
7.I.A.1: Maintain the number of FTE residents training in eligible children's teaching hospitals	FY 2018: 7,522 Target: 6,300 (Target Exceeded)	7,141	N/A	-7,141
7.VII.C.1: Percent of hospitals with verified FTE residents counts and caps	FY 2018: 100% Target: 100% (Target Met)	90%[93]	N/A	-90%
7.E: Percent of payments made on time	FY 2018: 100% Target: 100% (Target Met)	100%	N/A	-100%

Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	58	59	---
Average Award	$5,273,460	$5,762,712	---
Range of Awards	$27,737-$22,185,631	$29,233-$23,300,699	---

[92] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.
[93] A programmatic change requiring only 90% of hospitals be audited has been implemented.

Teaching Health Center Graduate Medical Education Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Current Law Mandatory Funding	$126,500,000	$81,445,000	---	-$81,445,000
Proposed Law Mandatory Funding	---	$45,055,000	$126,500,000	+$81,445,000
Total	$126,500,000	$126,500,000	$126,500,000	---
FTE	7	7	7	---

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

FY 2021 Authorization .....Expired at the end of FY 2019

Allocation Method ..... Formula Based Payment

Program Description and Accomplishments:

Primary care physician shortages persist, particularly in rural and other underserved communities.[94] Access to high quality primary care is associated with improved health outcomes and lower costs.[95, 96] A number of strategies are effective in incentivizing providers to choose careers in primary care and to practice in rural and underserved areas including positive training experiences in rural and underserved communities and rotations in community based practice locations.[97,98] There is evidence that physicians who receive training in community and underserved settings are more likely to practice in similar settings, such as health centers.[99]

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

[94] 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.
[95] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Quarterly. 2005; 83(3):457-502.
[96] 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.
[97] Washko, M, Snyder, J, & Zangaro, G. Where do physicians train? Investigating public and private institutional pipelines. Health Affairs. 2015; 34(5): 852-856.
[98] Connelly M, et al. Variation in Predictors of Primary Care Career Choice by Year and Stage of Training. Journal of General Internal Medicine. 2003; 18(3): 159-69.
[99] Chang C, O'Malley A, Goodman D. Association between Temporal Changes in Primary Care Workforce and Patient Outcomes. Health Services Research. 2017; 52:634–55.

number of these primary care providers. Teaching Health Centers (THCs) specifically have been shown to attract residents from rural and/or disadvantaged backgrounds who are more inclined to practice in underserved areas than those from urban and economically advantaged backgrounds.[100]

Unlike most Federal funding for graduate medical education (GME), THCGME payments support training in community-based ambulatory care settings, as opposed to in-patient care settings in hospitals. Although health centers receive federal funding to improve access to care, they often have difficulty recruiting and retaining primary care professionals.[101] Community health centers are also generally smaller organizations with smaller operating margins compared to teaching hospitals. The THCGME Program is uniquely positioned to meet these recruitment and retention needs by providing funding to support residents training in underserved communities. 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.

A sufficient and appropriate health workforce, efficient organization of health care teams, and training in value-based models of care are all critical components to meeting the Administration's priority of driving value and quality throughout the entire system. Health professions training programs such as the THCGME are essential players in value-based transformation of the healthcare system. In addition to increasing the number of primary care residents training in these community-based patient care settings, the THCGME Program meets the Administration's priority by increasing health care quality and improving overall access to care.

Program funds support the educational costs incurred by new and expanded residency programs. Along with supporting the salaries and benefits of residents and faculty, THCGME funds are used to foster innovation and support curriculum concepts aimed at improving the quality of 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 settings after graduation.

The Bipartisan Budget Act of 2018 included language which permits the Secretary to make payments for the maintenance of filled positions at existing approved THCs; expansion of FTEs at existing THCs, and the establishment of new THCs. The statute also outlines priorities for awarding new approved programs including a prioritization to applicants serving a health professional shortage area or medically underserved community, or in a rural area. HRSA issued a new FY 2020 notice of funding opportunity in June 2019 to support residencies for Academic Year 2020-2021. Starting in Academic Year 2020-2021, HRSA will award $120 million to 58

[100] Talib, Z, Jewers, MM, Strasser, JH, Popiel, DK, Goldberg, DG, Chen, C, Kepley, H, Mullan, Regenstein, M. Primary Care Residents in Teaching Health Centers: Their Intentions to Practice in Underserved Settings After Residency Training. Academic Medicine. 2018; 93(1): 98-103.
[101] 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.

teaching health centers - 53 continuation awards and 5 awards to establish new teaching health centers - increasing the maximum number of approved FTE slots to over 800. All five of the new programs are FQHC-based and will support nearly 50 resident FTEs beginning in Academic Year 2020-2021.

In Academic Year 2018-2019, the THCGME Program awarded 728[102] resident FTE slots that provided funding to 858 primary care medical and dental residents. While the number of FTE slots missed the target due to the unexpected loss of two grantees, the program managed to increase the number of residents funded by 11 over the prior academic year. 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 665,000 contact hours with these primary care patients. Additionally, most THCGME residents (80 percent) spent a significant part of their training in medically underserved and/or rural communities, providing over 1 million hours of patient care. Approximately 18 percent of residents reported coming from a financially or educationally disadvantaged background, and 26 percent of them reported 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 1,381 courses and training activities during the academic year, impacting over 11,000 healthcare trainees. Over 10,000 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 268 residents who completed the program in Academic Year 2018-2019, approximately 56 percent reported intentions to practice in a primary care setting, while 66 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 2019-2020). Of the 228 program completers from the prior academic year for whom employment data was available, most currently practice in a primary care setting (65 percent) and/or in a medically underserved community (50 percent).

Since the THCGME Program began, 1,148 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, [103] the THCGME Program has evidenced much stronger results. Cumulative follow-up data indicates that 65 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.

[102] Awarded FTE slots not the maximum resident FTE cap of up to 801 resident FTEs.
[103] Agency for Healthcare Research and Quality. Primary care workforce facts and stats no. 1. AHRQ Pub. No. 12-P001-2-EF. Rockville, MD. 2011.

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 2017[104]	$55,860,000
FY 2018	$126,500,000
FY 2019	$126,500,000
FY 2020	$126,500,000
FY 2021	$126,500,000

Budget Request

The FY 2021 Budget Request of $126.5 million is equal to the FY 2020 Enacted level. In Academic Year 2021-2022, the program expects to support around 740 FTE slots with a maximum resident FTE cap of up to 801 resident FTEs.

The FY 2021 President's Budget requests to remove the current capped amount of funds available to re-obligate funds recouped through the statutorily-required annual reconciliation process through awards to recipients. Current statutory language limits the total payments in a fiscal year to no more than the amount appropriated for that fiscal year. The President's Budget proposes to remove this limitation to allow HRSA to make additional payments with funds that may return from the annual required reconciliation (i.e., recoupment of unused funds at the end of a prior fiscal year) which is required by statute.

Section 340H(b)(2)(A) of the PHS Act limits the amount of funds made available through awards to the amount appropriated in a given fiscal year. Although the appropriated funds are no-year, HRSA is limited in its ability to use recouped funds to support FTEs in a subsequent FY due to this cap on annual spending. In order to maximize the appropriated funds, the budget is proposing to remove this limitation. The effect of this proposal would allow HRSA to utilize

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

all available funds (including those made available after reconciliation). In the past few academic years, the reconciliation amounts have ranged from $2.8 to $5 million.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[105]	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
6.I.C.5: Number of resident positions supported by Teaching Health Centers (Cumulative)[106]	FY 2018: 728 Target: 800 (Target Not Met)	730	740	+10
6.I.C.48: Percent of THCGME-supported residents training in rural and/or underserved communities	FY 2018: 80% Target: 80% (Target Met)	80%	80%	Maintain

Program Activity Data

THCGME Program Outputs	Year and Most Recent Result
Number of primary care residents funded by THCGME residencies[107]	FY 2018: 858
Number of primary care residents completing training	FY 2018: 268
Percent of residents who are from a disadvantaged and/or rural background	FY 2018: 35%
Percent of primary care resident program completers who intend to practice in primary care settings	FY 2018: 56%

[105] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.
[106] Measure captures the number FTEs resident slots awarded and not the maximum possible nor 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.
[107] Measure captures the number of individual residents supported, which is different than the FTE slots.

Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	56	58	58
Average Award	$2,145,978	$639,355	$1,090,513
Range of Awards	$223,813 - $8,293,868	$62,658-$6,052,986	$202,700-$5,523,575

National Practitioner Data Bank

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$18,814,000	$18,814,000	$18,814,000	---
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 2021 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 more than 1.5 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 2019, the NPDB facilitated more than 9 million queries from the NPDB to authorized health care providers.
- DPDB has launched attestation initiatives for HRSA's community health centers, hospitals, health plans, medical malpractice payers, and all other health care entities. To date, the attestation completion rate for selected health centers, hospitals, health plans, medical malpractice payers, and all other health care entities is over 90 percent.

Funding History

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

FY	Amount
FY 2017	$15,987,575
FY 2018	$16,922,234
FY 2019	$18,814,000
FY 2020	$18,814,000
FY 2021	$18,814,000

Budget Request

The FY 2021 Budget Request for the National Practitioner Data Bank program of $18.8 million in user fees, is the same as the FY 2020 Enacted level. This is based on HRSA's projections of queries on practitioners and organizations.

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)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
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 2019: 3,854,730 Enrolled Practitioners Target: 3,078,500 Enrolled Practitioners (Target Exceeded)	3,900,000	4,200,000	+300,000

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
8.III.B.7: Increase annually the number of disclosures of NPDB reports to health care organizations	FY 2019: 1,958,026 Disclosures Target: 1,850,000 (Target Exceeded)	1,980,000	2,020,000	+40,000

Health Workforce Cross-Cutting Performance Measures

The Bureau of Health Workforce (BHW) has tracked and reported on four cross-cutting measures for over 30 of its programs that reported performance data during Academic Year 2018-2019. The cross-cutting measures focus specifically on the diversity of individuals completing specific types of health professions training programs;[108] the rate in which individuals participating in specific types of health professions training programs are trained in medically underserved communities;[109] 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.[110]

During Academic Year 2018-2019, 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.[111]

With regard to the types of settings used to provide training, results showed that 65 percent of individuals participating in BHW-supported health professions training programs received at least a portion of their training in a medically underserved community surpassing the performance target of 55 percent. This is an improvement over last year's result of 60 percent and reflects the Bureau's continued emphasis aimed at increasing service and training in rural and underserved areas. As a result, more health professions trainees are being exposed to training and patient care in medically underserved communities than in prior years.

Results showed that 47 percent of individuals who graduated from or completed specific types of BHW-supported training programs reported working in medically underserved communities across the nation one year after graduation/completion.

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[108] 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, 27 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.

[109] 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.

[110] 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.

[111] 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).

Lastly, the percent of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program was 64 percent, far exceeding the target of 24 percent. This result is also an improvement over last year's result due to a continued focus on 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) [112]	FY 2020 Target [113]	FY 2021 Target	FY 2021 +/- FY 2020
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 2018: 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 2018: 65% 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.[114]	FY 2018: 47% Target: 40% (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 2018: 64% Target: 24% (Target Exceeded)	50%	TBD	TBD

[112] Most recent results are for Academic Year 2018-2019 and funded in FY 2018.
[113] Targets for FY 2020 are maintained on certain measures to prepare for inclusion of the CHGME program that year.
[114] 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 2018-2019 based on graduates from Academic Year 2017-2018.

Maternal and Child Health

TAB

MATERNAL AND CHILD HEALTH

Maternal and Child Health Block Grant

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$674,723,000	$687,700,000	$760,700,000	+$73,000,000
FTE	44	44	44	---

Authorizing Legislation - Social Security Act, Title V

FY 2021 Authorization $850,000,000

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 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, maternal mortality, and value-based care) 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 access to quality maternal and child health care services for mothers and children, 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 children with special health care needs; 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.

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 through the Title V Information System.[115]

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:

- An estimated 55 million women, infants, and children, including children with special health care needs, benefitted from a service supported by the State MCH Block Grant in FY 2018. Nationwide, the 59 State MCH Block Grants reached approximately 91percent of pregnant women, 99 percent of infants, and 54 percent of children.
- Access to health services for mothers has improved with support of the State MCH Block Grant program. The percentage of women who received early prenatal care in the first trimester of pregnancy increased from 71.0 percent in 2007 to 77.5 percent in 2018. Recognizing that improving maternal and child health in the United States will require, first of all, improving women's health before pregnancy, 46 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 MCH Block Grant program has played a lead role in the 19 percent decline in U.S. infant mortality from 7.2 infant deaths per 1,000 live births in 1997 to 5.8 infant deaths per 1,000 in 2017. 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, in 2018, 37 State Title V programs provided funding to support comprehensive maternal mortality reviews to identify contributing factors, monitor trends, and initiate appropriate action to reduce such events in the future. An additional 14 states were in the planning process to use Title V funds to support maternal mortality reviews. In Kentucky, for example, the maternal mortality review team's findings led to the development of a patient "safety bundle" for

[115] https://mchb.tvisdata.hrsa.gov/

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 coincided with 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.

Select National Outcome and National Performance Measures in effect from 1997 to 2017 illustrate the program's successes:

National Outcome or Performance Measures	Percent Change (1997 – 2017 unless otherwise noted)	Data Source
Infant Mortality Rate per 1,000 live births	19% decrease	National Vital Statistics System (NVSS)
Neonatal mortality rate per 1,000 live births	21% decrease	NVSS
Postneonatal mortality rate per 1,000 live births	24% decrease	NVSS
Perinatal mortality rate per 1,000 live births plus fetal deaths	19% decrease	NVSS
Child mortality rate, ages 1 through 9 per 100,000	33% decrease	NVSS
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	64% increase (2009-2018)	National Immunization Survey (NIS)
Percentage of children without health insurance	63% decrease (1997-2018)	National Health Interview Survey (NHIS)
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	9% increase (2007-2018)	NVSS

Special Projects of Regional and National Significance (SPRANS)

HRSA awards SPRANS grants to 1) address critical and emerging issues of regional and national significance in maternal and child health, and 2) support collaborative and innovative learning across states so programs can utilize existing best-practices and evidence. Of the $119.1 million

for SPRANS in FY 2020, Congress set aside approximately 11 percent to address four specific priorities: oral health, epilepsy, sickle cell disease, and Fetal Alcohol Syndrome. In addition, approximately 38 percent of the total SPRANS budget supports specific directives highlighted in the authorizing language, including genetics, hemophilia, training, and research. The remaining approximately 51 percent addresses critical and emerging issues in maternal and child health such as maternal mortality and opioid abuse prevention, and supports collaborative learning across states.

Critical and Emerging Issues in Maternal and Child Health

SPRANS supports projects that address critical and emerging issues in maternal and child health, including special projects that respond to Congressional priorities. For example:

- *Maternal mortality* –
    - *AIM* – SPRANS supports the Alliance for Innovation on Maternal Health (AIM) to reduce maternal mortality in the United States. To date, 27 states are enrolled in AIM, with participation from approximately 1,300 hospitals. With additional funding provided in FY 2019 and 2020, AIM is expanding to all U.S. States, the District of Columbia, and U.S. territories, as well as tribal entities.
    - FY 2019 SPRANS funding also supported three new state-focused efforts to improve maternal health outcomes and address disparities in maternal mortality and severe maternal morbidity.
        - *State Maternal Health Innovation Grants* – The State Maternal Health Innovation (STATE MHI) Program funds states working in concert with the State Title V agency to strengthen partnerships and collaboration by: establishing a state-focused Maternal Health Task Force, improving state-level data surveillance on maternal mortality and severe maternal morbidity, and promoting and executing innovation in maternal health service delivery.
        - The *Supporting Maternal Health Innovation Program* supports states and other stakeholders through capacity-building assistance to State MHI recipients and other HRSA-funded maternal health award recipients as they implement innovative and evidence-informed strategies. This funding supports the establishment of a national resource center to provide guidance to HRSA award recipients, states, and key stakeholders in improving maternal health.
        - *The Alliance for Innovation on Maternal Health (AIM) – Community Care Initiative* supports the development and implementation of non-hospital focused maternal safety bundles within community-based organizations and outpatient clinical settings across the U.S. This initiative builds upon the foundational work of AIM by utilizing a quality improvement framework to address mortality and morbidity among pregnant and postpartum women outside of hospital and other birthing facility settings.
    - *Opioids* – SPRANS supported AIM to develop a maternal safety bundle on the prevention and treatment of opioid use disorder during pregnancy and its associated adverse perinatal outcomes, including 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.
- A study on results of this CoIIN, led by researchers from the Health Resources and Services Administration (HRSA), showed early elective delivery decreased by 22 percent in the Southern states versus 14 percent in other regions. Alabama and Louisiana showed the largest reductions in the nation at more than 40 percent. Results in the South also showed that stopping smoking during pregnancy increased by 7 percent, infant back sleep position increased by 5 percent, and preterm birth fell by 4 percent; other regions only showed improvements of 2 percent for each of these outcomes measured.[116]

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 enhance early childhood systems at the state and community level to achieve improved outcomes in population-based children's developmental health and family well-being indicators. ECCS works with 12 states and 28 communities and supports an ECCS CoIIN Coordinating Center to build early childhood systems leadership, improve care coordination and systems integration, and improve policies and practices across sectors so that more children are thriving at age three and school ready by age five.

[116] https://ajph.aphapublications.org/doi/10.2105/AJPH.2018.304371

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

MCH Activities	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
State MCH Block Grant Awards	$555,380	$558,308	$617,831
SPRANS	$109,112	$119,116	$132,593
CISS	$10,231	$10,276	$10,276
Total	**$674,723**	**$687,700**	**$760,700**

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

MCH SPRANS Set-Aside Programs	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
SPRANS – Other	$96,798	$106,224	$124,474
SPRANS - Oral Health	$5,227	$5,250	$4,000
SPRANS – Epilepsy	$3,626	$3,642	$3,642
SPRANS - Sickle Cell	$2,986	$3,000	---
SPRANS - Fetal Alcohol Syndrome Demo	$475	$1,000	$477
Total SPRANS	**$109,112**	**$119,116**	**$132,593**

Funding History

FY	Amount
FY 2017	$641,700,000
FY 2018	$650,194,233
FY 2019	$674,723,000
FY 2020	$687,700,000
FY 2021	$760,700,000

Budget Request

The FY 2021 Budget Request for the Maternal and Child Health (MCH) Block Grant program of $760.7 million is $73.0 million above the FY 2020 Enacted level. The Request includes an

increase of $60.0 million in funding for formula awards to states to provide states with additional flexibility to support activities previously funded through a number of MCH categorical grant programs. Additionally, the Budget includes an increase of $13 million in SPRANS funding for a total of $132.59 million, of which $68 million will support the *Improving Maternal Health in America Initiative*, which focuses on a four-pillar strategy to achieve: 1) Healthy Outcomes for All Women of Reproductive Age by improving prevention and treatment, 2) Healthy Pregnancies and Births by prioritizing quality improvement, 3) Healthy Futures by optimizing post-partum health, and 4) Improve Data and Bolster Research to inform future interventions. This initiative builds on HRSA's efforts to improve maternal health and reduce maternal mortality and severe maternal morbidity. This funding will support:

- State Maternal Health Innovation Grants: An additional $30 million, for a total of $53 million, to expand the program to additional states. This program supports innovation among states to improve maternal health outcomes and address disparities in maternal health. With this funding, states collaborate with maternal health experts to implement state-specific actions plans in order to improve access to maternal care services, identify and address workforce needs, and support postpartum and interconception care services.
- Alliance for Innovation on Maternal Health (AIM): An additional $10 million, for a total of $15 million, to support implementation and expansion of evidence-based models of maternity care, including the maternal safety bundles implemented through AIM. The additional funding in 2021 will expand AIM to community care settings including health centers, IHS, and Tribal facilities.

The President's Budget prioritizes SPRANS funding for addressing maternal health and reduces funding for on-going, new and recompeting SPRANS awards to respond to emerging issues of regional and national significance and support collaborative learning across the states. 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 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
10.4: The percentage of children served by the Maternal and Child Health Block Grant[117] (Output)	FY 2018: Result: 56% Target: N/A (Baseline)	58%	58%	Maintain

[117] The term "children" includes both infants and children (0-21 years of age).

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
10.5: The percentage of pregnant women served by the Maternal and Child Health Block Grant (Output)	FY 2018: Result: 91% Target: N/A (Baseline)	87%	92%	+ 5 percentage points
10.IV.B.1: Decrease the ratio of the Black infant mortality rate to the White infant mortality rate *(*Outcome)	FY 2017: 2.2 to 1[118,119] Target: 2.0 to 1 (Target Not Met)	2.0 to 1	2.0 to 1	Maintain
10.III.A.1: Reduce the infant mortality rate (Outcome)	FY 2017: 5.8 per 1,000 Target: 5.8 per 1,000 (Target 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 2018: 8.3% Target: 7.8% (Target Not Met)	8.0%	8.0%	Maintain
10.III.A.3: Increase percent of pregnant women who received prenatal care in the first trimester (Outcome)	FY 2018: 77.5% Target: 79% (Target Not Met)	80%	80%	Maintain

[118] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018.Data are from the Multiple Cause of Death Files, 1999-2017,as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html

[119] Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, Drake P. Births: Final data for 2017. National Vital Statistics Reports; vol 67 no 8. Hyattsville, MD: National Center for Health Statistics. 2018.

Grant Awards Table – Maternal and Child Health Block Grant

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	59	59	59
Average Award	$9,232,429	$9,231,596	$10,224,978
Range of Awards	$147,073-$39,660,787	$147,060-$39,082,139	$162,885-$45,661,483

Grant Awards Table – SPRANS

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	243	246	272
Average Award	$440,507	$433,345	$428,710
Range of Awards	$11,219-$3,484,624	$11,219-$10,000,000	$11,219-$3,000,000

Grant Awards Table – CISS

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	14	14	13
Average Award	$637,283	$673,235	$640,609
Range of Awards	$208,501-$2,700,000	$410,771-$2,700,000	$410,771-$2,700,000

State Table

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2019 Final[120]	**FY 2020 Estimate[121]**	**FY 2021 Estimate[122]**	**Difference +/- 2020**
Alabama	$11,401,820	$11,436,123	$12,542,308	$1,106,185
Alaska	1,077,677	1,102,220	1,214,990	112,770
Arizona	7,394,328	7,378,658	8,773,998	1,395,340
Arkansas	6,966,533	6,932,732	7,640,428	707,696
California	39,660,787	39,082,139	45,661,483	6,579,344
Colorado	7,397,625	7,318,760	7,939,329	620,569
Connecticut	4,667,875	4,647,058	5,072,024	424,966
Delaware	1,992,794	2,021,547	2,184,026	162,479
District of Columbia	6,909,749	6,940,912	7,078,869	137,957
Florida	19,572,974	19,691,955	23,240,189	3,548,234
Georgia	17,133,550	17,029,221	19,192,425	2,163,204
Hawaii	2,159,575	2,137,424	2,268,777	131,353
Idaho	3,272,972	3,285,138	3,565,834	280,696
Illinois	21,222,869	21,085,669	23,032,783	1,947,114
Indiana	12,270,064	12,261,391	13,447,096	1,185,705
Iowa	6,505,246	6,503,109	6,925,087	421,978
Kansas	4,773,454	4,716,139	5,132,446	416,307
Kentucky	11,092,633	11,176,041	12,159,181	983,140
Louisiana	12,238,148	12,501,330	13,804,752	1,303,422
Maine	3,311,945	3,297,106	3,442,511	145,405
Maryland	11,756,544	11,821,935	12,495,623	673,688
Massachusetts	11,135,267	11,118,963	11,825,355	706,392
Michigan	18,855,463	18,817,408	20,573,013	1,755,605
Minnesota	9,098,601	9,081,270	9,742,391	661,121

[120] The poverty-based allocation for FY 19 uses 3-year poverty data from the American Community Survey, 2014-2016

[121] The poverty-based allocation for FY 20 uses 3-year poverty data from the American Community Survey, 2015-2017

[122] The poverty-based allocation for FY 21 uses 3-year poverty data from the American Community Survey, 2016-2018

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2019 Final[120]	**FY 2020 Estimate[121]**	**FY 2021 Estimate[122]**	**Difference +/- 2020**
Mississippi	9,228,087	9,243,441	10,066,954	823,513
Missouri	12,193,258	12,197,702	13,284,551	1,086,849
Montana	2,300,122	2,275,612	2,414,008	138,396
Nebraska	4,024,409	4,018,103	4,262,008	243,905
Nevada	2,121,400	2,119,621	2,641,158	521,537
New Hampshire	1,972,621	1,952,143	2,061,761	109,618
New Jersey	11,640,399	11,630,726	12,768,611	1,137,885
New Mexico	4,125,964	4,164,551	4,730,158	565,607
New York	38,206,443	38,261,546	41,466,617	3,205,071
North Carolina	17,406,891	17,426,938	19,409,886	1,982,948
North Dakota	1,738,945	1,745,477	1,823,876	78,399
Ohio	22,085,885	22,118,712	24,317,818	2,199,106
Oklahoma	7,049,999	7,179,799	8,116,401	936,602
Oregon	6,263,146	6,181,630	6,724,489	542,859
Pennsylvania	23,732,205	23,847,096	25,723,124	1,876,028
Rhode Island	1,646,441	1,629,925	1,778,734	148,809
South Carolina	11,496,042	11,467,943	12,572,817	1,104,874
South Dakota	2,174,073	2,188,849	2,339,984	151,135
Tennessee	11,875,637	11,816,877	13,252,157	1,435,280
Texas	34,479,260	34,875,018	41,808,444	6,933,426
Utah	6,160,252	6,112,864	6,472,054	359,190
Vermont	1,649,043	1,650,304	1,717,208	66,904
Virginia	12,278,402	12,330,317	13,457,958	1,127,641
Washington	8,893,654	8,770,997	9,661,924	890,927
West Virginia	6,114,105	6,160,550	6,553,753	393,203
Wisconsin	10,916,577	10,835,671	11,597,867	762,196
Wyoming	1,194,968	1,202,702	1,280,988	78,286
SUBTOTAL	**524,836,721**	**524,789,362**	**581,260,226**	**56,470,864**
American Samoa	490,242	490,198	542,946	52,748

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2019 Final[120]	**FY 2020 Estimate[121]**	**FY 2021 Estimate[122]**	**Difference +/- 2020**
Guam	757,152	757,084	838,551	81,467
Marshalls	228,778	228,758	253,374	24,616
Micronesia	517,478	517,432	573,111	55,679
Northern Marianas	463,007	462,965	512,783	49,818
Palau	147,073	147,060	162,885	15,825
Puerto Rico	15,785,792	15,784,367	17,482,871	1,698,504
Virgin Islands	1,487,068	1,486,934	1,646,938	160,004
SUBTOTAL	**19,876,590**	**19,874,798**	**22,013,459**	**2,138,661**
TOTAL Resources	**$544,713,311**	**$544,664,160**	**$603,273,685**	**$58,609,525**

Autism and Other Developmental Disabilities

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$50,377,000	$52,344,000	---	-$52,344,000
FTE	7	7	---	-7

Authorizing Legislation - Section 399BB of the Public Health Service Act, reauthorized by Public Law 113-157, Section 4 and Public Law, 116-60

FY 2021 Authorization $50,559,000

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 2019. 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. Data from the 2018 evaluation covering FY 2014 – FY 2016 showed that the LEND and DBP programs collectively:

- Provided diagnostic services to confirm or rule out ASD and other DDs to more than 340,000 children.
- Provided training to over 16,000 pediatricians, developmental-behavioral pediatrics specialists, and other health professionals.
- Provided more than 11,600 continuing education events on early screening, diagnosis, and intervention that reached nearly 600,000 pediatricians and other health professionals.

Research

To improve the health and well-being of children with ASD and other DDs, HRSA supports research networks, single investigator-led autism innovation projects, field-initiated research and secondary data analyses projects. HRSA supports research and development of reliable screening tools and guidelines for ASD and other developmental disabilities and the implementation of interventions to improve the physical and behavioral health of individuals with ASD and other DDs across the life course as well as research to address barriers to diagnosis and access to care for underserved populations. 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 from the 2018 evaluation covering FY 2014-FY 2016 include:

- Conducted 84 studies on physical and behavioral health issues related to ASD and other DDs, screening and diagnostic measures, early intervention, and transition to adulthood.
- Developed 32 new guidelines and tools, including diagnostic and screening tools that are helping to guide health care practice and delivery.
- Prepared 299 manuscripts for publication and delivered over 300 scientific conference presentations.

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. State grantees:

- Promoted access to more comprehensive coordinated services for ASD by establishing integrated teams of educators, physicians, and social service providers.
- Engaged families in program planning, community outreach, and training for providers;

- Implemented strategies to reduce disparities in early identification and treatment of ASD.

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

Funding History

FY	Amount
FY 2017	$46,985,000
FY 2018	$48,899,000
FY 2019	$50,377,000
FY 2020	$52,344,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Autism and Other Developmental Disabilities program of $0 is $52.3 million below the FY 2020 Enacted level. 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. The Budget includes an increase of $60.0 million in funding for Maternal and Child Health (MCH) Block Grant formula awards to states to provide states with additional flexibility to support activities previously funded through a number of MCH categorical grant programs, including Autism and Other Developmental Disabilities.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
50.I.A.1 Percent of long-term trainees (LEND, DBP) working with underserved populations, 5 years post-training. (Outcome)	FY 2016[123]: LEND 76% DBP 100% (Target 0.5 percentage point increase from prior year– LEND (75.3%): Target exceeded; DBP (85.7%): Target exceeded)	LEND: 76% DBP: 86.2%	N/A	N/A

[123] The data source for this measure is the Discretionary Grants Information System.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
50.I.A.2 Percent of long-term trainees (LEND, DBP) who at 2 and 5 years post-training, have worked in an interdisciplinary manner to serve the MCH population. (Outcome)	FY 2016 Result[124]: 1 year = 79.2 %; 5 years = 77.2% (Target 0.25 percentage point increase from prior year – 1 year (78%): Target exceeded; 5 years (80.6%): Target not met)	1 year = 79.2% 77.2%	N/A	N/A
50.I.A.3 Percent of MCHB Autism research programs supporting the production of scientific publications (Developmental) (Output)	Baseline data for FY 2017[125]: 100%	100%	N/A	N/A

Grant Award Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
LEND	$33,767,075	$35,485,778	---
DBP	$2,240,423	$2,284,870	---
Research	$7,516,804	$7,525,000	---
State Systems	$1,854,336	$1,854,316	---
Resource Centers	$896,000	$896,000	---
Number of Awards	83	87	---
Average Award	$557,526	$532,997	---

[124] FY 2016 data are from the previously worded measure. FY 2016 data only includes LEND, whereas both LEND and DBP will be included in the measure beginning with FY 2017 data, per the measures description.
[125] The data source for this measure is the Discretionary Grants Information System.

Sickle Cell Disease Treatment Demonstration Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$4,435,000	$5,205,000	---	-$5,205,000
FTE	2	2	---	-2

Authorizing Legislation - Sickle Cell Disease and Other Heritable Blood Disorders Research, Surveillance, Prevention, and Treatment Act of 2018

FY 2021 Authorization $4,455,000

Allocation Methods:

- Competitive cooperative agreement
- Contract

Program Description and Accomplishments

The Sickle Cell Disease Treatment Demonstration Program 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. For example, hydroxyurea was approved by the FDA in 1998; 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. Sickle Cell Disease Treatment Demonstration Program 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;
- Implementing telehealth strategies, such as Project ECHO, to educate health professionals on evidence-based treatment of sickle cell disease, such as the use of hydroxyurea; and
- Expanding and coordinating patient education, treatment, and care continuity.

In FY 2017, the program was re-competed and five organizations received grants to develop Regional Coordinating Centers that cover the United States. The program supports at least 30 states where more than 50 percent of the 100,000 individuals with sickle cell disease live in

the United States. Regional grantees are working 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.

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.

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

Funding History

FY	Amount
FY 2017	$4,444,000
FY 2018	$4,455,000
FY 2019	$4,435,000
FY 2020	$5,205,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Sickle Cell Disease Treatment Demonstration Program of $0 is $5.205 million below the FY 2020 Enacted level. 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. The Budget includes an increase of $60.0 million in funding for Maternal and Child Health (MCH) Block Grant formula awards to states to provide states with additional flexibility to support activities previously funded through a number of MCH categorical grant programs, including the Sickle Cell Disease Treatment Demonstration Program.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
51.1: Number of sickle cell patients served by SCDTDP network providers in the past year (Developmental) (Output)	Baseline data for FY2018 will be available December 2020[126]	N/A	N/A	---

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	5	5	---
Average Award	$704,829	$860,997	---
Range of Awards	$357,500-$1,072,500	$436,711-$1,281,994	---

[126] The data source for this measure will be collected from provider surveys via the SCDTDP National Coordinating Center.

Early Hearing Detection and Intervention/1

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$17,740,000	$17,818,000	$17,818,000	---
FTE	4	4	4	---

1/This program is formerly known as the James T. Walsh Universal Newborn Hearing Screening. The program name is changed to better reflect the broader use of funds.

Authorizing Legislation – Early Hearing Detection and Intervention Act of 2017, Public Health Service Act, Title III, Section 399M (as added by Public Law 106-310, Section 702; as amended by Public Law 111-337 and Public Law 115-71)

FY 2021 Authorization $18,628,145

Allocation Methods:

- Competitive grant
- Cooperative agreement

Program Description and Accomplishments

The Early Hearing Detection and Intervention (EHDI) program (formerly known as the James T. Walsh Universal Newborn Hearing Screening program) supports comprehensive and coordinated state and territory EHDI systems so families with newborns, infants, and young children up to three years of age that are deaf or hard of hearing receive appropriate and timely services that include hearing screening, diagnosis, and early intervention. This program focuses on:

- Increasing health professionals' engagement in and knowledge of the EHDI system;
- Improving access to early intervention services and language acquisition; and
- Improving family engagement, partnership, and leadership.

The Children's Health Act of 2000 (P.L. 106-310) authorized the UNHS Program in FY 2000. The EHDI Act of 2017 (P.L. 115-71) recently amended and reauthorized the program. The EHDI Program supports state and territorial efforts to:

- Develop statewide 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 EHDI 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 2017, 98.3 percent of infants overall were screened for hearing loss.[127] In addition, 65.2 percent of infants were diagnosed in accordance with expert guidelines, compared to 60.7 percent in FY 2015.[128] Additionally, the EHDI 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). In 2017, 91.1% of infants were screened before one month of age, 75.4% were evaluated before 3 months of age, and 66.7% were enrolled in early intervention before six months of age.[129] A lack of comprehensive data reporting requirements for service providers in states and variability across states in timely access to such providers, among other factors, continues to be a challenge.

The EHDI Program continues to focus on supporting early screening and diagnosis as recommended by Healthy People 2020. 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 EHDI 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.

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

Funding History

FY	Amount
FY 2017	$17,775,000
FY 2018	$17,818,000
FY 2019	$17,740,000
FY 2020	$17,818,000
FY 2021	$17,818,000

[127] 2017 CDC EHDI Hearing Screening & Follow-up Survey (HSFS); (https://www.cdc.gov/ncbddd/hearingloss/2017-data/01-2017-HSFS-Data-Summary-h.pdf).
[128] Ibid
[129] Ibid

Budget Request

The FY 2021 Budget Request for the EHDI program of $17.8 million is the same as the FY 2020 Enacted level. The Budget Request will continue to support 59 competitive grants to states and territories, in addition to two technical resource centers and supplemental awards to 12 Leadership Education in Neurodevelopmental and Related Disabilities training programs to train future leaders in pediatric audiology.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2020 Target +/- FY 2021 Target
13.2: Increase the percentage of infants with hearing loss enrolled in early intervention before six months of age. *(Output)*	FY 2017: 66.7%[130, 131] Target: 72% (Target Not Met)	72%	72%	Maintain
13.III.A.1: Percentage of infants suspected of having a hearing loss with a confirmed[132] diagnosis by three months of age. *(Output)*	FY 2017: 75.4 [133] Target: 77% (Target Not Met)	77%	77%	Maintain
13.III.A.3: Percentage of infants screened for hearing loss prior to one month of age. *(Output)*	FY 2016: 97.1%[134] Target 98% (Target Not Met)	98%	98%	Maintain

[130] 2017 CDC EHDI Hearing Screening & Follow-up Survey (HSFS): 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. Data can be found at https://www.cdc.gov/ncbddd/hearingloss/2017-data/01-data-summary.html

[131] 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.

[132] "Confirmed" diagnosis refers to a "documented" diagnosis which is consistent with CDC reporting.

[133] Ibid.

[134] Ibid.

Grant Awards Table[135]

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	59	59	59
Average Award	$226,373	$235,000	$235,000
Range of Awards	$53,491-$250,000	$235,000-$235,000	$235,000-$235,000

[135] Does not include Universal Newborn Hearing & Screening cooperative agreement ($1.2M in FY 2019; $0.9M in FY 2020), LEND supplements ($0.9M), Family Leadership in Language and Learning ($0.5M), and Advancing Systems of Services for Children and Youth with Special Health Care Needs: medical home capacity building and technical assistance to LEND Audiology grantees ($150K each).

Emergency Medical Services for Children

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$22,236,000	$22,334,000	---	-$22,334,000
FTE	5	5	---	-5

Authorizing Legislation – Public Health Service Act, Section 1910, as amended by Public Law 113-180, Section 2 and Public Law 116-49.

FY 2021 Authorization $22,334,000

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, reauthorized under the EMSC Reauthorization Act of 2019, 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 for health care practitioners in these settings to remain current on issues affecting children.

Additionally, EMS agencies and hospital emergency departments often lack 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; EMS personnel receive appropriate training for pediatric emergencies; and guidelines and agreements are in place to ensure the safe and effective transfer of children from one hospital to another as necessary.

In recent years, the EMSC program has invested in activities that have improved the pediatric readiness of prehospital services (EMS agencies) and emergency departments. Notable accomplishments include:

- Between 2011 and 2018, the proportion of hospitals with written interfacility transfer guidelines covering pediatric patients increased from 38% to 58%. These guidelines standardize procedures and facilitate communication between hospitals to prevent

adverse events and improve the delivery of timely, effective care to children in a medical emergency.[136]

- Between 2006 and 2018, the number of states that established a pediatric medical facility recognition program more than doubled from five to 12. These 12 states established a state or regional entity to perform on-site assessments of hospital emergency departments to assure the presence of critical resources and protocols needed to manage pediatric medical emergencies.[137]
- In 2017-2019, the EMSC program partnered with the Federal Office of Rural Health Policy (FORHP) to organize a federal steering committee to improve the coordination of care of children in emergency mental health crisis in rural regions, resulting in the development of the Critical Crossroads: Pediatric Mental Health Care in the Emergency Department Pathways Toolkit. This Pathways Toolkit aims to help hospitals identify, manage, and ensure continuity of care for children and adolescents in mental health crisis seeking care in an emergency department.[138]

The EMSC program supports the Pediatric Emergency Care Applied Research Network (PECARN) Program, which enables rigorous clinical research using pooled samples of pediatric patients across institutions to advance EMSC science and clinical practice. For example, the Network examined the impact of giving fluids intravenously to children with diabetic ketoacidosis (DKA), a clinical intervention that was often avoided for fear of causing brain injury. The study found that fluid hydration can be safe for children with DKA, allowing clinicians to administer the fluids on an individualized basis, which may prevent cognitive impairment and decrease the risk of other complications in these children.[139] In 2019, PECARN released a new clinical decision rule to help guide the practice of pediatricians. This rule focused on infants less than 2 months of age who present to the emergency department with fevers and demonstrated how physicians can more precisely identify babies who are at low risk of serious bacterial infections such as urinary tract infections, bacteria in the blood and bacterial meningitis. Better identification helps avoid unneeded spinal taps, antibiotic medications and hospitalizations, which can carry risks and can be costly. Nearly half a million febrile infants are evaluated in U.S. emergency departments each year. [140]

In addition, the EMSC program funds Targeted Issues grants, which support researchers to expand the evidence base in pediatric emergency medicine. For example, the Pediatric Evidence-Based Guidelines: Assessment of EMS System Utilization in States (PEGASUS) project

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[136] Genovesi, A.L., Olson, L.M., Telford, R., Fendya, D., Schenk, E., Morrison-Quintana, T., & Edgerton, E.A. (2017). Transitions of Care: The Presence of Written Interfacility Transfer Guidelines and Agreements for Pediatric Patients. *Pediatric Emergency Care*, doi: 10.1097/PEC.0000000000001210. (Epub ahead of print).

[137] Remick, K., Kaji, A.H., Olson, L., Ely, M., Schmul, P., McGrath, N., Edgerton, E., & Gausche-Hill, M. (2016). Pediatric Readiness and Facility Verification. *Annals of Emergency Medicine. 67*(3). 320-328.

[138] Critical Crossroads: Pediatric Mental Health Care in the Emergency Department - https://www.hrsa.gov/critical-crossroads.

[139] Kuppermann, N., Ghetti, S., Schunk, J.E., Stoner, M.J., Rewers, A., McManemy, J.K., Myers, S.R., Nigrovic, L.E., Garro, A., Brown, K.M., Quayle, K.S., Trainor, J.L., et al. (2018). Clinical Trial of Fluid Infusion Rates for Pediatric Diabetic Ketoacidosis. *New England Journal of Medicine, 378*(24), 2275-2287.

[140] Kuppermann N, Dayan PS, Levine DA, et al. A Clinical Prediction Rule to Identify Febrile Infants 60 Days and Younger at Low Risk for Serious Bacterial Infections. JAMA Pediatr. Published online February 18, 2019173(4):342–351.

developed four evidence-based guidelines to help prehospital health care providers deliver optimal care to children during airway management, allergic reactions, spinal care, and shock. The PEGASUS project then tested the application of these and five pre-existing guidelines in the management of pediatric asthma, bronchiolitis, croup, seizures, and pain in several states.[141]

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.

Funding History

FY	Amount
FY 2017	$20,113,000
FY 2018	$22,134,000
FY 2019	$22,236,000
FY 2020	$22,334,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the EMSC program of $0 is $22.3 million below the FY 2020 Enacted level. 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. The Budget includes an increase of $60.0 million in funding for Maternal and Child Health (MCH) Block Grant formula awards to states to provide states with additional flexibility to support activities previously funded through a number of MCH categorical grant programs, including the EMSC program.

[141] Marino, M.C., Ostermayer, D.G., Mondragon, J.A., Camp, E.A., Keating, E.M., Fornage, L.B., Brown, C.A., & Shah, M.I. (2018). Improving Prehospital Protocol Adherence Through a Bundled Educational Intervention. *Prehospital Emergency Care, 22*(3), 361-369.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
14.3: The percentage of responding EMS agencies nationwide that have a designated individual who coordinates pediatric emergency care (Outcome)	FY 2018: 23%[142] Target: N/A (Baseline)	24%	N/A	---
14.4: Percent of responding hospitals nationwide that have written interfacility transfer guidelines that cover pediatric patients and that include specific components of transfer (Outcome)	FY 2018: Result: 58%[143] Target: N/A (Baseline)	61%	N/A	---
14.5: Number of children enrolled in Pediatric Emergency Care Applied Research Network (PECARN) studies (Outcome)	FY 2019 Result: 125,759[144] Target: N/A	126,009	N/A	---

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	75	72	---
Average Award	$249,362	$272,078	---
Range of Awards	$130,000-$3,000,000	$130,000-$3,000,000	---

[142] The data source for this measure is the National EMSC Data Analysis Resource Center (NEDARC). Data are collected every 2 years.
[143] Ibid.
[144] The data source for this measure is the Data Coordinating Center.

Healthy Start

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$121,962,000	$125,500,000	$125,500,000	---
FTE	16	16	16	---

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

FY 2021 Authorization .....Expired

Allocation Method:

- Competitive grant/cooperative agreement

Program Description

The 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.

Following a plateau between 2000 and 2005, the infant mortality rate declined nearly 16 percent overall and 20 percent for non-Hispanic black infants between 2005 and 2017. However, the non-Hispanic black infant mortality rate continues to be more than twice that for non-Hispanic whites. The five leading causes of infant mortality include birth defects, preterm birth and low birthweight, maternal pregnancy complications, Sudden infant death syndrome, and injuries. There is a potential for reducing each of these causes of death, particularly among low-income families and communities. Preterm birth (defined as birth at less than 37 completed weeks of gestation) is a key risk factor for infant death. More than two-thirds of all infant deaths occur among infants born preterm. After declining from 2007 to 2014, the U.S. preterm birth rate increased nearly 4 percent from 9.57 percent in 2014 to 9.93 percent in 2017. Non-Hispanic black women continue to be more likely to experience preterm birth than non-Hispanic white women (13.93 and 9.05 percent, respectively, in 2017). Greater rates of preterm birth and preterm-related infant deaths among non-Hispanic blacks account for over half of the infant mortality gap compared to non-Hispanic whites. 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.

In FY 2019, Healthy Start funded 101 competitive grants in 34 States, the District of Columbia, and Puerto Rico. 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. For the FY 2019 competition, HRSA revised the program to a single funding level with a common set of expectations for all grantees in order to maximize the capacity of recipients to focus on service to pregnant women and infants. HRSA developed the single enhanced model and funding based on performance data from the current recipients as well as recipient input gathered at HRSA listening sessions. Recipient feedback indicated a desire to increase program capacity to serve more pregnant women during the project period and promote healthy pregnancy outcomes. Also for FY 2019, the program serves infants and families for the first 18 months after birth instead of up to 2 years after birth. This change allows the program to focus resources on its key purposes of infant mortality/women's health/perinatal health and associated milestones (e.g., provision of interconception care), while still ensuring support for children through critical milestones. This change also reflects feedback from current recipients in the field to increase program capacity to serve more pregnant women within the project period and promote healthy pregnancy outcomes.

Grantees use four 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) Improve family health and wellness to improve infant health and development;
3) Promote systems change to maximize opportunities for community action to address social determinants of health; and
4) Assure impact and effectiveness to conduct ongoing HS workforce development, data collection, 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 first 18 months after birth. 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, intimate partner 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, in-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; Title V State Maternal and Child Health Services 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 use 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 supported the Healthy Start Collaborative Improvement and Innovation Network (HS CoIIN), a collaborative learning partnership of 20 experienced grantees. This initiative strengthened the program by providing feedback to HRSA on how to effectively support Healthy Start grantees. In FY 2019, the Supporting Healthy Start Performance Project was awarded to a new provider to continue the EPIC Center and provide capacity building activities such as training, technical assistance, technology transfer, and information transfer/dissemination to Healthy Start programs.

Starting in FY 2019, Healthy Start also supports a new initiative to reduce maternal mortality through hiring of clinical service providers (e.g., nurse practitioners, certified nurse midwives, physician assistants, and other maternal-child advance practice health professionals) to provide clinical services, such as well-woman care and maternity care services, within program sites nationwide. These activities are funded through the additional $12 million provided to HRSA in the FY 2019 appropriation.

Program Accomplishments

Key program accomplishments highlighted below reflect FY 2018 outcomes among Healthy Start program participants.

This is the final year of data reporting for the cohort of grantees initially funded in FY 2014. Healthy Start serves high-risk women and their families in communities with elevated rates of infant mortality and adverse perinatal outcomes. The program met or exceeded two of the three performance measures for the program. The program did not meet its target for low birthweight births, though performance has remained stable since 2015, potentially reflecting the program's focus on reaching the highest risk populations.

- An important risk factor for infant mortality is the timing of entry into prenatal care. Healthy Start facilitates access to prenatal care for disadvantaged and high-risk women. In 2018, 77.8 percent of Healthy Start participants initiated prenatal care during the first trimester, exceeding the FY 2018 target of 75 percent.
- Low birth weight, or birth weight less than 2,500 grams, is a major contributor to infant mortality. In 2018, 10.3 percent of infants born to Healthy Start participants were low birth weight. Healthy Start did not meet the FY 2018 target of 9.6 percent. The percentage of low birth weight births in Healthy Start has remained relatively stable (approximately 10 percent) since 2015.
- The 2016-2018[145] infant mortality rate among Healthy Start participants was 6.99 per 1,000 live births which may reflect the high risk population targeted by the program. For comparison, the infant mortality rate in the United States for 2016-2017 was 5.83 per 1,000 live births (2018 data are not yet available from the Centers for Disease Control and Prevention (CDC)/National Center for Health Statistics (NCHS)).
- In addition, the program is now monitoring a multi-year infant mortality rate among the Healthy Start participants. This is the first year for which these data are being reported. In 2018, the number of individuals receiving case managed services through the program was 81,769. This exceeded the FY 2018 target of 69,000.

Consistent with the commitment to data-driven and evidence-based decision-making, in 2017, the Healthy Start program initiated a national evaluation to explore associations between program participation and participant-level characteristics, including behaviors, service use, and health outcomes. By collaborating with the CDC and state vital records offices, the evaluation was designed to examine the association between Healthy Start program participation and

[145] A multi-year infant mortality rate (IMR) is reported for 2016-2018. This allows the Healthy Start program to track infant mortality while taking into consideration that infant death is a rare event and when calculated within small populations, such as the Healthy Start program population, IMRs can appear to change substantially if there is even a small difference in the number of deaths within a single year. Such changes may be due to normal variation and are not necessarily caused by actual change in the underlying risk. The IMRs for the single years 2016 to 2018 are as follows:
2016: Healthy Start 5.57 per 1,000 live births, United States 5.87 per 1,000 live births
2017: Healthy Start 9.47 per 1,000 live births, United States 5.79 per 1,000 live births
2018: Healthy Start 6.26 per 1,000 live births, United States (data not yet available from CDC/NCHS)

maternal and infant outcomes using linked vital statistics and CDC Pregnancy Risk Assessment Monitoring System (PRAMS) data with a population-based external comparison group of non-participants. It is anticipated that findings from this evaluation will be made publicly available by the end of CY 2020.

Funding History

FY	Amount
FY 2017	$118,251,000[146]
FY 2018	$110,300,000
FY 2019	$121,962,000
FY 2020	$125,500,000
FY 2021	$125,500,000

Budget Request

The FY 2021 Budget Request for the Healthy Start program of $125.5 million is the same as the FY 2020 Enacted level. Within this total, funding is also continued at $15 million to allow grantees to hire clinical service providers at Healthy Start sites to provide direct access to well woman care and maternity care services. This will reduce barriers to care and better address health disparities among high-risk and underserved women. In FY 2021, the program will continue to serve women and families across the nation through the 101 grants awarded in the FY 2019 funding cycle. Healthy Start expects to serve at least 75,000 participants in FY 2021 with case management 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.

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, site visits and other program support costs.

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

Outcomes and Outputs Tables[147]

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
12.III.A.1: The percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester (Output)	FY 2018: 77.8% Target: 75% (Target Exceeded)	80%	80%	Maintain
12.III.A.2. Percent of singleton births weighing less than 2,500 grams (low birth weight) (Outcome)	FY 2018: 10.3% 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 (Output)	FY 2018: 81,769 Target: 69,000 (Target Exceeded)	70,000	75,000	+5,000

Grant Awards Table[148]

	FY 2019 Final[149]	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	101	101	101
Average Award	$1,043,748	$1,122,334	$1,100,000
Range of Awards	$154,262 - $1,092,899	$980,000 - $1,167,899	$1,100,000

[147] Fiscal year targets reflects calendar year data. Awards are made annually in April, thus the bulk of the data coincides with the fiscal year.
[148] Does not include grant offsets. Does not include $2M for the Supporting Healthy Start Performance Project.
[149] Does not include $4.9M for 13 awards, funded for 5 months, to get on cycle with remaining 87 awards in April. Does not include $2M for the HS CoIIN.

Heritable Disorders in Newborns and Children

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$16,311,000	$17,883,000	---	-$17,883,000
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 2021 Authorization……Expired

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 35 core 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 program is composed of six different projects.

- The **Newborn Screening Data Repository and Technical Assistance Program** 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 program also tracks and estimates the incidence of screened conditions. These data help the program 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 program 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; 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 newborn screening process or procedure that could negatively affect the quality, accuracy, or timeliness of newborn screening. 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 purpose of this program is to develop and deliver educational programs about newborn screening, counseling, testing, follow-up, treatment, and specialty services to parents, families, patient advocacy and support groups.
- 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.
- The Newborn Screening Interoperability portfolio includes 2 programs: the **State Newborn Screening Interoperability Planning Program** and the **Innovations in Newborn Screening Interoperability**. The purpose of these programs is to provide state newborn screening programs with expertise, training, and education in informatics and to support programs in the development and implementation of comprehensive data interoperability plans. The aim is to ensure accurate and timely data sharing between entities involved in the newborn screening system, including hospitals, providers, laboratories, registries, vital records and other state programs. The overall goal is to improve outcomes for newborns and children affected by a condition identified through newborn screening.

Until FY 2020, the Heritable Disorders in Newborns and Children program also supported the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (the Committee). The statutory authority for the Committee expired on September 30, 2019. All official business related to the Committee is halted at this time. The Committee previously provided national newborn screening guidance and standards as well as advised the Secretary on reducing mortality or morbidity from heritable disorders, conducted evidence-based reviews of conditions to recommend updates to the RUSP, and considered ways to ensure state and territory capacity to screen for RUSP conditions.

Since 2009, the program also supports the Clearinghouse of Newborn Screening Information 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 funding also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Funding History

FY	Amount
FY 2017	$13,850,000
FY 2018	$15,788,085
FY 2019	$16,311,000
FY 2020	$17,883,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Heritable Disorders in Newborns and Children program of $0 million is $17.883 million below the FY 2020 Enacted level. 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. The Budget includes an increase of $60.0 million in funding for Maternal and Child Health (MCH) Block Grant formula awards to states to provide states with additional flexibility to support activities previously funded through a number of MCH categorical grant programs, including the Heritable Disorders in Newborns and Children program.

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	17	22	---
Average Award	$763,590	$678,955	---
Range of Awards	$103,000-$3,300,000	$103,000-$3,300,000	---

Pediatric Mental Health Care Access

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$9,956,000	$10,000,000	$10,000,000	---
FTE	2	2	2	---

Authorizing Legislation – Public Health Service Act, § 330M (42 U.S.C. § 254c-19), as added by the 21st Century Cures Act, Section 10002 (P.L. 114-255)

FY 2021 Authorization……...$9,000,000

Allocation Method

- Competitive cooperative agreement

Program Description and Accomplishments

The Pediatric Mental Health Care Access Program promotes behavioral health integration in pediatric primary care by supporting the development of new, or the improvement of existing, statewide or regional pediatric mental health care telehealth access programs. These programs provide tele-consultation, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat and refer children with behavioral health conditions. This program works to address the shortages of psychiatrists, developmental-behavioral pediatricians, and other behavioral health clinicians who can identify behavioral disorders in children and adolescents and provide appropriate services through telehealth technologies that support and promote long-distance clinical health care, clinical consultation, patient and professional health-related education, public health and health administration.

A total of 13-20 percent of children living in the United States experience a mental disorder in a given year, and surveillance during 1994–2011 has shown the prevalence of these conditions to be increasing.[150] However, between 2010 and 2012, the percent of youth receiving any outpatient mental health service was estimated to be 13.3 percent.[151]

Compounding this, 34.3 percent of the U.S. population lives in a designated Mental Health Professional Shortage Area (population of designated MH HPSAs/U.S. population as of September 30, 2019) and only 27.2 percent of the need for mental health care in these Mental

[150] Centers for Disease Control and Prevention. Mental Health Surveillance Among Children – United States, 2005-2011. Morbidity and Mortality Weekly Report 2013:62(02), 1-35.
[151] Olfson, M, Druss, BG, Marcus, SC. Trends in Mental Health Care among Children and Adolescents. The New England Journal of Medicine. 2015:372, 2029-2038.

Health Professional Shortages Areas has been met.[152] Primary care physicians in these areas are often the first to identify behavioral health disorders and provide services. These primary care providers are able to identify severe behavioral health problems, but often have difficulty in identifying milder cases. This under-identification and lack of access to needed services may lead to conditions severe enough to impair child, adolescent, and family functioning, school performance, and safety.

Telehealth strategies, like the ones supported by the Pediatric Mental Health Care Access Program, connect primary care providers with specialty mental and behavioral health care providers and can be an effective means of increasing access to mental and behavioral health services for children and adolescents, especially those living in rural and other underserved areas. Results from this program are expected to be shared with the field and scaled up as feasible and appropriate.

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

Funding History

FY	Amount
FY 2018	$10,000,000
FY 2019	$9,956,000
FY 2020	$10,000,000
FY 2021	$10,000,000

Budget Request

The FY 2021 Budget Request for the Pediatric Mental Health Care Access program of $10 million the same as the FY 2020 Enacted level. The Budget Request will continue to support 21 statewide or regional pediatric mental health care telehealth access programs providing tele-consultation, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat and refer children with behavioral health conditions.

[152] Health Resources and Services Administration. Bureau of Health Workforce. Designated Health Professional Shortage Areas Statistics (September 30, 2019). Retrieved 12/2019. https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
52.1: Number of primary care providers enrolled in a statewide or regional pediatric mental health care access program. (Developmental) (Output)	FY 2019 (Baseline)[153]: 2,091	N/A	N/A	---
52.2: Percentage of primary care providers enrolled in a statewide or regional pediatric mental health care access program who receive tele-consultation on behavioral health conditions (Developmental) (Output)	FY 2019 (Baseline): 48.7%	N/A	N/A	---
52.3: Number of children and adolescents, 0-21 years of age, seen by primary care providers enrolled in a statewide or regional pediatric mental health care access program, who received at least one screening for a behavioral health condition using a standardized validated tool (Developmental) (Output)	FY 2019 (Baseline): 0	N/A	N/A	---
52.4: Among children and adolescents, 0-21 years of age, seen by primary care providers enrolled in a statewide or regional pediatric mental health care access program and who received at least one screening for a behavioral health condition using a standardized validated tool, the percentage who screened positive for a behavioral health condition (Developmental) (Output)	FY 2019 (Baseline): 0	N/A	N/A	---

[153] FY 2019 baseline data was collected via EHB Request for Information (RFI) from 8 of 21 grantees. All grantees will be reporting first year data in February 2020 via EHB RFI. Targets for FY 2020 and FY 2021 will be set at that time. These measures are being incorporated into the DGIS, and data will be collected from grantees using the NCC performance reports for future year reporting.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
52.5: Among children and adolescents, 0-21 years of age, seen by primary care providers enrolled in a statewide or regional pediatric mental health care access program, who screened positive for a behavioral health condition, the percentage who received treatment from the primary care providers or a referral to a behavioral clinician (Developmental) (Output)	FY 2019 (Baseline): 0	N/A	N/A	---

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	21	21	21
Average Award	$438,828	$440,569	$440,569
Range of Awards	$337,425 – $445,000	$337,425 - $445,000	$337,425 - $445,000

Screening and Treatment for Maternal Depression and Related Behavioral Disorders

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$4,978,000	$5,000,000	$5,000,000	---
FTE	1	1	1	---

Authorizing Legislation – Public Health Service Act, Section 317L-1, as added by the 21st Century Cures Act, Section 10005 (P.L. 114-255)

FY 2021 Authorization ……...……..$5,000,000

Allocation Method

- Competitive cooperative agreement

Program Description and Accomplishments

The Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program expands health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for maternal depression and related behavioral health disorders by providing training, real-time psychiatric consultation, and care coordination support to front-line health care providers, including in rural and underserved areas.

This program improves the mental health and well-being of pregnant and postpartum women and the social and emotional development of their infants. Experienced by one in seven women,[154] depression is the most common complication of pregnancy and within the first year of delivery.[155] Additionally, substance use can co-occur with mental disorders and is at least as common as many of the medical conditions typically screened for and managed during pregnancy.[156] These issues affect not only the mother, but can also affect the child's cognitive and emotional development. Intervening early and offering integrated services and support can prevent or reverse these affects.

[154] Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. Obstet Gynecol 2005;106:1071–83.
[155] American College of Obstetricians and Gynecologists 2015 committee opinion (Reaffirmed 2016), Screening for Perinatal Depression. Retrieved 7/2017 https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-ObstetricPractice/Screening-for-Perinatal-Depression
[156] Wright, T.E., Terplan, M., Ondersma, S.J., Boyce, C., Yonkers, K., et al. (2016). The role of screening, brief intervention, and referral to treatment in the perinatal period. American Journal of Obstetrics & Gynecology, 215(5), 539-547.

Despite the importance of screening and early intervention, these services are often unavailable due to limited access to behavioral health resources for front-line health care providers. A nationwide shortage of psychiatrists, especially perinatal psychiatrists, compounds this issue. Women in rural and medically underserved areas are especially vulnerable to these shortages and experience poorer health outcomes than urban women.

The Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program addresses these gaps by employing strategies such as telehealth to provide front-line health care providers with real-time psychiatric consultation and care coordination support, and training on evidence-based and culturally and linguistically appropriate screening, assessment, and treatment protocols. Project activities will increase universal screening in project areas, and improve access to treatment and referral for maternal depression and related behavioral health disorders, such as anxiety and substance use disorder, for pregnant and postpartum women.

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

Funding History

FY	Amount
FY 2018	$5,000,000
FY 2019	$4,978,000
FY 2020	$5,000,000
FY 2021	$5,000,000

Budget Request

The FY 2021 Budget Request for the Screening and Treatment for Maternal Depression and Related Behavioral Disorders program of $5 million is the same as the FY 2020 Enacted level. The Budget Request will continue to support 7 awards to expand health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for maternal depression and related behavioral health disorders by providing training, real-time psychiatric consultation, and care coordination support to front-line health care providers, including in rural and underserved areas.

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	7	7	7
Average Award	$646,210	$646,379	$646,379
Range of Awards	$627,525-$650,000	$627,525-$650,000	$627,525-$650,000

Family-To-Family Health Information Centers

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Mandatory Funding	$6,000,000	$6,000,000	$6,000,000	---
FTE	1	1	1	---

Authorizing Legislation - Social Security Act, Section 501(c)(1)(A) as amended by Public Law 114-10, Section 216, Public Law 115-123, Section 50501, and Public law 116-39

FY 2021 Authorization……...$6,000,000

Allocation Method:

- Competitive grant/co-operative agreement

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. Initially authorized by the Deficit Reduction Act of 2005, the program funded one health information center in each of the 50 states and the District of Columbia. Since then, F2F HICs have been developed in all territories and also for Indian tribes. Most recently, the Sustaining Excellence in Medicaid Act of 2019 reauthorized the program through FY 2024.

The 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.[157] 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.[158] 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 2018 F2F HICs provided services to 181,938 families, which exceeded the target of 174,300 families. In addition, in FY 2018, F2F HICs trained and provided information, resources, and referrals to 83,859 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.

Funding History

FY	Amount
FY 2017[159]	$4,655,000
FY 2018	$6,000,000
FY 2019	$6,000,000
FY 2020	$6,000,000
FY 2021	$6,000,000

Budget Request

The Family-to-Family Health Information Centers (F2F HICs) program is funded at $6 million for each fiscal year through FY 2024.

FY 2021 funding will support 59 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 2021 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

[157] 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

[158] Singer, G. H., Marquis, J., Powers, L. K., Blanchard, L., Divenere, N., Santelli, B., et al. (1999). A multi-site evaluation of parent to parent programs for parents of children with disabilities. *Journal of Early Intervention, 22*(3), 217-229 and Rearick, E. M., Sullivan-Bolyai, S., Bova, C., & Knafl, K. A. (2011).

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

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 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
15.III.C.1: Number of families with CYSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers (Output)	FY 2018: 181,938 [160] Target: 166,000 (Target Exceeded)	184,250	184,250	Maintain
15.III.C.2: Number of professionals who serve CYSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers (Developmental) (Output)	FY 2018: 83,859 [161]	84,700	84,700	Maintain
15.III.C.3: Percentage of families with CYSHCN served who report that the information or services received from Family-to-Family Health Information Centers helped prepare them to work with those who serve their children (Developmental) (Outcome)	FY 2018[162]: Baseline data available August 2020	N/A	N/A	---

[160] The data source for this measure was collected by Family Voices.
[161] Ibid.
[162] The data source for this measure will be collected from grantee surveys.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
15.III.C.4: Percentage of professionals served who reported the information or services received from the Family-to-Family Health Information Centers helped prepare them to work better with families of CYSHCN and/or others who serve CYSHCN (Developmental) (Outcome)	FY 2018[163]: Baseline data available August 2020	N/A	N/A	---

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	59	59	59
Average Award	$96,758	$96,750	$96,750
Range of Awards	$96,750-$97,200	$96,750	$96,750

[163] The data source for this measure will be collected from grantee surveys.

Maternal, Infant, and Early Childhood Home Visiting Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Mandatory Funding	$400,000,000	$376,400,000[164]	$400,000,000	---
FTE	38	38	38	---

Authorizing Legislation - Social Security Act, Section 511(j), as amended by Public Law 115-123, Section 50601

FY 2021 Authorization $400,000,000

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. Evidence-based home visiting can be cost-effective in the long term, with the largest benefits coming through reduced spending on government programs and increased individual earnings.[165]

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;

[164] FY 2020 reflects the post-sequestration funding amount.

[165] Michalopoulos, C, et. al. (2017). Evidence on the Long-Term Effects of Home Visiting Programs: Laying the Groundwork for Long-Term Follow-Up in the Mother and Infant Home Visiting Program Evaluation (MIHOPE). OPRE Report 2017-73. Available at: https://files.eric.ed.gov/fulltext/ED579153.pdf.

- Crime;
- Domestic violence;
- High rates of high school drop-outs;
- Substance abuse;
- Unemployment; or
- Child maltreatment.[166]

Grantees deliver services by implementing one or more of 17 evidence-based home visiting models, selected by the grantee, which meet HHS established evidence of effectiveness criteria and MIECHV criteria for implementation. Administered by the Administration for Children and Families (ACF), the Home Visiting Evidence of Effectiveness review (HomVEE)

While there is some variation across the 17 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.

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, which will be updated by October 1, 2020, as required under the Bipartisan Budget Act of 2018, 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.

MIECHV currently distributes funds for delivery of services under early childhood home visiting programs through two 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),

[166] 42 U.S.C. § 711(b)(1)(A).

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

Formula grants to states and territories

In FY 2019, HRSA awarded $351 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 2019, 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 ($12 million) is set aside for five-year competitive awards available to tribal entities. As of FY 2019, 29 tribal entities had received funding through the Tribal Home Visiting program, administered by ACF. There are currently 23 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).

Program Accomplishments

MIECHV state and territory grantees provided 5.2 million visits from FY 2012 through FY 2019. In FY 2019 states reported serving more than 154,000 parents and children in 896 counties across all 50 states, the District of Columbia, and five territories. This is a 350 percent increase in the number of participants served since FY 2012 (see Tables 1 and 2 below). Tribal grantees provided over 90,298 home visits from FY 2012 to FY 2018 and served over 3,751 parents and children in FY 2018.[167]

[167] FY 2018 is the most recently available data for Tribal grantees.

Table 1: Number of State/Territory Participants (FY 2012 – FY 2019)[168]

Fiscal Year	Number of Participants
2012	34,180
2013	75,970
2014	115,545
2015	145,561
2016	160,374
2017[169,170]	156,297
2018[171]	150,291
2019	154,496

Table 2: Number of Home Visits by State/Territory Grantees (FY 2012 – FY 2018)

Fiscal Year	Number of Home Visits
2012	174,257
2013	489,363
2014	746,303
2015	894,347
2016	979,521
2017[172,173]	942,676
2018[174]	930,595
2019	1,015,217

MIECHV currently serves approximately 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.

[168] 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).
[169] 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.
[170] Does not include data from Puerto Rico and the U.S. Virgin Islands due to reporting delays caused by Hurricanes Maria and Irma.
[171] Does not include data from the Commonwealth of the Northern Mariana Islands due to reporting delays caused by Super Typhoon Yutu.
[172] 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.
[173] Does not include data from Puerto Rico and the U.S. Virgin Islands due to reporting delays caused by Hurricanes Maria and Irma.
[174] Does not include data from the Commonwealth of the Northern Mariana Islands due to reporting delays caused by Super Typhoon Yutu.

MIECHV serves many at-risk families. In FY 2019:

- 70 percent of participating families had household incomes at or below 100 percent of the federal poverty guidelines ($25,750 for a family of four), and 41 percent were at or below 50 percent of those guidelines;
- 26 percent of adult program participants had less than a high school education, and 37 percent had only a high school degree or equivalent; and
- 12 percent of households included pregnant teens; 20 percent of households reported a history of child abuse and maltreatment; and 14 percent of households reported substance abuse.

Performance data collected to fulfill the statutory requirement of a three-year assessment of improvement[175] were most recently updated in FY 2016. These data indicate that 98 percent of states, territories, and non-profit grantees 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.

Following a redesign of the MIECHV performance measurement system, awardees began reporting on 19 standardized performance indicators and systems outcome measures in FY 2017. These new performance measures 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. Women enrolled in the MIHOPE evaluation faced 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. Released in November 2018,[176] findings from the MIHOPE Implementation Report include: that the local

[175] Performance data represent data submitted after three years of program implementation as required under Social Security Act, Title V, § 511(d)(1)(B)

[176] Duggan, Anne, Ximena A. Portilla, Jill H. Filene, Sarah Shea Crowne, Carolyn J. Hill, Helen Lee, and Virginia Knox (2018). *Implementation of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation*, OPRE Report # 2018-76A, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

programs that participated in MIHOPE served eligible families in disadvantaged communities with high levels of socioeconomic risk as intended by the program; most home visitors were well educated, trained and experienced; local programs focused on improving parenting and child development outcomes; and the tailoring of services to families' needs was especially evident in areas of substance use, mental health, and intimate partner violence. The MIHOPE Impact Report, released in January 2019,[177] presents evidence that MIECHV-funded home visiting services had positive effects for the families that participated in services, including in the quality of the home environment and the frequency of psychological aggression towards the child. The study provides evidence that differences in effects among the evidence-based models are generally consistent with the models' focuses.

Funding History

FY	Amount
FY 2017[178]	$372,400,000
FY 2018	$400,000,000
FY 2019	$400,000,000
FY 2020[179]	$376,400,000
FY 2021	$400,000,000

Budget Request

The Maternal, Infant, and Early Childhood Home Visiting Program is funded at $400 million for each fiscal year through FY 2022.[180] FY 2021 funding will support the state, territory, and tribal administration of locally run voluntary, evidence-based home visiting services for at-risk families that have been proven to help 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;
- Awards to 23 tribal entities; and
- Support for research, evaluation, and technical assistance for both corrective action and program improvement for state, territory, and tribal MIECHV grantees.

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

[177] Michalopoulos, Charles, Kristen Faucetta, Carolyn J. Hill, Ximena A. Portilla, Lori Burrell, Helen Lee, Anne Duggan, and Virginia Knox. 2019. *Impacts on Family Outcomes of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation.* OPRE Report 2019-07. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.
[178] FY 2017 reflects the post-sequestration funding amount.
[179] FY 2020 reflects the post-sequestration funding amount.
[180] FY 2020 and FY 2021 are subject to sequestration.

Home Visiting Research and Development Platform, the Home Visiting Collaborative Improvement and Innovation Network, a multi-site implementation study of Tribal Home Visiting, 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 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
37.1: Number of home visits to families receiving services under the MIECHV Program.[181] (*Output*)	State/ Territory/ Tribal: FY 2019[182]: 1,033,189 Target: 960,000 (Target Exceeded)	State/ Territory/ Tribal: 1,033,000	State/ Territory/ Tribal: 1,033,000	Maintain

[181] 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.

[182] Home Visiting Information System (HVIS). Results reflect the most recent data available, which include FY 2019 data for state and territory grants and FY 2018 data for Tribal grants.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
37.2: Number and percent of grantees that meet benchmark area data requirements for demonstrating improvement. (*Outcome)*	State/Territory: FY 2016: 55 (98%)[183] Target: 53 (95%) (Target Exceeded) Tribal: FY 2017: 24 (96%) Target: 20 (80%) (Target Exceeded)	State/ Territory: 55 (98%) Tribal: 22 (88%)	State/Territory: 55 (98%) Tribal: 22 (88%)	State/Territory: Maintain Tribal: Maintain
37.3: Number of participants served by the MIECHV Program (*Output)*	State/ Territory/Tribal: FY 2019[184]: 153,247 Target: 160,000 (Target Not Met)	State/ Territory/ Tribal: 160,000	State/ Territory/ Tribal: 160,000	Maintain
37.4: Percent of children enrolled in MIECHV who received daily early language and literacy support from a family member *(Developmental)*	FY 2019[185]: 72.6% (Baseline[186]): 65.4%	N/A	N/A	---
37.5: Percent of parents enrolled in MIECHV who were screened for depression after enrollment or after giving birth *(Developmental)*	FY 2019[187]: 80.0% Baseline[188]: 76.5%	N/A	N/A	---

[183] Ibid. Per statute, an initial assessment of improvement occurred after three years of program implementation. Current statute requires the next assessment of improvement following FY 2020, and every 3 years thereafter.
[184] Ibid. Results reflect the most recent data available, which includes FY 2019 data for state and territory grants and FY 2018 data for Tribal grants.
[185] Ibid. Results reflect state and territory grants only and reflect a two-year average from FY 2018 and FY 2019.
[186] Ibid. Results reflect state and territory grants only and reflect a two-year average from FY 2017 and FY 2018.
[187] Ibid. Results reflect state and territory grants only and reflect a two-year average from FY 2017 and FY 2018.
[188] Ibid. Results reflect state and territory grants only and reflect a two-year average from FY 2017 and FY 2018.

Grant Awards Tables[189]

	FY 2019 Final	FY 2020 Enacted[190]	FY 2021 President's Budget
Number of Awards	79	79	79
Average Award	$4,589,742	$4,297,152	$4,589,742
Range of Awards	$300,000-$20,813,184	$300,000-$20,813,184	$300,000-$20,813,184

[189] Does not include carryover funding.
[190] FY 2020 reflects post-sequestration funding

Ryan White
HIV/AIDS
TAB

RYAN WHITE HIV/AIDS

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (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 people with HIV. Sixty one percent of clients (patients) live at or below 100 percent of the Federal poverty level and approximately three-quarters of RWHAP clients are racial/ethnic minorities. The RWHAP statute indicates that the program is the "payor of last resort," meaning RWHAP funds can only be used for allowable services not covered by other Federal or state programs, or private insurance. Since 1990, RWHAP has developed a comprehensive system of safety net providers who deliver high quality direct health care and support services to over half a million people with HIV[191] – more than 50 percent of all people with diagnosed HIV in the United States.[192] This is one of the many reasons why HRSA is leading key components of the *Ending the HIV Epidemic: A Plan for America* - a 10-year initiative beginning in FY 2020.

Working within the RWHAP statute, funding priorities are guided by stakeholders at local and state levels, resulting in uniquely structured programs that address their jurisdictions' critical gaps and needs. HRSA also works in partnership with RWHAP recipients at state and local levels to use innovative, evidence informed approaches for community engagement, needs assessment, planning processes, policy development, service delivery, clinical quality improvement, and workforce development activities that are needed to support a robust system of HIV care, support and treatment.

The RWHAP provides HIV care and treatment services to a higher proportion of certain populations with HIV than their representation in the epidemic nationally. For example, according to the most recent Centers and Disease Control Prevention (CDC) data, 70 percent of people with diagnosed HIV in the United States are racial/ethnic minorities, while 73 percent of RWHAP clients are racial/ethnic minorities, meeting the target (to be within 3 points of the national percentage) by 3 percentage points.[193] Similarly, 24 percent of people with diagnosed HIV in the United States are women, while 27 percent of RWHAP clients are women, meeting the target (to be within 3 percentage points of the national percentage) by 3 percentage points.

The RWHAP is critical to ensuring that individuals with HIV are linked to care, retained in care, able to adhere to medication regimens, and ultimately, achieve viral suppression. These steps are not only crucial to ensuring the health outcomes of people with HIV but to preventing further

[191] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018. http://hab.hrsa.gov/data/data-reports. Published December 2019. Accessed December 2, 2019.
[192] Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 (Preliminary); vol. 30. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published November 2019. Accessed December 3, 2019.
[193] Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 (Preliminary); vol. 30. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published November 2019. Accessed December 3, 2019.

transmission of the virus,[194] which furthers the public health goal of ending the HIV epidemic in the United States.[195] Research studies demonstrate that people with HIV who take HIV medications daily as prescribed, and achieve and then maintain an undetectable viral load, have effectively no risk of sexually transmitting the virus to an HIV uninfected partner.[196,197] In the RWHAP, 87.1 percent of patients receiving RWHAP medical care are virally suppressed[198] compared to the general population of people with diagnosed HIV, who have a viral suppression rate of 62.7 percent,[199200] - an outcome measure that demonstrates the success of the program and results in major public health benefits.

According to a *Clinical Infectious Diseases* study, clients receiving care and support at RWHAP-funded facilities are associated with improved outcomes (such as viral suppression), compared to those not served by the RWHAP.[201] Furthermore, RWHAP patients are more likely to reach viral suppression regardless of other health care coverage (e.g., uninsured, Medicaid, Medicare, or private insurance). Not only do improved viral suppression rates reduce the transmission of HIV, they also result in significant cost-savings to the health care system.[202]

The RWHAP has made tremendous progress toward ending the HIV epidemic in the United States: from 2010 to 2018, HIV viral suppression among RWHAP patients has increased from 69.5 percent to 87.1 percent, and racial/ethnic, age-based, and regional disparities have decreased.[203] However, even with these positive outcomes, fully addressing the HIV epidemic domestically continues to be a challenge as the CDC estimates more than 1.1 million people in

[194] Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2010–2016. HIV Surveillance Supplemental Report, 2019; vol. 24. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published February 2019. Accessed August 23, 2019

[195] The goal of HIV treatment is to decrease viral load in people with HIV, ideally to an undetectable level, known as viral suppression. When viral suppression is achieved and maintained, the risk of transmitting HIV is reduced.

[196] 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.

[197] Rodger AJ et al for the PARTNER study group. Sexual activity without condoms and risk of HIV transmission in serodifferent couples when the HIV-positive partner is using suppressive antiretroviral therapy. JAMA, 2016;316(2):1-11. DOI: 10.1001/jama.2016.5148. (12 July 2016). Full free access.

[198] 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.

[199] Harris NS, Johnson AS, Huang YA, et al. *Vital Signs:* Status of Human Immunodeficiency Virus Testing, Viral Suppression, and HIV Preexposure Prophylaxis — United States, 2013–2018. MMWR Morb Mortal Wkly Rep 2019;68:1117–1123. DOI: http://dx.doi.org/10.15585/mmwr.mm6848e1

[200] Based on data reported by 41 States and the District of Columbia.

[201] 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.

[202]The lifetime cost of medical care and medications for a person with HIV 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.

[203] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2016. http://hab.hrsa.gov/data/data-reports. Published November 2017. Accessed July 20, 2018.

the United States have HIV, and almost 1 in 7 are unaware of their HIV.[204] In addition, approximately 40,000 HIV diagnoses occur every year.[205]

Ending the HIV Epidemic: A Plan for America

Beginning in FY 2020, the *Ending the HIV Epidemic*: *A Plan for America* (EHE) initiative aims to reduce new HIV infections to less than 3,000 per year by 2030. The multi-year EHE initiative will focus on 48 counties, Washington, D.C., San Juan (PR), as well as 7 states that have a substantial rural HIV burden. The initiative will bring the additional expertise, technology, and resources needed to end the HIV epidemic in the United States. The four Pillars of the initiative – Diagnose, Treat, Prevent, and Respond – will be implemented across the entire U.S. over the 10 years. Without this EHE initiative, new infections will continue and could increase, costing more lives and the U.S. government more than $200 billion in direct lifetime medical costs for HIV prevention and medication.

HRSA cooperative agreements will be awarded to the 39 RWHAP Part A recipients and 8 Part B recipients that encompass the 48 counties, Washington, D.C., San Juan (PR), as well as 7 states that have a substantial rural HIV burden. Jurisdictions will utilize their existing infrastructure to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States. Strategies for implementation are:

- Implementing evidence-informed practices shown to increase linkage, engagement, and retention in care targeted to those not yet diagnosed, those diagnosed but not in HIV care, and those who are in HIV care but not yet virally suppressed;
- Expand re-engagement and retention efforts for people with HIV who are not currently in care or who are not virally suppressed;
- Providing technical assistance and systems coordination to support effective strategic plans and activities to successfully implement the new initiative; and
- Expand workforce capacity through the efforts of the AIDS Education and Training Centers (AETCs).

The RWHAP's comprehensive system of HIV care and support services and effective system for medication delivery creates a very efficient and effective service delivery mechanism for this initiative.

Additional Priorities and Collaborative Efforts

In FY 2021, the HRSA RWHAP program will continue to ensure effective use of resources and a coordinated and focused public health response to HIV. HRSA will also continue to coordinate and collaborate with other federal, state, and local entities as well as national HIV organizations to further leverage and promote efforts to address the unmet care and treatment needs of people with HIV who are uninsured and underserved. These efforts help to align priorities, policies, and

[204] Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2010–2016. HIV Surveillance Supplemental Report 2019;24(No. 1). http://www.cdc.gov/ hiv/library/reports/hiv-surveillance.html. Published February 2019. Accessed December 4, 2019.
[205] Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 (Preliminary); vol. 30. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published November 2019. Accessed December 3, 2019.

activities in sustaining a multi-faceted and comprehensive Federal response to the HIV epidemic. Federal partners include the Office of the Assistant Secretary for Health (OASH), the Center for Disease Control (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 National HIV/AIDS Strategy (NHAS) for the United States: The NHAS provides a roadmap for federal, state, and local governments, national and community based organization, health care providers, people with HIV, and others. The goals are to reduce new HIV infections; increase access to care and improve health outcomes for people with HIV; reduce HIV-related health disparities and health inequities; and achieve a more coordinate national response to the HIV epidemic. The RWHAP will continue to coordinate with other Federal partners, grant recipients, and other partners to work towards achieving these four goals.

Perinatal Transmission: To achieve the Administration's goal of elimination of mother-to-child (perinatal) HIV transmission, the CDC and HRSA will continue efforts to invest in eliminating mother-to-child HIV transmission efforts, primarily through ongoing collaborations with state health departments and RWHAP providers.

Substance Use Disorder/Opioid Epidemic: In support of HHS's efforts to lead a national response to the opioid crisis, HRSA will continue to work collaboratively with other Federal partners to address opioid use disorder screening, treatment, and support for people with HIV.

Modernization

The Administration looks forward to working with the Congress to reauthorize the RWHAP to ensure that the allocation of Federal funds address the changing landscape of HIV across the United States. The FY 2021 Budget Request includes the following statutory changes through the RWHAP authorization which will also help support the Ending the HIV Epidemic initiative:

RWHAP Part A and B Supplemental Funding Methodologies: Reauthorization of the RWHAP should include changes to the funding methodologies for Parts A and B Supplemental funding to ensure that funds may be allocated to target populations experiencing high or increasing levels of HIV infections/diagnoses, such as minority populations, while continuing to support Americans with HIV across the nation. African Americans, for example, account for a higher proportion of new HIV diagnoses compared to other races/ethnicities. This data-driven approach would reduce burden for recipients and increase HHS's ability to effectively focus resources for HIV care, treatment, and support needs in states and eligible metropolitan areas based on metrics of need, geography, data quality, and performance.

Simplification and Modernization: The proposed changes would simplify, modernize and standardize certain statutory requirements and definitions for consistency across RWHAP

Parts. This would reduce burden, align and consolidate the differing provisions, eliminate those provisions in the statute that are no longer current as well as update certain provisions to make the statute more consistent with the current state of the US epidemic, and better direct resources to the jurisdictions where clients are currently residing. An example is modernizing data collection for the RWHAP to include the collection and submission of patient residential zip codes in order to better understand geographic distribution of patient demographics, outcomes and service utilization; understand the impact of the RWHAP by geographic location, including urban and rural differences; and display RWHAP patient data in alignment with CDC HIV surveillance data to determine shifts and trends. RWHAP patient level data is de-identified and encrypted prior to submission to HRSA so appropriate privacy protections are in place to ensure patient privacy and confidentiality.

Measuring Future Performance

Together, in FY 2021 RWHAP Parts A-D programs are anticipated to achieve the following performance goals:

- In FY 2021, the RWHAP will serve racial/ethnic minorities at a proportion not lower than 3 percentage points of national HIV prevalence data as reported by CDC.
- In FY 2021, 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.
- In FY 2021, at least 83 percent of all patients receiving HIV medical care and at least one viral load test will be virally suppressed.

Additional RWHAP Part-specific performance targets are in the sections that follow.

Outcomes and Outputs Table for Over-Arching Performance Measures

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
16.I.A.1: Percentage of people with diagnosed HIV served by the Ryan White HIV/AIDS Program who are racial/ethnic minorities.*(Output)*	2018: 73% Target: Within 3 percentage points of CDC data or 70% (Target Met)	Not lower than 3 percentage points of CDC data	Not lower than 3 percentage points of CDC data	Maintain
16.I.A.2: Percentage of people with diagnosed HIV served by the Ryan White HIV/AIDS Program who are women.*(Output)*	2018: 27% 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. *(Outcome)*	2018: 87.1% Target: 83% (Target Exceeded)	83%	83%	Maintain

RWHAP Part A - Emergency Relief Grants

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$655,876,000	$655,876,000	$655,876,000	---
MAI (non add)	$54,105,000	$54,105,000	$54,105,000	---
Total Funding	$655,876,000	$655,876,000	$655,876,000	---
FTE	44	44	44	---

Authorizing Legislation: Public Health Service Act, Section 2601, as amended by Public Law 111-87

FY 2021 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 areas 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. Seventy-two percent of all people with diagnosed HIV reside in a RWHAP Part A EMA or TGA.[206,207]

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 with HIV. The RWHAP requires EMAs and TGAs to utilize local needs assessments and planning processes to develop coordinated systems of HIV care in order to improve health outcomes for low-income people with HIV, thereby reducing transmission of HIV.

[206] Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 (Preliminary); vol. 30. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published November 2019. Accessed December 3, 2019.

[207] Centers for Disease Control and Prevention. HIV/AIDS data through December 2017 provided for the Ryan White HIV/AIDS Program, for fiscal year 2019. *HIV Surveillance Supplemental Report 2019*;24(No. 6). http://www.cdc.gov/hiv/library/reports/surveillance/. Published November 2019. Accessed December 3, 2019.

RWHAP Part A prioritizes primary medical care, access to antiretroviral treatment, and other core medical and supportive services in order to engage and retain people with HIV in care. The grants fund systems of care to provide services for people with HIV in 24 EMAs, which are jurisdictions with 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 people with diagnosed 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 RWHAP Parts A – D, and Part F AIDS Education and Training Center programs to evaluate and address the disproportionate impact of HIV 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 with diagnosed 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. Seventy-five percent of RWHAP Part A funds must be used to support core medical services. Eligible sub-recipients are community health centers, health departments, ambulatory care facilities, and other non-profit organizations providing services for people with HIV.

In 2018, 77 percent of RWHAP Part A clients were racial/ethnic minorities and 25 percent were women. In 2018, RWHAP Part A funded sites provided 3.6 million core medical service visits for health-related care utilizing a combination of RWHAP Parts A, B, C, and D funding. The number of visits for health-related services demonstrates the scope of RWHAP Part A in delivering primary care and related services for people with HIV by increasing the availability and accessibility of care.

Ending the HIV Epidemic: RWHAP Part A Jurisdictions

Thirty nine of the RWHAP Part A jurisdictions will receive a cooperative agreement to implement EHE initiative activities related to Pillar Two (Treat) and Pillar Four (Respond) in 2020. Jurisdictions will utilize their existing infrastructure to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States. The EHE initiative is more specifically addressed in the last section of this document.

RWHAP Part A Funding History

FY	Amount
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	$655,876,000
FY 2019	$655,876,000
FY 2020	$655,876,000
FY 2021	$655,876,000

Budget Request

The FY 2021 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part A of $655.9 million is equal to the FY 2020 Enacted level. This request will continue to support the provision of core medical and support services for people with HIV in the 24 EMAs and 28 TGAs.

The FY 2021 funding request proposes statutory changes through RWHAP authorization to the RWHAP Part A Supplemental funding methodology. These changes would allow HRSA to utilize a data driven framework developed by the Secretary to distribute RWHAP Part A Supplemental funding. This would ensure the allocation of funds to areas experiencing high or increasing of need while continuing to support people 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 in funded cities based on need, geography, data quality, and performance.

In 2018, 68 percent of all RWHAP clients were served by one of the 52 metropolitan areas funded under the RWHAP Part A. Approximately 72 percent of all people with diagnosed HIV reside within these metropolitan areas. The RWHAP serves populations that are diverse with multiple structural barriers to care (e.g., people with HIV at or below 100 percent Federal Poverty Level and/or those who are homeless).

The FY 2021 funding request will support the RWHAP Part A in achieving its target of providing 3.6 million core medical service visits for health-related care. 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 across service providers to develop and maintain a system of services, and serving diverse populations.

RWHAP Part A funding will also contribute to achieving the FY 2021 targets for performance goals that relate to cross-cutting activities, such as the percentage of racial/ethnic minorities and women served, percentage of clients who achieved viral suppression, and percentage of HIV-positive pregnant women served by RWHAP who receive antiretroviral medications.

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.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
17.I.A.2: Number of RWHAP Part A visits for health-related care.[208] *(Output)*	2018: 3.6M Target: 3.7M (Target Not Met)	3.6M	3.6M	Maintain

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	52	52	52
Average Award	$12,083,109	$12,083,109	$12,083,109
Range of Awards	$2,844,248 - $94,232,524	$2,844,248 - $94,232,524	$2,844,248 - $94,232,524

[208] This measure reports on core medical services. It replaces measure 17.I.A.1 that reported on only a subset of core medical services.

RWHAP Part A – FY 2019 Formula, Supplemental & MAI Grants[209]

Table 1. Eligible Metropolitan Areas

EMAs	Formula[210]	Supplemental	MAI	Total
Atlanta, GA	$16,691,703	$8,452,077	$2,547,018	$27,690,798
Baltimore, MD	$9,695,480	$5,411,707	$1,580,857	$16,688,044
Boston, MA	$9,276,289	$4,630,725	$1,018,413	$14,925,427
Chicago, IL	$16,680,261	$8,641,209	$2,366,011	$27,687,481
Dallas, TX	$11,191,253	$5,434,406	$1,436,623	$18,062,282
Detroit, MI	$5,790,139	$3,080,209	$823,800	$9,694,148
Ft. Lauderdale, FL	$9,536,333	$5,144,428	$1,244,179	$15,924,940
Houston, TX	$14,661,280	$7,404,298	$2,207,383	$24,272,961
Los Angeles, CA	$26,722,640	$13,682,879	$3,563,360	$43,968,879
Miami, FL	$15,481,459	$8,501,723	$2,613,762	$26,596,944
Nassau-Suffolk, NY	$3,260,952	$1,801,337	$431,322	$5,493,611
New Haven, CT	$3,260,952	$1,855,957	$446,012	$5,562,921
New Orleans, LA	$4,669,870	$2,653,985	$639,145	$7,963,000
New York, NY	$54,691,411	$30,924,433	$8,616,680	$94,232,524
Newark, NJ	$7,237,024	$4,040,968	$1,226,433	$12,504,425
Orlando, FL	$6,219,212	$3,066,489	$800,632	$10,086,333
Philadelphia, PA	$13,327,254	$7,480,747	$1,967,913	$22,775,914
Phoenix, AZ	$6,080,869	$3,074,432	$583,640	$9,738,941
San Diego, CA	$7,166,812	$3,591,710	$736,649	$11,495,171
San Francisco, CA	$9,329,858	$5,262,445	$766,126	$15,358,429
San Juan, PR	$6,175,525	$3,512,228	$1,169,745	$10,857,498
Tampa-St. Petersburg, FL	$6,254,578	$3,441,787	$666,355	$10,362,720
Washington, DC-MD-VA-WV	$18,150,030	$10,321,593	$2,821,388	$31,293,011
West Palm Beach, FL	$4,368,739	$2,361,937	$644,568	$7,375,244
Subtotal EMAs	**$285,919,923**	**$153,773,709**	**$40,918,014**	**$480,611,646**

[209] Awards to EMAs and TGAs include prior year unobligated balances.

[210] Hold Harmless expired in FY 2014.

Table 2. Transitional Grant Areas

TGAs	Formula	Supplemental	MAI	Total
Austin, TX	$3,163,723	$1,584,058	$351,071	$5,098,852
Baton Rouge, LA	$2,737,398	$1,361,121	$441,871	$4,540,390
Bergen-Passaic, NJ	$2,395,612	$1,270,028	$343,382	$4,009,022
Charlotte-Gastonia, NC-SC	$3,852,999	$1,861,271	$571,317	$6,285,587
Cleveland, OH	$2,923,072	$1,469,004	$377,592	$4,769,668
Columbus, OH	$2,964,045	$1,475,196	$287,778	$4,727,019
Denver, CO	$4,874,726	$2,494,410	$379,859	$7,748,995
Fort Worth, TX	$2,899,215	$1,437,985	$365,761	$4,702,961
Hartford, CT	$1,883,193	$1,057,448	$255,934	$3,196,575
Indianapolis, IN	$2,767,479	$1,385,089	$293,989	$4,446,557
Jacksonville, FL	$3,609,756	$1,849,173	$499,249	$5,958,178
Jersey City, NJ	$2,944,855	$1,644,459	$458,138	$5,047,452
Kansas City, MO	$2,675,161	$1,360,729	$269,638	$4,305,528
Las Vegas, NV	$4,035,043	$2,040,343	$446,899	$6,522,285
Memphis, TN	$4,009,630	$1,995,994	$666,355	$6,671,979
Middlesex-Somerset-Hunterdon, NJ	$1,664,326	$947,452	$232,470	$2,844,248
Minneapolis-St. Paul, MN	$3,675,623	$1,797,242	$364,578	$5,837,443
Nashville, TN	$2,507,639	$1,275,778	$271,511	$4,054,928
Norfolk, VA	$3,526,254	$1,742,613	$519,558	$5,788,425
Oakland, CA	$4,386,683	$2,247,171	$562,345	$7,196,199
Orange County, CA	$3,961,396	$1,997,575	$441,082	$6,400,053
Portland, OR	$2,590,104	$1,315,992	$139,502	$4,045,598
Riverside-San Bernardino, CA	$4,976,383	$2,542,054	$525,079	$8,043,516
Sacramento, CA	$2,151,850	$1,094,768	$198,063	$3,444,681
Saint Louis, MO	$3,899,159	$1,870,471	$470,067	$6,239,697
San Antonio, TX	$3,404,373	$1,685,372	$513,051	$5,602,796
San Jose, CA	$1,931,945	$990,978	$232,174	$3,155,097
Seattle, WA	$4,473,815	$2,204,638	$347,818	$7,026,271
Subtotal TGAs	**$90,885,457**	**$45,998,412**	**$10,826,131**	**$147,710,000**
Subtotal EMAs/TGAs	**$376,805,380**	**$199,772,121**	**$51,744,145**	**$628,321,646**

RWHAP Part B - HIV Care Grants to States

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$1,315,005,000	$1,315,005,000	$1,315,005,000	---
MAI (non add)	$10,145,000	$10,145,000	$10,145,000	---
ADAP (non add)	$900,313,000	$900,313,000	$900,313,000	---
Total Funding	$1,315,005,000	$1,315,005,000	$1,315,005,000	---
FTE	59	59	59	---

Authorizing Legislation: Public Health Service Act, Section 2611, as amended by Public Law 111-87

FY 2021 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 and provides grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and five Associated Pacific Jurisdictions to provide services for people with HIV. 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.

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 prevalent HIV 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 RWHAP 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 prevalent HIV cases. In addition, ADAP supplemental funds are a five percent set aside for states with severe need. ADAP provides FDA-approved prescription medications for people with HIV 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 people with HIV 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 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.

In 2018, 71 percent of RWHAP Part B clients were racial/ethnic minorities, and 26 percent were women. Seventy-five percent of RWHAP Part B funds must be used to support core medical services and in 2018, RWHAP Part B funded sites provided 2.2 million core medical service visits for health-related care utilizing RWHAP Parts A, B, C, and D funding. The number of visits for health-related services demonstrates the scope of RWHAP Part B in delivering primary care and related services for people with HIV by increasing the availability and accessibility of care.

Ending the HIV Epidemic - States

Seven RWHAP Part B recipients and the state of Ohio (on behalf of Hamilton County, which is currently not part of an EMA/TGA), will receive a cooperative agreement to implement EHE initiative activities related to Pillar Two (Treat) and Pillar Four (Respond) in 2020. Jurisdictions will utilize their existing infrastructure to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States. The EHE initiative is more specifically addressed in the last section of this document.

AIDS Drug Assistance Program

The RWHAP Part B has been successful in helping to ensure that people with HIV have access to the care and treatment services they need to live longer, healthier lives. According to the RWHAP ADAP Report, ADAPs, which are run by states and territories, continue to provide robust formularies of antiretroviral medications to treat HIV infection, prevent and treat opportunistic infections, manage side effects, and treat co-morbidities. 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 people with HIV have access to regular care, are started on, and adhere to, their antiretroviral medications.

According to the RWHAP ADAP data, the number of people with HIV receiving ADAP services has grown 37% over the last eight years from 208,809 clients in 2010, to 285,101 clients in 2018, exceeding the FY 2018 target by 25,570. In FY 2018, the RWHAP ADAP provided medication and health care coverage assistance for 28% of people diagnosed with HIV in the United States and 69 percent of the clients served by ADAPs were racial/ethnic minorities. Nationally, 82 percent of ADAP clients had incomes at or below 250 percent of the Federal poverty level.

ADAP Cost Containment: Increased demand for RWHAP ADAP services has led States to implement cost-containment strategies for their ADAPs. Cost-containment measures include using drug-purchasing strategies such as cost recovery through drug rebates and third party billing and directly negotiating pharmaceutical pricing. In addition, states have implemented cost-savings strategies such as recovering costs when another payor was primary, coordinating benefits with Medicare Part D, and improving drug-purchasing models. ADAPs have reported significant savings by participating in manufacturer rebate programs and recovering costs through insurance reimbursement.

Across the RWHAP, grant recipients are encouraged to maximize resources and leverage efficiencies. One example of this is within RWHAP Part B, where ADAPs use a variety of the above-mentioned strategies to maximize resources, which result in effective funds management, enabling ADAPs to serve more people. In 2018, ADAPs participating in cost-savings strategies on medications saved $2.1 billion, meeting the FY 2018 performance target by sustaining the results from the prior year. Over the last 5 years, ADAPs participating in medication cost-savings strategies saved $6.5 billion.

Elimination of ADAP Waiting Lists: Because of investments in RWHAP Part B, ADAP and the increased technical assistance activities for cost-containment measures, ADAP waiting lists decreased from a peak of 9,310 in September 2011, to zero in August 2015. Since FY 2010, HHS has taken several actions to stabilize the ADAP, including using emergency authority to target States with waiting lists or potential waiting lists, and to implement cost containment and cost savings measures.

In FY 2021, HRSA will continue the use of RWHAP 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 is particularly important as EHE initiative efforts diagnose more people with HIV and engage people who are out of HIV care and treatment. This funding also addresses the gaps in access created by ongoing cost-containment measures in many ADAPs such as HIV medication formulary reductions, lower client financial eligibility levels, and capped enrollment. However, with no individuals on the ADAP waiting lists, states requested and HRSA distributed $51.21 million in ERF funding in FY 2019. These funds are required to be used for 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 RWHAP Part B supplemental funds to assist in meeting shortfalls.

Due to availability of effective HIV medications, mother-to-child transmission in the United States has decreased dramatically since its peak in 1992 due to 1) an increased focus on HIV testing 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 2018, 99 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 2018 performance target by 9 percentage points. The RWHAP ADAP plays a crucial role that ensures access to HIV medications for pregnant women.

Funding History

FY	Amount	ADAP (Non-Add)
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	$1,309,251,000	($894,559,000)
FY 2019	$1,315,005,000	($900,313,000)
FY 2020	$1,315,005,000	($900,313,000)
FY 2021	$1,315,005,000	($900,313,000)

Budget Request

The FY 2021 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part B of $1.3 billion is equal to the FY 2020 Enacted level. This request includes $900.3 million for RWHAP ADAPs to provide access to life saving HIV related medications and direct health care services to people with HIV in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam and five Associated Pacific Jurisdictions. HRSA will continue to utilize the 311 authority to implement the Emergency Relief Fund to prevent, reduce, or eliminate ADAP waiting lists through cost containment and/or cost savings measures.

The FY 2021 Request re-proposes statutory changes through the RWHAP authorization to the RWHAP Part B Supplemental funding methodology. These changes would allow HRSA to utilize a data driven framework developed by the Secretary to distribute RWHAP Part B Supplemental funding. This would ensure the allocation of funds to areas experiencing high or increasing of need while continuing to support people 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 services based on need, geography, data quality, and performance.

As part of the program's efforts to continue to provide access to life-saving medications and related services for low-income people with HIV, the RWHAP has established a target for FY 2021 of serving at least 285,000 RWHAP ADAP clients. This target is based on anticipated steady funding - not demand. While the number of 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.

An important contributing factor to the demand for services for RWHAP ADAP continues to be access to HIV medications and high cost-sharing requirements for these medications. In order to meet this demand, the number of ADAPs participating in cost-savings strategies on medications will need to remain steady (the FY 2021 target is to maintain the previous year's output measure).

The FY 2021 funding request will support the RWHAP Part B in achieving its target of providing 2.2 million core medical service visits for health-related care. RWHAP Part B grant recipients will continue to work directly with uninsured people with HIV 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. ADAP resources will also support the continued:

- increase in RWHAP clients as more people with HIV are diagnosed, linked to care, and retained in care;
- increase in RWHAP growth as more people enter the health care system with coverage who require assistance with insurance premiums and cost-sharing; and,
- need for medication and/or health care coverage assistance for clients who remain uninsured.

HRSA and the CDC continue to collaborate to accelerate the elimination of perinatal HIV transmission in the United States. The FY 2021 funding request will support RWHAP ADAP to ensure that at least 96% of HIV-positive pregnant women served by the RWHAP will receive antiretroviral medications. RWHAP Part B funding will also contribute to achieving the FY 2021 targets for performance goals that related to cross-cutting activities, such as the percentage of racial/ethnic minorities and women served, and percentage of clients who achieved viral suppression.

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.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
18.I.A.2: Number of RWHAP Part B visits for health-related care.[211] *(Output)*	2018: 3.0M Target: 3.6M (Target Not Met)	3M	3M	Maintain
16.II.A.1: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. *(Output)*	2018: 285,101 Target: 259,531 (Target Exceeded)	285,000	285,000	Maintain
16.E: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. *(Efficiency's)*	2018: $2.1B Target: Sustain Prior Year Results or $2.1B (Target Met)	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.[212] *(Output)*	2018: 98% Target: 90% (Target Exceeded)	96%	96%	Maintain

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	59	59	59
Average Award	$22,335,070	$22,335,070	$22,335,070
Range of Awards	$50,000-$156,380,340	$50,000-$156,380,340	$50,000-$156,380,340

[211] This measure reports on core medical services. It replaces measure 18.I.A.1 that reported on only a subset of core medical services.
[212] This RWHAP overarching performance measure applies to RWHAP Parts A, B, C, and D and is not Part B specific.

RWHAP Part B – FY 2019 State Table[213]

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Alabama	$8,100,933	$2,010,447	$10,470,766	$316,265	$162,065	$21,060,476
Alaska	$500,000	$167,158	$573,082	$0	$0	$1,240,240
American Samoa	$50,000	$0	$788	$0	$0	$50,788
Arizona	$4,224,934	$3,367,621	$12,077,287	$0	$0	$19,669,842
Arkansas	$3,431,552	$0	$4,547,606	$0	$54,603	$8,033,761
California	$33,423,848	$6,375,772	$115,062,843	$167,898	$1,349,979	$156,380,340
Colorado	$3,409,873	$0	$9,680,906	$0	$83,415	$13,174,194
Connecticut	$2,699,111	$0	$8,582,828	$0	$0	$11,281,939
Delaware	$1,990,013	$427,043	$2,572,168	$192,153	$39,803	$5,221,180
Dist. of Columbia	$3,527,427	$0	$10,408,704	$0	$214,134	$14,150,265
F States Micronesia	$50,000	$0	$0	$0	$0	$50,000
Florida	$30,354,143	$5,919,497	$98,590,089	$472,350	$1,355,784	$136,691,863
Georgia	$14,641,185	$3,185,196	$54,479,256	$169,788	$659,283	$73,134,708
Guam	$200,000	$0	$88,288	$0	$0	$288,288
Hawaii	$1,613,722	$0	$2,085,797	$0	$23,459	$3,722,978
Idaho	$589,137	$2,362,242	$3,751,777	$0	$0	$6,703,156
Illinois	$9,549,487	$0	$35,693,840	$0	$456,274	$45,699,601
Indiana	$3,661,472	$4,910,680	$8,617,512	$0	$0	$17,189,664
Iowa	$1,470,402	$4,640,925	$5,807,994	$0	$0	$11,919,321
Kansas	$1,106,691	$3,563,449	$2,515,412	$0	$0	$7,185,552
Kentucky	$4,180,674	$0	$5,403,681	$278,150	$50,073	$9,912,578
Louisiana	$6,566,114	$0	$17,205,858	$0	$276,993	$24,048,965
Maine	$777,587	$766,952	$1,005,061	$0	$0	$2,549,600
Marshall Islands	$50,000	$0	$788	$0	$0	$50,788
Maryland	$7,823,385	$6,214,714	$25,662,560	$0	$472,434	$40,173,093
Massachusetts	$5,194,169	$2,738,613	$15,745,957	$0	$197,907	$23,876,646
Michigan	$5,108,493	$0	$13,401,603	$0	$192,370	$18,702,466
Minnesota	$2,068,277	$2,282,268	$6,371,693	$0	$70,142	$10,792,380
Mississippi	$5,876,638	$2,206,599	$10,322,134	$281,378	$135,686	$18,822,435
Missouri	$3,519,801	$0	$10,157,817	$0	$0	$13,677,618
Montana	$500,000	$388,101	$371,281	$0	$0	$1,259,382
N. Marianas	$50,000	$8,575	$5,518	$0	$0	$64,093
Nebraska	$1,259,386	$0	$1,627,805	$0	$0	$2,887,191
Nevada	$2,251,175	$0	$6,914,820	$0	$82,895	$9,248,890

[213] Awards include prior year unobligated balances.

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
New Hampshire	$275,060	$0	$826,355	$0	$0	$1,101,415
New Jersey	$10,066,553	$1,263,597	$29,726,948	$0	$509,250	$41,566,348
New Mexico	$1,858,281	$0	$2,401,899	$0	$0	$4,260,180
New York	$33,082,619	$9,985,945	$101,488,310	$587,721	$1,738,108	$146,882,703
North Carolina	$11,519,837	$2,762,432	$26,429,353	$305,004	$379,387	$41,396,013
North Dakota	$500,000	$108,362	$266,440	$0	$0	$874,802
Ohio	$7,221,439	$0	$17,305,181	$338,316	$0	$24,864,936
Oklahoma	$3,644,596	$0	$4,710,780	$230,899	$0	$8,586,275
Oregon	$41,305	$0	$4,074,705	$0	$0	$4,116,010
Pennsylvania	$10,726,651	$0	$27,711,308	$274,763	$413,971	$39,126,693
Puerto Rico	$5,655,258	$6,685,566	$29,639,890	$0	$311,896	$42,292,610
Republic of Palau	$50,000	$0	$7,095	$0	$0	$57,095
Rhode Island	$1,505,774	$1,625,709	$1,946,271	$190,342	$22,855	$5,290,951
South Carolina	$10,270,867	$5,946,187	$13,526,940	$564,017	$222,138	$30,530,149
South Dakota	$500,000	$0	$1,519,168	$0	$0	$2,019,168
Tennessee	$4,963,282	$0	$13,417,368	$0	$187,285	$18,567,935
Texas	$24,201,455	$0	$84,178,158	$0	$1,079,244	$109,458,857
Utah	$1,780,827	$1,027,268	$3,624,724	$0	$0	$6,432,819
Vermont	$500,000	$329,891	$403,601	$0	$0	$1,233,492
Virgin Islands	$342,169	$0	$368,506	$0	$9,514	$720,189
Virginia	$6,965,287	$0	$17,978,375	$370,525	$273,587	$25,587,774
Washington	$3,637,552	$3,691,384	$10,012,773	$0	$85,982	$17,427,691
West Virginia	$1,005,628	$2,623,704	$1,407,086	$0	$0	$5,036,418
Wisconsin	$3,616,794	$2,041,035	$4,698,956	$260,431	$57,221	$10,674,437
Wyoming	$500,000	$0	$249,886	$0	$0	$749,886
Total	$314,250,863	$89,626,932	$897,723,595	$5,000,000	$11,167,737	$1,317,769,127

RWHAP Part C - Early Intervention Services

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$201,079,000	$201,079,000	$201,079,000	---
MAI (non add)	$71,012,000	$71,012,000	$71,012,000	---
Total Funding	$201,079,000	$201,079,000	$201,079,000	---
FTE	52	52	52	---

Authorizing Legislation: Public Health Service Act, Section 2651, as amended by Public Law 111-87

FY 2021 Authorization……..……..…….…...Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

HRSA's Ryan White HIV/AIDS Program (RWHAP) Part C provides grants directly to community and faith-based organizations, 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 with HIV.

Minority AIDS Initiative (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 on, racial and ethnic minorities. RWHAP Part C MAI funding supports HIV care, treatment, and support services to racial/ethnic minorities. RWHAP 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 people with HIV disproportionately affected by the HIV epidemic and who have poor health outcomes, including ethnic and minority populations and youth. In 2018, RWHAP Part C funded sites served over 320,000 clients utilizing a combination of RWHAP Parts A, B, C, and D funding. Of the total clients served, 73 percent were racial/ethnic minorities and 26 percent were female.

The RWHAP has a history of creating effective patient-centered services that support strong provider and patient relationships. Providers funded through RWHAP Part C have the clinical

expertise and cultural competency to provide quality care and treatment to low-income, diverse people with HIV. In 2018, RWHAP Part C funded sites provided 2.2 million medical service visits for health-related care utilizing a combination of RWHAP Parts A, B, C, and D funding. The number of visits for health-related services demonstrates the scope of RWHAP Part C in delivering primary care and related services for people with HIV by increasing the availability and accessibility of care.

Expansion of Services

In 2018, HRSA expanded access to HIV care and treatment by funding 10 new RWHAP Part C clinics to provide comprehensive medical care and support services. Six of the ten new recipients are located in the southern United States, where there is the greatest burden of new HIV diagnoses, HIV cases, and deaths from HIV. Expanding patient access to direct HIV care services is a priority for HRSA.

Funding History

FY	Amount
FY 2012[214]	$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	$201,079,000
FY 2019	$201,079,000
FY 2020	$201,079,000
FY 2021	$201,079,000

Budget Request

The FY 2021 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part C of $201.1 million is equal to the FY 2020 Enacted level. This funding will support comprehensive medical, treatment and support services necessary to achieve improved health outcomes, such as improved viral suppression rates, essential to ending the HIV epidemic.

RWHAP Part C supports direct health care services for low income people with HIV who are uninsured or underserved. These services are considered essential to improving health outcomes and are a crucial part of the care network that links and retains people with HIV into health care. Such critical health care services include intensive case management and care coordination services, linking and retaining people with HIV into care, and getting them on antiretroviral medications as early as possible.

[214] Reflects Ryan White Budget Authority only (does not include $5.089 million in Health Center Program Budget Authority for RWHAP Part C grant recipients in FY 2012).

The funding request will support the RWHAP Part C in achieving its target of providing 2.2 million visits for health-related care in FY 2021. RWHAP Part C funding will also contribute to achieving the FY 2021 targets for performance goals that relate to cross-cutting activities, such as percentage of racial/ethnic minorities and women served, percentage of clients who achieved viral suppression, and percentage of HIV-positive pregnant women served by the RWHAP who receive antiretroviral medications.

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.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
19.II.A.3: Number of RWHAP Part C visits for health-related care.[215] *(Output)*	2018: 2.2M Target: 3.8M (Target Not Met)	2.2M	2.2M	Maintain

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	349	349	349
Average Award	$520,831	$520,831	$520,831
Range of Awards	$92,999-$1,507,775	$92,999-$1,507,775	$92,999-$1,507,775

[215] 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. The 2015 baseline and FY 2019 target was reported incorrectly in the FY 2019 Congressional Justification and has been corrected.

RWHAP Part D - Women, Infants, Children and Youth

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$75,088,000	$75,088,000	$75,088,000	---
MAI (non add)	$23,671,000	$23,671,000	$23,671,000	---
Total Funding	$75,088,000	$75,088,000	$75,088,000	---
FTE	11	11	11	---

Authorizing Legislation: Public Health Service Act, Section 2671, as amended by Public Law 111-87

FY 2021 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 115 RWHAP 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 women, infants, children, and youth with HIV and their affected[216] family members. RWHAP Part D also funds essential support services, such as case management and transportation that help clients' access medical care and stay in care.

Minority AIDS Initiative Funds (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. RWHAP Part D MAI funding supports HIV care, treatment, and support services to racial/ethnic minorities. In 2018, RWHAP Part D funded sites provided 1.6 million visits for health-related care and support services utilizing a combination of RWHAP Parts A, B, C, and D funding.

[216] Support services are available for family members who do not have 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.

The RWHAP Part D serves women, infant, children, and youth – populations disproportionately affected by HIV epidemic that have poor health outcomes. In 2018, RWHAP Part D funded sites served 215,125 clients utilizing a combination of RWHAP Parts A, B, C, and D funding. Of the total clients served, 75 percent were racial/ethnic minorities and 29 percent were female.

RWHAP 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 with HIV.

Funding History

FY	Amount
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	$75,088,000
FY 2019	$75,088,000
FY 2020	$75,088,000
FY 2021	$75,088,000

Budget Request

The FY 2021 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part D of $75.1 million is equal to the FY 2020 Enacted level. This funding will support the comprehensive array of medical and supports services necessary to achieve improved health outcomes, such as improved viral suppression rates, essential to ending the HIV epidemic.

RWHAP Part D supports health care services for low income people with HIV who are uninsured or underserved. These services are considered essential to improving health outcomes and are a crucial part of the care network that links and retains people with HIV 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 people with HIV into care, and getting them on antiretroviral medications as early as possible.

The funding request will support the RWHAP Part D in achieving its target of providing at least 1.6 million health-related care and support service visits in FY 2021. RWHAP Part D funding will also contribute to achieving the FY 2021 targets for performance goals that relate to cross-cutting activities, such as the percentage of racial/ethnic minorities and women served, percentage of clients who achieved viral suppression, and percentage of pregnant women with HIV served by the RWHAP who receive antiretroviral medications.

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.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
20.II.A.2 Number of RWHAP Part D visits for health-related care and support services [217] *(Output)*	2018: 1.6M Target: 1.7M (Target Not Met)	1.6M	1.6M	Maintain

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	115	115	115
Average Award	$583,894	$583,894	$583,894
Range of Awards	$113,823 - $2,185,691	$113,823 - $2,185,691	$113,823 - $2,185,691

[217] The 2018 target was reported incorrectly in the FY 2019 Congressional Justification and has been corrected.

RWHAP Part F - AIDS Education and Training Programs

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$33,611,000	$33,611,000	$33,611,000	---
MAI (non add)	$10,144,000	$10,144,000	$10,144,000	---
Total Funding	$33,611,000	$33,611,000	$33,611,000	---
FTE	5	5	5	---

Authorizing Legislation: Public Health Service Act, Sec. 2692(a), as amended by Public Law 111-87.

FY 2020 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 eight regional centers and two national centers that conduct targeted, multidisciplinary education and training programs for health care providers serving people with HIV in all states, DC, Puerto Rico, the U.S. Virgin Islands, and the Associated Jurisdictions. The RWHAP AETC improves the quality of life of people 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.

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 2017-2018, the proportion of racial/ethnic minority health care providers participating in RWHAP AETC training intervention programs was 49 percent, exceeding the most recent performance target by 6 percentage points.[218]

RWHAP AETCs currently train providers through a variety of training modalities, including didactics, clinical preceptorships, self-study, clinical consultation, communities of practice and

[218] Due to changes in the reporting instrument, an estimated proportion of racial/ethnic minority providers was calculated using data from the past three reporting years.

distance-based technologies. A variety of educational formats are used including skills building workshops, hands-on preceptorships and mini-residencies, on-site training, tele-education, and technical assistance. For example, the RWHAP AETC implemented an online interactive platform that hosts an HIV care and treatment curriculum targeted to health care professionals. Clinical faculty also provides timely clinical consultation in person or via the telephone or internet.

Funding History

FY	Amount
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	$33,611,000
FY 2019	$33,611,000
FY 2020	$33,611,000
FY 2021	$33,611,000

Budget Request

The FY 2021 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part F-AETC of $33.6 million is equal to the FY 2020 Enacted level. This funding will support targeted, multidisciplinary education and training programs for novice and experienced health care providers treating people with HIV in order to assure access to high quality HIV care delivered by competent providers. The RWHAP AETC program also provides expert advice to providers across the country on: HIV treatment; pre-exposure prophylaxis to reduce HIV transmission; substance use disorders; viral hepatitis co-infection; post-exposure prophylaxis, and the treatment of pregnant women with HIV and their newborns to prevent mother-to-child transmission.

The RWHAP AETC program funds a national curriculum for medical providers on HIV care and treatment to assure continued training of providers from medical/nursing school through in-service training. The central focus of RWHAP AETC training is to ensure high quality care and good patient outcomes through HIV care and treatment that is consistent with established treatment guidelines and reflects current research. This is increasingly important as people with HIV are living longer. In addition, the number of experienced HIV care professionals is projected to decrease as many of those who have worked in the epidemic since its inception reach retirement age. Training an expanded cadre of culturally competent, high quality providers is vital to increasing access to quality HIV care and treatment and improving health outcomes for people with HIV.

HRSA will continue to prioritize interactive training and technical assistance that result in health system strengthening and transformation. Focus will be on training health care providers, particularly racial/ethnic minority providers, to deliver high quality HIV care and treatment

services in primary care settings – settings that have typically not provided services to people with HIV.

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.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
21.V.B.1: Proportion of RWHAP AETC training intervention participants that are racial/ethnic minorities. *(Output)*	FY 2017: 49% Target: 43% (Target Exceeded)	46%	46%	Maintain

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	14	14	14
Average Award	$2,225,728	$2,083,555	$2,083,555
Range of Awards	$ 300,000- $4,293,630	$300,000 - $4,049,008	$300,000 - $4,049,008

RWHAP Part F - Dental Programs

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$13,122,000	$13,122,000	$13,122,000	---
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 2692(b) as amended by Public Law 111-87

FY 2021 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 with HIV 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 RWHAP DRP improves access to oral health care for low-income, people with HIV and ensures quality services by dental students, dental hygiene students, and dental residents for providing oral health care services to people with HIV. 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 people with HIV 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 2018, the RWHAP DRP awards were able to provide 38 percent of the total non-reimbursed costs requested by 51 participating institutions in support of oral health care. These institutions reported providing care to 26,334 people with HIV, 13,404 for whom no other funded source was available, missing the FY 2018 performance target by 12,102 individuals. In FY 2018, the demographic characteristics of patients who were cared for by institutions participating in the RWHAP DRP were 64 percent minority and 32 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 2018, RWHAP CBDPP funded 12 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 2019	FY 2020	FY 2021
RWHAP Dental Reimbursement Program	$8,977,802	$8,977,802	$8,977,802
RWHAP Community-Based Dental Partnership Program	$3,475,672	$3,475,672	$3,475,672

Funding History

FY	Amount
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	$13,122,000
FY 2019	$13,122,000
FY 2020	$13,122,000
FY 2021	$13,122,000

Budget Request

The FY 2021 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part F-Dental of $13.1 million is equal to the FY 2020 Enacted level. This funding will support oral health care for people with HIV and the reimbursement of applicant institutions through the RWHAP DRP and funding of the RWHAP CBDPP.

The FY 2021 funding request will support RWHAP target for reimbursing at least 26,000 people with HIV for a portion of their unreimbursed oral health costs through the RWHAP Dental Reimbursement Program.

The FY 2021 funding request also includes costs associated with the grant review and award process, follow-up performance reviews, information technology, and other program support costs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
22. I.D.1: Number of persons for whom a portion/percentage of their unreimbursed oral health costs were reimbursed. *(Output)*	2018: 26,334 Target: 38,436 (Target Not Met)	26,000	26,000	Maintain

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	63	63	63
Average Award	$196,305	$196,305	$196,305
Range of Awards	$6,195 - $1,545,922	$6,195 - $1,545,922	$6,195 - $1,545,922

RWHAP Part F - Special Projects of National Significance

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$25,000,000	$25,000,000	$25,000,000	---
FTE	2	2	2	---

Authorizing Legislation: Public Health Service Act, Section 2691, as amended by Public Law 111-87

FY 2021 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 interventions, models and strategies for HIV care to improve the retention and health outcomes of RWHAP clients.

As healthcare systems work under increasingly dynamic conditions, evidence-based and/or evidence-informed strategies are essential in order to ensure that research investments maximize healthcare value and improve public health. Implementation science plays a critical role in supporting these efforts. RWHAP SPNS-funded projects use implementation science - the scientific study of methods to promote the systematic uptake of research findings into routine practice - to improve the quality and effectiveness of health services, maximize resources, and improve health outcomes for people with HIV.

The RWHAP SPNS evaluates the effectiveness of various models, interventions, strategies, implementation, utilization, cost, and health-related outcomes. Systematic strategies are used to identify promising practices among RWHAP recipients and develop tool kits and other modalities that allow for rapid dissemination. Through these special projects, RWHAP SPNS grant recipients implement a variety of promising interventions which contribute to the advancement of public health knowledge and the ultimate goal of ending the HIV epidemic in the United States.

Of the 58 currently funded FY 2019 Ryan White HIV/AIDS Program SPNS grant recipients: 7 percent are community-based/AIDS services organizations; 19 percent are state/county/local departments of health; 21 percent are community health centers; 11 percent are academic-based clinics; and 42 percent are universities/evaluation and technical assistance providers.

Current SPNS initiatives include: building capacity to support innovative program model replication among RWHAP jurisdictions; enhancing linkages of sexually transmitted infections (STI) and HIV surveillance data in the RWHAP; strengthening systems of care for people with HIV and opioid use disorder; gathering evidence-informed approaches to improve health outcomes for people with HIV; implementation science projects to promote the replication of SPNS evidence–informed interventions; implementation of evidence-informed behavioral health models to improve HIV health outcomes for Black Men Who Have Sex With Men; improving health outcomes through the coordination of supportive employment and housing services; approaches to cure Hepatitis C among HIV/HCV co-infected people of color; and an initiative to promote the use of social media to improve engagement, retention, and health outcomes..

Funding History

FY	Amount
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	$25,000,000
FY 2019	$25,000,000
FY 2020	$25,000,000
FY 2021	$25,000,000

Budget Request

The FY 2021 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part F- Special Projects of National Significance (SPNS) of $25.0 million is equal to the FY 2020 Enacted level. The FY 2021 funding will support the continued development of innovative models of HIV care and treatment for populations that are significantly difficult to engage in continuous care and achieve viral suppression.

Through its funded demonstration projects, RWHAP SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models, interventions, and strategies, while promoting the dissemination and replication of successful ones. RWHAP SPNS funding also supports projects to build capacity in the health information technology (HIT) systems of RWHAP grant recipients and provider organizations to report client-level data and to improve health outcomes.

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.

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	29	19	40
Average Award	$762,301	1,091,589	$404,241
Range of Awards	$200,000 - $4,274,605	$296,596 - $5,324,435	$150,000 - $3,359,774

RWHAP – Ending the HIV Epidemic Initiative (EHE)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	—	$70,000,000	$165,000,000	+$95,000,000
FTE	—	30	30	---

Authorizing Legislation: Section 311 of the Public Health Service Act and Title XXVI of the Public Health Service Act

FY 2021 Authorization…….……..…….Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description

The Ending the HIV Epidemic (EHE)*: A Plan for America* initiative is an HHS-wide effort to reduce new infections by 75 percent in the next five years and by 90 percent in the next ten years, with the goal of decreasing the number of new HIV infections to fewer than 3,000 per year. HRSA will focus on linking people with HIV who are either newly diagnosed, diagnosed but currently not in care, or diagnosed and in care but not yet virally suppressed to the essential HIV care and treatment and support services needed to help them achieve viral suppression.

HRSA anticipates 18,000 additional people with HIV will be served by the RWHAP in the first year of the EHE initiative (FY 2020), and an additional 25,000 people with HIV will be served in the second year (FY 2021). Overall, a total of 43,000 people with HIV will be served through this initiative in the first two years of this 10-year initiative.

In FY 2021, funded RWHAP Part A and Part B jurisdictions encompassing the 48 counties, Washington, D.C., San Juan (PR), and seven states that have a substantial rural HIV burden will continue their focus on engaging people who are newly diagnosed with HIV, or diagnosed but currently not in care, or diagnosed and in care but not yet virally suppressed. These jurisdictions will continue to build off of their locally-developed work plans submitted through the Notice of Funding Opportunity in FY 2020. The jurisdictions will continue using evidence-based strategies to engage these populations into HIV medical care, treatment, and support services that will ensure retention and viral suppression. As patients are linked and retained in care, the jurisdictions will support the HIV care and treatment needs of the newly identified and re-engaged people with HIV.

The EHE funded technical assistance (TA) and systems coordination cooperative agreements will support strategies such as: data to care efforts; using acuity tools to identify and provide care for the most challenging patients; developing models such as low-barrier clinics to meet patients

where they are; rapid engagement and medication initiation protocols; and others that have been successful in the field. As lessons are learned from the first year, HRSA and the TA entity will work to utilize and disseminate those lessons nationally, so that as other resources are available, additional jurisdictions are able to plan EHE efforts early in the initiative.

The HRSA funded jurisdictions will work with their respective AIDS Drug Assistance Programs (ADAPs) to ensure necessary resources are available to provide assistance for medications and health care coverage premiums and cost-sharing for people newly diagnosed with HIV or re-engaged in care through the EHE initiative.

As part of the EHE initiative, the AIDS Education and Training Centers (AETCs) will work to expand workforce capacity by providing training and technical assistance to health care providers and paraprofessionals. This will include activities such as training health care providers on HIV medical care and treatment and PrEP service delivery; working with clinics and health care providers to develop culturally competent settings and approaches to the populations reached through the EHE initiative; and providing technical assistance on practice transformation in clinics to increase HIV testing, linkage to care, rapid ART delivery, and improved viral suppression.

Budget Request

The FY 2021 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) EHE initiative of $165.0 million is $95.0 million above the FY 2020 Enacted level. This funding will support HIV care and treatment for an estimated 43,000 clients in the 57 geographic locations that currently have more than 50% of new HIV diagnoses nationally, expand evidence-informed practices to link, engage, and retain people with HIV in care, and support capacity building, technical assistance, program implementation, and oversight.

HRSA estimates that 43,000 clients will be served by this initiative through FY 2021.

In FY 2021, HRSA will continue to direct RWHAP funding to the 48 counties, DC, San Juan (PR), and seven states that contain more than 50% of new HIV infections. Funding will continue to be awarded to the current 39 RWHAP Part As that contain one or more of the counties and the current eight RWHAP Part B states (including funding to the state of Ohio for Hamilton County which is not a RWHAP Part A). HRSA requires coordination with the respective AIDS Drug Assistance Program (ADAPs) to ensure necessary resources are available to provide assistance for medications and health care coverage premiums and cost-sharing for people newly diagnosed with HIV or re-engaged in care through the initiative. The RWHAP's comprehensive system of HIV care and support services and effective system for medication delivery creates a very efficient and effective service delivery mechanism for this initiative.

Starting in FY 2020 and continuing into FY 2021, HRSA will fund the AETCs to provide training and technical assistance to health care providers, clinics, and paraprofessionals as well as health departments to increase HIV testing, care and treatment, the provision of PrEP services, and retention in care.

HRSA will continue to direct funding to support technical assistance and systems coordination to enhance the current RWHAP data collection systems to provide timely monitoring of the initiative; to support dissemination of effective interventions to increase the number of people

with HIV served by the initiative; to provide additional technical assistance to jurisdictions to implement models of care that work to identify and link and retain the key populations for the EHE initiative.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
60.1 Number of new clients served through the EHE initiative *(Output)*	N/A	18,000	43,000	+25,000
60.2 Viral suppression among new clients served by the EHE initiative *(Outcome)*[219]	N/A	TBD	TBD	TBD

[219] This is a long-term measure without annual targets. The first target will be set for FY 2024.

Grants Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Jurisdiction Awards	---	47	47
Average Award	---	$1,200,000	$3,100,000
Range of Awards	---	N/A	N/A

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Technical Assistance Awards	---	2	2
Average Award	---	$2,500,000	$4,000,000
Range of Awards	---	N/A	N/A

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of AETC Awards	---	10	10
Average Award	---	$300,000	$900,000
Range of Awards	---	N/A	N/A

Healthcare Systems TAB

HEALTHCARE SYSTEMS

Organ Transplantation

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$25,437,000	$27,549,000	$17,164,000	-$13,385,000
PHS Evaluation Funds	---	---	$13,385,000	---
Total	$25,437,000	$27,549,000	$30,549,000	+$3,000,000
FTE	4	4	4	---

Authorizing Legislation: Public Health Service Act, Sections 371-378, as amended by Public law 108-216, Public Law 109-129, Public Law 110-144, Public Law 110-413, and Public Law 113-51

FY 2021 Authorization……..…….……..……..... Expired

Allocation Method:
- Contracts
- Competitive Grants/Co-operative Agreements
- Other (Interagency Support)

Program Description

The Organ Transplantation Program extends and enhances the lives of individuals with end-stage organ failure for whom an organ transplant is the most appropriate therapeutic treatment. HRSA 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). HRSA also invests in public education and outreach to increase the supply of deceased donor organs available for transplant and to ensure the safety of living organ donors.

The OPTN is a critical system that facilitates matching donor organs to individuals needing organ transplants. 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, attain the maximum benefit for the maximum number of waitlist candidates, make the best use of donor organs, and 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. The OPTN collects fees under the authority of 42 CFR §121.5(c).

The OPTN final rule (42 CFR §121.12) established the Advisory Committee on Organ Transplantation (ACOT), which is composed of experts in the field of organ transplantation, to provide recommendations to the Secretary on issues related to organ donation and transplantation. HRSA provides logistics and analytic support for periodic ACOT meetings. HRSA also engages in interagency activities that support organ donation and transplantation.

The SRTR provides analytic support to the OPTN in the development of organ allocation policies and performance evaluation. Additionally, the SRTR provides analytic support to HHS, including the ACOT. SRTR shares information publicly about the performance of transplant programs and organ procurement organizations at https://www.srtr.org/. It publishes online transplant program risk-adjusted patient and graft outcomes data as well as organ procurement organization risk-adjusted data on organs procured per donor. 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.

HRSA collaborates with the organ donation and transplantation community on efforts to promote awareness of the need for donated organs and to encourage public enrollment on organ donor registries (state or national). Outreach activities include:

- Public service announcement campaigns for radio, TV stations, and publications nationwide
- Educational web videos for reposting, download, and social media
- Radio Ad Spotlights during high traffic drive-time hours in designated markets with the highest numbers of African Americans, Asians, Hispanics or Latinos, and people 50 years and older. Data reveals gaps between the numbers of patients waiting for an organ and numbers of donors from these groups.
- Print ads in widely circulated publications such as major sporting event program guides
- Organ donation and transplantation related articles for newspapers and journals
- Downloadable print materials on a variety of topics for multiple audiences
- HRSA's organ donation sites: www.organdonor.gov and https://donaciondeorganos.gov
- Social media outreach
- Grant projects to test approaches to promote public awareness of the need for organ donation and increase registration in donor registries

<u>President's Executive Order on Advancing American Kidney Health</u>

On July 10, 2019, the President issued an Executive Order on Advancing American Kidney Health that provides increased support for living donors to further the goal of significantly increasing the supply of transplantable kidneys. Section 8 of the Executive Order specifically requires the Secretary of HHS to, in part, "…raise the limit on the income of donors eligible for reimbursement under the Program, allow reimbursement for lost-wage expenses, and provide for reimbursement of child-care and elder-care expenses."

Pursuant to the Executive Order, HRSA published in the *Federal Register* on December 20, 2019 a notice of proposed rulemaking to amend the regulation implementing the National Organ Transplant Act of 1984 (NOTA). HRSA's proposed rule would expand the scope of

reimbursable expenses for living donors to include lost wages, and childcare and eldercare expenses for those donors who lack other forms of financial support. This proposal could increase the number of transplant recipients receiving a better quality organ in a shorter time period from living donors.

In accordance with the Executive Order, HRSA will also release a *Federal Register Notice* (FRN) requesting public comment to amend the Reimbursement of Travel and Subsistence Expenses toward Living Organ Donation Program's eligibility guidelines to increase the household income eligibility threshold for the organ recipients, and the prospective living organ donors, above the current 300 percent of the HHS Poverty Guidelines.

Program Accomplishments

One of HRSA's primary goals for the Organ Transplantation Program is to increase the annual number of deceased donor organs transplanted. In CY 2019, the number of deceased donor organs transplanted was 35,742, which is an 8.8 percent increase over the CY 2018 total of 32,857. HRSA has achieved record-breaking numbers of deceased donor and overall organ transplants year over year since 2015.

Another important program goal is to increase the organ donor conversion rate, which is the rate potential organ donors become actual organ donors after death. The conversion rate has been a key performance metric and a priority for the Organ Transplantation Program since 2003. The conversion rate remained steady at approximately 72 percent in CY 2015 and CY 2016, but declined to 70 percent in CY 2017. In CY 2018, the conversion rate increased to 71 percent. HRSA will continue to monitor conversion rates and assess potential next steps.

The organ donor conversion rate is based on potential "eligible deaths," which includes potential donors aged 75 or below who are legally declared dead by neurologic criteria (brain death) and not excluded for other defined reasons related to certain risk factors. The 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."

Table 1. Conversion Rates and Eligible Deaths 2014-2018

Year	Number of Donors	Number of Eligible Deaths	Conversion Rate (%)	Change in Eligible Deaths (%)
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
2017	8,104	11,653	69.5	8.8
2018	8,272	11,661	70.9	0.1

Funding History

FY	Amount
FY 2017	$23,492,000
FY 2018	$25,486,000
FY 2019	$25,437,000
FY 2020	$27,549,000
FY 2021	$30,549,000

Budget Request

The FY 2021 Budget Request for the Organ Transplantation program of $30.5 million is $3.0 million above the FY 2020 Enacted level.

HRSA will target up to $9.5 million towards expanding support for living organ donors in support of the President's Executive Order on Advancing Kidney Health. The proposed budget provides funding for the implementation of these new policies and initiatives designed to expand support for living organ donation.

This work will be accomplished through HRSA's continued funding of the Reimbursement of Travel and Subsistence Expenses toward Living Organ Donation Program that provides reimbursement to living organ donors who lack other forms of financial support. In FY 2021, HRSA will continue funding a three-year demonstration project to assess the impact of reimbursement of lost wages on individuals' willingness to become living organ donors.

This request includes $18.5 million for the OPTN, SRTR, and public and professional education efforts to increase public awareness about the need for organ donation. Additionally, this request includes approximately $2.4 million for activities related to the Advisory Committee, interagency agreements, and other internal support and Program-related activities.

The funding request includes costs associated with the grant review and award process, follow-up performance reviews, 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 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
23.II.A.1: Annual number of deceased donor organs transplanted.[220] *(Output)*	FY 2019: 35,742 Target: 26,555 (Target Exceeded)	32,010	32,652	+642
23.II.A.8: Annual conversion rate of eligible donors. *(Output)*	FY 2018: 70.9% Target: 74.0% (Target Not Met)	74.50%	74.50%	Maintain

Grants Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	8	9	6
Average Award	$938,529	$881,140	$1,882,084
Range of Awards	$299,274-$3,250,000	$300,000-$3,250,000	$300,000-$7,300,000

[220] Performance Measure 23.II.A.1 2019 data using OPTN data as of January 14, 2020.

National Cord Blood Inventory

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$16,195,000	$17,266,000	$8,266,000	-$9,000,000
FTE	4	4	4	----

Authorizing Legislation: Public Health Service Act, Section 379, as amended by Public Law 114-104

FY 2021 Authorization…….....$23,000,000

Allocation Method…….…….....……Contract

Program Description

The National Cord Blood Inventory (NCBI) Program 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 cord blood units in the inventories of participating cord blood banks, are made available to patients for blood stem cell transplants through the C.W. Bill Young Cell Transplantation Program. Cord blood banks participating in the NCBI program also make cord blood units not suitable for transplantation available for preclinical and clinical research.

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 matched donors 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. The other 70 percent, or approximately 12,600 people, often search for a matched, unrelated adult donor or a matched umbilical cord blood unit.

Tissue types of blood stem cell donors must closely match their recipients for transplants to be successful. Since tissue types are inherited, patients are more likely to find closely matched donors within their own racial and ethnic groups. Due to the high rate of diversity in tissue types of underrepresented racial and ethnic populations, especially African-Americans, underrepresented racial and ethnic populations are less likely to find suitably matched adult marrow donors on the C.W. Bill Young Cell Transplantation Program Registry. Because umbilical cord blood can be used with a less stringent match in tissue types between donor and recipient than is the case for adult marrow donors, umbilical cord blood offers a chance of survival for patients who lack suitably matched related or unrelated adult donors, particularly

those from racially and ethnically diverse populations. For this reason, 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, geographic dispersion of collection and 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, 2018, the cumulative number of NCBI CBUs available through the Program was 96,977(Table 1). HRSA estimates that approximately 3,000 additional units will be collected and made available for patient searches in FY 2021. The number of units collected varies from year to year based on funding levels, contractor's ability to collect and store units from diverse populations, and contractor's licensure status.

Table 1. Cord Blood Collections

Fiscal Year	Number of Units Contracted	NCBI Cord Blood Units Collected and Made Available[1] for Patient Searches	Cumulative Units Made Available[221]
2014	7,469	8,654	69,903
2015	6,469	9,373	79,276
2016	5,840	6,167	85,443
2017	6,369	7,103	92,546
2018	7,787	4,431	96,977

The availability of umbilical cord blood has increased access to blood stem cell transplantation, particularly for patients who would not otherwise have well-matched adult donors. 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.

As shown in Table 2, the number of NCBI cord blood units released for transplants remained level in FY 2018 over FY 2017, at 493 and 494 cord blood units, respectively. The NCBI units

[221] 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, not all of the units collected with funds from a given fiscal year will be available on the registry during that same fiscal year.

released for transplantation and the total cord blood units released for transplantation through the C.W. Bill Young Cell Transplantation Program have been decreasing since FY 2015 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 still 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 should continue to serve an increasing number of patients. Underrepresented racial and ethnic populations account for over 60 percent of the cord blood units collected. HRSA will continue to monitor and assess trends in cord blood transplantation and will adjust transplant targets accordingly.

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
2014	544	1,359
2015	609	1,393
2016	529	1,154
2017	494	1,050
2018	493	949

In addition to directly growing the NCBI inventory, resources provided to NCBI-contracted banks have played an important role in stimulating the collection and banking of many other non-NCBI units. These CBUs may not meet minimum cell content thresholds established for the NCBI, but may be suitable sources of blood stem cells for smaller patients where acceptable cell doses can still be achieved using smaller units. Additionally, NCBI banks have provided researchers more than 94,000 cord blood units that were not be suitable for clinical transplantation but serve a wide variety of research purposes.

Funding History

FY	Amount
FY 2017	$12,239,000
FY 2018	$15,236,000
FY 2019	$16,195,000
FY 2020	$17,266,000
FY 2021	$8,266,000

Budget Request

The FY 2021 Budget Request for the National Cord Blood Inventory Program of $8.3 million is $9 million below the FY 2020 Enacted level. This Budget request 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. The request supports collecting and banking approximately 2,400 CBUs toward the statutory goal.

This Budget request will increase the number of patients in all population groups who are able to obtain life-saving transplants. Although the number of newly added CBUs will decrease from previous years, the size of the inventory will increase and should contribute to improved patient survival after transplant and allow access to higher cell doses and better tissue matches for patients.

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

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
40.II.A.1: The cumulative number of cord blood units from underrepresented racial and ethnic populations available through the C.W. Bill Young Cell Transplantation Program (NCBI & non-NCBI)[222](Output)	FY 2018: 170,398 Target: 80,809 (Target Exceeded)	145,721	148,721	+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) (Output)	FY 2018: 96,977 Target: 91,000 (Target Exceeded)	99,000	100,800	+1,800
40.II.A.3: The annual number of NCBI cord blood units released for transplant[223] (Output)	FY 2018: 493 Target: 535 (Target Not Met)	500	500	Maintain

Contracts Awards Table

[222] Data shows there are over 20,000 cord blood units designated as "unknown race/ethnicity" as not every cord blood bank requires donors to provide the information. Inability to properly categorize these units subsequently impacts tracked data. The 20,000 cord blood units are not included in this measure but are included in the total number of cord blood units available through the CWBYCTP.

[223] 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.

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Contracts	5	6	6
Average Contract	$3,038,825	$2,505,500	$1,170,833
Range of Contracts	$665,000-8,400,000	$500,000-4,950,000	$315,000-$2,500,000

C.W Bill Young Cell Transplantation Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$24,501,000	$30,009,000	$30,009,000	---
FTE	6	6	6	---

Authorizing Legislation: Public Health Service Act, Sections 379-379B, as amended by Public Law 114-104

FY 2021 Authorization…….…….$30,000,000

Allocation Method…….…….…….Contract

Program Description

The primary goal of the C.W. Bill Young Cell Transplantation Program is to increase the number of transplants for recipients suitably matched to biologically unrelated bone marrow[224] and umbilical cord blood donors. HRSA 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 matched donors 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 is similar to that of its predecessor, HRSA 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 C.W. Bill Young Cell Transplantation Program operates through three major contracts that require close coordination and oversight and supports an Advisory Council that provides recommendations to the HHS

[224] 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.

Secretary and 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 provides individualized patient services for ongoing searches for bone marrow donors or cord blood units. The OPA also assists patients with information regarding treatment options and payment 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 C.W. Bill Young Cell Transplantation Program meets its long-term goals for: (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 C.W. Bill Young Cell Transplantation Program also relies on two annual performance measures: (1) number of adult volunteer potential donors from underrepresented racial and ethnic populations listed 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 C.W. Bill Young Cell Transplantation Program continues to serve a diverse patient population, with umbilical cord blood playing a vital role in expanding access to transplants for patients from underrepresented racial and ethnic populations. 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 2018, more than 20.6 million potential adult volunteer donors were listed on the Program's registry. More than 3.8 million, or approximately 18 percent, self-identify as belonging to an underrepresented racial or ethnic population. HRSA expects the registry will list 4.08 million adult donors who self-identify as belonging to an underrepresented racial or ethnic population in FY 2021.

The cost of tissue typing per donor strongly influences the number of potential volunteer donors recruited for the Program's registry. The FY 2021 cost for each donor's tissue typing will remain at $58.00, the same cost as in FY 2020. Tissue typing identifies genetic markers that assist physicians in conducting donor searches on behalf of patients. Continued advances in tissue typing technology facilitate more efficient matching between potential donors and searching patients and allow patients to move more rapidly toward transplantation.

Funding History

FY	Amount
FY 2017	$22,056,000
FY 2018	$24,050,000
FY 2019	$24,501,000
FY 2020	$30,009,000
FY 2021	$30,009,000

Budget Request

The FY 2021 Budget Request for the C.W. Bill Young Cell Transplantation program of $30.0 million is the same as the FY 2020 Enacted level. This Budget request supports the Program's FY 2021 performance target of 4.08 million adult volunteer donors from underrepresented racial and ethnic populations listed on the Program's registry.

The Budget request prioritizes recruiting and tissue-typing new donors and continues the following activities: (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 2021 Budget request allows the C.W. Bill Young Cell Transplantation Program to continue critical planning in collaboration with HHS on a response to a national radiation or chemical emergency. In such an event, casualties could involve temporary or permanent marrow failure and may possibly require emergency transplants for individuals unable to recover marrow function.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
24.II.A.2: The number of adult volunteer potential donors of blood stem cells from minority race and ethnic groups (Output)	FY 2018: 3.78M Target: 3.94M (Target Not Met)	4.08M	4.08M	Maintain
24.1: The number of blood stem cell transplants facilitated by the Program [225] (Output)	FY 2017: 5,994 Target: 6,960 (Target Not Met)	N/A	N/A	N/A
24.2: The number of blood stem cell transplants facilitated for minority patients by the Program [226] (Output)	FY 2017: 875 Target: 1,150 (Target Not Met)	N/A	N/A	N/A
24.3: The rate of patient survival at one year, post- transplant [227] (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 [228] (Output)	FY 2017: 4,835 Target: 5,135 (Target Not Met)	N/A	N/A	N/A
24.E: The unit cost of human leukocyte antigen (HLA) typing of potential donors (Efficiency)	FY 2018: $58.00 Target: $58.00 (Target Met)	$58.00	$58.00	Maintain

Contracts Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	4	4	4
Average Award	$5,526,799	$6,784,710	$6,784,710
Range of Awards	$60,000-$16,700,000	$60,000-$21,600,000	$60,000-$21,600,000

[225] This is a long-term measure. The next target will be set for FY 2022.
[226]This is a long-term measure. The next target will be set for FY 2022.
[227] This is a long-term measure. The 2017 target for this measure, set at 69%, will be compared to actuals once available. The next target will be set for FY 2022.
[228] This is a long-term measure. The next target will be set for FY 2022.

Poison Control Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$22,746,000	$22,846,000	$22,846,000	---
FTE	2	2	2	---

Authorizing Legislation: Public Health Service Act, Sections 1271-1274, as amended by Public Law 113-77

FY 2021 Authorization .....Expired

Allocation Method:

- Contracts
- Competitive Grants/Co-operative Agreements

Program Description and Accomplishments

The Poison Control Program (PCP) was established in 2000 and 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; 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 PCP grant program supports Poison Control Centers' efforts to: 1) prevent and provide treatment recommendations for poisonings; 2) comply with operational requirements 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 in support of national toxic surveillance activities conducted by the Centers for Disease Control and Prevention (CDC).

The national toll-free Poison Help Line was established in 2001 to ensure universal access to Poison Control Center services. Individuals can call from anywhere in the U.S. and the territories and connect to the poison centers that serve their respective areas. The PCP maintains the number, provides translation services in over 150 languages, and offers services for the hearing impaired.

Today, a network of 55 Poison Control Centers, supported by 52 grant awards, provide cost-effective, quality health care advice to the general public and health care providers across the 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 callers. 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 mismanage medicine or when workers are exposed to harmful substances on the job. Emergency 911 operators refer poison-related calls to Poison Control Centers, and health care professionals regularly consult Poison Control Centers for expert advice on complex cases. Poison Control Centers 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, poison centers managed 2.5 million cases in 2018 a 2.96 percent decline from 2017. Of the approximate 2.0 million human exposure poisonings reported in 2018, Poison Control Centers managed about 66 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 24 percent of poison control calls. Consistent with the previous year, the top 5 substance classes most frequently involved in all human exposures were analgesics (10.8%), household cleaning substances (7.28%), cosmetics/personal care products (6.53%), sedatives/hypnotics/antipsychotics (5.53%), and antidepressants (5.22%). [229] Multiple studies have demonstrated that poison centers' accurate assessments and triage of poison exposures save dollars by reducing the severity of illness and death, and by eliminating or reducing the expense of unnecessary trips to emergency departments. Poison center consultations also decrease patients' lengths of stay in hospitals and decrease hospital costs. Health care facilities' use of poison centers continues to increase, indicating an increase in severity of poisonings and the need for toxicological expertise in clinical settings. 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, and the State and Local Government saves approximately $284.2 million in medical care costs and lost productivity.[230]

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 2019, the Poison Help media campaign included an investment of $320,442. Based on over 456 million media impressions through television, radio, and social media, the PCP was able to leverage an advertising return on investment of over $4.9 million.

In addition to providing the public and health care providers with treatment advice on poisonings, a second critical function of the Poison Control Centers 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

[229] David D. Gummin, James B. Mowry, Daniel A. Spyker, Daniel E. Brooks, Krista O. Osterthaler & William Banner: 2018 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 36th Annual Report, Clinical Toxicology.

[230] Value of the Poison Center System: Lewin Group Report for the American Association of Poison Control Centers. 2012

occurrences 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 Poison Control Centers to monitor exposures to e-cigarette devices and liquid nicotine, synthetic cathinones and cannabinoids, opioids, hand sanitizer, and laundry detergent packets. In another example, Poison Control Centers are on the frontline of the opioid epidemic handling opioid-related calls every day, resulting in 60,997 opioid misuse and abuse cases per year.

According to the CDC, in 2017, 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. Poison Control Centers 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 patients.

Poison Control Centers 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 poisonings. Additionally, Poison Control Centers 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 2017	$18,846,000
FY 2018	$20,810,000
FY 2019	$22,746,000
FY 2020	$22,846,000
FY 2021	$22,846,000

Budget Request

The FY 2021 Budget Request for the Poison Control Program of $22.8 million is equal to the FY 2020 Enacted level. This request will support the Poison Control Centers' infrastructure and core triage and treatment services. Poison Control Centers predominantly rely on state and local funding, as Federal funding accounts for approximately 13 percent of total Poison Control Center funding. While Poison Control Centers have innovatively secured funding from a variety of local sources, including philanthropic organizations, their financial stability is tenuous. Federal funding helps reinforce the nationwide Poison Control Center infrastructure, enabling Poison Control Centers to sustain their public health and toxic surveillance efforts.

In FY 2021, the PCP plans to issue grant continuation awards to 52 recipients. The National Toll-Free Hotline Services and Promotion of Number and Services will ensure access to Poison Control Centers 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.

The Nationwide Media Campaign will continue to educate the public and health care providers about the national toll-free number and build upon the existing national public awareness campaign, Poison Help, to highlight the role of Poison Control Centers in the public health system with a focus on Medicare and Medicaid beneficiaries. The goals of the campaign include increasing public awareness of the national Poison Help toll-free number; providing education on poisoning risk and prevention; and showcasing the role of the national network of Poison Control Centers 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.

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.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
25.III.D.3: Percent of inbound volume on the toll-free number. (Output)	FY 2019: 90% Target: 85.0% (Target Exceeded)	85%	85%	Maintain
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) [231]	FY 2017: 37% Target: 25% (Target Exceeded)	N/A	N/A	N/A
25.III.D.6: Percent of human exposure calls made to Poison Control Centers that came from health care facilities. (Output)	FY 2021: 24% Baseline (Target: 24%)	N/A	24%	N/A

[231] This is a long-term measure based on periodic survey data, reported about every 5 years. The next survey findings are expected in FY 2022, with results in 2023 once a final report is approved by HRSA.

Grants Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards [232]	52	52	52
Average Awards	$392,307	$392,307	$392,307
Range of Award	$12,466-$2,411,364	$12,466-$2,411,364	$12,466-$2,411,364

Contracts Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Contracts	2	2	2
Average Contract	$260,584	$415,722	$415,722
Range of Contracts	$54,871-$511,000	$500,000-$511,000	$500,000-$511,000

[232] There are 55 Poison Control Centers across the Nation. Fifty-two awards were made in FY 2019 and are anticipated in FY 2020 and FY 2021 under the Poison Control Stabilization and Enhancement 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 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$10,193,000	$10,238,000	$10,238,000	---
User Fees	---	---	$24,000,000	+$24,000,000
Total	$10,193,000	$10,238,000	$34,238,000	+$24,000,000
FTE	22	22	38	+16

Authorizing Legislation: Public Health Service Act, Section 340B, as amended by Public Law 111-309, Section 204

FY 2021 Authorization…….…….…….…….....SSAN

Allocation Method……...…….……..….Contract

Program Description and Accomplishments

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. These include Federally Qualified Health Centers, AIDS Drug Assistance Programs, and certain disproportionate share hospitals. The 340B Program helps these designated hospitals and clinics provide more care to additional patients.

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 2018, total sales in the 340B Program were approximately $24 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 5 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 Program oversight. 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 completed 1,293 covered entity audits, which included review of 17,946

offsite outpatient facilities and 27,235 contract pharmacies. Final audit results, including statuses of corrective actions, are available on HRSA's website. As of December 6, 2019, HRSA closed out and finalized 1,150 of the 1,293 audits conducted, with 38 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, performs 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 to ensure that all covered entities and manufacturers are in compliance with 340B program requirements.
- Publishes quarterly in the Office of Pharmacy Affairs Information System, Pricing Component, the verified ceiling prices of covered outpatient drugs available for purchase under the 340B Program.

The 340B Program includes the establishment of a Prime Vendor Program (PVP) to develop, maintain, and coordinate a program capable of facilitating distribution of covered outpatient drugs. By the end of 2018, the PVP had nearly 4,600 products available to participating entities below the 340B ceiling price, including 2,500 covered outpatient drugs with an estimated average savings of 27 percent below the 340B ceiling price. From 2009 to 2018, the PVP contracts provided over $1.3 billion in additional sub-ceiling savings for covered entities.

Funding History

FY	Budget Authority	User Fees
FY 2017	$10,213,000	---
FY 2018	$10,210,000	---
FY 2019	$10,193,000	---
FY 2020	$10,238,000	---
FY 2021	$10,238,000	$24,000,000

Budget Request

The FY 2021 Budget Request for the Office of Pharmacy Affairs/340B Drug Pricing Program of $10.2 million is equal to the FY 2020 Enacted level. Additionally, the FY 2021 Budget Request includes $24 million from user fees as a new revenue source. In FY 2021, 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 up to 0.1 percent (or one dollar for every thousand dollars) of the total 340B drug purchases paid by participating covered entities. Both appropriated resources and user fee revenue will support implementation of 340B Program statutory obligations, oversight of participating manufacturers and covered entities, operational improvements, and increased efficiencies using information technology.

The FY 2021 Budget Request also re-proposes to reform the 340B Program through a General Provision in the Labor and Health and Human Services Appropriations Act that would require covered entities to report both their savings and uses to HRSA, and provide HRSA with general regulatory authority. HRSA is currently evaluating its audit process and other program integrity efforts as they relate to HRSA's ability to enforce and require corrective action in a Program that is primarily administered by guidance. Guidance documents do not provide HRSA appropriate enforcement capability, which is why HRSA has requested regulatory authority in the President's Budget each year since FY 2017. General regulatory authority over the 340B Program would allow HHS to set clear enforceable standards of participation on all aspects of 340B program and will help ensure compliance with 340B Program requirements. Currently, hospitals participating in 340B are not required to report on 340B savings or how these savings are used to benefit patient populations. These reforms would help ensure low income and uninsured patients benefit from the Program, as intended, and strengthen program integrity and oversight activities.

FY 2021 Budget Authority

The FY 2021 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. 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.

The request supports facilitation of refunds and credits to entities that are overcharged by participating manufacturers as well as enhancements to the pricing system whereby covered entities access 340B ceiling price information via a secure website. System implementation began in the first two quarters of calendar year 2019, with manufacturers reporting data during the first quarter and prices being available to covered entities, after review and validation, on April 1, 2019.

The FY 2021 Budget Request for budget authority includes costs associated with contract award processes, follow-up reviews, information technology, and other program support costs.

FY 2021 User Fees

In FY 2021, HRSA will begin 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.

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. User fees 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.

HRSA plans to continue random and targeted audits of covered entities and manufacturers, as well as publish audit report summaries on the HRSA website to expand the 340B Program's compliance reach while managing program risk. User fees would provide the additional funding needed to hire and train staff to expand capacity to conduct additional covered entity audits in the future, conduct additional manufacturer audits, write reports, work with entities and manufacturers through the notice and hearing process, and finalize information for public dissemination.

Performance Measures

HRSA measures 340B Program performance by two key metrics: numbers of covered entities and manufacturers audits. As of October 1, 2019, participation levels included 12,414 covered entities and 34,629 associated sites participating in the 340B Program, for a total of 47,043 registered sites. The 47,043 covered entity sites have contract pharmacy arrangements that support 25,654 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 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
39.I.A.1: Covered Entity Audits Conducted (Output)	FY 2019: 200 Target: 200 (Target Met)	200	200	Maintain
39.I.A.2: Manufacturer Audits Conducted (Output)	FY 2019: 5 Target: 5 (Target Met)	5	5	Maintain

Contracts Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 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 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$13,646,000	$13,706,000	$11,653,000	-$2,053,000
FTE	50	50	50	---

Authorizing Legislation: Public Health Service Act, Section 320, as amended by Public Law 105-78, Section 211

FY 2021 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 1917. 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 clinical training on the diagnosis and management of Hansen's disease. The Program makes 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 *Mycobacterium leprae* or *Mycobacterium lepromatosis*, the bacterium that cause leprosy. Hansen's disease is 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 many health care providers are unaware of Hansen's disease and its symptoms. Early diagnosis and treatment prevent nerve involvement 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, consultative, and referral

services to private sector physicians. NHDP increases U.S. health care providers' knowledge by serving as an education and referral center.

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 indigent patient transportation.

Improving Health Outcomes: Hansen's disease is a life-long chronic condition that usually progresses to severe deformity when left untreated and unmanaged. Through a focus on early diagnosis and treatment, NHDP measures its impact on improving health outcomes for Hansen's disease patients by reducing the percentage of patients with grades 1 or 2 disability/deformity.[233] 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 is also 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 diagnosis and treatment. Currently, lab research is using 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.

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 the quality of care and health outcomes related to Hansen's disease.

Funding History

FY	Amount
FY 2017	$15,169,000
FY 2018	$13,650,000
FY 2019	$13,646,000
FY 2020	$13,706,000
FY 2021	$11,653,000

Budget Request

The FY 2021 Budget Request for the National Hansen's Disease Program of $11.7 million is $2.1 million below the FY 2020 Enacted level. This request supports the Program's primary focus on direct patient care activities and improving health outcomes for Hansen's disease

[233] 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 a loss of protective sensation and no visible deformity. Patients graded at 2 have visible deformities secondary to muscle paralysis and loss of protective sensation.

patients. The funding level also reflects improvements in health outcomes through research and health care provider education.

In FY 2021, NHDP will fund eleven ambulatory care contracts with continuing efforts to align resources with levels of care. Hansen's disease patients with severe complications 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 also provides free HD medication to all providers upon request for the care and treatment of HD patients in the U.S. and its territories.

NHDP plans to invest FY 2021 resources in a new Electronic Health Record system to capture patient care data, improve care coordination, and increase communication among staff and providers. The investment will include implementation and staff training costs. In FY 2021, the NHDP also plans to expand and enhance outreach and training activities to providers to improve early diagnosis and reduce permanent disability in patients.

The FY 2021 Budget Request will also support the first full year of NHDP's lease costs for its new administrative and clinical facility, following the Program's planned FY 2020 relocation to a different site in Baton Rouge, Louisiana. In FY 2019, NHDP initiated a process with the General Services Administration (GSA) to locate research space as the current lease for research activities expires in FY 2022. This process will continue through FY 2021, and HRSA anticipates future lease costs for research space to increase.

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 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
3.II.A.4.: Number of health care providers who have received training from NHDP (Output)	FY 2019: 681 Target 600 (Target Exceeded)	650	700	+50
3.II.A.1.: Percentage of patients at Grade 1 or 2 disability (Outcome)	FY 2019: 32% 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 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Resident Population: Inpatients	1	1	1
Baton Rouge Clinic: Outpatients	399	399	399
Baton Rouge Clinic: Outpatient Visits	2,261	2,261	2,261
Ambulatory Care Program (ACP) Contracts	11	11	11
ACP Clinic: Outpatients	819	819	819
ACP Clinic: Outpatient Visits	2,700	2,700	2,700

National Hansen's Disease Program – Buildings and Facilities

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$122,000	$122,000	---	-$122,000
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 320 and 321(a)

FY 2021 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 while meeting requirements to preserve the Carville historic district under the National Historic Preservation Act.

Funding History

FY	Amount
FY 2017	$122,000
FY 2018	$122,000
FY 2019	$122,000
FY 2020	$122,000
FY 2021	$---

Budget Request

There is no request in FY 2021 for Building and Facilities. HRSA has funds to complete minor renovation work. In FY 2021, HRSA operations that remain at Carville are solely for the Museum.

Payment to Hawaii

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$1,849,000	$1,857,000	$1,857,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Section 320(d), as amended by Public Law 105-78, Section 211

FY 2021 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 2017	$1,853,000
FY 2018	$1,852,000
FY 2019	$1,849,000
FY 2020	$1,857,000
FY 2021	$1,857,000

Budget Request

The FY 2021 Budget Request of $1.9 million is equal to the FY 2020 Enacted level. This request supports the payment made to the State of Hawaii for the medical care and treatment of persons with HD. It 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 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$9,284,000	$10,351,000	$5,000,000	-$5,351,000
FTE	3	3	3	---

Authorizing Legislation: Social Security Act, Section 711

FY 2021 Authorization ..... Indefinite

Allocation Method ..... Competitive Cooperative Agreements

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 affected by current policies as well as proposed statutory, regulatory, administrative, and budgetary changes in the Medicare, Medicaid and other key HHS 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. Rural Health Policy Development funds a number of programs to carry out these advisory and compliance roles, including supporting 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.

FORHP provides funding for the only federal research programs specifically designed to provide publically available, policy relevant studies on rural health issues. The Rural Health Research Center (RHRC) Program funds seven research centers to conduct policy-oriented health services research. The RHRCs produce policy briefs and peer-reviewed journal manuscripts and make their publications available to policy makers and other rural stakeholders at both the federal and state levels. The RHRC publications also align with Administration priorities, such as addressing opioid abuse. The Rapid Response Rural Data Analysis and Issue Specific Rural Research Studies Program supports one award to conduct rapid data analyses and short-term rural research studies. The Rural Health Research Dissemination Cooperative Agreement, currently awarded to the Rural Health Research Gateway, disseminates and promotes FORHP funded rural health

services research to stakeholders at the national, state, and community levels with the goal of informing and raising awareness of key policy issues important to rural communities. In FY 2019, these programs conducted and disseminated 56 research reports, including policy briefs posted on the Rural Health Research Gateway website and manuscripts published in peer-reviewed journals. The National Rural Health Information Clearinghouse Program, currently awarded to the Rural Health Information Hub, serves as a clearinghouse for information on rural health, including HRSA's rural health programs, for residents of rural areas in the United States and other rural health stakeholders.

In FY 2020, FORHP will establish a new Telementoring Training Center Program to provide training for academic medical centers and other centers of excellence to create technology-enabled telementoring learning programs that focus on reaching regionally diverse populations and addressing unique cultural aspects across rural areas.

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, FORHP continues to monitor and track the number of rural hospitals that have closed across the country. From January 1, 2010 to November 30, 2019, 119 rural hospitals have closed. FORHP has funded a number of grants that focus on addressing hospital closures, particularly mitigating the loss of services due to hospitals closing or facing financial distress.

Funding History

FY	Amount
FY 2017	$9,351,000
FY 2018	$9,325,000
FY 2019	$9,284,000
FY 2020	$10,351,000
FY 2021	$5,000,000

Budget Request

The FY 2021 Budget Request for the Rural Health Policy Development Program of $5.0 million is $5.4 million below the FY 2020 Enacted Level. This request will allow the following activities to continue at a reduced level of effort: Rural Health Research Center Cooperative Agreement; Rapid Response Rural Data Analysis and Issue Specific Rural Research Studies Program; the Rural Health Research Gateway; the Rural Health Information Hub; National Rural Health Policy, Community, and Collaboration Program; 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 2021.

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 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Output)	FY 2019 : 56 Target: 39 (Target Exceeded)	39	14	-25

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	15	15	12
Average Award	$758,041	$881,071	$458,750
Range of Awards	$100,000 - $2,500,000	$100,000 - $3,000,000	$67,500 - $1,500,000

Rural Health Care Services Outreach, Network and Quality Improvement Grants

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$76,942,000	$79,500,000	$89,500,000	+$10,000,000
FTE	9	9	9	---

Authorizing Legislation: Public Health Service Act, Section 330A, as amended by Public Law 110-355, Section 4 and Social Security Act, Section 711

FY 2021 Authorization (330A).....Expired

FY 2021 Authorization (711)…… Indefinite

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.

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.

- Outreach Service Grants focus on improving access to health care in rural communities through community coalitions and evidence based and promising practice models. These grants focus on disease prevention, health promotion, and can support the expansion of services around primary care, opioid use disorder treatment and prevention, behavioral health, and oral health care. Additionally, through the introduction of the Health Improvement Special Project track, a cohort of grantees within the Outreach Program have a specific focus on addressing cardiovascular disease risk through use of the Centers for Disease Control and Prevention (CDC) Heart Age Calculator. 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. HRSA plans to make 88 new awards.

- Rural Network Development Grants support formalized partnerships among health care providers and social and community service organizations collaborating to improve access and enhance the quality of healthcare in rural areas. The program focuses on demonstrating improved health outcomes resulting from network collaboration, as well as positioning healthcare networks and their products and services to be sustainable as the health care landscape continues to evolve. Grantees under this program are likely to focus on improving health outcomes, enhancing health care quality, and increasing services provided by the network. HRSA plans to make 46 continuing awards.

- Network Planning Grants assist in the development of integrated healthcare networks to address local health care challenges. The Network Planning program provides an opportunity for grantees to work on priority and emerging local public health issues, such as care coordination, patient engagement, rural hospital closure/conversion, telehealth, mental health, and substance use (particularly opioid use disorder). HRSA will make 20 new awards.

- Small Healthcare 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 increased care coordination, 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. HRSA will continue to support 32 awards in FY 2021.

- The Delta States Rural Development Network Grant Program provides network development grants to the eight states in the Mississippi Delta for network and rural health infrastructure development. This program is geographically targeted, given the health care disparities across this eight-state region. The program supports chronic disease management, oral health services, and recruitment and retention efforts for health professionals. The program requires grantees to focus on diabetes, cardiovascular disease, and obesity and to develop programs based on promising practices or evidence-based models. HRSA will make 12 continuing awards in FY 2021.

- Delta Region Community Health Systems Development Program help rural communities address their health care needs in a targeted manner and assists small rural hospitals and clinics improve their financial and operational performances. The program started with one cohort of nine rural communities and their hospitals in FY 2017. The program expanded to include a second cohort of two rural communities and their hospitals in FY 2018 and a third new cohort of ten rural communities and their hospitals in FY 2019. HRSA will close out the first cohort and continue the new cohorts in FY 2020. HRSA developed this program in FY 2017 in coordination with the Delta Regional Authority. HRSA will continue to support the Delta Region Community Health Systems Development award in FY 2021.

- Rural Maternity and Obstetrics Management Strategies (RMOMS) grants improve access and continuity of maternal and obstetrics care in rural communities. RMOMS goals include:

  (1) Developing a sustainable network approach to coordinate maternal and obstetrics care within a rural region;
  (2) Increase the delivery and access of preconception, pregnancy, labor and delivery, and postpartum services;
  (3) Developing sustainable financing models for the provision of maternal and obstetrics care; and
  (4) Improving maternal and neonatal outcomes.

  In FY 2019, HRSA created RMOMS in response to research by the University of Minnesota that revealed a decreasing availability of obstetric units in rural areas.[234] The HHS Rural Health Taskforce further validated these study results. HRSA will support continuing RMOMS grant awards in FY 2021.

  Beginning in FY 2021, HRSA will launch an HHS-wide *Improving Maternal Health in America Initiative*, which focuses on a four -pillar strategy to achieve: 1) Healthy Outcomes for All Women of Reproductive Age by improving prevention and treatment, 2) Healthy Pregnancies and Births by prioritizing quality improvement, 3) Healthy Futures by optimizing post-partum health, and 4) Improved Data and Bolster Research to inform future interventions. HRSA plans to spend an additional $10.0 million in FY 2021 for new RMOMS awards as part of the *Improving Maternal Health in America Initiative*.

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[235] tool to assess the economic impact of federal investments. 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

[234] Hung P, Henning-Smith C, Casey M, Kozhimannil, K. Access to Obstetric Services in Rural Counties Still Declining, with 9 Percent Losing Services, 2004-14. Health Affairs. 2017; 36 (9): 1663-1671. doi:10.1377/hlthaff.2017.0338
[235] https://www.ruralhealthinfo.org/econtool

each project periods end, the Outreach programs continually assess program sustainability. While sustainability rates may vary across grantee cohorts, HRSA expects the majority of projects to continue after federal funding. Across the 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[236] so that rural communities from across the country can benefit from Outreach program investments and results.

Funding History

FY	Amount
FY 2017	$65,500,000
FY 2018	$71,300,000
FY 2019	$76,942,000
FY 2020	$79,500,000
FY 2021	$89,500,000

Budget Request

The FY 2021 Budget Request for the Rural Health Care Services Outreach, Network and Quality Improvement Grants Program of $89.5 million includes $10.0 million above the FY 2020 Enacted Level specifically to improve maternal health. This request will allow HRSA to expand the Rural Maternity and Obstetrics Management Strategies (RMOMS) program that supports maternal health needs in rural communities. HRSA plans to fund new FY 2021 RMOMS awards in support of HHS's *Improving Maternal Health in America Initiative*. HRSA will also support continuing RMOMS grant awards in FY 2021, for a total of $12 million

In FY 2021, the Outreach Program will support the continuation of 94 existing grantees and 118 new competitive grants that will positively affect health care service delivery for over 420,000 people.

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

[236] https://www.ruralhealthinfo.org/community-health

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
29.IV.A.3. Track number of unique individuals who received direct services through FORHP Outreach grants, subject to availability of resources. (Output)	FY 2018: 1,930,243 Target: 420,000 (Target Exceeded)	200,000	200,000	Maintain
29.IV.A.4: Percent of Outreach Authority grantees that will continue to offer services after the federal grant funding ends.[237] (Outcome)	FY 2018: 100% Target: 75% (Target Exceeded)	75%	75%	Maintain

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	219	202	212
Average Award[238]	$264,541	$276,904	$302,149
Range of Awards	$88,099 - $8,000,000[239]	$100,000 - $10,000,000[240]	$100,000 - $10,000,000[241]

[237] 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.
[238]Average award amount does not include the Delta Region Community Health Systems Development Cooperative Agreement, which is $8.0 million in FY 2019 and $10.0 million in FY 2020 and FY 2021.
[239] This represents one cooperative agreement worth up to $8,000,000 for the Delta Region Community Health Systems Development Cooperative Agreement.
[240] This represents one cooperative agreement worth up to $10,000,000 for the Delta Region Community Health Systems Development Cooperative Agreement.
[241] This represents one cooperative agreement worth up to $10,000,000 for the Delta Region Community Health Systems Development Cooperative Agreement.

Rural Hospital Flexibility Grants

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$53,223,000	$53,609,000	--	-$53,609,000
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 2021 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 more than 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 2018, HRSA received an increase in appropriated funds for the Flex Program and allocated an additional $3 million across the 45 states to support ongoing efforts and ensure the program is meeting the goal of improving the financial viability of hospitals. With FY 2019 funds, HRSA targeted $2 million for a new three-year initiative supporting emergency medical services (EMS) across eight states and focusing on quality and operational improvement initiatives.

  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, through this program, can elect to submit quality data to CMS to demonstrate areas of high quality while also identifying areas for improvement. This provides an avenue for ensuring that CAH quality efforts are aligned with broader Medicare quality

initiatives. As a result of the Flex Program's Medicare Beneficiary Quality Improvement Project (MBQIP), ninety-six percent[242] of CAH's are reporting quality data to CMS.

- 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 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. 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. For the FY 2019 competitive cycle, HRSA partnered closely with the Veteran's Health Administration Office of Rural Health to connect the state level grantees with VHA knowledge and expertise.

Funding History

FY	Amount
FY 2017	$43,609,000
FY 2018	$49,470,000
FY 2019	$53,223,000
FY 2020	$53,609,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Rural Hospital Flexibility Grants Program of $0 is $53.6 million below the FY 2020 Enacted Level. The Budget prioritizes programs that provide direct health care services.

[242] Results based on the Flex Monitoring Team analysis of the 2016 CMS data.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
30.V.B.6: Increase the percent of Critical Access Hospitals participating in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (Output)	FY 2017: 84.4% Target: 74% (Target Exceeded)	85%	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. (Developmental)[243] (Outcome)	FY 2017: 72% (Target Not in Place)	70%	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. (Developmental) [244] (Outcome)	FY 2017: 54% (Target Not in Place)	47%	N/A	---

[243] FY 2015 was the first year of data for this measure. Targets were set beginning for FY 2019 Results.
[244] FY 2015 was the first year of data for this measure. Targets were set beginning for FY 2019 Results.

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	94	94	---
Average Award	$565,000	$565,000	---
Range of Awards	$18,000-$945,000	$23,732-$945,000	---

State Offices of Rural Health

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$9,928,000	$12,500,000	--	-$12,500,000
FTE	---	---	---	---

Authorizing Legislation: State Offices of Rural Health Reauthorization Act of 2018, Section 338J of the Public Health Service Act (42 U.S.C. 254r)

FY 2021 Authorization ..... Expires FY 2022

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

This grant program provides funding to establish and maintain a State Office of Rural Health (SORH) within states to strengthen rural health care delivery systems. Every dollar of federal support is 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.

Funding History

FY	Amount
FY 2017	$10,000,000
FY 2018	$10,000,000
FY 2019	$9,928,000
FY 2020	$12,500,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the State Offices of Rural Health Program of $0 is $12.5 million below the FY 2020 Enacted 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 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. (Output)	FY 2017: 69,303 Target: 82,549 (Target Not Met)	67,000	N/A	---
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. (Output)	FY 2017: 22,467 Target: 26,574 (Target Not Met)	23,484	N/A	---
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment initiatives. (Output)	FY 2017: 2,380 Target: 1,260 (Target Exceeded)	1,260	N/A	---

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted[245]	FY 2021 President's Budget
Number of Awards	50	50	---
Average Award	$179,108	$229,270	---
Range of Awards	$171,165 - $179,270	$229,270 – $229,270	---

[245] Average Award and Range of Awards based on 50 SORHs receiving the same amount.

Radiation Exposure Screening and Education Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$1,821,000	$1,834,000	$1,834,000	--
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 417C, as amended by Public Law 109-482, Sections 103 and 104

FY 2021 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 2018, the number of individuals screened at RESEP was 1,261.

Funding History

FY	Amount
FY 2017	$1,834,000
FY 2018	$1,834,000
FY 2019	$1,821,000
FY 2020	$1,834,000
FY 2021	$1,834,000

Budget Request

The FY 2021 Budget Request for the Radiation Exposure Screening and Education Program of $1.8 million is equal to the FY 2020 Enacted 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 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
32.1: Percent of RECA successful claimants screened at RESEP centers. (Outcome)	FY 2018: 19 % 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 2018: 79% Target: 72% (Target Exceeded)	77%	77%	Maintain
32.I.A.1: Total number of individuals screened per year. (Output)	FY 2018: 1,261 Target: 1,200 (Target Exceeded)	1,300	1,300	Maintain

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	8	8	8
Average Award	$228,919	$228,919	$228,919
Range of Awards	$119,461 - 281,733	$119,461 - 281,733	$119,461 - 281,733

Black Lung

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$10,921,000	$11,500,000	$11,500,000	--
FTE	1	1	1	---

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 2021 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 the recent years, most grantees have been able to use funds to upgrade equipment, enhance their workforce capacity and increase behavioral health screenings and care integration.

HRSA also funds the Black Lung Center for Excellence Program (BLCE) in supporting and strengthening the operations of BLCP awardees and their ability to examine and treat respiratory and pulmonary impairments in active and inactive coal miners. BLCE supports BLCP awardees through improved data collection, analysis and expanding the body of knowledge of the health status and needs of coal miners nationally.

In FY 2018, HRSA piloted a new patient-level data reporting system to capture the number of medical encounters a black lung disease patient may experience on a single trip to the clinic. HRSA can now track each unique patient encounter within a day, rather than measuring multiple encounters within a day as only one encounter. In FY 2018, the program supported 67,489 medical encounters with Black Lung disease patients, under the new reporting method. This exceeds the target of 20,000 that is based on the former reporting method; the targets will be formally changed in the near future.

Recent data highlights the continued need for black lung services. The National Institute of Occupational Safety and Health (NIOSH) identified a cluster of 60 progressive massive fibrosis (PMF) cases among current and former Appalachian 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 and July 2016.[246] The current prevalence of CWP among underground coal miners with 25 years or more of underground mining tenure in central Appalachia (Kentucky, Virginia, and West Virginia) is 20.6 percent and the national prevalence is over 10 percent.[247]

Funding History

FY	Amount
FY 2017	$7,250,000
FY 2018	$10,000,000
FY 2019	$10,921,000
FY 2020	$11,500,000
FY 2021	$11,500,000

Budget Request

The FY 2021 Budget Request for the Black Lung Program of $11.5 million is equal to the FY 2020 Enacted 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.

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

[246] Blackley DJ, Crum JB, Halldin CN, Storey E, Laney AS. "Resurgence of Progressive Massive Fibrosis in Coal Miners — Eastern Kentucky, 2016." MMWR 2016;65:1385–1389.
DOI: http://dx.doi.org/10.15585/mmwr.mm6549a1external

[247] Blackley DJ, Halldin CN, Laney AS. "Continued Increase in Prevalence of Coal Workers' Pneumoconiosis in the United States, 1970–2017", *American Journal of Public Health* 108, no. 9 (September 1, 2018): pp. 1220-1222.
DIO: https://doi.org/10.2105/AJPH.2018.304517

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
33.I.A.1: Number of miners served each year (Output)	FY 2018: 13,099 Target: 13,800 (Target Not Met)	13,800	13,800	Maintain
33.I.A.2: Number of medical encounters from Black Lung each year. (Output)	FY 2018: 67,489 Target: 20,000 (Target Exceeded)	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 2018: 1,341 Target: 1,314 (Target Exceeded	1,300	1,300	Maintain

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	16	16	16
Average Award	$675,359	$718,750	$718,750
Range of Awards	$125,000 - $1,954,576	$125,000 - $2,081,625	$125,000 - $2,081,625

Telehealth

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$24,324,000	$29,000,000	$29,000,000	---
FTE	2	2	2	---

Authorizing Legislation: Public Health Service Act, Section 330I and Section 330L, and Social Security Act, Section 711.

FY 2021 Authorization (Section 330I and 330L).....Expired

FY 2021 Authorization (Section 711).....Indefinite

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:

- 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.

  This program funds different cohorts of grantees, usually with unique clinical or population focus areas, although grantees can also provide other clinical services in their projects. All TNGP grantee cohorts focus on using telehealth technology to expand access to services. In addition, the program conducts project evaluations to establish an evidence-base assessing the effectiveness of telehealth care for patients, providers, and payers. HRSA will continue to support 29 TNGP grantees focused on improving access to health care services, in rural and underserved communities.

- Evidence-Based Tele-Behavioral Health Network (EB THNP) Program increases access to behavioral health care in rural and frontier communities by using telehealth technologies, given the shortage of mental health providers in many rural and underserved communities. The emphasis on data collection and research to further the

telehealth evidence base separates this program from other Telehealth Network Grants in OAT. HRSA expects to make new awards in FY 2021.

- 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 2021, HRSA expects to make new regional and national TRCs.

- Telehealth Center of Excellence (COE) program examines the efficacy of telehealth services in rural and urban areas and serves as a national clearinghouse for telehealth research and resources. HRSA expects to make new COE awards in FY 2021.

- Telehealth Research Centers (THRCs) conducts policy-relevant, clinically informed telehealth research and comprehensive evaluation of nationwide telehealth investments in rural areas and populations. As part of the research and evaluation, the Telehealth Research Centers will also work with Telehealth Network Grant Program awardees, helping them quantify and analyze their results and preparing summaries and publications of TNGP's clinical impact. HRSA anticipates making new awards in FY 2020 and will continue support for these awards in FY 2021.

- Licensure Portability Grant (LPG) 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. HRSA will continue to fund two awards for this program in FY 2021.

Funding History

FY	Amount
FY 2017	$18,500,000
FY 2018	$23,434,000
FY 2019	$24,324,000
FY 2020	$29,000,000
FY 2021	$29,000,000

Budget Request

The FY 2021 Budget Request for the Telehealth Program of $29 million is equal to the FY 2020 Enacted Level. HRSA will continue to utilize telehealth to provide access to healthcare in rural and underserved areas. In FY 2021, HRSA will make 30 new grant awards and continue 33 grants awards to strengthen the networks that provide telehealth services.

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[248]	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
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) [249]	FY 2017: 37% Target: 25% (Target Exceeded)	25%	25%	Maintain
34.1: The percent of TNGP grantees that continue to offer services after the TNGP funding has ended. [250](Outcome)	FY 2017: N/A	95%	N/A	N/A

[248] 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.

[249] In FY 2021, HRSA anticipates replacing this measure so no grantees will be expected to participate in telediabetes case management.

[250] This is a long-term measure based on the end date of the current cohort of grantees. The target date for this measure is FY 2020.

Measure[248]	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
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. (Output)[251]	FY 2017: 3,189 Target: 2,750 (Target Exceeded)	2,750	2,775	+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.[252] (Output)	FY 2017: 499 Target: 335 (Target Exceeded)	335	340	+5
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.[253] (Output)	FY 2017: 556 Target: 340 (Target Exceeded)	340	350	+10

[251] This is a demonstration program. Every three to four years, each cohort of TNGP grantees "graduates" from the program while a new cohort of grantees begin a new multi-year cycle of grant-supported telehealth activities. This measure is calculated as a cumulative number of total services by site. With each new cohort, the distribution of telehealth service types and the number of sites delivering one or more services may change. Therefore, the targets may need to be revised if there is evidence of a significant increase or decrease in the number of sites or services that new grantees select to provide.

[252] This is a demonstration program. Every three to four years, each cohort of TNGP grantees "graduates" from the program while a new cohort of grantees begins a new multi-year cycle of grant-supported telehealth activities. This measure is calculated as a cumulative number. With each new cohort, the distribution of telehealth service types which grantees select to provide may change. Therefore, the targets may need to be revised if there is evidence of a significant increase or decrease in grantees that are providing mental health services.

[253] Ibid.

Measure[248]	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 +/- FY 2020
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.[254] (Efficiency)	FY 2017: 35 per Million $ Target: 65 per Million $ (Target Not Met)	65 per Million $	65 per Million $	Maintain

Grant Awards Table

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	57	63	63
Average Award	$381,579	$460,317	$460,317
Range of Awards	$250,000 - $2,000,000	$250,000 - $2,000,000	$250,000 - $2,000,000

[254] 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 to four years a new cohort of grantee begins a new three- or four-year cycle of grant-supported activities, with grantees gradually expanding sites and services per dollar invested. With each new cohort, there is a start-up period where services are put in place but are not yet necessarily implemented, which increases the cost per site or service type. OAT has refined programs to focus on specific uses and users like school-based health clinics. The focus on innovation in the use of telehealth services rather than volume of telehealth services has increased cost per site or service type. As OAT seeks to focus telehealth funding on special areas, it will reexamine the target baseline for cost per site or service.

Rural Residency Planning and Development

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$9,956,000	$10,000,000	---	-$10,000,000
FTE	1	1	---	-1

Authorizing Legislation: Social Security Act, Section 711

FY 2021 Authorization ..... Indefinite

Allocation Method .....Competitive Grants/Cooperative Agreement

Program Description and Accomplishments

The Rural Residency Planning and Development Program seeks to expand the number of rural residency training programs and subsequently increase the number of physicians choosing to practice in rural areas. For the purpose of this program, rural residencies are allopathic and osteopathic physician residency training programs that primarily train in rural communities. This includes Rural Training Tracks (RTTs), a specific model of rural residency training in which residents receive more than 50 percent of their training in a rural location after spending their initial year in a larger, often urban, residency setting. Research has shown that residents often practice near where they complete their residency training. RTT graduates are twice as likely to practice family medicine in a rural setting as compared to family medicine residents trained in an urban program. The Federal Office of Rural Health Policy collaborates with HRSA's Bureau of Health Workforce (BHW) to fund two rural residency programs:

- Rural Residency Planning and Development (RRPD) creates new physician residency training programs that support physician workforce expansion in rural areas and that are sustainable beyond the grant performance period through public (i.e., Medicare or Medicaid), other state or private funding. Grantees may use funds to cover planning and development costs incurred while achieving program accreditation through the Accreditation Council for Graduate Medical Education (ACGME).

- Rural Residency Planning and Development Technical Assistance (RRPD-TA) funds a cooperative agreement that serves as a technical assistance center to support RRPD awardees.

In FY 2019, HRSA fully funded 27 three-year RRPD awards across 21 states. These awards support new rural residency programs in family medicine, internal medicine and psychiatry. Sixteen of the 27 awardees are using the RTT model for their residency programs. The RRPD

Program generated significant interest from rural stakeholders, and HRSA received more applications than anticipated.

In FY 2020, HRSA will fully fund a new cohort of RRPD awards as well as a new RRPD-TA program to provide technical assistance to the new RRPD awardees.

Funding History

FY	Amount
FY 2017	---
FY 2018	$14,958,000
FY 2019	$9,956,000
FY 2020	$10,000,000
FY 2021	---

Budget Request

The FY 2021 Budget Request for the Rural Residency Planning and Development Program of $0 is $10.0 million below the FY 2020 Enacted Level. HRSA's previously funded Rural Residency awards will remain active in FY 2021 and continue to provide assistance to rural entities seeking to establish new rural residency programs and to develop accredited residencies.

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

Grant Awards Table

	FY 2019 Final[255]	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	13	12	---
Average Award	$750,000	$770,833	---
Range of Awards	$750,000 - $750,000	$750,000 - $1,000,000	---

[255] Data represents 13 RRPD awards that were fully funded at the beginning of the project period using FY 2019 multi-year funds. An additional 14 awards were made at the same time using multi-year funding appropriated in FY 2018.

Rural Communities Opioid Response

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$120,000,000	$110,000,000	$110,000,000	---
FTE	7	7	12	+5

Authorizing Legislation: Social Security Act, Section 711

FY 2021 Authorization .....Indefinite

Allocation Method .....Competitive Grants/Cooperative Agreement

Program Description and Accomplishments

The Rural Communities Opioid Response Program (RCORP) initiative aims to reduce the morbidity and mortality associated with substance use disorder (SUD), including opioid use disorder (OUD), in high risk rural communities by providing funding and technical assistance to multi-sector consortia to enable them to identify and address OUD prevention, treatment, and recovery needs at the community, county, state, and/or regional levels.

RCORP is composed of three grant programs:

- RCORP-Planning provides one year of support to rural communities to strengthen their capacity to identify OUD workforce and service delivery needs and develop plans to address them. HRSA has awarded 265 RCORP-Planning awards since FY 2018, which have targeted nearly 1,000 rural counties nationwide and resulted in the development of broad and diverse consortia, with an average of 10 organizations per consortium. Over half of the FY 2019 Implementation grant recipients were recipients of FY 2018 Planning grants, which is a testament to the value of the one-year planning period for rural communities and the quality of technical assistance provided to Planning grantees. HRSA does not anticipate making new RCORP-Planning awards in FY 2021.

- RCORP-Implementation provides multi-year support to established rural consortia to implement a set of core OUD prevention, treatment, and recovery services that align with HHS' Five-Point Strategy to Combat the Opioid Crisis. HRSA awarded 80 Implementation awards in FY 2019. HRSA plans to award new Implementation awards in FY 2020 and new Implementation awards in FY 2021.

- RCORP-Medication-Assisted Treatment Expansion provides multi-year support for the establishment and/or expansion of Medication-Assisted Treatment (MAT) in Rural Health Clinic, Critical Access Hospital, Health Center Look-Alike, and Tribal settings to increase the number of access points where rural residents can receive evidence-based

treatment for OUD. The 12 three-year grants that HRSA fully funded in FY 2019 will remain active in FY 2021.

HRSA funds three cooperative agreements that provide information, technical assistance, and evaluation support to RCORP grantees. In FY 2021, HRSA will continue funding three Rural Centers of Excellence on Substance Use Disorders awards that provide multi-year support for the dissemination of best practices related to the treatment for and prevention of substance use disorders within rural communities, with a focus on the current opioid crisis. In FY 2021, HRSA will also continue supporting a cooperative agreement to conduct program-wide evaluation activities for the RCORP initiative and a cooperative agreement to provide technical assistance to RCORP grantees.

Funding History

FY	Amount
FY 2017	$---
FY 2018	$100,000,000
FY 2019	$120,000,000
FY 2020	$110,000,000
FY 2021	$110,000,000

Budget Request

The FY 2021 Budget Request for the Rural Communities Opioid Response Program of $110.0 million is equal to the FY 2020 Enacted Level. This request will enable HRSA to fund new RCORP-Implementation grants that provide needed SUD/OUD prevention, treatment, and recovery services to rural residents.

The request will also provide HRSA with flexibility to respond to the evolving needs of the opioid epidemic, including the addition of psychostimulants. Recent data from the Centers for Disease Control and Prevention (CDC) indicate that the rate of overdose deaths involving psychostimulants with abuse potential (e.g., methamphetamine) increased by over a third in rural counties between 2016 and 2017[256]. Additionally, HRSA has heard from rural stakeholders and grantees that psychostimulants currently pose a great concern for their communities. In FY 2021, HRSA will allocate funding to respond specifically to this increasing burden of psychostimulants in rural communities.

HRSA will continue to engage and partner with other federal agencies to promote a coordinated approach to combatting this devastating epidemic and identifying additional priority areas.

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

[256] Kariisa et al (2019), "Drug Overdose Deaths Involving Cocaine and Psychostimulants with Abuse Potential—United States, 2003-2017," *CDC Morbidity and Mortality Weekly Report*, https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6817a3-H.pdf

Grant Awards Table

	FY 2019 Final [257]	FY 2020 Enacted [258]	FY 2021 President's Budget[259]
Number of Awards	188	145	98
Average Award	$617,021	$717,241	$1,066,327
Range of Awards	$200,000 -$6,666,666	$200,0000 - $3,333,333	$500,000 - $3,333,333

[257] Data represents awards funded using one-year funds appropriated in FY 2019. Awards made during the FY19 project period using multi-year funds are not included.
[258] Data represents awards funded using one-year funds appropriated in FY 2020. Awards made during the FY20 project period using multi-year funds are not included.
[259] Data represents awards funded using one-year funds appropriated in FY 2021. Awards made during the FY21 project period using multi-year funds are not included.

Program Management

TAB

Program Management

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$154,568,000	$155,300,000	$151,993,000	-$3,307,000
FTE	770	770	770	---

Authorizing Legislation: Public Health Service Act, Section 301

FY 2021 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 several years, HRSA has 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.

Developing a 21st Century Workforce

Numerous efforts are underway to enhance efficiency and effectiveness of the agency and to ensure the workforce is positioned to succeed in the 21st century. The hiring process has been improved, reducing the time it takes to complete the hiring cycle from recruitment to onboarding.

HRSA is focused on intense employee engagement improvement efforts. The agency had over an 85% participant rate in the 2019 Federal Employee Viewpoint Survey (FEVS). HRSA performs custom analysis and consultations with organizations at all levels to inform improvement strategies.

Maintaining a skilled workforce is a top priority. In 2018, The HRSA Learning Institute (HLI) delivered 246 classes, including both in person and virtual. More than 1,330 HRSA employees participated in at least one class, an increase of 10 percent compared to 2017. HLI received and

assisted agency staff on requests for organizational development facilitation services, and collaborated with the Bureaus/Offices to create custom training curriculum.

Sharing Quality Services

HRSA relies on HHS-provided shared services for many of the services represented in this CAP goal, such as human resources, financial management, grants, and procurement. HRSA actively seeks out and deploys shared services to improve and simplify processes, and to maximize the efficiency of shared services with other components of HHS.

Creating a Culture of Program Integrity

Program Management also supports Enterprise Risk Management (ERM) activities that align with core principles and performance and strategic planning activities to reduce programmatic risk and improve performance. HRSA has established a HRSA-wide governance structure for enterprise-wide business operations and risk management activities to ensure a proactive and customer-focused suite of business operation services and risk management functions.

HRSA is currently engaged in ERM implementation strategies aligned with the revised OMB Circular A-123. Recent revisions to the circular's Appendices A and C, respectively, include prioritizing risk based assessments and a focus on fraud identification and prevention activities. HRSA's ERM efforts include Governance and Process support for the promotion of a risk-aware organizational culture, the creation of a comprehensive view of risks to drive strategic decision making and the establishment and communication of risk appetite.

Funding History

FY	Amount
FY 2017	$153,629,000
FY 2018	$154,615,000
FY 2019	$154,568,000
FY 2020	$155,300,000
FY 2021	$151,993,000

Budget Request

The FY 2021 Budget Request of $152 million is $3.3 million below the FY 2020 Enacted Level. 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 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 by enhancing HRSA's public-facing websites in compliance with OMB and DHS requirements, by implementing enterprise-wide Security Event Management using Splunk, and by initiating a successful "PhishMe" campaign to train HRSA staff to recognize and properly report suspicious emails.

- Continue implementation of the Enterprise Architecture, Capital Planning and Investment Control (CPIC) and Enterprise Performance Life Cycle (EPLC) processes.

- Enhance Electronic Handbooks (EHBs) by adding a team based approach to all modules, adding auto-save, and implementing a Modern Business analytics Platform (MDAP) using Tableau. Launched a new EHBs user interface for grantees with simpler navigation, widgets, fly-out menus, and other shortcuts.

- Continue modernizing the Data Warehouse. Developed a series of colorful and interactive Tableau dashboards to replace 130 legacy reports, giving HRSA staff and the public deeper analytical insight into HRSA funding, location, and program performance. Upgraded geocoding technology, resulting in 20 percent faster map generation and improved accuracy of Health Center site locations. Collapsed 250 web pages into 75, resulting in a simpler, more organized site that is easier to search and navigate.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
35.VII.A.4 Implement Enterprise Risk Management (ERM) (Output)	FY 2018: Contribute to HHS ERM efforts and continue to engage HRSA governance boards in ERM, per revised OMB circular A-123 (Target Met)	Assess HRSA's ERM implementation efforts, including alignment with	Analyze results of risk-based A-123 assessments,	N/A

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
	Target: Continue to implement Enterprise Risk Management, including developing a risk aware culture at HRSA (Target Met)	revised OMB Circular A-123 and Appendices A (reporting) and C (improper payments)	to inform ERM strategy.	
35.VII.B.1. Ensure Critical Infrastructure Protection: Security Awareness Training (Output)	FY 2018: 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 (Target Met) Target: 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. (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

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
35.VII.B.2 Ensure Critical Infrastructure Protection: Security Authorization to Operate (Output)	FY 2018: 100% of HRSA information systems were be assessed and Authorized to Operate (ATO). In addition, all systems went through continuous monitoring to ensure that critical patches were applied, security controls were implemented and working as intended, and risks were managed and mitigated in a timely manner. (Target Met) Target: 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 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
35.VII.B.2a Ensure Critical Infrastructure Protection: Security HSPD-12 Privilege and Non-Privilege (Output)	FY 2018: Privacy - 100% of HRSA staff (federal and contractor) accessing the HRSA network with Privileged accounts used PIV cards or other 2-factor authentication (Target Met) Target: 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 - 95% 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	+5 percentage points
35.VII.B.2b Ensure Critical Infrastructure Protection: Security Cyber Sprint (Output)	FY 2018: Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 days (Target Met) Target: 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: Critical findings within 15 days High findings within 30 days	Critical findings within 15 days High findings within 30 days
35.VII.B.2c Ensure Critical Infrastructure Protection: Security Privacy Impact Assessment (PIA) or Privacy Threshold Assessment (PTA) (Output)	FY 2018: 90% of systems that required a PIA or a Privacy Threshold Assessment (PTA) were identified (Target Met) Target: Identify 90% 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 95% of systems that require a PIA or a Privacy Threshold Assessment (PTA)	+5 percentage points

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
35.VII.B.2d Ensure Critical Infrastructure Protection: Security Phishing (Output)	FY 2018: 17 Phishing Campaigns completed (Target Exceeded) Target: 6 Phishing Campaigns completed (Target Exceeded)	12 Phishing Campaigns completed	24 Phishing Campaigns completed	+12 Phishing Campaigns
35.VII.B.4 Enterprise Architecture (Output)	FY 2018: Enterprise Architecture: 90% of IT investments were reported to OMB with mapping to at least one HHS segment and domain (Target Met) Target: Enterprise Architecture: 90% 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

Family Planning

TAB

Family Planning

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$285,220,000	$286,479,000	$286,479,000	---
FTE	8*	35	35	---

*Due to coding error, FTE is reporting lower than actual 35 FTE

Authorizing Legislation - Title X of the Public Health Service Act

FY 2020 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 assist individuals and families in determining the number and spacing of children and to provide access to voluntary family planning methods, services, and information to all who want and need them. Title X authorizing legislation requires that projects provide a broad range of effective and acceptable family planning methods and services, including fertility awareness-based methods, infertility services and services for adolescents. 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. According to the 2018 Family Planning Annual Report (FPAR) data (the most recent data available), services were provided through 99 family planning service grants that supported a nationwide network of 3,954 community-based sites that provided clinical and educational services to more than 3,939,749 persons. There was 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.

In 2018, OPA clinics and grantees were also involved in Chlamydia screening for over 886,000 females ages 15-24. Screening for Chlamydia is important to not only reduce the impact of sexually transmitted infections which continues to be on the rise in the United States, but also the impact on reducing infertility. Untreated Chlamydia infection may lead to the development of

pelvic inflammatory disease, which if left untreated may cause infertility. As a result of the Title X network, this screening resulted in the prevention of at least 1,050 cases of infertility in women ages 15-24. Additionally, the Title X program was responsible for the prevention of approximately 861,600 unintended pregnancies through the provision of family planning methods, counseling and education, and other clinical services. Over 1.2 million confidential HIV tests were also administered with 2,699 diagnosed as HIV positive.

In addition to providing grants to clinical service providers, the Title X Family Planning program supports the US Department of Health and Human Services, and the Office of the Assistant Secretary for Health's initiative to identify and provide solutions to reduce substance use disorders (SUD) and the impact that they have on future health outcomes. In 2019, the Title X program built off of an previously held expert work group focused on the identification of interventions to better incorporate and link SUD screening, referral, and treatment with Title X family planning centers. As a result of this, OPA is in the process of funding research program that focus on innovate ideas to improve the delivery of Title X family planning services, including funding program that integrate SUD screening, referral, and/or treatment with family planning and related reproductive health services. The awards were made in the Fall of 2019. OPA also continues to collaborate with SAMHSA's addiction Technology Transfer Centers (ATTCs) and other Federal and community-based programs in order to improve counseling, screening and referral for treatment services at Title X service sites.

In FY 2019, the program completed a 3-year initiative to improve the ability of Title X family planning projects to provide PrEP (Pre Exposure Prophylaxis) services on-site or by referral. This initiative included the development of a comprehensive tool, guidance and technical assistance for Title X family planning projects interested in providing PrEP services to reduce the risk of HIV infection. While the audience of this tool is Title X family planning service providers, it can also be used by other clinical care providers, including but not limited to STD clinics and other service sites which provide family planning and related preventive health services.

The Title X program will play a key role in helping to develop the STI Federal Action Plan. Emphasis will be directed to underserved populations or communities where high rates of STIs impact the ability of individuals to achieve healthy pregnancies. Though the response will be directed by the epidemiology of the specific infections, the program will build upon its expertise in providing training for all levels of family planning personnel to disseminate information, collect data and research improved delivery mechanisms for family planning services. Title X will work with other HHS OPDIVs to update clinical guidance and recommendations to ensure that high-quality counseling, education and family planning services are available to clients and providers.

Each year, the program provides guidance to grantees by identifying key issues which highlight areas of significance for Title X projects. The program will continue to emphasize the importance of making the broad range of family planning methods and services available at Title X family planning centers, including increased use of fertility awareness-based methods. Supporting the overall health of clients will continue to be an important focus of the program. Therefore, each Title X project should ensure that access to primary health care services, either

onsite or by referral is encouraged and, at a minimum, supported through robust referral linkages.

On March 4, 2019, the Final Rule, Compliance with Statutory Program Integrity Requirements – 84 FR 7714, pps. 7714-7791, to revise 42 CFR 59, was published in the Federal Register. The program regulations are currently in effect and the Title X Program is working with Grantees to assist with implementing the changes within the new set of regulations. The Title X program has modified its monitoring tools, guidance, and training to support Title X projects as well as ensure compliance with the rule and that program resources are used for their intended purposes.

In addition, 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. Grantees are urged to implement more efficient administrative systems, such as health information technologies, electronic health records, and payment management systems. Focusing on these areas will also assist in better data collection and increase the ability to report on the outputs and outcomes of Title X projects and the program.

Another trend, which the program believes will improve program performance, is increasing competition and the diversity in the types of grantees funded. Increased competition has led to more diversified grantees, improved cost recovery methods and different administrative structures, which, it is anticipated, will ultimately improve quality and service delivery.

Funding History

FY	Amount
FY 2017	$286,479,000
FY 2018	$286,479,000
FY 2019	$285,220,000
FY 2020	$286,479,000
FY 2021	$286,479,000

Budget Request

The FY 2021 President's Budget for Family Planning is $286.5 million, which is flat with the FY 2020 Enacted. The FY 2021 Budget request is expected to support family planning services for approximately 3,890,000 persons, with approximately 90 percent having family incomes at or below 200 percent of the federal poverty level. The FY 2021 request provides funding for family planning methods and related preventive health services, as well as related training, information, education and research to improve family planning service delivery.

The FY 2021 request will also allow the program to continue supporting the operation of Family Planning National Training Centers. These training centers focus on improving grantee capacity and skills of clinical providers in Title X service grant projects service providers in order to increase access and the quality of services for all individuals seeking Title X family planning services.

The targets for FY 2021 assume other sources of revenue that contribute to the family planning program at the grantee level will remain at current levels, including Medicaid, state and local government programs, other federal, state, and private grants, and private insurance.

OPA is increasing its focus on improving Chlamydia screening rates within the Title X projects. While OPA has always stressed the importance of screening for Chlamydia infection, following CDC's clinical recommendations, the continued increase in sexually transmitted infections over the past decade stresses the added importance of identifying and treating this preventable infection as early as possible. In addition, OPA is continuing to stress the importance of vaccination against HPV, screening for undiagnosed cervical tissue abnormalities, providing preconception care and counseling and basic infertility services, providing pregnancy testing and counseling, increasing access to fertility awareness-based methods (FABM), which includes natural family planning methods, hormonal and non-hormonal contraceptives methods, adolescent services and related education and counseling. These services, along with community-based education and outreach, assist individuals and families with effective family planning services, whether it be to prevent or achieve 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 training, 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 to serve, and based on the FPAR, billing revenue has continued to increase over the past decade. In addition, the program is assessing traditional and innovative ways to increase access to family planning and related preventive health services, specifically in rural and hard to reach areas.

In FY 2020 and continuing into FY 2021, the Title X family planning program will continue to develop and recommend additional performance measures for the program. These measures will include: (1) Increasing the number of unduplicated clients that receive the HPV (human papillomavirus) vaccine at Title X family planning centers; (2) Increasing the number of clients screened for substance use disorders; and (3) re-emphasizing the importance of screening for Chlamydia infection in females ages 15 – 24. It is anticipated that the new data collection system, FPAR 2.0 will begin collecting encounter-level data from Title X projects beginning January 1, 2021 which will increase the number of data elements collected, the accuracy and precision of the data, and better allow for OPA to use these data to direct program resources to improve performance.

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 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
36.II.A.1: Total number of unduplicated clients served in Title X service sites. *(Outcome)*	FY 2018: 3,939,749 Target: 4,018,000 (Target Not Met)	3,965,000	3,890,000	-75,000
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 2018: 89% 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 2018: 861,626 Target: 905,000 (Target Not Met)	912,000	880,000	-32,000
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 2018: 886,101 Target: 1,195,000 (Target Not Met)	1,030,000	943,000	-87,000
36.II.C.3: Increase the proportion of females' ages 15 – 24 attending Title X family planning clinics screened for Chlamydia infection. *(Outcome)*	FY 2018: 62.13% Target: 64.4% (Target Not Met)	85.0%	85%	Maintain

Efficiency Measure

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/- FY 2020 Target
36.E: Maintain the actual cost per Title X client below the medical care inflation rate. *(Efficiency)*	FY 2017: $335.36 Target: $336.69 (Target Exceeded)	$364.21	$367.70	+$3.49

Grant Awards Tables

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	90	90	90
Average Award	$2,866,666	$2,866,666	$2,866,666
Range of Awards	$150,000 - $21,000,000	$150,000 - $21,000,000	$150,000 - $21,000,000

Nonrecurring Expense Fund

TAB

Nonrecurring Expenses Fund

Budget Summary
(Dollars in Thousands)

Notification[260]	FY 2019	FY 2020[261]	FY 2021[262]
HRSA Investments	$13,000	TBD	TBD

Authorizing Legislation:

Authorization…….Section 223 of Division G of the Consolidated Appropriations Act, 2008

Allocation Method……..Direct Federal, Competitive Contract

Program Description and Accomplishments

The Nonrecurring Expenses Fund (NEF) permits HHS to transfer unobligated balances of expired discretionary funds from FY 2008 and subsequent years into the NEF account. Congress authorized use of the funds for capital acquisitions necessary for the operation of the Department, specifically information technology (IT) and facilities infrastructure acquisitions.

Budget Allocation

In FY 2019, HRSA received $13.0 million to support five NEF projects that will improve HRSA operations, strengthen the security of HRSA's data, and support the President's Management Agenda. HRSA is expanding Electronic Handbooks (EHBs) modernization efforts, enhancing EHBs security features, and supporting cloud migration activities. HRSA is also investing in security operations upgrades that identify and mitigate open source security risks across application portfolios and that resolve minor cybersecurity events through tool automation and orchestration. A final project focuses on developing dashboards that leverage internal and external health workforce data sets to enable HRSA to prioritize funding strategies to target specific areas of workforce need.

[260] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use. Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on December 4, 2018.
[261] HHS has not yet notified for FY 2020.
[262] HHS has not yet notified for FY 2021.

Supplementary Tables

TAB

Object Class Tables
(dollars in thousands)

DISCRETIONARY

OBJECT CLASS	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Full-time permanent (11.1)	157,906	168,718	161,247	-7,471
Other than full-time permanent (11.3)	6,014	6,182	6,018	-164
Other personnel compensation (11.5)	4,259	4,379	4,244	-135
Military personnel (11.7)	14,465	14,895	14,404	-491
Special personnel services payments (11.8)	85	88	89	+1
Subtotal personnel compensation	**182,729**	**194,262**	**186,002**	**-8,260**
Civilian benefits (12.1)	51,730	54,304	51,851	-2,453
Military benefits (12.2)	8,008	8,247	8,014	-233
Benefits to former personnel (13.1)	1,747	1,796	1,810	+14
Total Pay Costs	**244,214**	**258,609**	**247,677**	**-10,932**
Travel and transportation of persons (21.0)	3,505	3,505	3,291	-214
Transportation of things (22.0)	186	186	186	-
Rental payments to GSA (23.1)	16,405	16,405	15,752	-653
Rental payments to Others (23.2)	703	703	703	-
Communication, utilities, and misc. charges (23.3)	2,490	2,490	2,416	-74
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	109	109	-	-109
Other Contractual Services: 25.0	-	-	93	+93
Advisory and assistance services (25.1)	11,707	11,707	9,149	-2,558
Other services (25.2)	223,765	230,435	209,786	-20,649
Purchase of goods and services from government accounts (25.3)	180,108	177,488	145,700	-31,788
Operation and maintenance of facilities (25.4)	723	723	723	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	2,265	2,265	1,014	-1,251
Operation and maintenance of equipment (25.7)	4,154	4,154	3,586	-568
Subsistence and support of persons (25.8)	20	20	20	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	698	698	698	-
Subtotal Other Contractual Services	**423,440**	**427,490**	**370,769**	**-56,721**
Equipment (31.0)	5,445	5,445	4,566	-879
Land and Structures (32)	3,757	3,757	3,757	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	5,995,934	6,210,205	5,531,631	-678,574
Insurance Claims and Indemnities (42.0)	135,097	108,355	108,337	-18
Total Non-Pay Costs	**6,587,071**	**6,778,650**	**6,041,408**	**-737,242**
Total Budget Authority by Object Class	**6,831,285**	**7,037,259**	**6,289,085**	**-748,174**

PRIMARY HEALTH CARE

OBJECT CLASS	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Full-time permanent (11.1)	26,125	26,835	27,043	+208
Other than full-time permanent (11.3)	599	616	621	+5
Other personnel compensation (11.5)	450	463	466	+3
Military personnel (11.7)	2,979	3,067	3,160	+93
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**30,153**	**30,981**	**31,290**	**+309**
Civilian benefits (12.1)	8,622	8,863	8,932	+69
Military benefits (12.2)	1,571	1,617	1,666	+49
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**40,346**	**41,461**	**41,888**	**+427**
Travel and transportation of persons (21.0)	1,285	1,285	1,285	-
Transportation of things (22.0)	37	37	37	-
Rental payments to GSA (23.1)	1,555	1,555	1,555	-
Rental payments to Others (23.2)	2	2	2	-
Communication, utilities, and misc. charges (23.3)	215	215	215	-
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)	89,773	89,931	89,931	-
Purchase of goods and services from government accounts (25.3)	44,701	44,661	44,661	-
Operation and maintenance of facilities (25.4)	303	303	303	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	532	532	532	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	74	74	74	-
Subtotal Other Contractual Services	**135,383**	**135,501**	**135,501**	**-**
Equipment (31.0)	1,532	1,532	1,532	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	1,328,918	1,336,628	1,438,219	+101,591
Insurance Claims and Indemnities (42.0)	135,048	108,306	108,288	-18
Total Non-Pay Costs	**1,603,975**	**1,585,061**	**1,686,634**	**+101,573**
Total Budget Authority by Object Class	**1,644,321**	**1,626,522**	**1,728,522**	**+102,000**

HEALTH WORKFORCE

OBJECT CLASS	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Full-time permanent (11.1)	12,629	12,983	6,081	-6,902
Other than full-time permanent (11.3)	172	177	26	-151
Other personnel compensation (11.5)	173	178	55	-123
Military personnel (11.7)	1,318	1,358	564	-794
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**14,292**	**14,696**	**6,726**	**-7,970**
Civilian benefits (12.1)	3,997	4,109	1,847	-2,262
Military benefits (12.2)	651	670	275	-395
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**18,940**	**19,475**	**8,848**	**-10,627**
Travel and transportation of persons (21.0)	160	160	41	-119
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	656	656	169	-487
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	988	988	928	-60
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	17	17	1	-16
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	23,655	23,655	13,783	-9,872
Purchase of goods and services from government accounts (25.3)	32,780	32,780	10,007	-22,773
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	749	749	476	-273
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	-	-	-	-
Subtotal Other Contractual Services	**57,184**	**57,184**	**24,266**	**-32,918**
Equipment (31.0)	1,249	1,249	610	-639
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	985,466	1,114,777	335,562	-779,215
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**1,045,720**	**1,175,031**	**361,577**	**-813,454**
Total Budget Authority by Object Class	**1,064,660**	**1,194,506**	**370,425**	**-824,081**

MATERNAL AND CHILD HEALTH

OBJECT CLASS	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Full-time permanent (11.1)	8,239	8,470	6,674	-1,796
Other than full-time permanent (11.3)	407	418	368	-50
Other personnel compensation (11.5)	145	149	108	-41
Military personnel (11.7)	320	329	236	-93
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**9,111**	**9,366**	**7,386**	**-1,980**
Civilian benefits (12.1)	2,779	2,857	2,257	-600
Military benefits (12.2)	170	175	114	-61
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**12,060**	**12,398**	**9,757**	**-2,641**
Travel and transportation of persons (21.0)	506	506	444	-62
Transportation of things (22.0)	1	1	1	-
Rental payments to GSA (23.1)	616	616	469	-147
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	47	47	36	-11
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)	7,894	7,894	5,336	-2,558
Other services (25.2)	8,429	8,429	7,683	-746
Purchase of goods and services from government accounts (25.3)	15,095	15,095	11,711	-3,384
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	215	215	53	-162
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	5	5	5	-
Subtotal Other Contractual Services	**31,638**	**31,638**	**24,788**	**-6,850**
Equipment (31.0)	327	327	181	-146
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	877,283	898,251	883,342	-14,909
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**910,418**	**931,386**	**909,261**	**-22,125**
Total Budget Authority by Object Class	**922,478**	**943,784**	**919,018**	**-24,766**

HIV/AIDS

OBJECT CLASS	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Full-time permanent (11.1)	18,176	22,060	22,231	+171
Other than full-time permanent (11.3)	121	125	126	+1
Other personnel compensation (11.5)	311	320	322	+2
Military personnel (11.7)	2,839	2,923	3,014	+91
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**21,447**	**25,428**	**25,693**	**+265**
Civilian benefits (12.1)	5,786	7,073	7,128	+55
Military benefits (12.2)	1,651	1,701	1,753	+52
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**28,884**	**34,202**	**34,574**	**+372**
Travel and transportation of persons (21.0)	388	388	388	-
Transportation of things (22.0)	29	29	29	-
Rental payments to GSA (23.1)	2,066	2,066	2,066	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	389	389	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)	28,130	28,130	28,130	-
Purchase of goods and services from government accounts (25.3)	59,848	59,848	59,848	-
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	2,047	2,047	2,047	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	39	39	39	-
Subtotal Other Contractual Services	**90,064**	**90,064**	**90,064**	**-**
Equipment (31.0)	1,219	1,219	1,219	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	2,208,829	2,260,424	2,355,052	+94,628
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**2,302,984**	**2,354,579**	**2,449,207**	**+94,628**
Total Budget Authority by Object Class	**2,331,868**	**2,388,781**	**2,483,781**	**+95,000**

HEALTHCARE SYSTEMS

OBJECT CLASS	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Full-time permanent (11.1)	7,013	7,209	7,265	+56
Other than full-time permanent (11.3)	234	241	242	+1
Other personnel compensation (11.5)	245	252	254	+2
Military personnel (11.7)	1,305	1,344	1,385	+41
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**8,797**	**9,046**	**9,146**	**+100**
Civilian benefits (12.1)	2,406	2,473	2,492	+19
Military benefits (12.2)	625	644	663	+19
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**11,828**	**12,163**	**12,301**	**+138**
Travel and transportation of persons (21.0)	418	418	418	-
Transportation of things (22.0)	66	66	66	-
Rental payments to GSA (23.1)	1,150	1,150	1,150	-
Rental payments to Others (23.2)	701	701	701	-
Communication, utilities, and misc. charges (23.3)	216	216	216	-
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)	837	837	837	-
Other services (25.2)	59,322	65,834	56,790	-9,044
Purchase of goods and services from government accounts (25.3)	4,387	4,459	3,682	-777
Operation and maintenance of facilities (25.4)	34	34	34	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	2,265	2,265	1,014	-1,251
Operation and maintenance of equipment (25.7)	181	181	181	-
Subsistence and support of persons (25.8)	20	20	20	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	341	341	341	-
Subtotal Other Contractual Services	**67,387**	**73,971**	**62,899**	**-11,072**
Equipment (31.0)	288	288	288	-
Land and Structures (32)	1,577	1,577	1,577	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	30,479	33,043	22,417	-10,626
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**102,282**	**111,430**	**89,732**	**-21,698**
Total Budget Authority by Object Class	**114,110**	**123,593**	**102,033**	**-21,560**

RURAL HEALTH POLICY

OBJECT CLASS	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Full-time permanent (11.1)	2,599	2,672	2,776	+104
Other than full-time permanent (11.3)	263	270	266	-4
Other personnel compensation (11.5)	33	34	32	-2
Military personnel (11.7)	79	81	81	-
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**2,974**	**3,057**	**3,155**	**+98**
Civilian benefits (12.1)	892	917	966	+49
Military benefits (12.2)	42	44	45	+1
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**3,908**	**4,018**	**4,166**	**+148**
Travel and transportation of persons (21.0)	267	267	233	-34
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	152	152	134	-18
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	13	13	11	-2
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)	7,737	7,737	6,752	-985
Purchase of goods and services from government accounts (25.3)	3,999	3,999	3,616	-383
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	407	407	274	-133
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	-	-	-	-
Subtotal Other Contractual Services	**12,143**	**12,143**	**10,642**	**-1,501**
Equipment (31.0)	310	310	215	-95
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	297,679	301,391	231,433	-69,958
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**310,564**	**314,276**	**242,668**	**-71,608**
Total Budget Authority by Object Class	**314,472**	**318,294**	**246,834**	**-71,460**

PROGRAM MANAGEMENT

OBJECT CLASS	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Full-time permanent (11.1)	79,166	81,383	82,013	+630
Other than full-time permanent (11.3)	4,151	4,267	4,300	+33
Other personnel compensation (11.5)	2,818	2,897	2,920	+23
Military personnel (11.7)	5,094	5,245	5,404	+159
Special personnel services payments (11.8)	85	88	89	+1
Subtotal personnel compensation	**91,314**	**93,880**	**94,726**	**+846**
Civilian benefits (12.1)	25,954	26,681	26,888	+207
Military benefits (12.2)	2,988	3,077	3,170	+93
Benefits to former personnel (13.1)	1,747	1,796	1,810	+14
Total Pay Costs	**122,003**	**125,434**	**126,594**	**+1,160**
Travel and transportation of persons (21.0)	215	215	215	-
Transportation of things (22.0)	39	39	39	-
Rental payments to GSA (23.1)	9,869	9,869	9,869	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	600	600	600	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	93	93	93	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	6,704	6,704	6,704	-
Purchase of goods and services from government accounts (25.3)	11,174	8,523	4,050	-4,473
Operation and maintenance of facilities (25.4)	339	339	339	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	11	11	11	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	237	237	237	-
Subtotal Other Contractual Services	**18,465**	**15,814**	**11,341**	**-4,473**
Equipment (31.0)	521	521	521	-
Land and Structures (32)	2,179	2,179	2,179	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	515	516	522	+6
Insurance Claims and Indemnities (42.0)	20	20	20	-
Total Non-Pay Costs	**32,516**	**29,866**	**25,399**	**-4,467**
Total Budget Authority by Object Class	**154,519**	**155,300**	**151,993**	**-3,307**

FAMILY PLANNING

OBJECT CLASS	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Full-time permanent (11.1)	3,959	7,107	7,162	+55
Other than full-time permanent (11.3)	67	69	69	-
Other personnel compensation (11.5)	83	85	86	+1
Military personnel (11.7)	532	548	564	+16
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**4,641**	**7,809**	**7,881**	**+72**
Civilian benefits (12.1)	1,294	1,331	1,341	+10
Military benefits (12.2)	310	319	329	+10
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**6,245**	**9,459**	**9,551**	**+92**
Travel and transportation of persons (21.0)	267	267	267	-
Transportation of things (22.0)	14	14	14	-
Rental payments to GSA (23.1)	341	341	341	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	22	22	22	-
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)	2,975	2,975	2,975	-
Other services (25.2)	14	14	14	-
Purchase of goods and services from government accounts (25.3)	8,124	8,124	8,124	-
Operation and maintenance of facilities (25.4)	47	47	47	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	12	12	12	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	2	2	2	-
Subtotal Other Contractual Services	11,174	11,174	11,174	-
Equipment (31.0)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	266,767	265,173	265,081	-92
Insurance Claims and Indemnities (42.0)	29	29	29	-
Total Non-Pay Costs	**278,614**	**277,020**	**276,928**	**-92**
Total Budget Authority by Object Class	**284,859**	**286,479**	**286,479**	**-**

MANDATORY

OBJECT CLASS	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Full-time permanent (11.1)	50,281	51,689	52,104	+415
Other than full-time permanent (11.3)	883	908	915	+7
Other personnel compensation (11.5)	869	893	901	+8
Military personnel (11.7)	5,647	5,815	6,007	+192
Special personnel services payments (11.8)	-	123	124	+1
Subtotal personnel compensation	**57,680**	**59,428**	**60,051**	**+623**
Civilian benefits (12.1)	16,543	17,006	17,142	+136
Military benefits (12.2)	3,294	3,392	3,509	+117
Benefits to former personnel (13.1)	60	62	63	+1
Total Pay Costs	**77,577**	**79,888**	**80,765**	**+877**
Travel and transportation of persons (21.0)	321	321	321	-
Transportation of things (22.0)	2	2	2	-
Rental payments to GSA (23.1)	3,949	3,949	3,949	-
Rental payments to Others (23.2)	30	30	30	-
Communication, utilities, and misc. charges (23.3)	1,714	1,714	1,714	-
GSA Reimbursement Transaction Charge (23.5)	-	-	-	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	1	1	1	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	22,975	22,975	22,975	-
Other services (25.2)	44,097	44,097	44,097	-
Purchase of goods and services from government accounts (25.3)	126,655	126,655	126,655	-
Operation and maintenance of facilities (25.4)	41	41	41	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	635	635	635	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	11	11	11	-
Subtotal Other Contractual Services	**194,414**	**194,414**	**194,414**	**-**
Equipment (31.0)	2,914	2,914	2,914	-
Grants, subsidies, and contributions (41.0)	4,599,998	4,559,267	4,558,390	-877
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**4,803,343**	**4,762,612**	**4,761,735**	**-877**
Total Budget Authority by Object Class	**4,880,920**	**4,842,500**	**4,842,500**	**-**

Salaries and Expenses
(dollars in thousands)

DISCRETIONARY

OBJECT CLASS	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Full-time permanent (11.1)	157,906	168,718	161,247	-7,471
Other than full-time permanent (11.3)	6,014	6,182	6,018	-164
Other personnel compensation (11.5)	4,259	4,379	4,244	-135
Military personnel (11.7)	14,465	14,895	14,404	-491
Special personnel services payments (11.8)	85	88	89	+1
Subtotal personnel compensation	**182,729**	**194,262**	**186,002**	**-8,260**
Civilian benefits (12.1)	51,730	54,304	51,851	-2,453
Military benefits (12.2)	8,008	8,247	8,014	-233
Benefits to former personnel (13.1)	1,747	1,796	1,810	+14
Total Pay Costs	**244,214**	**258,609**	**247,677**	**-10,932**
Travel and transportation of persons (21.0)	3,505	3,505	3,291	-214
Transportation of things (22.0)	186	186	186	-
Rental payments to Others (23.2)	703	703	703	-
Communication, utilities, and misc. charges (23.3)	2,490	2,490	2,416	-74
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	109	109	-	-109
Other Contractual Services: 25.0	-	-	93	+93
Advisory and assistance services (25.1)	11,707	11,707	9,149	-2,558
Other services (25.2)	223,765	230,435	209,786	-20,649
Purchase of goods and services from government accounts (25.3)	180,108	177,488	145,700	-31,788
Operation and maintenance of facilities (25.4)	723	723	723	-
Medical care (25.6)	2,265	2,265	1,014	-1,251
Operation and maintenance of equipment (25.7)	4,154	4,154	3,586	-568
Subsistence and support of persons (25.8)	20	20	20	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	698	698	698	-
Subtotal Other Contractual Services	**423,440**	**427,490**	**370,769**	**-56,721**
Total Non-Pay Costs	**430,433**	**434,483**	**377,365**	**-57,118**
Total Budget Authority by Object Class	**674,647**	**693,092**	**625,042**	**-68,050**

MANDATORY

OBJECT CLASS	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Full-time permanent (11.1)	50,281	51,689	52,104	+415
Other than full-time permanent (11.3)	883	908	915	+7
Other personnel compensation (11.5)	869	893	901	+8
Military personnel (11.7)	5,647	5,815	6,007	+192
Special personnel services payments (11.8)	-	123	124	+1
Subtotal personnel compensation	**57,680**	**59,428**	**60,051**	**+623**
Civilian benefits (12.1)	16,543	17,006	17,142	+136
Military benefits (12.2)	3,294	3,392	3,509	+117
Benefits to former personnel (13.1)	60	62	63	+1
Total Pay Costs	**77,577**	**79,888**	**80,765**	**+877**
Travel and transportation of persons (21.0)	321	321	321	-
Transportation of things (22.0)	2	2	2	-
Rental payments to Others (23.2)	30	30	30	-
Communication, utilities, and misc. charges (23.3)	1,714	1,714	1,714	-
GSA Reimbursement Transaction Charge (23.5)	-	-	-	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	1	1	1	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	22,975	22,975	22,975	-
Other services (25.2)	44,097	44,097	44,097	-
Purchase of goods and services from government accounts (25.3)	126,655	126,655	126,655	-
Operation and maintenance of facilities (25.4)	41	41	41	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	635	635	635	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	11	11	11	-
Subtotal Other Contractual Services	**194,414**	**194,414**	**194,414**	**-**
Total Non-Pay Costs	**196,482**	**196,482**	**196,482**	**-**
Total Budget Authority by Object Class	**274,059**	**276,370**	**277,247**	**+877**

Detail of Full-Time Equivalent Employment

Programs	2019 Actual			2020 Estimate			2021 Estimate		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Bureau of Primary Health Care:									
Direct:									
Health Centers/Tort	272	47	319	272	47	319	272	47	319
Free Clinics Medical Malpractice	-	-	-			-	-	-	-
Total, Direct:	**272**	**47**	**319**	**272**	**47**	**319**	**272**	**47**	**319**
Mandatory:									
Health Centers	166	11	177	170	11	181	170	11	181
School-based Health Centers- Facilities (ACA)	8	-	8	4	-	4	4	-	4
Total, Mandatory	**174**	**11**	**185**	**174**	**11**	**185**	**174**	**11**	**185**
Total FTE, BPHC	**446**	**58**	**504**	**446**	**58**	**504**	**446**	**58**	**504**
Health Workforce:									
Direct:									
National Health Service Corps	5	-	5	5	-	5	6	-	6
NURSE Corps Loan Repayment & Scholarship	26	4	30	26	4	30	28	4	32
Centers for Excellence	2	-	2	2	-	2	2	-	2
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	1	7	6	1	7	-	-	-
Oral Health Training	5	1	6	5	1	6	-	-	-
Area Health Education Centers	4	-	4	4	-	4	-	-	-
Geriatric Programs	3	2	5	3	2	5	-	-	-
Behavioral Health Workforce Development Programs	11	2	13	11	2	13	11	2	13
Public Health/Preventive Medicine	4	1	5	4	1	5	-	-	-
Advanced Education Nursing Program	9	-	9	9	-	9	-	-	-
Nurse Workforce Diversity	2	1	3	2	1	3	-	-	-
Nurse Education, Practice & Retention	3	1	4	3	1	4	-	-	-
Nurse Faculty Loan Program	2	1	3	2	1	3	-	-	-
Children's Hospitals GME Program	19	1	20	19	1	20	-	-	-

Programs	2019 Actual			2020 Estimate			2021 Estimate		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Medical Student Education	-	-	-	-	-	-	-	-	-
Total, Direct	**113**	**16**	**129**	**113**	**16**	**129**	**53**	**6**	**59**
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	185	24	209	185	24	209	185	24	209
Teaching Health Center Graduate Medical Education	6	1	7	6	1	7	6	1	7
Total, Mandatory	**191**	**25**	**216**	**191**	**25**	**216**	**191**	**25**	**216**
Total FTE, Health Workforce	**338**	**42**	**380**	**338**	**42**	**380**	**278**	**32**	**310**
Maternal and Child Health Bureau:									
Direct:									
Maternal & Child Health Block Grant	44	-	44	44	-	44	44	-	44
Autism and Other Developmental Disorders	6	1	7	6	1	7	-	-	-
Sickle Cell Service Demonstrations	2	-	2	2	-	2	-	-	-
James T. Walsh Universal Newborn Hearing Screening	3	1	4	3	1	4	3	1	4
Emergency Medical Services for Children	5	-	5	5	-	5	-	-	-
Healthy Start	12	4	16	12	4	16	12	4	16
Heritable Disorders	3	-	3	3	-	3	-	-	-
Pediatric Mental Health Care Access Grants	2	-	2	2	-	2	2	-	2
Screening and Treatment for Maternal Depression	1	-	1	1	-	1	1	-	1
Total, Direct:	**78**	**6**	**84**	**78**	**6**	**84**	**62**	**5**	**67**
Mandatory									
Family to Family Health Info Centers	1	-	1	1	-	1	1	-	1
Home Visiting	36	2	38	36	2	38	36	2	38
Total, Mandatory	**37**	**2**	**39**	**37**	**2**	**39**	**37**	**2**	**39**
Total FTE, MCHB	**115**	**8**	**123**	**115**	**8**	**123**	**99**	**7**	**106**

Programs	2019 Actual			2020 Estimate			2021 Estimate		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
HIV/AIDS Bureau:									
Direct:									
Ryan White Part A	38	6	44	38	6	44	38	6	44
Ryan White Part B	53	6	59	53	6	59	53	6	59
Ryan White Part C	39	13	52	39	13	52	39	13	52
Ryan White Part D	8	3	11	8	3	11	8	3	11
Ryan White Part F	4	1	5	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	2	-	2
Ending HIV/AIDS	-	-	-	30	-	30	30	-	30
Total, Direct:	**145**	**29**	**174**	**175**	**29**	**204**	**175**	**29**	**204**
Reimbursable:									
OGAC Global AIDS	17	-	17	17	-	17	17	-	17
Secretary's Minority AIDS Initiative	-	-	-	-	-	-	-	-	-
Total, Reimbursable	**17**	**-**	**17**	**17**	**-**	**17**	**17**	**-**	**17**
Total FTE, HAB	**162**	**29**	**191**	**192**	**29**	**221**	**192**	**29**	**221**
Healthcare Systems Bureau:									
Direct:									
Organ Transplantation	4	-	4	4	-	4	4	-	4
National Cord Blood Inventory	3	1	4	3	1	4	3	1	4
C.W.Bill Young Cell Transplantation Program	6	-	6	6	-	6	6	-	6
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	44	5	49	44	5	49	44	5	49
Covered Countermeasures Compensation	3	2	5	3	2	5	3	2	5
Vaccine	14	5	19	16	5	21	23	5	28
Total, Direct:	**92**	**19**	**111**	**94**	**19**	**113**	**101**	**19**	**120**
Reimbursable:									
Hansen's Disease Center	1	-	1	1	-	1	1	-	1
340B	-	-	-	-	-	-	16	-	16
Total, Reimbursable	**1**	**-**	**1**	**1**	**-**	**1**	**17**	**-**	**17**

Programs	2019 Actual			2020 Estimate			2021 Estimate		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Total FTE, HSB	**93**	**19**	**112**	**95**	**19**	**114**	**118**	**19**	**137**
Federal Office of Rural Health Policy:									
Direct:									
Rural Health Policy Development	3	-	3	3	-	3	3	-	3
Rural Health Outreach Grants	8	1	9	8	1	9	8	1	9
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	1	-	1	1	-	1	1	-	1
Telehealth	2	-	2	2	-	2	2	-	2
Rural Communities Opioid Response	7	-	7	7	-	7	12	-	12
Rural Residency	1	-	1	1	-	1	-	-	-
Total FTE, FORHP	**25**	**1**	**26**	**25**	**1**	**26**	**27**	**1**	**28**
Family Planning (Direct)[263]	7	1	8	34	1	35	34	1	35
Program Management (Direct)	727	43	770	727	43	770	727	43	770
Subtotal Direct (non add)	1,459	162	1,621	1,518	162	1,680	1,451	151	1,602
Subtotal Reimbursable (non add)	52	1	53	52	1	53	68	1	69
Subtotal Mandatory (non add)	402	38	440	402	38	440	402	38	440
Total, Ceiling FTE	**1,913**	**201**	**2,114**	**1,972**	**201**	**2,173**	**1,921**	**190**	**2,111**

[263] Due to coding error, FTE is reporting lower than actual 35 FTE

FTEs Funded by P.L. 111-148 and Any Supplementals

(*Dollars in Thousands)*

		FY 2010		FY 2011		FY 2012		FY 2013		FY 2014		FY 2015	
Program	**Section**	**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		-	-	-	-	-	-	-	-	-	-	-	-
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
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		-	-	-	-	-	-	-	-	-	-	-	-
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		-	-	-	-	-	-	-	-	-	-	-	-
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
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
Total		**-**	**-**	**3,325,000**	**299**	**1,900,000**	**347**	**2,232,100**	**325**	**2,803,956**	**351**	**4,201,481**	**373**

Program	Section	FY 2016		FY 2017		FY 2018		FY 2019		FY 2020		FY 2021	
		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)	-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		3,600,000	240	3,510,661	225	3,800,000	174	4,000,000	177	4,000,000	181	4,000,000	181
Health Centers - Facilities Construction	H.R. 3590, Section 10503(c)	-	-	-	-	-	-	-	-	-	-	-	-
School-Based Health Centers-Facilities	H.R. 3590, Section 4101	-	7	-	9	-	9	-	8	-	4	-	4
National Health Service Corps:													
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(2)	-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		310,000	226	288,610	225	310,000	206	310,000	209	310,000	209	310,000	209
GME Payments Teaching Health Centers:	H.R. 3590, Section 5508												
P.L. 111-148 Mandatory		-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		60,000	8	55,860	8	126,500	10	126,500	7	126,500	7	126,500	7
Family to Family Health Information Centers:													
Non-P.L. 111-148 Mandatory	H.R. 3590, Section 5507	5,000	1	4,655	1	6,000	1	6,000	1	6,000	1	6,000	1
Home Visiting Program:													
P.L. 111-148 Mandatory	H.R. 3590, Section 2951	-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		400,000	37	372,400	44	400,000	42	400,000	39	400,000	39	400,000	39
Total		**4,**375**,000**	519	**4,**232**,186**	512	**4,**642**,500**	442	**4,**842**,500**	441	**4,842,**500	**441**	**4,**842**,500**	**441**

Good Accounting Obligation in Government Act (GAO-IG Act) Report

The information below addresses the requirements of the Good Accounting Obligation in Government Act (GAO-IG Act; Public Law 115-414) to provide a report identifying each public recommendation issued by the Government Accountability Office (GAO) and federal Offices of Inspectors General (OIG) which remains unimplemented for one year or more from the annual budget justification submission date. The recommendations below apply specifically to this division of HHS. Please refer to the General Departmental Management budget justification for more information on the Department's overall progress in implementing GAO and OIG recommendations.

Appendix 1: OIG-GAO Open Recommendations							
Report Number	**Report Title**	**Report Date**	**Recommendation Text**	**Concur / Non-Concur**	**Implementation Timeline**	**Implementation Status**	**Implementation Updates and Constraints**
GAO-07-52	Foreign Physicians: Data on Use of J-1 Visa Waivers Needed to Better Address Physician Shortages	11/30/2006	To better account for physicians practicing in underserved areas through the use of J-1 visa waivers, the Secretary of Health and Human Services should collect and maintain data on waiver physicians--including information on their numbers, practice locations, and practice specialties--and use this information when identifying areas experiencing physician shortages and placing physicians in these areas.	Concur	2020	In Progress	The Department of Homeland Security (DHS) Citizenship and Immigration Services issues J-1 Visa waivers to physicians. DHS does not report data on physicians granted J-1 Visa waivers to HHS. Because HHS does not have legal or regulatory authority to collect detailed data on J-1 Visa-waivered physicians, HRSA is not in a position to maintain a complete and accurate list of physicians granted J-1 Visa waivers. However, HRSA has taken steps to better understand the distribution of J-1 Visa-waivered physicians, including by working with states' Primary Care Offices that report data on physicians with J-1 Visa waivers when submitting information to HRSA for shortage designation purposes. As Conrad 30 J-1 Visa-waivered physicians are cumulatively the greatest bulk of placements nationally, this

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							accounting provides substantial data for the purposes of shortage designation. HRSA will work with HHS and GAO to close this recommendation.
GAO-11-836	Drug Pricing: Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement	9/23/2011	PPACA contained several important program integrity provisions for the 340B program, and additional steps can also ensure appropriate use of the program. Therefore, the Secretary of HHS should instruct the administrator of HRSA to finalize new, more specific guidance on the definition of a 340B patient.	Concur	NA	In Progress	HRSA is currently evaluating its audit process and overall program integrity efforts. This evaluation is centered on HRSA's ability to enforce program guidance that is not tied to the statute or regulations. Existing guidance does not provide HRSA appropriate enforcement capability. Binding and enforceable regulations for all aspects of the 340B Program would provide HRSA the ability to more clearly define and enforce policy and would significantly strengthen HRSA's oversight of the Program. The FY 2021 President's Budget includes a proposal to provide HRSA comprehensive regulatory authority. If this proposal were enacted, HRSA could regulate on patient definition.

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GAO-11-836	Drug Pricing: Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement	9/23/2011	PPACA contained several important program integrity provisions for the 340B program, and additional steps can also ensure appropriate use of the program. Therefore, the Secretary of HHS should instruct the administrator of HRSA to issue guidance to further specify the criteria that hospitals that are not publicly owned or operated must meet to be eligible for the 340B program.	Concur	NA	In Progress	HRSA is currently evaluating its audit process and overall program integrity efforts. This evaluation is centered on HRSA's ability to enforce program guidance that is not tied to the statute or regulations. Existing guidance does not provide HRSA appropriate enforcement capability. Binding and enforceable regulations for all aspects of the 340B Program would provide HRSA the ability to more clearly define and enforce policy and would significantly strengthen HRSA's oversight of the Program. The FY 2021 President's Budget includes a proposal to provide HRSA comprehensive regulatory authority. If this proposal were enacted, HRSA could further define hospital eligibility criteria in regulations.
GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement	6/28/2018	The Administrator of HRSA should require covered entities to register contract pharmacies for each site of the entity for which a contract exists.	Non-Concur	NA	Awaiting Disposition	HRSA's current process is responsive to GAO's recommendation for covered entity types other than hospitals and health centers. Because HRSA recognizes relationships of hospitals and health centers in a different manner (parent and child), and for administrative burden reasons, HRSA only requires that a contract pharmacy register with the parent covered entity,

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							notwithstanding that child sites can still utilize that pharmacy. HRSA does require all covered entity sites and contract pharmacy sites to be listed on the written contract, and this information is audited by HRSA. In addition, for the FY 2019 audit cycle, HRSA strengthened its risk-based audit strategy by including an assumption that all contract pharmacies registered with the parent entity would also be used by the child sites, prior to randomly selecting covered entities for audit.
GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement	6/28/2018	The Administrator of HRSA should issue guidance to covered entities on the prevention of duplicate discounts under Medicaid managed care, working with CMS as HRSA deems necessary to coordinate with guidance provided to state Medicaid programs.	Concur	2021	In Progress	HRSA has requested regulatory authority in every President's Budget since FY 2017 and has again requested this in the FY 2021 President's Budget. HRSA is currently evaluating its audit process and overall program integrity efforts. This evaluation is centered on HRSA's ability to enforce program requirements/guidance outside of the statue or regulations. Existing guidance does not provide HRSA appropriate enforcement capability. Binding and enforceable regulations for all aspects of the 340B Program would provide HRSA the ability to more clearly define and enforce policy and would

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							significantly strengthen HRSA's oversight of the Program.
GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement	6/28/2018	The Administrator of HRSA should incorporate an assessment of covered entities' compliance with the prohibition on duplicate discounts, as it relates to Medicaid managed care claims, into its audit process after guidance has been issued and ensure that identified violations are rectified by the entities.	Concur	2021	In Progress	HRSA updated its audit policy in April 2018 by adding an area for improvement (AFI) when Medicaid managed care claims were identified in audits where the covered entity was at risk for non-compliance. HRSA has requested regulatory authority in every President's Budget since FY 2017 and has again requested this in the FY 2021 President's Budget. HRSA notes that guidance does not provide HRSA appropriate enforcement capability. Binding and enforceable regulations for all aspects of the 340B Program would provide HRSA the ability to more clearly define and enforce policy and would significantly strengthen HRSA's oversight of the Program.
GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies	6/28/2018	The Administrator of HRSA should issue guidance on the length of time covered entities must look back following an audit to identify the full scope of	Concur	2021	In Progress	HRSA is currently evaluating its audit process and overall program integrity efforts. This evaluation is centered on HRSA's ability to enforce program guidance that is not tied to the statute or regulations. Existing guidance does not provide

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	Needs Improvement		noncompliance identified during the audit.				HRSA appropriate enforcement capability. HRSA has requested regulatory authority in every President's Budget since FY 2017 and has again requested this in the FY 2021 President's Budget. Binding and enforceable regulations for all aspects of the 340B Program would provide HRSA the ability to more clearly define and enforce policy and would significantly strengthen HRSA's oversight of the Program.
GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement	6/28/2018	The Administrator of HRSA should require all covered entities to specify their methodology for identifying the full scope of noncompliance identified during the audit as part of their corrective action plans, and incorporate reviews of the methodology into their audit process to ensure that entities are adequately assessing the full scope of noncompliance.	Non-Concur	NA	Awaiting Disposition	Beginning April 1, 2018, HRSA requires entities that are subject to target audits and re-audits to specify their methodology for identifying the full scope of noncompliance identified during the audit as part of their corrective action plans and to incorporate reviews of the methodology into their audit process to ensure that entities are adequately assessing the full scope of non-compliance. If implemented, GAO's recommendation could create a significant burden for all covered entities requiring them to produce additional documentation. HRSA has an efficient audit process to ensure that if there is a compliance issue, covered entities are able to resolve

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							the issue quickly and work in good faith with the manufacturer to determine if repayments may be owed.
GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement	6/28/2018	The Administrator of HRSA should require all covered entities to provide evidence that their corrective action plans have been successfully implemented prior to closing audits, including documentation of the results of the entities' assessments of the full scope of noncompliance identified during each audit.	Non-Concur	NA	Awaiting Disposition	Beginning April 1, 2018, HRSA requires entities that are subject to target audits and re-audits to specify their methodology for identifying the full scope of noncompliance identified during the audit as part of their corrective action plans and to incorporate reviews of the methodology into their audit process to ensure that entities are adequately assessing the full scope of non-compliance. Requiring all entities to provide evidence and documentation could create a significant burden for covered entities to comply with the additional documentation needed as part of the audit. HRSA has an efficient audit process to ensure that if there is a compliance issue, covered entities are able to resolve the issue quickly and work in good faith with the manufacturer to determine if repayments may be owed.

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GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement	6/28/2018	The Administrator of HRSA should provide more specific guidance to covered entities regarding contract pharmacy oversight, including the scope and frequency of such oversight.	Concur	2021	In Progress	HRSA is currently evaluating its audit process and overall program integrity efforts. This evaluation is centered on HRSA's ability to enforce program guidance that is not tied to the statute or regulations. Existing guidance does not provide HRSA appropriate enforcement capability. HRSA has requested regulatory authority in every President's Budget since FY 2017 and has again requested this in the FY 2021 President's Budget. Binding and enforceable regulations for all aspects of the 340B Program would provide HRSA the ability to more clearly define and enforce policy and would significantly strengthen HRSA's oversight of the Program.
OEI-05-03-00170	Status of the Rural Health Clinic Program	8/1/2005	HRSA should publish regulations to revise its shortage-designation criteria.	Concur	2020	In Progress	Health Professional Shortage Areas (HPSAs) are statutorily required to be reviewed annually and updated as necessary. HRSA has no statutory or other authority to mandate updates to Medically Underserved Areas or Medically Underserved Populations once they are designated. CMS, which certifies Rural Health Clinics, has not put forward a regulation outlining a process to decertify Rural Health

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							Clinics once they have been certified. As a result, as shortage designations are reviewed and de-designated for no longer meeting the criteria, a number of Rural Health Clinics will continue to exist outside of Health Professional Shortage Areas or Medically Underserved Areas, regardless of any updates to shortage designation process. HRSA will continue to work with HHS and OIG to close this recommendation.
OEI-05-09-00321	State Medicaid Policies and Oversight Activities Related to 340B-Purchased Drugs	6/14/2011	HRSA should share 340B ceiling prices with States	Concur	2021	In Progress	HRSA continues to work with CMS to determine whether the 340B ceiling price data can be released to states.
OEI-05-14-00430	State Efforts to Exclude 340B Drugs from Medicaid Managed Care Rebates	6/6/2016	HRSA should clarify its guidance on preventing duplicate discounts for MCO drugs	Concur	2021	In Progress	HRSA is internally discussing the issue of MCO drugs in the 340B Program and continues to work with CMS on effective ways to address the issue for both the Medicaid and 340B Program. Existing guidance does not provide HRSA appropriate enforcement capability. HRSA has requested regulatory authority in every President's Budget since FY 2017 and has again requested

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							this in the FY 2021 President's Budget.
OEI-12-04-00310	HHS Agencies' Compliance with the National Practitioner Data Bank Malpractice Reporting Policy	10/11/2005	HRSA should implement a corrective action process that would address unreported cases.	Concur	2021	In Progress	HHS continues to comply with Federal law and the Health Care Quality Improvement Act of 1986, which created the NPDB. Through its Medical Claims Review Panel (MCRP) chartered by the Secretary, HHS reviews claims for damage, injury, or death filed under the Federal Tort Claims Act (FTCA) against an HHS facility or health care practitioner covered under the FTCA.

Programs Proposed for Elimination

The following list shows the programs proposed for elimination in the FY 2021 Budget Request. Termination of these programs totals approximately $991.5 million in discretionary resources. Following each program is a brief summary and the rationale for its elimination.

(dollars in millions)

Program	FY 2020 Enacted
Loan Repayment/Faculty Fellowships[264]	$1.2
Scholarships for Disadvantaged Students[265]	$51.5
Health Career Opportunity Program[264]	$15.0
Primary Care Training and Enhancement[264]	$48.9
Oral Health Training Programs[264]	$40.7
Medical Student Education[3]	$50.0
Area Health Education Centers[2]	$41.3
Geriatric Programs[264]	$40.7
Public Health/Preventative Medicine[264]	$17.0
Advanced Nursing Education[264]	$75.6
Nursing Workforce Diversity[264]	$18.3
Nurse Education, Practice and Retention[264]	$43.9
Nurse Faculty Loan Program[264]	$28.5
Nurse Practitioner Residency Program	$5.0
Children's Hospital Graduate Medical Education[266]	$340.0
Autism and Other Developmental Disabilities[264]	$52.3
Sickle Cell Disease Treatment Demonstrations[264]	$5.2
Emergency Medical Services for Children[264]	$22.3
Heritable Disorders in Newborns and Children [264]	$17.9
National Hansen's Disease – Building and Facilities[264]	$0.1
Rural Hospital Flexibility Grants[264]	$53.6
State Offices of Rural Health[264]	$12.5
Rural Residency[3]	$10.0
Total Programs Proposed for Elimination	**$ 991.5**

[264] Proposed for elimination in the FY 2018, FY 2019 and FY 2020 budgets.
[265] Proposed for elimination in the FY 2017, FY 2018, FY 2019, and FY 2020 budgets.
[266] Proposed for elimination in the FY 2020 budget.

Loan Repayment/Faculty Fellowships (-$1.2 million)
The Budget eliminates funding for this training program. 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 (-$51.5 million)
The Budget eliminates funding for this training program. 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 (-$15.0 million)
The Budget eliminates funding for this training program. 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 (-$48.9 million)
The Budget eliminates funding for this training program. 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 (-$40.7 million)
The Budget eliminates funding for this training program. 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.

Medical Student Education (-$50.0 million)
The Budget eliminates funding for this training program. 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 (-$41.3 million)
The Budget eliminates funding for this training program. 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 (-$40.7 million)
The Budget eliminates funding for this training program. 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 (-$17.0 million)
The Budget eliminates this funding for training program. 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 (-$75.6 million)
The Budget eliminates funding for this Nurse training program. 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 (-$18.3 million)
The Budget eliminates funding for this Nurse training program. 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 (-$43.9 million)
The Budget eliminates funding for this Nurse training program. 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 (-$28.5 million)
The Budget eliminates funding for this training program. 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 Practitioner Residency Program (-$5.0 million)
The Budget eliminates funding for this training program. 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 (-$340.0 million)
The Budget eliminates funding for this training program. 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 Disabilities (-$52.3 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. States may continue to support these activities with their Maternal and Child Health Block Grant awards. The Budget includes an increase of $60.0 million in funding for Maternal and Child Health (MCH) Block Grant formula awards to states to provide states with additional flexibility to support activities previously funded through a number of MCH categorical grant programs, including Autism and Other Developmental Disabilities.

Sickle Cell Disease Treatment Demonstrations (-$5.2 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. States may continue to support these activities with their Maternal and Child Health Block Grant awards. The Budget includes an increase of $60.0 million in funding for Maternal and Child Health (MCH) Block Grant formula awards to states to provide states with additional flexibility

to support activities previously funded through a number of MCH categorical grant programs, including Sickle Cell Service Demonstrations.

Emergency Medical Services for Children (-$22.3 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. States may continue to support these activities with their Maternal and Child Health Block Grant awards. The Budget includes an increase of $60.0 million in funding for Maternal and Child Health (MCH) Block Grant formula awards to states to provide states with additional flexibility to support activities previously funded through a number of MCH categorical grant programs, including Emergency Medical Services for Children.

Heritable Disorders in Newborns and Children (-$17.9 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. States may continue to support these activities with their Maternal and Child Health Block Grant awards. The Budget includes an increase of $60.0 million in funding for Maternal and Child Health (MCH) Block Grant formula awards to states to provide states with additional flexibility to support activities previously funded through a number of MCH categorical grant programs, including Heritable Disorders.

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.

Rural Hospital Flexibility Grants (-$53.6 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 (-$12.5 million)
No funding is provided for this program, due to a shift in program priorities that emphasize direct health care services.

Rural Residency (-$10.0 million)
No funding is provided for this program, due to a shift in program priorities that emphasize direct health care services.

Physicians' Comparability Allowance (PCA) Worksheet

1) Department and component:

Department of Health and Human Services, Health Resources and Services Administration

2) Explain the recruitment and retention problem(s) justifying the need for the PCA pay authority.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*
FY19 included (4) Separations of which (2) resigned (1) reassigned and (1) retired. Their average length of service was 9.5 years.
In FY19, (1) vacancy announcement has been posted. Quality applicants have been limited. For example, 7 applications were received for this vacancy, however, only (4) applicants were considered highly qualified for the position.
To date there have been (2) Accessions.

3-4) Please complete the table below with details of the PCA agreement for the following years:

	PY 2019 (Actual)	**CY 2020 (Estimates)**	**BY* 2021 (Estimates)**
3a) Number of Physicians Receiving PCAs	31	37	37
3b) Number of Physicians with One-Year PCA Agreements	4	0	0
3c) Number of Physicians with Multi-Year PCA Agreements	27	37	37
4a) Average Annual PCA Physician Pay (without PCA payment)	$165,748	$165,586	$165,586
4b) Average Annual PCA Payment	$21,650	$21,658	$21,658

*BY data will be approved during the BY Budget cycle. Please ensure each column is completed.

5) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

In FY18 there were (3) resignations and (1) accessions. PCA in addition to their base salary was needed to meet their current salary or salary expectations.

6) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

n/a

Drug Control Budget
Health Resources and Services Administration

Resource Summary

	Budget Authority (in millions)		
	FY 2019 Enacted	FY 2020 Enacted	FY 2021 President's Budget
Drug Resources by Function			
Prevention	$114.500	$109.500	$94.100
Treatment	$550.500	$545.500	$560.900
Total Drug Resources by Function	**$665.000**	**$655.000**	**$655.000**
Drug Resources by Decision Unit			
Bureau of Primary Health Care	$545.000	$545.000	$545.000
Federal Office of Rural Health Policy	$120.000	$110.000	$110.000
Total Drug Resources by Decision Unit	**$665.000**	**$655.000**	**$655.000**
Drug Resources Personnel Summary			
Total FTEs (direct only)	--	--	--
Drug Resources as a percent of Budget			
Total Agency Budget (in Billions)	$11.7	$11.9	$11.2
Drug Resources percentage	5.7%	5.5%	5.8%

Program Summary
MISSION

The Health Resources and Services Administration (HRSA) is the primary Federal agency for improving access to health care for people who are geographically isolated, and economically or medically challenged.

BPHC

The Health Resources and Services Administration (HRSA) is the principal Federal agency charged with increasing access to primary health care for those who are medically underserved. For more than 50 years, HRSA-funded 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 for millions of people across the country. Health centers advance a model of coordinated, comprehensive, and patient-centered primary health care, integrating a wide range of medical, dental, mental health, substance use disorder (SUD), and patient services. Today, nearly 1,400 health centers operate approximately 12,000 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.

Health centers providing SUD services play an essential role in addressing the Nation's opioid epidemic. They offer a range of integrated services, including but not limited to Screening, Brief Intervention, and Referral to Treatment (SBIRT), counseling and psychiatry, 24-hour crisis intervention, detoxification, Medication-Assisted Treatment (MAT), and recovery support.

FORHP

The Federal Office of Rural Health Policy (FORHP) is responsible for advising on rural policy issues, conducting and overseeing policy relevant research on rural health issues, and administering grant programs that focus on supporting and enhancing health care delivery in rural communities. FORHP is statutorily charged with coordinating the activities within the Department that relate to rural health care and providing information to the Secretary and others in the Department with respect to the activities of other Federal departments and agencies that relate to rural health care. In addition to its policy roles, FORHP also administers a range of grant programs focusing on capacity building and enhancing health care delivery at the community and state levels as well as programs aimed at leveraging the use of health information technology and telehealth to enhance access to and the quality of health care services in rural and underserved areas.

FORHP launched the Rural Communities Opioid Response Program (RCORP) in FY 2018 to support treatment and prevention of substance use disorder, including opioid abuse, in rural communities at the highest risk for substance use disorder. The program goal is to reduce the morbidity and mortality associated with opioid overdoses in rural communities through the strengthening of the organizational and infrastructural capacity of multi-sector consortiums. These consortiums address prevention, treatment, and recovery focus areas at the community, county, state, and/or regional levels. This initiative reflects the high level of interest in and continued need for rural-focused funding to build robust opioid prevention, treatment, and recovery infrastructure and capacity in rural communities. HRSA has newly developed OMB-approved performance measures to support this new large-scale initiative.

METHODOLOGY

BPHC

Starting in FY 2016, the Health Center Program has been awarding targeted supplemental funding to support substance use disorder service expansion. For each of fiscal years 2016 – 2019, HRSA has provided new annual funding toward this effort that remains in Health Center Program base continuation funding in subsequent fiscal years. All of this targeted supplemental funding is scored as drug control funding.

FORHP

The allocation of funds for the Rural Community Opioid Response Program (RCORP) is through competitive grants and cooperative agreements. The entirety of these programs is scored as drug control funding.

BUDGET SUMMARY

The drug control budget for the Health Resources and Services Administration at the FY 2021 President's Budget Request is $655.0 million, the same level as FY 2020 Enacted.

Bureau of Primary Health Care

FY 2021 President's Budget Request: $545 million
(level with FY 2020 Enacted)

In FY 2021, the Health Center program plans to support nearly 1,400 grantees and provide primary health care services to nearly 29 million patients, including access to ongoing SUD services. Health centers will continue to provide SUD services for all age groups.

In FY 2018, the Health Center Program awarded approximately $350 million in an additional targeted supplemental funding opportunity for the expansion of SUD/MH in existing health centers. Approximately $200 million of the FY 2018 SUD/MH expansion awards were provided as one-time funding, and an additional $150 million was awarded as ongoing annual funding, to be included in health centers' base continuation funding in subsequent fiscal years, contingent upon sufficient Health Center Program appropriations.

In FY 2019, the Health Center Program awarded $201 million in new SUD/MH ongoing annual awards, and the FY 2020 President's Budget includes no additional drug resources. As a result, the reported amount of drug resources for FY 2018, and those projected for FY 2019 and FY 2020, reflect the ongoing annual SUD/MH awards initiated in FY 2016 through FY 2019 and projections in FY 2020 and FY 2021.

Federal Office of Rural Health Policy

FY 2021 President's Budget Request: $110 million
(level with FY 2020 Enacted)

In FY 2021, the Federal Office of Rural Health Policy will continue to invest in initiatives and support evidence-based strategies that address the specific substance use disorder issues and mental health services needs in rural communities. The FY 2021 President's Budget Request will fund new and continuing grants and cooperative agreements for RCORP to strengthen the infrastructure and capacity within rural communities at high risk for substance abuse disorders and provide needed prevention, treatment, and recovery services to rural residents.

The RCORP initiative is currently composed of three competitive grant programs and three cooperative agreements that provide technical assistance coordination, program evaluation, and dissemination of evidence-based programs and best practices.

- **RCORP-Planning** provides one year of support to rural communities to identify opioid use disorder issues in their communities and develop plans to resolve these issues. The one-year planning grant provides sufficient time and resources for communities to form

partnerships with other entities, conduct needs assessments, and plan ways to address specific issues being faced by the communities. HRSA does not anticipate making new RCORP-Planning awards in FY 2021.

- **RCORP-Implementation** provides multi-year support to rural communities to yield large-scale organizational and infrastructural improvements at the regional and state levels to address opioid use disorder, with a particular focus on treatment and recovery. HRSA plans to make new Implementation awards in FY 2021.

- **RCORP-Medication-Assisted Treatment (MAT) Expansion** provides multi-year support to eligible hospitals, health clinics, or tribal organizations to establish and/or expand MAT and increase the number of access points for individuals living in rural communities. HRSA will support the continuation of awards in FY 2021.

In FY 2021, HRSA will continue funding three Rural Centers of Excellence on Substance Use Disorders that support the dissemination of best practices related to the treatment for and prevention of substance use disorders within rural communities, with a focus on the current opioid crisis. Additionally, HRSA will continue supporting a cooperative agreement to conduct program-wide evaluation activities for the RCORP Initiative and another cooperative agreement to provide technical assistance to RCORP grantees.

Finally, in FY 2021, HRSA will allocate funding for new awards to respond specifically to the increasing burden of psychostimulants in rural communities. HRSA will continue to engage and partner with other federal agencies to promote a coordinated approach to combatting this devastating epidemic and identifying additional priority areas.

PERFORMANCE

Information regarding HRSA's Health Center Program's performance is based on the UDS. The table and accompanying text represent highlights of their achievements for the latest year for which data are available.

Health Resources and Services Administration		
	FY 2018 Target	FY 2018 Achieved
» Number of Health Center Program grantees providing SBIRT services	580	665
» Number of Health Center Program grantees providing substance abuse counseling and treatment services	515	688

HRSA is taking several approaches to improve access to high quality substance use disorder (SUD) services for medically underserved communities through the Health Center Program. General approaches include developing the infrastructure for high quality care through the adoption of health information technology (HIT) and the transformation of health centers to patient-centered medical homes (PCMH). PCMH and the meaningful use of HIT will enable enhanced access to care, better care coordination, and improved patient engagement.

Transformed health centers are better positioned to partner with other addiction-related services in the community including inpatient and outpatient SUD services.

To further improve access and raise the quality of SUD services, the availability of services on-site is essential. This is to be achieved by training health center clinicians to provide high quality and expanded services for those with addiction disorders. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based process used by primary care providers in health centers to detect and treat addiction effectively. Because many communities served by health centers have a high burden of addiction disorders, many health centers have chosen to co-locate and integrate SUD specialty services reflecting efficient and effective approaches in meeting patient needs. The integration of SUD services may include the provision of enhanced services, such as medication-assisted treatment (MAT), by primary care clinicians. In addition, HRSA provides guidance to health centers on collaboration with State agencies to ensure that appropriate standards of care are implemented and that referrals are coordinated.

Screening for substance use disorders has increased 53 percent since 2016 with the number of patients receiving screening, brief intervention, referral and treatment (SBIRT) increasing from 716,677 in 2016 to 1,099,001 in 2018. From 2016–2018, the number of health center providers eligible to prescribe MAT increased nearly 190 percent (from 1,700 in 2016 to 4,897 in 2018) and the number of patients receiving MAT increased 142 percent (from 39,075 in 2016 to 94,528 in 2018).

In 2018, 688 health centers provided SUD counseling and treatment services, exceeding the program 2018 target. Also in 2018, 665 health centers provided SBIRT services, exceeding the program FY 2018 target.

The Rural Communities Opioid Response program goal is to reduce the morbidity and mortality associated with opioid overdoses in rural communities through the strengthening of the organizational and infrastructural capacity of multi-sector consortiums. HRSA has developed OMB-approved performance measures to support this large-scale initiative, and data collection will begin in Spring 2020.

Significant Items

TAB

SIGNIFICANT ITEMS FOR INCLUSION IN L-HHS APPROPRIATIONS COMMITTEE FY 2021 CONGRESSIONAL JUSTIFICATION

FURTHER CONSOLIDATED APPROPRIATIONS ACT, 2020 (December 20, 2019)

1. **Area Health Education Centers. —** The agreement encourages HRSA to invest in interprofessional networks that address social determinates of health and incorporate field placement programs for rural and medically-underserved populations. **(Page 16)**

   Action to be Taken

   The AHEC Scholars Program is a longitudinal program targeted to health professions students and allied health professions students developed in FY 2017. As a supplement to the student's current curriculum, the AHEC Scholars Program consists of an interdisciplinary curricula (e.g., 2-year program) with a defined set of clinical, didactic, and community-based training activities focused on rural/underserved settings and populations. Each AHEC Scholars Program curriculum focuses on 6 core topic areas: (a) interprofessional education; (b) behavioral health integration; (c) social determinants of health; (d) cultural competency; (e) practice transformation; and (f) current/emerging health issues (e.g., Ebola or community-relevant).

   The AHEC Scholars Program has increased academic-community partnerships among the AHEC grantees in which more specialized team-based interdisciplinary training experiences in rural/underserved areas are available to health professions students of a variety of disciplines. Many of these training experiences occur within federally qualified health centers (FQHCs), acute care settings, primary care practices, and outpatient clinical settings. The AHEC Scholars Program has increased capacity to better track health professionals within rural/underserved areas through a 1-year follow up upon completion of the program. In FY 2020, HRSA will continue to support AHEC awards to maintain interdisciplinary community-based linkages to facilitate team-based interdisciplinary experiential training experiences in rural/underserved areas and populations.

2. **Nurse Education, Practice, Quality, and Retention. —** HRSA is directed to ensure that these grants include as an allowable use the purchase of simulation training equipment. HRSA shall give priority to grantees located in a medically-underserved area in a State with an age-adjusted high burden of stroke, heart disease, and obesity, and HRSA is encouraged to prioritize submissions that support high poverty rate communities. **(Page 16)**

   Action to be Taken

   HRSA is currently working on the NOFO to support the use of simulation to enhance nurse education and expand experimental learning opportunities. HRSA plans to release a competitive NOFO in 2020.

3. **Veterans' Bachelor of Science Degree in Nursing. —** HRSA is encouraged to consider the successful past practice of entities that have received funding from this nursing program in making new awards that support veterans and expand the nursing workforce. **(Page 17)**

Action to be Taken

In FY 2020, HRSA will continue to support the Veteran Nurses in Primary Care (NEPQR-VNPC) Training Program. Seven VNPC cooperative agreements were awarded in FY 2019. The VNPC program works to recruit and train Veteran nursing students and current RNs to practice at the full scope of their license in community-based primary care teams to increase access to care, with an emphasis on chronic disease prevention and control, including mental health and substance use conditions. The VNPC program provides professional development and primary care skillset training that addresses Veterans unique needs to faculty members, preceptors, and practicing primary care RNs.

4. **Nursing Workforce Diversity. —** HRSA shall give priority to eligible entities with training programs that serve one or more communities that have: (1) a poverty rate exceeding 32 percent and a median household income below $34,000 a year as reported by the Census Bureau's Small Area Income and Poverty Estimates program for 2017; and (2) are located in a State with an elderly population that exceeds 15 percent of the total State's population as reported by the Census Bureau for 2018. **(Page 17)**

Action to be Taken

In FY 2020, HRSA plans to re-compete a version of the Nursing Workforce Diversity program with an emphasis of increasing on increasing the eldercare workforce and increasing access to care in rural and underserved areas. Priority will be given to eligible entities in communities with a poverty rate exceeding 32 percent, and a median household income below $34,000 a year as reported by the Census Bureau's Small Area Income and Poverty Estimates program for 2017; and are located in a State with an elderly population that exceeds 15 percent of the total State's population as reported by the Census Bureau for 2018. All the previous grantees, which are institutions that have a program in place to support increasing the diversity in the nursing workforce, are eligible in addition to new applicants. Special consideration will be given to Historically Black Colleges and Universities, and other Minority Serving Institutions.

5. **Nursing Workforce Diversity. —** HRSA is directed to give priority to established and reputable nursing programs in historically black colleges and universities that can demonstrate increased educational opportunities for individuals from disadvantaged backgrounds. **(Page 17)**

Action to be Taken

HRSA is actively planning a Notice of Funding Opportunity. As a funding factor within the NOFO, HRSA will give priority to any applicant that has demonstrated an increase in educational opportunities for individuals from disadvantaged backgrounds within the last

four years. HRSA will also give priority to Historically Black Colleges and Universities (HBCUs) and other Minority Serving Institutions (MSIs).

6. **Medical Student Education. —** The agreement provides up to $35,000,000 to fund additional applications received in FY 2019. Of the remaining amount, the agreement directs HRSA to make supplementary grant awards to entities funded in FY 2019. **(Page 18)**

   Action to be Taken
   In FY 2020, HRSA will fund the five unfunded applications from the FY 2019 Notice of Funding Opportunity. The remaining funds will be provided as supplemental funding to the FY 2019 awardees.

7. **Organ Allocation Policy. —** HRSA and the Organ Procurement and Transplantation Network are encouraged to ensure the process for changing organ allocation policies is transparent, thorough, and accommodates the recommendations of transplantation and organ donation professionals. **(Page 20)**

   Action to be Taken
   HRSA and the Organ Procurement and Transplantation Network (OPTN), which is comprised of organ transplantation and donation professionals as well as representatives of donor and recipient families, are committed to an open and deliberative process for OPTN policy development including organ allocation policies. HRSA will continue to ensure that these processes are thorough and transparent with opportunity for the public to comment on all proposed OPTN policy changes.

8. **Rural Hospital Flexibility Grants. —** The agreement recommends HRSA give preference in grant awards to Critical Access Hospitals, as described in Senate Report 115-289. **(Page 21)**

   Action to be Taken
   The Medicare Rural Hospital Flexibility Grants (Title XVIII, §1820(g)(1) and (2) of the Social Security Act) authorizes HRSA to provide grants to states to fund activities to meet the needs of Critical Access Hospitals in the areas of quality and performance improvement and in rural Emergency Medical Services. The Program's FY 2019 Notice of Funding Opportunity included specific recommendations for states to include activities that improve population health, such as chronic disease management. These activities will continue throughout the five-year performance period that ends in FY 2024.

9. **Telehealth Centers of Excellence. —** The agreement provides $6,000,000 for the Telehealth Centers of Excellence (Centers) awardees. The Centers are encouraged to develop best practices for treating HIV through telehealth that can be replicated across rural America and accelerate progress toward the goal of eliminating HIV transmission. **(Page 21)**

Action to be Taken
HRSA will work with the Telehealth Centers of Excellence awardees to include the development of best practices for treating HIV through telehealth services among their grant activities.

HOUSE REPORT 116-62 (May 15, 2019)

1. **Rural Health Workforce. —** The Committee encourages HRSA to explore opportunities for collaboration and partnership with schools and programs that offer rural residencies, rural health certificates, or otherwise recognized rural curriculum in order to increase the placement of health care providers and professionals with rural health training in HRSA Health Workforce Programs. **(Page 38)**

   Action to be Taken
   In FY 2019, HRSA supported the rural health professions workforce through innovative training grant programs focused on expanding community-based residency training and incentivizing clinicians to work in rural and underserved communities. In Academic Year (AY) 2018-2019, HRSA funded programs utilized 5,811 training sites located in rural areas to provide customized academic training to better serve rural communities. More than 160,000 students and trainees from rural backgrounds participated in these programs (excluding National Health Service Corps and Nurse Corps). In FY 2019, one in three National Health Service Corps clinicians serve in rural areas and one in five Nurse Corps clinicians serve in rural areas.

   In FY 2020, HRSA will continue to support the rural health professions workforce through the:
   - Teaching Health Center Graduate Medical Education Program: In AY 2020-2021, HRSA will award $120 million to 58 teaching health centers - 53 continuation awards and 5 awards to establish new teaching health centers - increasing the maximum number of approved FTEs to over 800. Starting in AY 2020-2021, THCGME funding will support a total of 11 residency programs in rural areas.
   - National Health Service Corps Rural Community Loan Repayment Program: In FY 2020, HRSA will continue to support providers working in rural communities who use evidence-based treatment models to treat substance use disorders and opioid use disorders.

2. **Shortage Designation Modernization Project. —** The Committee is concerned that HRSA is implementing the Shortage Designation Management System without a thorough understanding of the potential impact of the revised Health Professional Shortage Area scores on States. The Committee requests a briefing from HRSA within 60

days of enactment of this Act on the revised methodology and implications for addressing health care workforce shortages in States. **(Page 38)**

Action to be Taken

HRSA plans to brief the Committee as requested on the Shortage Designation Management Project. The first phase of this project, which began in 2013, created the Shortage Designation Management System, the online system through which HPSAs are designated and scored. The latest phase of the project, which was completed in August 2019, implemented improvements to the data collection processes used to score HPSAs automatically designated by statute or regulation. The methodologies for designating and scoring HPSAs have not been changed during the Shortage Designation Management Project.

To determine the data sources that would be used for the August 2019 update, HRSA convened a working group with representatives of all site types that would be affected by the updates. These include Federally Qualified Health Centers and Look A-likes, CMS-certified Rural Health Clinics, Indian Health Service, Tribally-run clinics, and Urban Indian Organizations, and national stakeholder groups representing these entities. HRSA incorporated the working group's recommendations into the Auto-HPSA update.

Throughout this process, HRSA has provided outreach to all affected stakeholders in a variety of ways, including workgroups, presentations, conferences, and technical assistance sessions. Additionally, in October 2018, HRSA began distributing a series of nine Auto-HPSA update previews to stakeholders. The purpose of these previews was to prepare stakeholders for the update that would happen in August 2019, and to show the projected impact of the update on states and organizations at single points in time.

3. **Trafficking Awareness for Health Professionals. —** The Committee encourages HRSA to identify best practices for accredited schools of medicine or nursing to train students in identifying and responding to human trafficking victims and to respond appropriately to such individuals. Best practices should be developed in consultation with law enforcement personnel, social service providers, and other experts in the field of human trafficking. **(Page 38)**

Action to be Taken

In FY 2020, HRSA will consult with law enforcement personnel, social service providers, and other experts in the field of human trafficking to look into the possibility of supplementing webinar training for grantees that are medical and/or nursing schools.

4. **National Health Service Corps Loan Repayment Program. —** The Committee encourages HRSA to conduct a review of the National Health Service Corps Loan Repayment Program with a specific focus on the qualifications for the program and whether those qualifications, including designation as an HPSA, alone capture candidates that effectively address the health care needs of the community. **(Page 39)**

Action to be Taken

The National Health Service Corps continues to expand to address the health care needs of underserved communities. Through continued efforts to capture individuals with the desired qualifications to effectively address the health care needs of the community, HRSA plans to apply a funding priority to applicants who have completed HRSA education and training programs specifically dedicated to providing care to rural and underserved populations in need. Physicians and physician assistants who have completed HRSA's Primary Care Training Enhancement program will be afforded priority status when applying for NHSC LRP awards in FY 2020. Physicians and psychiatrists who have completed HRSA's Addiction Medicine Fellowship program will be afforded priority status when applying for NHSC LRP awards in FY 2021.

Following are three recent examples of HRSA's focusing on specific clinician qualifications to effectively respond to the community's need for opioid / substance use disorder treatment.

- HRSA launched the National Health Service Corps Substance Use Disorder (SUD) Workforce Loan Repayment Program in December 2018 to expand and improve access to quality opioid use disorder (OUD) and other SUD treatment in rural and underserved areas nationwide. This opportunity expanded the scope of SUD treatment providers and sites that are eligible for participation in the National Health Service Corps Loan Repayment Program; these include opioid treatment programs, office-based opioid treatment practices, and non-opioid outpatient SUD sites. HRSA initiated this program in FY 2019, making 1,074 awards to SUD clinicians, and will continue to administer this program in FY 2020.

- HRSA launched the NHSC Rural Community Loan Repayment Program in May 2019 to expand and improve access to quality OUD and other SUD treatment in underserved areas nationwide. Given the disproportionate impact of the opioid epidemic on rural areas, the NHSC Rural Community LRP is making loan repayment awards to rural OUD and SUD treatment providers.
    - The Rural Community Loan Repayment Program expands the scope of SUD treatment providers and sites that are eligible for participation in the National Health Service Corps Loan Repayment Program, including opioid treatment programs, office-based opioid treatment facilities, and non-opioid outpatient SUD treatment facilities. Providers receive loan repayment to reduce their educational financial debt in exchange for a service obligation to work at a rural National Health Service Corps-approved SUD treatment facility. HRSA made 174 Rural Community Loan Repayment Program awards in FY 2019, and will continue the program in FY 2020.

- In FY 2019 HRSA offered $5,000 incentive awards to current National Health Service Corps participants who obtained a DATA 2000 Waiver and capable of providing medication-assisted treatment (MAT). MAT is an evidenced based

treatment that combines medications, counseling and behavioral therapies, which is effective in the treatment of OUD and can assist in sustaining recovery. This increased funding was offered in conjunction with continuation awards to eligible National Health Service Corps participants. In addition, it recognized current National Health Service Corps providers that offer MAT while serving rural and underserved communities. HRSA made 192 of these supplemental awards and will continue the DATA waiver repayment bonus opportunity in FY 2020.

5. **Centers of Excellence. —** The Committee commends the Bureau of Health Workforce (BHW) on the continued implementation of COE and notes that partnerships with HRSA have allowed minority health professions institutions to address the need for diverse and culturally competent health professionals that contribute to the healthcare needs of underrepresented populations. The Committee asks that HRSA report within 120 days of enactment of this Act on the achievements and challenges of COE and the contribution COE makes to workforce development. **(Page 39)**

   Action to be Taken
   HRSA plans to submit a Report to Congress as requested.

6. **Health Careers Opportunity Program. —** The Committee encourages BHW to continue its improvement of the diversity and distribution of needed health care professionals through National Health Career Opportunity Program Academies (NHCOPA) and report back to Congress within 120 days of enactment of this Act on the progress of the NHCOPA pipeline. **(Page 39)**

   Action to be Taken
   HRSA plans to submit a Report to Congress as requested.

7. **Oral Health Training. —** The Committee directs HRSA to provide continuation funding for predoctoral and postdoctoral training grants initially awarded in fiscal year 2015, and for section 748 Dental Faculty Loan Program (DFLRP) grants initially awarded in fiscal years 2016, 2017, 2018 and 2019. **(Page 40)**

   Action to be Taken
   Continuation funding for predoctoral and postdoctoral training grants initially awarded in fiscal year 2015 is not possible as these grants will be concluding their statutorily mandated five-year project periods in fiscal year 2020. HRSA opened a new competition for the postdoctoral training program in fiscal year 2020 and plans to provide continuation funding for the predoctoral training grants initially awarded in fiscal year 2017.

   HRSA is planning to provide continuation funding for section 748 Dental Faculty Loan Program (DFLRP) grants initially awarded in fiscal years 2016, 2017 and 2018. Due to

increasing continuation commitments last year, HRSA did not make any new awards in fiscal year 2019 for DFLRP.

8. **Area Health Education Centers. —** The Committee encourages HRSA to support AHEC oral health projects that establish primary points of service and address the need to help patients find treatment outside of hospital emergency rooms. The Committee encourages HRSA to work with programs that have already been initiated by some State dental associations to refer emergency room patients to dental networks. **(Page 41)**

   Action to be Taken

   Multiple Area Health Education Centers (AHEC) will continue to support oral health activities through strategic academic-community partnerships with a variety of organizations including, state dental associations, state departments of health, primary care offices, and offices of rural health. Such partnerships have led to oral health initiatives in North Carolina, Hawaii, and Pennsylvania.

   The North Carolina AHEC offers programs for dental professionals throughout the state based on the needs expressed by the North Carolina Dental Society, the State Board of Dental Examiners, and the North Carolina Dental Hygienists Association. Most recently, the North Carolina AHEC partnered with the North Carolina Department of Health and Human Services to provide training to general practice dentists to prepare them to treat individuals with developmental disabilities. The training highlighted the importance of increasing various access points for dental care and included a clinical experience with volunteers from this vulnerable population.

   In partnership with the Office of Primary Care and Rural Health, the Hawaii AHEC collaborated in the planning of the rural health and oral health track of the annual Hawaii Health Workforce Summit. The Pennsylvania AHEC oral health activities include an annual Oral Health Conference providing technical assistance to multiple stakeholders across the state to address unmet oral health needs. In addition, the Colorado AHEC is an active partner with its state Oral Health Coalition. HRSA will continue to support the Area Health Education Centers awards to expand access to oral health care, continuing education opportunities for practicing health care professionals regarding oral health topics, and increase rural/underserved interprofessional experiential clinical training experiences.

9. **Nurse Practitioner Optional Fellowship Program. —** The Committee includes an increase of $20,000,000 to make grants to establish or expand optional community-based nurse practitioner fellowship programs that are accredited or in the accreditation process for practicing postgraduate nurse practitioners (NPs) in primary care or behavioral health. The Committee directs HRSA to give preference to Federally Qualified Health Centers (FQHCs), as defined by section 1861(aa)(4) of the Social Security Act. **(Page 43)**

Action to be Taken

For FY 2020 HRSA will develop a Notice of Funding Opportunity (NOFO) for an Advanced Nursing Education - Nurse Practitioner Optional Fellowship (ANE-NPOF) Program. This program will provide support to academic clinical practice partnerships between/among one or more each of academic institutions providing advanced nursing education, and community based clinical organizations providing primary care to rural and underserved populations.

Successful applicants will be community-based nurse practitioner fellowship programs that are accredited or in the accreditation process for practicing postgraduate nurse practitioners (NPs) in primary care or behavioral health. This NOFO will give preference to Federally Qualified Health Centers (FQHCs), as defined by section 1861(aa)(4) of the Social Security Act.

10. **Medical Student Education. —** The Committee includes $40,000,000 to expand support to colleges of medicine at public universities located in the top quintile of States projected to have a primary care provider shortage. This is $15,000,000 above the fiscal year 2019 enacted level and $40,000,000 above the fiscal year 2020 budget request. The Committee directs HRSA to maintain existing eligibility criteria for the second year of grants for this program. **(Page 44)**

Action to be Taken

In FY 2020, HRSA will fund the five unfunded applications from the FY 2019 Notice of Funding Opportunity. The remaining funds will be provided as supplemental funding to the FY 2019 awardees.

11. **Adverse Childhood Experiences. —** The Committee encourages the Maternal and Child Health Bureau (MCHB) to develop protocols to train professionals to screen, diagnose, and provide evidence-based interventions to individuals suffering from adverse childhood experiences such as child abuse and neglect, witnessing interpersonal violence, family substance abuse, family separation, parental divorce, parental loss, and mental illness, to promote developmental resiliency. **(Page 45)**

Action to be Taken

Currently, HRSA addresses ACEs through a variety of programs, including the Title V State Maternal and Child Health Block Grant program, Maternal, Infant, and Early Childhood Home Visiting Program, the Healthy Start program, as well as a number of workforce development and training programs, that improve maternal and child health across the lifespan. For example:

- **Bright Futures**, a HRSA-supported initiative led by the American Academy of Pediatrics (AAP), provides health care professionals and maternal and child health programs updated recommendations for pediatric health promotion, health supervision, and anticipatory guidance for well-child visits. These guidelines provide entry points for discussing adverse experiences with families.

- The AAP has created a companion resource to Bright Futures, the HRSA-funded **Trauma Toolbox for Primary Care**, for providers. This 6-part series provides guidance to primary care practitioners that may not be familiar with ACEs or how to care for families suffering from exposure to ACEs or other traumatic events.

12. **Breastfeeding Services and Supplies. —** The Committee urges HRSA, during the next review of the Women's Preventive Services Guidelines for breastfeeding services and supplies, to incorporate into the clinical and implementation considerations section of the guideline: evidence of the critical timeframe for breastfeeding initiation following delivery; and recommendations for assessing risk factors, initiating milk production and ensuring that women are able to build supply and sustain breastfeeding in the early post-partum period (as well as during the antenatal, perinatal, and the postpartum period) in both pre-term and term infants. **(Page 45)**

    Action to be Taken
    Currently, Women's Preventive Services Guidelines recommends comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to ensure successful initiation and maintenance of breastfeeding. In FY 2021, the Women's Preventive Services Initiative (WPSI) will undergo an open competition which will include a review of updated evidence for breastfeeding services and supplies.

13. **Infant-Toddler Court Teams. —** The Committee expects this increase of $7,000,000 above the fiscal year 2019 enacted level to: (1) build upon the work of sites established through the Quality Improvement Center for Research-based Infant Toddler Court Teams, including by providing training and technical assistance in support of such court teams' efforts across the country, and (2) support additional outreach sites to start a court team. **(Page 46)**

    Action to be Taken
    In FY 2020, HRSA will increase funding for the Infant Toddler Court Program (ITCP) by $7 million, for a total of $10 million, consistent with the FY 2020 appropriation. The ITCP works to address gaps in evidence-based practice and systems coordination for very young children and families involved in, or at risk for involvement in, the child welfare system. HRSA currently supports 50 outreach sites through sub-award funding and/or training and technical assistance. With the additional funding provided in FY 2020, HRSA will expand the provision of training and technical assistance in support of Infant Toddler Court teams' efforts across the country and will expand the number of outreach sites to start a court team.

14. **Maternal Mortality Disparities. —** The Committee encourages HRSA to work with States to collect comprehensive data associated with all pregnancy-associated and pregnancy-related deaths, regardless of the outcome of the pregnancy. **(Page 46)**

Action to be Taken

In FY 2020, HRSA will continue to support the State Maternal Health Innovation (State MHI) program, which supports state-led demonstrations to implement evidence-based interventions to address critical gaps in maternity care service delivery and reduce maternal mortality. The State MHI program includes activities to support surveillance, analysis and reporting of maternal health outcome data, including data on racial/ethnic and geographic disparities. In addition, HRSA's Title V Maternal and Child Health Block Grant program supports state data collection and analysis related to maternal health, maternal mortality and severe maternal morbidity. For example, in FY 2018, of the 39 States that reported having a maternal mortality review process in place, 38 States were using Title V funds to provide sole or partial support. Fourteen additional States were in the planning stages for initiating a maternal mortality review process, with Title V providing sole or partial support in 13 States.

15. **Set-aside for Oral Health. —** The Committee includes $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 continue to direct the design, monitoring, oversight, and implementation of these projects. **(Page 46)**

Action to be Taken

In FY 2019, with consultation/direction from HRSA's Chief Dental Officer, HRSA awarded $250,000 to the National Maternal and Child Center for Oral Health Systems Integration and Improvement program (COHSII) for the *Partnership for Integrating Oral Health Care into Primary Care* (PIOHCPC) project. This funding will support the continued provision of technical assistance, training, and other support for five PIOHCPC state team projects working to successfully and demonstrably implement the Inter-professional Oral Health Care Clinical Competencies (IPOHCCC) outlined in the 2014 report Integration of Oral Health and Primary Care Practice.

16. **National Living Donor Assistance Center Program. —** The Committee urges HRSA to consider the expansion of NLDAC to reimburse a comprehensive range of living donor expenses for the greatest possible number of donors, including lost wages, childcare, eldercare, and similar expenses for donor caretakers and expansion of income eligibility for the program to allow as many donors as possible to qualify. **(Page 50)**

Action to be Taken

On July 10, 2019, the President issued an Executive Order on Advancing American Kidney Health. The Executive Order outlines providing increased support for living donors to further the goal of significantly increasing the supply of transplantable kidneys (https://www.whitehouse.gov/presidential-actions/executive-order-advancing-american-kidney-health/). Section 8 of the Executive Order specifically requires the Secretary of

HHS to, in part, "…raise the limit on the income of donors eligible for reimbursement under the Program…."

In furtherance of that directive in the Executive Order, HRSA plans to amend the Reimbursement of Travel and Subsistence Expenses toward Living Organ Donation Program's eligibility guidelines through the Federal Register Notice toincrease the household income eligibility threshold for organ recipients, and prospective living organ donors, from the current 300 percent of the HHS Poverty Guidelines, to a higher threshold.

On December 20, 2019, HRSA published in the Federal Register a notice of proposed rulemaking to amend the regulation implementing the National Organ Transplant Act of 1984 (NOTA) to remove financial barriers to organ donation by expanding the scope of reimbursable expenses incurred by living organ donors to include lost wages, along with child-care and elder care expenses incurred by a primary care giver.

17. **Regenerative Cell Therapy Pilot Registry. —** The Committee looks forward to reviewing the state of the science report required by P.L. 114–104 on using adult stem cells and birthing tissues to develop new types of therapies for patients, for the purpose of considering the potential inclusion of such new types of therapies in the C.W. Bill Young Cell Transplantation Program. **(Page 50)**

Action to be Taken

In August 2019, the Secretary of Health and Human Services, in consultation with the Director of the National Institutes of Health, the Commissioner of the Food and Drug Administration, and the Administrator of the Health Resources and Services Administration, submitted a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives outlying recommendations on the appropriateness of new types of therapies for inclusion in the C.W. Bill Young Transplantation Program (CWBYCTP). In summary, the report noted that based on considerations from the respective agencies, members of the Advisory Council on Blood Stem Cell Transplantation, and the evolution of the field of stem cell-based therapies, the following were recommended criteria for inclusion of new cellular therapies in the CWBYCTP:

- Should include only those adult stem cell and birthing tissue products, including those with new uses outside of hematologic or immunologic reconstitution, that:
    - Are utilized as treatments for serious or life-threatening conditions, that require donor matching if appropriate, and,
    - Have been demonstrated to be safe and effective as evidenced by FDA approval, or if FDA approval is not required, through adoption as a standard of care.

The report further noted that based on the criteria above, the inclusion in the CWBYCTP of adult stem cells and birthing tissues for uses other than hematologic and immunologic

reconstitution is not recommended at this time. The report further stated that as the science advances and new classes of cell-based products are developed, that meet regulatory approval standards for safety and efficacy, it may be appropriate to include such products in the CWBYCTP. Therefore, re-evaluation by HRSA, NIH, and FDA (in conjunction with appropriate expert consultation) of the status of adult stem cells and birthing tissues for potential inclusion in the CWBYCTP is recommended on a periodic basis (every two to three years or as needed), with issuance of a report on the outcomes of such therapies). A copy of the full report can be found at https://bloodstemcell.hrsa.gov/sites/default/files/bloodstemcell/about/legislation/2019cwbillyoungreporttocongress.pdf

18. **Attracting Health Care Providers to Rural Communities. —** The Committee requests an update in the fiscal year 2021 Congressional Justification on the best practices and strategies to attract healthcare practitioners to rural clinics and hospitals in areas with healthcare professional shortages. **(Page 51)**

Action to be Taken

Studies show that health care providers who train in rural areas are more likely to practice in rural areas. In FY 2019, HRSA funded the Rural Residency Planning and Development (RRPD) program and made 27 awards to organizations across 21 states to develop newly accredited, sustainable rural residency programs in family medicine, internal medicine, and psychiatry. HRSA also continues to support the Rural Recruitment and Retention Network (3RNet), which places health care providers in rural and underserved practices. In FY 2019, the 3RNet program placed 2,380 clinicians in rural communities.

19. **Coordinating with USDA. —** The Committee encourages HRSA, namely the Federal Office of Rural Health Policy, to coordinate with USDA and, when established, the Rural Health Liaison to ensure communities have access to the full suite of federal resources and those resources are used effectively to improve health outcomes. **(Page 51)**

Action to be Taken

HRSA regularly promotes USDA rural development programs to ensure rural audiences are aware of these important resources. HRSA also continues to collaborate with USDA on the establishment of the Rural Health Liaison; HRSA plans to assist USDA with the development of essential resources, such as a listing of rural health programs and contacts within HHS, non-HHS rural organizations, and other external stakeholders. Once the Rural Health Liaison is established, HRSA will continue to work with USDA through the Liaison to ensure that communities have access to the full suite of federal resources to effectively improve health outcomes.

20. **Telementoring Training Center. —** The Committee directs HRSA to give preference to models of professional education and support that are adaptable to culturally and regionally diverse populations. **(Page 52)**

Action to be Taken
HRSA will develop a funding announcement for a Telementoring Training Center that will focus on reaching regionally diverse populations and addressing unique cultural aspects across rural areas.

21. **Telehealth. —** The Committee directs HRSA to conduct additional evaluations in conjunction with an academic medical center not previously funded through the Telehealth Centers of Excellence program that has experience providing telemedicine services across the care continuum in medically underserved areas in both rural and urban settings. **(Page 53)**

Action to be Taken
HRSA will assess how best to expand telehealth evaluation efforts within the Telehealth Research Center program.

22. **Telehealth Solutions and Virtual Models of Care. —** The Committee encourages the Secretary to consider pilot programs on a variety of telehealth solutions with the goal of finding an effective, scalable solution to treating substance use disorder in rural communities where access to care is limited. **(Page 53)**

Action to be Taken
HRSA will consider ways to leverage its telehealth program resources to focus on effective telehealth methods for treating substance use disorder in rural communities within its Evidence-Based Tele-Behavioral Health Network Program that is competitive in FY 2021.

23. **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 at an executive level authority with resources to oversee and lead HRSA oral health programs and initiatives. The Committee requests an update in the fiscal year 2021 Congressional Budget Justification request on how the CDO is serving as the agency representative on oral health issues to international, national, State or local government agencies, universities, and oral health stakeholder organizations. **(Page 54)**

Action to be Taken
The CDO position at HRSA is responsible for: coordinating oral health activities across all HRSA programs 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 all proposed oral health-related investments across the agency; leading a variety of cross-agency activities to advance oral health; serving as a featured speaker at HRSA stakeholder leadership meeting; representing the agency at professional conferences and meetings with domestic and international audiences; providing presentations on the agency's oral health portfolio to a variety of stakeholders; and overseeing and directing developmental opportunities to increase the oral health

professional pipeline including an annual symposium for dental students and residents interested in federal public health careers.

24. Oral Health Literacy. — The Committee includes $500,000 to continue the development of an oral health awareness and education campaign across relevant HRSA divisions, including the Health Centers Program, Oral Health Workforce, Maternal and Child Health, Ryan White HIV/AIDS Program, and Rural Health. The Committee directs HRSA to identify oral health literacy strategies that are evidence-based and focused on oral healthcare prevention and education, including prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer. The Committee expects the Chief Dental Officer to play a key role in the design, monitoring, oversight, and implementation of this project. **(Page 55)**

Action to be Taken

HRSA will collaborate across relevant agency components/programs to develop evidence-based oral health literacy approaches around early detection, disease prevention, and oral health promotion. The Chief Dental Officer will be involved in the design, planning, development, and monitoring of an oral health education campaign for health center patients, people living with HIV/AIDS, pregnant women and children, and rural or underserved populations.

Vaccine Injury Compensation Program

TAB

Vaccine Injury Compensation Program
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FY 2021 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 [$10,200,000] *$16,200,000* shall be available from the Trust Fund to the Secretary.

Amounts Available for Obligation

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Discretionary Appropriation:	$27,675,000	$32,270,000	$44,900,000
Transfer to Other Accounts	-$9,200,000		
Transfer from Other Accounts	$9,200,000		
Subtotal, adjusted Discretionary Appropriation	**$27,675,000**	**$32,270,000**	**$44,900,000**
Mandatory Appropriation	$225,921,000	$260,400,000	$265,600,000
Transfer to Other Accounts	-$225,921,000		
Transfer from Other Accounts	$225,921,000		
Subtotal, adjusted Mandatory Appropriation	**$225,921,000**	**$260,400,000**	**$265,600,000**
Spending Auth Offsets	---		
Administrative Expenses	27,675,000	32,270,000	44,900,000
Total HRSA Claims	225,921,000	260,400,000	265,600,000
Total New Obligations	**253,596,000**	**292,670,000**	**310,500,000**

Budget Authority by Activity

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Trust Fund Obligations: Post-10/1/88 claims	$225,921,000	$260,400,000	$265,600,000
Administrative Expenses: HRSA Direct Operations	$9,200,000	$10,200,000	$16,200,000
Total Obligations	$235,121,000	$270,600,000	$281,800,000

Budget Authority by Object

	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Insurance claims and indemnities	$260,400,000	$265,600,000	+$5,200,000
Salaries & Expenses/Other Services	$10,200,000	$16,200,000	+$6,000,000
Total	$270,600,000	$281,800,000	+$11,200,000

Authorizing Legislation

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
(a) PHS Act, Title XXI, Subtitle 2, Parts A and D:			
Pre-FY 1989 Claims	---	---	---
Post-FY 1989 Claims	$225,921,000	$260,400,000	$265,600,000
(b) Sec. 6601 (r)d ORBA of 1989 (P.L. 101-239):			
HRSA Operations	$9,200,000	$10,200,000	$16,200,000

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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2021	---	---	---	---

Vaccine Injury Compensation Program

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Claims BA	$225,900,000	$260,400,000	$265,600,000	+$5,200,000
Admin BA	$9,200,000	$10,200,000	$16,200,000	+$6,000,000
Total BA	$235,100,000	$270,600,000	$281,800,000	+$11,200,000
FTE	19	21	28	+7

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 2021 Authorization ..... …...Indefinite

Allocation Method ..... Other

Program Description and Accomplishments

Serving as an alternative to the traditional tort system, the National Vaccine Injury Compensation Program (VICP) compensates 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 or pregnant women. 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 claim reviews 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 compensation, and DOJ incorporates these recommendations in Rule 4(b) reports 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, healthcare 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 over $3.8 billion, the Vaccine Injury Compensation Trust Fund (Trust Fund) provides funding for VICP administration and for compensating 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 $0.75 excise tax on vaccines recommended by the CDC for routine administration to children or pregnant women. The excise tax applies to each disease prevented per vaccine dose. For example, influenza vaccine is taxed $0.75 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. Table 1 shows number of petitioners and vaccine injury compensation provided over the last five years.

Table 1. Growth in Families and Individuals Receiving Compensation

Fiscal Year	No. of Petitioners	Compensation ($ in millions)
2015	508	$226
2016	689	$253
2017	706	$282
2018	522	$227
2019	653	$226

VICP Administration

The number of claims filed has risen 60 percent from 803 claims filed in FY 2015 to 1,282 claims filed in FY 2019, primarily due to the increase in the number of seasonal influenza vaccine claims filed. During the same period, administrative funding has increased by only 23 percent from $7.5 million to $9.2 million, as shown in Table 2.

In FY 2017, HRSA began a backlog of vaccine injury claims awaiting medical review since the volume of claims exceeded resources available to conduct medical reviews. This backlog results in delays in compensating petitioners since claims remain in backlog status for more than ten months awaiting review. The cumulative claims backlog was 880 claims at the end of FY 2019, and HRSA anticipates the backlog to grow to 1,060 claims by the end of FY 2020.

Table 2. Five-Year Trend in Number of Claims Filed and Administrative Costs

Fiscal Year (FY)	No. of Claims Filed	Administrative Funding *($ in millions)*
2015	803	$7.50
2016	1,120	$7.50
2017	1,243	$7.75
2018	1,238	$9.20
2019	1,282	$9.20

Funding History – VICP Claims Compensation

FY	Amount
FY 2017	$282,945,120
FY 2018	$227,082,600
FY 2019	$225,900,000
FY 2020	$260,400,000
FY 2021	$265,600,000

Funding History – VICP Administration

FY	Amount
FY 2017	$7,750,000
FY 2018	$9,200,000
FY 2019	$9,200,000
FY 2020	$10,200,000
FY 2021	$16,200,000

Budget Request

VICP Claims Compensation - The FY 2021 Budget Request for VICP claims compensation of $265.6 million is $5.2 million above the FY 2020 Enacted level. This 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 2021 Budget Request for VICP Administration of $16.2 million is $6.0 million above the FY 2020 Enacted level. This request will support administrative expenses to process approximately 1,280 claims filed in FY 2021, including costs associated with medical expert reviews and expert testimony to the Court. This request will also allow HRSA to begin a multi-year effort to eliminate the claims backlog.

In FY 2021, HRSA will hire and train additional contractors who will conduct initial medical reviews of the claims, including the claims in backlog. HRSA will hire and train five physicians

to review the contractor's work, and HRSA will also hire two administrative staff to support claims processing.

Decreasing the size of the backlog over time depends on the rate of hiring and training of new staff and contractors. HRSA estimates that it could take multiple years to reduce the backlog. .

In addition, the VICP will continue to provide professional and administrative support to the ACCV, 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 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
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 2019: 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. *(Efficiency)*	FY 2019: 5 days Target: 10 days (Target Exceeded)	10 days	10 days	Maintain
26.II.A.5: Average time that lump sum only awards are paid from the receipt of all required documentation to make a payment. *(Efficiency)*	FY 2019: 1.3 days Target: 7 days (Target Exceeded)	4 days	4 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 2019: 92% Target: 98% (Target Not Met)	98%	98%	Maintain

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
26.II.A.7: Percentage of medical reports that are completed within 90 days of receipt of any medical records. *(Efficiency)*	FY 2019: 75% Target: 75% (Target Met)	75%	75%	Maintain
26.II.A.8 Percentage of FY 2017 and subsequently filed claims with any medical records assigned for medical review within 4 months of receipt from the Court. *(Outcome)*	FY 2019: 27% Target: 65% (Target Not Met)	65%	65%	Maintain