DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2015

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

MESSAGE FROM THE ADMINISTRATOR

I am pleased to present the FY 2015 Congressional Justification for the Health Resources and Services Administration (HRSA). HRSA is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable. This budget targets critical healthcare needs in underserved areas. To support this mission, the FY 2015 Budget requests $10.8 billion, of which $1.4 billion will be directed toward implementing new mandatory proposals.

The implementation of the Affordable Care Act (ACA) presents opportunities to improve access and care quality. A major component of our budget strategy is to ensure that HRSAs portfolio of programs, including the health center and health workforce programs, are fully aligned with the ACA. The ACA makes it possible for these programs to be more effective and have an even broader impact on the health of individuals across the country

In FY 2015, the Health Center program will continue to provide high quality, affordable and comprehensive primary care services in medically underserved communities even as insurance coverage expands. This makes Health centers a critical element of the nation's health care system. The Budget requests the resources needed to meet a surge in newly-insured patients seeking care at health centers across the country. The Budget includes $4.6 billion for the Health Center program, including $3.6 billion in mandatory funding through the ACA.

HRSA's FY 2015 budget invests resources to increase the number of health care practitioners in areas of the country experiencing shortages. HRSA is requesting $1.8 billion for HRSA workforce programs, a total that includes $1.2 billion in mandatory funding. As health insurance coverage increases, it is vital to make targeted investments that promote a high-performing health care workforce capable of meeting the increased demand. The request includes an increase of $530 million for a new mandatory program, Targeted Support for Graduate Medical Education, funded through a transfer from the Medicare Hospital Insurance Trust Fund. This new competitive program will fund teaching hospitals, children's hospitals and community based consortia of teaching hospitals to expand residency training with a focus on ambulatory and preventative care. The Budget also provides two new workforce initiatives, including $10 million to support a new Clinical Training in Interprofessional Practice program to increase the capacity of community-based primary health care teams to deliver quality care. The budget provides $4 million to fund new Rural Physician Training grants to help rural-focused training programs recruit and graduate students most likely to practice medicine in underserved rural communities.

The budget requests $1.3 billion to improve the health of mothers and children. This level includes $500 million in FY 2015 for the Maternal, Infant, and Early Home Visiting program.

The budget request also includes $125 million to improve both access to and the quality of health care in rural areas. It will strengthen regional and local partnerships among rural health care providers, expand community-based programs and promote the modernization of the health care infrastructure in rural areas. These efforts will enhance the ability of those insured through the ACA to obtain health care in rural communities.

Many Ryan White clients will continue to gain access to health insurance or see their current health insurance improve in FY 2015 as a result of ACA. The Budget includes $2.3 million for the Ryan White program to improve and expand access to care for persons living with HIV/AIDS. Of this amount $900 million is included for the AIDS Drug Assistance Program. The Budget request also proposes to consolidate funds from Part D to Part C. By merging the two programs resources can be better targeted to points along the care continuum to improve patient outcomes. The merger will expand the focus on women, infants, children and youth across all the funded grantees.

Our FY 2015 budget request places a strong emphasis on investing in programs that improve access to health care in underserved areas and allows the Health Resources and Services Administration to take important steps toward advancing the impact of the ACA and improving healthcare access, particularly for underserved populations.

Mary K. Wakefield, Ph.D., R.N.
Administrator

TABLE OF CONTENTS

FY 2015 Budget

Organizational Chart 1

Executive Summary 2
- Introduction and Mission 3
- Overview of Budget Request 4
- Overview of Performance 7
- All-Purpose Table 11

Health Resources and Services 16
Budget Exhibits 16
- Appropriations Language 17
- Language Analysis 20
- Amounts Available for Obligation 23
- Summary of Changes 24
- Budget Authority by Activity 26
- Authorizing Legislation 30
- Appropriations History Table 39
- Appropriations Not Authorized by Law 42

NARRATIVE BY ACTIVITY 44

PRIMARY HEALTH CARE 45
- Health Centers 45
- Free Clinics Medical Malpractice 58

HEALTH WORKFORCE 63
CLINICIAN RECRUITMENT AND SERVICE 63
- National Health Service Corps 63
- NURSE Corps 74

Faculty Loan Repayment Program 80
HEALTH PROFESSIONS 82
Summary of Request 82
Health Professions Training for Diversity 92
Centers of Excellence 92
Scholarships for Disadvantaged Students 98
Health Careers Opportunity Program 102
Health Care Workforce Assessment 106
The National Center for Health Workforce Analysis 106
Primary Care Training and Enhancement Program 109
Oral Health Training Programs 117
Rural Physician Training Grants Program 124
Teaching Health Centers Graduate Medical Education Payment Program 127
Targeted Support for Graduate Medical Education 131
Interdisciplinary, Community-Based Linkages 134
Area Health Education Centers Program 134
Geriatric Programs 138
Mental and Behavioral Health Education and Training Programs 147
Clinical Training in Interprofessional Practice 155
Public Health Workforce Development 158
Public Health and Preventive Medicine 158
Nursing Workforce Development 168
Advanced Nursing Education 168
Nursing Workforce Diversity 176
Nurse Education, Practice, Quality and Retention Program 180
Nurse Faculty Loan Program 185
Comprehensive Geriatric Education 190
Children's Hospitals Graduate Medical Education Payment Program 194
National Practitioner Data Bank 197
MATERNAL AND CHILD HEALTH 202
Maternal and Child Health Block Grant 202

Autism and Other Developmental Disorders 220
Traumatic Brain Injury 229
Sickle Cell Services Demonstration Program 235
James T. Walsh Universal Newborn Hearing Screening 237
Emergency Medical Services for Children 241
Healthy Start 250
Heritable Disorders Program 260
Family-To-Family Health Information Centers 267
Maternal, Infant, and Early Childhood Home Visiting Program 271
HIV/AIDS 277
Ryan White HIV/AIDS Treatment Extension Act of 2009 Overview 277
Emergency Relief Grants – Part A 292
HIV Care Grants to States – Part B 297
Early Intervention Services – Part C 304
Women, Infants, Children and Youth – Part D 307
AIDS Education and Training Programs – Part F 310
Dental Reimbursement Program – Part F 313
HEALTH CARE SYSTEMS 317
Organ Transplantation 317
National Cord Blood Inventory 327
C.W. Bill Young Cell Transplantation Program 332
Poison Control Program 337
Office of Pharmacy Affairs/340B Drug Pricing Program 342
Office of Pharmacy Affairs/340B Drug Pricing Program User Fees 347
National Hansen's Disease Program 352
National Hansen's Disease Program – Buildings and Facilities 358
Payment to Hawaii 359
RURAL HEALTH POLICY 362
Rural Health Policy Development 369
Rural Health Care Outreach Grants 372
Rural Access to Emergency Devices 377

Rural Hospital Flexibility Grants 379
State Offices of Rural Health 383
Radiation Exposure Screening and Education Program 386
Black Lung 389
Telehealth 392
OTHER PROGRAMS 398
Program Management 398
Family Planning 404

SUPPLEMENTARY TABLES 414
Budget Authority by Object Class 415
Salaries and Expenses 426
Detail of Full-Time Equivalent Employment 428
Programs Proposed for Elimination 433
FTE Funded by Mandatory Resources 435
Physicians' Comparability Allowance (PCA) Worksheet 436

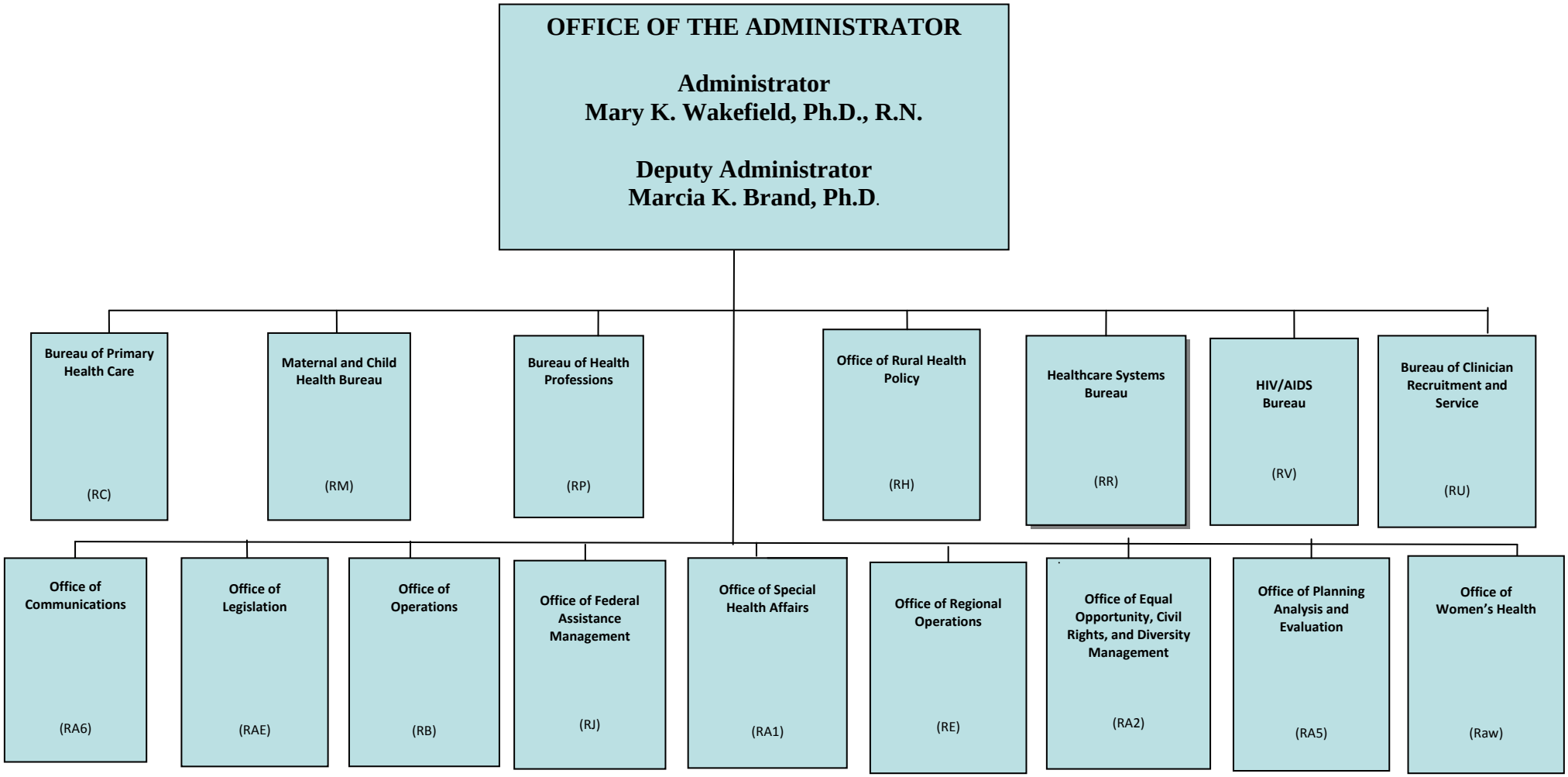
SIGNIFICANT ITEMS 439

Health Education Assistance Loans 459

Vaccine Injury Compensation Program 471

Department of Health and Human Services
Health Resources and Services Administration

Organizational Chart



Executive Summary

TAB

Introduction and Mission

The Health Resources and Services Administration (HRSA), an Agency of the U.S. Department of Health and Human Services (DHHS), is the principal Federal agency charged with increasing access to basic health care for those who are medically underserved. Health care in the United States is among the finest in the world but it is not accessible to everyone. Millions of families still face barriers to quality health care because of their income, lack of insurance, geographic isolation, or language and cultural barriers. The Affordable Care Act provided for substantial expansion of components of the HRSA-supported safety net, including the Health Center Program, the National Health Service Corps, and a variety of health workforce programs, to address these and other access problems. In addition, the expansion of health care coverage to many of the populations HRSA serves may result in savings that will allow some HRSA programs to reinvest resources in new areas. While implementation of health reforms and other factors may affect the structure and function of the safety net, assuring an adequate safety net for individuals and families who live outside the economic and medical mainstream remains a key HRSA role.

HRSA's mission as articulated in its Strategic Plan for 2010-2015 is: To improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. HRSA supports programs and services that target, for example:

- Americans who have trouble accessing health care--many of whom are racial and ethnic minorities,
- Over 50 million underserved Americans who live in rural and poor urban neighborhoods where health care providers and services are scarce,
- African American infants who still are 2.4 times as likely as white infants to die before their first birthday,
- The more than 1 million people living with HIV infection,
- The more than 100,000 Americans who are waiting for an organ transplant.

Focusing on these and other vulnerable, underserved groups, HRSA's leadership and programs promote the improvements in access, quality and equity that are essential for a healthy nation.

Overview of Budget Request

The FY 2015 President's program level request of $10.8 billion for the Health Resources and Services Administration (HRSA) is a net increase of $1.8 billion above the FY 2014 enacted level.

Highlights of the major programs are listed below:

Increases:

Health Centers +$1.455B in mandatory funding; -$495M in discretionary funding; total program $4.6B – This funding level is projected to serve approximately 31 million patients at the FY 2015 Budget Request level. This request is projected to provide approximately $800 million for major and minor capital development grants. In addition, this request is projected to support 150 new access point grants, and continuation activities for over 1,200 existing health centers, including recognition of centers performing at exceptional levels. This funding level also includes $3.6B appropriated under the Affordable Care Act.

Healthcare Workforce +$957M in mandatory funding; -$257M in discretionary funding; +$62M in Evaluation Funding; -$9M in User Fees; total program +$1.8B –

- +$527M for the National Health Service Corps. The combined appropriation request of $810M for the NHSC will support a field strength of 15,000 health care providers.

- -$14M for the Health Careers Opportunity Program. No funding is requested for this program.

- +$4M for Rural Physician Training Grants. This request will support a new grant program that will establish, expand and improve rural-focused physician training programs. The Rural Physician Training Grants Program will focus on recruiting and training physician students in rural settings with the goal of increasing the number of medical school graduates who practice in rural communities

- +$530M for the new Targeted Support for the Graduate Medical Education Program, funded by a transfer from the Medicare Hospital Insurance Trust Fund. The program supports training residents in high need specialties in addition to primary care, in community-based ambulatory care settings that provide a range of training experiences to address key health care workforce development needs. Approximately 13,025 residents will complete their training over ten years.

- -$30M for the Area Health Education Centers. No funding is requested for this program.

- +$10M for Clinical Training in Interpersonal Practice. This new program will increase the capacity of community-based primary health care teams to deliver care.

This funding will support approximately 19 awards of approximately $500,000 per year for five years.

- -$265M for the Children's Graduate Medical Education Program. In FY 2015, HRSA will establish a new Targeted Support for Graduate Medical Education Program to expand residency training, with a focus on ambulatory and preventive care, in order to advance higher value health care that reduces long term costs. The Targeted Support for Graduate Medical Education program will incorporate the CHGME program, and $100 million will be set aside specifically for children's hospitals in FY 2015.

- Advanced Education Nursing funding is funded through the PHS Evaluation Fund in this request. As a result, discretionary funding is decreased by $62M and PHS Evaluation Funds are increased by +$62M.

- -$9M for the National Practitioner Data Bank User Fees.

Maternal and Child Health +$126M Mandatory; total program $1.3B – This funding level supports an increase of $129M to extend and expand the Maternal, Infant, and Early Childhood Home Visiting program, and a decrease of $2.5M for Family to Family Health Information Centers, discontinuing the program. The Budget proposes to extend and expand the home visiting program beginning in FY 2015 by providing a substantial new investment of $15 billion through FY 2024 to ensure that our most vulnerable Americans are on track from birth, and that later educational investments, including Early Head Start, high quality child care, and high quality preschool, rest upon a strong foundation.

HIV/AIDS + $4M Discretionary; total program $2.298B – The FY 2015 request proposes to consolidate Part D to part C, increasing the budget by $4M. The Part C program will emphasize care across all lifecycles, gender, and ages thus assuring services for women, infants, children, and youth throughout the program.

Healthcare Systems +$7.5 in discretionary funding; +$7M in user fees, +$.5M for the Organ Transplantation program; total programs $111M - HRSA is proposing a 340B discretionary user fee program and is requesting an additional +$7M, maintaining an 0.1 percent fee on participating entities. The request also includes +$.5M for the Organ Transplantation program.

Program Management +$4M; total program $157M – This request supports program management activities for programs budgeted of $11B. In addition, funding is requested to support a new consolidated facility that will improve efficiency over time.

Vaccine +$1M; total program $7.5M - HRSA requests using $7.5M from the Trust Fund to cover the costs of internal medical claims review, external medical claims review by outside consultants (including, where warranted, expert testimony to the Court), professional and administrative support to the Advisory Commission on Childhood Vaccines, meeting specific administrative requirements of the National Childhood Vaccine Injury Act of 1986, processing

award payments, maintaining necessary records, and informing the public of the availability of the National Vaccine Injury Compensation Program.

Decreases:

Rural Health -$18M; total program $125M- The majority of rural health programs are requested at the same level as the FY 2014 enacted level, with the exception of the Rural and Community Access to Emergency Device program, and the Rural Hospital Flexibility Grants program. No funding is requested for the Rural and Community Access to Emergency Device program. Activities related to access to emergency medical devices and training in FY 2015 may be addressed through other funding sources available to grantees, such as the Rural Outreach and Rural Network Development programs. This request will continue to support 45 Flex grant programs to support critical access hospitals and 3 grants to support rural veterans.

Health Education Assistance Loans -$2.7M; total program $0. The Budget reflects the transfer of the HEAL Program from the Department of Health and Human Services to the Department of Education in FY 2014.

Overview of Performance

This Performance Budget documents the progress HRSA has made and expects to make in meeting the needs of uninsured and medically underserved individuals, special needs populations, and many other Americans. HRSA and its partners work to achieve the vision of "Healthy Communities, Healthy People." In pursuing that vision, HRSA's strategic goals are to: improve access to quality health care and services, strengthen the health workforce, build healthy communities, and improve health equity. The performance and expectations for HRSA programs are highlighted below, categorized by HRSA goals and HHS strategic objectives to indicate the close alignment of specific programmatic activities and objectives with broader HRSA and Departmental priorities. The examples illustrate ways HRSA helps states, communities and organizations provide essential health care and related services to meet critical needs.

Highlights of Performance Results and Targets

HRSA Goals: *Improve access to quality health care and services, Improve health equity*
HHS objectives for information through 2013 (Strategic Plan, 2010-2015):
Ensure access to quality, culturally competent care for vulnerable populations (1.E)
Emphasize primary and preventive care linked with community prevention services (1.C)
HHS objectives for information after 2013 (Strategic Plan, 2014-2018):
Ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations (1.E)
Emphasize primary and preventive care linked with community prevention services (1.C)

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 2015, the Health Center program projects that it will serve 31 million patients. This is an expected increase of 9.9 million over the 21.1 million persons served in FY 2012.

- HRSA expects to serve 32 million children through the Maternal and Child Health Block Grant (Title V) in FY 2015; 35.9 million were served in FY 2012.

- By reaching out to low-income parents to enroll their children in the Children's Health Insurance Program (CHIP) and Medicaid, HRSA improves access to critically important health care. In FY 2015, the number of children receiving Title V services that are enrolled in and have Medicaid and CHIP coverage is expected to be 14.5 million. In FY 2012, the number was 14.2 million.

- In FY 2015, HRSA's Ryan White HIV Emergency Relief Grants (Part A) and HIV Care Grants to States (Part B) are projected to support, respectively, 1.963 million visits and 1.63 million visits for health-related care (primary medical, dental, mental health, substance abuse, and home health). Approximately 1.99 million visits and 1.09 million visits, respectively, were supported in FY 2011.

- By supporting AIDS Drug Assistance Program (ADAP) services to an anticipated 212,107 persons in FY 2015, HRSA expects to continue its contribution to reducing AIDS-related mortality through providing drug treatment regimens for low-income, underinsured and uninsured people living with HIV/AIDS. More than 217,000 persons were served through ADAP in FY 2012.

- The number of organ donors and the number of organs transplanted have increased substantially in recent years. In FY 2015, HRSA's Organ Transplantation program projects that 25,400 deceased donor organs will be transplanted, up from 24,557 in FY 2012.

- 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, HRSA's C.W. Bill Young Cell Transplantation program projects that it will have 3.26 million adult volunteer potential donors of minority race and ethnicity listed on the donor registry in FY 2015. Nearly 3.1 million were listed on the registry in FY 2013.

- In FY 2012, the Black Lung program supported services to more than 12,500 active and retired coal miners and others with occupation-related respiratory and pulmonary impairments. In FY 2015, an estimated 13,000 miners and others will be served.

HRSA Goal: Strengthen the health workforce
HHS Objective for information through 2013 (Strategic Plan, 2010-2015):
Ensure that the Nation's health care workforce can meet increased demands (5.B)
HHS Objective for information after 2013 (Strategic Plan, 2014-2018):
Ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations (1.E)

HRSA works to improve health care systems by assuring access to a quality health care workforce in all geographic areas and to all segments of the population through the support of training, recruitment, placement, and retention activities.

- In FY 2013, the National Health Service Corps (NHSC) had a field strength of 8,899 primary care clinicians. The NHSC projects that a field strength of more than 15,400 primary care clinicians will be in health professional shortage areas in FY 2015.

- In FY 2013, 70% of NURSE Corps (formerly known as the Nursing Education Loan Repayment and Scholarship Program) participants extended their service contracts and committed to work at a critical shortage facility for an additional year.

- In FY 2013, 6,780 health care providers were deemed eligible for FTCA malpractice coverage through the Free Clinics Medical Malpractice program, which encourages providers to volunteer their time at sponsoring free clinics. The projection for this number is 7,800 in FY 2015.

HRSA Goal: *Improve access to quality health care and services.*
HHS Objective for information before 2013 (Strategic Plan, 2010-2015):
Improve health care quality and patient safety (1.B)
HHS Objective for information after 2013 (Strategic Plan, 2014-2018):
Improve health care quality and patient safety (1.B)

Virtually all HRSA programs help improve health care quality, including those programs or program components that focus on improving the infrastructure of the health care system.

- In FY 2015, 95.7% of Ryan White program-funded primary care providers will have implemented a quality management program, comparable to the figure in FY 2011.

- In FY 2015, 90% of Critical Access Hospitals (supported by the Rural Hospital Flexibility Grants program) will report at least one quality-related measure to Hospital Compare. This will be an increase from 79.7% in FY 2011.

HRSA Goal*: Improve health equity.*
HHS Objective for information through 2013 (Strategic Plan, 2010-2015):
Accelerate the process of scientific discovery to improve patient care (2.A)
HHS Objective for information after 2013 (Strategic Plan, 2014-2018):
Accelerate the process of scientific discovery to improve patient care (2.A)

- The National Hansen's Disease Program seeks to prevent and manage Hansen's disease (leprosy) though both clinical care and scientific research. The Program is conducting research that will ultimately permit development of the full animal model (armadillo) that will advance understanding of the disease in humans. In 2012, the Program defined parameters of nerve dysfunction in armadillos infected with the leprosy bacillus. In 2015, the Program will continue to pursue a relevant animal model for human leprosy.

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

Performance Management

Achieving a high level of performance is a Strategic Plan principle and a major priority for HRSA. 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. HRSA's performance management process has several integrated elements, including priority setting, action planning, and regular monitoring and review with follow-up.

Priority setting is done each fiscal year in which goals, that are linked to HRSA's Strategic Plan, are defined through the process of establishing performance plans for Senior Executive Service (SES) personnel. This process identifies goals that are supported, to the greatest extent possible, by quantitative or qualitative measures and targets. Goal leaders plan for the major actions that must be accomplished to achieve goals. Many of the goals are outcome-oriented and their achievement is largely dependent upon the direct actions of grantees, supported by HRSA. Other goals relate to internal processes and organizational functioning that reflect standards for how

HRSA does its business.

Performance monitoring is done by:
(a) Assessing achievement of performance measure targets,
(b) Monitoring, through the work of project officers and progress reports, grantees' interim progress and challenges associated with goal achievement, and
(c) Tracking key milestones that indicate, for example, the advancement or completion of major deliverables linked to accomplishment of goals.

Regular reviews of performance occur between goal leaders and the Administrator/Deputy Administrator. These reviews include monthly one-on-one meetings, mid-year and year-end SES performance reviews, and ad hoc meetings called to address emerging issues/problems. The meetings cover progress, successes, challenges, and possible course-corrections. Focused discussions of performance, particularly related to cross-cutting goals, are also held at Senior Staff meetings.

HRSA produces an *Annual Performance Report* that shows trends in performance of HRSA's Bureaus and Offices. The Report, posted on-line, provides information for performance assessment purposes and also gives transparency to HRSA's performance results.

All-Purpose Table
Health Resources and Services Administration

(Dollars in Thousands)

	FY 2013	FY 2014	FY 2015	
Program	**Final**	**Enacted**	**President's Budget**	**FY 2015 +/- FY 2014**
PRIMARY CARE:				
Health Centers	1,390,507	1,400,343	911,017	-489,326
Community Health Center Fund (mandatory)	1,465,397	2,144,716	3,600,000	+1,455,284
Health Center Tort Claims	88,983	94,893	88,983	-5,910
Subtotal, Health Centers	***2,944,887***	***3,639,952***	***4,600,000***	***+960,048***
School-Based Health Centers - Facilities (mandatory)	47,450	-	-	-
Free Clinics Medical Malpractice	38	40	40	-
Subtotal, PL Bureau of Primary Health Care (BPHC)	**2,992,375**	**3,639,992**	**4,600,040**	**+960,048**
Subtotal, Mandatory BPHC (non-add)	***1,512,847***	***2,144,716***	***3,600,000***	***+1,455,284***
Subtotal, Discretionary BA BPHC (non add)	***1,479,528***	***1,495,276***	***1,000,040***	***-495,236***
HEALTH WORKFORCE:				
CLINICIAN RECRUITMENT & SERVICE				
National Health Service Corps	-	-	100,000	+100,000
National Health Service Corps Fund (mandatory)	284,700	283,040	710,000	+426,960
National Health Service Corps Fund - (proposed)(non-add)			*400,000*	*+400,000*
Subtotal, NHSC	**284,700**	**283,040**	**810,000**	**+526,960**
NURSE Corps Scholarship and Loan Repayment Program	77,957	79,986	79,986	-
Loan Repayment/Faculty Fellowships	1,177	1,190	1,190	-
Subtotal, Clinician Recruitment & Service	***363,834***	***364,216***	***891,176***	***+526,960***
HEALTH PROFESSIONS				
Health Professions Training for Diversity:				
Centers of Excellence	21,482	21,711	21,711	-
Scholarships for Disadvantaged Students	44,497	44,970	44,970	-
Health Careers Opportunity Program	14,039	14,189	-	-14,189
Subtotal, Health Professions Training for Diversity	***80,018***	***80,870***	***66,681***	***-14,189***

	FY 2013	FY 2014	FY 2015	
Program	**Final**	**Enacted**	**President's Budget**	**FY 2015 +/- FY 2014**
Health Care Workforce Assessment	2,635	4,663	4,663	-
Primary Care Training and Enhancement	36,535	36,924	36,924	-
Oral Health Training Programs	30,681	32,008	32,008	-
Rural Physician Training Grants	-	-	4,000	+4,000
Targeted Support for Graduate Medical Education (proposed mandatory transfer)	-	-	530,000	+530,000
Children's Hospital Set-Aside (non-add)	-	-	*100,000*	*+100,000*
Interdisciplinary, Community-Based Linkages:				
Area Health Education Centers	28,211	30,326	-	-30,326
Geriatric Programs	29,011	33,321	33,321	-
Alzheimer's Prevention Fund	1,847	-	-	-
Subtotal, Geriatric Programs	***30,858***	***33,321***	***33,321***	**-**
Mental and Behavioral Health	2,740	7,916	7,916	-
Subtotal, Mental and Behavioral Health	***2,740***	***7,916***	***7,916***	**-**
Clinical Training in Interprofessional Practice	-	-	10,000	+10,000
Subtotal, Interdisciplinary, Community-Based Linkages	***61,809***	***71,563***	***51,237***	***-20,326***
Public Health Workforce Development:				
Public Health/Preventive Medicine	7,683	18,177	18,177	-
Nursing Workforce Development:				
Advanced Education Nursing	59,943	61,581	61,581	-61,581
PHS Evaluation Funds (non-add)	-	-	*61,581*	*+61,581*
Nursing Workforce Diversity	14,984	15,343	15,343	-
Nurse Education, Practice and Retention	37,113	38,008	38,008	-
Nurse Faculty Loan Program	23,256	24,562	24,562	-
Comprehensive Geriatric Education	4,248	4,361	4,361	-
Subtotal, Nursing Workforce Development	***139,544***	***143,855***	***143,855***	**-**
Children's Hospitals Graduate Medical Education Program	251,166	265,000	-	-265,000
Subtotal, Bureau of Health Professions	***610,071***	***653,060***	***825,964***	***+172,904***
Health Workforce Evaluation Funding	-	-	*61,581*	*+61,581*

	FY 2013	FY 2014	FY 2015	
Program	**Final**	**Enacted**	**President's Budget**	**FY 2015 +/- FY 2014**
National Practitioner Data Bank (User Fees)	*27,451*	*27,456*	*18,814*	*-8,642*
Subtotal, PL Health Workforce (BCRS, BHPr)	**1,001,356**	**1,044,732**	**1,797,535**	**+752,803**
Subtotal, Discretionary Health Workforce (non-add)	*687,358*	*734,236*	*477,140*	*-257,096*
Subtotal, Mandatory Health Workforce (non-add)	*284,700*	*283,040*	*1,240,000*	*+956,960*
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant	604,917	634,000	634,000	-
Autism and Other Developmental Disorders	44,652	47,218	47,218	-
Traumatic Brain Injury	9,245	9,344	9,344	-
Sickle Cell Service Demonstrations	4,419	4,466	4,466	-
James T. Walsh Universal Newborn Hearing Screening	17,674	17,863	17,863	-
Emergency Medical Services for Children	20,000	20,213	20,213	-
Healthy Start	98,064	101,000	101,000	-
Heritable Disorders	9,314	11,913	11,913	-
Family to Family Health Information Centers (mandatory)	4,745	2,500	-	-2,500
Maternal, Infant and Early Childhood Visiting Program (mandatory)	379,600	371,200	500,000	+128,800
MIECHV (Proposed) (non-add)	-	-	*500,000*	
Subtotal, Maternal and Child Health Bureau	**1,192,630**	**1,219,717**	**1,346,017**	**+126,300**
Subtotal, Discretionary MCHB (non add)	*808,285*	*846,017*	*846,017*	-
Subtotal, Mandatory MCHB (non add)	*384,345*	*373,700*	*500,000*	*+126,300*
HIV/AIDS:				
Emergency Relief - Part A	624,262	655,876	655,876	-
Comprehensive Care - Part B	1,287,535	1,315,005	1,315,005	-
AIDS Drug Assistance Program (Non-Add)	*886,313*	*900,313*	*900,313*	-
Early Intervention - Part C	194,444	201,079	280,167	+79,088
Children, Youth, Women & Families - Part D	72,361	75,088	-	*-75,088*
AIDS Education and Training Centers - Part F	32,390	33,611	33,611	-
Dental Reimbursement Program Part F	12,646	13,122	13,122	-
Subtotal, HIV/AIDS	***2,223,638***	***2,293,781***	***2,297,781***	***+4,000***

	FY 2013	FY 2014	FY 2015	
Program	**Final**	**Enacted**	**President's Budget**	**FY 2015 +/- FY 2014**
SPNS Evaluation Funding	*25,000*	*25,000*	*25,000*	-
Subtotal, HIV/AIDS Bureau	**2,248,638**	**2,318,781**	**2,322,781**	**+4,000**
HEALTHCARE SYSTEMS:				
Organ Transplantation	23,301	23,549	24,015	+466
National Cord Blood Inventory	11,147	11,266	11,266	-
C.W. Bill Young Cell Transplantation Program	21,877	22,109	22,109	-
Poison Control Centers	17,657	18,846	18,846	-
340b Drug Pricing Program/Office of Pharmacy Affairs	4,193	10,238	17,238	+7,000
340b Drug Pricing Program User Fees (non-add)	-	-	*7,000*	*+7,000*
Hansen's Disease Center	15,045	15,206	15,206	-
Payment to Hawaii	1,838	1,857	1,857	-
National Hansen's Disease Program - Buildings and Facilities	122	122	122	-
Subtotal, Healthcare Systems Bureau	**95,180**	**103,193**	**110,659**	**+7,466**
RURAL HEALTH:				
Rural Health Policy Development	9,252	9,351	9,351	-
Rural Health Outreach Grants	52,093	57,000	57,000	-
Rural & Community Access to Emergency Devices	2,340	3,364	-	-3,364
Rural Hospital Flexibility Grants	38,484	40,609	26,200	-14,409
State Offices of Rural Health	9,411	9,511	9,511	-
Radiation Exposure Screening and Education Program	1,815	1,834	1,834	-
Black Lung	6,695	6,766	6,766	-
Telehealth	10,786	13,900	13,900	-
Subtotal, Office of Rural Health Policy	**130,876**	**142,335**	**124,562**	**-17,773**
PROGRAM MANAGEMENT	151,450	153,061	157,061	+4,000
FAMILY PLANNING	278,349	286,479	286,479	-
HRS Program Level	**8,090,854**	**8,908,290**	**10,745,134**	**+1,836,844**
Appropriation Table Match	**5,854,664**	**6,054,378**	**5,292,739**	**-761,639**

	FY 2013	FY 2014	FY 2015	
Program	**Final**	**Enacted**	**President's Budget**	**FY 2015 +/- FY 2014**
Less Mandatory Programs	***2,183,739***	***2,801,456***	***5,340,000***	***+2,538,544***
Subtotal Proposed Mandatory(non-add)	-	-	*1,430,000*	
Subtotal Public Health Prevention Fund	*1,847*	-	-	-
Discretionary Program Level:				
HRS	**5,907,115**	**6,106,834**	**5,405,134**	**-701,700**
Funds Appropriated to Other HRSA Accounts:				
Vaccine Injury Compensation:				
Vaccine Injury Compensation Trust Fund (HRSA Claims)	235,000	235,000	235,000	-
VICTF Direct Operations - HRSA	6,464	6,464	7,500	+1,036
Subtotal, Vaccine Injury Compensation	**241,464**	**241,464**	**242,500**	**+1,036**
Discretionary Program Level:				
HRS	**5,907,115**	**6,106,834**	**5,405,134**	**-701,700**
Vaccine Direct Operations	6,464	6,464	7,500	+1,036
Total, HRSA Discretionary Program Level	**5,913,579[1]**	**6,113,298[1]**	**5,412,634**	**-700,664**
Mandatory Programs:	**2,183,739**	**2,801,456**	**5,340,000**	**+2,538,544**
Total, HRSA Program Level	**8,097,318[1]**	**8,914,754[1]**	**10,752,634**	**+1,837,880**
Less Programs Funded from Other Sources Mandatory:				
Prevention and Public Health Fund	*-1,847*	-	-	-
Less Programs Funded from Other Sources:				-
Evaluation - Special Projects of National Significance (SPNS)	*-25,000*	*-25,000*	*-25,000*	-
Evaluation - Health Workforce	-	-	*-61,581*	*-61,581*
National Practitioner Data Bank (User Fees)	*-27,451*	*-29,334*	*-18,814*	*+10,520*
340b Drug Pricing Program (User Fees)	-	-	*-7,000*	*-7,000*
Total HRSA Discretionary Budget Authority	**5,861,128**	**6,060,842**	**5,300,239**	**-760,603**

[1] For comparability purposes, the totals for FY 2013 and FY 2014 do not include funding for the Health Education Assistance Loans Program, which was transferred to the Department of Education pursuant to P.L. 113-76.

Health Resources and Services

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,**[**$1,495,276,000**]***$1,000,040,000*: *Provided*, That no more than **[**$40,000**]** *$40,000* shall be available until expended for carrying out the provisions of section 224(o) of the PHS Act**[**, including associated administrative expenses and relevant evaluations**]** : *Provided further*, That no more than **[**$94,893,000**]***$88,983,000* shall be available until expended for carrying out the provisions of Public Law 104–73 and for expenses incurred by the Department of Health and Human Services (referred to in this Act as "HHS") pertaining to administrative claims made under such law: *Provided further*, That **[**of funds provided for the Health Centers program, as defined by section 330 of the PHS Act, by this Act or any other Act for fiscal year 2014, not less than $110,000,000 shall be obligated in fiscal year 2014 as base grant adjustments and not less than $350,000,000 shall be obligated in fiscal year 2014 to support new access points including approved and unfunded applications from fiscal year 2013, grants to expand medical services, behavioral health, oral health, pharmacy, and vision services, and costs associated with the HHS administration of these grants**]***funds made available for carrying out section 330 of the PHS Act in this or any prior Act, including section 10503 of Public Law 111–148, may also be used for the construction and improvement of community health centers*.

HEALTH WORKFORCE

For carrying out titles III, VII, and VIII of the PHS Act with respect to the health workforce, section 1128E *and 1921(b)* of the Social Security Act, and the Health Care Quality Improvement Act of 1986, **[**$734,236,000**]***$477,140,000*: *Provided, That $100,000,000, to remain available until expended, shall be for the National Health Service Corp Program: Provided further*, That sections 747(c)(2)**[**, 751(j)(2),**]** *and* 762(k), and the proportional funding amounts in paragraphs (1) through (4) of section 756(e) 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 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 in addition to fees authorized by section 427(b) of the Health Care Quality Improvement Act of 1986, fees shall be collected for the full disclosure of information under such Act sufficient to recover the full costs of operating the National Practitioner Data Bank and shall remain available until expended to carry out that Act: *Provided further*, That fees collected for the full disclosure of information under the "Health Care Fraud and Abuse Data Collection Program", authorized by section 1128E(d)(2) of the Social Security Act, shall be sufficient to recover the full costs of operating the program, and shall remain available until expended to carry out that Act: *Provided further*, That fees collected for the disclosure of information under the information reporting requirement program authorized by section 1921 of the Social Security Act shall be sufficient to recover the full costs of operating the program and shall remain available until expended to carry out that Act:**]** *fees collected for the disclosure of information under section 427(b) of the Health Care Quality Improvement Act*

of 1986 and sections 1128E(d)(2) and 1921 of the Social Security Act shall be sufficient to recover the full costs of operating the programs authorized by such sections and shall remain available until expended for the National Practitioner Data Bank: Provided further, That funds transferred to this account to carry out section 846 and subpart 3 of part D of title III of the PHS Act may be used to make prior year adjustments to awards made under such sections*: Provided further, That, on April 1, 2015,available amounts appropriated under section 340H(g) of the PHS Act are hereby permanently cancelled, and an equal amount of funding is hereby appropriated to be available until expended to carry out such section: Provided further, That in addition to amounts provided herein, $61,581,000 shall be available from amounts available under section 241 of the PHS Act to carry out section 811 of the PHS Act*.

MATERNAL AND CHILD HEALTH

For carrying out titles III, XI, XII, and XIX of the PHS Act with respect to maternal and child health, title V of the Social Security Act, and section 712 of the American Jobs Creation Act of 2004, **[**$846,017,000**]***$846,017,000*: *Provided*, That notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act, not more than [$77,093,000] *$77,093,000* 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]*$10,276,000* shall be available for projects described in paragraphs (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, **[**$2,293,781,000**]**,*$2,297,781,000:* of which **[**$1,970,881,000**]** *$1,970,881,000* shall remain available to the Secretary through September 30, **[**2016**]***2017*, for parts A and B of title XXVI of the PHS Act, and of which not less than **[**$900,313,000**]** *$900,313,000* shall be for State AIDS Drug Assistance Programs under the authority of section 2616 or 311(c) of such Act: *Provided*, That in addition to amounts provided herein, **[**$25,000,000**]** *$25,000,000* shall be available from amounts available under section 241 of the PHS Act to carry out parts A, B, *and* C**[**, and D**]** of title XXVI of **[**the PHS**]** *such* Act to fund Special Projects of National Significance under section 2691 .

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, **[**$103,193,000**]***$103,659,000*, of which **[**$122,000**]***$122,000* shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center*: Provided, That the Secretary may collect a fee of 0.1 percent of each purchase of 340B drugs from entities participating in the Drug Pricing Program pursuant to section 340B of the PHS Act to pay for the operating costs of such program: Provided further, That fees pursuant to the 340B Drug Pricing Program shall be collected by the Secretary based on sales data that shall be submitted by drug manufacturers and shall be credited to this account, to remain available until expended*.

RURAL HEALTH

For carrying out titles III and IV of the PHS Act with respect to rural health, section 427(a) of the Federal Coal Mine Health and Safety Act *of 1969*, **[**the Cardiac Arrest Survival Act of 2000,**]** and sections 711 and 1820 of the Social Security Act, **[**$142,335,000**]***$124,562,000*, of which **[**$40,609,000**]***$26,200,000* 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, **[**$14,942,000 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**]** *$1,000,000* shall be to carry out 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, **[**$9,511,000**]***$9,511,000* shall be available for State Offices of Rural Health.

FAMILY PLANNING

For carrying out the program under title X of the PHS Act to provide for voluntary family planning projects, [$286,479,000] *$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, [$153,061,000]*$157,061,000*: *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’’: Provided further, That the Administrator may transfer funds between any of the accounts of HRSA with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be decreased by more than 3 percent by any such transfer.

Language Analysis

LANGUAGE PROVISION	EXPLANATION
[including associated administrative expenses and relevant evaluations]	Cite removed as language is legally unnecessary.
Provided further, That **[**of funds provided for the Health Centers program, as defined by section 330 of the PHS Act, by this Act or any other Act for fiscal year 2014, not less than $110,000,000 shall be obligated in fiscal year 2014 as base grant adjustments and not less than $350,000,000 shall be obligated in fiscal year 2014 to support new access points including approved and unfunded applications from fiscal year 2013, grants to expand medical services, behavioral health, oral health, pharmacy, and vision services, and costs associated with the HHS administration of these grants**]***funds made available for carrying out section 330 of the PHS Act in this or any prior Act, including section 10503 of Public Law 111–148, may also be used for the construction and improvement of community health centers*.	Language for the Health Centers program is clarified to allow funding for construction and improvements of health centers. Language regarding fiscal years 2013 and 2014 is removed.
Provided, That $100,000,000, to remain available until expended, shall be for the National Health Service Corps Program	Language added to provide discretionary funding for National Health Service Corps Program.
Provided further, That **[**for any program operating under section 751 of the PHS Act on or before January 1, 2009, 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 in addition to fees authorized by section 427(b) of the Health Care Quality Improvement Act of 1986, fees shall be collected for the full disclosure of information under such Act sufficient to recover the full costs of operating the National Practitioner Data Bank and shall remain available until	Language is clarified to define the fees that may be collected by the National Practitioner Data Bank program. Language regarding the Area Health Education Centers is removed because no funding is requested for this program. Citation regarding 340G-1 of the PHS Act is removed to increase program flexibility.

LANGUAGE PROVISION	EXPLANATION
expended to carry out that Act: *Provided further*, That fees collected for the full disclosure of information under the "Health Care Fraud and Abuse Data Collection Program", authorized by section 1128E(d)(2) of the Social Security Act, shall be sufficient to recover the full costs of operating the program, and shall remain available until expended to carry out that Act: *Provided further*, That fees collected for the disclosure of information under the information reporting requirement program authorized by section 1921 of the Social Security Act shall be sufficient to recover the full costs of operating the program and shall remain available until expended to carry out that Act:**]** *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, on April 1, 2015, available amounts appropriated under section 340H(g) of the PHS Act are hereby rescinded, and an equal amount of funding is hereby appropriated to be available until expended to carry out such section: *Provided further*, That in addition to amounts provided herein, $61,581,000 shall be available from amounts available under section 241 of the PHS Act to carry out section 811 of the PHS Act.	Language added to rescind unobligated balances for the Teaching Health Center Graduate Medical Education program and allow the remaining balances to be available until expended. Language is also added to provide PHS Evaluation Funds for the Advanced Education Nursing Program
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	Language added to authorize the Secretary to collect and spend user fees for the 340B Drug Pricing Program.

LANGUAGE PROVISION	EXPLANATION
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.	
[the Cardiac Arrest Survival Act of 2000]	Citation removed as no funding is requested for this program.
[$14,942,000 shall be available for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of health information technology and]	Citation removed as funding is not requested in FY 2015.
Provided further, That the Administrator may transfer funds between any of the accounts of HRSA with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be decreased by more than 3 percent by any such transfer.	Language added to provide permissive authority to the HRSA administrator to transfer funds between HRSA accounts.

Amounts Available for Obligation[2]

	FY 2013 Operating Level	FY 2014 Enacted	FY 2015 Estimate
Discretionary Appropriation:			
Annual……	$6,194,474,000	$6,054,378,000	$5,292,739,000
Transfer to Other Accounts	-$127,663,000		
Transfer from Other Accounts	$111,857,000		
Appropriations Permanently Reduced	-$324,004,000		
Subtotal, adjusted appropriation……	**$5,854,664,000**	**$6,054,378,000**	**$5,292,739,000**
Mandatory Appropriation:			
Transfer from the Prevention and Public Health Fund	+1,847,000		
Family to Family Health Information Centers…….	+4,745,000	+2,500,000	-
Primary Health Care Access:			
Community Health Center Fund	+1,465,397,000	+2,144,716,000	+3,600,000,000
School-Based health Centers - Facilities	+47,450,000		-
National Health Service Corps	+284,700,000	+283,040,000	+710,000,000
Subtotal Primary Health Care Access	**+1,797,547,000**	**+2,427,756,000**	**+4,310,000,000**
Early Childhood Visitation	+379,600,000	+371,200,000	+500,000,000
Subtotal, adjusted budget authority……	**+8,038,403,000**	**+8,855,834,000**	**+10,102,739,000**
Offsetting Collections……	+49,922,000	+52,315,000	+642,395,000
Offsetting Collections Temporarily Reduced……	-566,000		
Subtotal Spending Authority from offsetting collections	**+49,356,000**	**+52,315,000**	**+642,395,000[3]**
Unobligated balance, start of year……	+395,934,000	+386,291,000	+264,000,000
Unobligated balance, end of year……..	-386,291,000	-264,000,000	-154,000,000
Recovery of prior year obligations……	+ 31,536,000		
Unobligated balance, lapsing……	-2,024,000	-	-
Total obligations……	**$8,126,914,000**	**$9,030,440,000**	**$10,855,134,000**

[2]Excludes the following amounts for reimbursable activities carried out by this account: FY 2013 - $31,491,000 and 20 FTE; FY 2014 - $34,586,000 and 20 FTE; FY 2015 $34,877,000 and 20 FTE.

[3] Includes transfer from the Medicare Hospital Insurance Trust Fund.

Summary of Changes

2014 Enacted	
Total budget authority	$6,054,378,000
(Obligations)	(-$6,054,378,000)
2015 Estimate	$5,292,739,000
(Obligations)	(-$5,292,739,000)
2014 Mandatory	$2,801,456,000
(Obligations)	(-$2,801,456,000)
2015 Mandatory	$5,340,000,000
(Obligations)	(-$5,340,000,000)
Net Change	**+$1,776,905,000**
(Obligations)	**+$1,776,905,000**

	2014 Current		Changes from Base	
		Budget Authority		**Budget Authority**
Increases:				
	FTE		FTE	
A. Built in:	1830		+ 44	
1. January 2015 Civilian Pay Raise		$257,382,912		$1,581,569
2. January 2015 Military Pay Raise		$257,382,912		$218,518
3. Civilian Annualization of Jan. 2014		$257,382,912		$527,190
4. Military Annualization of Jan. 2014		$257,382,912		$72,839
Subtotal, built-in increases				**+$2,400,117**
B. Program:				
Discretionary Increases	**FTE**	**FY 2014**		
National Health Service Corps	-	-	+15	+$100,000,000
Rural Physician Training Grants				+$4,000,000
Clinical Training in Interprofessional Practice	-	-	+2	+$10,000,000
Early Intervention - Part C	40	201,079,000	+9	+$79,088,000
Organ Transplantation		23,549,000	-	+$466,000
Program Management		153,061,000	-	+$4,000,000
Subtotal Discretionary Program	**40**	**377,689,000**	**+26**	**+197,554,000**

Increases					
Mandatory Increases					
Community Health Center Fund (ACA)			2,144,716,000	-	+$1,455,284,000
National Health Service Corps	237		283,040,000	+35	+$426,960,000
Targeted Support for Graduate Medical Education	-			+26	+$530,000,000
Maternal, Infant and Early Childhood Visiting Program			371,200,000	-	+$128,800,000
Subtotal Mandatory Program Increases	**237**		**2,798,956,000**	**61**	**+$2,541,044,000**
Total Program Increases	**277**	**$**	**3,176,645,000**	87	**+$2,738,598,000**
Decreases:					
A. Built in:					
1. Pay Costs			**$257,382,912**		**-$2,400,117**
B. Program:					
Discretionary Decreases					
Health Centers			1,400,343,000	-	-$489,326,000
Health Center Tort Claims			94,893,000	-	-$5,910,000
Health Careers Opportunity Program			14,189,000	-	-$14,189,000
Area Health Education Centers	2		30,326,000	-2	-$30,326,000
Advanced Education Nursing	6		61,581,000	-6	-$61,581,000
Children's Hospitals Graduate Medical Education Program	18		265,000,000	-18	-$265,000,000
Children, Youth, Women & Families - Part D	13		75,088,000	-13	-$75,088,000
Rural & Community Access to Emergency Devices	2		3,364,000	-2	-$3,364,000
Rural Hospital Flexibility Grants			40,609,000	-	-$14,409,000
Subtotal Discretionary Program Decreases	**41**	**$**	**1,985,393,000**	**-41**	**-$959,193,000**
Mandatory Decreases					
Family to Family Health Information Centers (ACA)	2		2,500,000	-2	-$2,500,000
Subtotal Mandatory Program Decreases	**2**		**2,500,000**	**-2**	**-$2,500,000**
Total Program Decreases	**43**	**$**	**1,987,893,000**	**-43**	**-$961,693,000**
Net Change Discretionary	**81**	**$**	**2,363,082,000**	**-15**	**-$761,639,000**
Net Change Mandatory	**239**	**$**	**2,801,456,000**	**59**	**+$2,538,544,000**
Net Change Discretionary and Mandatory	**320**	**$**	**5,164,538,000**	**+44**	**+$1,776,905,000**

Budget Authority by Activity

(Dollars in Thousands)

	FY 2013	FY 2014	FY 2015
	Actual	**Base**	**President's Budget**
1. PRIMARY CARE:			
Health Centers	1,390,507	1,400,343	911,017
Community Health Center Fund (mandatory)	1,465,397	2,144,716	3,600,000
Health Center Tort Claims	88,983	94,893	88,983
Subtotal, Health Centers	***2,944,887***	***3,639,952***	***4,600,000***
School-Based Health Centers - Facilities (mandatory)	47,450	-	-
Free Clinics Medical Malpractice	38	40	40
Subtotal, Bureau of Primary Health Care (BPHC)	**2,992,375**	**3,639,992**	**4,600,040**
HEALTH WORKFORCE:			
2. CLINICIAN RECRUITMENT & SERVICE			
National Health Service Corps	-	-	100,000
National Health Service Corps (mandatory)	284,700	283,040	710,000
National Health Service Corps - (proposed)			*400,000*
Subtotal, NHSC	**284,700**	**283,040**	**810,000**
NURSE Corps Scholarship and Loan Repayment Program	77,957	79,986	79,986
Loan Repayment/Faculty Fellowships	1,177	1,190	1,190
Subtotal, Clinician Recruitment & Service	***363,834***	***364,216***	***891,176***
3. HEALTH PROFESSIONS			
Health Professions Training for Diversity:			
Centers of Excellence	21,482	21,711	21,711
Scholarships for Disadvantaged Students	44,497	44,970	44,970
Health Careers Opportunity Program	14,039	14,189	-
Subtotal, Health Professions Training for Diversity	***80,018***	***80,870***	***66,681***

	FY 2013	FY 2014	FY 2015
	Actual	**Base**	**President's Budget**
Health Care Workforce Assessment	2,635	4,663	4,663
Primary Care Training and Enhancement	36,535	36,924	36,924
Oral Health Training Programs	30,681	32,008	32,008
Rural Physician Training Grants			4,000
Targeted Support for Graduate Medical Education (Proposed transfer)			530,000
Children's Hospital Set-Aside (non-add)			*100,000*
Interdisciplinary, Community-Based Linkages:			
Area Health Education Centers	28,211	30,326	
Geriatric Programs	29,011	33,321	33,321
Alzheimer's Prevention Fund	1,847	-	
Subtotal, Geriatric Programs	***30,858***	***33,321***	***33,321***
Mental and Behavioral Health	2,740	7,916	7,916
Clinical Training in Interprofessional Practice			10,000
Subtotal, Interdisciplinary, Community-Based Linkages	***61,809***	***71,563***	***51,237***
Public Health Workforce Development:			
Public Health/Preventive Medicine	7,683	18,177	18,177
Nursing Workforce Development:			
Advanced Education Nursing	59,943	61,581	61,581
PHS Evaluation Funds (non-add)	-	-	*61,581*
Nursing Workforce Diversity	14,984	15,343	15,343
Nurse Education, Practice and Retention	37,113	38,008	38,008
Nurse Faculty Loan Program	23,256	24,562	24,562
Comprehensive Geriatric Education	4,248	4,361	4,361
Subtotal, Nursing Workforce Development	***139,544***	***143,855***	***143,855***
Children's Hospitals Graduate Medical Education Program	251,166	265,000	-
Subtotal, Bureau of Health Professions	***610,071***	***653,060***	***825,964***

	FY 2013	FY 2014	FY 2015
	Actual	**Base**	**President's Budget**
National Practitioner Data Bank (User Fees)	*27,451*	*27,456*	*18,814*
4. <u>MATERNAL & CHILD HEALTH:</u>			
Maternal and Child Health Block Grant	604,917	634,000	634,000
Autism and Other Developmental Disorders	44,652	47,218	47,218
Traumatic Brain Injury	9,245	9,344	9,344
Sickle Cell Service Demonstrations	4,419	4,466	4,466
James T. Walsh Universal Newborn Hearing Screening	17,674	17,863	17,863
Emergency Medical Services for Children	20,000	20,213	20,213
Healthy Start	98,064	101,000	101,000
Heritable Disorders	9,314	11,913	11,913
Family to Family Health Information Centers (mandatory)	4,745	2,500	
Maternal, Infant and Early Childhood Visiting Program (mandatory)	379,600	371,200	500,000
MIECHV (Proposed) (non-add)			*500,000*
Subtotal, Maternal and Child Health Bureau	**1,192,630**	**1,219,717**	**1,346,017**
5. <u>HIV/AIDS:</u>			
Emergency Relief - Part A	624,262	655,876	655,876
Comprehensive Care - Part B	1,287,535	1,315,005	1,315,005
AIDS Drug Assistance Program (Non-Add)	*886,313*	*900,313*	*900,313*
Early Intervention - Part C	194,444	201,079	280,167
Children, Youth, Women & Families - Part D	72,361	75,088	-
AIDS Education and Training Centers - Part F	32,390	33,611	33,611
Dental Reimbursement Program Part F	12,646	13,122	13,122
Subtotal, HIV/AIDS	***2,223,638***	***2,293,781***	***2,297,781***
SPNS Evaluation Funding	*25,000*	*25,000*	*25,000*
Subtotal, HIV/AIDS Bureau	**2,248,638**	**2,318,781**	**2,322,781**

	FY 2013	FY 2014	FY 2015
	Actual	**Base**	**President's Budget**
6. <u>HEALTHCARE SYSTEMS:</u>			
Organ Transplantation	23,301	23,549	24,015
National Cord Blood Inventory	11,147	11,266	11,266
C.W. Bill Young Cell Transplantation Program	21,877	22,109	22,109
Poison Control Centers	17,657	18,846	18,846
340b Drug Pricing Program/Office of Pharmacy Affairs	4,193	10,238	17,238
340b Drug Pricing Program User Fees (non-add)		-	*7,000*
Hansen's Disease Center	15,045	15,206	15,206
Payment to Hawaii	1,838	1,857	1,857
National Hansen's Disease Program - Buildings and Facilities	122	122	122
Subtotal, Healthcare Systems Bureau	**95,180**	**103,193**	**110,659**
7. <u>RURAL HEALTH:</u>			
Rural Health Policy Development	9,252	9,351	9,351
Rural Health Outreach Grants	52,093	57,000	57,000
Rural & Community Access to Emergency Devices	2,340	3,364	
Rural Hospital Flexibility Grants	38,484	40,609	26,200
State Offices of Rural Health	9,411	9,511	9,511
Radiation Exposure Screening and Education Program	1,815	1,834	1,834
Black Lung	6,695	6,766	6,766
Telehealth	10,786	13,900	13,900
Subtotal, Office of Rural Health Policy	**130,876**	**142,335**	**124,562**
8. PROGRAM MANAGEMENT	151,450	153,061	157,061
9. FAMILY PLANNING	278,349	286,479	286,479
Total, Budget Authority	**5,854,664**	**6,054,378**	**5,292,739**
FTE (excludes HEAL and Vaccine)	**1869**	**1904**	**1958**

Authorizing Legislation

		FY 2014 Amount Authorized	FY 2014 Appropriations Act	FY 2015 Amount Authorized	FY 2015 President's Budget
	PRIMARY HEALTH CARE:				
	Health Centers:				
1.	PHS Act, Section 330, as amended by the Health Care Safety Net Act of 2008, P.L. 110-355; as further amended by the Affordable Care Act, P.L. 111-148, Section 5601	7,332,924,155	1,400,343,000	8,332,924,155	911,017,000
2.	Community Health Center Fund (Affordable Care Act) P.L. 111-148, Section 10503; as further amended by the Health Care and Education Reconciliation Act, P.L 111-152, Section 2303	2,200,000,000	2,144,716,000	3,600,000,000	3,600,000,000
3.	Health Center Tort Claims: (Defense of Certain Malpractice and Negligence Suits) PHS Act, Section 224, as added by P.L. 102-501 and amended by P.L. 104-73	(appropriation - $10,000,000 per year is authorized under sec. 224; funding also comes from the Health Center line)	94,893,000	(appropriation - $10,000,000 per year is authorized under sec. 224; funding also comes from the Health Center line)	88,983,000
4.	Free Clinic Medical Malpractice: Section 224, PHS Act, as added to the PHS Act by P.L. 104-191; as amended by P.L. 111-148, Section 10608	appropriation - $10,000,000 per year is authorized	40,000	appropriation - $10,000,000 per year is authorized	40,000
	CLINICIAN RECRUITMENT & SERVICE:				
5.	National Health Service Corps (NHSC) PHS Act, Sections 331-338, as amended by the Health Care Safety Net Act of 2008, P.L. 110-355; as further amended by P.L. 111-148, Section 5207	893,456,433	--	1,154,510,336	100,000,000
6.	National Health Service Corps – Fund (Affordable Care Act) P.L. 111-148, Section 10503(b)(2)	305,000,000	283,040,000	310,000,000	710,000,000
7.	Nursing Education Loan Repayment (Nurse Corps Loan Repayment Program) and Scholarship Program (Nurse Corps Scholarship Program) – PHS Act, Section 846, as amended by P.L. 107-205, Section 103; as amended by P.L. 111-148, Section 5310	expired	79,986,000	expired	79,986,000
8.	Loan Repayments and Fellowships Regarding Faculty Positions (Faculty Loan Repayment) – PHS Act, Section 738 and 740(b), as amended by P.L. 111-148, Section 5402	5,000,000	1,190,000	expired	1,190,000
9.	Pediatric Loan Repayment PHS Act, Section 775, as added by P.L. 111-148, Section 5203	30,000,000	--	expired	--

		FY 2014 Amount Authorized	FY 2014 Appropriations Act	FY 2015 Amount Authorized	FY 2015 President's Budget
	HEALTH PROFESSIONS:				
10.	Centers of Excellence Section 736, PHS Act, as amended by P.L. 111-148, Section 5401	50,000,000	21,711,000	50,000,000	21,711,000
11.	Scholarships for Disadvantaged Students PHS Act, Section 737 and Section 740(a), as amended by P.L. 111-148, Section 5402(b)	SSAN	44,970,000	expired	44,970,000
12.	Health Careers Opportunity Program PHS Act, Section 739 and Section 740(c), as amended by P.L. 111-148, Section 5402	SSAN	14,189,000	expired	--
13.	National Center for Workforce Analysis PHS Act, Section 761, 792 and 806(f), as amended by P.L. 111-148, Section 5103	SSAN	4,663,000	expired	4,663,000
14.	Primary Care Training and Enhancement PHS Act, Section 747, as amended by P.L. 111-148, Section 5301	SSAN	36,924,000	expired	36,924,000
15.	Oral Health Training Programs PHS Act, Section 748, as added by P.L. 111-148, Section 5303	SSAN	32,008,000	SSAN	32,008,000
	Interdisciplinary, Community-Based Linkages:				
16.	Area Health Education Centers PHS Act, Section 751, as amended by P.L. 111-148, Section 5403	125,000,000	30,326,000	expired	--
17.	Education and Training Related to Geriatrics PHS Act, Section 753, as amended by P.L. 111-148, Section 5305	10,800,000 for FY 2011 – FY 2014	33,321,000	expired	33,321,000
18.	Mental and Behavioral Health PHS Act, Section 756, as added by P.L. 111-148, Section 5306	expired	7,916,000	expired	7,916,000
19.	Public Health /Preventive Medicine PHS Act, Section 765-768, as amended by P.L. 111-148, Section 10501	SSAN	18,177,000	SSAN	18,177,000
	Nursing Workforce Development:				
20.	Advanced Education Nursing PHS Act, Section 811, as amended by P.L. 111-148, Section 5308	SSAN	61,581,000	SSAN	61,581,000
21.	Nursing Workforce Diversity PHS Act, Section 821, as amended by P.L. 111-148, Sec. 5404	SSAN	15,343,000	SSAN	15,343,000

		FY 2014 Amount Authorized	FY 2014 Appropriations Act	FY 2015 Amount Authorized	FY 2015 President's Budget
22.	Nurse Education, Practice, Quality and Retention PHS Act, Section 831, amended by Section 201 of P.L. 107-205; as amended by P.L. 111-148, Section 5309	SSAN	38,008,000	expired	38,008,000
23.	Nurse Faculty Loan Program PHS Act, Section 846A, as amended by P.L. 111-148, Section 5311	SSAN	24,562,000	expired	24,562,000
24.	Comprehensive Geriatric Education PHS Act, Section 865, as re-designated by P.L. 111-148, Section 5310(b), and amended by Section 5312	SSAN	4,361,000	expired	4,361,000
25.	Children's Hospitals Graduate Medical Education Program: PHS Act, Section 340E, as amended by P.L. 108-490; as further amended by P.L. 109-307	expired	265,000,000	expired	--
26.	*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*	indefinite	27,456,000	indefinite	18,814,000
	MATERNAL & CHILD HEALTH:				
27.	Maternal and Child Health Block Grant: Social Security Act, Title V	indefinite	634,000,000	indefinite	634,000,000
28.	Autism and Other Developmental Disorders PHS Act, Section 399BB, as added by P.L. 109-416, Part R; Reauthorized: P.L. 112-32, Section 2	48,000,000	47,218,000	expired	47,218,000
29.	Traumatic Brain Injury Program: PHS Act, Sections 1252 and 1253, as amended by P.L. 106-310, Section 1304; as further amended by P.L.110-206, Section 6	expired	9,344,000	expired	9,344,000
30.	Sickle Cell Service Demonstration Grants: American Jobs Creation Act of 2004, P.L. 108-357, Section 712(c)	expired	4,466,000	expired	4,466,000
31.	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	SSAN	17,863,000	SSAN	17,863,000
32.	Emergency Medical Services for Children: PHS Act, Section 1910, as amended by P.L. 105-392, Section 415; Reauthorized: P.L. 111-148, Section 5603	30,387,656	20,213,000	expired	20,213,000
33.	Healthy Start: PHS Act, Section 330H(a)-(d), as amended by P.L. 106-310, Section 1501; as amended by P.L. 110-339, Section 2	expired	101,000,000	expired	101,000,000

		FY 2014 Amount Authorized	FY 2014 Appropriations Act	FY 2015 Amount Authorized	FY 2015 President's Budget
34.	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; and as further amended by P.L. 110-237, Section 1	expired	11,913,000	expired	11,913,000
35.	Family to Family Health Information Centers (Affordable Care Act, Section 501,), Social Security Act, as amended by P.L. 109-171, Section 6064; Reauthorized: P.L. 111-148, Section 5507, as amended by P.L. 112-240, Section 624	expired	2,500,000	expired	--
36.	Maternal, Infant and Early Childhood Visiting Program: Affordable Care Act, P.L. 111-148, Section 2951	400,000,000	371,000,000	expired	500,000,000
	HIV/AIDS:[4]				
37.	Emergency Relief - Part A PHS Act, Section. 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
38.	Comprehensive Care - Part B: PHS Act, Section. 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
39.	Early Intervention – Part C: PHS Act, Section. 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	280,167,000
40.	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	--
41.	*AIDS Drug Assistance Program (Non-Add)* *PHS Act, Section. 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*

4 **Please note that the Ryan White Program was authorized through September 30, 2013. However, the program will continue to operate. The 2009 reauthorization or the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87, October 30, 2009) does not include an explicit sunset clause. In the absence of a sunset clause, the program will continue to operate without a Congressional reauthorization.**

		FY 2014 Amount Authorized	FY 2014 Appropriations Act	FY 2015 Amount Authorized	FY 2015 President's Budget
42.	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
43.	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
44.	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
	HEALTHCARE SYSTEMS				
45.	Organ Transplantation: PHS Act, Sections 371 - 378, as amended by P.L. 108-216, P.L. 109-129 and P.L. 110-144; as amended by P.L. 110-413; as further amended by P.L. 113-51	expired	23,549,000	expired	24,015,000
46.	National Cord Blood Inventory: PHS Act, Section 379, as amended by P.L. 109-129, Section 3; as further amended by P.L. 111-264	23,000,000	11,266,000	20,000,000	11,266,000
47.	C.W. Bill Young Cell Transplantation Program: PHS Act, Sections 379-379B, as amended by P.L. 109-129, Section 3; as further amended by P.L. 111-264	30,000,000	22,109,000	33,000,000	22,109,000
48.	Poison Control Centers: PHS Act, Section 1271-1274, as amended by P.L. 106-174, as amended by P.L. 110-377; as further amended by P.L. 113-77	28,600,000	18,846,000	28,600,000	18,846,000
49.	340B Drug Pricing Program: PHS Act, Section 340B, as amended by P.L. 111-148, Section 7101-7103; as further amended by P.L. 111-152, Section 2302; and as amended by P.L. 111-309, Section 204	SSAN	10,238,000	SSAN	10,238,000
	340B Drug Pricing Program/User Fees	--	--	--	7,000,000
50.	National Hansen's Disease Program: PHS Act, Section 320, as amended by P.L. 105-78, Section 211	not specified	15,206,000	not specified	15,206,000
51.	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
52.	National Hansen's Disease - Buildings and Facilities: PHS Act, Section 320 and 321(a)	not specified	122,000	not specified	122,000

		FY 2014 Amount Authorized	FY 2014 Appropriations Act	FY 2015 Amount Authorized	FY 2015 President's Budget
	RURAL HEALTH:				
53.	Rural Health Policy Development: Social Security Act, Section 711, and PHS Act, Section 301	indefinite	9,351,000	indefinite	9,351,000
54.	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	57,000,000	expired	57,000,000
55.	Rural Access to Emergency Devices: PHS Act, Section 313, and Public Health Improvement Act, P.L. 106-505, Section 413	expired	3,364,000	expired	--
56.	Rural Hospital Flexibility Grants: SSA, Section 1820(j), as amended by P.L. 105-33, Section 4201(a), and P.L. 108-173, Section 405(f), as amended by, P.L. 110-275, Section 121	expired	40,609,000	expired	26,200,000
57.	State Offices of Rural Health: PHS Act, Section 338J, as amended by P.L. 105-392, Section 301	expired	9,511,000	expired	9,511,000
58.	Radiogenic Diseases: PHS Act, Section 417C, as amended by P.L. 106-245, Section 4, as further amended by P.L. 109-482, Section 103 and Section 104	indefinite	1,834,000	indefinite	1,834,000
59.	Black Lung: Federal Mine Safety and Health Act 1977, P.L. 91-173, Section 427(a)	indefinite	6,766,000	indefinite	6,766,000
60.	Telehealth: PHS Act, Sec. 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	expired	13,900,000	expired	13,900,000
61.	Family Planning: Grants: PHS Act Title X	expired	286,479,000	expired	286,479,000
62.	Program Management:	indefinite	153,061,000	indefinite	157,061,000
63.	Health Education Assistance Loans Program:	SSAN	2,687,000	SSAN	--
64.	Vaccine Injury Compensation Program Trust Fund: PHS Act, Title XXI, Subtitle 2, Parts A and D Section. 2110-19 and 2131-34	indefinite	235,000,000	indefinite	235,000,000

		FY 2014 Amount Authorized	FY 2014 Appropriations Act	FY 2015 Amount Authorized	FY 2015 President's Budget
	<u>Unfunded Authorizations</u>:				
	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 Affordable Care Act, P.L. 111-148, Section 4101(a)	expired		expired	
	School Based Health Centers - Operations PHS Act, Section 399Z-1, as added by Affordable Care Act, P.L. 111-148, Section 4101(b)	SSAN		expired	
	Health Information Technology Innovation Initiative PHS Act, Section 330(e)(1)(C), (Grants for Operation of Health Center Networks and Plans), as amended by P.L. 107-251, Section 101; as amended by P.L. 110-355, Section 2, General Health Center funding authority made permanent by P.L. 111-148, Section 5601	SSAN		SSAN	
	Health Information Technology Planning Grants PHS Act, Section 330(c)(1)(B) and Section 330(c)(1)(C), as amended by P.L. 107-251, Section 101				
	Electronic Health Record Implementation Initiative PHS Act, Section 330(e)(1)(C), as amended by P.L. 107-251, Section 101, as amended by P.L. 110-355, Section 2, General Health Center funding authority made permanent by P.L. 111-148, Section 5601	SSAN		SSAN	
	Tax Exclusion: National Health Service Corps Scholarships (tuition, fees, ORC) Internal Revenue Code, Section 117, as amended by P.L. 107-16, Section 413 and 901, (authority to sunset 12/31/2010), as amended by P.L. 111-312, Section 101 (authority to sunset 12/31/2012), as further amended by P.L. 112-240, Section 101 (sunset authority removed)	SSAN		SSAN	
	Tax Exclusion: National Health Service Corps Loan Repayment and State Loan Repayment Internal Revenue Code, Section 108, as amended by P.L. 108-357, Section 320 (no sunset authority), and as amended by P.L. 111-148, Section 10908	--		--	

		FY 2014 Amount Authorized	FY 2014 Appropriations Act	FY 2015 Amount Authorized	FY 2015 President's Budget
	Native Hawaiian Health Scholarships P.L. 100-579, as amended by P.L. 102-396, Section 9168, PHS Act Section 338K; as amended by P.L. 111-148, Section 10221	--		--	
	Students to Service (S2S) Loan Repayment Pilot Program PHS Act, Section 338B and Section 331(i)				
	Health Professions Education in Health Disparities and Cultural Competency PHS Act, Section 741, as amended by P.L. 106-525, Section 401, as amended by P.L. 111-148, Section 5307	SSAN		SSAN	
	Training Opportunities for Direct Care Workers PHS Act, Section 747A, as added by P.L. 111-148, Section 5302	Expired		expired	
	Continuing Ed Support for Health Professionals Serving in Underserved Communities PHS Act, Section 752, as amended by P.L. 111-148, Section 5403				
	Geriatric Career Incentive Awards PHS Act, Section 753(e), as amended by P.L. 111-148, Section 5305(a)	5,000,000		SSAN	
	Geriatric Academic Career Awards PHS Act, Section 753(c), as amended by P.L. 111-148, Section 5305(b)	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	not specified		not specified	
	Advisory Council on Graduate Medical Education PHS Act, Section 762(k), as amended by P.L. 107-251, Section 502, as amended by P.L. 111-148, Section 5103	expired		expired	

		FY 2014 Amount Authorized	FY 2014 Appropriations Act	FY 2015 Amount Authorized	FY 2015 President's Budget
	Health Professions Education in Health Disparities and Cultural Competency PHS Act, Section 807, as added by P.L. 106-525, Section 401(b), as amended by P.L. 111-148, Section 5307	expired		expired	
	Minority Faculty Fellowship Program PHS Act, Section 738 (authorized appropriation Section 740(b)), as amended by P.L.111-148, Section 5104, Section 5402, and Section 10501	SSAN		SSAN	
	State Health Care Workforce Development Grants [Prevention Fund], 42 U.S.C. 294r, as added by P.L. 111-148, Section 5102	5,000,000		expired	
	Allied Health and Other Disciplines PHS Act, Section 755	SSAN		SSAN	
	Nurse Managed Health Clinics [Prevention Fund], PHS Act, Section 330A-1, as added by P.L. 111-148, Section 5208	not specified		not specified	
	Patient Navigator Outreach & Chronic Disease Prevention Act of 2005: PHS Act, Section 340A, as added by P.L. 109-18, as amended by P.L. 111-148, Section 3510	SSAN		expired	
	Teaching Health Centers Development Grants, PHS Act, Section 749A, as added by P.L. 111-148, Section 5508	SSAN		SSAN	
	Report on Long Term Effects of Living Organ Donation, PHS Act, Section 371A	SSAN		SSAN	
	Congenital Disabilities PHS Act, Section 399T	not specified		not specified	

Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2005				
General Fund Appropriation:				
Base	6,022,833,000	6,305,333,000	6,941,280,000	6,858,624,000
Advance				
Supplementals				
Rescissions (Government-Wide)				-54,862,000
Rescissions (L/DHHS/E)				-747,000
Transfers				
Subtotal	6,022,833,000	6,305,333,000	6,941,280,000	6,803,015,000
FY 2006				
General Fund Appropriation:				
Base	5,966,144,000	6,443,437,000	7,374,952,000	6,629,661,000
Advance				
Supplementals				3,989,000
Rescissions (Government-Wide)				-66,297,000
Rescission, CMS				-4,509,000
Subtotal	5,966,144,000	6,443,437,000	7,374,952,000	6,562,844,000
FY 2007				
General Fund Appropriation:				
Base	6,308,855,000	7,095,617,000	7,012,559,000	6,390,691,000
Mandatory Authority				3,000,000
Advance				
Supplementals				
Rescissions				
Subtotal	6,308,855,000	7,095,617,000	7,012,559,000	6,393,691,000
FY 2008				
General Fund Appropriation:				
Base	5,795,805,000	7,061,709,000	6,863,679,000	6,978,099,000
Mandatory Authority				9,000,000
Advance				
Supplementals				
Rescissions (L/DHHS/E)				-121,907,000
Transfers				
Subtotal	5,795,805,000	7,061,709,000	6,863,679,000	6,865,192,000

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2009				
General Fund Appropriation:				
Base	5,864,511,000	7,081,668,000	6,943,926,000	7,234,436,000
Mandatory Authority				5,000,000
Advance				
Supplementals (P.L. 111-5)				2,500,000,000
Rescission of Unobligated Funds				
Transfers				
Subtotal	5,864,511,000	7,081,668,000	6,943,926,000	9,739,436,000
FY 2010				
General Fund Appropriation:				
Base	7,126,700,000	7,306,817,000	7,238,799,000	7,473,522,000
Advance				
Supplementals				
Rescissions				
Transfers				9,472,000
Subtotal	7,126,700,000	7,306,817,000	7,238,799,000	7,482,994,000
FY 2011				
General Fund Appropriation:				
Base	7,473,522,000		7,491,063,000	6,274,790,000
Supplementals				
Transfers				
Across-the-board reductions (L/HHS/AG, or Interior)				-$12,549,000
American Recovery and Reinvestment Act				$73,600,000
Subtotal	7,473,522,000		7,491,063,000	6,335,841,000
FY 2012				
General Fund Appropriation:				
Base	6,801,262,000			6,206,204,000
Advance				
Supplementals				
Rescissions				
Across-the-board reductions				$11,730,000

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
(L/HHS/AG, or Interior)				
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				
Supplementals				
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				
Supplementals				
Rescissions				
Transfers				
Subtotal	6,015,039,000		6,309,896,000	6,054,378,000
FY 2015				
General Fund Appropriation:				
Base	5,292,739,000			
Advance				
Supplementals				
Rescissions				
Transfers				
Subtotal	5,292,739,000			

Appropriations Not Authorized by Law

		Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2014
1.	Nursing Education Loan Repayment (Nurse Corps Loan Repayment Program) and Scholarship Program (Nurse Corps Scholarship Program) – PHS Act, Section 846, as amended by P.L. 107-205, Section 103; as amended by P.L. 111-148, Section 5310[5]	2007	SSAN	31,055,000	79,986,000
2.	Traumatic Brain Injury Program: PHS Act, Sections 1252 and 1253, as amended by P.L. 106-310, Section 1304, as further amended by P.L.110-206, Section 6	2012	SSAN	9,760,000	9,344,000
3.	Sickle Cell Service Demonstration Grants: Section 712(c), P.L. 108-357 of the American Jobs Creation Act of 2004	2009	10,000,000	10,000,000	4,466,000
4.	Organ Transplantation: PHS Act, Sections 371 - 378, as amended by P.L. 108-216, P.L. 109-129, and P.L. 110-144; as amended by P.L. 110-413; as further amended by P.L. 113-51[5]	1993	SSAN	2,767,000	23,549,000
5.	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	57,000,000
6.	Rural Access to Emergency Devices: PHS Act, Section 313, and Public Health Improvement Act, P.L. 106-505, Section 413	2006	5,000,000	1,485,000	3,364,000
7.	Rural Hospital Flexibility Grants: Social Security Act, Section 1820(j),	2012	SSAN	41,040,000	40,609,000

[5] Amendment does not include reauthorization.

		Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2014
	as amended by P.L. 105-33, Section 4201(a), and P.L. 108-173, Section 405(f), as amended by P.L. 110-275, Section 121				
8.	State Offices of Rural Health: PHS Act, Section 338J, as amended by P.L. 105-392, Section 301	2002	SSAN	4,000,000	9,511,000
9.	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[5]	2006	SSAN	6,814,000	13,900,000
10.	Family Planning: Grants: PHS Act Title X	1985	158,400,000	142,500,000	286,479,000
11.	Children's Hospitals Graduate Medical Education Program: PHS Act, Section 340E, as amended by P.L. 108-490, as further amended by P.L. 109-307	2011	330,000,000	268,356,000	265,000,000

Primary Health Care
Tab

PRIMARY HEALTH CARE

Health Centers

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$1,390,507,000	$1,400,343,000	$911,017,000	-$489,326,000
ACA	$1,465,397,000	$2,144,716,000	$3,600,000,000	+$1,455,284,000
FTCA	$88,983,000	$94,893,000	$88,983,000	-$5,910,000
Total	$2,944,887,000	$3,639,952,000	$4,600,000,000	+$960,048,000
FTE	269	269	269	---

Authorizing Legislation: Section 330 of the Public Health Service Act; as amended by Public Law 110-355 of the Health Care Safety Net Act of 2008; the Native Hawaiian Health Care Act of 1988; as amended by Section 9168 of Public Law 102-396, Section 224 of the Public Health Service Act; Public Law 111-148, the Affordable Care Act of 2010, Title V, Section 5601 and Title X, Section 10503. Public Law 111-152, Health Care and Education Reconciliation Act of 2010, Section 2303.

FY 2015 Authorization $8,332,924,155

FY 2015 CHC Fund Authorization.....$3,600,000,000

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

Program Description and Accomplishments

For more than 45 years, health centers have delivered comprehensive, high quality, cost-effective primary health care to patients regardless of their ability to pay. During that time, health centers have become the essential primary care provider for America's most vulnerable populations. Health centers advance the preventive and primary medical/health care home model of coordinated, comprehensive, and patient-centered care, coordinating a wide range of medical, dental, behavioral, and social services. Today, more than 1,200 health centers operate over 9,200 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. Nearly half of all health centers serve rural populations. In 2012, these community-based and patient-directed health centers served 21.1 million patients, providing almost 84 million patient visits, at an average cost of $686 (including Federal and non-Federal sources of funding). 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 serve a diverse patient population:

- People of all ages: Approximately 32 percent of patients in 2012 were children (age 17 and younger); about 7 percent were 65 or older.

- People without and with health insurance: Almost four in 10 patients were without health insurance in 2012. While the proportion of uninsured patients of all ages has held steady at nearly 40 percent, the number of uninsured patients increased from 4 million in 2001 to approximately 7.6 million in 2012, proportionate to the growth in Federal health center funding. The Health Center Program will continue to monitor the number of uninsured patients served on an annual basis, as it will continue to provide an understanding of the impact of Affordable Care Act implementation in the future.

- Special Populations: Some health centers also receive specific funding to focus on certain special populations including agricultural workers, individuals and families experiencing homelessness, those living in public housing, and Native Hawaiians. In 2012 health centers served more than 1.1 million individuals experiencing homelessness, over 900,000 agricultural workers and their families, approximately 220,000 residents of public housing and more than 6,600 Native Hawaiians.

- Health Care for the Homeless Program: Homelessness continues to be a pervasive problem throughout the U.S., affecting rural as well as urban and suburban communities. According to the HUD 2010 Annual Homeless Assessment Report to Congress, it was estimated that 1.6 million people were homeless. In 2012, more than 1.1 million persons experiencing homelessness were served by HRSA-funded health centers. In particular, the Health Care for the Homeless Program is a major source of care for homeless persons in the U.S., serving patients that live on the street, in shelters, or in transitional housing. Health Care for the Homeless grantees recognize the complex needs of homeless persons and strive to provide a coordinated, comprehensive approach to health care including substance abuse and mental health services.

- Migrant Health Centers: In 2012, HRSA-funded health centers served over 900,000 migratory and seasonal agricultural workers and their families. It is estimated these health center programs serve more than one quarter of all migratory and seasonal agricultural workers in the U.S. (National Agricultural Workers Survey – Department of Labor). The Migrant Health Center Program provides support to health centers to deliver comprehensive, high quality, culturally competent preventive and primary health services to agricultural workers and their families with a particular focus on the occupational health and safety needs of this population.

- Public Housing Primary Care Health Centers: The Public Housing Primary Care Program provides residents of public housing with increased access to comprehensive primary health care services through the direct provision of health promotion, disease prevention, and primary health care services. Services are provided on the premises of public housing developments or at other locations immediately accessible to residents. In

2012, HRSA-funded health centers served approximately 220,000 residents of public housing through these grants.

- Native Hawaiians: The Native Hawaiian Health Care Program, funded within the Health Center appropriation, improves the health status of Native Hawaiians by making health education, health promotion, and disease prevention services available through the support of the Native Hawaiian Health Care Systems. Native Hawaiians face cultural, financial, social, and geographic barriers that prevent them from utilizing existing health services. In addition, health services are often unavailable in the community. The Native Hawaiian Health Care Systems use a combination of outreach, referral, and linkage mechanisms to provide or arrange services. Services provided include nutrition programs, screening and control of hypertension and diabetes, immunizations, and basic primary care services. In 2012, Native Hawaiian Health Care Systems provided medical and enabling services to more than 6,600 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 center grantees are required to compete for their existing service areas at the completion of every project period (generally every 3 years). New health center grant opportunities are announced nationally and objective review committees (ORC), composed of experts who are qualified by training and experience in particular fields related to the Program, then review applications.

Funding decisions are made based on committee assessments, announced funding preferences and program priorities. In addition to the ORC score, various statutory awarding factors are applied in the selection of health center grants. These include funding priorities 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 a requirement for continued proportionate distribution of funds to the special populations served under the Health Center Program. Health centers demonstrate performance by increasing access, improving quality of care and health outcomes, and promoting efficiency.

Increasing Access: Health centers continue to serve an increasing number of the Nation's medically underserved. The number of health center patients served in 2012 was 21.1 million. This increased access beyond the 11.3 million patients served in 2002 represents over an 86 percent increase within a 10-year period, and an increase of approximately 3.2 million uninsured patients since 2002. Of the 21.1 million patients served and for those for whom income status is known, 93 percent were at or below 200 percent of the Federal poverty level and over 36 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.

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 vulnerable populations. For example, by monitoring timely entry into prenatal

care, the program assesses both quality of care as well as health center outreach efforts. 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 2000 to 70 percent in 2012, exceeding the target of 64 percent. It should also be noted that health centers serve a higher risk prenatal population than seen nationally, making progress on this measure a particular accomplishment.

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 women of childbearing age, a key group served by the Program. This measure is benchmarked to the national rate to demonstrate how health center performance compares to the performance of the nation overall. In 2011, 7.4 percent of babies born to health center prenatal care patients were low birth weight, a rate that is 8.6 percent lower than seen nationally (8.1%). In 2012, the health center rate was 7.1%, but the national rate is not available.

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 2012, 64 percent of adult health center patients with diagnosed hypertension had blood pressure under adequate control (less than 140/90). Additionally, 70 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%).

Promoting Efficiency: Health centers provide cost effective, quality primary health care services. The Program's efficiency measure focuses on maximizing the number of health center patients served per dollar as well as keeping cost increases below annual national health care cost increases while maintaining access to high quality services. In the analysis of the annual growth in total cost per patient, the full complement of services (medical, dental, mental health, pharmacy, outreach, translation, etc.) that make health centers a "health care home" is captured. In 2009, health center costs grew by two percent, well under the target growth rate of 5.8 percent. In 2010, health center costs grew by five percent, which was above the national rate. In 2011, the health center rate was 3.8 percent compared to a national rate of 3.9 percent. In 2012, the health center rate was 3.7 percent, equal to the national rate of 3.7 percent. The results reflect the short-term costs associated with managing operations while implementing significant facility improvements, including major construction and renovation projects.

It is expected that as health center capital improvement projects are completed, the long-term benefits of increased capacity and improved quality of care will be realized, and cost increases will remain below national comparison data, as has been the case historically. By keeping increases in the cost per individual served at health centers better than national per capita health

care cost increases, the Program has served more patients that otherwise would have required additional funding to serve annually, and 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 health centers' use of a multi- and interdisciplinary team that treats the "whole patient." This, in turn, is associated with the delivery of high quality, culturally competent and comprehensive primary health care services that not only increases access and reduces health disparities, but promotes more effective care for health center patients with chronic conditions.

The Program is implementing improvements that include: 1) a Patient-Centered Medical Home (PCMH) initiative designed to improve the quality of care in health centers and support their efforts to achieve national PCMH recognition or accreditation; and 2) program-wide collection of core quality of care and health outcome performance measures, such as hypertension and diabetes-related outcomes, from all grantees.

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.

> FQHCs and look-alikes demonstrated equal or better performance than private practice PCPs on select quality measures despite serving patients who have more chronic disease and socioeconomic complexity (Goldman LE, Chu PW, Tran H, Romano MJ, Stafford RS; 2. American Journal of Preventive Medicine 2012 Aug;43(2):142-9).
>
> Rural counties with a community health center site had 33 percent fewer uninsured emergency department (ED) visits per 10,000 uninsured populations than those rural counties without a health center site. Rural health center counties also had fewer ED visits for ambulatory care sensitive visits – those visits that could have been avoided through timely treatment in a primary care setting. (Rust George, et al. "Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties." Journal of Rural Health, Winter 2009 25(1):8-16.)
>
> Uninsured health center patients were more likely than similar patients nationally to report a generalist physician visit in the past year (82% vs. 68%), have a regular source of care (96% vs. 60%), receive a mammogram in the past two years (69% vs. 49%), and receive counseling on exercise (68% vs. 48%) (Shi L., Stevens G.D., and Politzer R.M. Medical Care 2007; 45(3): 206-213).
>
> Health centers providing enabling services that were linguistically appropriate helped patients obtain health care (Weir R, et al. Use of Enabling Services by Asian American, Native Hawaiian, and Other Pacific Islander Patients at 4 Community Health Centers. Am J Public Health 2010 Nov; 100(11): 2199 – 2205).
>
> Emergency department visits are higher in counties with limited access to primary care (Hossain MM, Laditka JN. Using hospitalization for ambulatory care sensitive conditions

to measure access to primary health care: an application of spatial structural equation modeling. Int J Health Geogr. 2009 Aug 28;8:51).

Federal Tort Claims Act (FTCA) Program: The Health Center Program administers the FTCA Program, under which employees of eligible health centers may be deemed to be Federal employees qualified for malpractice coverage under the FTCA. The health center, its employees, and eligible contractors are considered Federal employees immune from suit for medical malpractice claims while acting within the scope of their employment. The Federal government assumes responsibility for such claims. Key Program activities for risk mitigation include risk management of reviews and sites visits as well as risk management technical assistance and resources to support health centers. In FY 2009, 107 claims were paid through the FTCA Program, totaling approximately $45.6 million, in FY 2010, 103 claims were paid totaling $52.6 million, in FY 2011, 103 claims were paid totaling $82.8 million, in FY 2012, 107 claims were paid totaling $68.1 million, and in FY 2013, 107 claims were paid totaling $50.6 million.

Affordable Care Act

The Affordable Care Act authorized and appropriated $11 billion over five years to establish a Community Health Center Fund to provide for expanded and sustained national investment in health centers under Section 330 of the Public Health Service Act. Of this amount, $1.5 billion was appropriated to support major construction and renovation projects at community health centers nationwide and $9.5 billion to support ongoing health center operations, the establishment of new health center sites in medically underserved areas and expand preventive and primary health care services at existing health center sites. The amount appropriated to support health center services is $1 billion in FY 2011, $1.2 billion in FY 2012, $1.5 billion in FY 2013, $2.2 billion in FY 2014, and $3.6 billion in FY 2015.

Over the last three years, the Community Health Center Fund under the Affordable Care Act has supported more than 550 new access points/health center service delivery sites, nearly 600 capital development and immediate facility improvement grants, more than 1,700 quality improvement grants targeting the development of patient-centered medical homes, more than 130 expanded HIV treatment and care grants, outreach and enrollment activities in nearly 1,160 health centers nationwide, more than 40 health center controlled networks to promote health information technology and EHR adoption, and ongoing health center operations in over 1,200 health centers nationwide,.

Patient Centered Medical Homes: HRSA has established a goal related to the Health Center Program Patient Centered Medical Home (PCMH) Initiative. Since FY 2011, data has been collected on the percentage of health centers recognized as a patient centered medical home by national/state accrediting organizations. This is a HHS Priority Goal for FY 2012 through 2013. At the end of FY 2013, 33 percent of health centers were recognized as PCMHs. The FY 2015 target for this goal is for 55 percent of health centers to be recognized as PCMHs.

The Affordable Care Act presents opportunities for the safety net to serve patients who otherwise cannot afford or gain access to care. In FY 2015, the Health Center program will continue to provide high quality, affordable and comprehensive primary care services in medically

underserved communities across the country as insurance coverage expands. Health centers will also remain a vital source of primary care for insured patients seeking a quality source of care, often for services not covered by health insurance.

Funding History

FY	Amount
FY 2011	$1,580,749,000
FY 2011 ACA Funding	$1,000,000,000
FY 2012	$1,566,892,000
FY 2012 ACA Funding	$1,200,000,000
FY 2013	$1,479,490,000
FY 2013 ACA Funding	$1,465,397,000
FY 2014	$1,495,236,000
FY 2014 ACA Funding	$2,144,716,000
FY 2015	$1,000,000,000
FY 2015 ACA Funding	$3,600,000,000

Budget Request

The FY 2015 Budget Request is $4,600,000,000, which is $960,048,000 above the FY 2014 Enacted level, and includes $3,600,000,000 from ACA mandatory funding. This request is projected to provide approximately $800 million for capital development grants. In addition, this request is projected to support 150 new access point grants, and continuation activities for over 1,300 health centers operating nearly 9,500 primary care sites, including recognizing centers performing at exceptional levels.

The FY 2015 Budget Request also marks the final year of the ACA Health Center Fund. The FY 2015 Budget would extend the Health Center at $2.7 billion annually over FY 2016 – FY 2018. Health centers will continue to be a critical element of the health system, largely because they can provide an accessible and dependable source of primary care services in underserved communities. In particular, health centers emphasize coordinated primary and preventive services or a “medical home” that promotes 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 health information technology. The health center model also overcomes geographic, cultural, linguistic and other barriers through a team-based approach to care that includes physicians, nurse practitioners, physician assistants, nurses, dental providers, midwives, behavioral health care providers, social workers, health educators, and many others. Health centers also reduce costs to health systems; the health center model of care has been shown to reduce the use of costlier providers of care, such as emergency departments (EDs) and hospitals.

Health Center Fund ($, millions)	FY 2016	FY 2017	FY 2018

BA, mandatory	2,700	2,700	2,700

Continued funding for the Health Center Program in FY 2016 and beyond will maintain this vital source of primary care for insured and medically underserved patients seeking a quality source of care, often for services not covered by health insurance. After the passage of health insurance reform in Massachusetts, health centers saw a significant increase in newly-insured patients. From 2005 to 2012, the overall number of health center patients increased by more than 200,000 patients (more than 48 percent), even while the overall percentage of uninsured patients decreased by over 17 percent. Health centers also reduce geographic, cultural, linguistic, and other barriers through a team-based approach to care that includes physicians, nurse practitioners, physician assistants, nurses, dental providers, midwives, behavioral health care providers, social workers, health educators, and many others. Health centers 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 (EDs) and hospitals.

The FY 2015 Budget Request will support the program's achievement of its ambitious performance targets and continue to enable the provision of access to primary health care services and the improvement of the quality of care in the health care safety net. This request also supports $88,983,000 for the FTCA Program, which is $5,910,000 less than the FY 2014 President's Budget. Funding also includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up site visits and supports HRSA's Information Technology costs. The Program will continue to achieve its goal of providing access to care for underserved and vulnerable populations. Health centers served 21.1 million patients in 2012, and are projected to serve approximately 31 million patients at the FY 2015 Budget Request level.

As part of the program's efforts to improve quality of care and health outcomes, the health center program has established ambitious targets for FY 2015 and beyond. For low birth weight, the Program seeks to be at least 5 percent below the national rate. This is ambitious because health centers continue to serve a higher risk prenatal population than represented nationally in terms of socio-economic, health status and other factors that predispose health center patients to greater risk for LBW and adverse birth outcomes. The FY 2015 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 2015 target for the program's diabetes management measure is 71 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). These targets will be challenging to achieve because chronic conditions require treatment with lifestyle modifications, usually as the first step, and, if needed, with medication.

The Program will also continue to promote efficiency and aims to keep cost per patient increases below annual national health care cost increases, as noted in the Center for Medicare and Medicaid Services' (CMS) National Health Expenditure Amounts and Projections. By benchmarking the health center efficiency to national per capita health care cost increases, 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 target for

FY 2015 is to keep the program's cost per patient increase below the 2015 national health care cost increase. To assist in areas of cost-effectiveness, the Program offers technical assistance to grantees to review costs and revenues and develop plans to implement effective cost containment strategies. By restraining increases in the cost per individual served at health centers, the Health Center Program is able to serve a volume of patients that otherwise would have required additional funding to serve, and demonstrates that it delivers its high quality services at a more cost effective rate.

The FY 2015 Budget Request will also support the program's ongoing involvement in an agency-wide effort to improve quality and program integrity in all HRSA-funded programs that deliver direct health care. One example is an increased use of on-site evaluations at health centers to verify compliance with program policies. Another key step the Health Center Program has taken in this area is to establish a core set of clinical performance measures for all health centers. The Program has aligned its required clinical performance measures with the Department's Meaningful Use measures. These measures are also consistent with the overarching goals of 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; and asthma treatment. In FY 2012, the Health Center Program began collecting data on three additional clinical performance measures: coronary artery disease/cholesterol; ischemic vascular disease/aspirin; and colorectal cancer screening.

In addition to tracking these core clinical indicators, health center grantees also report their health outcome measures (low birth weight, diabetes, and hypertension) by race/ethnicity in order to demonstrate progress towards eliminating health disparities in health outcomes. To support quality improvement, the Program will continue to facilitate national and State-level technical assistance and training programs that promote quality improvements in health center data and quality reporting, clinical and quality improvement, and implementation of innovative quality activities. The Program continues to promote the integration of Health Information Technology (HIT) into health centers as part of HRSA's strategy to assure that key safety-net providers are not left behind as this technology advances.

Funding will support place-based demonstration projects targeting specific high-risk communities, and allow Community Health Centers to improve health outcomes for young children and coordinate with other HHS partners on early learning and other relevant services for those living in communities with highly concentrated poverty.

Funding will also allow the Program to continue to coordinate and collaborate with related Federal, State, local, and private programs in order to further leverage and promote efforts to expand and improve health centers. The Program will continue to work with the CMS and the Office of the National Coordinator for Health Information Technology (ONC) on HIT, and the Centers for Disease Control and Prevention (CDC) to address Migrant Stream Farmworker issues and HIV prevention initiatives, and the National Institutes of Health (NIH) on U.S.-Mexico Border health issues, among others. In addition, the Program will continue to coordinate with CMS to jointly review section 1115 Medicaid Demonstration Waivers. The Program will also work closely with the Department of Justice on the Federal Tort Claims Act (FTCA)

Program, which provides medical malpractice liability protection to section 330 supported health centers. Additionally, the proposed Budget will allow coordination with programs in the Departments of Housing and Urban Development, Education, and Justice (HUD, Ed, and DOJ).

Sources of Revenue: ($ in millions)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Health Centers:	**$2,855.9**	**$3,545.1**	**$3,651.0**
Other Sources:			
Medicaid	6,025.0	8,125.0	9,900.0
Medicare	950.0	1,225.0	1,425.0
CHIP	330.0	425.0	500.0
Other Third	1,350.0	2,025.0	2,500.0
Self Pay Collections	975.0	1,100.0	1,200.0
Other Federal Grants	500.0	585.0	675.0
State/Local/Other	2,650.0	3,260.0	3,800.0
TOTAL	**$15,635.9**	**$20,290.1**	**$23,651.0**

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
1.I.A.1: Number of patients served by health centers (Output)	FY 2012: 21.1M Target: 20.6M (Target Exceeded)	28.6M	31.0M	+2.4 M
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 2012: 87% Target: 88% (Target Virtually Met)	88%	88%	Maintain
1.I.A.2.c: Percentage of grantees that provide the following services either on-site or by paid	FY 2012: 72% Target: 70% (Target	70%	70%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
referral: (c) Mental Health/Substance Abuse (Output)	Exceeded)			
1.E: Percentage increase in cost per patient served at health centers compared to the national rate (Efficiency)	FY 2012: 3.7% Target: 20% below national rate (National Rate = 3.7%) (Target Not Met)	Below national rate	Below national rate	Maintain
1.II.B.2: Rate of births less than 2500 grams (low birth weight) to prenatal Health Center patients compared to the national low birth weight rate (Outcome)	FY 2011: 7.4%, 8.6% below national rate Target: 5% below national rate (Target Exceeded)	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 2012: 64% Target: 60% (Target Exceeded)	63%	63%	Maintain
1.II.B.4: Percentage of adult health center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent) (Outcome)	FY 2012: 70% Target: 71% (Target Virtually Met)	71%	71%	Maintain
1.II.B.1: Percentage of pregnant health center	FY 2012: 70% Target: 64%	65%	66%	+1 % point

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
patients beginning prenatal care in the first trimester (Output)	(Target Exceeded)			
1.II.A.1: Percentage of Health Center patients who are at or below 200 percent of poverty (Output)	FY 2012: 93% Target: 91% (Target Exceeded)	91%	91%	Maintain
1 II.A.2: Percentage of Health Center patients who are racial/ethnic minorities (Output)	FY 2012: 62% Target: 63% (Target Virtually Met)	63%	62%	-1% point
1.I.A.3: Percentage of health centers with at least one site recognized as a patient centered medical home (Outcome)	FY 2012: 13% Target: 13% (Target Met)	40%	55%	+15% points

Grants Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	1,215	1,289	1,349
Average Award	$2,150,000	$2,500,000	$2,500,000
Range of Awards	$163,000 - $14,200,000	$200,000 - $15,000,000	$200,000 - $15,000,000

Free Clinics Medical Malpractice

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$38,000	$40,000	$40,000	---
FTE	2	2	2	---

Authorizing Legislation: Section 224 of the Public Health Service Act.

FY 2014 Authorization ..... Indefinite

Allocation Method ..... Other

Program Description and Accomplishments

The Free Clinics Medical Malpractice Program encourages health care providers to volunteer their time at 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 have volunteer providers that they sponsor deemed. 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. They 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 2013, 6,780 volunteer health care providers received Federal malpractice insurance through the Program, exceeding the Program target.
In FY 2011, 168 free clinics operated with FTCA deemed volunteer clinicians; in FY 2012, 192 clinics participated; and in FY 2013, 227 clinics participated, exceeding the Program's annual target. The Program also examines the quality of services annually by monitoring the percentage of free clinic health professionals meeting licensing and certification requirements. Performance continues to meet the target with 100 percent of FTCA deemed clinicians meeting appropriate

licensing and credentialing requirements. In FY 2012, the Program supported 485,540 patient visits provided by free clinics sponsoring volunteer FTCA deemed clinicians.

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 vulnerable populations served by these clinics. In FY 2011, the cost per provider was $109 per provider; in FY 2012 the cost was $71 per provider; and in FY 2013 the cost was $89 per provider. In each year, the Program performance target has been exceeded.

To date there have been three claims filed. One claim was dismissed, and the others are pending. There have been no paid claims under the Free Clinics Medical Malpractice Program. The Program Fund has a current balance of approximately $1 million.

Funding History

FY	Amount
FY 2011	$40,000
FY 2012	$40,000
FY 2013	$38,000
FY 2014	$40,000
FY 2015	$40,000

Budget Request

The FY 2015 Budget Request is $40,000, which is the same as the FY 2014 President's Budget. The total request will support the Program's continued achievement of its ambitious performance targets addressing its goal of increasing access and capacity in the health care safety net.

Targets for FY 2015 focus on increasing the number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage to 7,800 while also increasing the number of free clinics operating with FTCA deemed volunteer clinicians to 260. The focus on quality will continue to hold the Program to a target of 100 percent for FTCA deemed clinicians meeting appropriate licensing and certification requirements. 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 $125 administrative cost per provider in FY 2015.

The FY 2015 Budget 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 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
2.I.A.1: Number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage (Outcome)	FY 2013: 6,780 Target: 5,100 (Target Exceeded)	7,200	7,800	+ 600
2.1: Patient visits provided by free clinics sponsoring volunteer FTCA deemed clinicians (Outcome)	FY 2012: 485,540 Target: 320,000 (Target Exceeded)	476,000	560,000	+ 84,000
2.I.A.2: Number of free clinics operating with FTCA deemed volunteer clinicians (Output)	FY 2013: 227 Target: 165 (Target Exceeded)	240	260	+ 20
2.I.A.3: Percent of volunteer FTCA deemed clinicians who meet certification and privileging	FY 2013: 100% Target: 100% (Target Met)	100%	100%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
requirements (Output)				
2.E: Administrative costs of the program per FTCA covered volunteer (Efficiency)	FY 2013: $89 Target: $155 (Target Exceeded)	$89	$89	Maintain

Health Workforce Tab

HEALTH WORKFORCE

CLINICIAN RECRUITMENT AND SERVICE

National Health Service Corps

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
NHSC BA	---	---	$100,000,000	+$100,000,000
NHSC (ACA) Mandatory	$284,700,000	$283,040,000	$310,000,000	+$26,960,000
NHSC Mandatory			$400,000,000	+$400,000,000
Total NHSC	$284,700,000	$283,040,000	$810,000,000	+$526,960,000
FTE BA	---		15	+15
FTE Mandatory	229	237	272	+35
Total FTE	229	237	287	+50

Authorizing Legislation: Public Health Service Act, Sections 331-338, as amended by Health Care Safety Net Act of 2008, P.L. 110-355, as further amended by P.L. 111-148, Section 5207 and Section 10503(b) (2)

FY 2015 Authorization $891,176,000

FY 2015 Authorization (Mandatory) $310,000,000

Allocation Method ..... Competitive Awards to Individuals

Program Description and Accomplishments

Since its inception in 1972, the National Health Service Corps (NHSC) has worked to build healthy communities by supporting qualified health care providers dedicated to working in areas of every State, Territory, and Possession of the United States with limited access to care. In 2012, NHSC clinicians working at NHSC service sites provided primary medical, oral, and mental and behavioral health care to 10.4 million underserved people in these communities, known as Health Professional Shortage Areas (HPSAs). As of December 31, 2013, there were nearly 59.4 million people living in 5,991 primary care HPSAs, with additional HPSAs being designated for dental and mental health shortages. Based on a panel size of 3,500 individuals to 1 physician, it would take nearly 7,954 physicians to eliminate these primary care HPSAs.

By the end of FY 2013, the NHSC offered recruitment incentives, in the form of scholarship and loan repayment support, to over 44,000 health professionals committed to providing care to underserved communities over its 42-year history. NHSC clinicians have expanded access to high quality health services and improved the health of underserved people.

In particular, the NHSC has partnered closely with the federally-funded Health Centers to help meet their staffing needs. Approximately 50 percent of NHSC clinicians serve in Health Centers around the Nation. The NHSC also places clinicians in other community-based systems of care that serve underserved populations, targeting HPSAs of greatest need.

In addition to the recruitment of providers, the NHSC also works to retain primary care providers in underserved areas after their service commitment is completed to further leverage the Federal investment and to build more integrated and sustainable systems of care. Retention in the Corps is defined as the percentage of NHSC clinicians who remain practicing in underserved areas after successfully completing their service commitment to the Corps. The NHSC does not provide Corps members with any additional financial incentives to remain in these underserved communities when promoting retention and in capturing retention rates. In FY 2012, the NHSC completed a long-term retention study, noting a 55 percent retention rate for clinicians remaining in service to the underserved 10 years after completing their NHSC commitment. This is a 6 percent increase compared to the 2000 rate of 52 percent. Moreover, the FY 2013 NHSC Participant Satisfaction Study reported a short-term retention (defined as up to two years after service completion) rate of 85 percent.

The Affordable Care Act (ACA) appropriated a total of $1.5 billion in new dedicated funding for the NHSC over five years starting in FY 2011 and allowed for programmatic changes to better support the recruitment and retention of primary care providers to communities in need. These changes included raising the maximum annual award for the NHSC Loan Repayment Program from $35,000 per year to $50,000. In addition, the ACA permanently authorized the NHSC to offer half-time loan repayment contracts. Additionally, all full-time NHSC participants will be able to fulfill the service commitment through teaching - up to 50 percent of the 40-hour week in a Teaching Health Center, and up to 20 percent in other facilities.

The NHSC Scholarship Program 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 probable success in a career in primary care in underserved communities. The Scholarship Program provides a predictable supply of clinicians who will be available over the next one to eight years, depending on the length of their training programs. Upon completion of training, NHSC scholars become salaried employees of organized systems of care in underserved communities.

The NHSC Loan Repayment Program offers fully trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service in a Health Profession Shortage Area (HPSA) of greatest need. In exchange for an initial minimum of two years of service, loan repayers receive up to $50,000 in loan repayment assistance. The loan repayment program recruits clinicians as they complete training and are immediately available for service, as well as seasoned professionals seeking an opportunity to serve the Nation's most vulnerable populations. In addition, the NHSC implemented an enhanced award structure in the Loan Repayment Program to encourage clinicians to seek placement in high-need HPSAs across the United States. Individuals who are employed in NHSC service sites with HPSA scores of 14 and higher were eligible to receive up to $50,000 for an initial two-year contract. Individuals working in HPSAs of 13 and below were eligible for loan repayment of up to $30,000 for a two-year contract. This policy has allowed the Corps to remain competitive with other loan repayment programs and help communities that have persistent workforce shortages. After the initial service period, NHSC loan repayers with additional eligible loans may apply for continuation awards in return for additional years of service.

The NHSC implemented the Critical Access Hospital (CAH) pilot program in FY 2012, which allows the inpatient setting of a CAH to qualify as an NHSC site. Prior to FY 2012, only the outpatient clinic of a CAH was eligible and NHSC clinicians were generally limited to no more than eight hours in the inpatient setting. With the pilot, clinicians may now spend up to 24 hours per week in the CAH, with no fewer than 16 hours being spent in an affiliated outpatient clinic. As of September 30, 2013, the NHSC has approved 176 Critical Access Hospitals as NHSC service sites.

The NHSC Students to Service (S2S) Loan Repayment Program provides loan repayment assistance of up to $120,000 to allopathic and osteopathic medical students in their last year of school in return for completing a primary care residency and working in rural and urban HPSAs of greatest need for three years. It is anticipated that the majority of these clinicians will begin service in FY 2016. After the initial service period, physicians with additional eligible loans may apply for continuation awards in return for additional years of service.

The State Loan Repayment Program (SLRP) is a grant program, which offers a dollar-for-dollar match between the State and the NHSC for loan repayment contracts to clinicians who practice in a HPSA in that State. The SLRP serves as a complement to the NHSC and provides flexibility to States to help meet their unique primary care workforce needs. In addition, the SLRP serves as a cost-efficient alternative to the NHSC, as the federal cost-per-clinician in SLRP is less given the matching requirement.

Due to the growing need for the NHSC to maximize the availability of clinicians to deliver primary care services, the NHSC Ready Responder Program sunsetted in FY 2013.

The combination of these programs allows flexibility in meeting the future needs (through scholars and S2S awardees) and the immediate needs (through loan repayers) of underserved communities. Tables 1 and 2 illustrate the students in the NHSC pipeline training to serve the underserved. Tables 3 and 4 illustrate the number and type of primary care providers serving in the NHSC.

Table 1. NHSC Pipeline by Program as of 09/30/13

Programs	**No.**
Scholarship Program	932
Students to Service Program	147
Total	**1,079**

Table 2. NHSC Pipeline by Discipline as of 09/30/13

Disciplines	**No.**
Allopathic/Osteopathic Physicians	723
Dentists	164
Nurse Practitioners	38
Physician Assistants	142
Certified Nurse Midwives	12
Total	**1,079**

Table 3. NHSC Field Strength by Program as of 09/30/13

Programs	**No.**
Scholarship Program Clinicians	493
Loan Repayment Program Clinicians	7,547
State Loan Repayment Clinicians	859
Total	**8,899**

Table 4. NHSC Field Strength by Discipline as of 09/30/13

Disciplines	**No.**
Allopathic/Osteopathic Physicians	2,402
Dentists	1,129
Dental Hygienists	183
Nurse Practitioners	1,409
Physician Assistants	1,168
Nurse Midwives	153
Mental and Behavioral Health Professionals	2,440
Other State Loan Repayment Clinicians	15
Total	**8,899**

In FY 2013:

Mandatory Funds*:*

- The ACA provides $284,700,000 for the NHSC. These funds were distributed as follows:

    - Field Line - $56.5 million. Expenditures from the NHSC Field Line are used to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, Primary Care Office cooperative agreements, and other support activities.
    - Scholarships - $39.8 million = 180 new awards and 16 continuations. The average new NHSC scholarship award was $207,992. The average NHSC scholarship continuation was $85,967.
    - Loan Repayment - $169.7 million = 2,106 new awards and 2,399 continuations. The average new NHSC Corps LRP award was $50,488. The average NHSC Corps LRP continuation was $26,263.
    - Students to Service Loan Repayment - $9.3 million = 78 new awards.
    - State Loan Repayment - $9.4 million = 447 Awards.

In FY 2013, the NHSC Field Strength was 8,899 clinicians who will provide primary health services to 9.3 million underserved individuals.

In FY 2014:

Mandatory Funds*:*

- The ACA provides $283,040,000 for the NHSC. These funds are projected to be distributed as follows:

    - Field Line - $64.0 M Expenditures from the NHSC Field Line are used to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, Primary Care Office cooperative agreements, and other support activities.
    - Scholarships - $37.8M = 171 new awards and 14 continuations.
    - Loan Repayment - $159.2 M = 2,070 new awards and 2,140 continuations.
    - Students to Service Loan Repayment - $12.0 M = 100 new awards.
    - State Loan Repayment - $10.0 M = 285 Awards.

By the end of FY 2014, the ACA will allow for a significant impact on the NHSC Field Strength, projected to be over 7,500 and serving the primary care needs of 7.9 million patients.

Funding History

FY	**Amount**
FY 2011	$ 24,848,000
FY 2011 Mandatory Funding	$290,000,000
FY 2012	---
FY 2012 Mandatory Funding	$295,000,000
FY 2013	---
FY 2013 Mandatory Funding	$284,700,000
FY 2014	---
FY 2014 Mandatory Funding	$283,040,000
FY 2015	$100,000,000
FY 2015 Mandatory Funding	$710,000,000

Budget Request

The FY 2015 Discretionary Budget Request is $100,000,000. This is an increase of $100,000,000 above the FY 2014 Enacted level. The ACA has appropriated $310,000,000 for the NHSC Fund in FY 2015 with an additional $400,000,000 being requested for a combined appropriation of $810,000,000. This request is part of new investments beginning in FY 2015 to bolster the Nation's health workforce and to improve the delivery of health care across the country. Between FY 2015 and FY 2020, HRSA will devote a total of $3.95 billion in mandatory funding to the National Health Service Corps to address health professional shortages in high-need rural and urban communities across the country.

NHSC Fund ($, millions)	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
ACA	$310					
Proposed	$400	$710	$710	$710	$710	$710

The NHSC funding supports scholarship and loan repayment programs, and does not fund direct health care services or benefits. This will address increased demands for health care services from an aging population. As a significant source of highly qualified, culturally competent clinicians for the Health Center Program, as well as other safety net providers, the NHSC can build on its success in assuring access to residents of HPSAs, removing barriers to care and improving the quality of care to these underserved populations. The NHSC Program is working with many communities in partnership with State, local, and National organizations to help address their health care needs.

Funding in FY 2015 for the NHSC Programs will support efforts to work with Health Centers and other community-based systems of care to improve the quality of care provided and reduce the health disparities gap. As measurement of these efforts:

In FY 2015:

Base Funds:

- The annual appropriation provides $100,000,000 for the NHSC.

NHSC Funds:

- The Budget provides $710,000,000 for the NHSC.

In FY 2015, the combination of the FY 2015 annual appropriation and the ACA will allow for a significant growth of the NHSC Field Strength, which is projected to be an historic high of approximately 15,000 and serving the primary care needs of more than 16 million patients. This request would restore the NHSC Field Strength to beyond the average strength of 10,000 achieved in FY 2011 and FY 2012, allowing the program to address the anticipated increased demand for access to primary care services in underserved communities and vulnerable populations resulting from the implementation of the ACA. This increase in FY 2015, will also allow the NHSC to explore the feasibility of expanding the eligible disciplines in high need specialties in the NHSC program on a temporary basis. A total mandatory budget of $710 million in FY 2015, with a stable budget each fiscal year thereafter, will allow the NHSC to sustain a projected stable, yearly Field Strength of 15,000 through FY 2020 and allow the NHSC to continue to grow the pipeline of primary care clinicians through the Scholarship and Students-to-Service Loan Repayment programs.

Table 5. Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Enacted	FY 2015 Target	FY 2015 +/- FY 2014
4.I.C.1: Number of individuals served by NHSC clinicians *(Outcome)*	FY 2013: 9.3 Million Target: 7.48 Million (Target Exceeded)	7.9 Million	16.2 Million	+ 8.3 Million
4.I.C.2: Field strength of the NHSC through scholarship and loan repayment agreements. *(Outcome)*	FY 2013: 8,899 Target: 7,128 (Target Exceeded)	7,520	15,438	+ 7,918
4.I.C.4: Percent of NHSC clinicians retained in service to the underserved for at least one year beyond the completion of their NHSC service commitment. *(Outcome)*	FY 2012: 85% 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 2013: 0.6% Target: ≤2.0% (Target Exceeded)	≤ 2.0%	< 2.0%	Maintain
4.I.C.6: Number of NHSC sites *(Outcome)*	FY 2013: 16,047 Target: 14,000 (Target Exceeded)	14,000	14,000	Maintain

Table 6. Loans/Scholarships Table

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Loans Repayments			$81,904,375
State Loans Repayments			
Scholarships			$14,595,625
Mandatory Loans	$169,767,976	$159,232,000	$496,220,625
Mandatory State Loans	$9,391,439	$10,000,000	$10,000,000
Mandatory Scholarships	$39,868,456	$37,808,000	$85,279,375
Mandatory Students to Service Loan Repayment	$9,255,637	$12,000,000	$12,000,000

Table 7. NHSC Awards, by program and funding category, FYs 2008-2015

Fiscal Year	2008	2009	2010	2011	2012	2013	2014	2015
AWARDS:								
Scholarship	76	88	25	5	-	-	-	64
Scholarship Continuation	18	8	5	1	-	-	-	-
Loan Repayment	867	949	1,335	448	-	-	-	1,599
Loan Repayment Continuation	668	705	701	-	-	-	-	-
State Loan Repayment	280	400	285	-	-	-	-	-
Students to Service Loan Repayment	-	-	-	-	-	-	-	-
ARRA Scholarship	-	70	185	-	-	-	-	-
ARRA Loan Repayment	-	829	2,214	1,053	-	-	-	-
ARRA State Loan Repayment	-	-	161	171	-	-	-	-
Mandatory Scholarships	-	-	-	248	212	180	171	367
Mandatory Scholarship Continuation	-	-	-	8	10	16	14	14
Mandatory Loan Repayment	-	-	-	2,612	2,342	2,106	2,070	8,868
Mandatory Loan Repayment Continuation	-	-	-	1,305	1,925	2,399	2,140	1,629

Table 7. NHSC Awards, by program and funding category, FYs 2008-2015

Fiscal Year	2008	2009	2010	2011	2012	2013	2014	2015
AWARDS:								
Mandatory State Loan Repayment	-	-	-	223	281	447	285	285
Mandatory Students to Service Loan Repayment	-	-	-	-	69	78	100	100

Table 8. NHSC Field Strength, by program and funding category, FYs 2008-2015

Fiscal Year	2008	2009	2010	2011	2012	2013	2014	2015
FIELD STRENGTH:								
Scholars	598	582	523	495	425	359	257	198
Loan Repayers	2,451	2,597	3,201	2,010	754	271	-	1,599
State Loan Repayment	514	763	581	285	-	-	-	-
USPHS Commissioned Corps Ready Responders	37	37	30	23	17	-	-	-
Community Scholarship Clinicians	1	-	-	-	-	-	-	-
Base Field Strength (as of 9/30)	**3,601**	**3,979**	**4,335**	**2,813**	**1,196**	**630**	**257**	**1,797**
ARRA Loan Repayers		829	3,032	3,267	1,089	59	-	-
ARRA State Loan Repayment	-	-	161	278	130	106	-	-
ARRA Scholars		-	2	4	71	103	82	101
ARRA Field Strength	-	**829**	**3,195**	**3,549**	**1,290**	**268**	**82**	**101**
Mandatory Scholars					6	31	137	241
Mandatory Loan Repayment		-	-	3,917	6,791	7,217	6,316	12,567

Table 8. NHSC Field Strength, by program and funding category, FYs 2008-2015

Fiscal Year	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
FIELD STRENGTH:								
Mandatory State Loan Repayment	-	-	-	-	625	753	728	732
Mandatory Field Strength	-	-	-	**3,917**	**7,422**	**8,001**	**7,181**	**13,540**
Total Field Strength	**3,601**	**4,808**	**7,530**	**10,279**	**9,908**	**8,899**	**7,520**	**15,438**
Placements:	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Grant	1,944	2,149	1,777	1,407	550	315	129	899
Non-Grant	1,657	1,830	2,558	1,406	646	315	128	899
ARRA Grant		448	1,310	1,775	593	134	41	51
ARRA Non-Grant		381	1,885	1,774	697	134	41	50
Mandatory Grant				1,959	3,414	4,000	3,591	6,770
Mandatory Non-Grant				1,958	4,008	4,001	3,590	6,770

NURSE Corps *(Formerly known as the Nursing Education Loan Repayment and Scholarship Program)*

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$77,957,000	$79,986,000	$79,986,000	---
FTE	32	32	32	---

Authorizing Legislation: Public Health Service Act, Section 846(a) as amended by Section 103, P.L. 107-205,Section 846(a), and Public Health Service Act, as amended by Section 5310, P.L. 111-148

FY 2015 Authorization ..... Expired

Allocation Method .....Competitive Awards to Individuals

Program Description and Accomplishments

In 2002, the Nurse Reinvestment Act amended Section 846 of the Public Health Service Act, adding the Nursing Scholarship Program to complement the established Nursing Education Loan Repayment Program. This section of the Nurse Reinvestment Act (Section 103) was referred to as the "National Nurse Service Corps" in the legislation. Reflecting the statute section title and goals of the program, NURSE Corps was chosen as the umbrella term referring to both loan repayment and scholarship programs. The programs formerly known as the Nursing Education Loan Repayment Program and the Nursing Scholarship Program were renamed and are now the NURSE Corps Loan Repayment Program and NURSE Corps Scholarship Program. This change in name does not reflect any changes in the program requirements or policies.

The NURSE Corps Loan Repayment Program (LRP), formerly known as the Nursing Education Loan Repayment Program, is a financial incentive program under which individual registered nurses (RNs) and advanced practice RNs (APRNs) such as nurse practitioners (NPs) enter into a contractual agreement with the Federal government to work full-time in a health care facility with a critical shortage of nurses, also known as a Critical Shortage Facility, in return for repayment of qualifying nursing educational loans. NURSE Corps LRP repays 60 percent of the principal and interest on nursing education loans of RNs and APRNs such as NPs with the greatest financial need in exchange for two years of full-time service at a health care facility with a critical shortage of nurses. Participants may be eligible to receive an additional 25 percent of the original loan balance for an additional year of full-time service in a critical shortage facility. A funding preference is given to those with the greatest financial need.

The ACA amended the NURSE Corps LRP to extend loan repayment to nurse faculty. FY 2010 was the first year NURSE Corps LRP made awards to nurse faculty. These awards assist in the recruitment and retention of nurse faculty at accredited schools of nursing by decreasing economic barriers that may be associated with pursuing a career in academic nursing.

The NURSE Corps Scholarship Program (SP), formerly known as the Nursing Scholarship Program, offers scholarships to individuals attending accredited schools of nursing in exchange for a service commitment payback of at least two years in health care facilities with a critical shortage of nurses after graduation. The NURSE Corps SP award reduces the financial barrier to nursing education for all levels of professional nursing students, thus increasing the pipeline. A first funding preference is given to qualified applicants with the greatest financial need and who are enrolled full-time in an undergraduate nursing program or a Master's NP program.

As measurements of that effort:

In FY 2013:

- NURSE Corps LRP made 580 new loan repayment awards and 606 continuation awards.
- NURSE Corps SP made 239 new scholarship awards and 21 continuation awards.
- The average new NURSE Corps LRP award was $56,178. The average NURSE Corps LRP continuation was $20,624.
- The average new NURSE Corps SP award was $93,117. The average NURSE Corps SP continuation was $28,031.

In FY 2013, 70 percent of NURSE Corps LRP participants who initially received awards in FY2011 came in for a continuation and committed to work at a critical shortage facility for an additional year. In addition, 55 percent of NURSE Corps SP awards were given to students obtaining their baccalaureate degree, and 38 percent of NURSE Corps SP awards were given to students obtaining their Master's NP degree for a total of 93 percent of NURSE Corps SP participants receiving obtaining their baccalaureate degree or advanced practice degree in nursing.

In FY 2014:

- NURSE Corps LRP expects to make 773 new loan repayment awards and 283 continuation awards.
- NURSE Corps SP expects to make 216 new scholarship awards and 24 continuation awards.

Funding History

FY	Amount
FY 2011	$93,292,000
FY 2012	$83,135,000
FY 2013	$77,957,000
FY 2014	$79,986,000
FY 2015	$79,986,000

Budget Request

The FY 2015 Budget Request is $79,986,000. The FY 2015 Request is equal to the FY 2014 Enacted Budget. This request will allow the program to maintain its efforts to address the anticipated demand for access to primary care services in Critical Shortage Facilities resulting from the implementation of the ACA.

There is a shortage of nurses, including advanced practice registered nurses, such as NPs, at health facilities in certain areas of the United States. The demand has intensified for nurses prepared in programs that emphasize leadership, patient education, case management, and care across a variety of delivery settings. National and State studies, including the HRSA's *Findings from the National Sample Survey of Registered Nurses - March 2008* demonstrate that the aging nursing workforce could reduce the supply of RNs in the future. Further, as the demand for primary health care services continues to grow as the population ages, NPs play a critical role in offering these services, as evidenced by many States expanding the role of these providers in recent years. The NURSE Corps is a part of the National strategy to alleviate the immediate shortfall in the number of working nurses and to assure an adequate supply of nurses in the future.

To increase the number of NPs participating in the program, the NURSE Corps will actively recruit NPs through outreach efforts to colleges, universities and associations. In FYs 2015, up to 50 percent of the NURSE Corps LRP and SP funding will be targeted to support NPs.

Funding for the NURSE Corps will continue to address the facilities with a critical shortage of nurses across the U.S. As a measurement of that effort:

In FY 2015:

- NURSE Corps LRP expects to make 769 new loan repayment awards and 291 continuation awards.
- NURSE Corps SP expects to make 207 new scholarship awards and 18 continuation awards.

The NURSE Corps expects the cost of nursing education to continue to rise, increasing the average award, and thereby decreasing the total number of awards for the NURSE Corps within a given funding amount. This will decrease the number of RNs and APRNs the NURSE Corps can support in health care facilities with a critical shortage of nurses.

The NURSE Corps LRP and SP are authorized under Section 846 of the Public Health Service Act [42 USC 297n] to work in partnership with other HHS programs to encourage more people to consider nursing careers and motivate them to serve in facilities of critical shortage. The performance measures gauge these programs' contribution to the HRSA strategic goals of improving access to health care and improving the health care systems through the recruitment and retention of nurses working in Critical Shortage Facilities. Increasing the number of nurses at facilities with a critical shortage of nurses will be a key output.

In FY 2015, the proportion of NURSE Corps LRP participants who come in for a continuation and commit to work at a critical shortage facility for an additional year is projected to be 52 percent.

Another measure of program performance is the number of NURSE Corps SP awards that are issued to participants pursuing a baccalaureate degree or advanced practice degree in nursing. This measure was initially developed in 2010 when the program only included undergraduate degrees in its first funding preference, resulting in a baccalaureate being the highest attainable degree in the first funding preference. In FY 2012, program shifted its focus to also include master's level Nurse Practitioners (NPs) in the first funding preference. As a result, the program is projecting that the proportion of NURSE Corps SP awardees obtaining their baccalaureate degree or advanced practice degree to be 85 percent in FY 2015. The program has created a new measure to reflect this programmatic shift to account for master's level NPs.

Table 1. Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Enacted	FY 2015 Target	FY 2015 +/- FY 2014
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 2013: 70% Target: 52% (Target Exceeded)	52%	52%	Maintain
5.I.C.5: Proportion of NURSE Corps LRP/SP participants retained in service at a critical shortage facility for at least one year beyond the completion of their NURSE Corps LRP/SP commitment.	FY 2012: 83% (Target Not in Place)	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 2013: 93% Target: 80% (Target Exceeded)	85%	85%	Maintain
5.E.1: Default rate of NURSE Corps LRP and SP participants. *(Efficiency)*	FY 2013: LRP: 0.96% Target: 3% (Target Exceeded) SP: 8.7% Target: 15% (Target Exceeded)	LRP: 3% SP: 15%	LRP: 3% SP: 15%	Maintain

Table 2. Loans/Scholarships Table

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Loans	$46,774,200	$47,991,600	$47,991,600
Scholarships	$23,387,100	$23,995,800	$23,995,800

Table 3. NURSE Corps Awards, by program, FYs 2008-2015

AWARDS	2008	2009	2010	2011	2012	2013	2014	2015
Scholarships								
New – RN	173	189	458	395	134	148	108	124
New – APRN					99	91	72	83
Continuations – RN	5	15	18	17	31	20	14	11
Continuations - APRN						1	10	7
Loan Repayment								
New – RN	199	717	842	671	272	161	344	423
New – APRN	35	121	112	85	234	292	157	192
New – NF			185	163	214	127	125	154
Continuations – RN	155	147	115	314	533	470	156	160
Continuations - APRN	37	24	20	71	97	12	71	73
Continuations – NF					102	124	57	58
Total	**604**	**1213**	**1750**	**1716**	**1716**	**1,446**	**1,114**	**1,285**

Table 4. NURSE Corps Field Strength, by program, FYs 2008-2015

FIELD STRENGTH[6]	2008	2009	2010	2011	2012	2013	2014	2015
Scholarship	292	285	252	282	475	558	458	245
Loan Repayment	749	1243	2112	2443	2592	2,001	1,490	1,686
Total	**1041**	**1528**	**2364**	**2725**	**3067**	**2,559**	**1,948**	**2,080**

[6] Field Strength for FYs 2007-2010 are estimates. The NURSE Corps did not begin to capture field strength numbers until FY 2011.

Faculty Loan Repayment Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$1,177,000	$1,190,000	$1,190,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 738(a), Public Health Service Act (authorized appropriation Section 740(b)), as amended by Section 5402, and Section 10501(d), P.L. 111-148

FY 2015 Authorization…….……..Expired

Allocation Method ..... Competitive Awards to Individuals

Program Description and Accomplishments

The Faculty Loan Repayment Program (FLRP) is a loan repayment program for health profession graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college or university 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 equal to the principal and interest amount made by the HHS Secretary for each year in which the recipient serves as a faculty member. The Secretary may waive the institution's matching requirements if the Secretary determines it will impose an undue financial hardship.

The ACA included physician assistants as an eligible discipline for the FLRP program. In FY 2010, FLRP began accepting applications from physician assistants.

In FY 2013:
The FLRP program made 21 new loan repayment awards.

In FY 2014:
The FLRP program is expected to make 20 new loan repayment awards.

Funding History

FY	Amount
FY 2011	$1,258,000
FY 2012	$1,243,000
FY 2013	$1,177,000
FY 2014	$1,190,000
FY 2015	$1,190,000

Budget Request

The FY 2015 Budget Request is $1,190,000. The FY 2015 Request is equal to the FY 2014 Enacted Budget. The program expects to make an estimated 20 new awards under the FY 2015 Budget Request to health profession graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college or university. The availability of pipeline programs, and the faculty to support them, will be imperative to ensuring a sufficient primary care workforce as key parts of the ACA are implemented in 2014 and beyond.

Table 1. Loans Table

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Loans	$1,083,554	$1,190,000	$1,190,000

HEALTH PROFESSIONS

The Bureau of Health Professions (BHPr) programs support the training and development of health professionals (particularly primary care providers) to improve the health care of our Nation's communities and vulnerable populations. The BHPr programs award grants to health professions schools and training programs across the United States to develop, expand and enhance training and to improve the distribution of the health care workforce. These programs also serve as a catalyst to advance changes in health professions training responsive to the evolving needs of the health care system, such as team-based practice.

In addition, the BHPr conducts studies of the health workforce to support effective decision making by policy makers at the state and national level, and BHPr maintains a database that helps protect the public from health care practitioners, providers, and suppliers with a history of malpractice, adverse actions, fraud or abuse.

Summary of Request

	FY 2013 Final	**FY 2014 Enacted**	**FY 2015 President's Budget**	**FY 2015 +/- FY 2014**
BA	$608,224,000	$653,060,000	$295,964,000	-$357,096,000
Prevention & Public Health Fund[7]	$1,847,000	---	---	---
Mandatory Transfer	---	---	$530,000,000	+$530,000,000
Total Program Level	$610,071,000	$653,060,000	$825,964,000	+$172,904,000
FTE	112	114	122	+8

Authorizing Legislation: Titles III, VII, and VIII of the Public Health Service Act as amended by the Affordable Care Act, P.L. 111-148.

Allocation Method .....Competitive Grants/Contracts

[7] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary

State of the Health Professions Workforce

The United States has a growing need for a range of healthcare providers, especially primary care providers, due largely to population growth, the aging of the U.S. population, and retirement within the existing health care workforce.[8,9] Strengthening the primary care workforce has been a key component of the Affordable Care Act (ACA).

In November 2013, HRSA released a report, *Projecting the Supply and Demand for Primary Care Practitioners Through 2020*,[10] that projects that both supply and demand for primary care services will increase through 2020. The report projects a shortage of primary care practitioners that is comparable to the one that exists today, including a shortage of about 20,400 primary care physician FTE in 2020. However, the supply of primary care nurse practitioners (NPs) and physician assistants (PAs) is projected to grow rapidly. This growth could significantly mitigate the projected shortage of primary care physicians if NPs and PAs are integrated into the primary care delivery system to a greater extent consistent with new, more efficient models of care promoted in the ACA, such as the Patient Centered Medical Home. HRSA is working across HHS to help identify ways to reduce barriers that limit innovative use of the health care workforce, and to encourage practice models that take advantage of the full spectrum of the health care workforce.

As noted in the projections report, national estimates often mask substantial distributional disparities at the local level. Many areas across the country have insufficient access to health care services, especially for rural and certain inner-city populations or have a need for other health care providers, including mental and behavioral health professionals. As of November 14, 2013, HRSA has designated approximately 5,800 rural or inner-city locations as primary care health professional shortage areas (HPSAs).[11] Without attention, the misdistribution of providers in certain parts of our Nation and among certain populations are likely to worsen as the population ages and needs more health care services. BHPr helps to alleviate the misdistribution of primary care providers by encouraging educational institutions to provide clinical training in medically underserved communities, including HPSAs, and to serve underserved populations such as the homeless, migrant workers, and veterans and their families.

A key driver of change within the health care system is the changing demographic profile of the Nation which highlights the importance of reducing health disparities – the differences in adverse health conditions that exist among specific population groups. Health disparities are a

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[8] U.S. Census Bureau, Population Division. (2012). Table 2. Projections of the Population by Selected Age Groups and Sex for the United States: 2015 to 2060. Available at: http://www.census.gov/population/projections/data/national/2012/summarytables.html

[9] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. (2010). "Population Aging and the Use of Office-based Physician Services" Available at: http://www.cdc.gov/nchs/data/databriefs/db41.htm

[10] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *Projecting the Supply and Demand for Primary Care Practitioners Through 2020.* Rockville, Maryland: U.S. Department of Health and Human Services 2013.

[11] U.S. Department of Health and Human Services, Health Resources and Services Administration. *Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas and Populations.* Available at: http://www.hrsa.gov/shortage/ Date Retrieved, February 12, 2014.

persistent health concern and prevent us from reaching the highest level of wellness possible across our nation. By 2060, the U.S. population will be considerably older and more racially and ethnically diverse, and while the non-Hispanic white population remains the largest single group, other groups will grow significantly and no group will have a majority.[12] It has been shown that racial/ethnic minority groups receive a lower quality of care and are less likely to receive routine care.[13] Increasing diversity in the workforce is an evidence-based strategy to reduce and eliminate health disparities and move our nation one step closer to health equity. A 2006 HRSA review of evidence-based research found that underrepresented minority health professionals are more likely to serve minority and other medically underserved populations. The review also found that minority patients tend to receive better interpersonal care from practitioners of their own race or ethnicity, particularly in primary care or mental health settings. Increasing participation of practitioners from diverse backgrounds in the healthcare workforce can help increase supply and improve distribution, as well as address health disparities.

Health Professions Strategic Priorities for 2015

BHPr has undertaken a nationwide effort to increase the supply and distribution of the health care workforce and enhance training opportunities to improve access to care for a Nation with diverse and complex needs. Given the demands on the health care system described above, BHPr has identified five core strategies to strengthen the health professions workforce and improve the delivery of health care. These strategies are designed to:

1. Increase capacity and improve the distribution of the primary care workforce through enhanced education and training opportunities;
2. Support innovations in health professions training that include team-based models of care founded on interprofessional education and clinical training experiences;
3. Reduce health disparities and promote health equity by increasing health care workforce diversity;
4. Enhance geriatric/elder care training and expertise; and,
5. Strengthen HRSA's capacity for workforce analysis.

Priority #1: Increase capacity and improve distribution of the primary care workforce supply through enhanced education and training opportunities

Recognizing that the demand for primary care physicians is expected to increase faster than the supply of primary care physicians, the FY 2015 request includes significant new support for physician training, including a new competitive grant program that will fund teaching hospitals, children's hospitals, and community-based consortia of teaching hospitals and/or other health care entities to expand residency training, with a focus on ambulatory and preventive care, in order to advance higher value health care that reduces long-term costs. The new Targeted

[12] U.S. Census Bureau. *U.S. Census Bureau Projections Show a Slower Growing, Older, More Diverse Nation a Half Century from Now.* Available at: www.census.gov/newsroom/releases/archives/population/cb12-243.html. Date Retrieved, February 12, 2014.

[13] Smedley BD, Butler AS, Bristow LR, editors. Institute of Medicine, Board on Health Sciences Policy, Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Health Care Workforce. *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce.* Washington, DC: National Academies Press 2004.

Support for Graduate Medical Education Program will incorporate two existing HRSA programs, the Children's Hospital Graduate Medical Education program and the Teaching Health Center Graduate Medical Education program. It will support training in high needs specialties in addition to primary care. Current awardees in those programs will be eligible to compete for funding through the Targeted Support's competitive grant program, with $100 million set aside specifically for children's hospitals in FY 2015 and 2016 using the current CHGME program formula and supporting the current types of providers in the program.

The FY 2015 request continues BHPr investments in the production of new primary care providers through programs authorized by Titles VII and VIII of the Public Health Service Act. HRSA recognizes that increasing the supply of primary care physicians is critical, but also that nurse practitioners, certified nurse midwives, and physician assistants can play an increasingly important role in service delivery as more of these practitioners enter the workforce and are incorporated into new models of primary care. These providers have demonstrated flexibility as they practice independently or partner with physicians in both primary care and specialty areas. Greater use of these providers has the potential to improve access, reduce expenditures, and change patterns of care.[14]

HRSA will also continue to partner with the Substance Abuse and Mental Health Services Administration (SAMHSA) on the Behavioral Health Workforce Education and Training (BHWET) grant program to expand the behavioral health workforce in support of the President's *Now Is The Time* initiative to reduce gun violence. The funding will be used to address critical shortages in behavioral health professionals and paraprofessionals trained to address the needs of transition-age youth (16-25), as well as earlier issues among children and adolescents and their families. Together, HRSA and SAMHSA will train an approximately 1,800 additional behavioral health professionals and 1,700 behavioral health paraprofessionals.

Priority #2: Foster innovations and improve quality of care through health professions training

In addition to the steady production of new providers, the U.S also needs to foster innovative approaches to training and practice to ensure that the Nation has access to high quality health care. The FY 2015 request includes a focus on improving the quality of care through enhanced health professions education, with a particular emphasis on public health, mental and behavioral health and interprofessional education. These efforts seek to combine knowledge and skills across disciplines to support team-based care that addresses the full range of health needs in order to maintain health and well-being and prevent disease, disability and premature death. Interprofessional education and collaboration among health care professionals are critical to timely, effective, and efficient coordinated care that improves safety and quality care outcomes, as noted in the Institute of Medicine Report on *Primary Care and Public Health: Exploring Integration to Improve Population Health.*[15]

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[14] Thomas S. Bodenheimer and Mark D. Smith. Primary Care: Proposed Solutions To The Physician Shortage Without Training More Physicians. Health Affairs, 32, no. 11 (2013): 1881-1886.
[15] Institute of Medicine. (2012) *Primary Care and Public Health: Exploring Integration to Improve Population Health.* Washington, D.C.: The National Academies Press.

The FY 2015 request builds on a history of supporting interprofessional education and teamwork and includes $10,000,000 for a new program on Clinical Training in Interprofessional Practice, which will help implement the findings of the National Center for Interprofessional Practice and Education at the University of Minnesota. The new grant program will support community-based training in interprofessional, team-based care to increase the capacity of primary care teams to deliver quality, coordinated, safe and efficient care to patients and families in collaboration with Community Health Centers and Federally Qualified Health Centers. The request will also continue support for the National Center for Interprofessional Practice and Education, which facilitates the transformation of the fragmented healthcare delivery system into an integrated health system where coordinated, collaborative, team-based practice, informed by interprofessional practice and education becomes the new national norm.

In addition, in FY 2015 BHPr will continue to develop and disseminate interprofessional and collaborative practice models through the Nurse Education, Practice, Quality and Retention Program. These projects support a range of health care professionals, including frontline workers, enhancing their skills and preparing them to be full participants in team-based care.

The FY 2015 request includes $18,177,000 for Public Health and Preventive Medicine, which will support a reorganized and strengthened Public Health Training Center program as well as investments in Preventive Medicine Residencies.

Priority #3: Reduce health disparities by increasing health care workforce diversity

HRSA continues a strong focus on reducing disparities in the workforce, and BHPr emphasizes diversity and cultural competency across all program areas. In FY 2015, BHPr will invest $44,970,000 in the Scholarships for Disadvantaged Students (SDS) which helps provide scholarships to health profession students from disadvantaged backgrounds with financial need, many of whom are underrepresented minorities.

The FY 2015 request also includes $21,711,000 for the Centers of Excellence. The Centers of Excellence (COE) Program seeks to increase the supply and quality of underrepresented minorities (URM) in the health professions workforce by providing grants to health professions schools and other public and nonprofit health or educational.

Priority #4: Focus on geriatric/elder care training and expertise including both professional and paraprofessional education

There is a growing demand for a health workforce that is sufficiently prepared to meet the specialized needs of an aging population. The number of people in the United States aged 65 and older is projected to grow by more than 14 million between 2010 and 2020—a 36 percent increase. Older people have about twice as many visits to physician offices as their younger counterparts, and about half of these visits are to primary care physicians. In FY 2013, HRSA's National Center for Health Workforce Research funded a Health Workforce Research Center (HWRC) with a focus on long-term care whose work will continue in FY 2015. The analyses conducted by this HWRC will support a better understanding of how the Nation's healthcare

workforce can best meet the needs of our aging population, and will inform HRSA's geriatrics training and education programs.

BHPr supports several programs whose primary goal is to improve access to quality health care for America's elderly by educating both students and current practitioners in the care of the geriatric patient. These programs emphasize interprofessional geriatric training, as care for geriatric patients must be coordinated across a wide range of providers who address various patient care needs. These programs also address the need to train and educate geriatric health workforce. A continued priority in FY 2015 will be the implementation of efforts to improve education and training around Alzheimer's Disease within the Geriatrics Education Centers, with a focus on prevention and early intervention.

Priority #5: Strengthen HRSA's capacity for workforce analysis

Given the central role of our health workforce in assuring access to care in a more effective health care system, the Nation needs to be able to assess and determine whether current production of health workers is likely to be sufficient to meet expected needs. Public and private decision makers will need a better understanding of health care trends and anticipated needs supported by robust data collection, analysis, and dissemination. HRSA's National Center for Health Workforce Analysis, which was created by the Affordable Care Act, tracks current and future workforce demands and the production of providers to serve as a resource to the Nation to guide policy development and inform future investments. As workforce decision making is a shared Federal and State responsibility. The National Center will work closely with stakeholders and share data and information to support effective decision making.

The National Center assesses demands across all health professions, and gives special attention to the important role of the primary care workforce in a more effective health care system. The center has developed systems to improve tracking primary care workforce supply and distribution in collaboration with the states and professional organizations. It also supports research on factors most likely to influence the future supply, demand, and distribution of the health care workforce, as well as the effectiveness of alternative strategies for more efficient and effective primary care.

Activities of the National Center are focused on achieving the following objectives:

- Building National capacity for health workforce data collection by working with States, professional associations, and others to develop and promote guidelines for data collection and analysis;
- Improving data management, data analysis, modeling and projections to support analysis and decision making;
- Building health workforce research capacity;
- Responding to information and data needs by translating data and findings to inform policies and programs, and;
- Informing the public on the current state and trends of the U.S. health workforce.

Veterans Initiatives

Many veterans received training as healthcare providers during their time of service in the US military. BHPr is committed to ensuring that veterans have the opportunity to translate these skills and become civilian health professionals across the country. BHPr continues to engage in a number of efforts related to increasing the number of veterans trained as health professionals. In FY 2013, BHPr funded a new Veterans-to-Bachelor of Science in Nursing (BSN) program to support veteran transition to civilian nursing careers, with a second cohort of awards in FY 2014. Also, applicants for other programs are encouraged to facilitate the transition of veterans into civilian health professions careers in several of BHPr programs—including the Advanced Education Nursing Traineeship and PA Training in Primary Care programs. In a related effort, BHPr continues to facilitate the 'Helping Veterans Become Physician Assistants Workgroup' that was formed through a partnership between public and private stakeholders in veteran and PA education who are invested in creating a path for veterans to become civilian PAs, as well as improve the quality of education received by veterans.

In addition to focusing efforts on increasing veterans' opportunities to transition into civilian health professions careers, BHPr is monitoring the rate at which training sites used by grantees identify veterans, active duty military, and military families as an underserved population. Results from performance data reported by BHPr grantees show that at least 1 out of every 3 sites used to provide clinical or experiential training to individuals participating in BHPr-funded programs during Academic Year 2012-2013 reported serving veterans, active duty military and/or military families. BHPr will continue to monitor these trends and work to increase the overall number of training sites that serve vulnerable populations including veterans and their families.

Program Performance Measurement and Evaluation Activities

BHPr's Office of Performance Measurement (OPM) is responsible for the Bureau's performance measurement coordination, reporting, evaluation, and analysis. Specifically, OPM is tasked with leading and coordinating all performance measurement, performance reporting, and program evaluation activities across the Bureau's Divisions and Offices; coordinating and supporting Bureau-wide efforts regarding the use of performance information to improve program planning and implementation; developing and maintaining working relationships within HRSA, as well as with other federal and non-federal agencies engaged in performance measurement and program evaluation activities; promoting quality improvement in the field of health professions education through ongoing collaboration and partnerships with national stakeholders; and working collaboratively with the National Center for Health Workforce Analysis.

Since FY 2011, OPM has led the development and implementation of an enhanced performance measurement system to better monitor and track outputs and outcomes associated with each of the over 40 health professions training and loan programs funded through the Bureau. Data collected through the enhanced system has enabled BHPr to identify and discuss the type and extent of training activities that are being conducted by grantees to meet requirements stipulated in each program's authorizing legislation. The implementation of an enhanced performance measurement system has also led to the development and implementation of several program evaluations—including the Nurse Faculty Loan Program, the Nursing Education, Practice, Quality and Retention program, and the Integrative Medicine Residency Program—which are all

currently taking place. Results obtained from the implementation of the new performance measures are highlighted throughout the program accomplishment sections in this document. BHPr will continue to use information obtained from these measures to strengthen program performance and ensure grantees are provided with the necessary technical assistance to comply with the legislative goals and purposes of each program.

As directed by Section 5103 of the Affordable Care Act, BHPr is developing a framework for the longitudinal evaluation of its health professions training and loan programs. OPM will develop a final framework for the longitudinal evaluation by the end of Academic Year 2014-2015 which is supported with FY 2014 funds. It is expected that the baseline year for the longitudinal evaluation will be in Academic Year 2015-2016 which is supported with FY 2015 funds.

Program Accomplishments

At the Bureau-level, BHPr has tracked and reported on three cross-cutting measures that focus specifically on the diversity of individuals completing specific types of health professions training programs[16]; the rate in which individuals participating in specific types of health professions training programs are trained in medically underserved communities[17]; and the rate in which individuals who complete specific types of health professions training programs report being employed or pursuing further training in a medically underserved community.

During Academic Year 2012-2013, results showed that 45% of graduates and program completers participating in BHPr-supported health professions training and loan programs were underrepresented minorities and/or from disadvantaged backgrounds[18]. While the FY 2012 target of 53% was not met, results showed that some programs had much greater diversity than others which can help identify areas where further investigation is needed. For example, while results showed that nursing programs had a rate of 55%; oral health programs had a rate of 42%; and the physician assistant program included in the calculation had a rate of 88%, while medicine programs (including residency programs) had a rate of 23%; and public health and behavioral health programs collectively had a rate of 38%. Since the measure captures race/ethnicity, as well as disadvantaged background, a direct comparison with the most recent data for graduates of health professions training program is not feasible. Nonetheless, BHPr will continue to use its new performance measures to further investigate potential reasons or factors associated with

[16] BHPr currently funds over 40 health professions training and loan programs that have varying types of data reporting requirements based on their 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, at least 20 of the 40+ BHPr-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 program's behavioral health programs, medicine programs, nursing programs, geriatric programs, and physician assistant programs, among others.

[17] A medically underserved community is an umbrella term that includes a medically underserved area, a health professional shortage area, and/or medically underserved populations.

[18] 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 financial and/or educational disadvantaged background (regardless of race).

these profession-specific rates and identify strategies for improving program performance in this area.

With regard to the types of settings used to provide training, results showed that 59% of individuals participating in BHPr-supported health professions training and loan programs received at least a portion of their training in a medically underserved community—exceeding the performance target set of 45%. Results showed that nursing programs had a rate of 51%; medicine programs (including residency programs) had a rate of 69%; oral health programs had a rate of 60%; public health and behavioral health programs collectively had a rate of 59%; and the physician assistant program included in the calculation had a rate of 74%. While the range of rates is smaller than the range observed for the first cross-cutting measure, further investigation is needed to better understand factors that either increase or decrease the rate in which individuals participating in a specific HRSA-supported program are exposed to training in this type of setting.

Lastly, results showed that 43% of individuals who graduated from or completed specific types of BHPr-supported training programs by June 30, 2012[19] reported working or pursuing further training in medically underserved communities across the nation one year after graduation/completion. Profession-specific differences were observed that require further investigation to better understand factors associated with this outcome.

Funding History

FY	Amount
FY 2011	$673,718,000
FY 2011 (ACA)	$230,000,000
FY 2011 (PPHF)	$20,000,000
FY 2012	$641,306,000
FY 2012 (PPHF)	$35,000,000
FY 2013	$608,224,000
FY 2013 (PPHF)	$1,847,000
FY 2014	$653,060,000
FY 2015	$295,964,000
FY 2015 (Mandatory transfer)	$530,000,000

Budget Request

The FY 2015 Budget Request is $825,964,000. The FY 2015 Request is $172,904,000 above the FY 2014 Enacted level. The FY 2015 request emphasizes development of the primary care workforce, and also increases training and education in interprofessional care and collaborative practice, renews BHPr's commitment to public health and preventive medicine, and sustains efforts to promote diversity and geriatric training and education. The FY 2015 request does not provide funding for the Health Careers Opportunity Program and the Area Health Education

[19] Measure is based on data reported about graduates and program completers from Academic Year 2011-2012.

Centers Program. Performance targets for the FY 2015 request have been adjusted based on the request and available trend data.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [20]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
6.I.B.1. Percentage of graduates and program completers of BHPr-supported health professions training programs who are underrepresented minorities and/or from disadvantaged backgrounds.	45% Target: 53% (Target Not Met)	46%	46%	Maintain
6.I.C.1. Percentage of trainees in BHPr-supported health professions training programs who received training in medically underserved communities.	59% Target: 45% (Target Exceeded)	50%	55%	+5 percentage points
6.I.C.2. Percentage of individuals supported by BHPr who completed a primary care training program and are currently employed or pursuing further training in underserved areas.[21]	43% Target: 43% (Target Met)	33%	34%	+ 1 percentage points
6.I.1. Percent of sites that provide interprofessional	--	Set Baseline	TBD	N/A

[20] Most recent results are for Academic Year 2011-2012 and funded in FY 2011, excluding measure 6.I.C.2.
[21] Service location data are collected on students who have been out of the HRSA program for 1 year. The results are from programs that have ability to produce clinicians with one-year post program graduation. Results are from Academic Year 2011-2012.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [20]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
training to individuals enrolled in a primary care training program.				

Health Professions Training for Diversity

Centers of Excellence

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$21,482,000	$21,711,000	$21,711,000	---
FTE	1	1	1	---

Authorizing Legislation: Section 736 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2015 Authorization $50,000,000

Allocation Method .....Competitive Grant/Contract

Program Goal and Description: The Centers of Excellence (COE) Program seeks to increase the supply and quality of underrepresented minorities (URM) in the health professions workforce by providing grants to health professions schools and other public and nonprofit health or educational entities that meet the eligibility requirements described below. Funds support programs of excellence that enhance the academic performance of URM students, support URM faculty development, and facilitate research on minority health issues.

Need: Greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-clinician communication. In addition, evidence suggests that minority health professionals are more likely to serve in areas with a high proportion of uninsured and underrepresented racial and ethnic groups.[22]

[22] U.S. Department of Health and Human Services, 2006; In the Nation's Compelling Interest: Ensuring Diversity in the Health Professions, Institute of Medicine, 2004.

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 regarding: (a) COEs at four designated Historically Black Colleges and Universities, (b) Hispanic COEs, (c) Native American COEs, and d) Other COEs.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Allopathic medicine • Dentistry • Graduate programs in behavioral or 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. • Facilitate opportunities for faculty and student research on minority health issues. • Train students at community-based health facilities serving minority individuals. • Provide stipends and fellowships to URM students and faculty.

Program Accomplishments: In Academic Year 2012-2013, the Centers of Excellence (COE) program supported over 135 different training programs and activities meant to prepare individuals to either apply to a health professions training program (academic recruitment) or maintain enrollment in such programs during the academic year (academic retention). Overall, programs and activities supported through the COE program reached over 7,600 trainees across the country. Results showed that 43% of trainees reached through the COE program identified as Hispanic; 25.6% identified as Non-Hispanic Black or African American; 1.1% identified as Non-Hispanic American Indian or Alaska Native; and 1.2% identified as Non-Hispanic Native Hawaiian or Other Pacific Islander. Overall, it is estimated that 7 out of every 10 trainees reached through the COE program are considered underrepresented minorities in the health professions.

For the first time, data were collected about other types of training activities that are required to be carried out through the COE program. For example, the authorizing legislation for the COE program requires grantees to use funds to support faculty-student research projects in topic areas specific to minority health. Results obtained from the implementation of new performance measures showed that grantees supported over 225 different types of faculty-student research projects that ranged from "*Exploring the Effects of Oxandrolone, Propranolol, And Exercise Effects on Muscle Mass and Function in Hispanic Children with Burns*" to "*Evaluating Novel Anticancer Agents in Breast Cancer Cells*". In total, 363 faculty members and 316 health professions students, residents and fellows participated in faculty-student research projects supported through the program during the academic year.

Grantees of the COE program are also required to use funds to improve curricular design in local campuses and improve the capacity and opportunity for faculty development. Results obtained from the implementation of new performance measures showed that COE grantees developed and implemented over 130 different curricular and other types of training activities—most of which were new academic courses and clinical rotations for health professions students, residents and fellows. It is estimated that over 11,000 trainees were reached through curricular activities supported through the program during the academic year. Lastly, with regard to faculty development, results obtained from the implementation of new performance measures showed that COE grantees supported nearly 150 different faculty-focused training programs and activities during the academic year. It is estimated that over 2,000 faculty-level trainees were reached through faculty development activities supported through the program.

Funding History

FY	Amount
FY 2011	$24,452,000
FY 2012	$22,909,000
FY 2013	$21,482,000
FY 2014	$21,711,000
FY 2015	$21,711,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, and HRSA's Information Technology costs.

Budget Request

The FY 2015 Budget Request is $21,711,000. The FY 2015 Request is the same as the FY 2014 Enacted level. This request will continue to fund an estimated 17 grants to provide support to qualifying health professions schools to facilitate faculty and student research on health issues particularly affecting URM groups, strengthen programs to enhance the academic performance of URM students attending the school, and promote faculty development in various areas, including diversity and cultural competency.

BHPr will begin an evaluation of the COE program in Academic Year 2014-2015 which is supported with FY 2014 funds. The retrospective-to-prospective evaluation of the COE program will primarily focus on identifying how grantees have carried out each of the activities identified in the program's authorizing legislation; in turn, these data will be used to identify how specific approaches and strategies used by grantees are associated with the degree in which program participants (i.e. students who are considered underrepresented minorities in the health professions) successfully apply to or maintain enrollment in a health professions training program.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [23]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
Percent of program participants who completed pre-health professions preparation training and intend to apply to a health professions degree program	--	--	Set Baseline	N/A
Percent of program participants who received academic retention support and maintained enrollment in a health professions degree program	--	--	Set Baseline	N/A
Percent of health professions students participating in research on minority health-related issues	--	--	Set Baseline	N/A
Percent of faculty members participating in research on minority health-related issues	--	--	Set Baseline	N/A
Number of URM students participating in research on minority health issues	282 Target: 536 (Target Not Met)	390	N/A[24]	N/A
Number of URM faculty participating in research on minority health issues	196 Target: 323 (Target Not Met)	323	N/A[18]	N/A

[23] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.
[24] Measure was discontinued in FY14.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	17	17	17
Average Award	$1,205,000*	$1,232,000*	$1,234,000
Range of Awards	$495,000-$4,215,000	$636,000-$4,202,000	$656,000-$4,211,000

***This average includes the $12M awarded to four designated Historically Black Colleges and Universities (HBCUs), which makes the average significantly higher than the $700,000 ceiling per budget period.

Health Professions Training for Diversity

Scholarships for Disadvantaged Students

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$44,497,000	$44,970,000	$44,970,000	---
FTE	4	4	4	---

Authorizing Legislation: Section 737 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2015 Authorization ..... Unspecified

Allocation Method .....Competitive Grant

Program Goal and Description: The Scholarships for Disadvantaged Students (SDS) program increases diversity in the health professions and nursing workforce by providing grants to eligible health professions and nursing schools for use in awarding scholarships to students from disadvantaged backgrounds with financial need, many of whom are underrepresented minorities (URMs). The SDS program aims to increase: 1) the number of graduates practicing in primary care, 2) enrollment and retention of URMs, and 3) the number of graduates working in medically underserved communities.

Need: Greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-clinician communication. In addition, evidence suggests that minority health professionals are more likely to serve in areas with a high proportion of uninsured and underrepresented racial and ethnic groups.[25]

Eligible Entities: Eligible entities are accredited schools of medicine, osteopathic medicine, dentistry, nursing, pharmacy, podiatric medicine, optometry, veterinary medicine, public health, chiropractic, allied health, and schools offering a graduate program in behavioral and mental health practice.

[25] U.S. Department of Health and Human Services, 2006; In the Nation's Compelling Interest: Ensuring Diversity in the Health Professions, Institute of Medicine, 2004.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:

• Allied health
  • Behavioral and mental health
  • Chiropractic
  • Dentistry
  • Allopathic medicine
  • Nursing
  • Optometry
  • Osteopathic medicine
  • Pharmacy
  • Physician assistants
  • Podiatric medicine
  • Public health
• Veterinary medicine
	• Undergraduate
	• Graduate
		• Provide scholarships to eligible full-time students.
		• Recruit and retain students from disadvantaged backgrounds including students who are members of racial and ethnic minority groups.

Program Accomplishments:

In Academic Year 2012-2013, the Scholarships for Disadvantaged Students (SDS) Program provided scholarships to 4,889 students from disadvantaged backgrounds, exceeding the target by 35%. Students who received SDS-funded scholarships were enrolled in 65 different types of health professions-related degree programs. The most common types of students who received scholarships during the academic year were those pursuing either graduate-level nursing degrees to become Nurse Practitioners (MSN or DNP), a Bachelor's Degree in Nursing (e.g., BS or BSN) or a graduate-level degree in specific allied health fields (e.g., speech therapy, physical therapy or occupational therapy). Results of performance measures showed that the majority of students were female (79%); between the ages of 20 and 29 (66%); and were provided a median award amount of $7,500. Further analyses of data showed that approximately 3 out of every 5 students who received an SDS-funded scholarship are considered underrepresented minorities in their respective professions. Additionally, 1,271 students who received an SDS-funded scholarship successfully graduated from their degree program by the end of Academic Year 2012-2013. Of those students who graduated, 59% are considered underrepresented minorities in their prospective professions, and 80% of graduates indicated an intention to work or pursue training in medically underserved communities.

Grantees of the SDS program partnered with over 2,500 different sites across the country to provide clinical training to over 4,800 students who received an SDS-funded scholarship during the academic year. These sites commonly included physician offices, hospitals, community health centers (CHC), VA Hospitals and clinics, FQHCs or look-alikes, and oral health facilities. Further analyses of data submitted by grantees about the characteristics of sites used to train students who received SDS-funded scholarships showed that 54% of training sites were located in a medically underserved community; 41% of training sites were in primary care settings; and 14% of training sites were located in rural areas (categories are not mutually exclusive).

In FY 2012, HRSA modified the Scholarships for Disadvantaged Students (SDS) Program to move from a formula-based award process to a competitive award process and increase the amount of support available to SDS recipients. These students now receive at least one-half the cost of their tuition up to $15,000. The program was also redesigned to: give priority to schools where at least 15% of graduates practice in primary care; at least 15% of graduates work in medically underserved communities; and, at least 15% of enrollment is underrepresented minorities. These changes were made to help bolster the primary care workforce, better address the needs of medically underserved areas, and better support underrepresented minorities. The primary purpose of evaluating the SDS grant program is to identify how the restructuring of the program is associated with changes, if any, in key outputs and outcomes over a specified period of time.

Funding History

FY	Amount
FY 2011	$49,042,000
FY 2012	$47,452,000
FY 2013	$44,497,000
FY 2014	$44,970,000
FY 2015	$44,970,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbooks, program oversight activities, and Information Technology costs.

Budget Request

The FY 2015 Budget Request is $44,970,000. The FY 2015 Request is the same as the FY 2014 Enacted level. This request will fund 99 continuation grant awards, supporting approximately 2,940 students.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[26]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
Number of disadvantaged students	4,889 Target: 3,620 (Target Exceeded)	2,940	2,940	Maintain
Number of URM students	2,947 Target: 2,350 (Target Exceeded)	1,820	1,820	Maintain
Percent of students who are URMs	60% Target: 65% (Target Not Met)	62%	62%	Maintain

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	99	99	99
Average Award	$414,000	$447,000	$447,000
Range of Awards	$40,000 – 610,000	$43,000 – 650,000	$43,000 – 650,000

[26] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.

Health Professions Training for Diversity

Health Careers Opportunity Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$14,039,000	$14,189,000	---	-$14,189,000
FTE	1	1	---	-1

Authorizing Legislation: Sections 739 and 740 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2015 Authorization .....Expired FY 2014

Funding Allocation .....Competitive Grant

Program Goal and Description: The Health Careers Opportunity Program (HCOP) seeks to increase the diversity of the health professions workforce by providing grants that improve the recruitment and enhance the academic preparation of students from economically and educationally disadvantaged backgrounds into the health professions. Grant projects support activities targeted to Kindergarten through 12th grade, baccalaureate, post-baccalaureate, and/or graduate students. Activities include formal academic and research training and programming, student enhancement services, counseling and mentoring services to assist students in successfully completing their education and training, student stipends, and financial planning resources. HCOP also exposes students to community-based primary healthcare experiences with public and private non-profit providers.

Need: Greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-clinician communication. In addition, evidence suggests that minority health professionals are more likely to serve in areas with a high proportion of uninsured and underrepresented racial and ethnic groups.[27]

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

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
Allied health Allopathic medicine Behavioral and mental health Chiropractic	• Elementary school • Middle school • High school • Undergraduate	• Identify, recruit, and select individuals from disadvantaged backgrounds for academic enhancement.

[27] U.S. Department of Health and Human Services, 2006; In the Nation's Compelling Interest: Ensuring Diversity in the Health Professions, Institute of Medicine, 2004.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
Dentistry Optometry Osteopathic medicine Pharmacy Physician assistants Podiatric medicine Public health Veterinary medicine	• Graduate	• Facilitate entrance to health professions schools. • Disseminate information on financial aid. • Provide stipend support. • Provide exposure at community-based primary health service facilities. • Provide counseling, mentoring, or other services to assist individuals to successfully complete their education. • Develop larger competitive applicant pool through partnerships with institutes of higher education, school districts, and other community-based linkages. • Provide preliminary education and health research training to assist students to successfully complete regular courses of education at such a school, or refer individuals to institutions providing such preliminary education.

Program Accomplishments: In Academic Year 2012-2013, the Health Careers Opportunity Program (HCOP) supported nearly 275 different training programs and activities to promote interest in the health professions among prospective students. In total, HCOP grantees reached over 7,100 trainees across the country—exceeding the program's performance target of 4,435 by 44.5%. Results showed that 23.6% of trainees reached through the HCOP identified as Hispanic; 51% identified as Non-Hispanic Black or African American; .5% identified as Non-Hispanic Native Hawaiian or Other Pacific Islander; and 1.4% identified as Non-Hispanic American Indian or Alaska Native. Overall, it is estimated that about 3 out of every 4 trainees reached through training programs and activities supported by the HCOP are considered underrepresented minorities in the health professions, and about 9 out of 10 trainees identify as coming from a financial or educational disadvantaged background.

Funding History

FY	Amount
FY 2011	$21,998,000
FY 2012	$14,779,000
FY 2013	$14,039,000
FY 2014	$14,189,000
FY 2015	---

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook (EHB), program oversight activities, and Information Technology costs.

Budget Request

No funding is requested in FY 2015. The FY 2015 Request is $14,189,000 below the FY 2014 Enacted level. The President's Budget is prioritizing investing in programs that have a more immediate impact on the production of health professionals by supporting students who have committed to and are in training as health care professionals. Federally funded health workforce development programs will continue to promote training of individuals from disadvantaged backgrounds. For example, efforts to strengthen the diversity of the health professions workforce include the Primary Care Training and Enhancement program, which requires applicants to include a description of their recruitment and retention strategies to increase the representation of underrepresented minority and/or disadvantaged trainees in their grant applications. Furthermore, many health professions training institutions have initiatives aimed at recruiting students from disadvantaged backgrounds.

Outcomes and Outputs Tables

Measure[28]	**Year and Most Recent Result /Target for Recent Result / (Summary of Result)** [29]	**FY 2014 Target**	**FY 2015 Target**	**FY 2015 Target +/- FY 2014 Target**
Total number of disadvantaged students in structured programs	6,418 Target: 4,435 (Target Exceeded)	Target: 4,435	N/A	N/A

[28] Program is not included in FY 2015 budget.
[29] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	17	17	---
Average Award	$670,000	$670,666	---
Range of Awards	$238,000-$750,000	$592,581-$750,000	---

Health Care Workforce Assessment

The National Center for Health Workforce Analysis

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$2,635,000	$4,663,000	$4,663,000	---
FTE	7	7	7	---

Authorizing Legislation: Sections 761, 792, and 806(f) of the Public Health Service Act, as amended by the Affordable Care Act

FY 2015 Authorization .....Expired FY 2014

Allocation Method…….……Grants/Contract

Program Description: The National Center for Health Workforce Analysis (National Center) 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. The National Center also evaluates the effectiveness of workforce policies in addressing workforce issues. The National Center is focused on:

- Building National capacity for health workforce data collection by working with States, professional associations, and others to develop and promote guidelines for data collection and analysis;
- Improving data management, data analysis, modeling and projections to support analysis and decision making as well as evaluation of the effectiveness of workforce programs and policies;
- Building health workforce research capacity;
- Responding to information and data needs by translating data and findings to inform policies and programs, and;
- Informing the public on the current state and trends of the U.S. health workforce through reports and timely dissemination.

Need: Producing a workforce of sufficient size and skills is essential to meeting the Nation's health care needs. Policy makers 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. Since the healthcare system and workforce is constantly changing, effective decision making at the Federal, State and local level requires that we continue to develop new and more sophisticated understanding about the current workforce and estimates of future demands.

Program Accomplishments:

Continuing its work to expand the range of data available through the Area Health Resources Files, the National Center has added state- and national-level data and improving the availability of on-line tools for accessing the data.

The National Center has initiated three Health Workforce Research Centers to perform research and data analysis on health workforce issues of national importance and one cooperative agreement to provide technical assistance to states working on data collection and health workforce planning.

The National Center will model supply and demand of health professionals across a range of health occupations.

The National Center makes health workforce information available through reports and on-line databases. In FY 2013, it published projections on the supply and demand for primary care providers, as well as other reports including one on the supply and education of the nursing workforce and a chartbook with data on the number of practitioners in 35 different health occupations.

Funding History

FY	Amount
FY 2011	$2,815,000
FY 2012	$2,782,000
FY 2013	$2,635,000
FY 2014	$4,663,000
FY 2015	$4,663,000

Budget Request

The FY 2015 Budget Request is $4,663,000. The FY 2015 Budget Request is the same as FY 2014 Enacted level. As the Nation continues to address health care needs of an aging population, State and National level analysis of healthcare workforce needs will be critical to making investments in the health workforce. To support these needs, the National Center continues to develop a projections model which allows a more sophisticated modeling of health workforce supply and demand, taking into account changing demand for health care services and the impact that changes in the delivery of health care will have on the supply of health professionals. The NCHWA Area Health Resources File continues to expand its focus on specific priority areas for health workforce development such as behavioral and mental health workforce needs, allied health professions, and oral health workforce.

Health Workforce Research Centers Grants Awards Table
Size of Awards

(whole dollars)	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 President's Budget**
Number of Awards	4	4	5
Average Award	$341,000	$341,000	$400,000
Range of Awards	$300,000-$375,000	$300,000-$600,000	$300,000-$600,000

Primary Care Training and Enhancement Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$36,535,000	$36,924,000	$36,924,000	---
FTE	5	5	5	---

Authorizing Legislation: Section 747 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2015 Authorization .....Expired FY 2014

Allocation Method .....Competitive Grant/Contract

Program Goal and Description: The purpose of the Primary Care Training and Enhancement (PCTE) program is to strengthen medical education for physicians and physician assistants to improve the quantity, quality, distribution, and diversity of the primary care workforce. PCTE grants help produce future primary care providers that are prepared to meet the changing healthcare needs of the nation by supporting the development of innovative medical education for physicians and physician assistants.

The six funding opportunities that comprise PCTE support a range of activities, including:

- predoctoral training;
- residency training;
- physician faculty development;
- support for academic administrative units;
- physician assistant (PA) education; and
- interprofessional joint graduate degree programs.

These activities vary in eligible applicants, trainees, and approved activities, allowing for grant activities to specifically address local, community, and trainee needs.

Need: National and international research demonstrate that high quality, accessible primary care improves health and reduces costs, with improved satisfaction for both recipients and providers of healthcare services.

Difficulty recruiting students to become primary care physicians is a principle obstacle to improving the primary care system. Twenty one percent, (6,327 of 29,171), of 2013 National Residency Match Program applicants filled family medicine, internal medicine, and pediatric positions. While this is an increase from 14.5 percent in 2012, the number of students choosing primary care specialties remains inadequate to fill the nation's need.[30,31] It is critical to note that

[30] PRWeb. (Mar 15, 2013). "U.S. Medical Students Celebrate in NRMP Match Day 2013 Results Ceremonies Today". http://www.prweb.com/releases/2013/3/prweb10522881.html

only a portion of the 6,327 incoming primary care residents will choose generalist careers that will address the nation's primary care need; the majority will choose to pursue a sub-specialty. The recent projections published by HRSA indicate that without changes to how primary care is delivered, the growth in primary care physician supply will not be adequate to meet demand in 2020, with a projected shortage of 20,400 physicians.[32].

Geographic mal-distribution also contributes to the shortage of primary care providers in many communities, both rural and urban. Even as the number of physicians increases, they tend to practice in areas where the supply is already high, as opposed to rural and inner city areas where need has been demonstrated and is reflected by suboptimal health outcomes.[33]

The physician and PA workforce must be prepared for the expected increase in demand for healthcare and to help develop the delivery system and practice models that will yield higher quality and improve efficiency. PAs are valuable primary care team members that are helping increase the capacity and quality of the healthcare system. The trends disfavoring primary care practice and working in underserved communities seen in physicians have been mirrored in PAs. Investments in the primary care workforce are needed to increase the number of practicing physicians and PAs and to enhance their educational experience.

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 • 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, residencies, and faculty development programs. • Primary care academic and community faculty development.

[31] American Academy of Family Physicians (AAFP). (Mar 12, 2012). "2012 Match Summary and Analysis". http://www.aafp.org/online/en/home/residents/match/summary.html
[32] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. Projecting the Supply and Demand for Primary Care Practitioners Through 2020. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.
[33] Academic Medicine (November, 2008). History of the Title VII Section 747 Grant Programs, 1963-2008 and their impact, Vol. 83, No.11.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
		• Support development and enhancement of infrastructure in primary care academic administrative units. • Support expansion of training opportunities by funding primary care physician residency positions and physician assistant stipends.

Program Accomplishments: Grant activities funded through the PCTE program support education in primary care for physician and PA students, residents, and faculty. Educational programs with a PCTE grant provide learning activities that teach knowledge and skills essential to primary care, including interprofessional education and practice, team-based clinical models, and public health. In addition, grant activities may support training in a variety of settings (e.g., hospitals, patient-centered medical homes, medically underserved communities, and community-based sites) with vulnerable populations, including homeless, chronically ill, HIV/AIDS, and older adults.

In Academic Year 2012-2013, grantees of the PCTE program[34] trained a total of 23,830 physician and PA students, medical residents and fellows.[35] Additionally, 5,182 of those students, residents, and fellows completed their training program at the end of the academic year. Almost one out of every 3 graduates were underrepresented minorities and/or from disadvantaged backgrounds (31%).

The PCTE program provided direct financial support to 532 students, residents, and fellows participating in their degree programs, medical residencies or fellowships. Results showed that the majority of trainees who received financial support were female (63%) and between the ages of 20 and 29 years (75%). They received an average award amount of $6,042, and received clinical training in a medically underserved community (82%) and/or primary care setting (88%) at some point during the academic year. Further analyses of data showed that about 1 out of every 4 trainees who received direct financial support reported coming from a financially or educationally disadvantaged background and about 1 out of every 4 trainees reported coming from a rural background.

For the first time, data were collected regarding other types of activities that can be carried out through the PCTE program. For example, the PCTE program grantees may use funds to develop and implement curricular and other educational activities to train students, residents and fellows across the health professions in primary care related topics. Results obtained from the

[34] Includes Pre-Doctoral Training, Residency Training, Physician Assistant Training, Physician Faculty Development and Academic Administrative Units in Primary Care grant activities.
[35] Includes trainees who received direct financial support (e.g., stipends, tuition support) as well as trainees enrolled in or trained through the academic program supported by the grant.

implementation of new performance measures showed that PCTE grantees developed and implemented 775 different curricular and educational activities—most of which were new academic courses, clinical rotations, and grand rounds for health professions students and advanced trainees. It is estimated that over 38,000 individuals were trained as a result of these activities.

In addition to training students, grantees may also use funds to support the training and ongoing professional development of faculty at their local institutions. Results obtained from the implementation of new performance measures showed that PCTE grantees supported 391 different types of faculty development activities (e.g, conferences, workshops, programs, among others) focused on topics that ranged from Patient-Centered Medical Home to Team-based Learning. It is estimated that 5,472 faculty-level trainees were trained as a result of these activities.

Two additional grant programs -- the Primary Care Residency Expansion Program (PCRE) and the Expansion of Physician Assistant Training Program (EPAT) -- were funded in 2010 and will continue to increase the number of physician and PA students trained in primary care through 2015. In Academic Year 2012-2013, the PCRE program cumulatively added an additional 332 residents to existing primary care residency programs. The first class of PCRE program completers will complete their residency training in Academic Year 2013-2014, supported with FY 2010 funding.

The EPAT program cumulatively added an additional 317 PA students to existing PA education programs. The first class of 37 EPAT graduates just completed their studies in Academic Year 2012-2013, supported with FY 2010 funding. While this first class of EPAT graduates did not meet the target, projections for program graduates show that the target will be met during the first half of Academic Year 2013-2014.

Funding History

FY	Amount
FY 2011	$39,036,000
FY 2012	$38,962,000
FY 2013	$36,535,000
FY 2014	$36,924,000
FY 2015	$36,924,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbook (EHB), program oversight activities, the Advisory Committee on Training in Primary Care Medicine and Dentistry, and the Council on Graduate Medical Education, and Information Technology costs.

Budget Request

The FY 2015 Budget Request is $36,924,000. The FY 2015 Request is the same as the FY 2014 Enacted level. This request will fund activities that aim to improve the quality of primary care providers, increase the capacity of PA education programs, promote interprofessional practice, enhance medical education through curriculum innovations and improve the distribution and diversity of the healthcare workforce. Through these activities, the PCTE programs seek to improve primary care quality and increase the appeal of primary care to students and current practitioners.

Outputs and Outcomes Tables

The PCTE program supports primary care workforce growth and diversification, curricular innovations, and development of academic infrastructure. The current outcome measures reflect these objectives. As PCTE awards continue to 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. Effective September 2012, grantees reported new performance measures that better assess grant impact. New measures include individual level data on specialty and practice setting selection, and details of didactic, clinical, and research training.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[36]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
6.I.C.4.a. Number of primary care physicians receiving training through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding: Primary Care Residency Expansion (PCRE) (cumulative)	332 Target: 344 (Target Not Met)	N/A[37]	N/A	N/A
6.I.C.4.b. Number of primary care physician	317 Target: 280	600[38]	N/A	N/A

[36] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.
[37] Measure is cumulative and captures the training of the three cohorts of residents funded through the PCRE program. Targets regarding the training of each cohort are applicable for FY 2011, FY 2012, and FY 2013.
[38] Measure is cumulative and captures the training of the four cohorts of physician assistant students funded through the EPAT program. Targets regarding the training of each cohort are applicable for FY 2011, FY 2012, FY 2013, and FY 2014

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[36]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
assistants receiving training through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding: Physician Assistance Expansion (EPAT) (cumulative)	(Target Exceeded)			
6.I.C.3.a: Number of primary care physicians who complete their education through HRSA's Bureau of Health Professions Programs supported with Prevention and Public Health funding (PCRE) (cumulative)	--	332	500[39]	+168
6.I.C.3.b: Number of physician assistants who complete their education through HRSA's Bureau of Health Professions Programs supported with Prevention and Public Health funding (EPAT) (cumulative)	37 Target: 140 (Target Not Met)	420	600[40]	+180
6.I.C.8: Number of Primary Care Patient Encounters	722,298 Target: 30,000 (Target Exceeded)	180,000	180,000	Maintain
Number of physicians completing a BHPr-funded residency or fellowship	---	---	Set Baseline	---

[39] Outputs based on forward-funded grants.
[40] Outputs based on forward-funded grants.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[36]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
Number of physicians graduating from a BHPr-funded medical school	---	---	Set Baseline	---
Number of physician assistants graduating from a BHPr-funded program	---	---	Set Baseline	---
Number of graduates from a BHPr-funded joint public health degree program	---	---	Set Baseline	---
Percent of physician and physician assistant trainees receiving at least a portion of their clinical training in an underserved area	73% Target: 59% (Target Exceeded)	52%	55%	+3 Percentage Points
Percent of physician and physician assistant graduates who practice in medically underserved areas	39% Target: 45% (Target Not Met)	35%	38%	+3 Percentage Points
Percent of graduates and program completers who are minority and/or from disadvantaged backgrounds	31% Target: 31% (Target Met)	35%	35%	Maintain
Number of graduates and program completers	5,182 Target: 7,500 (Target Not Met)	3,900	N/A[41]	---

[41] Measure discontinued in FY14

Grant Awards Table – Physician Training Grants
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	137	137	137
Average Award	$219,000	$219,000	$219,000
Range of Awards	$93,000-$491,000	$93,000-$491,000	$93,000-$491,000

Grant Awards Table – Physician Assistant Training Grants
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	31	31	31
Average Award	$155,000	$155,000	$155,000
Range of Awards	$94,000-$219,000	$94,000-$219,000	$94,000-$219,000

Oral Health Training Programs

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$30,681,000	$32,008,000	$32,008,000	---
FTE	2	2	2	---

Authorizing Legislation: Sections 748 and 340G of the Public Health Service (PHS) Act

FY 2015 Authorization: Section 748……Such Sums as Necessary
Section 340G…….……...Expired FY 12

Allocation Method: …….…Competitive Grant/Contract

Program Goal and Description: The Oral Health Training Programs are designed to increase access to culturally competent, high quality dental health services to rural and other underserved communities by increasing the number of oral healthcare providers working in underserved areas and improving training programs for oral health care providers. The Oral Health Training Programs are comprised of the following:

- Training in General, Pediatric, Public Health Dentistry and Dental Hygiene Program - provides funding in the form of grants or contracts to plan, develop, and operate, or participate in, approved professional training programs in the fields of general, pediatric, or public health dentistry for dental students, residents, practicing dentists, dental hygienists, or other approved primary care dental trainees. Training areas within this program include:
    - Predoctoral Training
    - Postdoctoral Training
    - Faculty Development
    - Dental Faculty Loan Repayment (DFLR)

- State Oral Health Workforce Improvement Program (SOHWI) - awards grants to States to help them develop and implement innovative programs to address the dental workforce needs of designated Dental Health Professional Shortage Areas (D-HPSAs) in a manner that is appropriate to the states' individual needs. There are twelve specific available activities listed in the authorizing legislation for this program and a thirteenth that allows the Secretary to fund innovative projects that are not specified in the law.

Need: Oral health is an essential component of overall health. Untreated oral diseases and conditions can have significant impacts on quality of life. Yet, according to a July 2011 study published by the Institute of Medicine (IOM) entitled, *Improving Access to Oral Health Care for*

Vulnerable and Underserved Populations,[42] vulnerable and underserved populations face persistent and systemic barriers to accessing oral health care. These barriers are numerous and complex and include social, cultural, economic, structural, and geographic factors, among others. The IOM Report specifically indicates that:

- In 2008, 4.6 million children did not obtain needed dental care because their families could not afford it.
- In 2011, there were approximately 33.3 million underserved individuals living in D-HPSAs.
- In 2006, only 38 percent of retired individuals had dental coverage.

For the first time, the Healthy People ten-year goal setting effort has identified Oral Health as a leading health indicator for 2020 (http://healthypeople.gov/2020/default.aspx).

A large proportion of dental school faculty and practicing dentists are nearing retirement age and will soon leave the workforce without adequate replacements to meet the growing the oral health needs of the U.S. population. Additional challenges to improving access to oral health services include the lack of coordination and integration of oral health, public health, and medical health care systems.

Discipline	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Training in General, Pediatric, and Public Health Dentistry	$20,143,000	$20,646,000	$20,646,000
State Oral Health Workforce Improvement	$10,538,000	$11,362,000	$11,362,000

Training in General, Pediatric, and Public Health Dentistry

The Training in General, Pediatric, and Public Health Dentistry 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.

[42] Institute of Medicine and National Research Council. *Improving access to oral health care for vulnerable and underserved patients*. Washington, DC: The National Academies Press, 2011.

Eligible Entities: Schools of dentistry, public or non-profit private hospitals, and public or non-profit private entities that have approved residency or advanced education programs and others determined eligible by the Secretary.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• General dentists • Pediatric dentists • Public health dentists • Dental hygienists	• Dental Hygiene Training Programs • Undergraduate • Graduate School (dental schools) • Pre- and Post-Doctoral Programs • Residency Programs	• Funds to plan, develop and 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, practicing dentists, and dental hygiene students 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. • Provide loan repayment to individuals who agree to serve as full-time dental faculty members in exchange for repayment of outstanding student loans based on each year of service. • 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.

Program Accomplishments: In Academic Year 2012-2013, the Oral Health Training Programs (including the Training in General, Pediatric, and Public Health Dentistry Program and the State Oral Health Workforce Improvement Grant Program) trained over 2,600 oral health students[43]--exceeding the program's performance target of 1,800 by 48%. Additionally, grantees of the Oral Health Training Programs were able to train 517 primary care dental residents, just under the target of 534. Projections for the training of primary care dental residents show that the target should be met in the next academic year. Further analysis of individual-level data showed that Oral Health Training Programs provided direct financial support to 398 oral health students, residents, and fellows participating in degree, residency, or fellowship programs in dentistry, public health, and/or dental hygiene. Results showed that the majority of students, residents, and fellows were female (52%), between the ages of 20 and 29 (80%), were provided a mean award amount of $8,835, and received clinical training in a medically underserved community (60%)

[43] Includes students who received direct financial support (e.g., stipends, tuition support) as well as students enrolled in or trained through academic programs supported by the grant.

and/or primary care setting (68%) during the academic year. Further analyses of data showed that about 1 out of every 8 students, residents, and fellows who received a financial award reported coming from a disadvantaged background, and about 1 out of every 5 students, residents, and fellows who received a financial award are considered underrepresented minorities in their prospective profession.

In addition to providing direct support to students, residents, and fellows in training programs, the Training in General, Pediatric, and Public Health Dentistry program also provided loan repayment to dentists for serving as teaching faculty. In Academic Year 2012-2013, the Dental Faculty Loan Repayment Program provided loan repayment to 38 faculty dentists. Results showed that the supported faculty were 50% female, generally between the ages of 30 and 39 (54%), were provided a mean loan repayment amount of $21,146, and the majority were either General Dentists (63%) or Pediatric Dentists (26%). Further analyses of data showed that about 1 out of every 5 faculty dentists who received loan repayments reported coming from a disadvantaged background.

Lastly, a total of 737 faculty members were trained through the faculty development activities funded by oral health training programs, exceeding the performance target of 190 by 388%. Results obtained from the implementation of new performance measures showed that grantees supported 78 different types of faculty development activities (e.g., conferences, workshops, certificate programs, among others). Faculty development focused on a range of topics from best practices in clinical teaching to clinical research design.

State Oral Health Workforce Improvement Grant Program

The State Oral Health Workforce Improvement Grant Program—which falls under BHPr's Oral Health Training Programs—aims to enhance dental workforce planning and development to meet the unique needs of each State.

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 / Oral Health Service Development[44]:**	**Grantee Activities:**
• Dentistry	• Primary and Secondary Education • Pre- and Post- Doctoral Programs • Residency Programs • Continuing Education	• Loan forgiveness and repayment provided to dentists who practice in D-HPSAs; serve as public health dentists for the Federal, State or local government; and/or provide services to patients regardless of their ability to pay. • Dental student recruitment and retention efforts. • Grants and low or no-interest student loans. • The establishment or expansion of dental

[44] Varies based on grantee activities

Designated Health Professions:	Targeted Educational Levels / Oral Health Service Development[44]:	Grantee Activities:
		residency programs. • Expand or establish oral health services and facilities for children with special needs. • Placement and support of dental trainees. • Continuing dental education. • Tele-dentistry. • Community-based prevention such as water fluoridation and dental sealants. • Programs that promote young students to pursue oral health or science professions. • Faculty recruitment programs at accredited dental training institutions. • The development of a State dental officer position or the augmentation of a State dental office. • Other activities deemed appropriate by the Secretary.

Program Accomplishments:

In Academic Year 2012-2013, the State Oral Health Workforce Improvement Grant Program carried out a number of community-based prevention activities authorized under statute. Analysis of performance measures showed that grantees established 5 new oral health facilities for children with special needs in dental health profession shortage areas (HPSAs). These new facilities treated 7,113 patients. Grantees also expanded 6 oral health facilities in dental HPSAs and treated 7,205 patients in these expanded facilities providing education, prevention, and restoration services; supported 28 teledentistry facilities, providing 127 patient care teledentistry encounters and 22 teledentistry training sessions; implemented 3 new and replaced 22 water fluoridation systems to provide optimally fluoridated water to over 2.8 million individuals; provided dental sealants to over 77,000 children; provided topical fluoride to over 61,000 individuals; provided diagnostic or preventive dental services to over 77,000 persons and oral health education to over 104,000 persons. State grantees hired 5 new state dental officers, 17 new dentists or hygienists, 3 fluoridation experts, 2 statisticians, 1 epidemiologist, and 9 administrative and other staff members in state dental offices. States also retained 42 positions in state dental offices that had been hired in previous years.

Funding History

FY 2011	$32,781,000
FY 2012	$32,392,000
FY 2013	$30,681,000
FY 2014	$32,008,000
FY 2015	$32,008,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbook (EHB), program oversight activities, and Information Technology costs.

Budget Request

The FY 2015 Budget Request is $32,008,000. The FY 2015 Request is the same as the FY 2014 Enacted level. This request will fund continuing and new awards in the Training in General, Pediatric and Public Health Dentistry and State Oral Health Workforce Improvement programs, and will aim to increase access to culturally competent, high-quality, dental health services to rural and other underserved communities by increasing the number, and improving the diversity and distribution, of oral health care providers and improving the training programs for future oral health care providers.

Outcomes and Outputs Tables

Measure	**Year and Most Recent Result /Target for Recent Result / (Summary of Result)**[45]	**FY 2014 Target**	**FY 2015 Target**	**FY 2015 Target +/- FY 2014 Target**
Number of students trained	2,658 Target: 1,800 (Target Exceeded)	2,200	2,200	Maintain
Number of residents trained	517 Target: 534 (Target Not Met)	534	534	Maintain
Number of faculty trained	737 Target: 190 (Target Exceeded)	190	190	Maintain
Number of faculty receiving loan repayments	38 Target: 28 (Target Exceeded)	28	36	+8

[45] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.

Grant Awards Table – Training in General, Pediatric, and Public Health Dentistry
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	55	55	55
Average Award	346,000	353,000	353,000
Range of Awards	$91,000-$973,000	$93,000-$735,000	$93,000-$735,000

Grant Awards Table – State Oral Health Workforce Improvement
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	24	24	23
Average Award	$430,000	$430,000	$451,000
Range of Awards	$212,000-$504,000	$206,000-$500,000	$423,000-$500,000

Rural Physician Training Grants Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	---	---	$4,000,000	+$4,000,000
FTE	---	---	---	---

Authorizing Legislation: Section 749B of the Public Health Service Act

FY 2015 Authorization .....Expired FY 2013

Allocation Method .....Competitive Grant

Program Goal and Description: The Rural Physician Training Grants Program seeks to increase the number of medical school graduates practicing in underserved rural communities. Grants funded through this program will support the planning, development, and operation of a medical education program to encourage students to practice in these areas. Funded grantees will recruit students most likely to practice medicine in underserved rural communities, and support innovations in medical school curriculum development. These programs will prepare physicians with the unique skill set required for rural practice, and develop rural-focused longitudinal clinical training activities and experiences. They will link targeted students with a continuum of rural practice and professional development that includes mentorship and career planning. Funds will assist students in obtaining post-graduate rural residency placements to achieve program goals. Successful grantees in this program will collaborate with appropriate partners such as other health professions programs, Area Health Education Centers, student loan and scholarship programs including the National Health Service Corps, awardees in the Targeted Support for Graduate Medical Education program, and rural graduate medical education programs such as rural training tracks.

Need: There are nearly 50 million people living in rural America who face ongoing challenges in accessing health care.[46] Rural residents have higher rates of age-adjusted mortality, disability, and chronic disease than their urban counterparts.[47] Rural areas also continue to suffer from a shortage of diverse providers for their communities' health care needs and face workforce shortages at a greater rate than their urban counterparts.[48][49] Of the 2,052 rural counties in the

[46] Population and Percent Distribution by Core Based Statistical Area (CBSA) Status for the United States, Regions, and Divisions, and for Puerto Rico: 2000 and 2009 (CBSA-EST2009-11).
[47] Economic Research Service (August 2009). Health Status and Health Care Access of Farm and Rural Populations. Economic Information Bulletin Number 57. Washington, D.C. U.S. Department of Agriculture.
[48] Area Resource File (ARF). 2008. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Rockville, MD.
[49] Doescher, M., Fordyce, M., Skillman S., WWAMI Rural Health Research Center Presentation: The Aging of the Rural Generalist Workforce. February 2009.

United States (U.S.), 1,582 (77 percent) are primary care health professional shortage areas (HPSAs).[50]

Eligible Entities: Accredited schools of allopathic or osteopathic medicine, or association approved by the Secretary for this purpose, or any combination or consortium of such schools.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:

• Allopathic and Osteopathic physicians	• Allopathic and Osteopathic medical schools	• Recruit medical school students who are most likely to practice medicine in underserved rural communities.
		• Plan, develop and operate a medical school education program to prepare students to practice in underserved rural areas.
		  • Implement curricula to prepare physicians with the unique skill sets required for rural practice.
		  • Develop longitudinal clinical experiences and activities.
		  • Assist students in obtaining post-graduate residency placements in underserved rural communities.
		• Link targeted students with a supportive continuum of professional development that includes mentorship and career planning.
		• Establish collaborative partnerships to achieve program goals.

Program Accomplishments: N/A

Funding History

FY	Amount
FY 2011	---
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	$4,000,000

[50] WWAMI Rural Health Research Center. Aging of the rural generalist workforce. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; July, 2009.

Budget Request

The FY 2015 Budget Request is $4,000,000. The FY 2015 Request is $4,000,000 above the FY 2014 Enacted level. This request will support a new grant program that will establish, expand and improve rural-focused physician training programs. The Rural Physician Training Grants Program will focus on recruiting and training physician students in rural settings with the goal of increasing the number of medical school graduates who practice in rural communities.

Outputs and Outcomes Tables

Measure	**Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)**	**FY 2014 Target**	**FY 2015 Target**	**FY 2015 +/- FY 2014**
Number of medical students trained in a rural curriculum	--	--	Set Baseline	--
Number of medical students receiving clinical training at rural sites	--	--	Set Baseline	--
Number of faculty trained to provide rural or primary care curriculum	--	--	Set Baseline	--
Number of medical students matching to primary care residencies or residencies located in rural areas	--	--	Set Baseline	--

Grant Awards Table – Rural Physician Training Grants
Size of Awards

(whole dollars)	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 President's Budget**
Number of Awards	---	---	10
Average Award	---	---	$350,000
Range of Awards	---	---	$300,000-$400,000

Teaching Health Centers Graduate Medical Education Payment Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	---	---	---	---
FTE	6	6	6	---

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

FY 2015 Authorization .....Such Sums as Necessary
(Not to exceed $230,000,000, for the period of fiscal years 2011 through 2015)

Allocation Method .....Formula Based Payments

Program Goal and Description: The Teaching Health Centers Graduate Medical Education Payment Program (THCGME) provides funding for residency training in primary care and dentistry in community-based, ambulatory settings. The THCGME program seeks to both bolster the primary care workforce through support for new and expanding primary care and dental residency programs and to improve the distribution of that workforce into needed areas through emphasis on underserved populations.

Need: Access to high quality primary care is associated with improved health outcomes and lower costs. There is evidence that physicians who receive training in community and underserved settings are more likely to practice in such environments, for example Health Centers.[51] Though Health Centers receive Federal funding to improve access to care, they have difficulty recruiting and retaining primary care professionals.[52] The THCGME program was established by the Affordable Care Act to increase and enhance the primary care workforce and to improve its distribution into underserved communities. Appropriated funding for this program was authorized for the period of FY 2011 through FY 2015. Over the past three years, interest in the program has grown considerably, with the number of supported programs growing from 11 residency programs in the first year of funding, Academic Year 2011-2012, to 44 in Academic Year 2013-2014. This growth in the THCGME program has translated to an increase in resident full time equivalents (FTEs) from 63 in Academic Year 2011-2012 to over 300 in Academic Year 2013-2014. Additional programs added in FY 2014 and FY 2015 will continue to increase the number of FTEs in training and multi-year programs, will continue to expand to training capacity so that the addition of new FTEs is additive until programs have trainees enrolled in all of the approved slots.

[51] Morris CG and Chen FM. Training Residents in Community Health Centers: Facilitators and Barriers. Annals of Family Medicine 2009; 7:488-94.
[52] Rosenblatt RA, Andrilla CH, Curtin T, Hart LG. Shortages of medical personnel at community health centers: Implications for planned expansion. JAMA 2006; 295:1042-9.

Eligible Entities: Community-based ambulatory patient care centers that operate an accredited primary care residency program in one or more of the following specialties: family medicine, general dentistry, geriatrics, internal medicine, internal medicine-pediatrics, obstetrics and gynecology, pediatrics, psychiatry, and pediatric dentistry. Eligible entities include, but are not limited to: Federally Qualified Health Centers (FQHCs), community mental health centers, rural health clinics, health centers operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization, and an entity receiving funds under Title X of the Public Health Service Act.

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

Program Accomplishments:

In FY 2011, 11 THCs began receiving payments and training 63 primary care medical and dental resident Full Time Equivalents (FTEs) in Academic Year 2011-2012. In FY 2012, 11 additional THCs received payments for a total of 22 programs supported in Academic Year 2012-2013. In FY 2013, the program grew further and supported more 44 residency programs and over 300 resident FTEs during Academic Year 2013-2014. The awardees include twenty-eight FQHCs, two FQHC Look-Alikes, two Area Health Education Centers (AHEC), two Native American Health Authorities, one community mental health clinic, one rural health clinic, and four additional community-based entities.

In Academic Year 2012-2013, the THCGME program awarded 143 resident FTE slots that provided funding to 158 primary care medical residents. Demographic analysis shows that over half (51%) of the residents were female and between 30 and 39 years (52%). All residents received training in a primary care setting (100%), and nearly all residents received training in a medically underserved community (87%) providing well over 100,000 hours of patient contact. Results also showed that THCGME residents served a number of specialized populations including veterans and their families, older adults, as well as children and adolescents. Further analysis of the data showed that almost 1 in 4 (23%) of the funded residents reported coming from a disadvantaged background and 1 in 5 (20%) residents reported having a rural background.

For the first time, data were collected regarding activities that can be carried out through the THCGME program to support residency training. For example, programs may use funds to develop and implement curricular and other educational activities to train primary care medical and dental residents as well as other students, fellows, and residents across the health professions

in primary care related topics. Results obtained from the implementation of new performance measures showed that THCGME programs developed and implemented 159 different curricular and educational activities—nearly all of which were new academic courses and clinical rotations for primary care residents. It is estimated that over 900 healthcare trainees, mostly primary care residents, were trained as a result of these activities.

A recent journal article highlighted the curricular and organizational innovations in many of the THCs, enabled by the THCGME's support for community-based training, rather than traditional Medicare GME which is paid only to hospitals[53]. These innovations included quality improvement and patient-centered medical home development. These educational elements are vital to the success of the ACA's triple aim.

Funding History

FY	Amount
FY 2011 ACA	$230,000,000
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---

Funding includes costs associated with processing of payments through the Grants Administration Tracking and Evaluation System (GATES), HRSA's electronic handbook, program oversight activities, and information technology costs.

Budget Request

The FY 2015 Budget requests appropriations language that would make current balances in the THCGME available until expended and thereby would avoid having these funds expire at the end of FY 2015. In addition, HRSA will establish a new Targeted Support for Graduate Medical Education Program to expand residency training, with a focus on ambulatory and preventive care, in order to advance the Affordable Care Act's goals of higher value health care that reduces long term costs. The Targeted Support for Graduate Medical Education program will incorporate the THCGME program.

[53] Chen et al. Teaching Health Centers: A new paradigm in graduate medical education. Acad Med 2012; 87

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[54]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
6.I.C.5: Number of primary care residents trained (Cumulative)[55]	143 Target: 143 (Target Met)	402	620	+218

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	44	55	60
Average Award	$643,189	$1,070,455	$1,732,500
Range of Awards	$75,000-$3,600,000	$37,500-$4,350,000	$75,000-$7,425,000

[54] Most recent results are for Academic Year 2012-2013 and funded in FY 2011.
[55] Measure captures the number of full-time equivalent (FTEs) resident slots supported and not the number of individuals receiving direct financial support through the program.

Targeted Support for Graduate Medical Education

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	---	---	$530,000,000[56]	+$530,000,000
FTE	---	---	26	+26

Authorizing Legislation**: ….....**New Authority

FY 2015 Authorization….....Unspecified

Allocation Method..... Competitive Grant

Program Goal and Description: The Targeted Support for Graduate Medical Education Program will fund teaching hospitals, children's hospitals, and community-based consortia of teaching hospitals and/or other health care entities to expand residency training in primary care or high-need specialties not supported by GME payments, in teaching hospitals and other community-based health facilities with a focus on ambulatory and preventive care, in order to advance the Affordable Care Act's goals of higher value health care that reduces long-term costs. The program will fund new residency slots using a competitive approach in which applicants demonstrate how their training of residents addresses key workforce objectives, such as: training and retaining residents in primary care; training and retaining residents in rural settings and in underserved areas; and, providing comprehensive primary care that includes oral health, behavioral health, prevention, and population health. This program will be funded from the Medicare Hospital Insurance Trust Fund and administered by HRSA.

Targeted Support for Graduate Medical Education will encourage innovation in training models and greater accountability in the use of GME funds. Funds will be targeted to training programs that feature concepts such as team-based care, the effective incorporation of health information technology into clinical practice, population health, and telemedicine.

The new Targeted Support for Graduate Medical Education Program will incorporate two existing HRSA programs, the Children's Hospital Graduate Medical Education program and the Teaching Health Center Graduate Medical Education program. Current awardees in those programs will be eligible to compete for funding through the Targeted Support's competitive grant program, with $100 million set-aside specifically for children's hospitals each year in FYs 2015 and 2016. In addition, teaching hospitals or other health entities developing new programs in outpatient or community-based settings would also be eligible for limited, short-term (no more than two years) "capacity building" grants to seek accreditation or modify their existing accreditation.

[56] Transfer from the Medicare Hospital Insurance Trust Fund

Need: In recent years, the overall numbers of residents trained in primary care and in rural areas have both declined. Current residency training is predominately hospital-focused so that residents have limited opportunities to provide continuous, on-going care to individuals such as those with chronic conditions in a range of community-based settings. In a June 2010 report, the Medicare Payment Advisory Committee recommended changes to the nation's GME funding in order to support the workforce skills needed for a changing healthcare system.[57] The report specifically called for changes to meet goals such as community-based care and giving students a broader set of training experiences.

Eligible Entities: Teaching hospitals, children's hospitals, and community-based consortia of teaching hospitals and/or other health care entities.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Physicians (including family medicine, general internal medicine, general pediatrics, and combined internal medicine and pediatrics)	• Residents	• Operate an accredited residency program. • Residents in community-based settings will provide patient care services during their training. • Provide financial support to programs seeking to obtain accreditation for their new or expanding community-based residency program.

Program Accomplishments: This is a new initiative with no programmatic history.

FY	**Amount**
FY 2011	---
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	$530,000,000

Budget Request

The FY 2015 Budget Request is $530,000,000. The FY 2015 Request is $530,000,000 above the FY 2014 Enacted level. A total of $5.23 billion is requested for FYs 2015 – 2024 to be transferred from the Medicare Hospital Insurance Fund. Over ten years, the program is expected to support approximately 13,000 residents to complete their training in community-based ambulatory care settings that provide a range of training experiences to address key health care workforce development needs. The program will advance key workforce goals, including the

[57] Report to the Congress: Aligning Incentives in Medicare (June 2010). Medicare Payment Advisory Commission. (available at http://www.medpac.gov).

training of more physicians in primary care and other specialties with shortages, aligning training with more efficient and effective care delivery models, and encouraging physicians to practice in rural and other underserved areas.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Number of primary care residents trained (Cumulative)	N/A	N/A	Set Baseline	---
Number of residents trained in an underserved area (Cumulative)	N/A	N/A	Set Baseline	---
Number of residents trained in a team-based setting (Cumulative)	N/A	N/A	Set Baseline	---

Grants Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	---	---	TBD
Average Award	---	---	TBD
Range of Awards	---	---	TBD

Interdisciplinary, Community-Based Linkages

Area Health Education Centers Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$28,211,000	$30,326,000	---	-$30,326,000
FTE	2	2	---	-2

Authorizing Legislation**:** Section 751 of the Public Health Service Act as amended by the Affordable Care Act

FY 2015 Authorization.....Expired FY 2014

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

Program Goal and Description: The Area Health Education Centers (AHEC) Program seeks to enhance access to high quality, culturally competent health care through community-based interprofessional clinical training, continuing education, and outreach activities that will ultimately improve the distribution, diversity, quality and supply of the primary care health professions workforce serving in rural and underserved health care delivery sites. The AHEC Program supports two types of awards: Infrastructure Development, and Point of Service Maintenance and Enhancement. The Infrastructure Development funds are used to plan, develop and implement AHEC centers that link the grantee school and at least two other disciplines with local educational and clinical sites. The Point of Service funds are awarded to AHEC programs and centers that have completed the Infrastructure Development phase to stabilize and evaluate evolving conditions that impact the outcomes of the program.

Need: Although the supply of other primary care providers is growing, ensuring an adequate supply of primary care providers for the future remains key to providing high quality health care. Ensuring an adequate supply of well-trained primary care providers is a particular concern for vulnerable and underserved populations, which include approximately 20 percent of Americans who live in rural or inner-city locations designated as health professional shortage areas. [58]

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.

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58 http://ersrs.hrsa.gov/reportserver/Pages/ReportViewer.aspx?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rs:Format=HTML4.0 (Accessed 8/9/2013)

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Allied 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 for primary care providers in underserved areas • High school students (9-12)	• Plan, develop, operate and evaluate AHEC Center(s). • Address health care workforce needs in the service areas coordinating with local workforce investment boards (WIBs). • Provide clinical rotations in primary care and community-based, interprofessional training. • Disseminate continuing education courses for health professionals with an emphasis on underserved areas and for health disparity populations. • Promote health careers including public health in the high school grades.

Program Accomplishments: In Academic Year 2012-2013, the Area Health Education Centers (AHEC) program supported various types of pre-pipeline (i.e. K-12), pipeline (i.e. health profession students) and continuing education training activities for thousands of trainees across the country. Results showed that the AHEC program supported community-based clinical training in primary care for over 13,000 medical school students and an additional 8,353 students from varying types of health professions training programs (e.g., nursing, physician assistant, behavioral health, among others). The AHEC program also supported over 3,000 different continuing education courses that were delivered to over 216,000 trainees nationwide. On average, each course was offered between 4 and 5 times; lasted about 5 hours in length; and had approximately 72 participants. It is estimated that about 1 out of every 4 trainees who participated in a CE offering reported being employed in a medically underserved community.

Funding History

FY	Amount
FY 2011	$33,142,000
FY 2012	$27,230,000
FY 2013	$28,211,000
FY 2014	$30,326,000
FY 2015	---

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, and Information Technology costs.

Budget Request

No funding is requested in FY 2015. The FY 2015 Budget Request is $30,326,000 below the FY 2014 Enacted level. While the AHEC Program exposes medical students and health professions students to primary care and practice in rural and underserved communities, the FY 2015 Budget Request reflects the prioritization of funding to programs that directly increase the number of primary care providers. It is anticipated that the AHEC Program grantees may be able to support on-going activities through other funding sources.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[59]	FY 2014 Target	FY 2015 Target[60]	FY 2015 Target +/- FY 2014 Target
No. of medical school trainees participating in community-based clinical training	3,411 Target: 22,600 (Target Not Met)	3,400	N/A	-3,400
No. of other health professions trainees participating in community-based clinical training	3,775 Target: 33,600 (Target Not Met)	3,500	N/A	-3,500
Number of trainees who received continuing education (CE) on topics including Cultural Competence, Women's Health, Diabetes, Hypertension, Obesity, and Health Disparities	216,155 Target: 366,000 (Target Not Met)	215,000	N/A	-215,000
Percent of CE trainees who report being currently employed in medically underserved areas	28% Target: 15.3% (Target Exceeded)	28%	N/A	-28%
No. of trainees receiving health career guidance and information from the AHEC Programs	249,464 Target: 456,000 (Target Not Met)	245,000	N/A	-245,000

[59] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.
[60] Program discontinued in FY 2015.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	57	55	--
Average Award	$455,000	$480,000	--
Range of Awards	$100,000- $1,199,000	$106,000-$1,275,000	--

Interdisciplinary, Community-Based Linkages

Geriatric Programs

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$29,011,000	$33,321,000	$33,321,000	---
Prevention and Public Health Fund[61] (Alzheimer's)	$1,847,000	---	---	---
Total Program Level	$30,858,000	$33,321,000	$33,321,000	---
FTE	5	5	5	---

Authorizing Legislation: Section 753 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2015 Authorization:
Geriatric Education Centers……..….Expired FY 2014
Geriatric Training for Physicians, Dentists, and
Behavioral/Mental Health Professionals……Expired FY 2014
Geriatric Academic Career Awards……..….Expired FY 2014

Allocation Method .....Competitive Grants/Contracts

Program Goal and Description: The Geriatrics programs seek to improve high quality interprofessional geriatric education and training to the health professions workforce, including geriatric specialists and non-specialists. The Geriatrics programs focus on increasing the number of geriatrics specialists and increasing geriatrics competencies in the generalist workforce to improve care for this often vulnerable, underserved population. Geriatrics programs include:

- Geriatrics Education Centers (GEC) - provides support to establish or operate GECs to train health professional faculty, students, and practitioners in the interprofessional diagnosis, treatment and prevention of disease, disability, and other health problems of the elderly. The GECs provide services to and foster collaborative relationships among health professions educators within defined geographic areas.

- Geriatrics Training for Physicians, Dentists, and Behavioral/Mental Health Professionals (GTPD) - supports fellowships and other training efforts that assist physicians, dentists,

[61] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

and behavioral and mental health professionals who plan to teach geriatric medicine, geriatric dentistry, or geriatric behavioral and mental health.

- Geriatrics Academic Career Awards (GACA) - promotes the development of academic clinician educators in geriatrics (including physicians, nurses, social workers, psychologists, dentists, pharmacists, and allied health professionals) by requiring them to provide clinical training in geriatrics, including training of interprofessional teams of health professionals.

Need: The Institute of Medicine identified three shortfalls that the health care system will face as the number of older Americans increases: 1) health care needs of older adults will be difficult to meet by the current health care workforce; 2) there will be severe shortages of geriatric specialists and other providers with geriatric skills; and 3) there will be increased demand for chronic care management skills.[62]

Geriatrics Programs

Programs	FY 2013 Final	FY 2014 Enacted	FY 2015 Request
Geriatrics Education Centers	$17,909,000	$16,457,000	$16,321,000
Geriatrics Education Centers (Alzheimer's)		$4,000,000	$4,000,000
Geriatric Education Centers (Alzheimer's - PPHF)[63]	$1,847,000	---	---
Geriatrics Training for Physicians, Dentists, and Behavioral/Mental Health Professionals	$8,028,000	$7,964,000	$8,000,000
Geriatrics Academic Career Awards	$4,940,000	$4,900,000	$5,000,000

Geriatrics Education Centers Program

The Geriatrics Education Centers (GECs) program—which falls under BHPr's Geriatrics Programs—aims to provide high quality interprofessional geriatrics education and training to the health professions workforce including geriatrics specialists and non-specialists. GECs provide interprofessional continuing education to health care practitioners on Alzheimer's Disease and related dementias.

Eligible Entities: Accredited schools of multiple health disciplines.

[62] Institute of Medicine. Retooling for an Aging America: Building the Health Care Workforce. Washington, DC: The National Academies Press; 2008.

[63] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

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 • Veterinary medicine	• Undergraduate • Graduate • Post-graduate • Practicing health care providers • Faculty • Direct service workers • Lay and family caregivers	• Interprofessional geriatrics education and training to students, faculty and practitioners. • 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.

Program Accomplishments: In Academic Year 2012-2013, the Geriatrics Education Centers (GEC) program supported various types of geriatrics-specific training for health professions students and faculty, as well as for current community-based providers. With regard to the continuing education (CE) of the current workforce, GEC grantees delivered over 1,650 different continuing education courses to over 94,000 trainees—exceeding the program's performance target by 58.5%. On average, each continuing education course was offered between 4 and 5 times; lasted about 4.7 hours; had about 26 participants; was primarily delivered face-to-face; and focused on emerging issues in the field of geriatrics (e.g., Alzheimer's disease, dementia, advances in palliative care, among others).

For the first time, data were collected on other training-related activities that are required to be carried out through the GEC program. For example, the authorizing legislation for the GEC program requires grantees to use funds to provide health professions students with clinical training in nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers. Results obtained from the implementation of new performance measures showed that GEC grantees partnered with over 650 healthcare delivery sites across the country to provide clinical and experiential training to over 25,000 trainees. It is estimated that 2 out of every 5 sites used by GEC grantees for the purposes of offering these types of training were primary care settings and/or were located in a medically underserved community.

In addition to training students, grantees are also required by law to use funds to support the training and retraining of faculty in geriatrics. Results obtained from the implementation of new performance measures showed that GEC grantees supported over 800 different faculty development activities and training programs (e.g., workshops, conferences, professional development activities, among others) during the academic year. It is estimated that over 17,500 faculty-level trainees were trained on geriatric-related topics as a result of these types of activities.

Geriatrics Training for Physicians, Dentists, and Behavioral and Mental Health Professionals

The Geriatrics Training for Physicians, Dentists, and Behavioral and Mental Health Professionals program—which falls under BHPr's Geriatrics Programs—aims to increase the supply of quality, culturally competent geriatrics faculty and to retrain mid-career faculty in geriatrics.

Eligible Entities: Accredited schools of medicine, schools of osteopathic medicine, teaching hospitals, and graduate medical education programs.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Dentistry • Medicine • Counseling - Marriage & family - Professional - Substance abuse • Osteopathic medicine • Psychology • Psychiatric nursing • Psychiatry • Social work	• Graduate • Post-graduate • Faculty	• Provide intensive one-year mid-career faculty retraining and/or two-year fellowship training in geriatrics. • Provide training in and exposure to the physical and mental disabilities of elderly individuals through a variety of service rotations, such as, geriatric consultation services, acute care services, dental services, geriatric behavioral or mental health units, day and home care programs, rehabilitation services, geriatric ambulatory care and comprehensive evaluation units, and community care programs for elderly individuals with developmental disabilities. • Apply contemporary educational delivery methods to interprofessional audiences. • Demonstrate application of administrative, clinical, teaching, and research skills as academic and clinical faculty.

Program Accomplishments: In Academic Year 2012-2013, the Geriatric Training for Physicians, Dentists and Behavioral/Mental Health Providers (GTPD) program funded 22 fellows in Geriatric Medicine; 18 fellows in Dentistry; 12 fellows in Geriatric Psychiatry; 5 fellows in Internal Medicine; 4 fellows in Family Medicine; 2 fellows in General Psychiatry; and

1 fellow in Clinical Psychology—for a total of 64 fellows. The majority of fellows were either non-Hispanic White (52%) or Non-Hispanic Asian (27%) and approximately 15% of fellows reported coming from a financial and/or educational disadvantaged background. Results showed that fellows received clinical training in over 200 different healthcare delivery sites across the country; the most common types of sites where fellows trained included Veteran's Affairs hospitals and clinics, private hospitals, and academic centers. It is estimated that nearly half of the sites (49%) where GTPD fellows received clinical training were located in a medically underserved community.

The GTPD program is multipurposed in that the program not only supports the training of fellows in specific types of geriatric settings, but also requires that each fellow dedicate at least 25% of their time for teaching health professions students about geriatric-related topics. Results obtained from the implementation of new performance measures showed that GTPD fellows delivered over 275 courses, workshops and other training activities focused on topics including oral health, chronic disease management and geriatric medicine, among others. It is estimated that over 5,600 trainees were trained as a result of these activities—the most common of which included medical school students, dental school students, residents in geriatrics and residents in geriatric psychiatry.

Geriatrics Academic Career Awards Program

The Geriatrics Academic Career Awards (GACA) program—which falls under BHPr's Geriatrics Programs—aims to promote the development of academic clinician educators who provide clinical training in geriatrics.

Eligible Entities: Eligible entities are schools of allopathic medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy or other allied health disciplines in an accredited health professions school.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
Allied health Allopathic medicine Dentistry Nursing Osteopathic medicine Pharmacy Psychology Social work	• Faculty	• Promote the career development of junior faculty as academic clinician educators in geriatrics. • Provide training in clinical geriatrics, including training of interprofessional teams of health professionals. • Provide junior faculty with opportunities to focus on teaching activities such as interprofessional geriatrics curricula development and integrating geriatrics into health professions curricula.

Program Accomplishments: In Academic Year 2012-2013, the Geriatrics Academic Career Award (GACA) program funded 60 faculty in geriatrics medicine, 1 faculty in clinical

psychology and 1 faculty in geriatrics physical therapy—for a total of 62 awardees. In total, GACA awardees delivered over 1,100 different courses, workshops and other types of training activities to over 53,000 trainees across the health professions—the most common of which included medical school students, residents in internal medicine and residents in geriatrics. On average, each training activity delivered by GACA awardees was offered at least twice; lasted about 8 hours in length; focused on topics such as geriatric medicine, palliative care and transitional care; had about 15 participants; and was offered primarily in the classroom or as part of a clinical rotation.

In addition to training health professions students, residents and fellows, GACA awardees are highly encouraged to engage in professional development and scholarly activities during each academic year as a way of advancing the field of geriatrics. Results obtained from the implementation of new performance measures showed that GACA awardees conducted presentations about their own research and other related topics at over 215 conferences at the local, state or national level and published a total of 108 peer-reviewed publications during the academic year.

Funding History

FY	Amount
FY 2011	$33,542,000
FY 2012	$30,629,000
FY 2012 (PPHF)	$2,000,000
FY 2013	$29,011,000
FY 2013 (PPHF)	$1,847,000
FY 2014	$33,321,000
FY 2014 (PPHF)	---
FY 2015	$33,321,000
FY 2015 (PPHF)	---

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, and Information Technology costs.

Budget Request

The FY 2015 Budget Request is $33,321,000. The FY 2015 Request is the same as the FY 2014 Enacted level. This request will fund 37 new and competing continuation Geriatric Education Center cooperative agreements, 12 new and competing Geriatric Training for Physician, Dentists, and Behavioral and Mental Health Professional grants, and 65 new Geriatric Academic Career Awards. This funding level also supports the 37 Geriatric Education Centers to provide interprofessional continuing education to health professionals on Alzheimer's disease. The amount of the award for GACA recipients is statutorily required to reflect any annual increases in the Consumer Price Index. However, award amounts to the GEC and GTPD programs are subject to reductions in their continuation funding if there is a reduction in available funding. In FY 2012 the cost of living adjustment (COLA) was 3.6 percent. The COLA for FY 2013 was1.7 percent, the award amount was then adjusted for sequestration. In 2014, the COLA was 1.5%.

Outcomes and Outputs Tables

The table below includes some performance measures that are still under development since the Alzheimer's education activities have only recently been initiated and baselines have not yet been established.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[64]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
6.I.C.12: Number of BHPr-sponsored interprofessional continuing education sessions provided on Alzheimer's disease	--[65]	Set Baseline	TBD	N/A
6.I.C.13: Number of trainees participating in interprofessional continuing education on Alzheimer's disease	--[66]	Set Baseline	TBD	N/A
Number of continuing education trainees[67]	94,194 Target: 59,413 (Target Exceeded)	79,521	79,521	Maintain
Number of GTPD Fellows	63 Target: 45 (Target Exceeded)	45	45	Maintain
Number of continuing education offerings delivered by GEC grantees	--	--	Set Baseline	N/A
Number of students who received geriatric-focused training in geriatric nursing homes, chronic and acute disease hospitals,	--	--	Set Baseline	N/A

[64] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.
[65] Baseline for this measure will be in FY 2014.
[66] Baseline for this measure will be in FY 2014.
[67] The wording of the measure has been revised to better reflect measures used for data collection.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[64]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
ambulatory care centers, and senior centers				
Number of faculty members participating in geriatric trainings offered by GEC grantees	--	--	Set Baseline	N/A
Number of individuals trained by GTPD fellows in geriatrics	--	--	Set Baseline	N/A
Number of geriatric-focused presentations at professional meetings by GACA awardees	--	--	Set Baseline	N/A
Number of geriatric-focused articles published by GACA awardees	--	--	Set Baseline	N/A
Number of GACA Awardees	62 Target: 68 (Target Not Met)	68	N/A[68]	N/A

[68] Measure was discontinued in FY14.

Grant Awards Table – Geriatric Education Centers Program
Size of Awards*

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	45	45	45
Average Award	$388,000	$512,000	$512,000
Range of Awards	$220,000-$445,000	$330,000-$559,000	$330,000-$530,000

*The increases in award amount include the support from Prevention and Public Health Fund.

Grant Awards Table – Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	12	12	12
Average Award	$650,000	$650,000	$650,000
Range of Awards	$378,000-$959,000	$411,000-$1,000,000	$600,000-$700,000

Grant Awards Table – Geriatric Academic Career Awards Program
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	57	57	65
Average Award	$75,000	$76,000	$77,000
Range of Awards	---	---	---

Interdisciplinary, Community-Based Linkages

Mental and Behavioral Health Education and Training Programs

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$2,740,000	$7,916,000	$7,916,000	---
Total Program Level[69]	$2,740,000	$7,916,000	$7,916,000	---
FTE	1	1	1	---

Authorizing Legislation: Section 755(b)(1)(J) of the Public Health Service Act.

FY 2015 Authorization: ..... Unspecified

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

Program Goal and Description: The Mental and Behavioral Health Education and Training Programs work to close the gap in access to mental and behavioral health services by increasing the number of adequately trained mental and behavioral health (including substance abuse) providers. This funding supports the following activities:

- Graduate Psychology Education (GPE) grants, which are awarded to doctoral psychology schools and programs to train psychologists to work with underserved populations. The GPE grants are designed to foster an integrated and interprofessional approach to addressing access to behavioral health care for vulnerable and underserved populations.

- Leadership in Public Health Social Work Education – funds centers of excellence at schools of social work to help develop the next generation of public health social workers and provide critical leadership, resources and training.

In addition, as part of the President's *Now Is The Time* initiative, HRSA partners with SAMHSA to expand the behavioral health workforce supporting clinical training for behavioral health professionals (including masters level social workers, psychologists, marriage and family therapists, psychiatric mental health nurse practitioners, professional counselors, as well as doctoral-level psychologists) and paraprofessionals. Funding for this joint effort is provided by SAMHSA. This activity, Behavioral Health Workforce Education and Training (BHWET), builds on HRSA's Mental and Behavioral Health Education and Training (MBHET) grants, funded in FY 2012 for 3 years through the Prevention and Public Health Fund.

[69] The FY 2015 Budget continues a $35 million initiative to expand the behavioral health workforce, with funding provided by SAMHSA and the program implemented through a partnership with HRSA.

Need: Mental disorders rank in the top five chronic illnesses in the U.S. The National Alliance on Mental Illness reported approximately six percent, or one in 17 Americans suffers from a serious mental illness.[70] Serious mental illnesses cost society approximately $193.2 billion in lost earnings per year. Individuals suffering from a serious mental illness earned at least 40 percent less than people in good mental health, confirming that mental disorders contribute to significant losses of human productivity.[71]

	FY 2013 Final	**FY 2014 Enacted**	**FY 2015 President's Budget**	**FY 2015 +/- FY 2014**
Leadership in Public Health Social Work Education program	---	$1,000,000	$1,000,0000	---
Graduate Psychology Education Program	$2,740,000	$6,916,000	$6,916,000	---

Leadership in Public Health Social Work Education

The Leadership in Public Health Social Work Education Program—one of two grant programs within BHPr's Mental and Behavioral Health Education and Training Programs— funds centers of excellence at schools of social work and public health to help develop the next generation of social workers and provide critical leadership, including public health, resources and training. The program supports masters and doctoral level training in a range of social work and leadership competencies.

Eligible Entities: Eligible entities are accredited schools of social work and public health.

[70] National Alliance on Mental Illness. (2008). What is Mental Illness? Mental Illness Fact Sheet, November 4, 2008.

[71] Kessler, R.C., Heeringa, S., Lakoma, M.D., Petukhova, M., Rupp, A.E., Schoenbaum, M., Wang, P.S., and Zasavslu. A.M. (2008). The individual-level and societal-level effects of mental disorders on earnings in the United States: Results from the National Comorbidity Survey Replication. American Journal of Psychiatry; June; 165(6): 703-711.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Social work • Public Health	• Masters and doctoral level	• Graduate public health social work training for leadership roles in service, administration, research, education, and advocacy related to programs providing health and related services for populations of mothers and children (infants through adolescents) and families, including those with special health care needs; • Development and dissemination of curricula, teaching models, and other public health educational resources to enhance MCH content in social work training programs; and • Regional and National continuing education, consultation and technical assistance in public health social work geared to the needs of the MCH community.

Program Accomplishments: N/A

Graduate Psychology Education Program

The Graduate Psychology Education program—which falls under BHPr's Mental and Behavioral Health Education Programs—aims to increase the supply of trained doctoral-level psychologists prepared to address the behavioral health needs of vulnerable and underserved populations.

Eligible Entities: Eligible entities include accredited doctoral psychology programs within institutions of higher education, and other public or private non-profit entities. Applicants must demonstrate that the training within an accredited graduate program in clinical psychology will occur in collaboration with two or more disciplines other than psychology.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Graduate Psychology (doctoral)	• Accredited Graduate Psychology (Doctoral level) Schools and Programs • Accredited internships in public and private nonprofit institutions	• Provide integrated and interprofessional education and clinical training leading to a doctoral degree in psychology. • Increase access to quality behavioral health services to vulnerable, underserved, and needy populations. • Increase the number of prepared psychologists with doctoral degrees serving the medically underserved communities.

Program Accomplishments: In Academic Year 2012-2013, the Graduate Psychology Education (GPE) program provided stipend support to 112 students and fellows participating in a practicum, pre-degree internship or post-doctorate fellowship in clinical psychology. Results showed that the majority of students and fellows who received a stipend were female (81%); between the ages of 20 and 29 (64%); were provided a median award amount of $10,295; and received clinical training in a medically underserved community (93%) and/or a primary care setting (88%) during the academic year. Further analyses of data showed that about 1 out of every 5 students and fellows who received a stipend reported coming from a financial or educational disadvantaged background and about 1 out of every 4 students and fellows who received a stipend are considered underrepresented minorities in their prospective profession.

For the first time, data were collected regarding other types of activities that are required to be carried out through the GPE program. For example, the GPE program requires that grantees use funds to develop and implement curricular and other educational activities to train students, residents and fellows across the health professions in behavioral-health related topics. Results obtained from the implementation of new performance measures showed that GPE grantees developed and implemented 99 different curricular and educational activities—most of which were new academic courses and clinical rotations for health professions students. It is estimated that over 1,400 trainees were trained as a result of these activities.

In addition to training students, grantees are also required to use funds to support the training and ongoing professional development of faculty at their local institutions. Results obtained from the implementation of new performance measures showed that GPE grantees supported 16 different types of faculty development activities (e.g, conferences, workshops, among others) focused on topics that ranged from advances in therapeutic approaches to psychopharmacology. It is estimated that 100 faculty-level trainees were trained as a result of these activities.

Program Accomplishments for the Mental and Behavioral Health Education and Training Grants - In Academic Year 2012-2013, the Mental and Behavioral Health Education and Training (MBHET) grants supported 86 graduate-level students participating in either a social work practicum or a pre-degree internship in clinical psychology. Results showed that the majority of students who received a stipend were female (84%); between the ages of 20 and 29 (49%); were provided a median award amount of $10,000; and received clinical training in a medically underserved community (90%). Further analyses of data showed that about 1 out of every 3 students who received a stipend reported coming from a financial or educational disadvantaged background and about 2 out of every 5 students are considered underrepresented minorities in their prospective profession.

As required by the authorizing legislation for the MBHET grants, grantees are required to develop and implement curricular and other educational activities to train students, residents and fellows across the health professions in behavioral health-related topics. Results showed that MBHET grantees developed and implemented over 96 different curricular and educational activities—most of which were new academic courses, clinical rotations and field placements for behavioral health students. It is estimated that over 2,900 health trainees were trained as a result of these activities.

Funding History

FY	Amount
FY 2011	$2,927,000
FY 2012	$2,892,000
FY 2012 (PPHF)	$10,000,000
FY 2013	$2,740,000
FY 2014	$7,916,000
FY 2014 (PPHF)	---
FY 2015	$7,916,000
FY 2015 (PPHF)	---

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and program oversight activities, and Information Technology costs.

Budget Request

The FY 2015 Budget Request is $7,916,000. The FY 2015 Request is the same as the FY 2014 Enacted level. This funding will continue to support grants in the GPE and Leadership in Public Health Social Work Education programs.

In FY 2015, HRSA will also continue to partner with SAMHSA on the Behavioral Health Workforce Education and Training (BHWET) grant program to expand and increase the clinical service capacity of the behavioral health workforce. With $35 million provided by SAMHSA, HRSA and SAMHSA together will support clinical training for approximately 1,800 additional behavioral health professionals and 1,700 additional paraprofessionals beyond those trained in FY 2014.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [72]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
6.I.C.16: Number of students receiving training via clinical Internships in Psychology or Field Placements in Social Work focused on working with high need and high demand populations.	---	145	N/A[73]	N/A
6.I.C.17: Number of graduates entering practice with high need and high demand populations	---	57	N/A[5]	N/A
6.I.2: Percent of graduates entering practice with high need and high demand populations	---	78%	N/A[5]	N/A
Number of graduate-level psychology students supported	---	Set Baseline	TBD	---
Number of interprofessional students trained	---	Set Baseline	TBD	---
Percent of graduate-level psychology students supported who complete a pre-degree internship in a primary care setting	---	Set Baseline	TBD	---

[72] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.
[73] Measures for the MBHET program will be discontinued in FY 2015, as no new funding for this program is anticipated. HRSA will report on outcomes associated with the MBHET program for FY 2012, FY 2013, and FY 2014.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [72]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
Percent of grantees who develop or enhance curriculum that integrates behavioral health into primary care	---	Set Baseline	TBD	---
Number of Trainees	1,414 Target: 614 (Target Exceeded)	875	N/A[74]	N/A
Number Graduates	52 Target: 90 (Target Not Met)	105	N/A[75]	N/A
Number of Graduates entering practice in MUCs	47[76] Target: 75 (Target Not Met)	32	N/A[77]	N/A
Percent of Graduates entering practice in MUCs	58%[78] Target: 83% (Target Not Met)	29%	N/A[79]	N/A

Grant Award Table – Leadership in Public Health Social Work Education
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	--	3	3
Average Award	--	$333,000	$333,000
Range of Awards	--	$300,000-$350,000	$300,000-$350,000

[74] Measure will be discontinued in FY 2014.
[75] Measure will be discontinued in FY 2014.
[76] Based on 1-year follow-up data reported for students who completed training requirements in Academic Year 2011-2012. Data available only for 47 out of the 110 graduates reported in the FY 2014 Congressional Justification.
[77] Measure will be discontinued in FY 2014.
[78] Based on 1-year follow-up data reported for students who completed training requirements in Academic Year 2011-2012. Data available only for 47 out of the 110 graduates reported in the FY 2014 Congressional Justification.
[79] Measure will be discontinued in FY 2014.

Grant Award Table - Graduate Psychology Education
Size of Awards

(whole dollars)	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 President's Budget**
Number of Awards	16	37	37
Average Award	$156,000	$168,000	$168,000
Range of Awards	$122,000 - $190,000	$128,000 – $190,000	$128,000 - $190,000

Interdisciplinary, Community-Based Linkages

Clinical Training in Interprofessional Practice

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	---	---	$10,000,000	+$10,000,000
FTE	---	---	2	+2

Authorizing Legislation**:** Sections 747, 748, 750, 811, and 831 of the Public Health Service Act, as amended by the Affordable Care Act.

FY 2015 Authorization….....Such Sums as Necessary

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

Program Goal and Description: The Clinical Training in Interprofessional Practice Program (CTIPP) will support community-based clinical training in interprofessional, team-based care to increase the capacity of primary health care teams to deliver quality, coordinated, safe and efficient care to patients, families and communities. This initiative will help bring to scale the findings of the National Center for Interprofessional Practice and Education at the University of Minnesota, funded in FY 2012 to, among other things, serve as a hub for generating high quality, efficient and equitable practice models for interprofessional education and practice that will be ready for broader implementation in the field. The CTIPP grants will fund clinical training for practitioner teams spanning multiple disciplines. The program may complement the Teaching Health Center Graduate Medical Education program which supports clinical training for medical residents. The CTIPP grants will also support the development of new infrastructure and other supports (e.g., recruitment, retention and training strategies) needed for interprofessional practice. The teams will include, at a minimum, physicians, physician assistants, oral health practitioners, nurse practitioners and nurses, and may also include behavioral health, allied health and other practitioners (e.g., community health workers), as well as health care administrators. The training grants will include support for the development of this type of clinical training program, as well as direct financial support to students participating in the program.

Need: New models of interprofessional clinical practice are needed that achieve the key health care goals of better care, improved health outcomes, and lower cost. Interprofessional education and training experiences in interprofessional collaborative practice environments can facilitate the development of a health care workforce that is capable of providing high quality, high-value care to patients, families and communities in new and transforming delivery systems. Many academic health centers, where most health professionals are trained, have embraced the principles and elements of interprofessional education (IPE) and the need for delivery systems to achieve better health outcomes, at a lower cost, for the population served.

HRSA has made investments through its grant programs to provide increased interprofessional education opportunities for physicians, dentists, nurses, and public and behavioral health providers to increase their exposure to the concepts of interprofessional education and collaborative team-based care. Still, HRSA supported trainees too often have limited opportunities to get experiential clinical training in collaborative, team-based care delivery environments. Establishing and supporting a network of interprofessional clinical practice environments is necessary to better leverage HRSA's existing interprofessional education training investments and to forge efficient partnerships between academia and health care delivery systems.

Eligible Entities:

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Physicians (family medicine, general internal medicine, general pediatrics, and combined internal medicine and pediatrics) • Physician assistants • Nurses (including advanced practice nurses) • Dentists • Dental hygienists • Behavioral Health • Allied Health	• Graduate and undergraduate students in medicine, nursing, dentistry, behavioral health, allied health and other health care fields	• Plan and implement innovations in health professions education and training to support interprofessional primary care practice. • Provide community based training for interprofessional primary care teams. • Provide financial support to students participating in training and education around interprofessional primary care practice.

Program Accomplishments: This is a new initiative with no programmatic history.

Funding History

FY	**Amount**
FY 2011	---
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	$10,000,000

Budget Request
This is a new initiative. The FY 2015 Budget Request is $10,000,000. The FY 2015 Request is $10,000,000 above the FY 2014 Enacted level. This request will support approximately 19 awards of approximately $500,000 per year for five years, pending the availability of funds. A multi-year, longitudinal evaluation will be conducted, as well. The funding announcement

developed for this initiative will prioritize applications from organizations that develop their projects in partnership with HRSA-funded service delivery programs (e.g., Community Health Centers, Ryan White programs) that have achieved documented quality standards (e.g., designation as a PCMH or achievement of key patient outcome performance measures).

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
To Be Determined	---	---	**Set Baseline**	---

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	---	---	19
Average Award	---	---	$500,000
Range of Awards	---	---	$500,000

Public Health Workforce Development

Public Health and Preventive Medicine

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$7,683,000	$18,177,000	$18,177,000	---
Total Program Level	$7,683,000	$18,177,000	$18,177,000	---
FTE	2	4	4	---

Authorizing Legislation: Sections 765, 766, 767 and 768 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2015 Authorization……..Unspecified

Funding Allocation.....Competitive Grant

Program Goal and Description: The Public Health and Preventive Medicine program includes funding for the following grant programs:

- Public Health Training Centers (PHTC) Program - Funds schools of public health and other programs that provide graduate or specialized training in 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. Education and training provided by the PHTC Program reflect the core public health competencies as defined by the Council on Linkages between Academia and Public Health Practice and support essential public health services.

- Public Health Traineeship (PHT) Program - Provides grants to accredited institutions for the provision of graduate or specialized training in public health through traineeships for students in biostatistics, epidemiology, environmental health, toxicology, nutrition, or maternal and child health.

- Preventive Medicine Residency (PMR) Program - Supports post-graduate physician training by funding the planning, development, operation, or participation in approved residency programs in preventive medicine and public health. Preventive medicine physicians are uniquely trained in both clinical medicine and public health in order to promote, and maintain health and well-being and reduce the risks of disease, disability, and death in individuals and populations.

Integrative Medicine Program (IMP) – Supports a national center of excellence for integrative primary care, funded for three years in FY 2014, on integrative primary care for the purpose of developing and disseminating best practices for integrative medicine training for physicians and nurses, psychologists, and other primary care and behavioral health professionals. The national center will actively promote the use of evidence-based curricula for integrative primary care in medical residency programs.

Need: The strength of the public health system rests on its ability to deliver essential public health services, and a capable and qualified public health workforce is a key factor in an organization's ability to deliver those essential services**.** Public health workers protect and improve the health of communities through education, disease prevention and health promotion, monitoring, research, and provision of services to address community health problems. The Institute of Medicine and other have identified a need for more physicians in primary care careers, as well as the need for more experienced public health professionals equipped to address the growing burden of chronic disease in this country is predicted.[80] [81] Public health workers need foundational training in core public health skills and competencies as well as education and training to maintain and upgrade their skills.

Program	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Public Health Training Centers Program	$4,593,000	$9,864,000	$13,064,000
Public Health Traineeships	---	$2,500,000	---
Preventive Medicine Residency Program	$3,090,000	$3,813,000	$5,113,000
Integrative Medicine	---	$2,000,000	---

Public Health Training Centers Program

The Public Health Training Centers (PHTC) program—which falls under BHPr's Public Health and Preventive Medicine programs—aims to strengthen the workforce in 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 and to provide essential services. Beginning in FY 2014, the PHTC program will be reorganized and strengthened, with an emphasis on distance learning (modeled after successful distance learning programs in higher education) and on building the public health workforce capacity to provide essential public health services as a complement to CDC efforts focused largely on basic public health sciences. The network is envisioned to encompass 25-30 individual PHTCs supporting the public health workforce across a geographic region of 1-5 states, depending on the size of the public health workforce and the nature of the public health needs in the geographic areas to be served. The redesigned PHTC

[80] Institute of Medicine. Committee on Training Physicians for Public Health Careers. *Training Physicians for Public Health Careers.* The National Academies Press. 2007

[81] Bodenheimer T, Chen E, Bennett HD. Confronting the Growing Burden of Chronic Disease: Can the U.S. Health Care Workforce Do the Job? *Health Affairs* January 2009 vol. 28 no. 1 64-74.

network will be brought to scale in FY 2015, following an initial planning and redesign phase occurring in FY 2014.

Eligible Entities: Accredited schools of public health or other public or nonprofit private institutions accredited for the provision of graduate or specialized training in public health.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Public health workforce including nurses, physicians, dentists, veterinarians, social workers, epidemiologists, nutritionists, sanitarians, and others.	• Graduate public health professional students • Existing public health professionals at all levels in the workforce	• Provide graduate or specialized training in public health in the areas of preventive medicine, health promotion and disease prevention, and improve access to and quality of health services in medically underserved communities. • Establish or strengthen field placements for students. • Involve faculty and students in collaborative projects to enhance public health services to medically underserved communities. • Assess the health personnel needs of the service area and assist in the planning and development of training programs to meet such needs.

Program Accomplishments: In Academic Year 2012-2013, grantees of the Public Health Training Centers (PHTC) program supported various types of training activities for public health students and their faculty, as well as for members of the current public health workforce. With regard to the continuing education (CE) of the current workforce, PHTC grantees delivered over 1,800 CE courses to over 207,000 trainees during the academic year. On average, each CE course was offered between one and two times; lasted about 4.5 hours; had about 32 trainees; was delivered either entirely online or included a web-based component; was geared primarily toward entry-level public health workers; and focused on competencies in the areas of either analytics, community dimensions of practice, or public health sciences. It is estimated that close to 1 out of every 4 trainees who was trained through CE activities reported being employed in a medically underserved community and/or rural area.

As required by the authorizing legislation for the PHTC program, grantees used funds to coordinate field placements for over 1,200 graduate-level public health students across the country. Results showed that the majority of students who participated in field placements were female (76%); between the ages of 20-29 (76%); in the second year of their graduate program (60%); and received some level of stipend support to help defray costs associated with tuition and reasonable living expenses (56.5%). Further analyses of data showed that about 1 out of every 5 students who participated in field placements coordinated through the PHTC program reported coming from a financial and/or educational disadvantaged background and/or are considered underrepresented minorities in the public health profession. Information provided about sites used showed that grantees partnered with over 700 different public health

organizations in over 35 states to place public health students during the academic year; of these, 53% of sites were located in a medically underserved community.

For the first time, data were collected regarding other types of activities that are required to be carried out through the PHTC program. For example, PHTC grantees are required to use funds to support faculty-student collaboration projects that address emerging public health issues in communities located in each grantee's geographical service area. Results obtained from the implementation of new performance measures showed that PHTC grantees supported over 150 different faculty-student collaboration projects that primarily focused on assisting community-based organizations with developing and conducting needs assessments and/or developing and implementing evidence-based public health programming. It is estimated that over 400 faculty members and over 1,100 students across the health professions participated in these types of projects during the academic year.

Public Health Traineeship Program

The Public Health Traineeship (PHT) program—which falls under BHPr's Public Health and Preventive Medicine programs—aims to increase the number of professionals trained in public health fields of which there is a shortage in the United States.

Eligible Entities: Schools of public health, other public or nonprofit private entities accredited by the Council on Education for Public Health, and other public or nonprofit private institutions.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Public health workforce in the designated public health shortage fields.	• Graduate (Master's and doctoral)	• Support graduate education in public health in the fields of epidemiology, environmental health, biostatistics, toxicology, nutrition, and maternal and child health. • Award traineeships to individuals to provide for tuition, fees, stipends, and allowances for reasonable living expenses.

Program Accomplishments: In Academic Year 2012-2013, the PHT program supported a total of 425 public health students. Results showed that the majority of students supported were: female (76%); between the ages of 20-29 (73%); enrolled in a Masters of Public Health (MPH) degree in Epidemiology, Environmental Health or Health Policy and Management; and received a median award amount of $1,526. Further analyses of data showed that 46% of public health students supported are considered underrepresented minorities in their prospective profession and about 25% of students supported reported coming from a disadvantaged background. A total of 106 out of the 425 students supported completed their degree program by the end of the academic year. Nearly 53% of graduates indicated an intention to pursue employment or further training in a medically underserved community.

Preventive Medicine Residency Program

The Preventive Medicine Residency (PMR) program—which falls under BHPr's Public Health and Preventive Medicine programs—aims to increase the number of preventive medicine physicians in public health specialties.

Eligible Entities: Accredited schools of public health, allopathic or osteopathic medicine; accredited public or private nonprofit 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.

Program Accomplishments: In Academic Year 2012-2013, the Preventive Medicine Residency (PMR) grant program supported a total of 55 residents—most of which were completing residencies in either General Preventive Medicine or a dual-focused residency in Preventive Medicine and Public Health. The majority of residents supported through the program were female (71%); between the ages of 30 and 39 (64%); in the last year of their residency (53%); and received clinical or experiential training in a primary care setting (58.2%) and/or a medically underserved community (76.4%). Further analyses of data showed that about 1 out of every 5 residents supported through the program reported coming from a financial or educational disadvantaged background and about 1 out of every 4 residents are considered underrepresented minorities in their prospective profession. During the academic year, 26 out of the 55 residents completed their residency; of these, approximately 1 out of every 2 residents indicated an intention to work or pursue further training in a medically underserved community, while 1 out of every 4 residents indicated an intention to work or pursue further training in primary care.

For the first time, data were collected regarding other types of activities that are required to be carried out through the PMR grant program. For example, PMR grantees are required to use funds to support infrastructure-related activities (e.g., curriculum development and enhancement). Results obtained from the implementation of new performance measures showed that PMR grantees developed and implemented 15 different curricular and other training-related activities---most of which were new or enhanced courses or clinical rotations for residents and faculty in the preventive medicine residency program.

Integrative Medicine Program

The Integrative Medicine Program (IMP) program—which falls under BHPr's Public Health and Preventive Medicine program— supports a national center for excellence in integrative primary care. The center delivers technical assistance, conducts evaluation, builds the evidence based for integrative primary care and integrates that information into curricula for residency training, provides leadership for the integrative medicine grantees, disseminates information on the process and outcomes of the integrative primary care curricular initiatives and promotes integration of evidence based curricula regarding integrative primary care into medical residencies.

Eligible Entities: Eligible entities for the national center of excellence are nonprofit entities with a strong record of leadership in the field of integrative medicine curriculum development.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Primary care physicians • Nurses • Psychologists • Other primary care and behavioral health professionals	• Residency training • Continuing Education	• Provide technical assistance to residency programs • Evaluate integrative medicine residency programs Provide leadership for integrative medicine residency programs • Disseminate information on process and outcomes of integrative primary care curricular activities • Support subawards for integrative medicine residency training

Program Accomplishments:

In Academic Year 2012-2013, the Integrative Medicine Program (IMP) supported the training of 59 residents across 15 different types of preventive medicine residency programs. The majority of residents trained through the program were female (58%); between the ages of 30 and 39 (63%); and primarily received clinical or experiential training in physician offices and hospitals across the country. Further analyses of data showed that about 1 out of every 5 residents trained through the program are considered underrepresented minorities in their prospective profession. During the academic year, 22 out of the 59 residents completed their residency; of these, approximately 2 out of every 5 residents indicated an intention to work or pursue further training in a medically underserved community, while 1 out of every 3 residents indicated an intention to work or pursue further training in primary care.

For the first time, data were collected regarding other types of activities that are required to be carried out through the IMP. For example, IMP grantees are required to use funds to support infrastructure-related activities (e.g., curriculum development and enhancement), as well as faculty development. Results obtained from the implementation of new performance measures

showed that IMP grantees developed and implemented 33 different curricular and other training-related activities---most of which were new or enhanced courses or clinical rotations for residents and faculty in the preventive medicine residency program. Lastly, the IMP supported over 25 different faculty development activities across the 12 grants that focused on providing specialized training opportunities on integrative medicine to current preventive medicine faculty. It is estimated that over 150 faculty-level trainees were trained as a result of these activities.

Funding History

FY	Amount
FY 2011	$9,609,000
FY 2011 (PPHF)	$20,000,000
FY 2012	$8,144,000
FY 2012 (PPHF)	$25,000,000
FY 2013	$7,683,000
FY2014	$18,177,000
FY 2015	$18,177,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, and Information Technology costs.

Budget Request

The FY 2015 Budget Request is $18,177,000. The FY 2015 Request is the same as the FY 2014 Enacted level and will provide continuation funding for Public Health Training Centers and 3 Preventive Medicine Residency grants. The national center for excellence in integrative primary care will continue operations with funding provided in FY 2014. The Budget proposes to include Public Health Traineeship grants in the Science, Technology, Engineering, and Mathematics (STEM) Education reorganization proposal.

Outcomes and Outputs Tables

The table below includes some developmental performance measures for activities supported through the Prevention and Public Health Funds. Because these activities have not yet been initiated and baselines have not been established, these measures may require revisions when they are implemented.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [82]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
6.I.C.9: Number of trainees participating in continuing education sessions delivered by PHTCs	207,543 Target: 205,645 (Target Exceeded)	23,000[83]	23,000	Maintain
6.I.C.18: Number of instructional hours offered by PHTCs	13,711 (Baseline)[84]	9,320	9,320	Maintain
6.I.C.19: Number of PHTC-sponsored public health students that completed field placement practicums in State, Local, and Tribal Health Departments	277[85] (Baseline)	150[86]	150	Maintain
6.I.C.14: Number of residents enrolled in preventive medicine programs that have incorporated evidence-based integrative medicine principles into the curriculum (including both practica and	--[87]	N/A[88]	N/A	N/A

[82] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.
[83] Targets reduced to reflect cohort effects.
[84] Baseline for this measure will be in FY 2012.
[85] Baseline for this measure will be in FY 2012.
[86] Target reflects cohort effects.
[87] Baseline for this measure will be in FY 2013.
[88] Program was discontinued in FY 2014. HRSA will report outputs for FY 2012 and FY 2013.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [82]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
didactic academic course work)				
6.I.C.15: Number of technical assistance consultations provided by the National Coordinating Center for Integrative Medicine (NccIM)	--[89]	N/A[90]	N/A	N/A
Number of residents participating in residencies	55 Target: 45 (Target Exceeded)	40	55	+15
Number of residents completing training	26 Target: 20 (Target Exceeded)	15	20	+5
Number of URM residents completing training	7 Target: 9 (Target Exceeded)	7	N/A[91]	N/A
Percent of URM residents completing training	27% Target: 20% (Target Exceeded)	20%	N/A[92]	N/A

[89] Baseline for this measure will be in FY 2013.
[90] Program was discontinued in FY 2014. HRSA will report outputs for FY 2012 and FY 2013.
[91] Measure was discontinued in FY 2014.
[92] Measure was discontinued in FY 2014.

Grant Awards Table – Public Health Training Centers Program
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	37	11	11
Average Award	$110,000	$850,000	850,000
Range of Awards	$100,000-$150,000	$650,000-$1,100,000	$650,000-$1,100,000

Grant Awards Table – Public Health Traineeships
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	---	30	---
Average Award	---	$83,000	---
Range of Awards	---	$50,000-$100,000	---

Grant Awards Table – Preventive Medicine Residency Program
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	8	10	13
Average Award	$380,000	$380,000	$380,000
Range of Awards	$300,000-$600,000	$300,000-$600,000	$300,000-$600,000

Grant Awards Table – Integrative Medicine Program
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	----	1	----
Average Award	----	$2,000,000	----
Range of Awards	----	$2,000,000	----

Nursing Workforce Development

Advanced Nursing Education

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$59,943,000	$61,581,000		-$61,581,000
PHS Evaluation Funds			$61,581,000	+$61,581,000
FTE	6	6	6	---

Authorizing Legislation: Section 811, Public Health Service Act, Title VIII, as amended by the Affordable Care Act

FY 2015 Authorization ..... Such Sums as Necessary

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

Program Goal and Description: The Advanced Nursing Education Programs provide funding for institutions to create or expand projects that support the enhancement of advanced nursing education and practice. The Advanced Nursing Education Programs are comprised of the following:

- Advanced Nursing Education (ANE) Grants - The goal of the ANE grants is to increase the supply of advanced practice nurses. These grants provide funding for institutions to enhance their instructional programs for advanced nursing education and practice, including nurse practitioners, clinical nurse specialists, nurse midwives, nurse anesthetists, nurse administrators, public health nurses and other specialties requiring advanced education. Examples of activities include curriculum development, training in new technologies and interprofessional practice.

- The Advanced Education in Nursing Traineeship (AENT) –. This program aims to increase the number of advanced education nurses or nurse midwives who are trained to practice in primary care. The program awards grants to accredited institutions in order to provide traineeships. The grants support all or part of the costs of tuition, books, and fees of the program of advanced nurse education, and the reasonable living expenses of the individual during the traineeship.

- Nurse Anesthetist Traineeship (NAT) – The goal of the NAT program is to increase the number of nurse anesthetists especially for underserved populations or for people who are underrepresented in the health care workforce. The program awards grants to accredited institutions that train nurse anesthetists in order to support traineeships. The

grants support all or part of the costs of tuition, books, fees and reasonable living expenses of the individual during the traineeship.

Need: The combined factors of an aging workforce and population growth are expected to result in increased demand for health care services, in particular primary care services. Advanced practice registered nurses (APRNs) are a critical part of the primary care workforce and will be needed in growing numbers to meet this increasing demand. Building this workforce will require support for advanced nursing education students, specifically those electing primary care practice disciplines. In addition, this program is responsive to the evolving health care needs of patients and families and to ensure that advanced nursing education programs prepare nurses with the skills to meet these needs and provide care in complex, high-tech health care systems that are moving to team-based models of care.

Advanced Nursing Education Programs

Programs	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Advanced Nursing Education	$34,943,000	$36,581,000	$36,581,000
Advanced Education Nursing Traineeship	$22,750,000	$22,750,000	$22,750,000
Nurse Anesthetist Traineeship	$2,250,000	$2,250,000	$2,250,000

Advanced Nursing Education Grants

The ANE grants support advanced education program development in schools of nursing and seek to increase the size and quality of the advanced practice nurse workforce.

Eligible Entities: Schools of nursing, academic health centers, and other private or public entities accredited by a national nursing accrediting agency recognized by the Secretary of the U.S. Department of Education.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Nurse practitioners • Clinical nurse specialists • Nurse midwives • Nurse anesthetists • Nurse educators • Nurse administrators • Public health nurses	• Graduate (master's and doctoral)	• Build and enhance advanced nursing education programs.

Program Accomplishments: The Advanced Nursing Education (ANE) grants fund a number of activities—including several traineeships and an expansion program with the aim to increase the size of the advanced nursing workforce. In Academic Year 2012-2013 (FY 2012), grantees of the ANE program trained 10,060 nursing students and this exceeded the program's performance target of 6,255 by 61%. This program also produced a total of 1,865 graduates—exceeding program performance target of 1,785. Forty one (41%) percent of students trained were underrepresented minorities and/or from disadvantaged backgrounds, this exceeded performance target of 24%.

In Academic Year 2012-2013, the Advanced Nursing Education Expansion (ANEE) program supported a total of 381 graduate-level nursing students across 22 different types of Nurse Practitioner programs. Of the 381 students supported, 148 graduated by the end of the academic year. Results showed that the majority of students supported (59%) graduated from a Masters- or Doctoral-level Nurse Practitioner program with a focus on Family (a recognized primary care discipline in the field of nursing); were female (89%); between the ages of 20 and 29 (41%); and received clinical training in medically underserved communities (96%) and/or primary care settings (69%) during the academic year. It is estimated that 1 out of every 4 students who graduated are considered an underrepresented minority in the field of nursing and that about 1 out of every 5 students who graduated report coming from a financial and/or educational disadvantaged background. Lastly, data reported at the time of graduation showed that about 52% of graduates intend to pursue employment or further training in medically underserved communities across the country.

To date, the ANEE program has produced a total of 249 Nurse Practitioners—101 in Academic Year 2011-2012 and 148 in Academic Year 2012-2013. While the program was not projected to produce this many Nurse Practitioners by this date, difficulties in recruitment led to grantees distributing funds to first and second year nursing students during the initial year of the program; as a result, 101 second-year nursing students were supported and ultimately graduated from their nursing programs in Academic Year 2011-2012. The funding of these 101 students has caused the program to significantly exceed the number of Nurse Practitioners it was expected to produce by the end of Academic Year 2012-2013 (Target: 110; Actual: 249).

Advanced Education Nursing Traineeship Program

The Advanced Education Nursing Traineeship (AENT) program aims to increase the number of advanced education nurses trained to practice as primary care nurse practitioners or nurse midwives by providing traineeships to offset the costs of tuition, textbooks and reasonable living expenses.

Eligible Entities: Schools of nursing, academic health centers, and other private or public entities accredited by a national nursing accrediting agency recognized by the Secretary of the U.S. Department of Education.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Nurse practitioners • Clinical nurse specialists • Nurse midwives • Nurse anesthetists • Nurse educators • Nurse administrators • Public health nurses	• Graduate (master's and doctoral)	• Provide education and training for nurses to provide quality primary health care in homes, ambulatory care, long-term care, acute care, and other health care settings. • Provide traineeships for tuition, fees, books, and reasonable living expenses.

Nurse Anesthetist Traineeship Program

The NAT program aims to increase access to nurse anesthetist care for underserved populations who are underrepresented in the health care workforce.

Eligible Entities: Schools of nursing, academic health centers, and other private or public entities accredited by a national nursing accrediting agency recognized by the Secretary of the U.S. Department of Education.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Nurse anesthetists	• Graduate programs in nurse anesthesia (master's and doctoral)	• Supports education of nurse anesthetists to provide quality health care in underserved areas, including Health Professional Shortage Areas (HPSAs). • Provide traineeships for tuition, fees, books, and reasonable living expenses.

Program Accomplishments: The AENT program was previously a formula-based program that supported nurses of all disciplines. The program has been redesigned and now places an increased emphasis on supporting nursing students who will specialize in primary care, and awards are now determined through an objective review process rather than a formula.

In Academic year 2012-2013 (FY 2012), grantees of the AENT and the NAT programs exceeded performance targets regarding the number of traineeships supported in FY 2012. Analysis of performance data showed that grantees of the AENT and NAT programs provided direct financial support to 5,545 nursing and nurse anesthesia students—exceeding the program's performance target of 2,910 by 90%. Among students supported, 1,708 graduated and were ready to enter the workforce and this exceeded the program's performance target of 1,510. Furthermore, the number of minority or disadvantaged students supported in academic year 2012-2013 was 1,585—exceeding performance target by 2%. Further analysis showed that 773

(35%) students who graduated from AENT and NAT programs in academic years 2012-2013 (FY 2012) entered practice in a medically underserved community.

Funding History

FY	Amount
FY 2011	$64,046,000
FY 2012	$63,469,000
FY 2013	$59,943,000
FY 2014	$61,581,000
FY 2015	$61,581,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, technical assistance and related program outreach activities, and activities of the National Advisory Council on Nurse Education and Practice which is charged with the responsibility of advising the Secretary and Congress on PHS Title VIII Nursing Workforce Development programs, and Information Technology costs.

Budget Request

The FY 2015 Budget Request is $61,581,000. The FY 2015 Request is the same as the FY 2014 Enacted level, which will allow BHPr to continue investing in advanced nurse education. HRSA is also evaluating whether recent changes in the Advanced Education Nursing Traineeship (AENT) program have improved enrollment and graduation rates. Since FY 2012, the applications have been objectively reviewed to identify schools with particularly strong advanced nursing education curriculum and infrastructure.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [93]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
6.1.C.7: Number of Primary Care Nurse Practitioner students supported[94]	381 Target: 300 (Target Exceeded)	300	300	Maintain
6.1.C.3.c: Number of nurse practitioners who complete their education through HRSA's Bureau of Health Professions	249 Target: 110 (Target Exceeded)	430	600	+170

[93] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.
[94] Outputs are based on forward-funded grants.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [93]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
programs supported with Prevention and Public Health funding (cumulative)[95]				
6.1.C.4.c: Number of nurse practitioners receiving training through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding (Cumulative)[96]	483 Target: 260 (Target Exceeded)	600	N/A	N/A
Number of students trained	10,060 Target: 6,255 (Target Exceeded)	6,255	6,255	Maintain
Proportion of students trained who are underrepresented minorities and/or from disadvantaged backgrounds[97]	41% Target: 24% (Target Exceeded)	24%	24%	Maintain
Number of graduates from advanced nursing degree programs[98]	1,865 Target: 1,785 (Target Exceeded)	1,485	1,485	Maintain
Number of students supported in AENT program	--	--	Set Baseline	N/A
Number of graduates from AENT program	--	--	Set Baseline	N/A
Number of students supported in NAT program	--	--	Set Baseline	N/A
Number of graduates from NAT program	--	--	Set Baseline	N/A

[95] Outputs are based on forward-funded grants.
[96] This measure reflects the number of nurse practitioner and nurse midwife students who received funding through the ANEE program annually.
[97] The wording for this measure has been revised from previous budget documents to better reflect measures collected.
[98] The wording for this measure has been revised from previous budget documents to better reflect measures collected.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [93]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
Percent of graduates from AENT and NAT programs employed in underserved areas	--	--	Set Baseline	N/A
Number of students supported	5,545 Target: 2,910 (Target Exceeded)	3,775	N/A[99]	N/A
Number of graduates supported	1,708 Target: 1,510 (Target Exceeded)	2,425	N/A[100]	N/A
Number of graduates practicing in underserved areas	773 Target: 780 (Target Not Met)	1,050	N/A[101]	N/A
Number of minority or disadvantaged students trained	1,585 Target: 1,560 (Target Exceeded)	1,560	N/A[102]	N/A

Grant Awards Table – ANE

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	103	120	120
Average Award	$339,252	$320,575	$320,575
Range of Awards	$79,500-589,400	$79,500-589,400	$79,500-589,400

[99] Measure will be discontinued in FY 2014.
[100] Measure will be discontinued in FY 2014.
[101] Measure will be discontinued in FY 2014.
[102] Measure will be discontinued in FY 2014.

Grant Awards Table – AENT

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	70	125	125
Average Award	$325,000	$342,000	$342,000
Range of Awards	$165,000-$330,000	$220,000-$440,000	$220,000-440,000

Grant Awards Table – NAT

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	80	82	82
Average Award	$28,125	$27,439	$27,439
Range of Awards	$2,800-69,000	$2,800-69,000	$2,800-69,000

Nursing Workforce Development

Nursing Workforce Diversity

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$14,984,000	$15,343,000	$15,343,000	--
FTE	1	1	1	---

Authorizing Legislation: Section 821 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2015 Authorization ..... Such Sums as Necessary

Allocation Method ..... Competitive Grant/Contract

Program Goal and Description: The Nursing Workforce Diversity (NWD) program helps create a more diverse nursing workforce by increasing nursing education opportunities for individuals from disadvantaged backgrounds, including racial and ethnic minorities underrepresented among registered nurses. The program supports: student stipends and scholarships, pre-entry preparation, advanced education preparation, and retention activities. The NWD program will increase nursing education opportunities for individuals from disadvantaged backgrounds to produce a more diverse nursing workforce. The program will help meet the increasing need for culturally competent, quality health care for the nation's rapidly diversifying population and help close the gap in health disparities.

Need: A diverse health care workforce with diverse leadership is necessary to help meet the needs of a diverse population and reduce health disparities and inequities. A U.S. HHS Office of Minority Health report identifies 14 principles for minority health equity, including the recommendation for health care professional schools and the health care workforce to represent and reflect the diverse communities.[103] The 2008 National Sample Survey of Registered Nurses reports that only 17 percent of the nursing workforce comes from racial/ethnic minority groups.

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, and tribes and tribal organizations.

[103] U.S. Department of Health and Human Services, Office of Minority Health, (July, 2009). Ensuring that health care reform will meet the health care needs of minority communities and eliminate health disparities, Available at: http://minorityhealth.hhs.gov/Assets/pdf/Checked/1/ACMH_HealthCareAccessReport.pdf

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Registered Nurses (RNs) • Second degree students	• Pre-Entry Preparation - middle school students - high school students - high school graduates or equivalent - certified nursing assistants - licensed practical or vocational nurses • Diploma or Associate Degree RNs • Individuals with bachelor's degree in another discipline • RNs who matriculate into accredited bridge or degree completion program within the three-year project period. • Baccalaureate degree	• Use academic, social and financial supports to support basic preparation and educational advancement of disadvantaged and minority nurses for leadership positions within the nursing profession and the health care community. • Support pre-entry academic advising, mentoring, and enrichment activities. • Prepare diploma or associate degree RNs to become baccalaureate-prepared RNs. •

Program Accomplishments: In Academic year 2012-2013, (FY 2012) the focus of the Nurse Workforce Diversity program continued to reflect a higher emphasis on students and graduates of diploma and college-level nursing programs over those at the elementary/secondary levels. Changes in the focus of the program were made in an attempt to ultimately increase the number of nursing graduates eligible to take the licensing exam. As a result, FY 2012 performance targets regarding the number of program participants at the elementary/secondary levels were not met; however number of college and pre-entry nursing program participants was 2,279 and this exceeded performance target of 1,300 by over 100%.

Results showed that number of nursing program students trained was 5,058—exceeding target of 3,350 by 51%. Furthermore, 1,234 nursing students graduated from nursing programs and this also exceed program target of 950 by 23%. Analysis of performance data for FY 2012 revealed that grantees of the NWD program provided scholarships to 1,478 students—exceeding the program's performance target of 735 by over 100%. Performance measures and related targets for FY 2014 and beyond will be adjusted to reflect modifications in the focus of the NWD program so as to better capture appropriate outputs and outcomes.

Funding History

FY	Amount
FY 2011	$16,009,000
FY 2012	$15,819,000
FY 2013	$14,984,000
FY 2014	$15,343,000
FY 2015	$15,343,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, technical assistance and related program outreach activities, and activities of the National Advisory Council on Nurse Education and Practice which is charged with advising the Congress and Secretary on PHS Title VIII Nursing Workforce Development programs, and Information Technology costs.

Budget Request

The FY 2015 Budget Request is $15,343,000. The FY 2015 Request is the same as the FY 2014 Enacted level. This request will fund the education of pre-nursing and nursing students to become registered nurses and the preparation of participants for entry into a professional nursing program through pre-entry preparation, retention and stipend/scholarship program activities.

Outcomes and Outputs Tables

Measure	**Year and Most Recent Result /Target for Recent Result / (Summary of Result)** [104]	**FY 2014 Target**	**FY 2015 Target**	**FY 2015 Target +/- FY 2014 Target**
Percent of program participants who are underrepresented minorities and/or from disadvantaged backgrounds	---	---	95%	---
Percent of program participants who completed pre-college preparation training and intend to apply to a nursing degree program	---	---	Set Baseline	---
Percent of program participants who received academic retention support and maintained enrollment in a nursing degree program	---	---	Set Baseline	---
Percent of underrepresented minority	59% Target: 70%	70%	N/A[105]	---

[104] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.
[105] Measure will be discontinued in FY14.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [104]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
students	(Target Not Met)			
Percent of white disadvantaged students/participants	35% Target: 27% (Target Exceeded)	35%	N/A[106]	---
Number of nursing program students	5,058 Target: 3,350 (Target Exceeded)	2,500	N/A[107]	---
Number of post high school, college, and pre-entry nursing students	2,779 Target: 1,300 (Target Exceeded)	300	N/A[108]	---
Number of K-12 students/participants	4,240 Target: 5,900 (Target Not Met)	1,500	N/A[109]	---
Number of nursing students graduating from nursing programs	1,234 Target: 950 (Target Exceeded)	750	N/A[110]	---
Number of nursing students expected to receive scholarships	1,478 Target: 735 (Target Exceeded)	1,000	N/A[111]	---

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	41	45	45
Average Award	$338,000	$316,000	$316,000
Range of Awards	$112,000-$523,000	$135,000-$528,000	$135,000-$528,000

[106] Measure will be discontinued in FY14.
[107] Measure will be discontinued in FY14.
[108] Measure will be discontinued in FY14.
[109] Measure will be discontinued in FY14.
[110] Measure will be discontinued in FY14.
[111] Measure will be discontinued in FY14.

Nursing Workforce Development

Nurse Education, Practice, Quality and Retention Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$37,113,000	$38,008,000	$38,008,000	---
FTE	4	4	4	---

Authorizing Legislation: Section 831 and Section 831A of the Public Health Service Act, as amended by the Affordable Care Act

FY 2015 Authorization Section 831 .....Expired FY 2014

FY 2015 Authorization Section 831A……Expired FY 2012

Allocation Method .....Competitive Grant/Contract

Program Goal and Description: The Nurse Education, Practice, Quality and Retention (NEPQR) Program is broad in scope and supports initiatives to expand the nursing pipeline, promote career mobility, enhance nursing practice, increase access to care and interprofessional clinical training and practice, and support retention. This program seeks to build and expand nursing educational programs to increase the number of qualified nurses in the health care workforce.

Need: A growing and aging population continues to increase the demand for nursing services. At the same time, the nursing workforce is steadily aging and projected retirements from the workforce are expected to significantly shrink the supply of qualified personnel. The NEPQR program seeks to address this gap by increasing our nation's nursing workforce capacity and addressing the inequitable distribution of the nursing workforce across the United States. Grant support is provided for academic, service, and continuing education projects designed to enhance nursing education, improve the quality of patient care, increase nurse retention and strengthen the nursing workforce.

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

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Registered nurses • Certified nursing assistants • Home health aides • Licensed practical nurses	• Baccalaureate education • Advanced nursing education • Licensed practical nurses • Certified nursing	• Expand enrollment in baccalaureate nursing programs. • Provide education in new technologies including distance learning methodologies.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Licensed vocational nurses	assistants • Home health aides	• Develop internships and residency programs. • Develop career ladder programs to promote career mobility in nursing. • Develop cultural competencies. • Offer programs to promote nurse retention. • Skill development in care enhancements congruent with emerging health care systems. • Increase access to care for underserved and high-risk populations and interprofessional clinical training and practice for basic and advanced practice nurses.

Program Accomplishments: The Nurse Education, Practice, Quality and Retention program (NEPQR) program has a variety of legislative goals and purposes that ultimately aim to increase the size, preparation and quality of the nursing workforce. In Academic year 2012-2013, a number of grants were funded to support several of the program's legislative purposes such as expanding the size of academic programs that are able to confer a baccalaureate degree of science in nursing (BSN); recruiting and training individuals as qualified personal and home care aides in occupational shortage and/or high demand areas; training qualified nursing assistants and home health aides to meet the growing healthcare needs of the aging population; and/or supporting nurse-managed health clinics that serve as primary care access points in areas where primary care providers are in short supply.

With regard to the expansion of BSN degree programs, the NEPQR program funded 10 expansion projects which resulted in the training of over 1,600 BSN students during academic year. Of these, a total of 416 graduated and will enter the workforce as baccalaureate-level nurses. The NEPQR program was not able to meet its goal of funding 22 expansion projects, as recent funding opportunities have been specific to other purposes of the program. Performance targets for FY 2014 and beyond will be adjusted to take into account the current and expected number of grants that will be funded to focus on BSN program expansion, as well as other purposes of the NEPQR program.

The NEPQR program also funded a number of grants to focus on the recruitment and training of individuals as qualified nursing assistants and personal and home care aides. Results showed that over 4,600 individuals completed these types of NEPQR-supported programs –exceeding the performance target of 1,723 by over 100%. Further analysis revealed that a total of 1,336 students received financial support to help defray costs associated with tuition during the academic year. It is estimated that 7 out of every 10 students who received support reported coming from a disadvantaged background and about 3 out of every 10 students who received support are considered underrepresented minorities in this profession.

Lastly, the NEPQR program funded several Nurse Managed Health Clinics (NMHC) with the primary purpose of serving as clinical training sites for students across the health professions. It is estimated that over 1,600 health professions students were trained as a result of these activities—though the majority of students trained at BHPr-supported NMHCs were nursing students pursuing a graduate-level nurse practitioner degree in family care. Results from the analyses of demographic data showed that the majority of students trained at HRSA-supported NMHCs were female (82%) and between the ages of 20-29 (72.1%). Further analyses of data showed that the majority of NMHCs and associated training sites were primarily located in medically underserved communities (97%) and served as a primary care setting for their local community (65%).

Funding History

FY	Amount
FY 2011	$39,653,000
FY 2012	$39,638,000
FY 2013	$37,113,000
FY 2014	$38,008,000
FY 2015	$38,008,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, technical assistance and related program outreach activities, and activities of the National Advisory Council on Nurse Education and Practice which is charged with advising the Secretary and Congress on PHS Title VIII Nursing Workforce Development programs, and Information Technology costs.

Budget Request

The FY 2015 Budget Request is $38,008,000. The FY 2015 Request is the same as the FY 2014 Enacted level. This request will fund projects to increase the educational opportunities, clinical practice skills, and utilization of the nursing workforce to enhance the quality of patient care. Projects to develop and disseminate collaborative practice models that incorporate the full range of health care workers in team-based care are of particular interest. BHPr is funding a National Center for Interprofessional Practice and Education (National Center) to provide infrastructure for leadership, expertise, and support to enhance the coordination and capacity building interprofessional practice and education among health professions across the U.S. and particularly in medically underserved areas.

The HRSA BHPr Performance Management Handbook (BPMH) Investment supports the Nurse Education, Practice, Quality and Retention Program with program administration, grants administration and monitoring, management reporting, and grantee performance measurement and analysis. The BPMH supports the strategic and performance outcomes of the Program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner.

Outcomes and Outputs Tables

The NEPQR program has several purposes and solicits applications addressing any of its education, practice and retention purposes, one of which is accelerated BSN education projects. The purposes of the NEPQR are broad and flexible, allowing the program to address the emerging needs in nursing workforce development to advance education and practice priorities. As the program adapts to these emerging needs and priorities in the future, new outcome measures will be added as appropriate.

Measure	**Year and Most Recent Result /Target for Recent Result / (Summary of Result)** [112]	**FY 2014 Target**	**FY 2015 Target**	**FY 2015 Target +/- FY 2014 Target**
6.I.C.6: Number of Personal Care and Home Health Aides completing training program	4,624 Target: 1,723 (Target Exceeded)	N/A[113]	N/A	---
Number of nursing students trained in interprofessional team-based care	---	---	Set Baseline	---
Number of interprofessional students trained in team-based care	---	---	Set Baseline	---
Number of expanded BSN education projects	10 Target: 22 (Target Not Met)	22	N/A[114]	---
Number of BSN student participants	1,645 Target: 4,860 (Target Not Met)	4,860	N/A[115]	---

[112] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.
[113] Program will be discontinued in FY13.
[114] Measure will be discontinued in FY14.
[115] Measure will be discontinued in FY14.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	97	89	90
Average Award	$366,000	$403,000	$415,000
Range of Awards	$48,000 - $772,000	$48,000 - $788,000	$134,000 - $788,000

Nursing Workforce Development

Nurse Faculty Loan Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$23,256,000	$24,562,000	$24,562,000	---
FTE	1	1	1	---

Authorizing Legislation: Section 846A of the Public Health Act, as amended by the Affordable Care Act

FY 2015 Authorization .....Expired FY 2014

Allocation Method .....Formula Grant

Program Goal and Description: The Nurse Faculty Loan Program (NFLP) supports the establishment and operation of a loan fund at participating schools of nursing to assist nurses in completing their graduate education to become qualified nurse faculty. The NFLP seeks to increase the number and diversity of qualified nursing faculty. Eligible schools receiving awards under the NFLP are required to contribute to the loan fund at least one-ninth of the award amount. Following graduation from the nursing program, the nursing school will cancel up to 85 percent of the loan principal and interest in exchange for the loan recipient's full-time nursing faculty service at a school of nursing, with a designated percentage cancelled each year for up to four years. The NFLP loans are repayable and/or cancelled over a ten-year repayment period.

Need: An insufficient number of qualified nursing faculty continues to be the primary barrier to accepting all qualified students at nursing colleges and universities. The current nurse faculty vacancy rate is particularly acute for doctorally-prepared faculty. Between 200-300 doctorally prepared faculty have been eligible for retirement annually over the past decade, and between 200-280 mastered-prepared faculty will be eligible to retire annually or over the next five years.[116] Equally pressing is lack of diversity in the nursing faculty ranks. A survey of nurse educators conducted by the National League for Nursing and the Carnegie Foundation's Preparation for the Professions Program found that only 7% of nurse educators were minorities compared with 16% of all U.S. faculty.[117] The lack of faculty diversity limits nursing schools' ability to deliver culturally-appropriate health professions education needed to address the needs of the nation's rapidly diversifying population and close the gap in health disparities. Moreover, faculty diversity is an essential ingredient in the efforts to diversify the nursing education pipeline and workforce overall.

[116] American Association of Colleges of Nursing (http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-faculty-shortage). Nurse Faculty Shortage Fact Sheet (updated April 14, 2011).
[117] Kaufman, K. Headlines from the NLN - introducing the NLN/Carnegie national survey of nurse educators: compensation, workload, and teaching practice. Nursing Education Perspectives 2007;28(3):164-9.

Eligible Entity: Accredited schools of nursing who offer advanced nursing education degree program(s) that will prepare graduate students for roles in education.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Nursing	• Graduate (master's and doctoral)	• **Loan Fund:** - Provides funding to nursing schools to establish and operate revolving loan fund. - Provide low interest rate loans to nursing students. - Loans may be used to pay costs of tuition, fees, books, laboratory expenses, and other education expenses. - Requires institutional match of at least 1/9 of the Federal contribution to loan fund. - Students are limited to five years of loan support. • **Loan Cancellation Provision:** - Provide loan cancellation upon completion of service with 85 percent cancellation after 4 years of service.

Program Accomplishments: In Academic Year 2012-2013, the Nurse Faculty Loan Program (NFLP) supported a total of 2,259 nursing students pursuing a graduate-level degree as nurse faculty—exceeding the program's performance target of 1,510 by 49.6%. Results showed that the majority of NFLP loan recipients were female (93%); between the ages of 40 and 59 (63%); and received a median loan amount of $10,470. Further analyses of data showed that 14% of students who received a loan reported coming from a disadvantaged background and about 1 out of every 4 students who received a loan are considered underrepresented minorities. Of the 2,259 students who received a NFLP-funded loan, a total of 336 graduated from their degree programs by the end of academic year—exceeding the program's performance target of 275 by 22%. It is estimated that about 1 out of every 5 NFLP loan recipients who graduated is considered an underrepresented minority in the nursing profession.

Results obtained for Academic Year 2012-2013 supported trends identified in a 5-year retrospective evaluation of the NFLP program that was conducted by BHPr last calendar year. For example, the great majority of NFLP loan recipients (73%) were enrolled in a doctoral program versus a masters-level program (27%). Findings from the evaluation of the NFLP program showed that between Academic Year 2006-2007 and Academic Year 2010-2011, the average number of loan recipients per institution who were enrolled in a doctoral-level program doubled (average for AY 06-07: 3; average for AY 10-11: 7) while the average number of NFLP loan recipients who were enrolled in a masters-level program decreased in Academic Year 2008-2009 and has remained stable ever since (average for AY 08-09: 3). This trend in funding a higher number of loan recipients in doctoral-level programs may be supported by the fact that

previous studies (AACN, 2012) have shown that most faculty vacancies require that candidates pursuing a job opportunity as nurse faculty have, at a minimum, doctoral-level training.

The number of schools that received new NFLP grant awards in FY 2012 was 112. While the performance target of 114 was not met, it is important to clarify that 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. Therefore, although 112 schools received a NFLP award this academic year, 170 schools provided NFLP loans to nursing students in Academic Year 2012-2013.

Funding History

FY	Amount
FY 2011	$24,848,000
FY 2012	$24,553,000
FY 2013	$23,256,000
FY 2014	$24,562,000
FY 2015	$24,562,000

Funding includes costs associated with processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, technical assistance and related program outreach activities, and activities of the National Advisory Council on Nurse Education and Practice which is charged with advising Congress and the Secretary on PHS Title VIII Nursing Workforce Development programs, and Information Technology costs.

Budget Request

The FY 2015 Budget Request is $24,562,000. The FY 2015 Request is the same as the FY 2014 Enacted level. This request will fund schools of nursing in establishing and operating loan funds for the NFLP. In FY 2015, the program will be redesigned based on program evaluation data to better help students to get faculty positions, including targeting a portion of the funds for doctoral faculty preparation. The program will continue its focus on efforts to increase the number of doctorally-prepared nurse faculty. Ongoing support for faculty production is critical to building the pipeline needed to assure the full capacity of the nation's future nursing workforce.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [118]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
Number of graduate-level nursing students who received a loan[119]	2,259 Target: 1,510 (Exceeded)	2,200	2,200	Maintain
Number of loan recipients who graduated from an advanced nursing degree program[120]	336 Target: 275 (Target Exceeded)	275	275	Maintain
Percent of loan recipients who graduated from an advanced nursing degree program and obtained a full-time faculty appointment within 12 months	---	---	Set Baseline	---
Number of schools receiving NFLP awards	112[7] Target: 114 (Target Not Met)	114	N/A[121]	---

[118] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.
[119] The wording for this measure has been revised from previous budget documents to better reflect measures collected.
[120] The wording for this measure has been revised from previous budget documents to better reflect measures collected.
[121] Measure will be discontinued in FY14.
[7] An additional 58 schools had sufficient funds in their loan funds from previous NFLP awards and did not request funds this year. A total of 170 schools gave NFLP awards to students.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	103	114	114
Average Award	$215,000	$215,000	$215,000
Range of Awards	$5,900-2,520,000	$5,900-2,520,000	$5,900-2,520,000

Nursing Workforce Development

Comprehensive Geriatric Education

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$4,248,000	$4,361,000	$4,361,000	---
FTE	--	--	1	+1

Authorizing Legislation: Section 865 of the Public Health Service (PHS) Act, as amended by the Affordable Care Act

FY 2015 Authorization .....Expired FY 2014

Allocation Method .....Competitive Grant/Contract

Program Goal and Description: This program provides support to train and educate individuals in providing geriatric care for the elderly. Program goals are accomplished through curriculum development and dissemination, continuing education, and traineeships for individuals preparing for advanced nursing education degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population.

Need: More than 65 million people, 29 percent of the adult U.S. population, provide care for a chronically ill, disabled or an aged family member or friend during any given year and spend an average of 20 hours per week providing care for their loved one.[122] In addition, the Institute of Medicine[123] reported that direct-care workers, also referred to as paraprofessionals, are the primary providers of paid hands-on care, supervision, and emotional support for older adults in the U.S., primarily in nursing homes, assisted living facilities, and home and community-based settings. Projected employment for home health aides and personal and home care aides in 2020 will reach 3,191,900. This represents an increase of approximately 70 percent in the growth of jobs available in these occupations between 2010 and 2020 and makes them among the fastest growing jobs in the country[124].

Eligible Entities: Schools of nursing, health care facilities, programs leading to certification as a nursing assistant, and partnerships of such a school and facility or program and facility.

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[122] National Alliance for Caregiving in collaboration with AARP (2009). Caregiving in the United States 2009. www.caregiving.org/data/Caregiving_in_the_US_2009_full_report.pdf

[123] Institute of Medicine (2008). Retooling for an Aging America: Building the Health Care Workforce. National Academies Press, Washington, DC.

[124] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2012-13 Edition*, Home Health and Personal Care Aides, on the Internet at http://www.bls.gov/ooh/healthcare/home-health-and-personal-care-aides.htm (visited *May 22, 2012*).

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• All health professions • Direct service workers • Individuals	• Certificate • Diploma • Undergraduate • Graduate • Post-graduate • Individuals with no professional education	• Provide training to individuals who will provide geriatric care for the elderly. • Develop and disseminate curricula relating to treatment of health problems of elderly individuals. • Train faculty in geriatrics. • Provide continuing education to individuals who provide geriatric care. • Establish traineeships for individuals preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population.

Program Accomplishments: In Academic Year 2012-2013, the Comprehensive Geriatric Education Program (CGEP) supported numerous types of geriatric-related training programs and activities for health professions students and their faculty, as well as for community-based healthcare providers across the country. With regard to the continuing education (CE) of the current workforce, CGEP grantees offered over 150 different CE courses to over 11,600 trainees across the health professions. On average, each continuing education course was offered between four and five times; had about 37 participants (which can include providers, residents, and support staff, among others); lasted nearly 2 hours in length; was primarily delivered face-to-face; and focused on emerging issues in the field of geriatrics (e.g., advances in geriatric medicine, quality improvement in patient care, and healthy aging, among others).

For the first time, data were collected about other training-related activities that are required to be carried out through the CGEP. For example, the authorizing legislation for the CGEP requires that grantees use funds to support traineeships for individuals who are preparing for advanced nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population. Results obtained from the implementation of new performance measures showed that CGEP grantees awarded traineeships to a total of 74 students—the majority of which (81%) are pursuing a Masters Degree in Nursing to become Nurse Practitioners in the fields of Adult Gerontology or Acute Care in Adult Gerontology. It is estimated that the median award amount provided to students was $15,000

and that approximately 1 out of every 4 students who received a traineeship award are considered an underrepresented minority in their prospective profession.

Grantees of the CGEP are also required by law to use funds to develop or enhance curricula and other types of training activities related to the treatment of health problems among the elderly. Results obtained from the implementation of new performance measures showed that grantees developed and implemented over 120 different geriatric-focused training activities to include new continuing education courses for current providers, as well as new academic courses and clinical rotations for health professions students, residents and fellows across the country focused on these issues. It is estimated that a total of 4,500 trainees were reached as a result of these activities. Lastly, grantees of the CGEP are also required to use funds to train faculty members in geriatrics. Results obtained from the implementation of new performance measures showed that CGEP grantees supported over 40 different faculty development activities and programs. It is estimated that over 300 faculty-level trainees were trained on emerging issues in the field of geriatrics (e.g., pain management among the elderly, advances in patient engagement, among others) as a result of these activities.

Funding History

FY	Amount
FY 2011	$4,539,000
FY 2012	$4,485,000
FY 2013	$4,248,000
FY 2014	$4,361,000
FY 2015	$4,361,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, and Information Technology costs.

Budget Request

The FY 2015 Budget Request is $4,361,000. The FY 2015 Request is the same as the FY 2014 Enacted level. This request will fund 16 new Comprehensive Geriatric Education Program grantees. The Affordable Care Act expanded the use of funds for the Comprehensive Geriatric Education Program to include the establishment of traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population. Twelve of the 18 currently funded grantees provide traineeship support in addition to addressing at least one additional statutory purpose. In FY 2015, it is anticipated that more grants with traineeship support will be awarded. Since the average cost for a grant with a traineeship component is $270,000, the overall number of grants that can be funded will decrease. In FY 2015, it is estimated that 79 traineeships will be provided.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [125]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
Number of CGEP Grantees	18 Target: 16 (Target Exceeded)	18	16	-2

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	18	18	16
Average Award	$218,000	$218,000	$222,000
Range of Awards	$160,000-$250,000	$160,000-$250,000	$173,000-$270,000

[125] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.

Children's Hospitals Graduate Medical Education Payment Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$251,166,000	$265,000,000	---	-$265,000,000
FTE	18	18	---	-18

Authorizing Legislation: Section 340E of the Public Health Service Act; Public Law 109-307

FY 2015 Authorization ..... Expired

Allocation Method ..... Formula Based Payment

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

Need: Adequate residency training in pediatric care is important for residents who pursue a variety of specialties. Compared with other teaching hospitals, freestanding children's hospitals receive little to no GME funding from Medicare because children's hospitals have such a low Medicare caseload.

Eligible Entities: Freestanding children's teaching hospitals.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Pediatric • Pediatric medical subspecialties • Pediatric surgical subspecialties • Adult primary care • Adult Medical subspecialties • Adult surgical subspecialties • Dentistry	• 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.

Program Accomplishments: In FY 2012, 55 children's hospitals received CHGME funding. Based on the most recent year for which performance information was reported, these children's hospitals reported being responsible for the training of 6,015 full-time equivalent (FTE) residents on and off site.[126] Approximately 43 percent of the FTEs were pediatric residents, 31 percent were pediatric subspecialty residents, and 26 percent were non-pediatric residents such as family practice residents or cardiology residents rotating in children hospitals to learn about care of children in their respective areas of expertise.

Funding History

FY	Amount
FY 2011	$268,356,000
FY 2012	$265,171,000
FY 2013	$251,166,000
FY 2014	$265,000,000
FY 2015	---

Funding includes costs associated with processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, and Information Technology costs.

Budget Request

HRSA will establish a new Targeted Support for Graduate Medical Education Program to expand residency training, with a focus on ambulatory and preventive care, in order to advance higher value health care that reduces long term costs. The Targeted GME program supports training in high need specialties in addition to primary care. As children's hospitals are one of the entities eligible to compete for these new competitive grants, the Targeted Support for Graduate Medical Education program will incorporate the CHGME program. Within the total, $100 million will be set aside specifically for children's hospitals in FYs 2015 and 2016 using the current CHGME program formula and supporting the current types of providers in the program.

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

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[127]	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
7.I.A.1: Maintain the number of FTE residents in training in eligible children's teaching hospitals	6,015 Target: 5,900 (Target Exceeded)	6,000	---	---
7.VII.C.1: Percent of hospitals with verified FTE residents counts and caps	100% Target: 100% (Target Met)	100%	---	--
7.E: Percent of payments made on time	100% Target: 100% (Target Met)	100%	---	--

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	54	54	---
Average Award	$4,991,000	$1,629,000	---
Range of Awards	$37,000-$20,515,000	$9,000-$6,161,000	---

[127] Most recent results are for Academic Year 2012-2013 and funded in FY 2012.

National Practitioner Data Bank

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$27,451,000	$27,456,000	$18,814,000	-$8,642,000
FTE	46	46	46	---

Authorizing Legislation: Section IV, P.L. 99-660; Healthcare Quality Improvement Act of 1986, as amended by P.L. 100-177; Section 1921 of the Social Security Act as amended by Section 5(b), Medicare and Medicaid Patient Protection Act of 1987 (P.L. 100-93), and Omnibus Budget Reconciliation Act of 1990 (P.L. 100-508); Subtitle C of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191), establishes Section 1128E of the Social Security Act; and Section 6403 of the Patient Protection and Affordable Care Act of 2010, Public Law 111-148 (ACA).

FY 2015 Authorization ..... Indefinite

Allocation Method ..... User Fee Program

Program Goal and Description: The purpose of the National Practitioner Data Bank (NPDB) is to improve health care quality, promote patient safety, and deter fraud and abuse in the health care system by providing information about past adverse actions of practitioners, providers, or suppliers to authorized health care entities and agencies. The NPDB serves as a flagging system intended to prompt a comprehensive review of health care practitioners' licensure activity, medical malpractice payment history and record of clinical privileges. Used in conjunction with information from other sources, the NPDB assists in promoting quality health care.

Need: The Nation must have ongoing protections to best ensure the safety and integrity of health care. To this end, State licensing boards, hospitals and other health care entities, and professional societies must be encouraged to identify and discipline those who engage in unprofessional behavior. The NPDB provides vital information to authorized users that impedes the ability of incompetent health care practitioners to move from State to State without discovery of previous substandard performance or unprofessional conduct. Further, the Data Bank is designed to reduce healthcare fraud and abuse by collecting and disclosing to authorized entities information 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.

Program Accomplishments:

- Enhanced technology to reduce reliance on paper files in the Disputes Resolution program (an administrative review process that assess that relevant data included in an Data Bank report meets the NPDB legal requirements).
- Closed a record number of *Dispute Cases* in FY 2013 (127 cases, compared to 113 in FY 2012).
- Implemented a new compliance framework where the top 12 most queried professions for all U.S. states and territories are reviewed over a 2-year cycle. As of October 2013, 778 professions were reviewed, of which 92% (712) were compliant with Data Bank reporting requirements during 2010 – 2011. Posted real-time updates of compliance data on the public website. Initiated electronic attestation for State Licensing and Certification Boards and other system enhancements to improve the quality of Data Bank data and reduce burden on reporting entities.
- Developed two interactive web-based applications to facilitate independent analysis of information relating to medical malpractice payments and adverse actions taken against practitioners' licenses, clinical privileges, professional society memberships, and eligibility to participate in Medicare/Medicaid.
- Implemented paperless registration renewal, allowing 96% of entities to renew their Data Bank registration on-line. This effort streamlined the user experience and reduced paper usage by over 100,000 pages annually.
- Consolidated three statutory authorities into one regulation (45 CFR part 60), eliminating the redundancy between the Healthcare Integrity and Protection Data Bank (HIPDB) and the NPDB as mandated by Section 6403 of the 2010 Patient Protection and Affordable Care Act. Deployed software changes that converted data and integrated the business rules to merge the systems into a single Data Bank.
- Implemented Express Self-Query, allowing health care practitioners to purchase their own data bank profile on-line instantly as an alternative to the traditional two-week paper-based process. This enhancement improved the user experience and reduced paper consumption by 61%.
- Implemented numerous system changes to create workflow efficiencies for external and internal users.
- Revised the NPDB Guidebook and released a draft for public comment. Solicited comments to assist NPDB in clarifying and revising a final version of the Guidebook for release in CY 2014.

Funding History

The table below shows the user fees (revenue) collected during the last five years:

FY	Amount
FY 2011	$26,976,194
FY 2012	$29,242,584
FY 2013	$27,451,000
FY 2014	$27,456,000
FY 2015	$18,814,000

Budget Request

As mandated by the Health Care Quality Improvement Act, the NPDB does not receive appropriated funds. Instead, the NPDB 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 Data Bank 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. The merger of the HIPDB and the NPDB into one Data Bank has reduced query fee costs for most users. Instead of paying a separate fee to query each data bank, the single integrated system gives users comprehensive output through paying only one query fee.

Over the past two years, program operational expenses have declined due to several factors including the HIPDB merger, negotiation of lower contract costs, reduced travel, and internal process streamlining.

In FY 2013, HRSA acquired economic forecasting software to model estimated revenue under various fee scenarios. The software can calculate fees that balance income and expenses several years into the future. HRSA calculated a new fee schedule that keeps fee collections in balance with the lower operating expenses. The new fees will be published in the Federal Register with an effective date of October 1, 2014.

The NPDB estimate for FY 2015 is 6,104,000 queries on practitioners and organizations, and 100,000 self-queries. Under this estimated scenario, HRSA projects fee collections of $18,814,000, which is lower than in previous years.

The NPDB is a web based electronic reporting and querying system that has been operational since 1999. Reports and queries can be submitted interactively using the web-based system or via XML-based batch electronic file transfer. Credit card and Electronic Funds Transfer (EFTs) transactions are securely processed using the U.S. Department of Treasury's Pay.gov service. The IT investment supports HRSA Strategic Goal 1 (Improve access to quality health care and services) Subgoal D (Strengthen health systems to support the delivery of quality health services).

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
8.III.B.5: Increase the number of practitioners enrolled in Continuous Query (which is a subscription service for Data Bank queries that notifies them of new information on enrolled practitioners within one business day.)	FY 2013 Result: 1,524,696 Enrolled Practitioners FY 2013 Target: 1,074,000 Enrolled Practitioners (Target Exceeded)	1,550,000	1,625,000	+75,000
8.III.B.6: Increase annually the number of reports disclosed to health care organizations through Continuous Query.	FY 2013 Result: 15,348 Disclosures FY 2013 Target: 13,800 Disclosures (Target Exceeded)	18,400	20,700	+2,300

Maternal and Child Health Tab

MATERNAL AND CHILD HEALTH

Maternal and Child Health Block Grant

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$604,917,000	$634,000,000	$634,000,000	---
FTE	31	31	31	---

Authorizing Legislation - Title V of the Social Security Act.

FY 2015 Authorization $850,000,000

Allocation Methods:

- Direct Federal/intramural
- Contract
- Formula grant/co-operative agreement
- Competitive grant/co-operative agreement

Program Description and Accomplishments

The mission of the Maternal and Child Health (MCH) Block Grant Program, as authorized under Title V of the Social Security Act, is to improve the health of all mothers, children, and their families. These legislated responsibilities reduce health disparities, improve access to health care, and improve the quality of health care. Specifically, the Program seeks to: (1) assure access to quality care, especially for those with low-incomes or limited availability of care; (2) reduce infant mortality; (3) provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at risk pregnant women); (4) increase the number of children receiving health assessments and follow-up diagnostic and treatment services; (5) provide and ensure access to preventive and primary care services for low income children as well as rehabilitative services for children with special health needs; (6) implement family-centered, community-based, systems of coordinated care for children with special health care needs (CSHCN); and (7) provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

Section 502 of the Social Security Act states that of the amounts appropriated, up to $600,000,000, 85 percent is for allocation to the States, and 15 percent is for Special Projects of Regional and National Significance (SPRANS) activities. Any amount appropriated in excess of $600,000,000 is distributed as follows: 12.75 percent is for Community Integrated Service Systems (CISS) activities; of the remaining amount, 85 percent is for allocation to the States, and

15 percent is for SPRANS activities. Appropriations language waives this provision and provides a stated amount for SPRANS and CISS.

The MCH Block Grant is at its core a public health program that reaches across economic lines to improve the health of all mothers and children. Created as a partnership with State MCH programs and with broad State discretion, State Title V programs use appropriated formula grant funds for: capacity and systems building, public information and education, knowledge development, outreach and program linkage, technical assistance, provider training, evaluation, support for newborn screening and genetic services, lead poisoning and injury prevention, additional support services for children with special health care needs, and promotion of health and safety in child care settings.

Special efforts are made to build community capacity to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling. Where no services are available, States also use Title V to provide categorical direct care such as prenatal care or services for children with special health care needs. The Title V program is the payer of last resort.

In an era of expanding health care coverage under the Patient Protection and Affordable Care Act (ACA), the MCH programs and services supported under the Title V formula block grant and its discretionary grants will serve to assure continuity of care and to reduce coverage gaps created by shifts in the insurance eligibility status of individuals. The Maternal and Child Health Block Grant is both a safety net program and the major public health program serving mothers, infants, children, including children with special health care needs, and their families. In order for there to be measurable gains toward improving the nation's maternal and child health, insurance coverage expansion will need to be accompanied by a significant investment in health promotion and disease prevention strategies that focus on this population. Even the best designed insurance plans provide limited benefits, which result in gaps in coverage. These gaps pose particular challenges for families of children and youth with special health care needs in accessing needed services at an affordable cost. Lessons learned from the State Children's Health Insurance Program implementation illustrate that eligibility for health insurance programs does not automatically translate into enrollment without sustained efforts and investment.

Table 1. Maternal and Child Health Block Grant Activities ($ in thousands)

MCH Activities	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
State Block Grant Awards[128]	$520,696	$546,631	$546,631
SPRANS	$74,488	$77,093	$77,093
CISS	$9,733	$10,276	$10,276
Total	$604,917	$634,000	$634,000

Additional activities beyond the State Title V MCH Block Grants that support the improved health care of mothers and children are SPRANS and CISS. SPRANS funds support projects (through grants, contracts, and other mechanisms) in research, training, genetic services and newborn screening and follow-up, sickle cell disease, hemophilia, and maternal and child health improvement. SPRANS projects must:

- Support national needs and priorities or emerging issues;
- Have regional or national significance; and
- Demonstrate ways to improve State systems of care for mothers and children.

CISS projects (through grants, contracts, and other mechanisms) seek to increase the capacity for service delivery at the local level and to foster formation of comprehensive, integrated, community level service systems for mothers and children using one or more of six specified strategies:

- Provide maternal and infant home health visiting, health education, and related support services for pregnant women and infants up to one year old;
- Increase participation of obstetricians and pediatricians under Titles V and XIX;
- Integrate MCH service delivery systems;
- Operate MCH centers under the direction of not-for-profit hospitals;
- Increase MCH projects in rural areas; and
- Provide outpatient and community-based services for children with special healthcare needs.

[128] Through the MCH Block Grant, HRSA distributes funding to the States, provides oversight by requiring States to report progress annually on key MCH performance/outcome measures and indicators, and offers technical assistance to States to improve performance. Each State is responsible for determining its MCH priorities, based on the findings of a comprehensive Needs Assessment every five years, targeting funds to address the identified priorities and reporting annually on its progress. The MCH Block Grant emphasizes accountability in ensuring that States meet the legislative and programmatic requirements while providing appropriate flexibility for each State to address the unique needs of its MCH population.

Table 2. Maternal and Child Health Block Grant SPRANS Set-Aside Grants ($ in thousands)

MCH SPRANS Set-Aside Programs	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
SPRANS	$64,206	$66,238	$66,238
SPRANS - Oral Health	$3,576	$3,775	$3,775
SPRANS – Epilepsy	$3,449	$3,642	$3,642
SPRANS - Sickle Cell	$2,805	$2,961	$2,961
SPRANS - Fetal Alcohol	$452	$477	$477
Total SPRANS	$74,488	$77,093	$77,093
CISS	$9,733	$10,276	$10,276

The MCH Block Grant Program provides support to all 59 States and jurisdictions. Consistent with other HRSA programs, the MCH Block Grant addresses three overarching goals: 1) improving access to quality health care and services; 2) improving health equity; and 3) building healthy communities.

Funds are allotted to States based on a legislated formula which provides the amount allotted to each State in FY 1983, and when the amount available exceeds that level, the excess is distributed based on the States' proportion of children in poverty. Historically, the State Title V MCH Block Grant allocations were calculated based on the child poverty data reported in the U.S. Census Bureau's decennial census. The American Community Survey (ACS) replaced the decennial census long form as the source for annual State-specific child poverty statistics. Beginning in FY 2013, data from the ACS is being used as the reference data for calculating the annual State Title V MCH Block Grant formula allocations. The State table reflects the use of 3-year ACS child poverty data, based on the 2010 3-year estimates released in October 2011 for the FY 2013 allocations. The 2011 3-year child poverty estimates released in October 2012 are used for the FY 2014 State allocations. Planning estimates for FY 2015 are based on the 2012 3-year poverty estimates, which were released in October 2013.

Accomplishments

By working to improve access to quality health care and services, the Program has been able to exceed the targets for both the number of children served by the States under Title V (35.9 million in FY 2012) and the number of children receiving Title V services who have Medicaid and Child Health Insurance Program (CHIP) coverage (14.2 million in FY 2012). The MCH Block Grant Program served approximately one million fewer children in FY 2012 than in FY 2011, when the largest number of children (37.4 million) were served since data collection began in the Title V Information System in the 1990's. Of the children served by Title V, approximately 600,000 fewer children had Medicaid and CHIP coverage in FY 2012 than in

FY 2011. The number of children served by the program who had Medicaid and CHIP coverage was the lowest reported level since FY 2007. Despite this decrease, the number served in FY 2012 reflects a significant increase over the FY 2002 baseline of 5.9 million. Increased coverage under Medicaid and CHIP for children receiving Title V services better assures access, availability, and continuity of care to a wide range of preventive and acute care services. Exceeding the targets is significant as these increases occurred in a period of severe financial constraints at the State and local levels.

Health Equity

Title V programs work to improve health equity and eliminate disparities in health outcomes through the removal of economic, social, and cultural barriers to receiving comprehensive, timely, and appropriate healthcare. The ratio of the Black infant mortality rate compared to the White infant mortality rate decreased from 2.4:1 to 2.24:1 from FY 2002 to FY 2010. While the infant mortality rate did not change significantly for white infants between 2009 and 2010, there was an 8.0 percent decrease for black infants. Preliminary data indicate that the ratio of black-to-white infant mortality rates did not change from FY 2010 to FY 2011 (National Vital Statistics Reports).

The infant mortality rate is a widely used indicator of the nation's health. The State Title V Program plays an important role in the delivery of appropriate and effective care for high-risk pregnant women and infants. Efforts to reduce the overall infant mortality rate continue, with the rate having decreased from 9.2 per 1,000 live births in 1990 to 6.2 per 1,000 live births in 2010. From 2009 to 2010, the infant mortality rate decreased by 3.8 percent. Based on preliminary data, the infant mortality rate decreased to an all-time low of 6.1 infant deaths per 1,000 births in 2011 (National Vital Statistics Report).

HRSA has identified infant mortality as a priority issue and is working collaboratively with the Association of State and Territorial Health Officials (ASTHO), the Association of Maternal and Child Health Programs (AMCHP), CityMatCH, the March of Dimes (MOD) and other Federal partners, including the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services(CMS), to support a Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality. The CoIIN was launched in the U.S. Department of Health and Human Services' (HHS) Region IV and Region VI States in FY 2012 and in Region V in March 2013. Further expansion of the infant mortality CoIIN to the other HHS Regions is planned for FY 2014; it will also include support through HRSA's Healthy Start program which is referenced below. Ultimately, this effort will inform and advance the national strategy to address infant mortality that was announced by Secretary Kathleen Sebelius at the Child Survival Call to Action in June 2012.

States have long been engaged in activities to reduce infant mortality and to address the disparities that exist among racial groups relative to birth outcomes. The CoIIN provides an opportunity to move beyond the traditional dissemination of information, by engaging self-motivated participants from multiple settings in the full spectrum of change implementation – from defining the problem, to crafting an intervention, to implementation and evaluation and, finally, to the diffusion and adaptation of effective innovations in new settings. Key elements of

a COIIN include: 1) reliance on distance-based technology for all Team activities; 2) expectation of rapid, on-going communication across all levels of the Team with its members being part of the solution; and 3) commitment to ensuring that work processes are transparent. The CoIIN is designed to facilitate collaborative learning and the adoption of proven quality improvement principles and practices among participating States to reduce infant mortality and improve birth outcomes.

The five Priority Strategies identified for the Region IV and Region VI CoIIN to reduce infant mortality and improve birth outcomes are:

- Reduce non-medically indicated early elective delivery at <39 weeks;
- Enhance interconception care in Medicaid - Improve access to preconception and interconception care among women served by Medicaid;
- Increase smoking cessation among pregnant women;
- Promote safe sleep in order to reduce SIDS/SUID; and
- Expand perinatal regionalization.

Comprised of representatives from the 13 States in Region IV and Region VI, each of the five Strategy Teams is led by content, data, and methods experts in addition to support staff from the MCHB and partner organizations. Team Leads are content experts drawn almost exclusively from the 13 participating States, while the Data and Methods Experts include individuals with topical epidemiological or methodological expertise. State representatives to each CoIIN team include individuals in leadership positions within their State and the Regions as a whole, such as Title V Directors, State Health Officials, academics, researchers, and Federal partners.
The four strategy areas identified by the six States in Region V for their CoIIN to reduce infant mortality and improve birth outcomes are:

- Social Determinants of Health;
- Preconception Health/Interconception Care;
- SIDS/SUID/Safe Sleep; and
- Early Elective Delivery.

Opportunities to Reduce Low Birth Weight

The Maternal and Child Health Bureau (MCHB) continues to explore and promote evidence-based practices to reduce the incidence and better understand the causes of low birth weight. Nationally, the number of low birth weight infants (less than 2500 grams) has been steadily increasing. From 2002 to 2006, the rate of low birth weight infants increased from a baseline of 7.8 percent to 8.3 percent. The low birth weight rate improved slightly in 2007 to 8.2 percent and has remained essentially stable (National Vital Statistics Reports). The rate of low birth weight decreased slightly to 8.1 percent in 2011. Most of the decrease can be attributed to infants delivered at moderately low birth weight (i.e., 1500 - 2499 grams).

Increases in the number of low birth weight infants have been influenced by: 1) the rise in the multiple birth rate; 2) greater use of obstetric interventions; 3) increases in maternal age at childbearing; and 4) increased infertility therapies. The delivery of very low birth weight infants (i.e. babies born weighing less than 1500 grams) at facilities with specialized equipment and personnel significantly contributes to reducing the risk of mortality. Following a decline from 75.2 percent to 71.7 percent between FY 2002 and FY 2004, the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates increased annually to a high of 77.3 percent in FY 2009. Despite a decrease in FY 2010 to 74.5 percent, the percent of very low birth weight infants delivered in risk-appropriate care facilities reached the highest reported level (79.0 percent) in FY 2011 since States began reporting on this measure in the 1990s.

The Bureau continues to work with the States to monitor and better understand the factors that contribute to risk appropriate care for very low birth weight infants. In one of the Strategy teams participating in the Region IV and Region VI CoIIN initiative, national experts are working together to identify strategies for increasing appropriate maternal and neonatal care in 13 southern States. The Perinatal Regionalization CoIIN Strategy Team, which consists of State Health Officers, Medicaid Directors, physician organizations, MCH Directors and community leaders, is engaged in an 18 – 24 month collaborative effort to develop and implement strategies for rapid, sustainable improvement. By August 2014, the Perinatal Regionalization CoIIN Strategy Team hopes to reach its Quality Improvement Aim Statement of increasing the percent of mothers who deliver very low birth weight infants at appropriate level of care facilities to 90 percent or a 20 percent increase above baseline in the Region IV and Region VI States.

The establishment of a comprehensive prenatal and perinatal care system helps to assure that very low birth weight infants are delivered in risk-appropriate care facilities. The Program partnered with CDC and AMCHP to publish an article in the December 22, 2010 issue of the Maternal and Child Health Journal, examining State measures of risk-appropriate care for very low birth weight infants and identified potential areas for improvement. State regionalization models and measures of risk-appropriate care were found to vary greatly. Mechanisms identified for better measurement of risk-appropriate care included regulation of regionalization programs, data surveillance, review of adverse events, and consideration of geography and demographics. Specific State actions included antenatal or neonatal transfer arrangements, telemedicine networks, acquisition of funding, provision of financial incentives, and patient education.

A 2009 study conducted by the Cecil G. Sheps Center and supported by the MCHB examined the trends in the rate of very low birth weight deliveries in an appropriate hospital and explored reasons that States give for change in this marker. States report that systems exist for coordinating care among multiple providers, but the extent to which regionalized perinatal care systems are regulated and prescribed varies considerably. States are examining where very low birth weight births occur and why some do not occur in facilities for high-risk deliveries. Understanding whether health care systems factors have played a role in a poor outcome, and identifying which factors could potentially be modified would be an important contribution to improving this indicator. Surveillance of very low birth weight births is necessary for the success of quality improvement initiatives, as is frequently cited by States.

Prenatal Care for Pregnant Women and their Infants

Prenatal care is one of the most important interventions for ensuring the health of pregnant women and their infants. Data on the timing of prenatal care are derived from the 1989 and the 2003 Revisions of the U.S. Standard Certificate of Live Birth. Due to substantive changes in how information was reported on the timing of prenatal care in the 2003 Certificate, the two formats are not directly comparable. Prenatal care data based on the revised certificate show a less favorable picture of prenatal care utilization in the U.S. than do the data from the unrevised certificate. However, most of the difference can be attributed to changes in reporting rather than changes in prenatal care utilization.

Based on the 2012 Natality Public Use file, which reflects the revised birth certificate assessment of prenatal care timing from 38 States and the District of Columbia (representing 86 percent of all U.S. births), almost three-fourths (74.1%) of women began care within the first 3 months of pregnancy. Due to differences in the number of States using the 2003 Standard Certificate of Live Births for reporting on prenatal care utilization, natality data for 2012, 2011 and 2010 are not directly comparable. In 2011 and 2010, the percent of women reportedly beginning first trimester prenatal care was 73.7 percent (representing 83 percent of all U.S. births) and 73.1 percent (representing 76 percent of all U.S. births), respectively. Across all three reporting years, early initiation into prenatal care was less common among Black and Hispanic women compared with White women. Given the increasing prevalence of diabetes, obesity and pregnancy-induced hypertension during pregnancy, there is a need for such risk factors to be monitored and for timely and appropriate prenatal care to be provided.

Building State MCH Data Capacity

The MCHB has worked with the State MCH programs to build a data capacity that supports the performance elements in the Title V MCH Block Grant. Efforts have centered on the development of client-based data systems that more accurately capture the direct, enabling and population-based services provided, as required. Previously reported data on the number of children served by Title V and the number of children served who have Medicaid and CHIP coverage were often based on the direct services provided. In addition, increases in the number of children served by Title V who have Medicaid and CHIP coverage reflect the ongoing efforts of the States to do outreach to eligible populations and to increase participation in these programs. The MCHB regularly provides technical support to the States around the priorities identified in their comprehensive five-year needs assessments and the areas of needed technical assistance outlined in their annual applications. In the State MCH Block Grant applications, health disparities, which include disparities in the Black and White Infant Mortality Rates, and healthy perinatal and birth outcomes are frequently identified areas of needed technical assistance. Increasingly, the State Title V programs request technical assistance in anticipation of the implementation of the Patient Protection and Affordable Care Act (ACA) of 2010 to assess its impact on MCH populations and the delivery of Title V services. Building on a history of continuous re-evaluation of MCH population needs, State Title V programs are poised to make needed transitions to support the building of new infrastructures that will help to ensure the efficiency and effectiveness of the ACA by better leveraging existing resources, addressing

identified gaps in services delivery and promoting optimal health outcomes for all MCH populations.

The FY 2014 Enacted level includes appropriations language which provides SPRANS set aside funds for Oral Health ($3.78 million); Sickle Cell ($2.96 million); Epilepsy ($3.64 million); and Fetal Alcohol ($0.48 million).

Funds were also used to support the development of the National Survey of Children's Health (NSCH). Previous national surveys on children's health (the NSCH and the National Survey on Children with Special Health Care Needs) used the State and Local Area Integrated Telephone Survey (SLAITS) mechanism, which utilizes the sampling frame of the ongoing CDC-Sponsored Immunization Survey (CSIS). SLAITS provides resources for field surveys on a wide range of health and welfare related topics using the CSIS screening sample. The survey provides representative, reliable and previously unavailable information on: 1) special healthcare needs among children in 50 States and the District of Columbia; and 2) the competency of the service systems in meeting the needs of these children and their families. However, because SLAITS uses phones as the primary contact mechanism, response rates were declining and the cost to interview cell phone only households with children was becoming prohibitive. Therefore, funds are being used to support development of more cost-effective and efficient methods for collecting the data in future surveys.

Affordable Care Act

Given that the responsibility for implementing the ACA largely falls to the States and that many of its provisions address maternal and child health, State Title V programs are lending critical support for ensuring its success in increasing access to health care, providing greater insurance protections and improving the quality of care for the MCH population. Significant opportunities exist within the ACA to enhance State MCH programs and services that are currently being provided. Some of these opportunities are already being realized, as many of the Title V programs serve as the designated administrative lead in their State health agencies for three new ACA programs, specifically, the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, the Personal Responsibility Education Program (PREP) Grants and the State Abstinence Education Program. While these programs are enhancing the ability of State Title V programs to provide home visitation, pregnancy prevention and teen support, thsee funds do not eliminate the need for Title V funding to meet the broader and more complex needs of the nation's mothers, infants, children, including children with special health needs, and their families.

Title V will continue to be a primary source of support for ensuring the health and well-being of the nation's MCH population. While the ACA will provide improved coverage of health care services for a greater percentage of the MCH population, Title V will remain an essential source of support for the States' public health infrastructure in providing for pediatric specialty care service, care coordination and case management for children and youth with special health care needs and for other MCH population-based services, such as preconception care, oral health, newborn screening, Birth Defects Registry and Child Death Reviews. As a result of the ACA, there will be improvements in services for children with special health care needs and their

families, particularly related to insurance and financing. However, some States report that families of children with special health care needs will face continuing challenges in the affordability of rising private insurance co-payments and premiums, as well as non-covered services, such as nursing care, physical therapy, durable medical equipment and medical foods. Further, the ACA affects the insurance coverage of less than 10 percent of children nationally. Therefore, the population seeking services supported through the Title V MCH Block Grant is not likely to decrease significantly in the States once the ACA is fully implemented.

In recent years, the State MCH Block Grant allocations have been either level funded or reduced. This has challenged the ability of States to move to new or expanded systems of care for addressing ongoing or emerging MCH priorities. Expansion of insurance coverage to many women and children, and opportunities for implementing preventive care guidelines (e.g., *Bright Futures* guidelines for practitioners) under the provisions of the ACA will require additional capacity at the State level for assuring access to sustainable and affordable quality health care services for all MCH populations, particularly for populations who are underserved and vulnerable. The goals of the Title V program and the goals of the ACA are complementary. Through their annual reporting on the National and State performance/outcome measures and health indicators, State Title V programs are well positioned to continuously assess measurable improvements and gaps in the delivery of health care services and changes in the health status of the MCH population.

State Title V programs have a long history of developing comprehensive and innovative systems of care, particularly for children and youth with special health care needs. Access to health care through a medical home has been a longstanding priority of the State Title V programs. Building comprehensive systems of care, family involvement, collaboration and coordination with public and private partners have been at the core of the Federal, State and community Title V efforts. States have worked in partnership with their State Medicaid programs, as defined in the Inter-Agency Agreements that have been developed between each State's Medicaid and Title V programs. This service delivery system and partner/provider network will serve to support the effective and efficient implementation of the ACA in creating a continuum of care that is not fragmented and addresses the health needs of the MCH population in a family-centered and culturally sensitive manner. While the ACA will increase access to health care through expanded insurance coverage, cultural barriers may exist which could impact one's decision to seek the appropriate care. The MCH partnerships and family navigators can lend valuable support to reducing such access barriers.

Specific areas in which the State Title V programs can complement and support the effective and efficient implementation of the ACA in assuring that the needs of the MCH population are met include:

- Provide outreach, training, and information dissemination for families, health care professionals and the general public around the provisions of the ACA and changes in Medicaid eligibility and enrollment procedures;
- Coordinate outreach and enrollment of individuals in Medicaid, CHIP or the State health insurance marketplace, in accordance with the Title V legislative requirements;

- Coordinate outreach to promote enrollment of providers in Accountable Care Organizations, which include Medicaid and CHIP, in accordance with the Title V legislative requirements;
- Assist families in "navigating" through the new benefits provided under the ACA to promote enrollment, reduce barriers and link with available resources and referral systems;
- Collaborate with the State Medicaid programs to integrate the Title V programs into ACA-supported efforts to expand the availability of health homes for MCH populations, especially for underserved populations;
- Leverage existing Title V resources, provider networks and public/private partnerships to address gaps in coverage and to assure that MCH population needs, particularly children with special health care needs, are met;
- Identify provider shortages at the community level which may result from the increased demand for services and utilize existing provider networks to lend available support;
- Expand provision of population-based and preventive services which complement the provisions under the ACA in promoting improved health outcomes for all MCH populations;
- Support provider training through the Title V MCH Block Grant program on cultural competency and working with individuals with special health care needs to promote health equity and enhanced service delivery for all MCH populations;
- Seek opportunities for increased collaboration with community care providers, community health centers, school-based health centers and health care homes in implementing the ACA provisions; and
- Explore opportunities to partner with Medicaid around the implementation of electronic health records and improved coding and billing procedures.

In assuring that all eligible women, children and families are enrolled in a health plan and linked to available services, State MCH programs will continue to coordinate and provide outreach, screening and enrollment services through their existing networks of MCH service providers. In addition, MCH programs at the State and community levels have specialized experience in targeting high-risk and culturally diverse populations who are often difficult to reach and enroll in health care coverage programs.

As described above, the MCH Block Grant funds support a wide range of activities that include infrastructure and systems building; research; provider training; technical assistance; outreach and case management; health education services; and other enabling support that go beyond the provisions of the ACA. As the ACA is implemented, eligible rehabilitative or other direct services will continue to be covered under Medicaid or private insurance. The Title V Maternal and Child Health Block Grant will remain the payer of last resort, per its authorizing legislation.

Funding History

FY	Amount
FY 2006	$692,521,000
FY 2007	$693,000,000
FY 2008	$666,155,000[129]
FY 2009	$662,121,000[130]
FY 2010	$660,710,000
FY 2011	$656,319,000
FY 2012	$638,646,000
FY 2013	$604,917,000
FY 2014	$634,000,000
FY 2015	$634,000,000

Budget Request

The FY 2015 Budget Request is $634,000,000, the same as the FY 2014 Enacted level. Title V is the only Federal program that focuses solely on improving the health of all mothers, adolescents and children, whether insured or not, through a broad array of public health and community-based programs that are designed and carried out through well-established Federal/State partnerships. The budget request will help State Title V programs support capacity and infrastructure building, population-based and enabling services, as well as the provision of direct healthcare services where no services are available. In these latter roles, Title V programs serve as a safety net for uninsured and underinsured children, including CSHCN. Title V continues to play a valuable, complementary role to CHIP and Medicaid programs and will continue to do so as ACA is implemented.

The FY 2015 targets for the number of children served by the Title V Block Grant and the number of children receiving Title V services who are enrolled in and have Medicaid and CHIP coverage are 32 million and 14.5 million, respectively. For the rate of infant mortality, the FY 2015 target is 6.0 per 1,000 births.

The MCHB will continue to monitor emerging issues and areas of needed technical assistance in providing technical support to the States. In addition, the MCHB will continue to explore promising models and effective strategies that promote improved maternal and child health outcomes.

SPRANS and CISS funds will support innovative projects in the areas of: collaborative and quality improvement efforts in MCH programs, such as the Collaborative Improvement and Innovation Network (CoIIN) and the Maternal Health Initiative; applied and translational research that has the potential to improve health services and care delivery, and to promote health and wellbeing among MCH populations, including research addressing language development in early childhood and its impact on school achievement; MCH workforce training

129 Reflects moving $20 million to the Autism and Other Developmental Disorders Program.

130 Reflects moving $6.9 million to the Newborn Screening for Heritable Disorders Program.

in areas such as pediatric pulmonary centers, behavioral health, nutrition, schools of public health, and adolescent health; and a variety of MCH Improvement Projects (MCHIP) including: adolescent health; SIDS; "Bright Futures" guidelines for practitioners; medical homes; early childhood comprehensive care systems; the development and testing of the most cost-effective methods for collecting reliable state-specific and national information on the health and well-being of the overall child population, and children with special health care needs; and oral health disease prevention and early treatment interventions; the development and testing of the most cost-effective methods for collecting reliable state-specific and national information on the health and well-being of the overall child population, and children with special health care needs. SPRANS and CISS both complement and help ensure the success of State Title V, Medicaid, and CHIP programs, building community capacity to create family-centered, integrated systems of care for mothers and children, including children with special healthcare needs.

In addition, Title V funds the only statutorily required genetic services program. This program funds initiatives to facilitate the early identification of children with genetic conditions and works to increase public and professional knowledge of how genetic risk factors affect health in order to create more responsive systems of care. The newborn screening and genetics public health infrastructure activities are designed to help support State newborn screening and genetics programs, integrate newborn and genetic screening programs with other community services and medical homes, and strengthen existing newborn and genetic screening and service programs. The programs also are established to aid State MCH officials, health care providers, public health professionals and families, and individuals in responding to new scientific findings and technologies in the fields of genetic medicine and newborn screening. Special emphasis is being given to the financial implications and the implementation of genetic services and technologies for maternal and child health populations.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
10.I.A.1: The number of children served by the Maternal and Child Health Block Grant *(Output)*	FY 2012: 35.9M Target: 33M (Target Exceeded)	31M	32M	+1M
10.I.A.2: Increase the number of children receiving Maternal and Child	FY 2012: 14.2M Target: 14M (Target	14M	14.5M	+0.5M

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Health Block Grant services who are enrolled in and have Medicaid and CHIP coverage *(Output)*	Exceeded)			

Long Term Objective: Promote outreach efforts to reach populations most affected by health disparities

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
10.IV.B.1: Decrease the ratio of the Black infant mortality rate to the White infant mortality rate *(Output)*	FY 2011: 2.2 to 1[131] Target: 2.1 to 1 (Target Not Met)	2.1 to 1	2.1 to 1	Maintain

[131] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012. Deaths: Preliminary Data for 2011, National Vital Statistics Reports, Vol. 61, No. 6, October 2012.

Long Term Objective: Promote effectiveness of healthcare services.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
10.III.A.1: Reduce the infant mortality rate (Baseline - 2005: 6.9/1,000) *(Outcome)*	FY 2011: 6.1 per 1,000[131] Target: 6.6 per 1,000 (Target Exceeded)	6.1 per 1,000	6.0 per 1,000	-0.1 per 1,000
10.III.A.2: Reduce the incidence of low birth weight births *(Outcome)*	FY 2011:[132] 8.1% Target: 8.2% (Target Exceeded)	8.1%	8.0%	-0.1% point
10.III.A.3: Increase percent of pregnant women who received prenatal care in the first trimester *(Outcome)* (New Baseline- FY 2006: 69%)[133]	FY 2012: 74.1%[134] Target:70% (Target Exceeded)	72%	73%	+1% point
10.III.A.4: Increase percent of very low-birth weight babies who are delivered at facilities for high-risk deliveries and neonates *(Outcome)*	FY 2011: 79.0%[135] Target: 76% (Target Exceeded)	76%	77%	+1% point

[132] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012. Births: Final Data for 2011, National Vital Statistics Reports, Vol. 62, No. 1, June 2013.
[133] A new FY 2006 baseline and the FY 2007 result for this measure are based on the use of the 2003 Revised U.S. Standard Birth Certificate. The FY 2007 – FY 2010 targets were established based on the use of the 1989 unrevised Birth Certificate. Therefore, the targets and results should not be compared until FY 2011 when targets and results are both based on the Revised Birth Certificate.
[134] Detailed Technical Notes prepared by the National Center for Health Statistics, Centers for Disease Control and Prevention. User Guide to the 2012 Natality Public Use File.
[135] Source: Title V Information System, HRSA/MCHB (https://mchdata.hrsa.gov/TVISReports).

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
10.3: Increase maternal survival rate (deaths/100,000 live births) *(Outcome)*[136]	FY 2007: 12.7 to 100,000[137]	N/A	N/A	N/A

Grant Awards Table

Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	59	59	59
Average Award	$8,687,760	$9,123,532	$9,123,532
Range of Awards	$138,397 - $36,320,452	$145,338 - $35,506,440	$145,338 - $38,748,713

[136] This is a long-term measure with no annual targets.
[137] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention. Deaths: Final Data for 2007, Vol. 58, No. 19, May 2010.

State Table

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2013 Final[138]	FY 2014 Estimate[139]	FY 2015 Estimate[140]	Difference +/- 2014
Alabama	10,807,018	11,289,793	11,287,487	-2,306
Alaska	1,009,552	1,053,140	1,055,115	1,975
Arizona	6,512,204	7,172,686	7,196,997	24,311
Arkansas	6,628,562	6,906,551	6,878,440	-28,111
California	35,373,937	38,506,440	38,748,713	242,273
Colorado	7,120,349	7,452,963	7,441,248	-11,715
Connecticut	4,436,848	4,592,208	4,602,972	10,764
Delaware	1,918,877	1,972,854	1,957,840	-15,014
District of Columbia	6,865,189	6,910,635	6,896,471	-14,164
Florida	17,375,673	18,936,067	19,042,698	106,631
Georgia	15,634,663	16,675,849	16,780,281	104,432
Hawaii	2,061,568	2,161,853	2,172,251	10,398
Idaho	3,123,332	3,248,201	3,265,382	17,181
Illinois	20,161,097	21,151,855	21,112,727	-39,128
Indiana	11,606,560	12,182,600	12,169,679	-12,921
Iowa	6,332,401	6,524,401	6,492,524	-31,877
Kansas	4,527,045	4,750,504	4,745,889	-4,615
Kentucky	10,661,680	11,058,320	11,010,561	-47,759
Louisiana	11,583,571	12,018,309	12,038,724	20,415
Maine	3,244,066	3,309,140	3,316,998	7,858
Maryland	11,351,770	11,628,475	11,645,378	16,903
Massachusetts	10,646,937	10,982,014	10,990,478	8,464
Michigan	18,096,610	18,931,373	18,889,079	-42,294
Minnesota	8,806,865	9,119,747	9,080,105	-39,642
Mississippi	8,908,656	9,203,033	9,196,539	-6,494
Missouri	11,681,344	12,131,536	12,095,772	-35,764
Montana	2,236,161	2,289,565	2,277,334	-12,231
Nebraska	3,848,989	3,991,202	4,003,238	12,036
Nevada	1,760,014	2,013,329	2,071,561	58,232
New Hampshire	1,915,606	1,966,112	1,983,007	16,895

[138] Based on ACS 2010 3-year poverty data.
[139] Based on ACS 2011 3-year poverty data.
[140] Based on ACS 2012 3-year poverty data.

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2013 Final[138]	FY 2014 Estimate[139]	FY 2015 Estimate[140]	Difference +/- 2014
New Jersey	10,864,291	11,295,693	11,298,356	2,663
New Mexico	3,818,704	4,064,073	4,061,443	-2,630
New York	36,320,452	37,627,382	37,618,748	-8,634
North Carolina	16,290,355	17,188,876	17,226,333	37,457
North Dakota	1,707,611	1,736,011	1,732,090	-3,921
Ohio	21,144,317	22,154,629	22,037,187	-117,442
Oklahoma	6,692,198	6,988,115	6,967,374	-20,741
Oregon	5,896,904	6,212,108	6,243,419	31,311
Pennsylvania	22,764,692	23,496,911	23,480,330	-16,581
Rhode Island	1,555,974	1,631,318	1,628,196	-3,122
South Carolina	10,922,196	11,405,394	11,379,104	-26,290
South Dakota	2,098,753	2,147,943	2,138,599	-9,344
Tennessee	11,121,570	11,709,635	11,663,331	-46,304
Texas	31,290,844	34,036,233	33,903,204	-133,029
Utah	5,890,899	6,136,959	6,168,518	31,559
Vermont	1,625,665	1,648,124	1,647,948	-176
Virginia	11,668,846	12,054,594	12,047,912	-6,682
Washington	8,353,436	8,803,795	8,820,235	16,440
West Virginia	5,936,982	6,063,005	6,047,520	-15,485
Wisconsin	10,509,321	10,911,731	10,879,846	-31,885
Wyoming	1,162,702	1,202,934	1,211,037	8,103
SUBTOTAL	**493,873,856**	**518,646,218**	**518,646,218**	**-**
American Samoa	461,320	484,459	484,459	-
Guam	712,484	748,221	748,221	-
Marshalls	215,281	226,080	226,080	-
Micronesia	486,950	511,375	511,375	-
Northern Marianas	435,692	457,546	457,546	-
Palau	138,397	145,338	145,338	-
Puerto Rico	14,854,505	15,599,597	15,599,597	-
Virgin Islands	1,399,338	1,469,528	1,469,528	-
SUBTOTAL	**18,703,967**	**19,642,144**	**19,642,144**	**-**
TOTAL Resources	**512,577,823**	**538,288,362**	**538,288,362**	**-**

Autism and Other Developmental Disorders

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$44,652,000	$47,218,000	$47,218,000	---
FTE	7	7	7	---

Authorizing Legislation - Section 399BB of the Public Health Service Act.

FY 2015 Authorization .....Expired

Allocation Methods:

- Direct Federal/intramural
- Contract
- Competitive grant/co-operative agreement
- Other

Program Description and Accomplishments

The Combating Autism Act of 2006 authorized a program for early detection, education and intervention activities on autism and other developmental disorders. This Program supports activities to:

- provide information and education on autism spectrum disorders (ASD) and other developmental disabilities (DD) to increase public awareness;

- promote research into the development and validation of reliable screening tools and interventions for autism spectrum disorders and other developmental disabilities and disseminate information;

- promote early screening of individuals at higher risk for autism spectrum disorders and other developmental disabilities as early as practicable, given evidence-based screening techniques and interventions;

- increase the number of individuals who are able to confirm or rule out a diagnosis of autism spectrum disorders and other developmental disabilities; and

- increase the number of individuals able to provide evidence-based interventions for individuals diagnosed with autism spectrum disorders or other developmental disabilities.

In FY 2008, $36,354,000 was appropriated for this program of which approximately $20 million was moved from the Maternal and Child Health Block Grant training programs for Leadership Education in Neurodevelopmental and Related Disabilities (LEND) and

Developmental Behavioral Pediatrics. Funds were used to expand these interdisciplinary training programs as well as support the following programs: autism intervention research network grants to study the effectiveness of interventions for autism and related developmental disabilities; demonstration grants to develop models of systems of services for children with autism and other developmental disabilities; grants to disseminate current and accurate information to families and consumers on early identification, diagnosis and access to services; grants to disseminate screening intervention and guideline information; and other technical assistance and evaluation.

In FY 2009, $42 million was appropriated including an additional $6 million to: expand the LEND Program; support autism intervention research grants to study evidence-based practices for interventions to improve the health and well-being of children and adolescents with ASD and other DD; support grants that analyze secondary data, expand demonstration grants to develop models of systems of services for children with ASD and other DD; expand grants to resource centers to disseminate ASD information to families and consumers; disseminate screening intervention and guideline information; and support for other technical assistance and evaluation activities.

In FY 2010, $48 million was appropriated including an additional $6 million to expand the LEND interdisciplinary training programs, including four new planning grants; expand the autism intervention research grants, and to support additional State demonstration grants, supplements to developmental-behavioral pediatrics training programs, resource centers and a national evaluation. Developmental-behavioral pediatrics training programs have developed nine case studies on ASD and will disseminate to pediatric residency training programs and practicing primary care providers to improve screening, diagnosis and treatment of ASD.

In FY 2011, $47,708,000 was appropriated. This budget supported 43 LEND interdisciplinary training programs, providing services and training to 41 States, and their reach extends beyond those States because of partnerships formed and services provided across State lines; 10 Developmental-Behavioral Pediatrics training grants; three research networks and 15 autism intervention research projects examining areas of particular interest to families as outlined in the Interagency Autism Coordinating Committee's 2010 Strategic Plan for Autism Spectrum Disorder Research; and 13 State demonstration grants, resource centers, and a national evaluation. All activities continue to be coordinated with the Centers for Disease Control and Prevention's (CDC) Learn the Signs. Act Early. public awareness campaign; the State Demonstration Program jointly sponsors the campaign in four States – Washington, Missouri, Utah, and Alaska.

In FY 2012, $47,142,000 was appropriated. This budget supported 43 LEND interdisciplinary training programs, providing services and training to 41 States, with many extending training and services across multiple States, further extending their reach; 10 Developmental-Behavioral Pediatrics training programs; three research networks and 14 autism intervention research projects examining areas of particular interest to families and many addressing the needs of underserved populations; and 13 State demonstration grants, two resource centers, and a national evaluation.

In FY 2013, $44,652,000 was appropriated. This budget supported 43 LEND interdisciplinary training programs, providing services and training to 41 States, with many extending training and services across multiple States, further extending their reach; 10 Developmental-Behavioral Pediatrics training programs; four research networks and 14 autism intervention research projects examining areas of particular interest to families and many addressing the needs of underserved populations; 13 State systems grants (nine state implementation grants and 4 state planning grants) providing support to improve the system of health care including early identification and coordination of care; two resource centers; and a national evaluation.

The FY 2014 enacted funding amount is $47,218,000. This budget supports 43 LEND interdisciplinary training programs, providing services and training to 41 States, with many extending training and services across multiple States, further extending their reach; 10 Developmental-Behavioral Pediatrics training programs; 5 research networks and 12 autism intervention research projects examining areas of particular interest to families and many addressing the needs of underserved populations; 13 State systems grants (nine state implementation grants and 4 state planning grants) providing support to improve the system of health care including early identification and coordination of care; 2 resource centers; and a national evaluation. All activities continue to be coordinated with the CDC's activities and with priorities of the Interagency Autism Coordinating Committee (IACC).

Progress Report – Selected Findings

GAO Review: In calendar year 2012, the GAO reviewed HRSA's oversight of the Combating Autism Act programs. On February 27, 2013, the GAO released its report entitled: "Combating Autism Act: HHS Agencies Responded with New and Continuing Activities, Including Oversight." There were no recommendations from the GAO review, and the full report is available here: http://www.gao.gov/products/GAO-13-232. GAO found: "HRSA, the only HHS agency that has awarded grants specifically as a result of the CAA, regularly collects and reviews information from grantees to oversee individual CAA grantees and programs. HRSA awarded approximately $164 million in grants to 110 CAA grantees from fiscal years 2008 to 2011; though, some of these grantees were already receiving funds prior to the CAA. To oversee these grantees, HRSA requires they regularly submit progress reports and financial reports. The agency also requires grantees to obtain prior approval before making certain changes to their projects. GAO reviewed documentation from an unbiased random sample of 22 grantees, which were representative of the 110 CAA grantees. GAO found that CAA grantees submitted all required reports. Many grantees submitted prior-approval requests for changes to their projects. Most frequently, grantees requested to carry over unobligated funds from the current year to the next budget period. GAO found that HRSA staff routinely collected and reviewed information submitted by the grantees and appropriately documented their review and approval of these submissions. HRSA also conducted site visits and provided technical assistance as a means of overseeing grantees. HRSA conducted site visits with 9 of the grantees in our sample during the period of our review, while only 2 of these were required sites visits. Besides overseeing grantees, HRSA monitors its overall CAA programs by regularly collecting performance reports from grantees. In addition, in December 2012, HRSA released a grant-management operations manual to outline its overall approach for monitoring its CAA programs."

Report to Congress: In October 2013, HRSA submitted a detailed account of HRSA's progress on its autism activities from 2008-2011 in a Report to Congress titled: Results of the Combating Autism Act Initiative: HRSA's Efforts to Improve ASD Service Delivery Through Research, Training, and State Implementation Grants Fiscal Year(s) 2008-2011. A Report to Congress with findings through 2012 was submitted to the National Institute of Mental Health (NIMH) in September 2013. A new HRSA study starting with investments from September 30, 2011 to present is currently underway and contributed to the HHS 2013 Report to Congress. Selected findings from the completed evaluation are presented here.

Reducing Barriers

Reported increases in the number of children that received diagnostic evaluations over the course of the grant period provide an early indication of progress toward the goal of reducing barriers to ASD services. In 2009–2010, the 39 LEND grantees supported with CAAI [(Combating Autism Act Initiative)] funding collectively provided diagnostic evaluations to more than 35,000 children. The following year, the number of diagnostic evaluations provided through a LEND program-affiliated clinic exceeded 44,000. Including the children who received diagnostic evaluations from a CAAI-supported LEND program in 2008–2009, nearly 92,000 children were evaluated over the 3-year grant period.

Grantees further worked to improve access to ASD services in several ways. To enable more families to get the services they need regardless of their ability to pay, the grantees helped advance health insurance and billing improvements. To create more coordinated systems of care for ASD, they mapped existing resources, identified gaps in services, and worked to build more interdisciplinary collaboration among providers from different disciplines, such as medicine and education.

The LEND and DBP [(Developmental-Behavioral Pediatrics)] grantees provided Title V and other agencies with technical assistance to expand community-based services for ASD. The research grantees developed and disseminated ASD toolkits and clinical guidelines to support health care providers and families.

State systems grantees worked at the local, regional, and State levels to improve access to coordinated, comprehensive, timely, and evidence-based screening, diagnostic, and intervention services for ASDs and other DDs. By taking a public health approach that includes identifying available resources and gaps in services, building awareness among professionals and the public of the need for early identification and intervention for ASD, and building a more integrated system of services for ASD, the state grantees have achieved significant gains that will continue to spur improvements past their grant periods. States implemented different approaches in their efforts to improve services. Strategies included: partnering with existing programs, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to promote regular developmental screenings for this underserved population; training primary care practices on medical home concepts and how to develop care coordination plans for children with special health care needs; and piloting quality improvement learning collaboratives to increase early screening and reduce wait times for diagnostic services.

Finally, all grantees focused on the particular needs of underserved populations as a means of reducing disparities in access to ASD services.

Training

To address the shortage of health care professionals who are qualified to provide screening and diagnostic evaluation for ASD and other DD, the LEND and DBP programs expanded their training resources and assisted local agencies and practices in building their capacity to provide community-based ASD services. The LEND and DBP programs expanded the number of professionals in the pipeline by:

- Increasing the number of trainees enrolled in their programs. During the 2009–2010 grant year, the LEND and DBP programs collectively trained close to 2,500 medium-term and 1,400 long-term trainees.[141]

- The following grant year, the number of medium- and long-term trainees increased by 13 percent and 22 percent, respectively.

- By the 2011-2012 grant year, the LEND and DBP programs collectively trained 3,039 medium-term and 1,474 long-term trainees.

- Increasing the number of trainees that received ASD-focused didactic training. Between the 2009–2010 and 2010-2011 grant years, the number of medium-term trainees enrolled in ASD-focused coursework increased by 8.2 percent and the number of long-term trainees increased by 13.6 percent.

- Providing more clinical training opportunities focused on ASD screening and diagnosis. In the final year of the grant, close to 1,500 medium-term trainees and more than 1,100 long-term trainees had participated in clinical practices covering ASD screening, diagnostic evaluation, and/or intervention.

The grantees also responded to the training needs of practicing pediatricians and other professionals who had limited experience identifying ASD in children. Between 2009 and 2011, the LEND and DBP grantees collectively offered more than 1,600 continuing education (CE) events pertaining to ASD screening, diagnostic evaluation, and evidence-based interventions for children with ASD. In 2012 alone, the LEND and DBP grantees provided 917 CE events. From 2009-2011, these grantees also offered more than 4,000 outreach trainings related to valid and reliable screening and diagnostic tools, and/or evidence-based interventions for ASD and other DD, with the numbers increasing from year to year. In 2012 alone, they offered 2,136 outreach trainings.

[141] Medium-term trainees are those who complete between 30 and 200 hours of training during 1 academic year. Long-term trainees are those who complete more than 300 hours of training.

Awareness Building

To promote early screening, diagnostic evaluation, and intervention, the grantees engaged in various strategies aimed at building awareness of ASD among providers, parents, and the public. A few of their accomplishments are highlighted below:

- To raise public awareness, the State grantees disseminated messages about ASD through various media outlets, including film events, radio and televised public service announcements, and library campaigns. They also developed web sites and web portals for online dissemination of ASD materials. Additionally, they distributed screening kits, autism toolkits, as well as print materials and resources to medical providers and other professionals. Family-focused materials included resource roadmaps, directories, navigator guides, and autism guidebooks.

- During the grant period, the LEND and DBP training programs developed and/or disseminated close to 2,000 ASD-related educational products to health care practices and providers, educators, and parents.

- The research grantees reached more than 4,000 health professionals through various training events, such as grand rounds presentations and scientific conference presentations. Collectively, they reached more than 6,000 individuals through community outreach sessions.

Research

To improve the health and well-being of children with ASD, the research grantees conducted studies addressing such topics as the efficacy of ASD interventions, early identification of ASD in minority populations, family well-being, and transition and developed consensus-based guidelines to support families and professionals in providing treatment for children with ASD. These tools may, for example, help to quickly assess a child's engagement level on the playground or help parents manage their children's sleep behavior. Over eighty manuscripts have been published to date.

In addition to conducting studies, the research grantees developed guidelines to support evidence-based clinical decision-making, and toolkits to support clinicians and parents in identifying and treating the medical and behavioral issues that commonly occur in children with ASD. Together, the research grantees developed eight medical guidelines, one comprehensive guideline report, 14 toolkits for providers and parents to use in monitoring and managing ASD symptoms, and seven new behavioral measures for assessing a child's progress over time. More specifically:

- The Autism Intervention Research Network on Physical Health (AIR-P) drafted eight clinical guidelines in the areas of sleep, gastrointestinal problems, neurology, genetics and metabolic screening decisions, and medication choice and monitoring. Three of these guidelines (insomnia, constipation and medication choice) have since been finalized and were published in a Pediatrics Journal Supplement on HRSA CAAI Autism

Intervention Research Programs in November 2012. The AIR-P Network has implemented intensive improvement efforts to improve clinical outcomes in areas identified by the Network (current areas include insomnia and constipation) and improve access for children and adolescents with ASD.

- The Autism Intervention Research Network on Behavioral Health (AIR-B) developed a comprehensive consensus-based guidelines report assessing the scientific evidence on behavioral, educational, and medical interventions and their impact on ASD symptoms. This report was published in the Pediatrics journal supplement of HRSA CAAI autism intervention research programs in November 2012.

- To help parents and professionals manage health-related concerns that are commonly associated with ASD, the AIR-P network developed toolkits on medication management, sleep management, behavioral management, toileting, blood draw guidelines for parents and providers, and tools for day-to-day living. Other toolkits in the pipeline include transition of youth and young adults, feeding, and informing families of diagnosis.

- The AIR-B network developed new validated measures to track a child's progress and assess the effectiveness of behavioral ASD interventions over time. These new measures can be used by a diverse group of care providers in a variety of settings.

- The Developmental-Behavioral Pediatrics Research Network (DBPNet) was funded in FY 2010 and has established a collaborative scientific and clinical research network to foster research activities for children with ASD and other developmental disabilities.[142] DBPNet has developed the national research agenda for Developmental-Behavioral Pediatrics research through the Delphi process. The DBPNet is currently conducting studies on clinical practice variation, feasibility of electronic health record data in describing clinical practice, nature of referrals to DBP clinicians, family navigation to reduce disparities in timely autism diagnosis and access to early intervention, and has completed a study on research training in DBP fellowship programs. The DBPNet fosters the development of new investigators in developmental-behavioral pediatrics. The Network has awarded a Young Investigator to conduct a multi-site pilot study with mentorship from senior investigators across the network to study the association of maternal immune status with autism severity and behavioral impairments. DBPNet continues to strengthen the DBP research infrastructure by fostering the development of the next generation of DBP researchers, supporting research opportunities for its Network investigators, and promoting collaboration with and involvement of researchers external to the Network in DBPNet studies.

- In collaboration with all HRSA/MCHB funded CAAI autism intervention research programs, the AIR-P Network spear-headed the development of a journal supplement on HRSA CAAI autism intervention research programs and findings. The supplement includes manuscripts from select HRSA CAAI autism intervention research projects. The journal supplement was published in *Pediatrics* in November 2012 and covers a rich

[142] Blum, N.J.; DBPNet Steering Committee (2012) The Developmental-Behavioral Pediatrics Research Network: another step in the development of the field**.** Journal of Developmental Behavioral Pediatrics.33(1):78-83.

and diverse compilation of research and practice improvement related to the care and well-being of children and youth with autism and related neurodevelopmental disorders.

Other significant R40 research projects explore the use of family navigators to facilitate identification and diagnosis of ASD among Latino families; intervention strategies for improving the health care transition for youth with ASD; a culturally compatible parent to parent model of support and service coordination for families with a preschool child with ASD; and teleconsultation training for parents to perform Applied Behavior Analysis (ABA) therapy for their rural, underserved children with ASD.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2011	$47,708,000
FY 2012	$47,142,000
FY 2013	$44,652,000
FY 2014	$47,218,000
FY 2015	$47,218,000

Budget Request

The FY 2015 Budget Request is $47,218,000, the same as the FY 2014 Enacted level. Comparable activities will be supported in FY 2015 including 43 LEND training programs, 10 developmental-behavioral pediatrics training programs, 9 active State systems grants, four State planning grants, 5 autism intervention research networks, 2 resource centers, and 14 research grants examining areas of particular interest to families as outlined in the Interagency Autism Coordinating Committee's Strategic Plan for Autism Spectrum Disorder Research as well as addressing the needs of underserved populations. All activities will continue to be coordinated with the Interagency Autism Coordinating Committee and, in particular, with the CDC's Learn the Signs.Act Early. public awareness campaign.

A contract for a new program evaluation was initiated in FY 2013, examining program findings from 2011 forward. Results from this evaluation will be included in the next Report to Congress.

In FY 2015 funds will be used to continue and expand activities initiated in FY 2008 to:

- Provide information, education and coordination;
- Promote research into evidence based practices for interventions and the development of reliable screening tools;
- Promote the development, dissemination and implementation of guidelines;
- Promote early screening and intervention;

- Train providers to diagnose and provide care for individuals with ASD and other DD;
- Develop innovative strategies to integrate and enhance existing investments, including translating research findings on interventions, guidelines, tools and systems management approaches to training settings, communities and into practice; and
- Promote life-course considerations, from developmental screening in early childhood to transition to adulthood issues.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Grants:			
LEND	$26,451,215	$28,042,255	$28,042,255
DBP	$1,771,910	$1,880,630	$1,880,630
Research	$9,149,715	$9,698,698	$9,698,698
State Systems	$2,761,315	$2,991,645	$2,991,645
Resource Centers	$886,141	$939,309	$939,309
Number of Awards	86	85	87
Average Award	$475,430	$512,383	$500,604

Traumatic Brain Injury

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$9,245,000	$9,344,000	$9,344,000	---
FTE	---	---	---	---

Authorizing Legislation - Sections 1252 and 1253 of the Public Health Service Act.

FY 2015 Authorization .....Expired

Allocation Methods……..….Formula grant/Competitive grant

Program Description and Accomplishments

The purpose of the Traumatic Brain Injury (TBI) Program is to increase access to rehabilitation and other services to individuals with traumatic brain injury. The program funds the development and implementation of statewide systems that ensures access to comprehensive and coordinated TBI services including: transitional services, rehabilitation, education and employment, and long-term community support. On average, 1.7 million Americans will sustain a TBI each year[143]. It is estimated that up to 90,000 of these individuals will experience long-term, sometimes life-long, impairments as a result of their injury[144]. Such statistics likely underestimate the actual incidence of TBI because surveillance only captures injuries for which medical treatment is sought. Timely, comprehensive treatment is vital not only to save lives, but also to improve the quality of life for TBI survivors. Thus, HRSA emphasizes early diagnoses and intervention, and access to medical home and system of care.

TBI can cause a range of symptoms, which may include, but is not limited to, memory loss, difficulty concentrating, confusion, irritability, personality changes, fatigue, and headaches. Individuals with TBI may need a variety of services and supports, including rehabilitation, counseling, academic and vocational accommodations, independent living assistance, transportation assistance, and vocational training. These services and supports are often fragmented across different State systems of care, making access difficult for families. Through the TBI Program, State and Territorial governments receive funding to help individuals with TBI

[143]Faul M, Xu L, Wald MM, Coronado VG. Traumatic Brain Injury in the United States: Emergency Department Visits, Hospitalizations and Deaths 2002–2006. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2010. Traumatic Brain Injury in the United States: A Report to Congress. December 1999. http://www.cdc.gov/ncipc/pub-res/tbi_congress/TBI_in_the_US.PDF

[144]Traumatic Brain Injury in the United States: A Report to Congress. December 1999. http://www.cdc.gov/ncipc/pub-res/tbi_congress/TBI_in_the_US.PDF

and their families receive the comprehensive care and services they need to manage ongoing conditions caused by the injury.

The TBI Program consists of two distinct grant programs: 1) the State Implementation Partnership Grants (competitive grant), and 2) the State Protection and Advocacy Systems Grants (formula grant).

State Implementation Partnership Grants

The goal of State Implementation Partnership Grants is to address barriers to needed services encountered by children, youth, and adults with TBI. States and Territories assess the need for TBI services and resources within their State or Territory and facilitate the development or expansion of a comprehensive, multidisciplinary, and easily accessible system of care for individuals with TBI and their families. The system of care emphasizes diagnosis, intervention and resource facilitation consistent with the model of a medical home. Thus, grant activities will increase access to rehabilitation and other services by (1) screening to identify individuals with TBI, (2) building a trained TBI workforce by providing professional training, (3) providing information about TBI to families and referrals to appropriate service providers, and (4) facilitating access to needed services through resource facilitation. A performance goal for this program is to "increase the number of total State partnerships and/or collaborations with governmental and non-governmental organizations." The FY 2012 data show that 441 partnerships have been forged since 2009. The Program anticipates that the number of collaborations/partnerships in which TBI grantees participate will be 350 in FY 2014, as a new cohort of grantees will be active and begin forging new partnerships.

Since 2009 the focus of grant awards has changed to reflect an increased emphasis on those special populations with high rates of TBI that have not necessarily received adequate attention in the past, including veterans, children and youth, incarcerated juveniles, those with substance abuse problems, as well as Native Americans and African Americans. All grantees have made progress in developing and linking accessible TBI services and supports.

Activities include educating consumers, families, and professionals on available TBI resources/services, screening for TBI in criminal/juvenile justice facilities, homeless shelters, and schools, training health professionals in various disciplines to identify and effectively serve individuals with TBI, providing case management services to coordinate care across treatment areas, and assisting families who are transitioning from one system to another (e.g., military discharge to community re-entry, hospital acute care to school re-entry). New performance measures have been developed to determine if individuals with TBI and their families were able to access needed services due to their interaction with grantees and if professionals receiving training from grantees report that they are better able to assess and meet the needs of individuals with TBI and their families. Baseline data for these measures for FY 2014 will be available in FY 2015, at which time annual targets will be established.

State Protection and Advocacy Systems Grants

Section 1253 of the Public Health Service Act recognizes that State Protection and Advocacy (P&A) systems are critical to achieving the goals and objectives of the TBI Program. In FY 2003, grants were awarded to all 57 P&A systems to evaluate capacity and to develop plans to ensure P&A services, including individual and family advocacy, self-advocacy training, specific self-advocacy assistance, information and referral services, and legal representation. These formula grants continue to be awarded to 57 States, Territories, and one Native American Consortium. A key performance measure for this program will be to "increase the number of trainings conducted by the TBI Protection and Advocacy Grant Program." An additional new performance measure will assess not only the number but also the impact of P&A activities by asking providers and individuals with TBI and their families if the training and information provided helped recipients to better provide/access TBI services.

Programs	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
State Grants for Demonstration Projects	$4,985,047	$5,500,000	$5,250,000
Protection and Advocacy Grants	$3,099,593	$3,099,593	$3,099,593

The TBI program also provides funding for a national technical assistance center. The Traumatic Brain Injury Technical Assistance Center (TBITAC) was funded at $698,000 for FY 2013 and is budgeted at $500,000 for FY 2014 and FY 2015 if funds are available. The TBITAC has been responsible for providing technical assistance to grantees, maintaining a national listserv on issues that affect TBI service delivery with approximately 1500 subscribers, maintaining an online collaboration space for grantees to share best practices for building and maintaining service-delivery infrastructure, and developing educational materials for the public about TBI. Beginning in FY 2015, the Center will expand its role to include analyzing the impact of the HRSA TBI program.

Funding for the TBI Program also includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbooks, follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2011	$9,878,000
FY 2012	$9,760,000
FY 2013	$9,245,000
FY 2014	$9,344,000
FY 2015	$9,344,000

Budget Request

The FY 2015 Budget Request is $9,344,000.the same as the FY 2014 Enacted level. This funding level will support approximately 21 State Implementation Partnership grants are anticipated to be awarded in FY 2015. These awards will allow the States to create a statewide system of care that links agencies including Education, Vocational Rehabilitation, Social Services, Mental Health, Substance Abuse, Corrections, Housing, and Transportation to ensure a comprehensive and sustainable system of care is navigable for individuals with TBI and their families.
TBI Protection and Advocacy grants will receive approximately $3.1 million in FY 2015 awarded to 57 States and Territories, same as FY 2013 and FY 2014.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
11.V.B.6 Percentage of grantees that achieve the 4 core components of the TBI Implementation Partnership Grant Program within the 4 year project period. (*Output)*	FY 2012: 100% Target: N/A (Baseline)	100%	100%	Maintain
11.V.B.4. Number of total State partnerships and/or collaborations with governmental and	FY 2012: 441 Target: 154 (Target Exceeded)	350[145]	350[146]	Maintain

[145] This target is lower than the FY 2012 result because it reflects the activities of a new cohort of grantees.
[146] This target is lower than the FY 2012 result because it reflects the activities of a new cohort of grantees.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
non-governmental organizations. (*Output)*				
11.V.B.8. Increase the number of individuals that receive trainings conducted by the TBI Protection and Advocacy Grant Program. (*Outcome)*	FY 2012: 38,457 Target: N/A (Baseline)	38,000	38,000	Maintain
11.V.B.9 Proportion of individuals with TBI and/or their families who report that a State Implementation Partnership grantee provided, or helped them to better access, TBI-related services.[147] (Developmental)	N/A	N/A	N/A	N/A
11.V.B.10 Proportion of professionals participating in a HRSA grantee activity who report that they are better able to assess the needs of TBI survivors and/or their families and facilitate improved access to	N/A	N/A	N/A	N/A

[147] This developmental measure does not currently have annual targets. Baseline data for 2014 will be available in 2015 whenfuture year targets will be established.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
rehabilitative and other services.[148] (Developmental)				
11.V.B.11 Proportion of persons with TBI and/or their families who report that a HRSA TBI Protection and Advocacy Grantee helped them to better access services.[149] (Developmental)	N/A	N/A	N/A	N/A

Grant Awards Table

Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	20/57[150]	22/57[150]	21/57[150]
Average Award	$249,252/ $54,379[150]	$250,000/ $54,379[150]	$250,000/ $54,379[150]
Range of Awards	$240,000-$250,000/$20,000-$146,000[150]	$240,000-$250,000/ $20,000-$146,000[150]	$240,000-$250,000/$20,000-$146,000[150]

[148] This developmental measure does not currently have annual targets. Baseline data for 2014 will be available in 2015 and future year targets will be established in FY 2016.
[149] This developmental measure does not currently have annual targets. Baseline data for 2014 will be available in 2015 and future year targets will be established in FY 2016.
[150] State Implementation Partnership Grantees/Protection and Advocacy Grantees

Sickle Cell Services Demonstration Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$4,419,000	$4,466,000	$4,466,000	---
FTE	2	2	2	---

Authorizing Legislation - Section 712(c) of the American Jobs Creation Act of 2004.

FY 2015 Authorization .....Expired

Allocation Methods……..……Competitive co-operative agreement/Contract

Program Description and Accomplishments

The legislative requirement of the Sickle Cell Disease Demonstration Program is to support the development and establishment of systemic mechanisms to improve the prevention and treatment of Sickle Cell Disease and its complications, including the coordination of service delivery for individuals with Sickle Cell Disease; genetic counseling and testing; bundling of technical services related to the prevention and treatment of sickle cell disease; training of health professionals; and identifying and establishing efforts related to the expansion and coordination of education, treatment, and continuity of care for individuals with Sickle Cell Disease as authorized in Public Law 108-357, Section 712(c). This funding opportunity will support the development of Sickle Cell Regional Collaboratives.

Due to advancements in treatment of sickle cell disease, life expectancy of persons with sickle cell has increased. However, the population has not benefitted from improved therapies equally. In 2008, NIH released a report stating that although hydroxyurea had been proven to be an effective therapy for the management of sickle cell disease, only 10 percent of sickle cell patients that could benefit from hydroxyurea had access to the therapy. Several barriers to accessing hydroxyurea were identified, including a lack of awareness of the benefits of hydroxyurea, a limited number of providers willing to prescribe hydroxyurea, a lack of clarity of hydroxyurea treatment regimen and other provider and patient level barriers.

Since its creation in FY 2005, the Sickle Cell Disease Demonstration Program has developed multiple strategies to disseminate information to providers regarding prevention of morbidity and mortality associated with the sickle cell disease. These strategies have included improving the use of hydroxyurea in medical homes co-managed by primary care providers and hematologists; decreasing time to first pain medicine in the emergency room settings, and improving provider education through curriculum development and networking strategies. In FY 2014, the program will be reorganized to support geographically distributed regions to fund collaboratives across multiple states. This re-envisioned program will create regional collaboratives using a Collective

Impact approach to create partnerships between grantees and sickle cell centers and FQHCs to put the demonstration program on a path to obtaining national reach, which was not possible under the previous structure. Through geographically distributed regions, HRSA intends to broaden the reach of the Sickle Cell Disease Treatment Demonstration Program (SCDTDP) to the national level effort for sickle cell care delivery and data collection. This will require a reduction in the number of grantees but an increase in the amount of funds per grantee. FY 2015 activities will focus on maintaining the efforts started in FY 2014 to increase the number of sickle cell patients that have access to a sickle cell medical home by increasing co-management of sickle cell disease by hematologists and primary care providers.

HRSA has also been strengthening its collaborative efforts with other HHS agencies to improve sickle cell care. NIH has been developing sickle cell disease clinical management guidelines and HRSA is collaborating with NIH, CDC and other HHS partners to adapt and institutionalize the sickle cell practice guidelines into a national strategy. This strategy will include data elements that can be used across HHS programs.

Funding History

FY	Amount
FY 2011	$4,721,000
FY 2012	$4,665,000
FY 2013	$4,419,000
FY 2014	$4,466,000
FY 2015	$4,466,000

Budget Request

The FY 2015 Budget Request is $4,466,000, the same as the FY 2014 Enacted level and will (1) support four geographically distributed regional projects with nationwide exposure for enhanced access to comprehensive, coordinated, culturally-effective, and family centered high quality services for individuals with sickle cell disease; (2) expand and upgrade data collection efforts and improve capacity to generate evidence of effectiveness through evaluating network activities and outcomes; and (3) focus on increasing the number of providers that are involved with the care of individuals with sickle cell disease by increasing capacity of university medical centers and hematologists to provide technical assistance and educational opportunities.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	9	4	4
Average Award	$356,618	$900,906	$900,906
Range of Awards	$356,618 - $356,618	$875,000 – $925,000	$875,000 - $925,000

James T. Walsh Universal Newborn Hearing Screening

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$17,674,000	$17,863,000	$17,863,000	---
FTE	5	5	5	---

Authorizing Legislation - Section 399M of the Public Health Service Act.

FY 2015 Authorization .....Expired

Allocation Methods……Competitive grant/Co-operative agreement

Program Description and Accomplishments

The James T. Walsh Universal Newborn Hearing Screening Program began in FY 2000 with the purpose of assisting states to develop newborn hearing screening and early intervention programs. The program supports the following Healthy People 2020 Objectives: Increase the proportion of newborns who are screened for hearing loss by no later than age 1 month, have audio logic evaluation by age 3 months, and are enrolled in appropriate intervention services no later than age 6 months.

To implement the program, the Maternal and Child Health Bureau awards competitive grants to States and one national technical assistance center. Collaboration with the Centers for Disease Control and Prevention (CDC) and National Institutes of Health's National Institute on Deafness and Other Communication Disorders is ongoing to coordinate programs at the national and State levels. For FY 2009 and FY 2010, additional supplemental funds were directed toward reducing loss-to-follow-up by implementing strategies to assure that infants identified through screening receive timely diagnosis and early intervention, and that parents are connected to ongoing family-to-family support. In 2013, non-competing continuation awards were made to 58 grantees and 1 national resource center in the form of a cooperative agreement.

The Universal Newborn Hearing Screening Program has been successful in increasing the percentage of newborns screened for hearing loss prior to hospital discharge. In 2005, 95 percent of newborns were screened for hearing loss prior to hospital discharge, exceeding the target of 94 percent according to data collected by the National Center for Hearing Assessment and Management. In FY 2006, the (CDC's) National Center for Birth Defects and Developmental Disabilities (NCBDDD) began collecting State data for the first time on newborn hearing screening services. For FY 2011, data from the NCBDDD indicate that 98 percent of newborns were screened before one month of age, most before discharge from the newborn nursery. In addition, the Loss to Documentation/Follow-up (LTD/F) rate dropped from 46 percent to 39 percent. In 2011, the Loss to Documentation/Follow-up rate continued to drop to 34.9%. Although most of the States now have laws mandating hearing screening for newborns, few have comprehensive reporting provisions. Hospitals report screening in nearly all U.S. hospitals, save military birthing hospitals. Service providers (audiologists, primary care

practitioners and Early Intervention providers) in the continuum of services do not routinely report in many places.

An independent evaluation of the Program was completed in 2006. Findings were used to implement a quality improvement initiative. This initiative focused on implementation of recommendations for programmatic changes which have proven to be effective in reducing loss to follow-up. These strategies have been incorporated into subsequent grant guidance. Program funding includes a National Resource Center, staffing, costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbooks, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2011	$18,884,000
FY 2012	$18,660,000
FY 2013	$17,674,000
FY 2014	$17,863,000
FY 2015	$17,863,000

Budget Request

The FY 2015 Budget Request is $17,863,000, the same as the FY 2014 Enacted level. The FY 2015 request will support 58 awards and 1 national resource center in the form of a cooperative agreement to assist the program in achieving the FY 2015 target of screening 98 percent of infants prior to one month of age.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
13.1: Increase the percentage of children with non-syndromic hearing loss entering school with developmentally appropriate language skills.[151] *(Outcome)*	FY 2004: 20% (Baseline)	N/A	N/A	N/A
13.2: Increase the percentage of infants with hearing loss enrolled in early intervention before 6 months of age.[152] [153] (Baseline – FY 2009: 68%) *(Output)*	FY 2011: 68% Target: 67% (Target Exceeded)	70%	72%	+2% points
13.III.A.1: Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by 3 months of age. *(Output)*	FY 2011: 71% Target: 63% (Target Exceeded)	75%	77%	+2% points
13.III.A.3: Percentage of infants screened for hearing loss prior to one month of age. *(0utput)*	FY 2011: 98% Target: 98% (Target Met)	98%	98%	Maintain

[151] This long-term measure does not have annual targets. The first long-term target of 85% was set for FY 2013.
[152] CDC has been collecting data annually since 2006. Baseline updated to reflect annual data collection. Previously data were collected by the National Center for Hearing Assessment and Management.
[153] This measure is to be tracked annually in light of new Part C of IDEA regulations which mandate collaboration with Title V programs including newborn hearing screening programs.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	59 (58 grants and 1 cooperative agreement)	59 (58 grants and 1 cooperative agreement)	59 (58 grants and 1 cooperative agreement)
Average Award	$243,747 (grants) $997,468(cooperative agreement)	$243,747 (grants) $997,468 (cooperative agreement)	$243,747 (grants) $997,468 (cooperative agreement)
Range of Awards	$130,912-$263,680 (grants) $997,468 (cooperative agreement)	$130,912-$263,680 (grants) $997,468 (cooperative agreement)	$130,912-$263,680 (grants) $997,468 (cooperative agreement)

Emergency Medical Services for Children

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$20,000,000	$20,213,000	$20,213,000	---
FTE	4	4	4	---

Authorizing Legislation - Section 1910 of the Public Health Service Act.

FY 2015 Authorization .....Expired

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

Program Description and Accomplishments

The Emergency Medical Services for Children (EMS-C) Program, established in 1984, is the only Federal program that focuses specifically on improving the pediatric components of the emergency medical services (EMS) system. The Institute of Medicine (IOM) and other national experts have stated that there are significant gaps across the country in providing quality care to children in emergencies. Pediatric emergency care begins with the 911 call through the delivery of the patient to the appropriate hospital and ultimately returning the child to the community. The mission of the EMS-C program is to reduce child and youth mortality and morbidity resulting from severe illness or trauma.

The EMS-C Program provides infrastructure support to 49 states, all territories and the Freely Associated States to ensure that pediatric emergency care provided in these locales is integrated into the larger emergency medical services system. By having a universal presence across the United States, the program aims to reach its goal of ensuring that all children receive optimal emergency care no matter where they are. Each of these entities works towards implementing the same prehospital and hospital quality performance measures which represents the largest national effort for standardized pediatric emergency care. Unfortunately, variability in care continues to exist due to geographical, jurisdictional and workforce issues that can prevent children receiving the right care at the right time. To improve the quality of pediatric emergency care, the EMS-C Program continues to invest in initiatives that promote pediatric emergency care evidence-based or evidence-informed practices in the field.

The EMS-C Program allocates over 95% of its funds through competitive grants to state governments and institutions of higher learning. The four main programs are: 1) State Partnership grants (States, Territories and the Freely Associated States) (58); 2) Targeted Issues grants that address pediatric emergency care issues of national significance (6); 3) State Partnership Regionalization of Care demonstration grants that develop models to improve pediatric emergency care capacity in rural and tribal communities (6): and 4) Pediatric Emergency Care Applied Research Network (PECARN) grants (6) to conduct meaningful and

rigorous multi-institutional studies in the management of acute illness and injury in children across the continuum of emergency medicine.

In FY 2013, the EMS-C investment has resulted in the following accomplishments:

- Three entities from the Freely Associated States (Republics of Palau and Marshall Islands, and the Federated States of Micronesia) became new state partnership grantees. This is the first time these locales have been able to formally address the needs of children in the emergency care setting. They are developing essential partnerships with established EMS-C grantees in the Pacific Basin to address the challenges of access to pediatric care, inter-island transport and workforce development.

- In a joint effort, States, with their EMS-C State Partnership grantees, have partnered with the American Academy of Pediatrics, the Emergency Nurses Association, the American College of Emergency Physicians and others to ensure all emergency departments meet the 2009 joint policy statement of 22 national organizations for "The Care of Children in the Emergency Department" (Pediatrics, 2009). Through a coalition process these groups are engaging hospital emergency departments to participate in a quality improvement initiative called "The National Pediatric Readiness Project" that supports improving delivery systems at the local level to ensure children receive the right care at the right time. Simple system changes such as weighing a child in kilograms rather than pounds to prevent medical errors, ensuring that interfacility transfer agreements are in place, and that at the local level emergency departments have a physician or nurse champion for pediatric emergency care can greatly improve the care provided to children. Over 4,000 emergency departments across the nation have participated in assessing their readiness to care for children which represents approximately 80% of the nation's emergency departments. Approximately half of these emergency departments see less than 15 pediatric patients a day.

- The State Partnership Regionalization of Care (SPROC) demonstration grantees are working on models to bring urban, rural and tribal communities together to provide seamless care for children. They are exploring avenues to expand healthcare networks within and beyond their state borders, establish pediatric medical recognition systems, expand access to EMS education through distance learning, the use of tele-consultation, novel referral structures to prevent unnecessary transport of children from their community and methods to evaluate these initiatives. They are partnering with cultural liaisons to assure the integration and representation of tribal and rural communities in project development and implementation. The goal is for these demonstration projects to serve as models for other communities in the country.

- To address the lack of evidence-based practices in pediatric prehospital care, a new competitive Targeted Issues funding opportunity was launched in FY 2013. Two strategies were implemented: first to establish an EMS agency research network infrastructure to assess the feasibility of conducting pediatric prehospital research modeled after the PECARN and second to fund individual grants focusing on increasing knowledge on effective clinical care protocols, data collection, or training in pediatric prehospital care. Six grants were awarded

which represents the only federal funding opportunity focusing on increasing the evidence and quality of pediatric prehospital care.

- The PECARN grantees have established an efficient multi-center research network (18 sites representing over one million pediatric visits annually) that participates in multiple forms of research: randomized controlled trials, implementation as well as translational research. Two studies specifically have impacted practice in pediatric emergency medicine. One randomized controlled study demonstrated that a steroid medication, commonly used by clinicians, was not an effective treatment for a prevalent pediatric respiratory illness, bronchiolitis (N Engl J Med, 2007). The next study examined over 40,000 children suffering head injury to identify clinical predictors to determine which children would need radiologic testing for evaluation of mild traumatic brain injury (Lancet, 2009). Further funding supports the evaluation of this decision tool being integrated into electronic medical records to provide point of care support in the clinical management of mild traumatic brain injury. The change in clinical practice from these two studies has resulted in improved safety for children by decreasing inappropriate use of medications or radiological studies as well as potentially decreasing inappropriate use of health care resources.

Collaborations

To further achieve system improvements, the EMS-C Program works in collaboration with the Federal Interagency Committee on EMS (FICEMS), a legislated federal entity with a composite of key agencies that intersect with the emergency medical services system. The FICEMS ensures collaboration and integration of Federal activities within HHS (HRSA, ASPR, CDC, IHS, and CMS) and between DOT, DHS, DOD, and FCC. EMS-C brings the only pediatric perspective to this Federal group which sets national agendas and policies for emergency medical services. In addition to FICEMS, EMS-C works with individual Federal agencies to ensure the integration of pediatric priorities in the overall EMS system.

A primary partner within the Department of Transportation's National Highway Traffic Safety Administration (NHTSA) is the Office of Emergency Medical Services (OEMS). EMS-C collaborates with OEMS on the advancement of standardized and evidence based prehospital medical protocols, strategies that support regionalization of trauma care, instituting a culture of safety in the EMS setting, and partnering in the implementation of the National EMS Information System. EMS-C Program's partnership with OEMS ensures pediatric relevant issues are integrated into the larger EMS policies, education agendas and guidelines. Working with the Indian Health Service (IHS), EMS-C assures the availability of pediatric-specific training initiatives tailored to the needs of tribal EMS and IHS medical facility professionals. In addition, the EMS-C Program utilizes the Agency for Health Care Research and Quality (AHRQ) to provide national data on childhood mortality secondary to injury and referral patterns of pediatric patients among various designations of Trauma Centers. The most recent collaboration is with the Department of Defense United States Uniformed Health Services (USUHS) School of Medicine to develop a pediatric trauma curriculum for trauma surgeons and nurses. The military experience abroad has highlighted the gap in pediatric trauma training for nurses and surgeons and is similar to workforce shortages domestically in rural communities. The development of this pediatric trauma curriculum will be integrated into established training supported by the

American College of Surgeons Committee on Trauma. This will ensure dissemination and integration into practice.

Measuring Impact

Systematically, the EMS-C Program measures its impacts through the results of performance measures.. In the short term, the program focuses on the quality of care provided in the pre-hospital and hospital settings by assuring continuing pediatric education. Performance measures that require survey assessment are collected every 3 years (FY 2013-2014 next reporting year), while self-reported data is collected annually. Each year, State grantees assess the adoption of required pediatric training for Basic Life Support (BLS) and Advanced Life Support (ALS) providers during recertification (Measure 14.V.B.2A & 2B). Through FY 2012, 42 grantees had adopted requirements for recertification of BLS providers and 44 grantees had adopted requirements for recertification of ALS providers. States grantees also assess yearly their states' recognition system to take care of pediatric medical emergencies and traumatic emergencies (Measure 14V.B.4A & 4B). In FY 2012, 25 grantees had made significant progress in implementing a pediatric medical recognition system and 48 grantees for a trauma system capable of caring for pediatric emergencies. Each of these reported annual measures exceeds the established targets.

Decreasing pediatric mortalities due to serious injury is a long-term outcome of the EMS-C Program that is tracked annually. Data from the Healthcare Cost Utilization Project (HCUP) is utilized to assess trends in pediatric mortality due to injuries. The EMS-C program assesses the percent reduction in pediatric injury mortality annually from the HCUP administrative data (Measure 14.1.A). Small reductions in absolute mortality rates can represent a significant number of lives saved, so an annual goal of 0.5 percent reduction is presented rather than the absolute rate decrease. In FY 2010, there was a 14.8% reduction from FY 2009 in children ages 0-15 years with injury severity score greater than 15 who died. This equates to an estimated 106 lives saved in FY 2010 or the equivalent of 5 classrooms full of children.

The EMS-C program tracks other health quality indicators that address the quality of care being delivered in States and territories as well as the permanence of EMS-C in State systems. Program requires all State/Territory grantees to collect data every three years for some measures.

In FY 2010, national survey data collected by Program grantees demonstrated the following results:

- Each State determines whether its ambulances that transport children have all of the appropriate pediatric equipment available. Success for this performance measure is noted when all ambulances transporting children in a State carry all of the necessary pediatric equipment. The results are presented first as the proportion of equipment carried on ambulances nationally, the proportion that has all of the equipment, and finally, the number of States with 100% compliance. Of the EMS vehicles responding to 911 calls for pediatric patients, representing 22,067 ambulances, Basic Life Support (BLS) ambulances had 91 percent of all the recommended pediatric equipment and Advanced Life Support (ALS) ambulances had 96 percent of all the recommended pediatric

equipment. Although a majority of ambulances have the majority of essential equipment, only 22 percent of BLS ambulances and 39 percent of ALS ambulances had 100 percent of the recommended pediatric equipment. Only two entities, Hawaii and the District of Columbia, have all of the BLS recommended pediatric equipment and supplies (Measure 14.V.B.3A) and two entities, Maryland and the District of Columbia, have all the ALS recommended pediatric equipment and supplies on 100 percent of the ambulances (Measure 14.V.B.3B). Missing items include essential lifesaving equipment and therefore the Program continues to direct efforts to assure that 100 percent of the recommended equipment is on 100 percent of the ambulances in every State/Territory.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbooks, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2011	$21,369,000
FY 2012	$21,116,000
FY 2013	$20,000,000
FY 2014	$20,213,000
FY 2015	$20,213,000

Budget Request

The FY 2015 Budget Request is $20,213,000, the same as the FY 2014 Enacted level. This request supports the program's efforts to achieve its FY 2015 performance targets. The EMS-C Program will continue to support and strengthen its presence in States, territories and Freely Associated States to ensure the attainment of the results of program performance measures. Engagement of the prehospital community to include family representatives and cultural liaisons representing the families and children in all funded jurisdictions, as well as emergency departments and hospitals, is vital to a high quality continuum of care for children. The development and dissemination of models of regionalized care are needed to address variability in pediatric emergency care. Additionally, continued support of evidence-based practices in emergency medical services for children is needed to provide the most appropriate care. Success in these areas will support attaining the results of proposed program performance measures. Recent study results published by the International Journal of Emergency Medicine, National Survey of Pediatric Services Available in U.S. Emergency Departments, suggest a continued need for improvements to ensure access to emergency care for children (Sullivan et al. 2013, 6:13).

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
14.V.B.2.A: Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of BLS providers. *(Output)*	FY 2012: 42 Target: 41 (Target Exceeded)	44	45	+1
14.V.B.2.B: Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of ALS providers. *(Output)*	FY 2012: 44 Target: 41 (Target Exceeded)	46	47	+1
14.1.A: Percent reduction in mortality rate for children with an injury severity score greater than 15. *(Outcome)*[154]	FY 2010: 14.8% reduction [155] (Target Exceeded)	0.5% reduction from prior year	0.5% reduction from prior year	Maintain

[154] The new data source for this measure is the National Emergency Department Sample (NEDS). Data is reported from the most currently available pediatric mortality data. Source: Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality.

[155] The annual percent reduction is calculated by the difference in mortality rate from the previous year divided by the base year rate, the reference Mortality Rate for FY 2009 is 5.72% and Mortality Rate in FY 2010 is 4.87% among children 0-15 years of age.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
14.V.B.3A: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care based on nationally-recommended pediatric equipment available on BLS ambulances. *(Output)*	FY 2010 Result: 2 Target: 1 (Target Exceeded)	N/A[156]	N/A	N/A
14.V.B.3B: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care based on nationally-recommended pediatric equipment available on ALS ambulances. *(Output)*	FY 2010 Result: 2 Target: 1 (Target Exceeded)	N/A[156]	N/A	N/A

[156] Data on measures (14.V.B.3A & B) is only collected every three years. N/A is listed for non-data collection years. Data is currently being collected for the grant project period 3-1-2013 to 2-28-2014 (EMSC program FY 2013) and will be validated by August 2014. The next data collection cycle is in FY 2016 (3-1-2016 to 2-28-2017) and will be validated by August 2017, FY 2017.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
14.V.B.4A: Increase the number of awardees that have made significant progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric medical emergencies. *(Output)*	FY 2012 Result: 25 Target: 15 (Target Exceeded)	25	26	+1
14.V.B.4B: Increase the number of awardees that have made significant progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric traumatic emergencies. *(Output)*	FY 2012 Result: 48 Target: 45 (Target Exceeded)	49	49	Maintain

Grant Awards Table

Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	78	78	78
Average Award	$226,146	$226,146	$226,146
Range of Awards	$40,000-$2,800,000	$40,000-$2,800,000	$40,000-$2,800,000

Healthy Start

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$98,064,000	$101,000,000	$101,000,000	---
FTE	4	4	4	---

Authorizing Legislation - Section 330H of the Public Health Service Act.

FY 2015 Authorization ..... Expired

Allocation Method ..... Competitive grant/co-operative agreement

Program Description and Accomplishments

The Children's Health Act of 2000 (P. L. 106-310) amended the Public Health Service Act to provide "such sums as necessary" for continuation and expansion of a distinct Healthy Start program of grants that use community-designed and evidence-supported strategies aimed at reducing infant mortality and improving perinatal outcomes in project areas with high annual rates of infant mortality and other perinatal indicators.

Healthy Start (HS) aims to reduce disparities in infant mortality and adverse perinatal outcomes by: 1) improving women's health, 2) promoting quality services, 3) strengthening family resilience, 4) achieving collective impact, and 5) increasing accountability through quality improvement, performance monitoring, and evaluation. HS works to reduce "the disparity in health status between the general population and individuals who are members of racial or ethnic minority groups." 42 U.S.C. § 254 c-8(e)(2)(B). HS services begin in the prenatal period and follow the woman and child through two years after the end of the pregnancy.

Through a lifespan approach and a focus on the interconception health of women, the Healthy Start program aims to reduce disparities in access to and utilization of health services, improve the quality of the local health care system, empower women and their families, and increase consumer and community voices and participation in health care decisions.

Through grants to communities with exceptionally high rates of infant mortality (at least 1½ times the U.S. national average) and other perinatal outcomes (such as low birthweight, preterm delivery, maternal morbidity and mortality), and/or high indicators of poor perinatal outcomes (such as poverty, education, access to care, and other socioeconomic factors), HS continues to focus on these contributing factors, particularly among non-Hispanic Black and other disproportionately affected populations. In these geographically, racially, ethnically, and linguistically diverse low income communities, HS supports communities to address the needs of high risk women and their families before, during and after pregnancy.

Adverse Pregnancy Outcomes in United States

Each year in the United States, more than four million women become pregnant, according to data from National Center for Health Statistics. This resulted in 4.13 million live births in 2009, a three percent decrease from 2008. In comparison, in 2007 there were 4.3 million live births, a one percent increase in births from 2006 and the highest number of births ever registered in the United States.[157] While most women have a safe pregnancy and deliver a healthy infant, that is not the experience for all women. Major and persistent racial and ethnic disparities exist in the proportion of pregnancy-related maternal deaths, in preterm births, and in infant mortality. Preterm birth (births at less than 37 completed weeks of gestation) is a key risk factor for infant death. Since the mid-1980s, the percentage of preterm births in the U.S. has been rapidly increasing. For example, from 2000 to 2005, the percentage of preterm births increased from 11.6 percent to 12.7 percent representing an almost one percent increase. In 2005, 68.6 percent of all infant deaths occurred to preterm infants, up from 65.6 percent in 2000.[158] The 2009 overall national preterm rate was 12.18 percent. Although a portion of the increase in preterm births over the last decade was due to an increase in multiple births, the percentage of preterm births also increased among singleton births.

Racial Disparities in Pregnancy Outcomes

There are significant racial disparities in preterm births and infant death rates in the U.S. For example, in 2005 the preterm birth rate for non-Hispanic White infants was 10.92 percent compared to 17.47 percent for non-Hispanic Black infants. Similarly, the preterm-related infant mortality rate for non-Hispanic Black infants was 3.4 times higher than that of non-Hispanic White infants.[159] Despite considerable research efforts to understand and prevent these adverse outcomes, the factors that make some pregnancies more vulnerable than others have not been clearly identified or defined. Emerging research indicates that environmental, biological and behavioral stressors occurring over the lifespan of the mother from her earliest life experiences until she delivers her own child may account for a significant portion of the disparities. These social determinants of health may hold the key to reducing infant mortality. Moreover, it may take specific interventions that are consistently provided over several generations to reduce and eliminate the factors responsible for the disparities in adverse birth outcomes.

Interconception Healthcare

The interconception period (the time between the end of a woman's pregnancy to the beginning of her next pregnancy) is a critical time to modify risk factors, particularly those such as tobacco use, that are causally associated with infant mortality. Interconception healthcare reduces complications from a recent pregnancy and/or prevents the development of a new health problem (obesity, diabetes, depression, and hypertension) in both the woman and her children. A leading

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[157] Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2009. National Vital Statistics Reports Web release; vol. 59 no. 3. Hyattsville, MD: National Center for Health Statistics. 2010.

[158] MacDorman MF, Mathews TJ. Recent Trends in Infant Mortality in the United States. NCHS Data Brief, no 9. Hyattsville, MD: National Center for Health Statistics. 2008.

[159] National Center for Health Statistics, Infant Mortality Statistics from the 2005 Period Linked Birth/Infant Death Data set, NVSR, vol. 57 no. 2, revised July, 2008.

risk factor of a future poor birth outcome is a previous poor birth outcome. Therefore, a focus on interconception care targeting high risk women is a hallmark of HS. Additionally, interconception healthcare provides a valuable opportunity to reduce or eliminate risks before one or more future pregnancies to ensure healthier (full term) infants and mothers.

Healthy Start - Community Collaborations to Address Pregnancy Outcomes

HS has a key role in strengthening families and creating the foundation for optimal infant and young child health and development, including early learning. HS includes activities and components that support the Administration's early childhood priority on building a ladder of opportunity for all children and families. HS is the first rung of that ladder beginning before, during, and after pregnancy and serving families for the first two years of a child's life.

HS works with individual communities to build upon their existing resources (including outreach, health education, case management, and utilization of prenatal/postnatal care) to improve the quality of, and access to, healthcare for women and infants at both service and system levels through the implementation of innovative community-driven and community-based interventions. At the service level, beginning with direct outreach by Healthy Start community health workers to women at high risk for poor perinatal outcomes, Healthy Start projects ensure that the mothers and infants have ongoing sources of primary and preventive healthcare and that their basic needs (housing, psychosocial, nutritional and educational support and job skill building) are addressed. Following assessments and screening for perinatal depression and other risk factors, Healthy Start case managers provide linkages with appropriate services and health education for risk reduction and prevention. Mothers and infants are linked to a medical home and followed, at a minimum, from entry into prenatal care through two years after delivery.

At the system level, every Healthy Start project has developed a consortium composed of neighborhood residents, community key leaders, perinatal care clients or consumers, medical and social service providers, as well as faith-based and business community representatives. Together these key stakeholders and change agents identify and address the system barriers in their community, such as fragmentation in service delivery, lack of culturally appropriate health and social services, and barriers to accessing care. Healthy Start projects are required to have strong collaborative linkages with State programs including Title V Maternal and Child Health Block Grant, Medicaid, Children's Health Insurance Program, and local perinatal systems such as those in community health centers. The close connection between these services assists in reducing significant risk factors, such as tobacco and alcohol use, while promoting behaviors that can lead to healthy outcomes for women and their families. These positive relationships and effects, beginning during the perinatal period, continue to be monitored for both mother and baby for two years post-delivery to ensure that they remain linked to ongoing sources of primary care. Knowing the importance of a healthy family and healthy home, as appropriate, the needs of the entire family are addressed.

HRSA has also worked closely with ASTHO, AMCHP, CityMatCH, the March of Dimes and other Federal partners to support the CoIIN to reduce infant mortality, which is supported through Title V as well as Healthy Start. The CoIIN was launched in Region IV and Region VI

States in FY 2012 and in Region V in March 2013. Ultimately, these efforts will inform and advance the national strategy to address infant mortality that was announced by Secretary Kathleen Sebelius at the Child Survival Call to Action in June 2012.

Populations Served by Healthy Start

There are currently 104 Healthy Start projects serving populations within 191 counties in 39 States, the District of Columbia, and Puerto Rico. Many of these communities have high poverty and major crime rates. Parents at highest risk typically have less than a high school education, are low income and have limited access to safe and secure housing. Medical healthcare providers are limited and often can only be reached after long commutes on crowded public transportation.

For example, the Genesee County Michigan Healthy Start serves a predominantly African American population. In the target area there is 41 percent unemployment for those 16 years and older. Families in the Healthy Start project area continue to fare worse than their counterparts in Genesee County and significantly worse than others in Michigan. The Healthy Start project area has fewer high school graduates compared to the rest of the county. For example, only 76 percent of those 25 and older graduated from high school which is below the figure of 83.4 percent for the State of Michigan and 83.1 percent for the entirety of Genesee County. Currently, 20 percent of the target area population lives below the Federal Poverty Level. The household income in the project area is $29,982 which is considerably lower than the County and the State.

The Strong Beginnings Healthy Start Project in Grand Rapids, Michigan serves predominantly (94%) high risk African American (AA) women. In 2010, Grand Rapids had an unemployment rate of 30.6% for AAs and 11.2% for Whites. The target population is within an area of concentrated poverty with a poverty level of 43.7% for children younger than 18. The poverty rate for AA children is twice that of White children, at 73.4% versus 35.8% in 2010. Infant mortality, low birth weight and very low birth weight rates were high on a three year average among AA from 2007 -2009 at 17.3, 13.6 and 3.3 per 1000, respectively. The infant mortality rate for AAs were nearly four times higher than for White infants at 4.4 per 1000. Also, women in the Healthy Start program were more likely to be diagnosed with clinical depression, domestic violence, substance abuse and homeless and unwanted pregnancy.

Selected Healthy Start Successes

Many Healthy Start projects have achieved significant improvements in perinatal outcomes among the population they serve, as measured by reductions in infant mortality rates and the rates of low and very low birthweight, as well as improvements in access to care.

Reduction in Infant Deaths in Healthy Start Project Areas

Overall, Healthy Start is successful in reducing infant mortality in the Nation's highest risk populations for adverse outcomes (African Americans, American Indians/Native Americans). In contrast to the total national infant mortality rate of 6.14 in 2010, the infant mortality rate for

Healthy Start participants was 4.7 infant deaths per 1,000 live births for 2010 – remembering that HS serves the highest risk women in some of the highest risk communities.

There are many examples of Healthy Start communities where infant mortality reductions have occurred. For example, the Genesee County Healthy Start project has proven to be effective in reducing infant mortality rates among program participants. The infant mortality rate for the project years 2008-2011 has averaged 5.8 per 1,000 live births, below the Healthy People 2020 Objective of 6.0 per 1,000 live births. Trends in infant mortality rates in Central Hillsborough Healthy Start participants decreased from 19.2 per 1,000 live births in 1998 to 9.4 per 1,000 live births in 2010. Additionally, the South Carolina Low Country Healthy Start Project reported no infant deaths for program participants enrolled in the Healthy Start program in 2010 and 2011.

Among African Americans in 2007, the infant mortality rate for the HS program participants in Saginaw County's (MI) Great Beginnings Healthy Start was only 5.8 per 1,000 live births. In the Jacksonville (FL) Healthy Start, a program that focuses on high risk interconceptional women and which also serves a predominantly African American population, the infant mortality rate was reported at 15.6 per 1,000 live births in 2001, 14.0 per 1,000 live births in 2005 and no infant deaths in 2009. The infant mortality rate for the northern Wisconsin tribes served by the Great Lakes Intertribal Councils Honoring Our Children Project for 2007 was 17.1 per 1,000 live births; in contrast, the infant mortality rate was only 6 per 1,000 live births among program participants for 2009.

Several other Healthy Start communities reported a reduction in infant mortality rates. In fact, ten Healthy Start communities report no infant deaths among program participants for the three years 2008-2010: Mississippi County, AR; Maricopa County, AZ; Chicago, IL; all three HS sites in Raleigh, NC; Pembroke, NC; Las Cruces, NM; Portland, OR; and Philadelphia, PA; an additional five communities reported no infant deaths over the three years 2008-2010: Mobile, AL; Fresno, CA; Memphis, TN; Atlanta, GA; Wichita, KS.

Low and Very Low Birthweight

Low Birthweight (LBW), or birth weight less than 2,500 grams, is a major contributor to infant mortality and has been dramatically reduced among Healthy Start participants. The national LBW rate increased more than 20 percent from the mid-1980s through 2006, but has recently shown a slight decrease. In 2009, the national LBW rate was 8.16% which was a slight decrease from the 2008 rate of 8.18 percent. However, racial disparities persist in LBW rates. For example, in 2009 the LBW rate among non-Hispanic whites was 7.19 percent compared to 13.61 percent for non-Hispanic Black infants. Similarly, in 2009 the VLBW or birth weight of less than 1,500 grams, was 1.16 percent for non-Hispanic White infants compared to 3.06 percent for non-Hispanic Black infants. In 1998, the National LBW was 7.6 percent, and 65 percent of all infant deaths were attributed to LBW (Source: NVSS, NC).

Many Healthy Start projects achieved significant reductions in Low and Very Low Birth weight (LBW and VLBW) births. For example, the Mississippi County Arkansas EOC, Inc. in Blytheville, AR, improved its LBW rate from a high of 12.5 percent in 2006 to 0 percent in 2009. Baltimore Healthy Start decreased its LBW rate from 13.2 percent in 2006 to 4.9 percent in 2009. In 2009 Healthy Start Southeast Chicago's LBW for program participants was 11.9%,

and in 2011 it dropped to 8.1%. In 2011, the Grand Rapids Healthy Start VLBW for program participants was 0% compared to non-program participant Blacks which was 4.1%. In addition, among the Pittsburgh Healthy Start, Inc. participants, the VLBW rate is similar to the VLBW for the entire community which was 1.76 percent in 2009. Kalamazoo (MI) Healthy Baby Healthy Start has reduced the racial disparity in prematurity to the point that non-Hispanic Black Healthy Start participants have pregnancies that are as healthy (i.e., full term and normal weight) as their non-Hispanic neighbors. In 2009 Multnomah County, which serves predominately African Americans, LBW was 9.4 and target area African Americans not in the program LBW was 9.1; by 2010 Multnomah Healthy Start participants LBW was 4.3 compared with non-program participant African Americans, which was 6.3. For 2004-2009, for HS participants in Genesee County the LBW rate averaged 10.5 percent. The LBW rate continued to decrease with a three year (2007-2009) average of 8.84 percent. The percent of SC Low Country Healthy Start program participants delivering a low birth weight infant was reduced from 15.8% in 2010 to 13.1% in 2011. The very low birth weight percent fell from 6.3% to 3.7% for all live births. When singleton births only are considered, the data showed low birth weight infants were reduced from 13.8% in 2010 to 9.8% in 2011 and for singleton very low birth weight births the percent dropped from 4.7% in 2010 to 2.8% in 2011.

Increasing Prenatal Care

An important risk factor for infant mortality is late entry into prenatal care. In 2008, the national mortality rate for infants of mothers who began prenatal care after the first trimester of pregnancy or not at all was 27.25 per 1,000. This rate was 413 percent higher than the rate for infants of mothers who began care in the first trimester (NVSS, NCHS, 2007). The population served by the Healthy Start projects are by definition disadvantaged and high risk. The proportion of Healthy Start clients receiving early prenatal care has historically been very low. While nationally, 82.8 percent of pregnant women received prenatal care in the first trimester in 1998, first trimester entry into prenatal care for Healthy Start projects participants was only 41.8 percent. The reason for this low early prenatal care utilization, however, is not lack of insurance coverage since most Healthy Start clients are Medicaid eligible, and thus additional coverage through the Affordable Care Act (ACA) will have little effect on early prenatal care utilization for the Healthy Start population. Through outreach, health education and care coordination, Healthy Start grantees have played an important role in connecting their clients to services and improving access to and the utilization of prenatal care services for members of the communities served by their programs.

Healthy Start grantees have extensive experience as health care navigators and have successfully connected their clients to services, resulting in an increase in the proportion of women receiving early prenatal care. For example, from 1998 to 2007, the Healthy Start projects had increased first trimester early-entry into prenatal care (EPNC entry) of their population from 41.8 percent to 68.5 percent and in 2011, EPNC climbed to 75 percent. And, the percent of SC Low Country Healthy Start program participants receiving prenatal care in the first trimester increased from 83% in 2010 to 86% in 2011. The Milwaukee Healthy Start first trimester EPNC was 75% compared to target area which was 58%.

Addressing Barriers to Healthcare Access

Because of Medicaid coverage, medical insurance is usually not a barrier for receiving care during pregnancy through 60 days following delivery and Healthy Start projects have been able to connect women and children who are eligible for Medicaid with health care service providers. During the FYs 2001 – 2005 project period 74 percent of the pregnant women enrolled in Healthy Start had no health insurance at the time of enrollment. Healthy Start staff completed Medicaid or CHIP applications on all uninsured Healthy Start participants. In total, 969 (98%) of 991 Medicaid/CHIP applications submitted by Healthy Start were approved for Medicaid or CHIP coverage. By reducing a significant barrier to utilizing appropriate healthcare, Healthy Start projects have made important strides in helping at-risk mothers have healthy babies and families.

Healthy Start will continue to play a critical role in providing case management and care coordination services that enable women to access health care services essential to improving maternal and infant health outcomes. Increasing the inter-pregnancy interval (the time between pregnancies) increases a woman's chances of having a better birth outcome with a subsequent pregnancy. This financial barrier to care is compounded by the extremely limited healthcare services for the under/uninsured in many Healthy Start project areas. Many providers of this target population groups are reluctant to see uninsured women and children. Healthy Start projects have been able to help women and children eligible for Medicaid. Healthy Start projects reported many successes in this area. For example, in the Saint Louis Healthy Start Community in 2011, 88% of 1 year olds received the full schedule of age appropriate immunizations, and 99% of women and children had a medical home.

Funding History

FY	Amount
FY 2011	$104,361,000
FY 2012	$103,532,000
FY 2013	$98,064,000
FY 2014	$101,000,000
FY 2015	$101,000,000

Budget Request

The FY 2015 Budget Request is $101,000,000, the same as the FY 2014 Enacted level. The requested funding will continue to support up to 100 Healthy Start sites. It is expected that over 40 states and jurisdictions will continue to have Healthy Start services. Approximately 450,000 participants will continue to receive Healthy Start services.

The proposed FY 2015 Budget Request will allow HRSA to continue to build on the successes and lessons learned over the past 24 years of Healthy Start. Healthy Start will include designing activities and components that will support the Administration's priorities of building a ladder of opportunity for all children. Healthy Start will be the first rung of that ladder by working to reduce infant mortality and improve birth outcomes.

Healthy Start begins before the child is born, in fact before the child is conceived, and includes pre-conception and well-woman care. Parenting education before, during, and after the pregnancy is critical to a family's success. Furthermore, a healthy woman is more likely to have a positive birth outcome and healthy child. So Healthy Start works to ensure women and families have a comprehensive medical home and that these families are able to navigate through the healthcare system to receive integrated and coordinated care. Healthy Start will continue to build resilience in program participants and the communities being served.

Healthy Start prepares families to continue their climb on the ladder of opportunity and success through ensuring a seamless handoff of a healthy infant to the next rungs of quality childcare, Home Visiting, Early Head Start, and preschool. The FY 2015 targets for performance measures 12.III.A.I (increase annually the percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester) and 12.III.A.2 (percent of singleton births weighing less than 2,500 grams (low birth weight)) are 75 percent and 9.6 percent, respectively.

All Healthy Start projects are committed to reducing disparities in perinatal health and infant mortality by transforming their communities, strengthening community-based systems to enhance perinatal care and improving the health of the women and infants in their communities. Healthy Start promotes the uniform implementation of well-defined evidence-supported interventions and the ongoing monitoring of the impact of these interventions on the perinatal outcomes and factors that contribute to these outcomes. To achieve this goal, Healthy Start will continue to support staff training and education through the development of standardized Healthy Start curricula, practice tool kits, technical assistance, and peer to peer mentoring.

Outcomes and Outputs Tables

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2014 Target**	**FY 2015 Target**	**FY 2015 +/- FY 2014**
12.1: The infant mortality rate (IMR) per 1,000 live births among Healthy Start Program clients.[160] *(Outcome)* (Baseline- 2004: 7.65 per 1000 live births)	FY 2010: 4.7 per 1,000 live births	N/A	N/A	N/A

[160] This long-term measure does not have annual targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
12.III.A.1: Increase annually the percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester. *(Outcome)*	FY 2011: 75% Target: 75% (Target Met)	75%	75%	Maintain
12.III.A.2: Percent of singleton births weighing less than 2,500 grams (low birth weight) *(Outcome)*	FY 2011: 9.8% Target: 9.6% (Target Exceeded)	9.6%	9.6%	Maintain
12.E: Increase the number of persons served by the Healthy Start Program with a (relatively) constant level of funding. *(Efficiency)*	FY 2011: 548,450 Persons Served Target: 524,500 (Target Exceeded)	466,259	445,259	-21,000

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	107	Up to 104	Up to 100
Average Award	$872,182	$1,000,000	$1,000,000
Range of Awards	$245,539 – $2,256,940	$255,000-$2,350,000	$750,000- $2,000,000

Heritable Disorders Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2014 +/- FY 2015
BA	$9,314,000	$11,913,000	$11,913,000	---
FTE	3	4	4	---

Authorizing Legislation - Sections 1109 – 1112 & 1114 of the Public Health Service Act.
Authorization: 1109 .....Expired
Authorization: 1110 .....Expired
Authorization: 1111 .....Expired
Authorization: 1112 .....Expired
Authorization: 1114… .....Expired

Allocation Methods……Contract/Competitive grant/Co-operative agreement

Program Description and Accomplishments

The programs and activities under this Act are established to enhance, improve or expand the ability of States and local public health agencies to provide screening, counseling or health care services to newborns and children having or at risk for heritable disorders. Universal newborn screening provides early identification and follow-up for treatment of infants affected by certain genetic, metabolic, hormonal and/or functional conditions. It is expected that newborn and child screening will expand as the capacity to screen for genetic and congenital conditions increases.

In 2003, most states were only screening for six genetic disorders. Currently, the majority of states are testing for at least 29 of the 31 conditions on the Recommended Uniform Screening Panel (RUSP). As a result of this newborn screening expansion, approximately 3,400 additional newborns each year have received earlier intervention and potentially life-saving treatments.

Improved Newborn and Child Screening For Heritable Disorders, Section 1109

Severe Combined Immunodeficiency (SCID) Program, Section 1109
The SCID Program began in FY 2014 to support wider implementation, education, and awareness of newborn screening for SCID and related disorders. The purpose of this program is to increase the number of states and/or territories that include screening for SCID as part of their newborn screening program, resulting in a greater number of newborns that are screened, identified, and referred for treatment for SCID. Specifically, the program is targeting to increase the number of the following:

1. Newborn screening programs with laboratory capacity and performance capability to conduct newborn screening for SCID,
2. Active, sustainable SCID newborn screening programs,
3. Newborns screened for SCID,
4. Newborns referred to the medical community for SCID follow-up, and
5. Newborns with SCID that demonstrate improved health outcomes and/or receive life-saving treatment.

Newborn Screening Demonstration Program, Section 1109
The Newborn Screening (NBS) Demonstration Program has the purpose of supporting the development, dissemination and validation of screening protocols and newborn screening infrastructure needs for additional conditions added to the RUSP. To implement the program, the Maternal and Child Health Bureau will award competitive grants to States. The NBS Demonstration Program will focus on enhancing screening infrastructure, as well as the education and training of various stakeholders on testing methodology and follow-up protocols.

The goals of the NBS Demonstration Program:

1. Enhance, improve or expand the capacity of State and local public health agencies and hospitals to: provide screening, provide counseling, report and link the results of screening to needed follow-up health care services, and/or perform the necessary quality assurance, outcomes analysis and other public health surveillance functions;

2. Assist in providing health care professionals and newborn screening program personnel with education in newborn screening and training in relevant new technologies;

3. Develop and deliver educational programs (at appropriate literacy levels) about specific conditions screened as part of newborn screening, counseling, testing, follow-up, treatment, and specialty services to parents, families, and patient advocacy and support groups; and

4. Establish, maintain, and operate a system to coordinate and assess screening programs and follow-up relating to additional conditions added to the newborn screening state panel.

Newborn Screening Data Repository and Technical Assistance Center, Section 1109
The Newborn Screening Data Repository and Technical Assistance Center was awarded FY 2012 as a cooperative agreement to provide technical assistance on the implementation of State-based public health newborn screening and other genetics programs, as appropriate, through resource development, State education and training, policy initiatives, disorder surveillance, evidence-based data collection, evaluation, and collaborative efforts with stakeholders, including federal and non-federal partners. Activities support new and ongoing efforts at the state, regional, and national levels to increase awareness, knowledge, and understanding of newborn screening, to facilitate harmonization of newborn screening activities, and to improve the quality

of newborn screening and related genetic services across the United States through innovation and technology. Key goals of the program include:

1. Develop, coordinate, and provide technical assistance through innovative educational and quality improvement activities related to newborn screening and short term follow-up that are responsive to information gaps identified by providers and public health professionals; provide technical assistance and relevant resources so that States may assess and address their needs and challenges.

2. Incorporate current technology to develop a national newborn screening data repository to standardize, maintain, and analyze quantitative quality measures, case definitions and other data to evaluate the impact of State and Territorial newborn screening programs.

3. Support activities that strengthen the integration of child health information systems, laboratory performance and quality assurance, short and long term newborn screening follow-up and public health interactions at the community, state, regional, and national levels.

4. Provide a forum for timely, interactive communication between state and public health stakeholders.

5. Develop an innovative methodology for states to assess quality assurance and improvement within their newborn screening systems.

Integrating NBS Long Term Follow-up Into Primary Care Initiative, Section 1109
The Integrating NBS Long Term Follow-up Into Primary Care Initiative was funded in FY 2013. Two grantees are funded to link to a number of Community Health Centers to support the follow-up of individuals identified by NBS to have a heritable condition. The Program funds competitive grants to organizations that work with primary care practices to identify the NBS population followed by their clinics and answer the following questions: 1) Are children/adolescents receiving coordinated care through a medical home; 2) How are children/adolescents doing clinically? Are children identified through newborn screening who are enrolled in care doing better than those identified clinically? 3) Are clinicians providing long term follow-up care within a medical home? 4) Do children within a practice have the opportunity to enroll in clinical research?

Evaluating the Effectiveness of Newborn and Child Screening (NBS) Programs, Section 1110

Established in 2004, the grant program includes seven Regional Genetic Service Collaboratives (RCs) and a National Coordinating Center. The program supports newborn screening and long-term follow-up activities. The program is in the third cycle of funding. The RCs continue to undertake a regional, collaborative approach to address the misdistribution of genetic resources and services, the quality of services, and issues in accessing and utilizing services faced by families and primary health care providers. Collaborative projects focus on the life course of the individuals affected with or at risk of heritable disorders and their families. Special emphasis is given to medically underinsured and rural populations with attention to cultural sensitivity.

The Collaboratives include all States, U.S. Territories, and the District of Columbia. The stakeholders represent State public health professionals, genetics specialists, primary care providers, consumers, and the public. Accomplishments include using telemedicine to increase newborn screening follow-up and genetic service visits to individuals with heritable disorders, developed standardized data sets and definitions of conditions on the RUSP for long-term monitoring of follow-up and treatment of inborn errors of metabolism by provider access, and developed an international informatics system for the collection and display of data from true positive patients identified through newborn screening.

The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, Section 1111

In accordance with the Newborn Screening Saves Lives Act, if reauthorized, the Committee will continue to: 1) provide advice, technical information and systematic evidence-based and peer-reviewed recommendations to the Secretary of Health and Human Services to enhance, expand or improve the ability of the Secretary to reduce the mortality or morbidity from heritable disorders; 2) address the public health impact of newborn screening expansion; 3) periodically update the RUSP, as appropriate, based on the decision-matrix; and 4) consider ways to ensure that all States attain the capacity to screen for conditions on the RUSP.

From 2010-2011, the Committee facilitated the expansion of screening activities with the addition of Severe Combined Immunodeficiency and Critical Congenital Heart Disease to the RUSP. In 2012, a decision matrix was refined as a methodological tool for systematically evaluating the magnitude and certainty of the net benefit of screening and the capacity of state newborn screening programs to implement screening for nominated conditions.

In April 2013, the Secretary established the Discretionary Advisory Committee on Heritable Disorders in Newborns and Children (DACHDNC) which fulfills the functions previously undertaken by the former Committee referenced above. The DACHDNC continues to provide advice to the Secretary about aspects of newborn and childhood screening and technical information for the development of policies and priorities that will enhance the ability of the State and local health agencies to provide for newborn and child screening, counseling and health care services for newborns and children having, or at risk for, heritable disorders.

The Clearinghouse of Newborn Screening Information, Section 1112

Established in 2008, the Clearinghouse is a central repository of current educational and family support and services information, materials, resources and research, for the following purposes: 1) increase awareness, knowledge, and understanding of newborn screening by parents and family members of newborns, health professionals, industry representatives, and the public; 2) increase expectant individuals and families' awareness, knowledge, and understanding of newborn disease and screening services; and 3) links to current quality indicators data on newborn screening performance. To implement the program, the Maternal and Child Health Bureau awarded a cooperative agreement.

The Interagency Coordinating Committee (ICC) on Newborn and Child Screening, Section 1114

The Newborn Screening Saves Lives Act established the ICC and is composed of the Administrator of HRSA, the Director of CDC, the Director of AHRQ, and the Director of NIH. Other federal agencies have liaisons on the committee as well. The ICC was delegated to HRSA and CDC to serve as co-chairs. Per the legislation, the ICC serves to respond to Secretarial requests to assess existing activities and infrastructure in order to make recommendations for programs to collect, analyze and make data available on the heritable disorders recommended by the Committee and coordinate collaborative efforts for newborn and child screening among all agencies in HHS.

Activities to date include responding to Secretarial requests to provide input regarding recommendations from the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children concerning: newborn screening for critical congenital heart disease, the use and storage of newborn screening residual blood samples and data quality assurance in newborn screening.

Funding History

FY	Amount
FY 2011	$9,952,000
FY 2012	$9,834,000
FY 2013	$9,314,000
FY 2014	$11,913,000
FY 2015	$11,913,000

Budget Request

The FY 2015 Budget Request is $11,913,000, the same as the FY 2014 Enacted level.

Improved Newborn and Child Screening For Heritable Disorders, Section 1109

Continued funding for the Severe Combined Immunodeficiency (SCID) Program will support the wider implementation, education, and awareness of newborn screening for SCID. The program can continue to assist states and territories to include screening for SCID as part of their newborn screening program so that more newborns are screened, identified, and referred for the appropriate treatment.

The Newborn Screening Demonstration Program – Funding will allow for the continued development and enhancement of state newborn screening systems and the dissemination of best practices. Continued funding will also allow for additional technical assistance to States considering the addition of new conditions to their State NBS panel. Funding will also allow grantees to establish, maintain, and operate health information technology systems that will collect information on the detection of new conditions and patient outcomes and utilize the data to assess and coordinate follow-up treatment.

The Newborn Screening Data Repository and Technical Assistance Center – With stable funding, the Center will continue to provide technical assistance and programmatic support for the State public health programs, particularly as new conditions for newborn screening are considered and implemented throughout the U.S. The Center will also be able to continue to work to ensure the quality of the newborn screening process. The Newborn Screening Saves Lives Act also requires facilitating the harmonization of newborn screening standards and quality measures for newborn screening programs. The Center has developed quality measures and newborn screening case definitions. With continued support, the Center will continue to collect important data related to quality improvement and identifying cases. In turn, these data will be used for evaluation and quality assessment of newborn screening across the US. The Center will also continue to interface at multiple levels with various other stakeholders and HRSA funded programs.

Integrating NBS Long Term Follow-up Into Primary Care - FY 2015 will be year three of three of the Program. Continued stable funding will allow for continued integration and evaluation of newborn screening long term follow-up practices into community health centers.

Evaluating the Effectiveness of Newborn and Child Screening Programs, Section 1110

Regional Genetic and Newborn Screening Services Collaborative - The Regional Collaborative Program began its third cycle in 2012 and will be in year three of a five year project period. With stable funding the Regional Collaborative will continue to provide the services and projects outlined to complete their third grant cycle. As health care reform matures, and as its capacity to personalize health care is realized, the integration of genetic medicine into the health care delivery system is essential. Continued funding will also address insurance coverage and reimbursement for genetic testing and treatment services, and the impact of the Affordable Care Act and State options on individuals with heritable disorders.

The Advisory Committee on Heritable Disorders in Newborns and Children, Section 1111

In accordance with the Newborn Screening Saves Lives Act, the Committee will continue to: 1) provide advice, technical information and systematic evidence-based and peer-reviewed recommendations to the Secretary to enhance, expand or improve the ability of the Secretary to reduce the mortality or morbidity from heritable disorders; 2) address the public health impact of newborn screening expansion; 3) periodically update the RUSP, as appropriate; and 4) consider ways to ensure that all States attain the capacity to screen for conditions on the RUSP as well as address other legislative requirements toward facilitating the harmonization of newborn screening standards and quality measures for newborn screening programs.

In April 2013, the Secretary established the Discretionary Advisory Committee on Heritable Disorders in Newborns and Children (DACHDNC) which fulfills the functions previously undertaken by the former Committee referenced above. The DACHDNC continues to provide advice to the Secretary about aspects of newborn and childhood screening and technical information for the development of policies and priorities that will enhance the ability of the State and local health agencies to provide for newborn and child screening, counseling and health care services for newborns and children having, or at risk for, heritable disorders.

The Clearinghouse of Newborn Screening Information, Section 1112

The Clearinghouse will be re-competed in FY 2014. Continued stable funding will allow for ongoing support of a central repository of current educational and family support and services information, materials, resources and research for the following purposes: 1) increase awareness, knowledge, and understanding of newborn screening by parents and family members of newborns, health professionals, industry representatives, and the public; 2) increase expectant individuals and families' awareness, knowledge, and understanding of newborn diseases and screening services; and 3) link to the Newborn Screening Data Repository and Technical Assistance Center which maintains current data on quality indicators of newborn screening performance.

The Interagency Coordinating Committee (ICC) on Newborn and Child Screening, Section 1114

The ICC will continue to undertake relevant activities including: 1) assess existing activities and infrastructure, in order to make recommendations for programs to collect, analyze, and make data available on the heritable disorders recommended by the Committee; and 2) make recommendations for the establishment of regional centers for the conduct of applied epidemiological research on effective interventions to promote the prevention of poor health outcomes resulting from such disorders, as well as provide information and education to the public on such effective interventions. In FY 2014, the Secretary referred the DACHDNC's recommendation of adding Pompe disease to the RUSP to the ICC for additional review and input. The Act specifies that the ICC be composed of the Administrator of HRSA, the Director of CDC, the Director of AHRQ, and the Director of NIH. CMS and ASPE staffs serve as liaisons to the ICC.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	17	24	24
Average Award	$461,922	$410,528	$410,528
Range of Awards	$109,401 – $935,000	$300,000 – $850,000	$300,000 – $850,000

Family-To-Family Health Information Centers

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$4,745,000	$2,500,000	---	-$2,500,000
FTE	---	2	---	-2

Authorizing Legislation - Section 501(c)(1)(A) of the Social Security Act.

FY 2015 Authorization .....Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Family-to-Family Health Information Centers (F2F HICs) Program is authorized to fund family-staffed/run centers that provide information, education, technical assistance and peer support to families of children and youth with special health care needs (CSHCN). This program accomplishes this intent by assisting families and professionals so that "families with CSHCN will partner in decision making at all levels" of health care decision making.

Currently, the Program has been extended through the amendment of section 1203 of the "pathway for SGR Reform Act of 2013" (P.L.113-67) with $2,500,000 for FY 2014. Previously, the program was funded through FY 2013 by the American Taxpayer Relief Act of 2012 (P.L. 112-240), Sec. 624 at a funding level of 5 million dollars. Previous appropriations include the Deficit Reduction Act of 2005 (P.L. 109-171) and Section 5507(b) of the Patient Protection and Affordable Care Act of 2010 (ACA) (P.L. 111-148) which extended the program through FY 2012.

As in FYs 2010-2013, the Program in FY 2014 will support centers in 50 States and the District of Columbia to: (1) assist families of CSHCN to make informed choices about healthcare in order to promote good treatment decisions, cost effectiveness and improved health outcomes; (2) provide information regarding the healthcare needs of and resources available for CSHCN; (3) identify successful health delivery models; (4) develop, with representatives of healthcare providers, managed care organizations, healthcare purchasers, and appropriate State agencies, a model for collaboration between families of CSHCN and health professionals; (5) provide training and guidance regarding the care of CSHCN; (6) conduct outreach activities to families, health professionals, schools and other appropriate entities; and (7) be staffed by such families who have expertise in Federal and State public and private healthcare systems; and by health professionals.

Currently, 51 centers are collecting data on the issues facing families regarding services and financing of those services while working with Medicaid, Education, Title V, and other agencies

to inform them of families' needs. In addition to being directly involved in state ACA efforts, Centers are also disseminating information on the implementation of ACA and encouraging family leaders to be involved in the planning within their states such as planning for health insurance Marketplaces and Navigator Programs. Other information disseminated through fact sheets, newsletters and listservs are helping families understand the new provisions and how they impact individual access to coverage, such as the extension of Federal dependent coverage to age 26. In addition, many are working with the Bureau of Primary Health Care's Federally Qualified Health Centers to implement medical/health homes through training and providing materials. Some of the centers are also working with the Administration on Aging's *Aging and Disability Resource Center*s on the "no wrong door" approach for sharing resource information across the lifespan for people with disabilities. As states launch their ACA Marketplaces, these centers are key in providing families of CSHCN health information to make informed health insurance choices and support in accessing health care.

Program works with grantees, in collaboration with the National Center for Family/Professional Partnerships, on monthly technical assistance calls to enhance program content and data collection, including impact data.

In FY 2008, 75,532 families with CSHCN were provided information, education and/or training from Family-to-Family Health Information Centers. In FY 2009 more than 92,000 families were provided information. These exceeded the targets set for those years. In addition, for FY 2009, 65 percent of families responded that their center's assistance was useful to extremely useful in helping them be better partners in decision-making with their child's provider), exceeding the target. In FY 2010, no targets were set due to the fact that the program funding was scheduled to end. But the number of families served was 121,476.

In FY 2011, 146,813 families were provided information (one-on-one assistance, unduplicated count) by 50 centers and approximately 86 percent of families served responded that their center's assistance was useful to extremely useful in helping them be better partners in decision-making at any level, exceeding the target for that year. The number of families served in FY 2012 increased to 147,280 with 94% of those served stating the F2F HIC was useful in helping families be better partners in decision-making, again exceeding the annual target. Overall, since the program's inception, the F2F HICs program has realized a 51% increase in the number of families served and an increase of over 34 percentage points in the proportion of families served who report a positive outcome (as of FY 2012). In FY 2013, the targeted number of 124,000 families served was exceeded with 140,151 actually being served. In addition, 91% of families reported that they were better able to partner in decision making exceeding the target of 87%. FY 2014 data will be collected and reported in the fall of 2014.

Funding also is obligated for costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System and HRSA's Electronic Handbooks, and follow-up performance reviews.

Funding History

FY	Amount
FY 2011	$5,000,000
FY 2012	$5,000,000
FY 2013	$4,745,000
FY 2014	$2,500,000
FY 2015	---

Budget Request

The authorization for this program expires in FY 2014 and additional funds are not requested. Instead, families with Children with Special Health Care Needs can seek supports and wrap around services through state grants provided by the Maternal and Child Health Block Grant.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
15.III.C.1: Number of families with CSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers (*Output)*	FY 2013: 140,151 Target: 124,000 (Target Exceeded)	124,000	N/A	N/A
15.III.C.2: Proportion of families with CSHCN who received services from the Family-to-Family Health Information Centers reporting that they were better able to	FY 2013: 91% Target: 87% (Target Exceeded)	87%	N/A	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
partner in decision making at any level. (Outcome)				

Grant Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards[161]	51	51	N/A
Average Award	$95,700	$49,019	N/A
Range of Awards	$95,700 - 107,700	$49,019-$107,700	N/A

[161] The number of actual base awards.

Maternal, Infant, and Early Childhood Home Visiting Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$379,600,000	$371,200,000	$500,000,000	+$128,800,000
FTE	22	22	22	---

Authorizing Legislation - Section 511 of the Social Security Act.

FY 2015 Authorization .....Expired
Allocation Methods:

- Direct federal/intramural
- Contract
- Formula grant/co-operative agreement
- Competitive grant/co-operative agreement

Program Description and Accomplishments

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program was established in FY 2010 under the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) to be collaboratively implemented by Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF). The purpose of the MIECHV Program is: (1) strengthen and improve the programs and activities carried out under Title V; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

At-risk communities were identified through a statewide assessment of needs and existing resources to meet those needs. HRSA and ACF regard the home visiting program as one of several service strategies, built on a tiered evidence framework and embedded in a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development as well as strong parent-child relationships. Both agencies envision voluntary, evidence-based home visiting programs as part of an early childhood system for promoting health and well-being for pregnant women, children through age 5 and their families which includes a range of other services such as well-child health care, child care, Head Start, pre-kindergarten, special education, and the early elementary grades.

In FY 2012, there were 56 eligible entities for this program: forty-seven states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa; in addition, nonprofits were eligible to provide services in the states that relinquished funding: Florida, North Dakota and Wyoming. While most of the program funds are allocated to the state home visiting grants and general technical assistance, three percent is set aside for awards available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations and three percent is set aside for Research, Evaluation, and Technical Assistance to state grantees.

The Program enables eligible entities to provide voluntary, evidence-based home visiting programs to promote: maternal and newborn health; prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; school readiness and achievement; reduction in crime or domestic violence; family economic self-sufficiency; and coordination and referrals for other community resources and supports.

This program requires participating states to utilize evidence-based home visiting models and provides an exciting opportunity for states and the Federal government to work together to deploy proven programs and to build upon the existing evidence base. The program allows for continued experimentation with new home visiting models and evaluation of both new and existing approaches so that, over time, policymakers and practitioners will have more refined information about the approaches that work best, how different approaches work for different populations or targeted outcomes, and the relative costs and benefits of different models.

Grants to states are available to be administered by the lead state agency designated by the Governor to act on behalf of the state. American Indian awards can be awarded to an Indian Tribe, Tribal Organization, or Urban Indian Organization as defined in section 4 of the Indian Health Care Improvement Act.

In FY 2010, 56 state and territory formula grants and 13 American Indian awards were awarded. In FY 2011, 55 state and territory formula grants, 22 state and territory competitive grants, and 19 American Indian awards were awarded. In FY 2012, 53 state and territory formula grants; one grant (based on the state formula) to a non-profit organization to provide services in the state that relinquished funds (North Dakota); 16 new state and territory competitive grants in addition to 22 competitive continuation grants; and, six new awards to American Indian Tribes (in addition to the 19 existing continuing American Indian awards).

In FY 2013, 52 state and territory formula grants, and two new grants (based on the state formula) to non-profit organizations to provide services in the states that relinquished funds (Florida and Wyoming) in addition to one continuing nonprofit award (North Dakota); 13 new state and territory competitive grants in addition to 22 competitive continuation grants; and 25 continuing American Indian awards were awarded.

In FY 2014, 52 new state and territory formula grants, one new grant (based on the state formula) to a non-profit organization to provide services in Oklahoma, three continuing nonprofit awards, 31 continuing competitive grants to states, and 25 continuing American Indian awards are expected to be awarded.

Funding History

FY	Amount
FY 2011 ACA Funding	$250,000,000
FY 2012 ACA Funding	$350,000,000
FY 2013 ACA Funding*	$379,600,000
FY 2014 ACA Funding*	$371,200,000
FY 2015	$500,000,000

*The ACA included $400 million for the Maternal, Infant, and Early Childhood Home Visiting program in FY 2013 and FY 2014, but those amounts were reduced by 5.1% and 7.2%, respectively, due to sequestration in accordance with the Budget Control Act of 2011.

Budget Request

The FY 2015 Budget Request is $500,000,000. The FY 2015 Request is $128,800,000 above the FY 2014 Enacted level. This level of funding will provide:

- awards to 52 State and territory grantees and four non-profit organizations to expand the reach of voluntary, evidence-based home visiting programs;
- 12 continuing awards to American Indian tribes and up to 41 new awards;
- support for research, evaluation, and corrective action technical assistance for States

The increased level of funding will provide opportunities for both the State and Tribal MIECHV programs to reach more communities and enroll more families. Even within the communities that are being reached by MIECHV, the total number of home visiting slots is generally quite small, and many existing grantees with large service areas are experiencing wait lists for services. A larger investment demonstrates HHS's commitment to serving the at-risk population through the MIECHV program.

The funding for research and evaluation will specifically support activities such as the statutorily required national evaluation, a home visiting research network, investigator-initiated research grants, contracts to support review of models as evidence-based and a tribal early childhood research center.

Further, technical assistance support to grantees including contracts to continue providing technical support to States and territories on data systems, performance measurement, and quality improvement, to evaluate promising practices, to support a tribal resource center, and to enhance the efficiency and effectiveness of MIECHV programs through learning collaboratives and other activities.

Voluntary evidence-based home visiting services through MIECHV program are a critical element of the President's early learning initiative. These programs have been critical in improving maternal and child health outcomes in the early years, leaving long-lasting, positive impacts on parenting skills, children's cognitive, language, and social-emotional development, and school readiness. Some home visiting programs have been found to reduce Medicaid costs through fewer preterm births and emergency room use.

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The President proposes to extend and expand the home visiting program beginning in FY 2015 by providing a substantial new investment of $15 billion through FY 2024 to ensure that our most vulnerable Americans are on track from birth, and that later educational investments, including Early Head Start, high quality child care, and high quality preschool, rest upon a strong foundation.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
37.1: Number of home visits to families receiving services under the MIECHV program.[162] (*Output*)	State/Territory/ Tribal: FY 2012: 169,139[163] (Target Not In Place)	State/Territory/ Tribal: 450,000	State/Territory/ Tribal: 500,000	State/Territory/ Tribal: +50,000
37.2: Number and percent of grantees that meet benchmark area data requirements for demonstrating improvement. (*Outcome-Developmental)*	N/A[164]	N/A	State/Territory: 45 (80%) Tribal: N/A	State/Territory: N/A Tribal: N/A

[162] 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 for improved 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.

[163] Information includes data (as of May 20, 2013) for tribal MIECHV program. During FY 12, state MIECHV provided 168,380 home visits and tribal MIECHV provided 759 home visits.

[164] Data are anticipated to be available in FY 2014-2015 when states are required to report on benchmarks (i.e., after the end of the 3rd year of program operations).

Grant Awards Tables

Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	115	112	200
Average Award	$2,960,000	$3,060,000	$2,340,000
Range of Awards	$270,000-$11,230,000	$270,000-$11,920,000	$270,000-$12,000,000

Ryan White HIV/AIDS

Tab

RYAN WHITE HIV/AIDS

Ryan White HIV/AIDS Treatment Extension Act of 2009 Overview

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$2,223,638,000	$2,293,781,000	$2,297,781,000	+$4,000,000
ADAP (non add)[165]	$886,313,000	$900,313,000	$900,313,000	---
MAI (non add)	$159,372,000	$169,077,000	$169,077,000	---
SPNS[166]	$25,000,000	$25,000,000	$25,000,000	---
Total Funding	$2,248,638,000	$2,318,781,000	$2,322,781,000	+$4,000,000
FTE	153	153	149	-4

**The amounts include funding for Special Projects of National Significance (SPNS) funded from Department PHS Act evaluation set-asides in FY 2013 and proposed for FY 2014 and FY 2015.*

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2015 Authorization……...…...Expired

Allocation Method .....Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program, the largest Federal program focused exclusively on domestic HIV/AIDS care, provides services that are intended to 1) reduce the use of more costly inpatient care, 2) increase access to care for underserved populations, and 3) improve the quality of life for people living with HIV/AIDS (PLWH). Recent studies have demonstrated that individuals with HIV on antiretroviral medications who achieve viral load suppression are less likely 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

[165] AIDS Drug Assistance Program (ADAP) Authorizing Legislation: Secs. 2611-31, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87.
[166] Special Projects of National Significance (SPNS) Authorizing Legislation: Sec. 2691, PHS Act, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87.

on HIV incidence as well. The Ryan White HIV/AIDS Program funding pays for primary health care and treatment including referrals to specialty care and serves as a payer of last resort. The Ryan White HIV/AIDS Program pays for services not covered by health insurance, but are critical to ensuring that individuals diagnosed with HIV are linked to and retained in care, and get started on and adhere to their medications regimens. The Program serves more than half a million (N=553,999 – preliminary 2011 estimate) low-income people with HIV/AIDS in the U.S. each year. Twenty-eight percent of those served by the Ryan White HIV/AIDS Program are uninsured, and an additional 59 percent are underinsured.

In July 2010, the Administration released the first comprehensive *National HIV/AIDS Strategy (NHAS) for the United States*. The NHAS was the result of unprecedented public input, including 14 HIV/AIDS community discussions held across the country, an online suggestions process, various expert meetings and other inputs. Senior officials at HRSA were involved in a Federal interagency working group that reviewed recommendations from the public and worked with the Office of National AIDS Policy to develop the NHAS.

The NHAS has three primary goals:

1. reducing the number of people who become infected with HIV;
2. increasing access to care and optimizing health outcomes for people living with HIV; and
3. reducing HIV-related health disparities.

Reaching these goals requires broad support across federal, state, local, and tribal governments, business, faith-based communities, philanthropy, the scientific and medical communities, educational institutions, people living with HIV, and others.

Because the Ryan White HIV/AIDS program plays a critical role in filling gaps in the health care system and reaching out to underserved and difficult to reach populations, it has been understood that the program, and the HIV/AIDS Bureau (HAB), would take a leading role among agencies across the Federal government in meeting the second and third NHAS goals.

For example, the second goal of the NHAS, to increase access to care and improve health outcomes for people living with HIV, has two targets directly related to the mission of the HIV/AIDS Bureau:

1. to increase the proportion of newly diagnosed patients linked to care within three months of their HIV diagnosis from 65 percent to 85 percent; and
2. to increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care from 73 percent to 80 percent.

But in recent years, as studies have determined that antiretroviral treatment reduces HIV transmission by 96 percent, we now know that the Ryan White program also has a central role to play in meeting the first NHAS goal- preventing new HIV infections- by ensuring that individuals living with HIV have access to regular care and are started on and adhere to their antiretroviral medications.

HAB is working closely with its grantees to meet all three goals. Progress in achieving these goals to date shows that of the 302,466 HIV+ clients who had at least one Ryan White HIV/AIDS Program funded outpatient ambulatory medical care (OAMC) visit in CY 2011 and at

least one OAMC visit date, 228,217 (75.5 percent) had at least two OAMC visit dates at least three months apart.

HAB supports the White House Executive Order to accelerate improvements in HIV prevention and care in the US through the HIV Care Continuum Initiative. HAB has focused its efforts to prevent and treat HIV infection given there are still significant gaps along the HIV care continuum – the sequential stages of care from being diagnosed to receiving optimal treatment and move closer to an AIDS-free generation.

The Ryan White HIV/AIDS Program demonstrates a comprehensive and data-driven approach in how government has targeted dollars toward the development of a highly effective service delivery system. The distinct components of the Ryan White HIV/AIDS Program serve very specific purposes. The FY 2015 Budget Request of $2.32 billion for the Ryan White HIV/AIDS Program includes:

Part A: $655.9 million, which provides grants for 24 Eligible Metropolitan Areas (EMAs) and 28 Transitional Grant Areas (TGAs) disproportionately affected by HIV/AIDS;

Part B: $1,315.0 million, which provides grants to 59 States and Territories to improve the quality, availability, and organization of HIV/AIDS health care and support services; this includes $900.3 million to provide access to FDA approved, HIV-related medications through the AIDS Drug Assistance Program (ADAP). The ADAP serves primarily low-income PLWH who have limited or no access to needed medication and is the nation's prescription drug safety net for PLWH;

Part C: $280.2 million, which provides grants directly to 351 grantees (i.e. Federally-qualified health centers, family planning clinics, rural health clinics, Indian Health Service facilities; community-based organizations, and nonprofit faith-based organizations) to support outpatient HIV early intervention services and ambulatory care. In FY 2015, the Part D Program will be merged with the Part C Program to better target resources to points along the care continuum and populations most in need. Savings are realized through increased efficiencies and decreased overlap;

Part F:

- $33.6 million for AIDS Education and Training Center (AETC) grants to organizations to support education and training of health care providers through 11 Regional Centers, more than 130 Local Performance Sites, and three National Centers;
- $13.1 million for the HIV/AIDS Dental Reimbursement Program, a program that provides reimbursement to dental schools, hospitals with postdoctoral dental education programs, and colleges with dental hygiene programs for uncompensated costs incurred in providing oral health treatment to patients with HIV disease; and
- $25.0 million for Special Projects of National Significance (SPNS) funded from the Department PHS Act evaluation set-aside. Examples of SPNS initiatives include expanding the capacity of grantees to: 1) utilize standard electronic client information data systems to report client level data; 2) take a more systems level/public health approach to test people who do not know their status and link them to care; and 3) develop innovative health home models for homeless, multiply diagnosed patients to improve outcomes along the continuum

of care. These SPNS initiatives reflect priorities of the NHAS and Affordable Care Act (ACA).

Ryan White Minority AIDS Initiative (MAI): Within the total amount included for the Ryan White HIV/AIDS Program, the FY 2015 Budget requests $169.1 million to address the disproportionate impact of HIV/AIDS on communities of color. RWHAP MAI dollars focus specifically on the elimination of racial and ethnic disparities in the delivery of comprehensive, culturally and linguistically appropriate HIV/AIDS care and treatment in the United States. To achieve this objective, the Ryan White HIV/AIDS Program uses MAI funds to conduct the following activities:

- Provide service grants to health care providers who have a history of providing culturally and linguistically appropriate care and services to racial and ethnic minorities;

- Increase the training of health care professionals in order to expand the number of them with HIV treatment expertise who are then better able to provide medical care for racial and ethnic minority adults, adolescents, and children with HIV disease; and

- Support education and outreach services to increase the number of eligible racial and ethnic minorities who have access to the AIDS Drug Assistance Program (ADAP).

Minority AIDS Initiative (MAI) Funding

(Whole dollars)	FY 2013	FY 2014	FY 2015
Part A	$50,784,000	$54,105,000	$54,105,000
Part B	$9,522,000	$10,145,000	$10,145,000
Part C	$67,327,000	$71,012,000	$94,683,000 *
Part D	$22,218,000	$23,671,000	N/A
Part F – AETC	$9,521,000	$10,144,000	$10,144,000
Part F – Dental	---	---	---
Total MAI Funding	$159,372,000	$169,077,000	$169,077,000

* Part C and Part D consolidated in FY 2015.

Program Accomplishments

The Ryan White HIV/AIDS Program has developed outcome measures and other indicators that allow for ongoing monitoring of the Minority AIDS Initiative MAI program's effectiveness. These indicators include:

1. client-level health outcomes (the MAI client-level health outcomes indicators facilitate improving and stabilizing client CD4 counts and reducing client viral load counts);
2. rates of kept appointments and retention in care (only reported in the MAI Report; will be integrated into RSR for reporting in 2016); and
3. the proportion of health care providers trained in the clinical management of HIV/AIDS who serve primarily uninsured and underinsured minority populations.

Program Performance: The HIV/AIDS Bureau continues to demonstrate excellent performance in improving access to health care, improving health outcomes, improving quality of health care, and promoting efficiency. The Ryan White HIV/AIDS Program uses various strategies to achieve its performance goals including:

1. Targeting resources to high-risk areas;
2. Ensuring availability, access to and excellence of critical HIV-related care and support services and optimizing health outcomes for people living with HIV;
3. Working to assure patient adherence;
4. Directing outreach and prevention education and testing to populations at disproportionate risk for HIV infection;
5. Tailoring services to populations known to have delayed care-seeking behaviors (e.g., by varying hours; offering care in various sites, offering linguistically and culturally appropriate services); and
6. Collaborating with other programs and providers for referrals to Ryan White HIV/AIDS Program service providers.

Improving Access to Health Care: The Ryan White HIV/AIDS Program works to improve access to health care by addressing the disparities in access, treatment, and care for populations disproportionately affected by HIV/AIDS including racial/ethnic minorities. The Ryan White HIV/AIDS Program provides HIV/AIDS care and treatment services to a significantly higher proportion of racial/ethnic minorities than their representation among AIDS cases as reported by the Centers for Disease Control and Prevention (CDC). The proportion of Ryan White clients who were racial/ethnic minorities in 2007 was 72 percent, compared to the 64.1 percent of CDC-reported AIDS cases. In 2008, 73 percent of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities compared to 65.9 percent of CDC-reported AIDS cases. In FY 2009, 73 percent of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities, compared to 66.4 percent of CDC-reported AIDS cases. In FY 2010, the proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs was 72 percent, compared to 66.5 percent of CDC-reported AIDS cases among racial/ethnic minorities. In 2011, 72.2 percent of Ryan White HIV/AIDS Program clients were racial/ethnic minorities, compared to 66.7 percent of CDC-reported AIDS cases among racial/ethnic minorities. In FY 2012, 72.6 percent of Ryan White HIV/AIDS Program clients were racial/ethnic minorities; at this time CDC data is not available for comparison.

In 2007 and 2008, 33 percent of persons served by the Ryan White HIV/AIDS Program were women. This compares to 23 percent of CDC reported AIDS cases among women in 2007 and 2008. In FY 2009, 32 percent of the Ryan White HIV/AIDS Program clients were women, compared to the 23.3 percent of CDC-reported AIDS cases. In FY 2010, the proportion of women in Ryan White HIV/AIDS funded programs was 31 percent, compared to 23.5 percent of CDC-reported AIDS cases among women. In 2011, 30.1 percent of Ryan White HIV/AIDS Program clients were women; compared to 24.8 percent of CDC-reported AIDS cases. In FY 2012, 29.1 percent of Ryan White HIV/AIDS Program clients were women; at this time CDC data is not available for comparison.

Improving Health Outcomes: In FY 2012, ADAP served 244,436 clients through State ADAPs, exceeding the target. In FY 2011, the AIDS Drug Assistance Program (ADAP) served 211,037 clients through State ADAPs. The number of AIDS Drug Assistance Program (ADAP) clients

served through State ADAPs in FY 2010 was 208,809 (14,770 persons above the 2009 annual results). In FY 2009, the AIDS Drug Assistance Program (ADAP) served 194,039 clients through State ADAPs. In FY 2008, the AIDS Drug Assistance Program (ADAP) served 175,194 clients through State ADAPs. In 2007, the ADAP served 163,925 clients through State ADAPs. FY 2007 results cannot be compared with the FY 2007 target because the actual performance is based on the revised measure using annual data and the target is based on the previous measure utilizing quarterly Program data. In the period, FY 2007 – FY 2012 substantial growth occurred in the persons served in the State ADAP programs of 32.9 percent or 80,512 additional ADAP clients served in these six years. About 60 percent of HIV positive people in regular care in the U.S. received their medications through State ADAPs in 2012.

CDC estimates that more than 1.1 million people in the United States are living with HIV infection, and almost 1 in 6 (15.6 percent) are unaware of their HIV infection. Approximately 50,000 new infections occur each year. In 2011, 679,531 persons learned their serostatus from Ryan White HIV/AIDS Programs, exceeding the target of 583,730. In FY 2011, the new Ryan White Services Report (RSR) was implemented. The RSR is a new client-level reporting system that changed how the HIV testing data is reported. Previously, Ryan White-funded providers reported on all HIV testing, regardless of the source of funding for the testing. Approximately 40percent of HIV testing reported in FY 2010 and earlier was not supported by Ryan White HIV/AIDS Program funds. Under the new reporting requirements, only HIV testing funded by the Ryan White HIV/AIDS Program is reported, thus the results from FY 2011 are smaller than data reported from previous years. In FY 2010, 1,205,257 persons learned their serostatus from the Ryan White HIV/AIDS Program. In FY 2009, 871,696 persons learned their serostatus from the Ryan White HIV/AIDS Program. The number of persons learning their serostatus from the Ryan White HIV/AIDS Program was 739,779 in FY 2008. In 2007, the number of persons who learned their serostatus from Ryan White HIV/AIDS Programs was 738,181. These efforts demonstrate that the Ryan White HIV/AIDS Program has made important strides in testing people in the United States who do not know their serostatus.

Mother-to-child transmission in the U.S. has decreased dramatically since its peak in 1992 due to the use of anti-retroviral therapy which significantly reduces the risk of HIV transmission from the mother to her baby. In 2012, the Ryan White HIV/AIDS Program provided 95.6 percent of HIV-positive pregnant women served by the program with anti-retroviral medication, exceeding the target. In FY 2011, the Ryan White HIV/AIDS Program provided 92.3 percent of HIV-positive pregnant women with antiretroviral medications. The proportion of Ryan White HIV/AIDS Program HIV-positive pregnant women receiving anti-retroviral medications in 2008, 2009, and 2010 was 87 percent. In FY 2007, the Ryan White HIV/AIDS Program provided 85.1 percent of HIV-positive pregnant women in the Program with anti-retroviral medications. The percentage of HIV-positive pregnant women in the Ryan White HIV/AIDS Program receiving anti-retroviral medication has grown 10.5 percentage points in the years FY 2007 – FY 2012.

Improving the Quality of Health Care: A major focus of the Ryan White HIV/AIDS Program is improving the quality of care that its clients receive. The Ryan White HIV/AIDS Treatment Modernization Act of 2006 directed grantees to develop, implement, and monitor clinical quality management programs to ensure that service providers adhere to established HIV clinical practices and quality improvement strategies; and that demographic, clinical, and health care utilization information is used to monitor trends in the spectrum of HIV-related illnesses and the

local epidemic. This legislative requirement continues in the Ryan White HIV/AIDS Extension Act of 2009. The proportion of new Ryan White HIV/AIDS Program-funded primary care medical providers that implemented a quality management program by 2008 was 92.3 percent. In 2009, 94.5 percent of Ryan White HIV/AIDS Program-funded primary medical care providers had implemented a quality management program. In 2010, 95.2 percent had implemented such a program. In 2011, 95.7 percent of medical care providers implemented a quality management program. Improvements continued in 2012 with 96.5 percent of medical care providers implementing a quality management program, exceeding the target.

CD4 cell measurement is a key test used to assess the functioning of the immune system, guide decisions about the urgency of starting HIV treatment, and monitor immune recovery during HIV treatment. Viral load tests measure the amount of HIV in the blood and are used along with CD4 cell counts to decide the urgency of starting HIV treatment and to monitor response to therapy. The proportion of new Ryan White HIV/AIDS Program clients who were tested for CD4 and viral load in 2008 and 2009 were: CD4-86.4 percent and Viral Load-84.4 percent and CD4-84.7 percent and Viral Load-81.3 percent, respectively. In 2010, the Ryan White HIV/AIDS Program provided CD4 count testing to 84.7percent of new clients and viral load testing to 82.9 percent of these new clients. The implementation of HRSA/HAB's new client-level data reporting system, the Ryan White Services Report (RSR), included a change in how CD4 count and viral load data are reported. These data are now collected for all HIV infected clients that are served, rather than just new clients. The FY 2011 result was 87.6 percent were tested for CD4 and 83.7 percent were tested for viral load. The FY 2012 result was 87.7 percent of clients were tested for CD4 and 86.2 percent were tested for viral load. The FY 2012 result fell short of the target for CD4 tests by 0.5 percentage point and exceeded the target of clients receiving viral load testing by 2 percentage points.

Promoting Efficiency: State ADAPs use a variety of strategies to contain costs which results in a more effective use of funding, and enables ADAPs to serve more people. Cost-containment measures used by ADAPs include: using drug purchasing strategies like seeking cost recovery through drug rebates and third party billing; direct negotiation of pharmaceutical pricing; reducing ADAP formularies; capping enrollment; and lowering financial eligibility levels. ADAP savings strategies on medications resulted in a savings of $265.2 million in 2007 and a $374.2 million savings in 2008. In 2009, the ADAP program had cost-savings on medications of $487.3 million. In 2010, ADAP cost-savings strategies for medication resulted in savings of $551.2 million. In 2011, the ADAP program had cost-savings on medication of $616.1 million, exceeding the target by $64.9 million.

Funding History

FY	Amount[167]
FY 2005	$2,073,296,000
FY 2006	$2,061,275,000
FY 2007	$2,137,795,000
FY 2008	$2,166,792,000
FY 2009	$2,238,421,000
FY 2010	$2,312,179,000
FY 2011	$2,336,665,000
FY 2012	$2,392,178,000
FY 2013	$2,248,638,000
FY 2014	$2,318,781,000
FY 2015	$2,322,781,000

Budget Request

The FY 2015 Budget Request for the Ryan White HIV/AIDS Programs of $2,322,781,000 is $4,000,000 above the FY 2014 Enacted level.

In FY 2015, the Ryan White HIV/AIDS Programs (RWHAP) will continue its central goals of 1) ensuring that individuals living with HIV have access to care and 2) improving the quality of life of those infected with HIV and those affected by the epidemic. In cities and states where the number of insured RWHAP clients begins to increase, the program will continue to provide services not covered by insurance but which are critical to providing quality comprehensive HIV care.

In FY 2015 HRSA's HIV/AIDS Bureau will also continue to work with Ryan White grantees to increase their focus on and support of services along the HIV care continuum that are not covered by insurance, but which are critical to ensuring that HIV positive individuals get linked into care and started on antiretroviral medications as early as possible. This work will support an additional central goal of the Ryan White HIV/AIDS Program of ensuring that individuals living with HIV are linked into care and get started on and adhere to life-saving and extending antiretroviral medications. Achieving this goal is not only crucial to ensuring the health and wellbeing of individuals living with HIV, but to preventing further transmission of the virus and ultimately ending the HIV epidemic in our country.

Through the types of activities discussed above , the Ryan White HIV/AIDS Program will continue to support the NHAS and its three primary goals:

1. Reducing the number of people who become infected with HIV;
2. Increasing access to care and optimizing health outcomes for people living with HIV; and
3. Reducing HIV-related health disparities.

The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the

[167] Includes SPNS.

importance of getting people living with HIV into care early after infection and started on antiretroviral medications to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to reduce HIV infection in high-risk communities and reduce stigma and discrimination against people living with HIV. The Minority AIDS Initiative (MAI) budget will continue the Ryan White HIV/AIDS Program's efforts to reduce HIV/AIDS-related health disparities in communities of color, strengthen organizational capacity, and expand HIV-related services to minority populations. The MAI funds will support primary health care and related services; outreach and education to improve minority access to HIV/AIDS treatment medications; and targeted, multidisciplinary education and training programs for health care providers treating minority PLWHA.

The Program will continue to appropriately target men who have sex with men, racial/ethnic minorities, specifically Black and Latino populations, because these groups are disproportionately impacted by HIV/AIDS. In addition, the NHAS targets these populations for more resources given their increased risk for HIV. Men who have sex with men are over forty times more likely to become infected with HIV compared with other men, and young black men are the only population in the U.S. in which the rate of new HIV infections are increasing. At some point in their lifetimes, 1 in 16 black men will be diagnosed with HIV infection, as will 1 in 32 black women. With regard to women, data from the 2010 CDC Surveillance Report in August 2011 show that together, black and Hispanic women represent 28 percent of all U.S. women. However, women in these two groups accounted for 64 percent of the estimated total of AIDS diagnoses for women. The FY 2015 targets for the proportion of racial/ethnic minorities and women served in Ryan White HIV/AIDS-funded programs are five percentage points above CDC reported national AIDS prevalence data.

In FY 2015, the Program will aim to reach the following performance targets. The number of clients served by ADAPs given the FY 2015 Budget Request is predicted to be 212,107 clients. The ADAP target reflects adjustments for our current performance and resources, in addition to medical inflation, rising health insurance premiums, reported decreases in state contributions and decreases in drug rebates, and increased costs of laboratory testing associated with antiretroviral use (e.g. resistance, tropism and Human Leukocyte Antigen (HLA) testing for patients). The FY 2015 target for persons who learn their serostatus from Ryan White HIV/AIDS programs is 676,003. The budget will also support the Program's ongoing efforts to improve the quality of health care for PLWHA. The FY 2015 target for the percentage of Ryan White HIV/AIDS Program-funded primary care providers that will have implemented a quality management program is 95.7 percent. The FY 2015 targets for new HIV infected clients who are tested for CD4 and for viral load are 88.2 percent and 84.3 percent, respectively.

In FY 2015, the Ryan White HIV/AIDS Program will continue to coordinate and collaborate with other Federal, State, and local entities as well as national AIDS organizations in order to further leverage and promote efforts to address the unmet care and treatment needs of persons living with HIV/AIDS who are uninsured or underinsured. The Ryan White HIV/AIDS Program's work in collaboration with others has been a key to its success. Federal partners include the Office of the Assistant Secretary for Health (OASH), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration

(SAMHSA), the Centers for Medicare and Medicaid Services (CMS), 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.

The Ryan White HIV/AIDS Program funds two IT Investments. It funds the HRSA-HAB Upgrading & Maintaining RW CAREWare investment, which directly supports the strategic and performance outcomes of the HIV/AIDS Bureau (HAB) by providing to grantees and providers a free and technically-supported software to manage their HIV care, treatment, and services data at the clinic level and be able to report these data in the required format to HAB at the end of the year. The software also generates HAB's performance measures in a standardized fashion, outcomes that are essential for monitoring and ultimately improving the quality of HIV care.

The Ryan White HIV/AIDS Program's investment in the HRSA Performance Management Handbook (HPMH), which was formerly known as the HRSA-OIT Electronic Handbooks (EHBs), supports the strategic and performance outcomes of the program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner. The HPMH supports the Ryan White HIV/AIDS Program with program administration, grants administration and monitoring, management reporting, and grantee performance measurement and analysis.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
16.1: Number of racial/ethnic minorities and the number of women served by Ryan White HIV/AIDS-funded programs.[168] *(Outcome)*	FY 2005: 412,000/ 195,000 (Baseline)	422,300/ 199,875	N/A	N/A
16.I.A.1: Proportion of persons served by the Ryan White HIV/AIDS Program who are racial/ethnic minorities. *(Outcome)*	FY 2012: 72.6% (CDC = Not Yet Available for Comparison)	5 percentage points above CDC data	5 percentage points above CDC data	Maintain

[168] These are long-term measures without annual targets. FY 2014 is the long-term target year.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
16.I.A.2: Proportion of persons served by the Ryan White HIV/AIDS Program who are women. *(Outcome)*	FY 2012: 29.1% (CDC = Not Yet Available for Comparison)	5 percentage points above CDC data	5 percentage points above CDC data	Maintain
16.III.A.2: Proportion of HIV infected Ryan White HIV/AIDS Program clients that received medical care who were tested for CD4 count and viral load. *(Output)*[169]	FY 2012: CD4 – 87.7% Viral Load – 86.2% Target: CD4-88.2% Viral Load-84.3% (Target Not Met but Improved)	CD4 = 88.2% Viral Load = 84.3%	CD4 = 88.2% Viral Load = 84.3%	Maintain
16.2: Reduce deaths of persons due to HIV infection.[170] *(Outcome)*	FY 2003: 4.7 per 100,000 (Baseline)	3.1 per 100,000	N/A	N/A
16.II.A.1: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. *(Output)*	FY 2012: 244,436 Target: 217,324 (Target Exceeded)	211,988	212,107	+119
16.II.A.2: Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs. *(Output)*	FY 2011: 679,531 Target: 583,730 (Target Exceeded)	679,531	676,003	-3,528
16.II.A.3: Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive anti-retroviral medications. *(Output)*	FY 2012: 95.6%% Target: 90% (Target Exceeded)	90%	90%	Maintain

[169] The implementation of HRSA/HAB's new client-level data reporting system, the Ryan White Services Report (RSR), included a change in how CD4 count and viral load data are reported. These data are now collected for all HIV-positive clients who receive outpatient ambulatory medical care, rather than just new clients. The FY 2011 result is from the new data system.

[170] These are long-term measures without annual targets. FY 2014 is the long-term target year.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
16.3: Percentage of Ryan White HIV/AIDS Program- funded HIV primary medical care providers that have implemented a quality management program and will meet two "core" standards included in the October 10, 2006 "Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents".[171]	FY 2005: 63.7% (Baseline)	90%	N/A	N/A
16.III.A.1: Percentage of Ryan White HIV/AIDS Program-funded primary medical care providers that will have implemented a quality management program. *(Output)*	FY 2012: 96.5% Target: 95.7% (Target Exceeded)	95.7%	95.7%	Maintain
16.E: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. *(Efficiency)*	FY 2011: $616.1M Target: $551.2M (Target Exceeded)	Sustain FY 13 results	Sustain FY 14 results	N/A

[171] These are long-term measures without annual targets. FY 2014 is the long-term target year.

Impact of ACA Implementation on the Ryan White HIV/AIDS Program

As part of the continued implementation of the Affordable Care Act (ACA) in 2015, millions of Americans will be eligible for health insurance and coverage through provisions Medicaid expansion and Exchange implementation. Additionally, access to specific healthcare services is expanded through required coverage for preventative services and essential health benefits.

The Ryan White HIV/AIDS Program will be directly affected by the ACA health insurance expansions as uninsured individuals living with HIV/AIDS continue to enroll in private health insurance or expanded Medicaid. By statute, Ryan White-funded programs are the payer of last resort – as such, they fill gaps in care not covered by other resources, including private and public health insurance. HRSA HAB has issued Policy Clarification Notices #13-01 through #13-06 as well as program letters which provide guidance to Ryan White HIV/AIDS Program grantees on ACA implementation related to Ryan White HIV/AIDS Program legislative and programmatic requirements.

Services provided by the Ryan White HIV/AIDS Program are critical for maintaining PLWH in treatment, which contributes to the nation's overall public health. Recent research shows that treatment reduces HIV transmission by 96 percent, highlighting the importance of ensuring that all individuals living with HIV have access to care and are prescribed antiretroviral therapy (ART). By keeping PLWH in care and on medications, the Ryan White HIV/AIDS Program plays a critical role in preventing the spread of HIV epidemic, as people living with HIV who are on antiretrovirals and virally suppressed are much less likely to transmit the infection.

Data from the Center for Disease Control and Prevention indicates that currently only approximately 25 percent of individuals living with HIV in the United States receive ART resulting in suppression of the virus. Such findings underscore the importance of supporting effective interventions for linking HIV positive individuals into care, retaining them in care, and helping them adhere to their ART regiments. The continuum of interventions that begin with outreach and testing and result in ART and viral suppression is generally referred to as the HIV Continuum of Care.

• **Population**: In 2011, over 550,000 clients received one or more service from the Ryan White HIV/AIDS Program. Seventy-two percent of the clients served (Parts A through D) were racial/ethnic minorities; 47.3 percent were Black/African American; 22.3 percent were Hispanic; and Asians, Native Hawaiian/Pacific Islanders, American Indians/Alaska Natives and multi-racial clients comprised 2.7 percent of all clients served by the program. Males comprised 68.5 percent of clients served; 30.7 percent were females. Almost 41 percent of clients served were 25 to 44 years of age; 47.5 percent were 45-65 years of age, and clients age 65 years or older comprised 2.9 percent of all clients. Children 12 years and younger comprised 2.1 percent of clients served, and youth 13 to 24 years of age comprised 6.7 percent of persons receiving Ryan White HIV/AIDS Program funded services.

Twenty-five percent of the clients served by the Ryan White HIV/AIDS Program in 2011 were uninsured, and 29 percent were Medicaid recipients. Privately insured clients comprised almost 13 percent of those served by the program; nine percent were Medicare enrollees; almost eight percent had other types of public insurance such as Tricare; and four percent reported having

other types of insurance. Twelve percent of clients served had multiple types of insurance in 2011.

Sixty-seven percent of all clients served in 2011 had household incomes below or equal to 100 percent of the federal poverty level (FPL). Another 21.2 percent reported household incomes of 101 to 200 percent FPL; 6.4 percent reported incomes of 201-300 percent FPL, and 5.2 percent of clients served had incomes greater than 300 percent FPL. Uninsured clients served by Ryan White HIV/AIDS Programs are potentially eligible to obtain services through access to Medicaid, private insurance or other sources. An increase in demand for services due to increased access to insurance is not anticipated.

• **Services Provided**: By statute, the RWHAP is the payer of last resort. The program will only pay for eligible services that are not covered or minimally covered by other private or public insurance. The program currently provides, and will continue to provide, uncovered services for those patients with or without insurance to ensure that vulnerable populations receive care and treatment support necessary to remain in care. In addition, HRSA has directed its grantees to vigorously pursue eligibility for other funding sources (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.

RWHAP will continue to provide services, such as dental care, that are not currently available through Medicaid and/or other insurance options. The program will also continue to pay allowable co-pays, deductibles, and insurance premiums to ensure that eligible individual remain in care.

• **Reimbursements**: By statute, RWHAP funds may not be used for any item or service "for which payment has been made or can reasonably be expected to be made" by another payment source (Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1) and 2671(i) of the Public Health Service Act.). This means that grantees and subgrantees must assure that they make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their subgrantees are expected to vigorously pursue eligibility for other funding sources (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite Ryan White HIV/AIDS Program grant resources to new clients and/or needed services.

In many cases, Ryan White HIV/AIDS Program providers are required by statute to become Medicaid providers. As such, these grantees are already capable of receiving third-party payments for services. Further, HRSA is encouraging grantees that are direct-service providers to reach out to health insurers in order to get into their health insurance networks, so that they can continue to provide services to patients currently in their care.

• **Administrative Costs**: While it is not known exactly how increases in health care coverage will affect administrative costs for Ryan White HIV/AIDS Program grantees, HRSA anticipates that the Ryan White HIV/AIDS Program will continue to provide uncovered services for newly insured patients, in the same way it provides services for those patients who are currently

covered by other public or private insurance. The Ryan White HIV/AIDS Program has statutorily defined limits on administrative costs for some of the grantees. It is anticipated that the proportion of administrative costs for grantees spent on coordination of benefits will increase as more clients have access to different types of insurance and Medicaid.

• **Continuing Need for Ryan White HIV/AIDS Program**: The program will continue to provide needed core medical and support services for patients who will not be covered. Further, the Ryan White HIV/AIDS Program will continue to play an important role for PLWH in states that are not expanding Medicaid. In 2011, fifty-eight percent of uninsured non-ADAP Ryan White HIV/AIDS Program clients (n=72,079) resided in states not expanding Medicaid. Among these clients, 70 percent had incomes at or below 100 percent FPL and may remain uninsured as ACA is implemented since they do not qualify for premium tax credits and/or cost-sharing reductions to help them afford a private health plan in the Marketplace. However, it should be noted that if resources are available, Ryan White HIV/AIDS program grantees and sub-grantees may elect to pay premiums and cost-sharing for eligible Ryan White clients to enroll in a plan offered in the Marketplace when it is cost-effective and in accordance with the Ryan White HIV/AIDS Program policy.

Emergency Relief Grants – Part A

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$624,262,000	$655,876,000	$655,876,000	---
MAI (non add)	$50,784,000	$54,105,000	$54,105,000	---
SPNS	$7,588,000	$7,588,000	$7,588,000	---
Total Funding	$631,850,000	$663,464,000	$663,464,000	---
FTE	37	37	37	---

Authorizing Legislation: Secs. 2601-10, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87.

FY 2015 Authorization…….……..…….Expired

Allocation Method ..... Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part A funds are used to provide a continuum of care for people living with HIV disease who are primarily low income, underserved, uninsured and underinsured. Part A grants are distributed to metropolitan areas experiencing the greatest burdens of the country's HIV/AIDS epidemic and provide those communities with resources they need to confront the highly concentrated epidemic within the jurisdiction.

Part A of the Ryan White HIV/AIDS Program prioritizes primary medical care, access to anti-retroviral therapies, and other core services as the areas of greatest medical need for persons with HIV disease. The grants fund systems of care to provide 13 core medical services and additional support services for individuals with HIV/AIDS in 24 Eligible Metropolitan Areas (EMAs), which are jurisdictions with 2,000 or more AIDS cases over the last five years, and 28 transitional grant areas (TGAs) (jurisdictions with at least 1,000 but fewer than 2,000 AIDS cases over the last five years). Two-thirds of the funds available for EMAs and TGAs are awarded according to a formula based on the number of living cases of HIV/AIDS 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. MAI grant awards are determined based on the number of minorities living with HIV and AIDS in a jurisdiction.

In 2011, 75 percent of Part A clients were people of color and 28 percent were women. In 2007, Part A provided 2.65 million visits for health-related care (primary medical, dental, mental

health, substance abuse, rehabilitative, and home health), 2.60 million visits were provided in 2008, 2.59 million visits in FY 2009, and 2.63 million visits in FY 2010. In FY 2011, Part A provided 1.994 million visits for health-related care (primary medical, dental, mental health, substance abuse, and home health). This did not meet the target due to change in the data source used for measuring HAB's performance, resulting in a lower number of calculated visits. In the historic data source (RDR), the data were limited to funding source. However, visit data were provided in the aggregate. In the current data source (RSR), the data are filtered at a more precise level resulting in the exclusion of data that may have been included in the historical aggregate data run.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Performance Management Handbook, technical assistance, and program monitoring including performance reviews, and Information Technology costs.

Use of funds

Part A supports a comprehensive continuum of quality, community-based care for low-income individuals and families with HIV/AIDS. Eligible service categories include core medical services and support services, as defined by the legislation. Use of Part A Ryan White HIV/AIDS Program funds is locally determined, guided by a Planning Council, mandated by statute for EMA grantees and established by the chief elected official (CEO) of each EMA or TGA. Eligible organizations for sub-grants under Part A include ambulatory care facilities, community health centers, and a variety of other organizations serving PLWH.

Funding History

FY	Amount[172]
FY 2005	$610,094,000
FY 2006	$603,576,000
FY 2007	$603,993,000
FY 2008	$627,149,000
FY 2009	$663,082,000
FY 2010	$678,074,000
FY 2011	$672,529,000
FY 2012	$666,071,000
FY 2013	$624,262,000
FY 2014	$655,876,000
FY 2015	$655,876,000

Budget Request

The FY 2015 Budget Request for the Ryan White HIV/AIDS Part A Program of $655,876,000 is equal to the FY 2014 Enacted level and will support program activities and services for PLWHA in the 24 Eligible Metropolitan Areas (EMAs) and 28 Transition Grant Areas (TGAs).

[172] Excludes comparable amounts for SPNS.

In FY 2015, many Part A grantees will be directly affected by the Affordable Care Act health insurance expansions as uninsured individuals living with HIV/AIDS continue to enroll in private health insurance or expanded Medicaid. In cities where the number of insured Ryan White HIV/AIDS Program clients increase, Part A grantees will continue to provide services not covered by private or public insurance but which are essential to 1) providing quality comprehensive HIV care such as intensive case management and care coordination services, and 2) linking individuals living with HIV into care and started on ART as early as possible. Supporting interventions that get people linked into care and on medications is critical to prevent the spread of the epidemic as studies have found that treatment reduces HIV transmission by 96 percent. Cities in jurisdictions without significant Medicaid expansion will continue to use their RWHAP funds to provide critical primary care services and life savings medication.

The FY 2015 target for the number of visits for health-related care (primary medical, dental, mental health, substance abuse, and home health) is 1.963 million visits. Part A funding will also contribute to achieving the FY 2015 targets for the Ryan White HIV/AIDS Program's over-arching performance measures, including proportion of racial/ethnic minorities and women served, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
17.I.A.1: Number of visits for health-related care (primary medical; oral health; mental health; substance abuse; home health; and home and community based services). *(Output)*	FY 2011: 1.994 M Target: 2.63 M (Target Not Met)	1.994 M	1.963M	-31,000

Grant Awards Table – Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	53	52	52
Average Award	$11,213,948	$12,000,000	$12,000,000
Range of Awards	$1,808,203 - $102,711,769	$1,935,000 - $109,900,000	$1,935,000 - $109,900,000

Part A – FY 2013 Formula, Supplemental & MAI Grants[173]

Table 1. Eligible Metropolitan Areas

EMAs	Formula[174]	Supplemental	MAI	Total
Atlanta, GA	$13,615,476	$5,843,520	$2,024,218	$21,483,214
Baltimore, MD	12,836,162	4,308,754	1,745,100	18,890,016
Boston, MA	8,521,933	3,620,502	871,694	13,014,129
Chicago, IL	16,232,059	7,105,949	2,159,230	25,497,238
Dallas, TX	9,392,078	3,846,691	1,085,231	14,324,000
Detroit, MI	5,398,374	2,432,486	774,661	8,605,521
Ft. Lauderdale, FL	9,452,815	4,263,652	1,201,521	14,917,988
Houston, TX	12,300,806	5,687,127	1,762,110	19,750,043
Los Angeles, CA	24,362,797	10,816,566	3,038,947	38,218,310
Miami, FL	14,825,391	6,814,430	2,494,085	24,133,906
Nassau-Suffolk, NY	3,616,314	1,535,310	416,055	5,567,679
New Haven, CT	4,068,220	1,514,041	453,285	6,035,546
New Orleans, LA	4,530,946	2,036,937	599,851	7,167,734
New York, NY	66,150,073	27,149,260	9,412,436	102,711,769
Newark, NJ	8,034,986	3,424,394	1,266,781	12,726,161
Orlando, FL	5,663,959	2,434,435	703,411	8,801,805
Philadelphia, PA	14,327,187	6,061,813	1,981,425	22,370,425
Phoenix, AZ	5,268,619	2,289,403	436,810	7,994,832
San Diego, CA	7,163,666	2,905,827	606,591	10,676,084
San Francisco, CA	12,893,506	4,320,619	710,899	17,925,024
San Juan, PR	8,315,471	2,759,857	1,268,065	12,343,393
Tampa-St. Petersburg, FL	5,917,396	2,760,060	596,963	9,274,419
Washington, DC-MD-VA-WV	18,874,619	8,291,309	2,801,339	29,967,267
West Palm Beach, FL	5,098,010	2,022,167	658,050	7,778,227
Subtotal EMAs	**$296,860,863**	**$124,245,109**	**$39,068,758**	**$460,174,730**

[173] Awards to EMAs and TGAs include prior year unobligated balances.
[174] EMAs' Hold Harmless Amounts are included in their Formula Awards. TGAs are not eligible for Hold Harmless.

Table 2. Transitional Grant Areas[175]

TGAs	Formula	Supplemental	MAI	Total
Austin, TX	$2,671,975	$1,092,531	$260,289	$4,024,795
Baton Rouge, LA	2,573,414	1,044,713	405,036	4,023,163
Bergen-Passaic, NJ	2,464,598	964,625	325,655	3,754,878
Charlotte-Gastonia, NC-SC	3,570,419	1,339,246	504,102	5,413,767
Cleveland, OH	2,718,122	1,013,628	327,795	4,059,545
Columbus, OH	2,688,497	1,092,722	229,692	4,010,911
Denver, CO	5,014,653	1,960,556	335,176	7,310,385
Fort Worth, TX	2,438,960	949,296	264,889	3,653,145
Hartford, CT	2,125,046	905,479	276,443	3,306,968
Indianapolis, IN	2,484,538	1,044,056	229,050	3,757,644
Jacksonville, FL	3,487,241	1,560,562	468,584	5,516,387
Jersey City, NJ	2,987,029	1,325,514	431,996	4,744,539
Kansas City, MO	2,726,668	1,169,700	245,097	4,141,465
Las Vegas, NV	3,565,862	1,432,375	341,702	5,339,939
Memphis, TN	4,299,658	1,803,996	688,005	6,791,659
Middlesex-Somerset-Hunterdon, NJ	1,656,738	701,745	208,830	2,567,313
Minneapolis-St. Paul, MN	3,492,368	1,479,749	313,352	5,285,469
Nashville, TN	2,939,172	1,156,932	293,453	4,389,557
Norfolk, VA	3,516,296	1,453,553	501,534	5,471,383
Oakland, CA	3,989,731	1,761,598	474,896	6,226,225
Orange County, CA	3,758,426	1,595,430	362,671	5,716,527
Ponce, PR	1,111,519	487,961	208,723	1,808,203
Portland, OR	2,537,522	1,051,606	108,908	3,698,036
Riverside-San Bernardino, CA	4,561,728	2,017,336	400,222	6,979,286
Sacramento, CA	1,951,282	830,010	153,627	2,934,919
Saint Louis, MO	3,748,741	1,570,398	415,413	5,734,552
San Antonio, TX	2,789,337	1,141,613	378,611	4,309,561
San Jose, CA	1,765,554	741,077	187,754	2,694,385
Seattle, WA	4,455,191	1,768,826	275,908	6,499,925
Subtotal TGAs	**$88,090,285**	**$36,456,833**	**$9,617,413**	**$134,164,531**
Subtotal EMAs/TGAs	**$384,951,148**	**$160,701,942**	**$48,686,171**	**$594,339,261**

[175] Note: In FY 2013, Caguas, PR; Dutchess County, NY; Vineland, NJ; and Santa Rosa, CA did not receive TGA grants. Rather, Part A funds were transferred to Part B and a portion awarded to PR, NY, NJ, and CA. These funds could be used to maintain services in these areas.

HIV Care Grants to States – Part B

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$1,287,535,000	$1,315,005,000	$1,315,005,000	---
ADAP (non add)	$886,313,000	$900,313,000	$900,313,000	---
MAI (non add)	$9,522,000	$10,145,000	$10,145,000	---
SPNS	$14,077,000	$14,077,000	$14,077,000	---
Total Funding	$1,301,612,000	$1,329,082,000	$1,329,082,000	---
FTE	57	57	57	---

Authorizing Legislation: Secs. 2611-31, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87.

FY 2015 Authorization……Expired

Allocation Method ..... Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part B, the largest of the Ryan White HIV/AIDS programs, provides grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and five U.S. Pacific Territories or Associated Jurisdictions to provide services for people living with HIV/AIDS, including outpatient medical care, HIV-related prescription medications, case management, oral health care, continuation of health insurance coverage, mental health and substance abuse services, and support services.

Part B includes the AIDS Drug Assistance Program (ADAP), which supports the provision of HIV medications and related services, including insurance premium assistance. Seventy-five percent of Part B funds must be used to support 13 core medical services. Part B funds are distributed through base and supplemental grants, ADAP and ADAP supplemental grants, Emerging Communities (ECs) grants, and Minority AIDS Initiative grants. The base awards are distributed by a formula based on a state or territory's living HIV/AIDS cases weighted for cases outside of Part A-funded jurisdictions. Supplemental grants are available to eligible states with demonstrated need. Emerging communities (ECs) are metropolitan areas that do not qualify as EMAs or TGAs but have 500-999 cumulative reported AIDS cases over the last five years. States apply on behalf of the ECs for funding through the Part B base grant application.

Over the past four years, the convergence of several factors has resulted in significant budget challenges for the RWHAP Part B program. These include the economic downturn, a national HIV testing initiative that has brought more people infected with HIV into care, federal recommendations for treatment of HIV regardless of CD4 count, and continued improvements in HIV care and treatment that has prolonged survival, increasing HIV prevalence. RWHAP Part B grants provide critical resources for States and territories to meet these increased demands and provide life-saving HIV/AIDS care, treatment, and support for people living with HIV/AIDS without access to health care.

Congress designates a portion of the Part B award to support the ADAPs. The ADAPs provide FDA-approved prescription medications for people with HIV/AIDS who have limited or no prescription drug coverage. The majority of ADAP funds are distributed by a formula based on living HIV/AIDS cases, although five percent of the funds are set aside for states with severe need. ADAP funds also may be used to purchase health insurance for eligible clients or to pay for services that enhance access, adherence, and monitoring of drug treatments. Individual ADAPs operate in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, Commonwealth of the Northern Mariana Islands, and the Republic of the Marshall Islands.

Due to the combination of factors mentioned above, a number of States implemented or significantly increased waiting lists for people to enroll in their ADAP programs and implemented other cost-containment mechanisms such as restricting the income eligibility for their programs. In FY 2010, FY 2011, FY 2012, and FY 2013 HHS took several actions to address the ADAP crisis:

- In FY 2010, HHS used emergency authority to redistribute and transfer $25 million from other HHS resources to provide direct assistance to help State ADAP programs eliminate their waiting lists and to address cost containment measures.

- The FY 2011 Budget included an additional $50 million for State ADAPs.

- In FY 2012, $75 million in emergency funding for ADAPs included $35 million in redirected funding announced by President Obama on World AIDS Day and $40 million in continuation emergency funding first appropriated in FY 2011.

- In FY 2013, HHS redirected an additional $35 million above the FY 2013 final enacted funding level for State ADAPs.

As a result of the increased investments in ADAP and the increased technical assistance activities for cost-containment measures in FY 2012, the program provided 244,436 clients with HIV-related medications.

The RWHAP Part B programs have been successful in helping to ensure that people living with HIV/AIDS can access the care and treatment services they need to stay healthy longer. Recent studies have demonstrated that individuals with HIV on antiretroviral medications who achieve viral load suppression are less likely 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 Ryan White program in meeting the first NHAS goal – preventing new HIV infections – by ensuring that individuals living with HIV have access to regular care and are started on and adhere to their antiretroviral medicals.

The number of visits for health-related services demonstrates the effectiveness of the Part B program in delivering primary care and related services for individuals infected with HIV by increasing the availability and accessibility of care. Part B programs provided 2.06 million visits of health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) in 2007. In FY 2008, Part B provided 2.02 million visits for health-related care. In FY 2009, the Part B program provided 2.11 million visits for health-related care. In FY 2010, 2.20 million visits were provided for health-related care. In FY 2011, the Part B program provided 1.086 million visits for health-related care. This did not meet the FY 2011 target due to the change in the data source used for measuring HAB's performance, resulting in a lower number of calculated visits. In the historic data source (RDR), the data likely over included visits. In the current data source (RSR), the data are filtered at a more precise level resulting in the exclusion of data that may have been included in the historical run given the way the analysis was done with aggregate data or data combined from several elements. The change in the data source from RDR to RSR resulted in a lower number of calculated visits which is attributed to using client-level data (RSR) and how the data analysis is done. ADAP served 163,925 clients in 2007 and 175,194 clients in 2008. In FY 2009, 194,039 clients were served through State ADAPs. In FY 2010, 208,809 clients were served through State ADAPs. In FY 2012, 244,436 ADAP clients were served through State ADAPs, exceeding the target. In FY 2012, 62.3 percent of the244,436 clients served by ADAPs were people of color. Nationally, more than 79.2 percent of ADAP clients had incomes at or below 200 percent of the federal poverty level.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Performance Management Handbook, technical assistance and program monitoring including performance reviews, and Information Technology costs.

Funding History

FY	Amount[176]	ADAP (Non-Add)
FY 2005	$1,121,836,000	($787,521,000)
FY 2006	$1,119,744,000	($789,005,000)
FY 2007	$1,195,500,000	($789,546,000)
FY 2008	$1,195,248,000	($794,376,000)[177]
FY 2009	$1,223,791,000	($815,000,000)
FY 2010	$1,276,791,000	($858,000,000)
FY 2011	$1,308,141,000	($885,000,000)
FY 2012	$1,360,827,000	($933,299,000)
FY 2013	$1,287,535,000	($886,313,000)
FY 2014	$1,315,005,000	($900,313,000)
FY 2015	$1,315,005,000	($900,313,000)

Budget Request

The FY 2015 Budget Request for the Ryan White HIV/AIDS Part B Program of $1,315,005,000 is equal to the FY 2014 Enacted level. This request will support the provision life-saving medications and health care services to persons living with HIV in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam and five Pacific jurisdictions.

In FY 2015, many RWHAP Part B grantees will be directly affected by the Affordable Care Act health insurance expansions as uninsured individuals living with HIV/AIDS continue to enroll in private health insurance or expanded Medicaid. In states where the number of insured RWHAP clients increase, Part B grantees will continue to provide services along the HIV care continuum that are not covered by private or public insurance but which are essential to 1) providing quality comprehensive HIV care such as intensive case management and care coordination services, and 2) linking and retaining individuals living with HIV into care and started on and adhering to ART regimens as early as possible. Supporting interventions that get people linked into care and on medications is critical not only to ensuring the health and wellbeing of individuals living with HIV, but also to preventing the spread of the epidemic, as studies have found that treatment reduces HIV transmission by 96 percent.

States continue to face fiscal challenges and shortfalls in meeting the growing HIV epidemic in their jurisdictions. In addition, as the HHS treatment guidelines are fully implemented and all people diagnosed with HIV are offered treatment, the demand for ADAP will increase. The FY 2015 Budget Request reflects a strong commitment to partnering with States to respond to the HIV epidemic.

As a result of the increased investments in ADAP in FY 2011 and HRSA providing intensive technical assistance to states to prevent, reduce and eliminate waiting lists, the number of people living with HIV on ADAP waiting lists has decreased from a peak of 9,310 in September 2011 to zero as of November 21, 2013. However, most ADAPs have implemented cost-containment

[176] Excludes comparable amounts for SPNS.
[177] FY 2008 actual expenditure was $813,858,028 due to the hold harmless provision. For FY 2008, the statute requires that the grant not be less than 100percent of the FY 2007 total grant.

measures to avoid future waiting lists. The budget maintains the Federal commitment to supporting States and their ADAP programs. The FY 2015 Budget Request includes $900,313,000 for AIDS drug assistance programs to provide access to life saving HIV related medications. The FY 2015 clients served target is 212,107. This federal investment, combined with the Affordable Care Act health insurance expansions, will help ensure that all people living with HIV/AIDS have access to life-saving medications that suppress the virus and prevent the spread of the epidemic.

HRSA has developed a model for estimating the federal share of the marginal cost of serving ADAP clients. The model takes into account many of the factors affecting purchasing power, such as increases in cost of HIV/AIDS drugs; the legislative requirement that all State ADAPs maintain a minimum drug formulary, including new drug classes; and the impact of Medicare Part D, rebates, medical inflation and insurance coverage. The marginal cost model provided federal share cost estimates based on the application of the model to informs the Program's projected target for number of ADAP clients from 2008 - 2012. During the FY 2013, FY 2014 and FY 2015 budget processes, the cost and program indexes and assumptions made in the marginal cost model were reviewed. The model retains utility in predicting ADAP performance targets, thus the models projection of the total ADAP earmark cost to support serving ADAP clients was extended through 2015 by using a linear trend model to estimate the per client costs. The FY 2015 target for the number of visits for health related care (primary, medical, dental, mental health, substance abuse, and home health) is 1.63 million visits.

Part B funding will also contribute to achieving the FY 2015 targets for the Ryan White HIV/AIDS Program's over-arching performance measures, including proportion of racial/ethnic minorities and women served, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
18.I.A.1: Number of visits for health-related care (primary medical; oral health; mental health; substance abuse; home health; and home and community based services). *(Output)*	FY 2011: 1.086 M Target: 2.19 M (Target Not Met)	2.19 M	1.63 M	-0.56 M

Grant Awards Table – Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	59	59	59
Average Award	$21,003,745	$21,440,000	$21,440,000
Range of Awards	$38,488-$153,752,041	$39,250-$156,830,000	$39,250-$156,830,000

Part B – FY 2013 State Table[178]

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Alabama	$7,550,206	$155,153	$13,978,676	$318,125	$137,322	$22,139,482
Alaska	500,000	8,871	856,092	-	-	1,364,963
American Samoa	45,927	-	2,463	-	-	48,390
Arizona	3,735,341	194,284	12,196,674	-	93,539	16,219,838
Arkansas	3,306,039	64,621	4,504,984	-	41,624	7,917,268
California	32,285,048	1,738,531	116,854,899	165,278	1,055,941	152,099,697
Colorado	3,381,421	176,709	11,345,301	-	68,366	14,971,797
Connecticut	3,237,675	314,808	10,149,812	-	122,863	13,825,158
Delaware	2,226,604	-	2,910,559	209,836	38,266	5,385,265
District of Columbia	4,199,932	-	14,092,127	-	220,080	18,512,139
F. States Micronesia	30,916	-	7,572	-	-	38,488
Florida	29,369,435	2,920,207	103,940,760	492,156	1,194,951	137,917,509
Georgia	12,007,138	566,494	45,323,227	189,264	495,990	58,582,113
Guam	178,590	-	80,040	-	-	258,630
Hawaii	1,520,474	-	1,962,973	-	18,036	3,501,483
Idaho	534,516	-	1,516,747	-	-	2,051,263
Illinois	8,863,963	-	35,366,372	-	386,979	44,617,314
Indiana	3,269,469	144,250	8,161,509	-	-	11,575,228
Iowa	1,251,928	28,913	2,672,265	-	-	3,953,106
Kansas	1,071,006	-	2,415,263	-	-	3,486,269
Kentucky	3,641,796	-	5,085,766	259,735	39,025	9,026,322
Louisiana	5,859,282	541,649	21,163,888	-	232,531	27,797,350
Maine	766,355	-	989,385	-	-	1,755,740
Marshall Islands	43,631	-	2,609	-	-	46,240
Maryland	8,525,280	-	27,565,018	-	448,950	36,539,248

[178] Awards include prior year unobligated balances.

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Massachusetts	4,879,516	467,966	13,917,303	-	159,222	19,424,007
Michigan	4,701,176	193,249	12,420,524	-	165,431	17,480,380
Minnesota	1,862,148	109,271	5,800,789	-	56,117	7,828,325
Mississippi	5,753,198	-	7,481,081	285,122	119,185	13,638,586
Missouri	3,523,498	-	9,673,525	-	-	13,197,023
Montana	500,000	-	806,583	-	-	1,306,583
N. Marianas	38,597	-	8,314	-	-	46,911
Nebraska	1,160,480	-	1,620,611	-	13,818	2,794,909
Nevada	2,025,526	-	5,990,352	-	59,980	8,075,858
New Hampshire	500,000	-	966,937	-	-	1,466,937
New Jersey	10,956,960	1,033,447	38,185,626	-	467,391	50,643,424
New Mexico	1,716,249	-	2,215,724	-	-	3,931,973
New York	36,680,591	3,789,690	110,870,226	647,455	1,764,079	153,752,041
North Carolina	10,620,710	378,372	26,383,734	287,748	326,071	37,996,635
North Dakota	500,000	-	183,465	-	-	683,465
Ohio	7,276,118	-	15,303,043	300,091	158,733	23,037,985
Oklahoma	3,347,142	-	4,591,130	214,476	-	8,152,748
Oregon	1,630,669	85,580	4,524,566	-	21,006	6,261,821
Pennsylvania	11,444,980	-	27,855,846	264,024	384,094	39,948,944
Puerto Rico	9,033,821	535,819	23,226,498	-	323,557	33,119,695
Republic of Palau	39,274	-	3,326	-	-	42,600
Rhode Island	1,159,278	-	2,335,679	177,183	18,914	3,691,054
South Carolina	10,383,057	234,875	13,672,663	550,984	195,143	25,036,722
South Dakota	500,000	-	721,999	-	-	1,221,999
Tennessee	5,096,140	269,140	18,569,966	-	178,574	24,113,820
Texas	20,003,411	1,024,013	62,084,124	-	779,104	83,890,652
Utah	1,590,669	37,904	3,548,513	-	-	5,177,086
Vermont	500,000	-	362,929	-	-	862,929
Virgin Islands	500,000	9,569	608,063	-	9,364	1,126,996
Virginia	6,973,843	323,524	23,781,353	380,014	243,566	31,702,300
Washington	3,419,972	-	10,305,535	-	62,849	13,788,356
West Virginia	982,126	-	1,343,568	-	-	2,325,694
Wisconsin	3,446,896	84,494	5,236,519	258,509	48,490	9,074,908
Wyoming	500,000	-	247,318	-	-	747,318
Total	**$310,648,017**	**$15,431,403**	**$897,992,413**	**$5,000,000**	**$10,149,151**	**$1,239,220,984**

Early Intervention Services – Part C

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$194,444,000	$201,079,000	$280,167,000	+$79,088,000
MAI (non add)	$67,327,000	$71,012,000	$94,683,000	+$23,671,000
SPNS	$2,433,000	$2,433,000	$3,335,000	+$902,000
Total Funding	$196,877,000	$203,512,000	$283,502,000	+$79,990,000
FTE	40	40	49	+9

Authorizing Legislation: Secs. 2651-67, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87.

FY 2015 Authorization……..……..…….…...Expired

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part C of the Ryan White HIV/AIDS Program provides direct grants to community and faith-based primary health clinics and public health providers in 49 states, Puerto Rico, the District of Columbia, and the U.S. Virgin Islands. Part C programs are the primary means for targeting HIV medical services to underserved and uninsured people living with HIV/AIDS in specific geographic communities, including rural and frontier communities. Part C programs target the most vulnerable communities, including people of color, men-who-have-sex-with men (MSM), women, and low-income populations. Part C programs have the cultural competency and expertise to provide care to these underserved and vulnerable populations. In 2011, 71 percent of those served by Part C clinics were people of color and 29 percent were female. Part C providers are central to the nation's HIV testing initiatives, providing HIV counseling and testing to more than 467,765 people in 2011.

The number of persons receiving primary care services under Early Intervention Services programs was 236,745 in FY 2007 and 247,133 in FY 2008. The 2009 results show 255,429 clients were served by the Early Intervention Services program and 273,157 in FY 2010. In FY 2011, 256,347 clients were served by the Early Intervention Services program, exceeding that target by 918.

Funding includes costs associated with FTEs, grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Performance

Management Handbook, technical assistance and program monitoring including performance reviews, and Information Technology costs.

Funding History

FY	Amount[179]
FY 2005	$195,578,000
FY 2006	$193,488,000
FY 2007	$193,721,000
FY 2008	$198,754,000
FY 2009	$201,877,000
FY 2010	$206,383,000
FY 2011	$205,564,000
FY 2012[180]	$215,086,000
FY 2013	$194,444,000
FY 2014	$201,079,000
FY 2015	$280,167,000

Budget Request

The FY 2015 Budget Request for the Ryan White HIV/AIDS Part C Program of $280,167,000 is $79,088,000 above the FY 2014 Enacted level. Of this increase, $75,088,000 is the result of consolidating the Part D program (using the FY 2014 level) with the Part C Program. HIV+ clients served under Part D are eligible for services under the consolidated program, and the merged program will emphasize care across all vulnerable populations, genders and ages. By merging the two programs resources can be better targeted to points along the care continuum to improve patient outcomes. The merger will expand the focus on women, infants, children and youth across all the funded grantees and will increase points of access for the population and reduce duplication of effort and reporting/administrative burden among currently co-funded grantees. The Part C Program will provide early intervention services, access to care, and primary care services for 312,000 people living with HIV/AIDS.

There have been significant changes in the HIV/AIDS epidemic since the Ryan White Program was first established in 1990. The previous concerns regarding perinatal HIV transmission and limitations for HIV care and treatment addressed by the Part D Program have been addressed with an expansion of pharmaceutical HIV treatment options and a substantial reduction in perinatal HIV transmission. In response to the changing national HIV epidemiology, client needs, and the National HIV/AIDS Strategy, the Part D program has evolved to closely resemble the Part C program. This request would permit populations previously served by Part D to be served easily by the Part C Program structure. The consolidated program will continue to provide allowable services under Parts C and D that continue to meet the needs of the community.

[179] Excludes comparable amounts for SPNS.
[180] Reflects Ryan White BA only (does not include $5.089 million in Health Center Program BA for Part C grantees in FY 2012).

In FY 2015, many Part C grantees will be directly affected by the Affordable Care Act health insurance expansions as uninsured individuals living with HIV/AIDS continue to enroll in private health insurance or expanded Medicaid. In states and cities where the number of insured Ryan White HIV/AIDS Program clients increases, Part C grantees will continue to provide services along the HIV care continuum that are not covered by private or public insurance but which are 1) critical to providing quality comprehensive HIV care such as intensive case management and care coordination services, and 2) linking and retaining individuals living with HIV into care and started on and adhering to ART regimens as early as possible. Supporting interventions that get people linked into care and on medications is critical not only to ensuring the health and wellbeing of individuals living with HIV, but also to preventing the spread of the epidemic, as studies have found that treatment reduces HIV transmission by 96 percent.

The FY 2015 target for the number of people receiving primary care services under Early Intervention Services programs is 312,807. Part C funding will also contribute to achieving the FY 2015 targets for the Ryan White HIV/AIDS Program's over-arching performance measures including: proportion of racial/ethnic minorities and women served, persons learning of their serostatus from Ryan White HIV/AIDS Programs, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
19.II.A.1: Number of people receiving primary care services under Early Intervention Services programs. *(Output)*	FY 2011: 256,347 Target: 255,429 (Target Exceeded)	268,877	312,807	+43,930

Grant Awards Table – Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	357	356	400
Average Award	$503,967	$522,460	$650,000
Range of Awards	$79,167-$1,305,534	$81,859-$1,349,920	$350,000-$1,500,000

Women, Infants, Children and Youth – Part D

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$72,361,000	$75,088,000	--	-$75,088,000
MAI (non add)	$22,218,000	$23,671,000	--	-$23,671,000
SPNS	$902,000	$902,000	--	-$902,000
Total Funding	$73,263,000	$75,990,000	--	-$75,990,000
FTE	13	13	--	-13

Authorizing Legislation: Sec. 2671, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87.

FY 2015 Authorization……Expired

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The Part D program focuses on providing access to coordinated, family-centered primary medical care and support services for HIV-infected women, infants, children, and youth (WICY) and their affected family members. It also funds support services, like case management and childcare that help clients get the care they need. Eligible organizations are public or private nonprofit entities that provide or arrange for primary care for HIV-positive women, infants, children, and youth. Part D programs include community based organizations, hospitals, and State and local governments. Currently, there are 115 WICY programs in 39 states and Puerto Rico.

The Part D grantees play a role in implementation of the National HIV/AIDS Strategy through continued provision of care, treatment and support services for women, children and youth living with HIV/AIDS.

The number of female clients provided comprehensive services, including appropriate services before and during pregnancy, to reduce perinatal transmission in FY 2011 was 60,621 (age 13 and above). The number exceeded the FY 2011 target by 5,266. In FY 2010, the Part D program provided comprehensive services to 53,753 female clients and to 55,335 female clients in FY 2009. In FY 2008, 57,773 females received such services. In FY 2007, Part D programs provided services to 48,485 female clients. The results for FY 2007, FY 2008, and FY 2009 also exceeded the targets. The total number of clients served in Part D in FY 2011 was 187,819.

This number includes 3,812 infants (ages 0-2 years), 5,543 children (ages 2-12 years), 17,130 youth (ages 13-24 years), and 161,326 persons ages 25 years and older. Of the 79,594 persons served in Part D in FY 2010, 75 percent were female and 25 percent were males, and less than one percent were transgendered or unknown/unreported. The vast majority of Part D clients served was HIV infected (94 percent), with the remainder largely affected family members. Of the clients with known race and ethnicity, the majority (76 percent) were members of racial or ethnic minority groups. The data source used for measuring HAB's performance has changed, resulting in a higher number of clients being reported and a different demographic distribution. In the historic data source (RDR), Part D data were submitted in a separate section. In the current data source (RSR), the data are submitted in a single file. In cases where a provider is multiply-funded by different RWHAP grantees, the data would be inclusive of all clients who received these services. Many Part D providers are multiply-funded and therefore, the data cannot be filtered. Therefore, it would include more clients than have been included in the historical run.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Performance Management Handbook, technical assistance and program monitoring including performance reviews, and Information Technology costs.

Funding History

FY	Amount[181]
FY 2005	$72,519,000
FY 2006	$71,744,000
FY 2007	$71,794,000
FY 2008	$73,690,000
FY 2009	$76,845,000
FY 2010	$77,621,000
FY 2011	$77,313,000
FY 2012	$77,167,000
FY 2013	$72,361,000
FY 2014	$75,088,000
FY 2015	---

Budget Request

The FY 2015 Budget Request for the Ryan White HIV/AIDS Part D Program of $0 is $75,088,000 below the FY 2014 Enacted level and discontinues the Part D Program. The Part D program will be consolidated with the Part C program. The merger will expand the focus on women, infants, children and youth across all the funded grantees and will increase points of access for the population and reduce duplication of effort and reporting/administrative burden among currently co-funded grantees.

[181] Excludes comparable amounts for SPNS.

There have been significant changes in the HIV/AIDS epidemic since the Ryan White Program was first established in 1990. The previous concerns regarding perinatal HIV transmission and limitations for HIV care and treatment addressed by the Part D Program have been addressed with an expansion of pharmaceutical HIV treatment options and a substantial reduction in perinatal HIV transmission. In response to the changing national HIV epidemiology, client needs, and the National HIV/AIDS Strategy, the Part D program has evolved to closely resemble the Part C program. This request would permit populations previously served by Part D to be served easily by the Part C Program structure. The consolidated program will continue to provide allowable services under Parts C and D that continue to meet the needs of the community.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
20.II.A.1 Number of female clients[182] provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission. *(Output)*	FY 2011: 60,621 Target: 55,355 (Target Exceeded)	52,790	N/A	N/A

Grant Awards Table – Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	115	115	---
Average Award	$587,000	$609,190	---
Range of Awards	$94,829-$2,143,182	$98,395-$2,223,765	N/A

[182] Female clients counted are age 13 and above.

AIDS Education and Training Programs – Part F

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$32,390,000	$33,611,000	$33,611,000	---
MAI (non add)	$9,521,000	$10,144,000	$10,144,000	---
Total Funding	$32,390,000	$33,611,000	$33,611,000	---
FTE	5	5	5	---

Authorizing Legislation: Sec. 2692(a), PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87.

FY 2015 Authorization……...….Expired

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The AETC network includes 11 Regional Centers encompassing a network of more than 100 local performance sites; three National Centers; nine Telehealth Training Centers; three Graduate Medical Education (GME) projects; and five Nurse Practitioner/Physician Assistant (NP/PA) projects. AETCs offer specialized clinical education and consultation on HIV/AIDS transmission, treatment, and prevention to front-line health care providers, including physicians, nurses, physician assistants, dentists and pharmacists.

AETCs provide a critical area of support for the National HIV/AIDS Strategy (NHAS) by increasing access to quality HIV/AIDS care through the provision of clinical HIV/AIDS training for providers who serve the most vulnerable and hard to reach populations. The clinical management of HIV/AIDS, particularly the use of ART is the central focus of training. This is increasingly important as the HIV epidemic expands in the United States with improved testing rates and prolonged survival. In addition, the number of trained 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 will be vital to meet the NHAS goals of expanding access to quality HIV/AIDS care and treatment.

The AETCs target training to providers who serve minority populations, the homeless, rural communities, incarcerated persons, federally qualified community and migrant health centers, and Ryan White HIV/AIDS Program sites. AETC-trained providers are more competent with regard to HIV care and more willing to treat persons living with HIV than other primary care

providers. The AETCs provide education in a variety of formats including skills building workshops, hands-on preceptorships and mini-residencies, on-site training, tele-education and technical assistance. Clinical faculty also provides timely clinical consultation in person or via the telephone or internet. Based in leading academic centers across the country, the AETCs use nationally recognized faculty opinion leaders and HIV researchers in the development, implementation, and evaluation of the education and training offered.

During the period July 1, 2011 through June 30, 2012, 53.4 percent of all providers participating in AETC training self-identified as racial/ethnic minorities or were providers with 50 percent of more of their caseload comprised of HIV-positive clients identified as racial/ethnic minorities.

Forty-three percent of the AETC program training interventions were provided to racial/ethnic minorities in 2007, and the 2008 results show 44 percent of those trained were racial/ethnic providers. The 2009 results show the AETC program training interventions comprised 43 percent racial/ethnic minorities. In 2010, the proportion of racial/ethnic minority health care providers participating in AETC training intervention programs was 42 percent. In 2011 and 2012, the proportion of racial/ethnic minority health care providers participating in AETC training intervention programs was 43.4 percent, exceeding the target in both years by 0.4 percent.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Performance Management Handbook, technical assistance and program monitoring including performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2005	$35,051,000
FY 2006	$34,646,000
FY 2007	$34,701,000
FY 2008	$34,094,000
FY 2009	$34,397,000
FY 2010	$34,745,000
FY 2011	$34,607,000
FY 2012	$34,542,000
FY 2013	$32,390,000
FY 2014	$33,611,000
FY 2015	$33,611,000

Budget Request

The FY 2015 Budget Request for the Ryan White HIV/AIDS AETC Program of $33,611,000 is equal to the FY 2014 Enacted level. This request will support targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS. Funding will support the training of additional health care providers to deliver high quality HIV/AIDS care and treatment services in primary care settings that have not typically provided

services to people living with HIV. The AETCs are an important part of the Ryan White HIV/AIDS Program and play a vital role in ensuring the highest quality of care among providers. HRSA will continue to prioritize for the AETCs interactive training that demonstrates effectiveness to change provider behavior. This funding will support the goal of 43 percent as the proportion of AETC training intervention participants that are racial/ethnic minorities.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
21.V.B.1: Proportion of AETC training intervention participants that are racial/ethnic minorities. *(Output)*	FY 2011: 43.4% Target: 43% (Target Exceeded)	43%	43%	Maintain

Grant Awards Table – Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	31	31	20
Average Award	$969,240	$1,000,000	$1,550,000
Range of Awards	$142,500-$4,038,816	$150,000-$4,290,000	$234,000-$4,500,000

Dental Reimbursement Program – Part F

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$12,646,000	$13,122,000	$13,122,000	---
FTE	1	1	1	---

Authorizing Legislation: Sec. 2692(b), PHS Act, as amended by P.L. 106-345, as amended by PL109-415, as amended by P.L.111-87.

FY 2015 Authorization…….…….Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The HIV/AIDS Dental Reimbursement Program provides access to oral health care for people living with HIV/AIDS 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 dental education institutions, the Dental Reimbursement Program improves access to oral health care for people living with HIV and trains dental and dental hygiene students and dental residents to provide oral health care services to people living 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.

The Community-Based Dental Partnership Program supports collaborations between dental education programs and community-based partners to deliver oral health services in community settings while training students and residents enrolled in accredited dental educations programs. 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 living 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.

Dental Reimbursement Program

Programs	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Dental Reimbursement Program	$8,457,568	$8,776,000	$8,776,000
Community-Based Dental Partnership Program	$3,521,079	$3,653,000	$3,653,000

In FY 2012, the Dental Reimbursement Program (DRP) awards met 29.5 percent of the total non-reimbursed costs reported by 53 participating institutions in support of oral health care. These institutions reported providing care to 39,810 HIV-positive individuals, for whom no other funded source was available. This number exceeded the goal by 5,570 individuals or 16.3percent. This represents a 3.6 percent increase from FY 2011 for persons whom a portion/percentage of their unreimbursed oral health costs was reimbursed. In FY 2011, the demographic characteristics of patients who were cared for by institutions participating in the DRP were: 19 percent women, 43.5 percent minority.

In FY 2013, the Community-Based Dental Partnership Program funded 12 partnership grants to collaborate and coordinate between the dental education programs and the community-based partners in the delivery of oral health services. Community-Based Dental Partnership grants have a three year project period.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Performance Management Handbook, technical assistance and program monitoring including performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2005	$13,218,000
FY 2006	$13,077,000
FY 2007	$13,086,000
FY 2008	$12,857,000
FY 2009	$13,429,000
FY 2010	$13,565,000
FY 2011	$13,511,000
FY 2012	$13,485,000
FY 2013	$12,646,000
FY 2014	$13,122,000
FY 2015	$13,122,000

Budget Request

The FY 2015 Budget Request for the Ryan White HIV/AIDS Dental Service Program of $13,122,000 is equal to the FY 2014 Enacted level and will support oral health care for people with HIV. This budget supports the reimbursement of applicant institutions through the Dental Reimbursement Program and funding of the Community Based Dental Partnership Program. Part F Dental Reimbursement is a cost effective way to provide dental care. The FY 2015 target for the number of persons for whom a portion of their unreimbursed oral health costs will be reimbursed is 39,810.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
22.I.D.1: Number of persons for whom a portion/ percentage of their unreimbursed oral health costs were reimbursed. *(Output)*	FY 2012: 39,810 Target: 33,316 (Target Exceeded)	33,316	39,810	+6,494

Grant Awards Table – Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	65	65	65
Average Award	$184,286	$191,170	$191,170
Range of Awards	$182-$794,640	$190-$824,500	$190-$824,500

Health Care Systems Tab

HEALTH CARE SYSTEMS

Organ Transplantation

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$23,301,000	$23,549,000	$24,015,000	+$466,000
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 371-378, as amended by P.L. 108-216, P. L. 109-129 and P.L. 110-144, as further amended by P.L. 110-413

FY 2015 Authorization…….……..……..... Expired

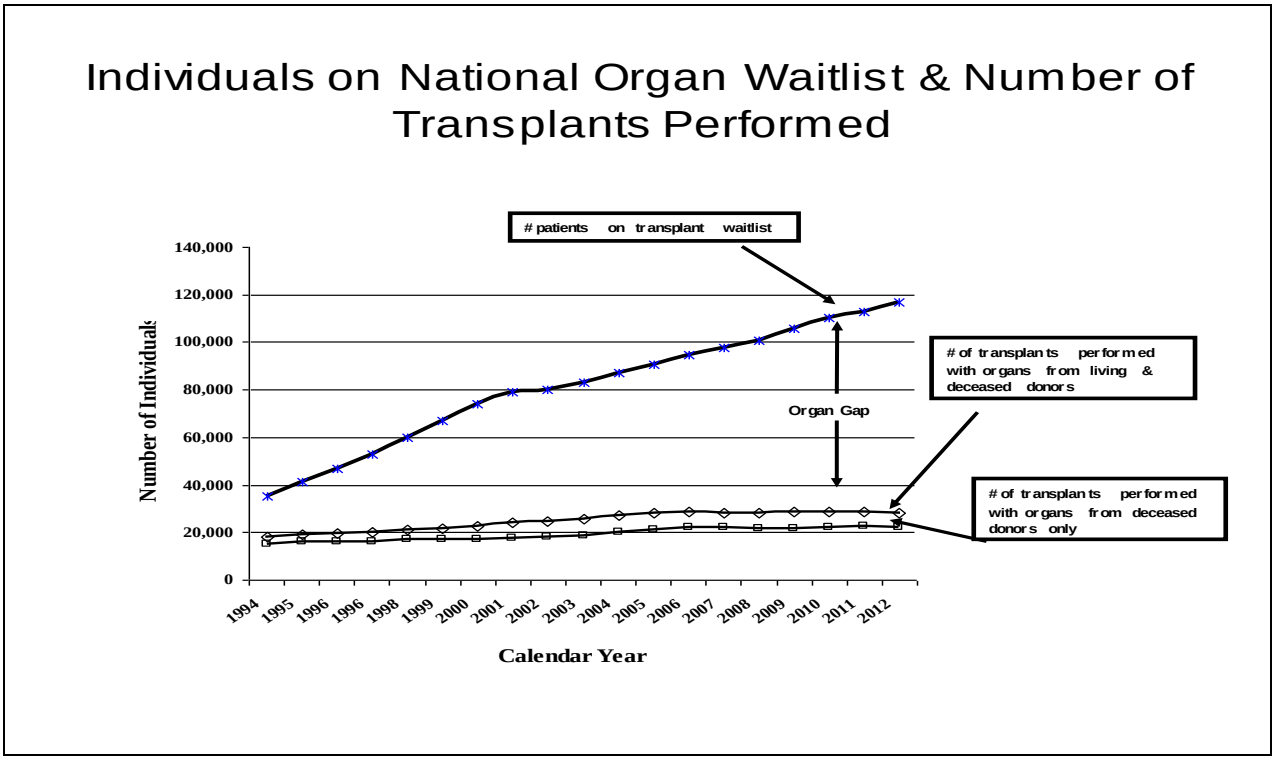
Allocation Method…….....Contracts/Competitive Grants/Cooperative Agreements

Program Description and Accomplishments

The National Organ Transplant Act of 1984 (NOTA), as amended, provides the authorities for the Organ Transplantation Program. The primary purpose of the Program is to extend and enhance the lives of individuals with end-stage organ failure for whom an organ transplant is the most appropriate therapeutic treatment. The Program works towards achieving this goal by providing for a national system, the Organ Procurement and Transplantation Network (OPTN), to allocate and distribute donor organs to individuals waiting for an organ transplant. The allocation of organs is guided by organ allocation policies developed by the OPTN with analytic support provided by the Scientific Registry of Transplant Recipients (SRTR). In addition to the efficient and effective allocation of donor organs through the OPTN, the Program also supports efforts to increase the supply of deceased donor organs made available for transplantation and to ensure the safety of living organ donation.

Ideally, an organ that provides optimal benefit would be available for every transplant candidate at the most appropriate time. Unfortunately, the demand for organ transplantation greatly exceeds the available supply of organs (see Figure 1). This trend is anticipated to continue, unless there is a major breakthrough in medical technology that will obviate the need for donor organs or the incidence of end-stage organ failure in the U.S. dramatically declines. At the end of 2012, there were 116,695 patients listed on the waiting list and 6,304 individuals died (approximately 17 per day) while waiting for a donor organ.

Figure 1. Individuals on National Organ Waitlist & Number of Transplants Performed



The Program goals are summarized by two overarching measures: (1) increase the annual number of deceased donor organs transplanted; and (2) increase the total number of expected life-years gained in the first five years after the transplant for all kidney and kidney-pancreas transplant recipients (from deceased donors) as compared to what would be expected for these recipients had they remained on the waiting lists.

The first goal of increasing the annual number of deceased donor organs transplanted is based on converting the number of 'eligible deaths' into actual donors (donor conversion rate). An 'eligible donor' is defined as any heart-beating individual meeting the criteria for neurological death, age 70 years or under, who has not been diagnosed with exclusionary medical conditions published by the OPTN. In 2012, 24,557 deceased donor organs were transplanted, 23.2 percent below target of 31,979 and a 1.7 percent decrease over the 2011 result. In 2011, 24,973 deceased donor organs were transplanted, a 1.5 percent increase above the 2010 result. In 2010, 24,598 deceased donor organs were transplanted, a 1.5 percent increase above the 2010 result. In 2010, 24,598 deceased donor organs were transplanted, a two percent increase above the 2009 result. In 2009, 24,116 deceased donor organs were transplanted, a slight increase over the 23,933 deceased donor organs transplanted in 2008. Overall, the number of deceased organs transplanted since 2009 has remained flat.

The number of deceased donor organs made available for transplantation is primarily dependent on the number of eligible donors. Since 2002, the number of eligible donors has decreased. The number of eligible deaths in 2002 was in excess of 12,000. This number has steadily decreased to slightly above 9,000 in 2011 and 2012. Improved prevention and treatment efforts have in

part contributed to the decrease in the number of eligible donors. Fewer severe head traumas and improved management of brain injuries have resulted in fewer patients proceeding to brain death. The National Highway and Safety Administration reports traffic accident deaths in 2011 fell to the lowest level ever in the U.S. since 1949. In 2008, the eligible deaths consisted of 3,281 head trauma deaths. In 2012, head trauma deaths decreased to 2,878. From 2008 to 2012, head trauma deaths made up approximately 33 percent of eligible deaths. Another reason for the decrease in the number of eligible deaths is that first-time cardiovascular events (resulting in anoxic brain injuries that may lead to brain death) have seen a 28 percent reduction in the event fatality rate since 1990 as a result of improvements in emergency and acute care. Hospital deaths have also been declining, which is congruent with the trend of the decreasing number of eligible deaths.

A major component of efforts to increase organ donation in the last decade was a series of Breakthrough Collaboratives that began in late 2003 to rapidly increase the number of deceased donors and number of donor organs made available for transplant through the sharing of best practices. Breakthrough Collaboratives apply an intensive methodology, established by the Institute for Healthcare Improvement (IHI), to successfully generate and sustain improvements in healthcare systems. The first Collaborative, the Organ Donation Breakthrough Collaborative, was initiated in September of 2003 and established a goal of increasing the organ donation conversion rate from 52 percent in 2003 to 75 percent by FY 2013. While the number of eligible deaths has been decreasing, the donor conversion rate has increased steadily. The conversion rate was 69.1 percent in 2009, 71.2 percent in 2010, 72.71 percent in 2011, and 72.60 percent in 2012 representing a 39.62 percent improvement from the 52 percent baseline in 2003. The collaborative model has been very successful in attaining significant improvement early as best practices have become institutionalized. More recently the gains have been more modest and the rate of improvement has plateaued as we reach natural boundaries. Since the first Collaborative, the focus has changed over time to include efforts to improve: (1) the number of organs made available; (2) the capacity of organ procurement organizations (OPOs) and transplant centers to effectively manage more organ donors and perform more organ transplants; and (3) efforts to expand the use of other types of organ donors such as cardiac-death donors and expanded criteria donors.

The Health Resources and Services Administration (HRSA) has continued to invest in several activities to sustain and improve upon the gains of the Breakthrough Collaboratives. From 2009 to 2014, the umbrella for these activities is the "Donation and Transplantation Community of Practice" (DTCP). The major focus of the DTCP is to sustain and increase the achievements of the Collaboratives and institutionalize identified best practices. The DTCP continues the "all teach, all learn" knowledge-sharing model through local and regional networks and interaction known as the Donation Service Area (DSA) Action Teams and Regional Collaboratives. The 58 DSAs are the areas served by each OPO. The Action Team consists of representatives of the OPO, donor hospitals, transplant centers, and in some cases, other partners in the donation process (e.g., eye and tissue banks, State hospital association members, donor registry professionals). Successful strategies at the DSA level are shared at the regional level – there are 11 regions designated by the OPTN in the U.S. These local (DSA) and regional efforts culminate in the National Learning Congress (NLC), HRSA's major event educating and recognizing organizations that have met national goals in increasing organ and tissue donation:

75 percent conversion rate, 3.75 organs transplanted per donor, and 10 percent of donors being donated after cardiac death. Through the NLC, best practices identified and refined through DSA action and regional strategies are shared nationally. Attendees include professionals from OPOs, hospitals, transplant centers, eye and tissue banks, hospital associations, donor designation entities, and others. In addition, several topic-specific sharing and educational experiences are convened during the year.

Additionally, HRSA is seeking and sustaining partnerships with key organizations that touch the donation and transplantation processes, including entities with capabilities in professional development, healthcare, and public education. These organizations share best practices in the medical management of organ donors to increase the number of organs that can be recovered from each donor. Maximizing donor potential is especially critical because more donors are being accepted under extended medical, age, and recovery criteria. HRSA has implemented an education program to leverage web-based technological capabilities to better meet the educational needs of the community. HRSA has undertaken activities to educate healthcare professionals about honoring donor designation, and to increase support of potential donor families, all of which have an impact on conversion rate.

HRSA has engaged in numerous outreach initiatives to increase the number of Americans enrolled in their state donor registry as potential donors. Registry enrollment is a key goal and outcome measure of most of Program's public outreach strategies. It is widely recognized within the donation community that 99 percent of individuals who die and are medically eligible, and enrolled in a state donor registry actually become donors. In the case of people who die without some type of donor designation, the family must decide whether to donate those organs. With this in mind, the Program has supported, through grants and contracts, a wide array of outreach initiatives with the ultimate goals of increasing state donor registry enrollment. While some effort also is given to increasing family consent and knowledge about living donation, the preponderance of Program's outreach efforts focus on increasing registry enrollment. As examples, the many print and electronic materials produced by the Program all encourage the public to go to organdonor.gov and sign up in their state donor registry. In 2012, nearly 60,000 visitors to organdonor.gov clicked through to their state registry.

The Program initiated two major national campaigns, one targeting the 50+ population and the other involving hospitals throughout the nation in encouraging donation among their staff, patients, and communities. The American Hospital Association and 10 other national associations collaborate with the Program on this initiative. More than 800 hospitals across the country are actively involved and enrollment continues to grow. The primary goal for the hospital campaign is state donor registry enrollment.

The Program is collaborating with the Agency for Community Living and the National Institutes of Health/National Institute on Aging on a national campaign to inform 50+ population that they are not too old to be donors and to encourage them to enroll in their state donor registry. This campaign was launched in May 2012 with a radio media tour that resulted in 15 interviews, 5,116 broadcasts aired by 2,736 stations and network affiliates, and a total of 18.5 million gross impressions.

HRSA also supported the repetition of a national survey of donation attitudes and practices that was previously conducted in 2005. Both surveys were conducted under contract by the Gallup Organization.

Highlights from the 2012 report include the following:

- General support for organ donation was strong and sustained for nearly the last 20 years with 94.9 percent supporting or strongly supporting organ donation in 2012. There has been an increase, however, since 2005 in the percentage of the population that strongly supports the donation of organs for transplant.

- There was an increase from 2005 (51.3 percent) to 2012 (60.1 percent) in the percentage of the population that indicated their intent to donate on their driver's license. African Americans (39.6 percent) were the least likely to have indicated their intent to donate on their license with Whites (67.2 percent) and Asians (54.1 percent) being most likely.

- In 2012, roughly twice the percentage of respondents age 66 and over reported having granted permission for organ donation on their driver's license as that same age group did in 2005.

- Willingness to be a living donor for a family member increased from 29.0 percent in 2005 to 73.3 percent in 2012.

- There was strong and considerable consistency in the percentage of respondents in 2005 (80.4 percent) and 2012 (80.0 percent) who believed a system of presumed consent would result in an increased number of organs. While the percentage who indicated they would support or strongly support such a system in the U.S. was higher in 2012 (51.1 percent) than in 2005 (41.9 percent), it was still considerably lower in both years than the percentage of respondents who thought presumed consent would be a more effective system.

- There was a significant increase from 2005 (16.7 percent) to 2012 (25.4 percent) in the fraction of the population reporting that a financial incentive would make them more likely to donate their own organs. However, the majority of the population (63.6 percent in 2012) reported that financial incentives would have no effect on their decision.

The Program is making progress towards achieving its second long-term goal of increasing the total number of expected life-years gained in the first five years after the transplant for all kidney and kidney-pancreas transplant recipients (from deceased donors) as compared to what would be expected for these recipients had they remained on the waiting lists. The goal is to increase the total lifetime benefit achieved by all transplant recipients.

As with the first long-term goal of increasing the number of deceased donor organs transplanted, the life-years-gained goal has annual targets representing incremental marginal gain (i.e., the average number of life-years gained for each kidney transplant recipient) and the total number of expected life-years gained for all individuals receiving a kidney transplant in a given year.

Therefore, achieving the long-term goal is dependent on the marginal improvement gained via each transplant performed, as well as by increasing the total number of kidney transplants performed.

In FY 2009, the average number of life-years gained per transplant was revised upward from 0.420 to 0.430 and the total expected life-years gained was revised upward from 4,851 years to 4,868 years. In FY 2010, the Program fell short of its average number of life-years gained per transplant target (0.380 average, actual versus 0.427 average, target) and its total expected life-years gained (4,381 years, actual versus 6,213 years, target). In FY 2011, the average number of life-years gained per transplant was .340 and the total expected life-years gained decreased to 4,069 years compared to a target of 6,565 years. In FY 2012, the average number of life-years gained per transplant was .320 and the total expected life-years gained decreased to 3,709 years compared to a target of 6,928 years.

The decrease in the average and total expected life-years gained in FY 2011 is because of further improvements by transplant centers in prolonging the expected life-years for patients on the waitlist. This is likely related to improvements in dialysis management resulting in reductions in relative waitlist death. While life-years gained on the waitlist have improved, the benefits of transplant in terms of life-years gained still exceed the increased life-years gained on the waitlist. Comparatively in FY 2009, the average number of life-years gained on the waitlist was 4.06 years versus 4.50 years with a transplant. In FY 2010, the average number of life-years gained on the waitlist was 4.14 years versus 4.53 years with a transplant. In FY 2011, the average number of life-years gained on the waitlist was 4.19 years versus 4.54 years with a transplant. In FY 2012, the average number of life-years gained on the waitlist was 4.26 years versus 4.58 years with a transplant. In the last three years, the percent increase in life-years gained on the waitlist has more than doubled the percent increase in life-years gained with a transplant (4.93 percent versus 1.78 percent).

An important component of the total expected life-years gained is the number of kidney transplants performed. The main reason the performance goal was not met is because fewer than the projected number of deceased kidney transplants were performed in FY 2012. Increasing the marginal improvement gained by each kidney transplant may also be improved by revising how kidneys are allocated. Over the past several years, the OPTN has made incremental improvements to the kidney allocation policy. Even with these improvements, the current policy still places great emphasis on the amount of time individuals wait for an organ transplant as opposed to the differential clinical benefit which may be afforded for each individual waiting for a transplant. In June 2013 the OPTN approved a new kidney allocation policy that will place less emphasis on time on the waiting list and more emphasis on medical determinants that will seek to maximize benefit to the patient and maximize the use of deceased donor kidneys. This policy change is currently being programed into the OPTN computer system and is expected to be implemented by the end of calendar year 2014. It is anticipated that this new policy will improve the expected five-year survival benefit post-transplant.

Funding History

FY	Amount
FY 2011	$24,896,000
FY 2012	$24,015,000
FY 2013	$23,301,000
FY 2014	$23,549,000
FY 2015	$24,015,000

Budget Request

The FY 2015 Budget Request is $24,015,000. The FY 2015 Request is $466,000 above the FY 2014 Enacted level. The FY 2015 Request will continue support for the Organ Transplantation Program in achieving the FY 2015 performance targets: transplant 25,400 deceased donor organs and achieve 4,502 expected life-years gained for the five year post-transplant period for kidney and kidney/pancreas transplants performed.
Funding includes costs associated with grant reviews, processing of grants through the GrantSolutions and HRSA's Electronic Handbook (EHB), and follow-up performance reviews. The EHB supports the Organ Transplantation Program with program administration, grants administration and monitoring, management reporting, and grantee performance measurement and analysis. The funding also includes IT investment costs to support the strategic and performance outcomes of the Program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner.

The following activities will be supported with the requested funding:

Contract to operate the OPTN ($5.50 million) — The OPTN is a critical system necessary to facilitate the matching of individuals needing an organ transplant and donor organs. Organ allocation policies developed by the OPTN prioritize the allocation of deceased donor organs to individuals waiting for an organ. The policies are under continual review and refinement to achieve the best outcomes for patients. Given the critical shortage of organs, these policies strive to achieve the maximum benefit for the recipient as well as make the best use of donor organs, consistent with the policy development requirements of the OPTN final rule (42 CFR §121). HRSA utilizes a competitive contracting process to award the contract to operate the OPTN. The costs of operation of the OPTN are funded with appropriated funds and revenues generated by patient registration fees collected by the contractor under authority of 42 CFR §121.5(c).

Contract to operate the SRTR ($6.715 million) — The major purpose of the SRTR is to provide analytic support to the OPTN in the development of organ allocation policies and program performance evaluation. Additionally, the SRTR provides analytic support to HHS, including the Advisory Committee on Organ Transplantation. In an effort to make information about the performance of transplant programs and organ procurement organizations more widely available to the public, the SRTR publishes on the Internet transplant program risk-adjusted patient and graft outcomes and organ procurement organization risk-adjusted organ transplanted per donor. The SRTR also publishes online a comprehensive Annual Data Report that includes most current ten years of data on waitlist, transplant and deceased donor organ donation. The current contract expires in September 2015. HRSA will award a new competitive contract in FY 2015 to

continue this critical function. FY 2015 funds will support the final 6 months of the existing contract and a one-year base period of the planned new contract.

Grants to Support Projects to Increase Organ Donation ($5.862 million) — HRSA awards three types of competitive, peer-reviewed grants to public and nonprofit private entities to test and replicate new approaches for increasing organ donation, promote public awareness about organ donation, and support development and improvements of State donor registries:

1) Social and Behavioral Interventions to Increase Solid Organ Donation: this is a research grant program to implement and test the effectiveness of social and behavioral strategies for increase individual or family consent for organ donation. Beginning in FY2013, the program provided the option for applicants to conduct projects to educate parents about the need for pediatric donors.

2) Clinical Interventions to Increase Organ Procurement: This is a research grant program focusing on clinical activities that begin after consent is determined or given at time of death and extend until transplantation. These donor-management-related activities influence whether a potential donor actually progresses to become a donor and the number and quality of organs that may be procured for transplantation. The Program does not intend to initiate any new or continuation grant projects in this year funding.

3) Public Education Efforts to Increase Organ Donation: This program supports projects to replicate on a broader scale, strategies that we found to be successful in the research grant program or strategies or models that have demonstrated effectiveness in other areas of health behavior change. Beginning in FY 2013, the program provided the option for applicants to conduct projects that educated parents about the need for pediatric donors.

Cooperative Agreement to Provide Support for Reimbursement of Travel and Subsistence Expenses toward Living Organ Donation ($3.0 million) — The purpose of this cooperative agreement is to provide reimbursement of travel and subsistence expenses to living organ donors, in accordance with 42 U.S.C. 274f, who are not able to receive travel and subsistence expenses support under any state compensation program, insurance policy, or under any Federal or state health benefits program; by an entity that provides health services on a prepaid basis; or by the recipient of the organ.

The Regents of the University of Michigan (Michigan) were awarded this cooperative agreement through a competitive grant cycle in both FY 2006 and FY 2010 to operate this Program. To accomplish the goals of the program Michigan collaborated with the American Society of Transplant Surgeons to establish the National Living Donor Assistance Center (NLDAC). While the Program does not promote living organ donation and has no performance goals for increasing the number of living organ donors, this activity helps increase access to transplantation, particularly for individuals of lesser financial means.

The number of applications for funding has steadily increased since the beginning of the Program. During the initial baseline period (October 2007 through August 2008) the program

received 247 applications. Recently, the Program has received 745 applications for the period September 2010 through August 2011 and 881 applications for the period from September 2011 through August 2012. The number of applications received during September 2011 through August 2012 represents an increase of nearly 18 percent over the prior year and an increase of more than 240 percent over the baseline period of October 2007 through August 2008. The Program facilitated 1,485 living donor transplants from October 2007 through August 2012. As of the end of August 2012, an additional 186 prospective living donors had been approved for reimbursement pending the organ donation procedures. The median household income for transplant recipients who received an organ facilitated by NLDAC is approximately $25,870 and the median household income for the donors is approximately $31,418. In September 2014, HRSA will award a new cooperative agreement through a competitive grant cycle to continue the operations of the Program.

Activities to Support Public and Professional Education ($2.788 million) — The Program, independently and in collaboration with the organ donation and transplant community and other stakeholders, supports a variety of public and professional education and outreach efforts designed to increase organ donation. Included in this category are projects designed to educate various segments of the population using communication options appropriate to the message and audience including: public service announcements broadcast via electronic media, virtual meetings, webinars, printed materials, documentaries, educational programs for the classrooms, national organ donation events, and Web sites. HRSA will continue to support innovative strategies for outreach efforts to encourage public commitment to organ donation. The Program supports education initiatives and other activities in collaboration with the OPTN and with major medical and professional organizations that are influential in organ and tissue donation. These activities are designed to increase the number of organ donors and number of deceased donor organs made available for transplantation.

Advisory Committee on Organ Transplantation and Interagency Activities to Support Donation and Transplantation ($0.15 million) — The OPTN final rule (42 CFR §121.12) authorizes the creation of an Advisory Committee on Organ Transplantation (ACOT) to provide recommendations to the Secretary on issues related to organ donation and transplantation. The Program supports the activities of the ACOT including the logistics for periodic meetings and analytic requirements.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
23.II.A.1: Increase the annual number of deceased donor organs transplanted.	FY 2012: 24,557 Target: 31,979 (Target Not Met)	25,014	25,400	+386
23.II.A.7: Increase the total number of expected life-years gained in the first 5 years after the transplant for all deceased kidney and kidney-pancreas transplant recipients compared to what would be expected for these patients had they remained on the waiting list.	FY 2012: 3,709 Target: 6,928 (Target Not Met)	4,433	4,502	+69
23.II.A.8: Increase the annual conversion rate of eligible donors.	FY 2012: 72.60% Target: 72.90% (Target Not Met)	73.25%	73.50%	+0.25% points

Grants Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	17	16	18
Average Award	$577,611	$481,007	$459,440
Range of Awards	$197,254-$2,273,332	$200,000-$3,000,000	$200,000-$3,000,000

National Cord Blood Inventory

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$11,147,000	$11,266,000	$11,266,000	---
FTE	4	4	4	---

Authorizing Legislation - Public Health Service Act, Section 379, as amended by Section 3, P.L. 109-129 as amended by P.L. 111-264

FY 2015 Authorization…….....$20,000,000

Allocation Method…….…….....……Contract

Program Description and Accomplishments

The National Cord Blood Inventory (NCBI) Program, established through legislation renewed on October 8, 2010, 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, as well as other units in the inventories of participating cord blood banks, are made available to physicians and patients for blood stem cell transplants through the C.W. Bill Young Cell Transplantation Program (the Program), which is authorized by the same law. Cord blood banks participating in the NCBI Program also make cord blood units available for preclinical and clinical research focusing on cord blood stem cell biology and the use of cord blood stem cells for human transplantation and cellular therapies.

Blood stem cell transplantation is potentially curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year nearly 18,000 people in the U.S. are diagnosed with illnesses for which blood stem cell transplantation from a matched donor is their best treatment option. Often, the first choice donor is a sibling, but only 30 percent of people have a fully tissue-matched brother or sister. For the other 70 percent, or approximately 12,600 people, a search for a matched unrelated adult donor or a matched umbilical cord blood unit must be performed.

The tissue types of blood stem cell donors must be closely matched with those of their recipients in order for the transplant to be successful. Since tissue types are inherited, patients are more likely to find a closely matched donor within their own racial and ethnic group. However, due to the high rate of diversity in the tissue types of racial and ethnic minorities, especially African-Americans, racial and ethnic minorities are less likely to find a suitably matched adult marrow donor on the Registry of the Program. Because umbilical cord blood can be used with a less perfect match in tissue type between donor and recipient than is the case for adult marrow donors, umbilical cord blood offers a chance of survival for patients who lack a suitably tissue-matched relative and who cannot find an adequately matched unrelated adult donor through the Program. Minority patients, especially African-American patients, are especially likely to

benefit from additional cord blood units. For these reasons, the Health Resources and Services Administration's (HRSA's) policy for the NCBI continues to emphasize increasing the number of cord blood units collected from minority donors.

In the early years of umbilical cord blood transplantation, the majority of transplants were performed for pediatric recipients because of the smaller number of blood stem cells present in cord blood relative to adult marrow. However, the introduction of multiple cord blood unit transplants and NCBI-led increases in the size of the cord blood inventory, including units with a larger concentration of blood stem cells, have increased the availability of cord blood for adult recipients. Consequently, in each fiscal year since FY 2008, the number of adult patients receiving cord blood transplants has surpassed the number of pediatric recipients.

The NCBI provides funds through competitive contracts for the collection and storage of qualified cord blood units by a network of cord blood banks in the U.S. Contract awards are made based on assessment of technical merit, overall quality, ability to collect from diverse populations, geographic dispersion of offerors, evaluation of past performance, and evaluation of proposed costs. When exercising option years beyond the original one-year base period of a contract, current performance including progress toward financial self-sufficiency and compliance with contract terms are carefully considered. Additionally, HRSA continues to place particular emphasis on the demonstrated ability of offerors to collect and bank significant numbers of cord blood units from African-American donors.

HRSA awarded six contracts to the first cohort of umbilical cord blood banks to collect for the NCBI in November 2006. Two additional banks were added in September 2007, and five more banks were added in FY 2008 through FY 2010. No new cord blood banks were added during the period FY 2011 – FY 2013. Currently, 13 banks hold NCBI contracts. As of September 30, 2013, 63,960 NCBI cord blood units were available through the Program (Table 1). An additional 15,632 units will be collected with funds already awarded through FY 2013. A cumulative total of 86,624units of cord blood will be collected with all funds awarded during the period FY 2007 – FY 2015. We estimate that approximately 5,500 additional units will be collected with funds awarded in FY 2015.

During the first year of collections for the NCBI (FY 2007), four cord blood units from this then-very-small inventory were released for transplantation, with an additional 104 units released for transplantation during FY 2008. During FY 2009, 458 units were released for transplantation, 530 units were released in FY 2010, 690 units were released in FY 2011, and 714 were released in FY 2012 and FY 2013 with many units currently under evaluation for use by patients in need of transplant (Table 2). The benefit of large volume units, such as those collected with HRSA funds, is demonstrated by the fact that all of the NCBI units released for transplantation have cell counts well above the levels generally available prior to implementation of the NCBI Program. Many recipients of these cord blood units, especially those patients whose ancestry is not from northwest Europe, had no well-matched adult donor. As the inventory continues to grow, the diverse units comprising the NCBI will serve an increasing number of patients from populations that have difficulty obtaining cells from a well-matched adult donor. Of the cord blood units collected with funds awarded from FY 2007 - FY 2013, over 60 percent will be from racial and ethnic minorities.

The potential of cord blood to sharply increase access to transplantation is being realized in several ways. First, cord blood has accounted for about one half of the growth in transplants over the life of the NCBI Program, and 17 percent of all transplants facilitated through the Program during FY 2013 utilized cord blood. Multiple-unit transplants continue to rise, from approximately 21 percent of all cord blood transplants during FY 2007 to approximately 30 percent in FY 2013.

For minority patients, cord blood has been especially critical in increasing access to transplantation, with approximately 33 percent of all cord blood transplants facilitated by the Program in FY 2013 being for minority patients. In comparison, only 29 percent of the cord blood transplants facilitated by the Program in FY 2007 were for minority patients. Regional studies in areas with diverse patient populations (e.g., New York City and Houston) have shown that the majority of adult patients receiving cord blood transplants lacked adequately matched adult donors; thus cord blood was their only chance for life-saving transplants.

In addition to directly growing the NCBI inventory, the support provided to NCBI-contracted banks has played an important role in stimulating the collection and banking of many other (non-NCBI) units. Typically, these cord blood units do not meet the minimum cell content threshold established for the NCBI. While these other units may not meet this threshold, they remain a suitable source of blood stem cells, especially for smaller patients where an acceptable cell dose can still be achieved using smaller units. Finally, NCBI banks have provided to researchers more than 30,000 non-NCBI units, for a wide variety of pre-clinical and clinical research.

Table 1. Cord Blood Collections

Fiscal Year	Cumulative Units Made Available[183]
2007	2,017
2008	11,870
2009	22,920
2010	34,744
2011	43,340
2012	53,609
2013	63,960

[183] Due to the lag between when cord blood units are collected and when they have been fully tested and qualified for listing on the public registry, all of the units collected with funds from a given fiscal year will not be made available on the registry during that same fiscal year.

Table 2. Cord Blood Units Released for Transplantation

Fiscal Year	NCBI Units Released for Transplantation
2007	4
2008	104
2009	458
2010	530
2011	690
2012	714
2013	714

Funding History

FY	Amount
FY 2011	$11,910,000
FY 2012	$11,887,000
FY 2013	$11,147,000
FY 2014	$11,266,000
FY 2015	$11,266,000

Budget Request

The FY 2015 Budget Request is $11,266,000. The FY 2015 Request is equal to the FY 2014 Enacted level. This funding will be used to support 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 and will, therefore, increase the number of patients in all population groups who are able to obtain life-saving transplants. Cell dose and degree of match between patient and cord blood unit are both strongly associated with transplant outcomes. Therefore, a larger inventory of publicly available cord blood units also will contribute to improved patient survival after transplant because a growing inventory of high cell count cord blood units will allow better tissue matches between patients and cord blood units. Funding at the requested level is estimated to support the collection and banking of approximately 5,500 additional cord blood units assuming an average price to HRSA of $1,800 per cord blood unit. The average price is expected to increase by approximately $300 per cord blood unit to account for the additional costs for cord blood banks to comply with regulatory requirements. However, HRSA will continue to still seek significant discounts for each cord blood unit through competitive negotiations. With the addition of the cord blood units added in FY 2015, approximately 70,500 NCBI units will be available for searching patients through the C.W. Bill Young Cell Transplantation Program by the end of FY 2015.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Increase the cumulative number of minority cord blood units available through the C.W. Bill Young Cell Transplantation Program (NCBI & non-NCBI	FY 2013: 87,763 Target: 75,000 (Target Exceeded)	86,000	89,300	+3,300
Increase the size of the National Cord Blood Inventory (cumulative # of units banked and available through the C.W. Bill Young Cell Transplantation Program)	FY 2013: 63,960 Target: 55,000 (Target Exceeded)	65,000	70,500	+5,500
Increase the annual number of NCBI cord blood units released for transplant	FY 2013: 714 Target: 725 (Target Not Met)	730	750	+20

Contracts Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Contracts	11	13	14
Average Contract	$929,358	$786,575	$785,825
Range of Contracts	$222,700-$1,522,220	$152,113-$1,540,960	$200,000-3,000,000

C.W. Bill Young Cell Transplantation Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$21,877,000	$22,109,000	$22,109,000	---
FTE	6	6	6	---

Authorizing Legislation: Public Health Service Act, Sections 379-379B, as amended by Section 3, P.L.109-129, as amended by P.L. 111-264

FY 2015 Authorization……..$33,000,000

Allocation Method……..……..……Contract

Program Description and Accomplishments

The primary goal of the C.W. Bill Young Cell Transplantation Program (the Program) is to increase the number of transplants for recipients suitably matched to biologically unrelated donors of bone marrow and umbilical cord blood. The Program works toward 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 for public and professional education; and (6) collecting, analyzing, and reporting data on transplant outcomes. Blood stem cell transplantation is potentially curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year nearly 18,000 people in the U.S. are diagnosed with life-threatening illnesses where blood stem cell transplantation from a matched donor is their best treatment option. Often, the ideal donor is a sibling, but only 30 percent of people have a fully tissue-matched brother or sister. For the other 70 percent, or approximately 12,600 people, a search for a matched unrelated adult donor or a matched umbilical cord blood unit must be performed.

Per authorizing legislation renewed on October 8, 2010 (The Stem Cell Therapeutic and Research Reauthorization Act of 2010, P.L. 111-264), the C.W. Bill Young Cell Transplantation Program is the successor to the National Bone Marrow Donor Registry. While the scope of activities required of the Program is similar to that of its predecessor, the Program has expanded responsibility for collecting, analyzing, and reporting data on transplant outcomes, to include all allogeneic blood stem cell transplants as well as other therapeutic uses of blood stem cells. The Program is operated through four major contracts that require close coordination and oversight. The authorizing legislation also requires an Advisory Council at the Department level to provide recommendations to the Secretary and to the Health Resources and Services Administration (HRSA) on activities related to the Program.

The major components of the Program are: (1) a Cord Blood Coordinating Center responsible for facilitating transplants with blood stem cells from umbilical cord blood units (including HRSA-funded National Cord Blood Inventory units) and providing expectant mothers with information on options regarding the use of umbilical cord blood (i.e., public donation, private storage, research and discard); (2) a Bone Marrow Coordinating Center responsible for recruiting adult potential donors of blood stem cells, especially from underrepresented ethnic and racial minority populations and for facilitating transplants with blood stem cells from adult donors; (3) a combined Office of Patient Advocacy and Single Point of Access to assist patients from diagnosis to survivorship, identifying the gaps in services and offering programs to help meet the needs of patients, and to enable physicians to search for and obtain a suitable blood stem cell product from an adult donor or cord blood unit; and (4) a Stem Cell Therapeutic Outcomes Database responsible for collecting outcomes data on related and unrelated donor blood stem cell transplants and implementing an approach to collecting data on emerging therapeutic uses of donated blood stem cells.

Contracts for all components of the Program are awarded through a competitive contracting process that emphasizes technical merit. Contract opportunities are announced nationally and proposals are evaluated by technical review committees composed of individuals with expertise in fields related to the Program. Funding decisions are made based on committee assessments of technical merit, evaluation of past performance, and evaluation of proposed costs. When exercising option years beyond the original base period of the contracts, HRSA considers contractor performance and compliance with contract terms. During FY 2012, four new infrastructure contracts were awarded. FY 2015 funds will be used to support the fourth year of contract activities for the Program.

Performance measures are incorporated into the contracts and monitored quarterly to ensure that the Program meets its three long-term goals related to: (1) increasing the number of blood stem cell transplants facilitated annually; (2) increasing the number of transplants facilitated annually for minority patients; and (3) increasing one-year post-transplant patient survival. The Program's long-term goals are supported by two annual measures: (1) the increase in the number of adult volunteer potential donors of minority race and ethnicity on the Registry; and (2) the decrease in the 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.

The purpose of the Program is to increase the number of unrelated blood stem cell transplants facilitated for patients in need. The Program exceeded all three of its FY 2013 long-term goals which were to: (1) facilitate 5,513 transplants (6,283 were facilitated); (2) facilitate 845 minority transplants (992 transplants for minority patients were facilitated); and (3) increase the rate of patient survival at one-year post-transplant from 62 percent in 2003 to 69 percent in 2013 (the survival rate was 71 percent).

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. The Program continues to serve a diverse patient population, with umbilical cord blood playing a vital role in expanding access to

transplant for minority patients. Adding to the pool of potential adult volunteer blood stem cell donors also helps accomplish this goal. As of the end of FY 2013, more than 11.2 million potential adult volunteer donors were listed on the Program's registry. More than 3.05 million (27 percent) of the 11.2 million potential adult donors listed on the Program's registry, they self-identify as belonging to a racial/ethnic minority group. This exceeded the FY 2013 goal of 2.85 million. The cost of tissue typing strongly influences the number of potential volunteer donors who can be recruited to the Program's registry. Reductions in the cost of typing make it possible to recruit more donors for a given level of funding. The FY 2015 cost for each donor's tissue typing will remain $40.81, the same level negotiated and achieved in FY 2012. Though the goal of typing costs are to remain the same, cost may be increased if it is determined that the level of tissue typing specificity needs to increase (due to technological advances) that could result in more rapid matching between potential donors and searching patients.

Funding History

FY	Amount
FY 2011	$23,374,000
FY 2012	$23,330,000
FY 2013	$21,877,000
FY 2014	$22,109,000
FY 2015	$22,109,000

Budget Request

The FY 2015 Budget Request is $22,109,000. The FY 2015 Request is equal to FY 2014 Enacted level. This funding will be used to support the Program's performance target of having 3,260,000 adult volunteers from racially/ethnically diverse minority population groups listed on the Program's registry. These funds also will support the major Program components (Cord Blood Coordinating Center, Bone Marrow Coordinating Center, Office of Patient Advocacy, Single Point of Access, and Stem Cell Therapeutic Outcomes Database). The majority of funds will be used to recruit and tissue-type new donors. The Program will also continue: (1) collecting comprehensive outcomes data on both related and unrelated-donor blood stem cell transplants; (2) assessing quality of life for transplant recipients; (3) working with foreign transplant centers to obtain data on U.S. stem cell products provided to them for transplant; and (4) collecting data on emerging therapies using cells derived from bone marrow and umbilical cord blood. Importantly, FY 2015 funding will allow the Program to continue critical planning to respond to a radiation or chemical emergency that would leave some casualties with temporary or permanent marrow failure, and to facilitate emergency transplants for those casualties who would not otherwise recover marrow function.

The Program funds the HRSA HSB Data Analysis and Reporting Investment. Limited funding will go towards IT operations and maintenance costs (for one of the four major infrastructure contracts for the Program) in support of data analysis activities and ensuring security compliance. The investment in IT supports the strategic and performance outcomes of the Program by efficiently and effectively facilitating data analysis.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
24.II.A.2: Increase the number of adult volunteer potential donors of blood stem cells from minority race and ethnic groups. (Outcome)	FY 2013: 3.05M Target: 2.85M (Target Exceeded)	3.18M	3.26M	+0.08M
24.1: Increase the number of blood stem cell transplants facilitated by the Program[184](Outcome)	FY 2013: 6,283 Target: 5,513 (Target Exceeded)	N/A	N/A	N/A
24.2: Increase the number of blood stem cell transplants facilitated by the Program for minority patients.[185] (Outcome)	FY 2013: 992 Target: 845 (Target Exceeded)	N/A	N/A	N/A
24.3: Increase the rate of patient survival at one year, post-transplant.[186] (Outcome)	FY 2013: 71% Target 69% (Target Exceeded)	N/A	N/A	N/A
24.E: Decrease the unit cost of human leukocyte antigen (HLA) typing of potential donors. (Efficiency)	FY 2013: $40.81 Target: $40.81 (Target Met)	$40.81	$40.81	$0

[184] This is a long-term measure. After FY 2013, the next year for which long-term targets are set is FY 2017. The FY 2017 target has been established at 6,960.
[185] This is a long-term measure. After FY 2013, the next year for which long-term targets are set is FY 2017. The FY 2017 target has been established at 1,150.
[186] This is a long-term measure. After FY 2013, the next year for which long-term targets are set is FY 2017. The FY 2017 target remains 69%.

Contracts Awards Table Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Contracts	5	5	5
Average Contract	$5,006,938	$4,317,583	$4,317,583
Range of Contracts	$723,623-$13,948,000	$35,000-$16,156,593	$45,000-$16,000,000

Poison Control Program

	FY 2013 Final	FY2014 Enacted	FY 2015 President's Budget	FY2015 +/- FY2014
BA	$17,657,000	$18,846,000	$18,846,000	---
FTE	3	4	4	---

Authorizing Legislation – Public Health Service Act, Sections 1271-1274, as amended by Public Law 106-174, as amended by Public Law 110-377, as amended by Public Law 113-77.

FY 2015 Authorization .....National Toll Free Number - $700,000

FY 2015 Authorization .....Nationwide Media Campaign - $800,000

FY 2015 Authorization .....Poison Control Center Grant Program – $28,600,000

Allocation Method ..... Contracts/Competitive Grants/Co-operative Agreements

Program Description and Accomplishments

The Poison Control Program (PCP) is authorized through Public Law 113-77, the Poison Center Network Act. The Program is legislatively mandated to fund poison centers; establish and maintain a single, national toll-free number (800-222-1222) to ensure universal access to poison center services and connect callers to the poison center serving their area; 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 Poison Help Line, 800-222-1222, was established in 2001 to ensure universal access to poison control center (PCC) services. Individuals can call from anywhere in the United States (U.S.) and will be connected to the poison center that services their area. The PCP maintains the number and provides translation services in over 150 languages. Services are also provided for the hearing impaired.

Through the nationwide Poison Help media campaign, the PCP has been working to educate the public about the 800 number and increase awareness of poison center services. In FY 2006, the percent of inbound call volume on the toll-free number was 66 percent. This increased to nearly 86 percent in FY 2013. In FY 2006, only 19 percent of national survey respondents were aware that PCC calls were handled by health care professionals. This increased to 25 percent in FY 2012, meeting the long-term target.

For over 50 years, PCCs have been our Nation's primary defense against injury and death from poisonings. Today there is a national network of 55 PCCs that provides cost effective, quality

health care advice to the general public and health care providers alike across the entire U.S. including American Samoa, the District of Columbia, the Federated States of Micronesia, Guam, Puerto Rico, and the U.S. Virgin Islands. Twenty-four hours a day, seven days a week, health care providers and other specially trained poison experts provide poisoning triage and treatment recommendations at no cost to the caller. A hallmark of poison center case management is the use of follow up calls to monitor case progress and medical outcomes. Poison centers are not only consulted when children get into household products, but also when seniors and people of all ages take too much medicine or when workers are exposed to harmful substances on the job. Emergency 911 operators refer poison-related calls to PCCs and health care professionals regularly consult PCCs for expert advice on complex cases. PCCs are a critical resource for emergency preparedness and response as well as for other public health emergencies.

According to the American Association of Poison Control Centers (AAPCC) in 2012, more than 3.3 million calls were managed by poison centers, an average of more than 9,000 calls per day. Approximately 2.2 million poisonings were reported, 93 percent of all poisoning exposures occurred in people's homes, and 1.7 million unnecessary visits to healthcare facilities were avoided.

Multiple studies have demonstrated that accurate assessment and triage of poison exposures by poison centers save dollars by reducing severity of illness and death, and eliminating or reducing the expense of unnecessary trips to an emergency department.[2, 3] Consultation with a poison center can also significantly decrease the patient's length of stay in a hospital and decrease hospital costs.[187,188,189,190] In fact, utilization of poison centers by health care facilities continues to increase, underscoring the increase in the severity of poisonings and the need for toxicological expertise in clinical settings.[191] It is estimated that every dollar invested in the poison center system saves $13.39 in medical costs and lost productivity, for a total savings of more than $1.8 billion every year. Of that $1.8 billion, the Federal government saves approximately $662.8 million in medical care savings and reduced productivity.[192]

In addition to providing the public and health care providers with treatment advice on poisonings, a second critical function of the PCCs is the collection of poison exposure and surveillance data. Multiple Federal agencies, including the Centers for Disease Control and Prevention (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,

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[187] Vassilev ZP, Marcus SM. Impact of a Poison Control Center on the Length of Hospital Stay for patients with Poisoning. J Toxicol Environ Health Part A. 2007; 70(2): 107-110

[188] Zaloshnja, E., Miller, T.R., Jones, P., Litovitz, T.; Coben, J.; Steiner, C.; Sheppard, M. (2006). The potential impact of poison control centers on rural hospitalization rates for poisonings. Pediatrics. 118(5), 2094-2100.

[189] Healthcare Cost and Utilization Project [HCUP] (2007). 2005 National Inpatient Sample. Rockville, MD: Agency for Healthcare Research and Quality, Department of Health and Human Services.

[190] Zaloshnja, E., Miller, T.R., Jones, P., Litovitz, T.; Coben, J.; Steiner, C.; Sheppard, M. The impact of poison control cents on poisoning-related visits to emergency departments, U.S. 2003. Am J Emerg Med. 2008.

[191] Bronstein AC, Spyker DA, Cantilena LR Jr, et al. 2011 annual report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 29th annual report. Clin Toxicol (Phila). 2012;50:911-1164.

[192] Value of the Poison Center System: Lewin Group Report for the American Association of Poison Control Centers. 2011.

characterization, or ongoing tracking of outbreaks and other public health threats. In addition, many State health departments collaborate directly with poison centers within their jurisdictions. For example, States and Federal agencies used data from PCCs to monitor fungal meningitis, carbon monoxide exposures related to Hurricane Sandy, and laundry detergent poisonings. Additionally, the Office of National Drug Control Policy (ONDCP) and the Department of Justice's Drug Enforcement Administration (DEA) have used PCCs' data to monitor the rise in the abuse of synthetic drugs and inform policy development.

Additionally, PCCs provide public and health care provider education. PCCs' health educators actively work to change behaviors to reduce poisonings and promote awareness and utilization of poison center services in their communities. Education efforts, for example, focus on medication safety as a way to reduce unnecessary medication-related emergency room visits, hospitalizations and rehospitalizations. According to the CDC, in 2010, the most recent year for which data are available, unintentional poisoning was the second leading cause of unintentional injury deaths behind motor vehicle crashes. Among people 25 to 64 years old, however, unintentional poisoning was the leading cause of death. Ninety-one percent of unintentional poisonings were caused by prescription drugs, primarily opioid analgesics. These drugs were implicated in more poisoning deaths than heroin and cocaine combined. Among the actions outlined in the ONDCP's prescription drug abuse prevention plan, Epidemic: Responding to America's Prescription Drug Abuse Crisis, are educating parents, youth, and patients about the dangers of abusing prescription drugs, educating prescribers about the safe and appropriate use of these drugs, and developing convenient and environmentally responsible medication disposal programs. PCCs are active partners in these efforts and both the PCCs and the PCP have participated in the National Prescription Drug Take Back events sponsored by the DEA.

PCCs also provide clinical toxicology training to multidisciplinary providers to help them better manage poisoning and overdose cases.

Funding History

FY	Amount
FY 2011	$21,866,000
FY 2012	$18,830,000
FY 2013	$17,657,000
FY 2014	$18,846,000
FY 2015	$18,846,000

Budget Request

The FY 2015 Budget Request is $18,846,000. The FY 2015 Request is equal to the FY 2014 Enacted level. Funding for the PCP will primarily be used to support the PCCs' infrastructure and core triage and treatment services. PCCs predominantly rely on State and local funding, as Federal funding accounts for less than 10 percent of total funding for the majority of PCCs. While PCCs have innovatively secured funding from a variety of local sources, including philanthropic organizations, their financial stability is tenuous. Many State funded poison control centers have been faced with termination due to State budgetary shortfalls in recent

years. Federal funding helps reinforce the nationwide PCC infrastructure, enabling PCCs to sustain their public health and toxico-surveillance efforts.

The following activities will be supported with the requested funding at the FY 2015 Request:

Support and Enhancement Grant Program ($17.346 million): Grant funds will be used to continue supporting PCCs' efforts to prevent poisonings, provide treatment recommendations, and comply with operational requirements needed to attain or sustain accreditation. This request also includes costs associated with processing of grants through the GrantSolutions and HRSA's Electronic Handbooks (EHBs), and conducting follow-up performance reviews.

National Toll-Free Hotline Services and Promotion of Number and Services ($1.5 million): Ensuring access to PCCs through the national toll-free Poison Help hotline is a critical public health service that improves the quality of healthcare. The Program will fund and manage the toll-free number 24 hours a day, every day of the year. Funding will also be used to support translation services for non-English speaking callers.

As legislatively mandated, the Program will continue to fund the nationwide Poison Help campaign to educate the public and health care providers about the national toll-free number. The PCP will continue to promote the hotline among the public and providers as well as engage other Federal grantees including community health centers, 340B Drug Pricing Program participants, geriatric education centers, rural health associations and Head Start programs.

The FY 2015 target is to increase the percent of all calls routed to the PCCs using the toll-free number to 83 percent. Additionally, the PCP aims to maintain the 71 percent of human poison exposure calls made to PCCs that were managed outside of a health care facility, as reported by the AAPCC. This will be a challenge because the U.S. is in the grip of an epidemic of prescription drug overdoses, which is increasing emergency room visits.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY2014
25.III.D.3: Increase percent of inbound volume on the toll-free number. (Output)	FY 2013: 85.6% Target: 73.7% (Target Exceeded)	75%	83%	8% points
25. III.D.4: Percent of national survey respondents who are aware that calls to poison control centers	FY 2012: 25% (Target Not in Place)	N/A	N/A	N/A

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY2014
are handled by health care professionals. (Outcome)[193] (FY 2006 Baseline: 19%)				
25. III.D.5: Percent of human poison exposure calls made to PCCs that were managed by poison centers outside of a healthcare facility. (Output)	FY 2010: 71% (Baseline)	N/A	71%	N/A

Grants Awards Table Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	53[194]	52[195]	52[196]
Average Awards	$313,203	$306,437	$306,437
Range of Award	$12,466-$1,966,881	$12,466-$1,867,636	$12,466-$1,867,604
Range of Contracts	$1,282-$9,963	$9,342-$300,000	$9,609-$300,000

[193] This is a long term measure. FY 2016 is the first year for which there is a target. The FY 2016 target is 25 percent.
[194] In FY 2013, there were 57 PCCs across the Nation. Fifty-three awards were made under the Support and Enhancement Grant Program, representing 56 of the 57 centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers.
[195] In FY 2014, we expect that there will be 55 PCCs across the Nation. Fifty-two awards will be made under the Support and Enhancement Grant Program, representing all of the poison centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers.
[196] In FY 2015, we expect that there will be 55 PCCs across the Nation. Fifty-two awards will be made under the Support and Enhancement Grant Program, representing all of the poison centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers.

Office of Pharmacy Affairs/340B Drug Pricing Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$4,193,000	$10,238,000	$10,238,000	---
FTE	3	3	7	+4

Authorizing Legislation - Public Health Service Act, Section 340B as amended by Sections 7101-7103, P.L. 111-148, as further amended by Section 2302, P.L. 111-152, and as amended by Section 204, P.L. 111-309

FY 2015 Authorization…….…….…..SSAN

Allocation Method……...…….……..….Contract

Program Description and Accomplishments

The 340B Drug Pricing Program (340B Program) requires drug manufacturers to provide discounts or rebates to a specified set of HHS-assisted programs and hospitals that meet the criteria in the Public Health Service Act and the Social Security Act for serving a disproportionate share of low income patients. The following health care providers are eligible to purchase outpatient drugs at 340B prices: all Health Resources Services Administration (HRSA)-assisted Federally Qualified Health Centers; Black Lung Clinics; Ryan White HIV/AIDS Programs including AIDS Drug Assistance Programs; Comprehensive Hemophilia Treatment Centers; Indian Health Service tribal organizations and Urban Indian Programs; Centers for Disease Control and Prevention-assisted sexually transmitted disease (STD) and tuberculosis (TB) clinics; Native Hawaiian Centers; Title X Family Planning Clinics; certain disproportionate share hospitals; children's hospitals; Federally Qualified Health Center Look-A-Likes; Free-Standing Cancer Centers; Critical Access Hospitals; Rural Referral Centers; and Sole Community Hospitals.

The 340B Program requires drug manufacturers to give covered entities a discount that is at least 23.1 percent below Average Manufacturer Price (AMP) for brand name drugs; 13 percent below AMP for generic drugs; and 17.1 percent below AMP for clotting factor and pediatric drugs. For FY 2013, covered entities will save an estimated $3.8 billion on their outpatient drug expenditures by participating in the 340B Program. The total savings in FY 2014 and FY 2015 are expected to increase as participation in the 340B Program increases. Drug purchases under the 340B Program represent approximately 2 percent of all U.S. drug purchases.

The Prime Vendor Program (PVP) established under Section 340B (a)(8) is responsible for the negotiation of pharmaceutical prices below the 340B ceiling price as well as contracting for wholesale distribution of pharmaceuticals to covered entities. The PVP is free and voluntary.

The PVP contract was re-competed and awarded in 2009 to Apexus, a non-profit organization. By the end of Fiscal Year 2013, the PVP had over 7,000 drugs under contract with an estimated average savings of 10 percent below the 340B ceiling price. In addition, the PVP has contracts for other value-added pharmacy products and services such as vaccines, diabetic supplies, pharmacy software, and outpatient pharmacy automation. Since 2009, the PVP contracts provided over $230 million in additional savings for covered entities enabling them to further expand their pharmacy programs and address growing patient needs during difficult economic times. Apexus has also established "shareback" payments to participating covered entities. These funds allow the covered entities to purchase more medications at a reduced cost for their patients. The 340B Prime Vendor continues to build on the value that this public/private business arrangement brings to covered entities and the government. Current PVP trends are expected to continue, and savings are expected to increase substantially in subsequent years.

The technical assistance contract will provide assistance and expertise in the delivery of pharmaceutical services for the Office of Pharmacy Affairs and 340B covered entities. The two major areas of focus include (1) Program Integrity, Information, and Analysis and (2) Program Development.

Program Growth

By the end of FY 2013, 21,922 covered entities sites were registered in the 340B Program. The 340B Program is expected to continue experiencing growth each year. The number of contract pharmacies registered in the 340B Program serving covered entities has increased to over 11,953 pharmacies with 340B contracting arrangements and continues to grow since the final publication of guidance allowing multiple contract planning arrangements.

Funding History

FY	Amount
FY 2011	$4,480,000
FY 2012	$4,472,000
FY 2013	$4,193,000
FY 2014	$10,238,000
FY 2015	$10,238,000

Budget Request

The FY 2015 Budget Request is $10,238,000. The FY 2015 Request is equal to the FY 2014 Enacted level. From the inception of the 340B Program in 1992, the entire cost of administering the Program, including the development of guidelines and the provision of technical assistance to eligible grantees, has been borne by HRSA program management funds until FY 2009 when a line item of $1,470,000 was established. The line item was expanded to $2,220,000 in FY 2010 because of the need to make major improvements in program operations as identified by audits and evaluations conducted by the Office of Inspector General (OIG). In addition, $1,584,000 of Affordable Care Act (ACA) funds was used to design systems and begin enrolling and supporting the five new eligible entity-types identified in ACA. The program received line item

appropriations of $4,480,000 in FY 2011, $4,472,000 in FY 2012, $4,193,000 in FY 2013, and $10,238,000 in FY 2014. Continued funding in FY 2015 is necessary to continue to oversee the 340B Program, implement major improvements in operations and to resolve identified deficiencies of the current level of operations. The areas of focus include:

- Non-compliance with the 340B pricing requirements - 340B Program pricing errors are caused by a variety of problems including: incorrect package size data; omissions in data needed to compute 340B ceiling prices; and mistakes in 340B prices offered by drug manufacturers and/or wholesalers. HRSA computes the 340B ceiling prices using data that manufacturers' supply to the Center for Medicare & Medicaid Services (CMS). Funds from the FY 2015 Request will continue to support the 340B pricing system, publication of policies regarding the computation of 340B ceiling prices, implement a systematic quarterly comparison of 340B ceiling prices with the selling prices offered by manufacturers and drug wholesalers, and follow-up efforts to resolve problems wherever they arise in the data supply chain.

- Errors and omissions in HRSA's covered entity database - HRSA's staff and its contractors have continued to take a number of steps to improve the integrity, transparency, and reliability of the database of covered entities. This includes purging duplicate and obsolete entity records and adding updated entity information. While there have been great advances in improving the integrity and accuracy of the 340B database in response to deficiencies identified by the OIG, a sustained and systematic approach is needed to maintain this accuracy and integrity. HRSA will continue to require the verification of eligibility of entity types in FY 2015. In FY 2015, the continued administration of a systematic verification system will allow annual online verification of all records in the 340B database. HRSA considers the integrity of the 340B database to be a crucial responsibility that requires ongoing maintenance and development in order to effectively administer the 340B Program and meet the obligations of the Secretary and the law.

- Program Regulations and Guidance - In FY 2015, HRSA will continue to support the implementation of program regulations and guidance to provide oversight to maintain the integrity of the 340B Program.

- The 340B Drug Pricing Program funds the HRSA, Healthcare Systems Bureaus' Office of Pharmacy Affairs Information System (OPAIS) IT Investment. OPAIS is a multi-function web-based database system that provides information on covered entities, contract pharmacy arrangements, and manufacturers who have signed agreements with DHHS. This IT Investment supports the strategic and performance outcomes of the Program by facilitating access to clinically and cost effective pharmacy services among safety-net clinics and hospitals (known as the covered entities) that participate in the 340B Program.

Affordable Care Act

The ACA expanded the type of entities eligible for participation in the 340B Program to include children's hospitals, critical access hospitals, free standing cancer hospitals, rural referral centers, and sole community hospitals. Since August 2010, the Program has enrolled over 2,200 newly eligible sites. They will continue to be enrolled as applications are made to the Program. In addition, new program integrity provisions were enacted which include civil monetary penalties, administrative dispute resolution, orphan drug exclusion, pricing transparency, and annual recertification for all covered entity types.

Information Technology

The 340B Drug Pricing Program funds the HRSA - HSB Office of Pharmacy Affairs Information System (OPAIS) IT Investment. OPAIS is a multi-function web-based database system that provides information on covered entities, contracted pharmacy arrangements, and manufacturers who have signed agreements with DHHS. This IT Investment supports the strategic and performance outcomes of the program by facilitating access to clinically and cost effective pharmacy services among safety-net clinics and hospitals (known as the covered entities) that participate in the 340B Program.

HRSA-Supported Performance Outcomes

The primary products are the 340B online public access database, required by legislation, for use by stakeholders of the 340B Program, and the pricing module to be used to validate manufacturers' calculations of the 340B ceiling price. This investment allows the Office of Pharmacy Affairs to improve its ability to respond to customer needs and improve 340B Program integrity. This project supports element 1.1 – to ensure accountability for business results by making sure stakeholders have accurate 340B Program data on which to base their sales projections or other business decisions.

In FY 2015, funding will be used to support the continued registration of the covered entity types eligible to participate in the 340B Program, with a target of 18,003 sites served.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Covered Entity Sites Served	FY 2013: 21,922 Target: 16,970 (Target Exceeded)	17,479	18,003	+524

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
TA Consultations	FY 2011: 6,484 Target: 4,885 (Target Exceeded)	6,536	0[197]	-6,536

Contracts Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Contracts	2	3	3
Average Contract	$2,096,500	$3,042,388	$3,042,388
Range of Contracts	$2,096,500-$2,096,500	$3,127,164-$6,000,000	$3,127,164-$6,000,000

[197] The technical assistance contract awarded to provide technical assistance to 340B participants through a call center was ended on 9/30/2012. Currently, there is not a mechanism in place to capture this data.

Office of Pharmacy Affairs/340B Drug Pricing Program User Fees

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	---	---	$7,000,000	+$7,000,000
FTE	---	---	---	---

Authorizing Legislation - Public Health Service Act, Section 340B as amended by Sections 7101-7103, P.L. 111-148, as further amended by Section 2302, P.L. 111-152, and as amended by Section 204, P.L. 111-309

FY 2015Authorization…….….....SSAN

Allocation Method .....Contract

Program Description and Accomplishments

The Health Resources and Services Administration (HRSA) 340B Drug Pricing Program User Fees would provide additional ongoing funding sources to be able to administer the new authorities and responsibilities. Funds are also needed to address recommendations by the Office of Inspector General (OIG) and Government Accountability Office (GAO) to make major improvements in program integrity. The user fee provides the resources needed to improve program integrity and implement statutory provisions while reducing the government expenditure of taxpayer dollars.

The 340B user fee in FY 2015 is 0.1 percent (or one cent for every thousand dollars) of the total 340B drug purchases paid by participating covered entities. These funds shall be available until expended. The fee will be collected from the covered entities into a no-year account established by the Secretary for use by the Secretary and designees in administering operations of the 340B Program including integrity provisions and access to covered drugs and services for 340B eligible entities.

The administration of the user fee system will include the manufacturers periodic reporting to the Secretary. Reporting will include the purchases by entity under the 340B program and the establishment of the user fee as a percent of such drug purchases under the Program. The collected fee is in addition to the entity's cost to purchase the drug at the 340B price. This fee will be paid by and collected from the entity, through a mechanism established by the Secretary, and remitted to the Secretary. The Secretary will establish a mechanism to ensure that the full user fee is clearly identified and fully remitted to the Secretary as a condition of participation in the program. The calculation of the 340B ceiling price is not affected by this provision. The 340B entities receive a significant benefit and the user fee is designed to ensure the cost of administering the Program is paid for with a small fraction of the received benefit. Without the

user fee, the funding necessary to administer this Program comes exclusively from the taxpayers. The user fee will create a sustainable funding source generated by those who benefit from the program to meet the demands of the existing growth of the Program, the changing marketplace, and the new statutory program requirements.

The FY 2015 user fee set at the 0.1 percent level, in addition to Office of Pharmacy Affairs' proposed line item budget, will fund the program's current and increased program integrity.

Program Growth

By the end of FY 2013, 21,922 eligible covered entity sites were registered in the 340B Program. The 340B Program is expected to continue experiencing growth each year. The number of contract pharmacies registered in the 340B Program serving covered entities has increased to over 11,950 pharmacies with 340B contracting arrangements and is expected to continue growing at an accelerated rate for the newly eligible covered entities. This is a result of the March 2010 publication of a Federal Register Notice allowing multiple contract pharmacy arrangements.

Funding History

FY	Amount
FY 2011	---
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	$7,000,000

Budget Request

The FY 2015 Budget Request is $7,000,000. The FY 2015 Request is $7,000,000 above the FY 2014 Enacted level. The 340B user fee system will establish the necessary requirements for manufacturers and covered entities to efficiently administer this user fee system that will provide operations, oversight and integrity for the 340B Drug Pricing Program. The user fee will support the natural growth of the 340B Program and fund new authority, responsibilities, and oversight. The user fee will ensure a reliable and continuous funding source for HRSA to fully administer the 340B Program and will allow HRSA to better monitor compliance among both manufacturers and covered entities. In anticipation of expected further growth of the Program and additional responsibilities relating to increased eligibility and maintaining integrity and compliance, this funding mechanism will ensure the Program continues to operate successfully and effectively.

A legislative proposal has also been proposed to establish sustainable 340B sales reporting process and a user fee mechanism to be collected from 340B participating entities for the purpose of administering Section 340B of the Public Health Service Act. The statutory change would ensure the user fee is both efficiently and effectively implemented. With statutory language, HRSA would have additional authority to enforce program requirements and

implement the program integrity provisions as outlined by the OIG and GAO. The collected fee will be remitted to the Secretary for use in administering all operations of the Program including program integrity measures and providing access to covered drugs and services for 340B eligible entities. This amount would not affect the calculation of the entity's total acquisition cost of a 340B drug.

The user fee will address current information deficiencies as well as provide significant resources needed to address both long term goals to improve the program by addressing OIG requirements and the expanded statuary requirements of Affordable Care Act.

As stated in P.L. 111-148, HRSA is required to develop and implement a system to verify the accuracy of the 340B ceiling price in the marketplace. HRSA needs to develop and publish defined standards and methodology for the calculation of ceiling prices as well as put in place a new transparent system to calculate the official Federal 340B ceiling price and make it available to the covered entities through the secured internet website that protects proprietary pricing data. HRSA also needs to perform oversight activities such as spot checks of sales transactions by covered entities, selective auditing of manufacturers and wholesalers, inquire into the cause of any pricing discrepancies and take necessary corrective actions. The corrective actions include making sure the manufacturers issue timely refunds for routine retroactive adjustments and for exceptional circumstances such as erroneous or intentional overcharges. In addition, all covered entities are required to be recertified and their information updated on an annual basis or sooner to ensure the integrity of the system and information in the HRSA database is accurate.

Specifically, the user fee collected will cover the long-term goals of the Program that include expanded authority under Affordable Care Act and recommendations from the OIG and GAO. The areas of focus include:

User Fee System – HRSA will develop and publish defined standards and methodology for the calculation of the user fee and reporting requirement of manufacturer sales data from which the fee will be calculated. The system will also support the verification of payments by the covered entities.

Office of Pharmacy Affairs Information Systems (OPAIS) - Manufacturers are required to report their 340B ceiling prices directly to HHS. HRSA will develop a system of verifying ceiling price calculations, post 340B ceiling prices to a secure website, utilize spot checks of sales, and develop a system of refunds where appropriate. HRSA is required to establish a single, universal, and standardized identification system by which each covered entity site can be identified by manufacturers, distributors, and covered entities for purposes of facilitating ordering, purchasing, and delivery of covered drugs, including the processing of charge-backs for such drugs. In addition, HRSA is required to make system improvements and add procedures to enable and require covered entities to regularly update the information via the internet website. The system will verify the accuracy of information regarding covered entities that are listed on the website.

Compliance and Oversight - Compliance issues are addressed primarily when they emerge as complaints from manufacturers, covered entities, or non-governmental interest groups. HRSA

currently has no systematic method of monitoring manufacturer or covered entity compliance with the 340B law, P.L. 111-148, and HRSA's published guidelines. OIG reports on October 18, 2005, titled "Deficiencies in the Oversight of the 340B Drug Pricing Program (OEI-05-02-00072)"; and on July 14, 2006, titled "Review of 340B Prices (OEI-05-02-00073)" and the GAO report on September 23, 2011, titled "Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement" have outlined recommendations for program oversight and compliance. Among five recommendations to correct non-compliance among manufacturers, the OIG urged HRSA to institute oversight mechanisms to validate its 340B price calculations and the prices charged by manufacturers to participating entities. HRSA has not been able to fully implement these recommendations due to limited resources. The GAO report recommended selective audits of covered entities to ensure program compliance. With the limited resources currently available, HRSA has been unable to fully implement this compliance and oversight function.

Administrative Dispute Resolution Process - HRSA is authorized by P.L 111-148 to establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased and claims by manufacturers of violations, including appropriate procedures for the provision of remedies and enforcement of such process through mechanisms and sanctions.

Civil Monetary Penalties - HRSA has new authority to impose sanctions in the form of civil monetary penalties for manufacturers and covered entities. HRSA will have the authority, under P.L. 111-148, to impose up to a $5,000 penalty to manufacturers for each instance of knowingly and intentionally overcharging a covered entity. In addition, HRSA will have the authority, under P.L. 111-148 to require covered entities to pay monetary penalties to manufacturers in the form of compounded interest for knowing of intentional violations of diversion and/or removing and disqualifying the covered entity from the 340B Program for a designated period of time as penalty when violations are found to be systematic and egregious.

Non-compliance with the 340B Pricing Requirements - 340B Program pricing errors are caused by a variety of problems including: incorrect package size data, omissions in data needed to compute 340B ceiling prices, and mistakes in 340B prices offered by drug manufacturers and/or wholesalers. As a first step in correcting these problems, HRSA negotiated an intra-agency agreement with the Center for Medicare & Medicaid Services (CMS), permitting HRSA to compute the 340B ceiling prices using data that manufacturers supplied to CMS. Funds from the FY 2015 Request will continue to support publication of policies regarding the computation of 340B ceiling prices; implement a systematic quarterly comparison of 340B ceiling prices with the selling prices offered by manufacturers and drug wholesalers, and follow-up efforts to resolve problems wherever they arise in the data supply chain.

Information Technology

Office of Pharmacy Affairs Information Systems (OPAIS) – OPAIS is a multi-function web-based database system that provides information on covered entities, contracted pharmacy arrangements, and manufacturers who have signed agreements with DHSS. This investment will support enhancements to ensure the accuracy of database contact information for both covered

entities required to remit the user fee and manufacturers required to report sales data. In addition, the pricing system will be enhanced to verify the 340B ceiling prices, posting of the prices to a secure website, and the periodic checking of manufacturer reported pricing data.

User Fee System – The User Fee system is a multi-functional web-based system that will provide for the calculation and collection of the user fee and reporting requirement of manufacturer sales data from which the fee will be calculated. The system will also support the verification of payments by the covered entities.

Outputs and Outcomes Tables

The Program measures are under development.

National Hansen's Disease Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$15,045,000	$15,206,000	$15,206,000	--
FTE	62	62	62	---

Authorizing Legislation: Public Health Service Act, Section 320, as amended by Section 211 of the Public Law 105-78

FY 2015 Authorization ..... Indefinite

Allocation Method ..... Contract/Direct Federal/Intramural

Program Description and Accomplishments

The National Hansen's Disease Program (NHDP) has been providing care and treatment for Hansen's Disease (leprosy) and related conditions since 1921. The Program provides medical care to any patient living in the United States (U.S.) or Puerto Rico through direct patient care at its facilities in Louisiana, by contracting with 13 regional outpatient clinics and by providing cost free drug regimens, consultations, laboratory services and outpatient referral services as a safety net for private sector physicians (PSP) managing cases of Hansen's Disease. As of FY 2012, there were nearly 3,500 patients cared for through the NHDP's outpatient clinics and over 500 cared for by PSPs. The Program is a national health care infrastructure that provides training and education to health professionals to promote early detection and treatment provided through direct patient care. The Program also conducts scientific research at the world's largest and most comprehensive laboratory dedicated to Hansen's Disease. The Program is the only dedicated provider of expert Hansen's Disease treatment services in the U.S. and a crucial source of continuing education for providers dealing with the identification and treatment of the disease in the U.S.

Increasing Quality of Care: Early diagnosis and treatment are the keys to blocking or arresting the trajectory of Hansen's Disease-related disability and deformity. This goal can only be achieved if there are enough health care providers in the U.S. with knowledge of the disease and access to the support provided by the NHDP through its function as an outpatient clinic, training, education, and referral center. Increasing knowledge about Hansen's Disease in the U.S. medical community is expected to lead to earlier diagnosis and intervention, resulting in a decrease in Hansen's Disease-related disabilities. In FY 2012, the NHDP exceeded its program performance target of 150, and trained 202 private sector physicians. In FY2013, NHDP again exceeded the performance target and trained 259 physicians.

Improving Health Outcomes: Hansen's Disease is a life-long chronic condition which left untreated and unmanaged will usually progress to severe deformity.

Through its focus on early diagnosis and treatment, the NHDP is monitoring its impact on improving health outcomes for Hansen's Disease patients through the prevention of increases in the percentage of patients with grades 1 or 2 disability/deformity[198]. In FY 2005, 51 percent of patients had grades 1 or 2 disability. In FY 2006, that figure was 46 percent; in FY 2007, that figure was 47 percent; and in FY 2008, the result was 45 percent, exceeding the target of 50 percent each year. In FY 2009, the result was 53 percent. This increase is attributable to an increased number of patients seen in 2009 and additional emphasis placed on conducting hand screens in the outpatient clinics. In FY 2010, the result was 47 percent, exceeding the target of 50 percent. Most recent results are from FY 2011 where 40 percent of patients had grades 1 or 2 disability, again exceeding our target.

The Program is also working to improve health outcomes through advances in Hansen's Disease research. The Program is measuring its advances in scientific knowledge through breakthroughs in genomic and molecular biology. Performance measures have included the development of six protective biological response modifiers (BRMs) and six white blood cell subtype markers (CMs) that are important in host resistance to Hansen's Disease. These markers and other progress will aid in the study of defective nerve function in infected armadillos which will ultimately permit development of a full animal model for human Hansen's Disease. In FY 2007, the Program met its target and developed the second of the 12 reagents (BRM-2) needed to produce a relevant animal model, as well as the first of six white blood cell subtype markers (CM-1). In FY 2008, the Program met its target and developed the third of the 12 reagents (BRM-3) needed to produce a relevant animal model, as well as the second and third of six white blood cell subtype markers (CM-2 and CM-3). In FY 2009, the Program met its target and developed BRM-4 and CM-4. In FY 2010, the Program met its target and demonstrated defective nerve function in infected armadillos. In FY 2011, the Program again met its target and developed a "DNA fingerprint" to provide evidence that linked leprosy transmission from armadillos to humans in the Southern U.S. In FY 2012, the Program pursued relevant animal models for human leprosy by defining parameters of nerve dysfunction in armadillos infected with the leprosy bacillus.

Promoting Efficiency: The NHDP outpatient care is comprehensive and includes treatment protocols for multi-drug therapy, diagnostic studies, consultant ancillary medical services, clinical laboratory analysis, hand and foot rehabilitation, leprosy surveillance, and patient transportation for indigent patients. The NHDP is committed to improving overall efficiency by controlling the cost of care at all of its outpatient clinics while keeping increases in the cost per patient served at or below the national medical inflation rate.

By restraining increases in the annual cost per individual served by the Ambulatory Care Program Clinics and at the NHDP's outpatient clinic below the national medical inflation rate, the Program can continue to serve more patients that otherwise would have required additional

[198] Disability/deformity is measured based on the World Health Organization scale, which ranges from 0-2. Patients graded at 0 have protective sensation and no visible deformities. Patients graded at 1 have loss of protective sensation and no visible deformity. Patients graded at 2 have visible deformities secondary to muscle paralysis and loss of protective sensation.

funding. In FY 2010, the cost per patient served through outpatient services was $1,142, reflecting an increase of 4.9 percent and slightly higher than the national medical inflation rate of 3.9 percent. In FY 2011, the cost per patient served through outpatient services was $1,057, a decrease of 7.4 percent, well below the national inflation rate of 4.13 percent. In FY 2012, the cost per patient served through outpatient services was $1,015, a decrease of 4.0 percent, well below the national inflation rate of 3.43 percent.

Funding History

FY	Amount
FY 2011	$16,077,000
FY 2012	$16,045,000
FY 2013	$15,045,000
FY 2014	$15,206,000
FY 2015	$15,206,000

Budget Request

The FY 2015 Budget Request is $15,206,000. The FY 2015 Request is equal to the FY 2014 Enacted level. The entire FY 2015 Budget Request will support the Program's achievement of its performance targets. The Program will continue its goals in the area of increasing quality of care and improving health outcomes for Hansen's Disease patients.

A national promotion effort targeted at physicians whose practice may include individuals with Hansen's Disease (e.g., dermatologists, infectious disease and family practice physicians) is underway, as well as focused efforts to train health care providers in Hansen's Disease where clusters of newly diagnosed cases are appearing. A performance target for FY 2015 Budget Request is to train 150 physicians, improving their knowledge and ability to diagnose and treat Hansen's Disease.

In the area of Hansen's Disease disability/deformity prevention, both the Program's existing case management efforts, as well as its activities to train more private sector physicians to recognize Hansen's Disease and initiate treatment earlier, will help prevent further increases in the level of disability/deformity among Hansen's patients, maintaining the Grade 1 and Grade 2 levels of deformity at 50 percent.

The Program's FY 2015 target for its research measure is to pursue a relevant animal model for human leprosy. The Program will also continue to promote efficiency by targeting in FY 2015 cost per patient increases below the national medical inflation rate.

The FY 2015 funding will support the Program's continued coordination and collaboration with related Federal, State, local, and private programs to further leverage and promote efforts to improve quality of care, health outcomes, and research related to Hansen's Disease.

Areas of collaboration include a partnership with the Food and Drug Administration (FDA) Drug Shortage Program to distribute the drug clofazimine to over 500 providers nationally. At the

request of the FDA, the Program agreed to manage the investigational new drug (IND) application that makes clofazimine available in the U.S. for treatment of leprosy. The NHDP has recently entered into collaboration with the Centers for Disease Control (CDC), to develop Hansen's Disease training and educational material for healthcare providers in the Western Pacific Islands.

The Program is the sole worldwide provider of reagent grade viable leprosy bacilli, and continues to collaborate with researchers worldwide to further the study of and scientific advances related to the disease. To support the Program training initiative of increasing the awareness of leprosy in the U.S. the Program has facilitated outpatient management of leprosy in the U.S. by providing to private sector physicians additional laboratory, diagnostic, consultation and referral services.

Outputs and Outcomes Table

Measure	Year and Most Recent Result/Target for Recent Result/ (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
3.E.: Maintain increases in the cost per patient served in the outpatient clinics to below the medical inflation rate (Efficiency)	FY 2012: -4.0% Target: Below national medical inflation rate Target: 3.43% (Target Exceeded)	Below national medical inflation rate	Below national medical inflation rate	Maintain
3.II.A.2.: Number of private sector physicians who have received training from the NHDP (Output)	FY 2013: 259 Target: 150 (Target Exceeded)	150	150	Maintain
3.II.A.3.: Number of patients provided Hansen's Disease outpatient care through the NHDP (Output)	FY 2012: 3,490 Target: 3,000 (Target Exceeded)	3,000	3,000	Maintain
3.III.A.1.: Develop an animal model for the full spectrum of clinical complexities of human Hansen's Disease (Output)	FY 2012: Defined parameters of nerve dysfunction in armadillos infected with the leprosy bacillus Target:	Pursue relevant animal model for human leprosy	Pursue relevant animal model for human leprosy	Maintain

Measure	Year and Most Recent Result/Target for Recent Result/ (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
	Pursue relevant animal model for human leprosy (Target Met)			
3.II.A.1.: Percent increases in the level of Hansen's Disease related disability and deformity among patients treated and managed by the NHDP (Percentage of patients at Grades 1 and 2)	FY 2011: 40% Target: 50% (Target Exceeded)	50%	50%	Maintain

Additional Outputs and Outcomes

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
NHDP Resident Population	15	14	14
NHDP Non-Residential Outpatients	177	177	177
Ambulatory Care Program (ACP) Clinics	13	13	13
ACP Clinic Patients (Outpatients)	3,000	3,000	3,000
ACP Clinic Patient Visits	16,000	16,000	16,000
NHDP Non-Residential Outpatient Visits	22,000	22,000	22,000

National Hansen's Disease Program by Sub – Activity

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Administration	$ 1,512,000	$ 1,575,000	$ 1,714,000
Clinical Care	5,511,000	5,169,000	4,934,000
Regional Centers	1,895,000	2,521,000	2,528,000
Research	2,373,000	2,356,000	2,438,000
Facility Operations	2,416,000	2,339,000	2,346,000
Assisted Living Allowance	1,338,000	1,246,000	1,246,000
Total	$15,045,000	$15,206,000	$15,206,000

National Hansen's Disease Program – Buildings and Facilities

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$122,000	$122,000	$122,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 320 and 321(a)

FY 2015 Authorization ..... Indefinite

Allocation Method ..... Direct Federal

Program Description and Accomplishments

This activity provides for the 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. The projects are intended to assure that the facility provides a safe and functional environment for the delivery of patient care and training activities; and meets requirements to preserve the Carville historic district under the National Historic Preservation Act.

Funding History

FY	Amount
FY 2011	$127,000
FY 2012	$127,000
FY 2013	$122,000
FY 2014	$122,000
FY 2015	$122,000

Budget Request

The FY 2015 Budget Request is $122,000. The FY 2015 Request is equal to the FY 2014 Enacted level. The total request is required for continued renovation and repair work on patient areas, to complete minor renovation work on the Carville museum, and to continue regular renovation and repair work on clinic areas and offices.

Outputs and Outcomes Tables

See National Hansen's Disease Program.

Payment to Hawaii

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$1,838,000	$1,857,000	$1,857,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Section 320(d), as amended by Section 211 of Public Law 105-78

FY 2015 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 2011	$1,964,000
FY 2012	$1,960,000
FY 2013	$1,838,000
FY 2014	$1,857,000
FY 2015	$1,857,000

Budget Request

The FY 2015 Budget Request is $1,857,000. The FY 2015 Request is equal to FY 2014 Enacted level.

Outputs and Outcomes Tables

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Average daily HD Kalaupapa patient load	17	16	16
Total Kalaupapa and Halemohalu patient hospital days	2,944	2,603	2,603
Total Kalaupapa homecare patient days	2,629	2,723	2,723
Total Hawaiian HD Program outpatients	272	278	278
Total outpatient visits	6,978	5,826	5,826

Rural Health Policy

TAB

RURAL HEALTH POLICY

Summary of the Request

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$130,876,000	$142,335,000	$124,562,000	-$17,773,000
FTE	8	10	8	-2

Established in 1987, the Office of Rural Health Policy (ORHP) serves as a focal point for rural health activities within the Department. The Office is specifically charged with serving as a policy and research resource on rural health issues as well as administering grant programs that focus on supporting and enhancing health care delivery in rural communities.

ORHP advises the Secretary and other components of the Department on rural health issues with a particular focus on working with rural hospitals and other rural health care providers to ensure access to high quality care in rural communities. The Department has maintained a significant focus on rural activities for more than 21 years. Historically, rural communities have struggled with issues related to access to care, recruitment and retention of health care providers and maintaining the economic viability of hospitals and other health care providers in isolated rural communities.

There are nearly 50 million people living in rural America who face ongoing challenges in accessing health care.[199] Rural residents have higher rates of age-adjusted mortality, disability, and chronic disease than their urban counterparts.[200] Rural areas also continue to suffer from a shortage of diverse providers for their communities' health care needs and face workforce shortages at a greater rate than their urban counterparts.[201,202] Of the 2,052 rural counties in the United States (U.S.), 1,582 (77 percent) are primary care health professional shortage areas (HPSAs).[203]

One of the annual performance measures used to gauge rural health activities is from the Rural Health Care Services Outreach Grant program authority. Programs under this authority provided both direct and indirect services for 2,451,969 individuals in FY 2009, which exceeded the target of 828,360. This was a substantial improvement from FY 2006 in which 627,120 individuals

[199] Population and Percent Distribution by Core Based Statistical Area (CBSA) Status for the United States, Regions, and Divisions, and for Puerto Rico: 2000 and 2009 (CBSA-EST2009-11).
[200] Economic Research Service (August 2009). Health Status and Health Care Access of Farm and Rural Populations. Economic Information Bulletin Number 57. Washington, D.C. U.S. Department of Agriculture.
[201] Doescher, M., Fordyce, M., Skillman S., WWAMI Rural Health Research Center Presentation: The Aging of the Rural Generalist Workforce. February 2009.
[202] Area Resource File (ARF). 2008. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Rockville, MD.
[203] WWAMI Rural Health Research Center. Aging of the rural generalist workforce. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; July, 2009.

were served. This measure was revised to examine the increase in the number of people receiving direct services through the ORHP Outreach grant. This measure focuses on only direct patient care such as screenings and treatment which is clearer, easier to interpret, easier to quantify, and, thus, more accurate. In FY 2010, 383,776 people received direct services through the ORHP Outreach grants, exceeding the target of 380,000. In FY 2011, 615,849 people received direct services, exceeding the target of 385,000 people. In FY 2012, 747,952 people received direct services, exceeding the target of 390,000.

Improving Rural Health Initiative

The goal for the President's "Improving Rural Health Care Initiative" is to build healthier rural populations and communities through evidence-based practices. ORHP will improve the coordination of rural health activities within Health Resources and Services Administration (HRSA), across the Department of Health and Human Services (DHHS), as well as other Federal Departments by leveraging rural health funds to improve the health of rural populations. Approximately $80.4 million of the total amount requested for the ORHP supports the President's initiative to improve rural health; specifically $57,000,000 from Rural Health Care Services Outreach; $9,511,000 from the State Offices of Rural Health; and $13,900,000 from Telehealth.

The goal of the initiative is to improve the access to and quality of health care in rural areas. To achieve this goal, the initiative focuses on five activities:

- Strengthening rural health care infrastructure;
- Improving the recruitment and retention of health care providers in rural areas;
- Building an evidence base for programs that improve rural community health;
- Providing direct health care services; and
- Improving the coordination of rural health activities within HRSA, DHHS, and across the Federal Government.

Affordable Care Act

The Affordable Care Act presents opportunities to provide comprehensive care and services to individuals who otherwise cannot afford or gain access to care by extending health insurance coverage and improving coordinated care. The HRSA Rural Health programs and activities do not have any direct funding from the Affordable Care Act, but may be affected by the expansions to comprehensive services and insurance coverage. As the Affordable Care Act shifts the reimbursement to clinicians from the volume of care provided to the value of care provided, the FY 2015 request supports the continued need for wrap-around services that the Rural Health programs provide.

In addition, the ORHP continues to collaborate with HHS agencies and other Federal Departments to achieve the activities in the President's "Improving Rural Health Care Initiative." The following four programs within the ORHP support these five activities.

Rural Health Care Services Outreach, Network, and Quality Improvement

The Rural Health Outreach authority includes a range of programs designed to improve access to care, coordination of care, integration of services and to focus on quality improvement in health care for rural communities. These programs are among the only non-categorical grants within DHHS, which allows grantees to determine the best way to meet local need. This flexibility in funding reflects the unique nature of health care challenges in rural communities and the need to allow communities to determine the best approach to addressing local health concerns. The broad non-categorical nature of the programs also allows ORHP to focus funding on key emerging needs. For example, in the first couple of years of the "Improving Rural Health Care Initiative," ORHP was able to focus funding on two key areas of need through funding of Network Development grants. The first focused on health care workforce development in 2010; the second on the adoption of health information technology in 2011. ORHP awarded 20 awards in the workforce development program and plans to conduct a short-term and long-term evaluation to ultimately determine the number of students who end up practicing in rural. The program focuses on a range of disciplines including mental health, dental, pharmacy, allied health, including primarily physician assistants, nursing and residency programs. In addition, ORHP awarded 41 health information technology grants in 2011 to adopt HIT and to reach meaningful use stages 1 and 2. ORHP will evaluate this program as well to understand lessons learned when the program ends in 2015. In FY 2013, ORHP continued to focus on the "Improving Rural Health Care Initiative," and made 15 awards in the Rural Health Information Technology (HIT) Workforce, which focuses on increase the number of qualified HIT professionals in rural areas. These programs help to improve access to and the quality of health care in rural areas by supporting three of the initiative's five components: strengthening rural health care infrastructure, providing direct health care service, and improving the recruitment and retention of health care providers in rural areas.

State Offices of Rural Health Grants

This program provides funding to the State Office of Rural Health located in each state to provide technical and other assistance, information dissemination to rural health providers and helps rural communities recruit and retain health care professionals. This program also supports improving the recruitment and retention of health care providers in rural areas component of the initiative.

Rural Training Track Technical Assistance Grant-New Program for Rural Physician Training Grants

This pilot program provides technical assistance to new and established Rural Training Track (RTT) family medicine residency programs in which the first year of training takes place in urban-based locations and the second and third years of residency occur in rural locations. The technical assistance is provided to help RTT programs across the Nation expand residency training and ultimately physician practice in rural areas; increase the number of medical students that match to RTT residency programs; and work with rural communities that have an interest in creating new programs. There are currently 32 active programs, which include 3 programs

opening in 2014. This initiative also supports the "recruitment and retention of health care providers in rural areas" component of the initiative.

Telehealth Grants

This program expands the use of telecommunications technologies within rural areas that can link rural health providers with specialists in urban areas, thereby increasing access and the quality of healthcare provided to rural populations. Telehealth technology also offers important opportunities to improve the coordination of care in rural communities by linking rural health care providers with specialists and other experts not available locally. These grants support the initiative by strengthening rural health care infrastructure.

Coordinating Programs for a Targeted Investment

The programs listed above support the initiative. In addition, ORHP will use the existing funds to continue to conduct program evaluations and build an evidence base for new ways to improve health care in rural communities. Evaluations will focus on measuring:

- The program impact on the health status of rural residents with chronic conditions such as diabetes, cardiovascular disease, and obesity;
- The return on investment for rural grantees and communities; and
- The economic impact of the Federal investment in rural communities.

The initiative will also identify successful models, lessons learned and common challenges faced by rural grantees through a Rural Community Health Gateway. These best practices will be disseminated across the Nation as models that can be replicated through the Gateway.

Finally, as part of the initiative, ORHP will work to increase coordination with other agencies that fund programs that benefit rural communities within HRSA, DHHS, and across the Federal Government. This will include increasing rural participation in health professional training and service programs in Title VII and VIII of the Public Health Service Act as well as the National Health Service Corps. In 2010, ORHP began working collaboratively with the Department of Agriculture on a variety of issues ranging from defining frontier communities to coordinating telehealth and broadband access. The ORHP expanded its work with the Department of Veteran Affairs in 2011 while also reaching out to work collaboratively with the Department of Labor, Education and Transportation. In 2012, ORHP supported three workshops with USDA to focus on access to capital to support health information technology.

Funding History

FY	Amount
FY 2011	$137,568,000
FY 2012	$138,172,000
FY 2013	$130,876,000
FY 2014	$142,335,000
FY 2015	$124,562,000

Budget Request

The FY 2015 Budget Request is $124,562,000. The FY 2015 Request is $17,773,000 below the FY 2014 Enacted level. The FY 2015 Budget Request will fund the following rural health activities:

- $57,000,000 for the Rural Health Care Services Outreach, Network, and Quality Improvement Programs. This funding will continue to support key activities for Rural Health Care Services Outreach, Network and Quality Improvement Grants Programs. One of the goals of the "Improve Rural Health Care Initiative" is to help existing rural networks improve the coordination of health services in rural communities and strengthen the rural health care systems as a whole. This effort supports that goal. The ORHP expects that 405,000 people will receive direct services in FY 2015 which reflects the start of a new grantee cohort.

- $9,351,000 for Rural Health Policy Development. Funding will support activities, including the Rural Health Research Center cooperative agreement program, rapid response policy analysis, as well as policy analysis and information dissemination activities on a range of rural health issues. The FY 2015 target for these activities is 35 reports.

- $26,200,000 for Rural Hospital Flexibility Grants. This request provides funding for the Rural Hospital Flexibility Program, which provides grants to support a range of activities focusing on Critical Access Hospitals (CAHs). The activities supported through this funding will continue to support efforts by CAHs to report quality data to Hospital Compare. The FY 2015 target for this activity is 90 percent.

- $9,511,000 for the State Offices of Rural Health Grants. This funding will continue to support key activities for the State Offices of Rural Health (SORH) Program and will support a grant award to each of the 50 states. It is part of HRSA's Improve Rural Health Initiative to provide technical and other assistance to rural health providers and help rural communities recruit and retain health care professionals. The SORH Program anticipates that it will provide 68,277 technical assistance encounters directly to clients in FY 2015. The program also expects 22,632 clients (unduplicated) will receive technical assistance directly from SORHs in FY 2015.

- $1,834,000 for Radiation Exposure Screening and Education Program (RESEP). The purpose of this program is to provide grants to States, local governments, and appropriate health care organizations to support programs for individual 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. This program expects to screen 1,366 individuals in FY 2015.

- $6,766,000 for Black Lung Clinics. The purpose of this program is to commit funds through project grants for establishing clinics that provide for the outreach and education, diagnosis, treatment, rehabilitation, and benefits counseling of active and retired coal miners and other with occupation-related respiratory and pulmonary impairments. This program expects to serve 13,000 miners in FY 2015.

- $13,900,000 for the Telehealth Grants. The funds will support: (1) Telehealth Network Grant Program grantees (up to 26 grants); (2) Telehealth Resource Center Grant Program grantees (up to 14 grants); and (3) the Licensure Portability Grant Program (2 grants). It is expected that the proportion of diabetic patients enrolled in a Telehealth diabetes management program will be 30 percent by FY 2015 for the FY 2012-2015 cohort.

The request includes no funding for the Rural and Community Access to Emergency.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
27.1: Reduce the proportion of rural residents of all ages with limitation of activities caused by chronic conditions.[204] (Outcome) FY 2000: 14.67% (Baseline)	FY 2010: 14.2% Target: 13.9% (Target Not Met)	N/A	N/A	N/A
29.IV.A.3. Increase the number of people receiving direct services through ORHP Outreach grants. (Outcome)	FY 2012: 747,952 Target: 390,000 (Target Exceeded)	400,000	405,000	+5,000
27.2: Increase the proportion of critical access hospitals with positive operating margins. [205] (Outcome)	FY 1999: 10% Target: N/A (Baseline)	N/A	N/A	N/A

[204] This is a long-term measure with FY 2013 as a long-term target date. FY 2010 was an earlier long-term target date to be reported in FY 2012.
[205] This is a long-term measure with FY 2013 as a long-term target date.

Grants Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	360	360	338
Average Award	$348,559	$348,559	$348,121
Range of Awards	$69,387-$1,543,618	$69,387-$1,543,618	$69,387-$1,543,618

Rural Health Policy Development

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$9,252,000	$9,351,000	$9,351,000	---
FTE	1	1	1	---

Authorizing Legislation - Section 301 of the Public Health Service Act, Section 711 of the Social Security Act.

FY 2015 Authorization ..... Indefinite

Allocation Method ..... Competitive Grant

Program Description and Accomplishments

Rural Health Policy Development activities are a key component of the Federal Office of Rural Health Policy (ORHP) and support a range of policy analyses, research and information dissemination. The Office is charged in its authorizing language to advise the Secretary on how Departmental policies affect rural communities and to conduct research to inform its policy analysis activities. The Office is also charged with supporting information dissemination and the operation of a clearinghouse on national rural health initiatives.

The ORHP Rural Health Research Center program is a major component of Rural Health Policy Development activities. It is the only Federal research program specifically designed to provide both short- and longer-term policy relevant studies on rural health issues. There are currently seven funded rural health research centers. In the past, efforts to understand and appropriately address the health needs of rural Americans were severely limited by the lack of information about the rural population and the impact of Federal policies and regulations on the rural health care infrastructure. The work of the centers is published as Policy Briefs, and reports released via other venues, such as academic journals, and research papers made available to policy makers at both the Federal and State levels.

In addition to the Rural Health Research Center program, the Rural Health Policy Development Activities support three additional programs that focus on data and trend analysis on new and ongoing policy issues. These agreements are used to support data needs across the Department. Finally, Rural Health Policy Development Activities support dissemination activities of ORHP research and policy products.

Another major component of Rural Health Policy Development is the Office's work in staffing the National Advisory Committee on Rural Health and Human Services, which advises the Secretary on rural health and human service programs and policies and produces an annual report on critical rural issues for the Secretary.

Rural Health Policy Development also plays an important role in serving as a broker of information on rural health issues through a cooperative agreement with the Rural Assistance Center (RAC). In keeping with the statutory mandate, the Office established the RAC as a clearinghouse for anyone in need of rural health policy and program information. The RAC responds individually to hundreds of inquiries each month by both phone and e-mail and disseminates information through its web site and various reports and information guides on a range of key rural health issues.

In FY 2012, the Rural Health Policy Development efforts of ORHP produced 46 research reports, exceeding the target of 30 reports. This number includes policy briefs and full reports that were released on the Rural Health Research Gateway website as well documents that were published in peer-reviewed journals.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and Health Resources and Services Administration's (HRSA) electronic handbook, and follow-up performance reviews, and information technology costs.

Funding History

FY	Amount
FY 2011	$9,885,000
FY 2012	$9,866,000
FY 2013	$9,252,000
FY 2014	$9,351,000
FY 2015	$9,351,000

Budget Request

The FY 2015 Budget Request is $9,351,000. The FY 2015 Request is equal to the FY 2014 Enacted level. This request will support activities such as the Rural Health Research Center (RHRC) grant program as well as general technical assistance and information dissemination related to these issues. This program will support the production of 35 reports in FY 2015 as well as policy brief, manuals and other resources focusing on identifying best practices in rural communities.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Outcome)	FY 2012: 46 Target: 30 (Target Exceeded)	35	35	Maintain

Grants Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	13	13	13
Average Award	$603,719	$603,719	$603,719
Range of Awards	$120,000-$1,543,618	$120,000-$1,543,618	$120,000-$1,543,618

Rural Health Care Outreach Grants

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$52,093,000	$57,000,000	$57,000,000	---
FTE	2	2	2	---

Authorizing Legislation - Section 330A of the Public Health Service Act, as amended by Section 201, P.L. 107-251, as amended by Section 4, P.L. 110-355.

FY 2015 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Rural Health Care Services Outreach, Network and Quality Improvement Grants are a subcomponent of the Office of Rural Health Policy (ORHP). The purpose of the grants is to improve access to care, coordination of care, integration of services and to focus on quality improvement. The grants began as a demonstration program in 1993 and were formally authorized in 1996. There are multiple grant programs administered under this authority. All of the grants support collaborative models to deliver basic health care services to the 50 million Americans living in rural areas. The Outreach authority includes a range of programs designed to improve access to and coordination of health care services in rural communities. Five of these programs are part of HRSA's "Improve Rural Health Care Initiative" to strengthen the regional and local partnerships among rural health care providers, improve recruitment and retention of health care professionals in rural areas, and provide direct health care services. Grantees are required to demonstrate the impact of their program through outcome-focused measures. Grantees submit baseline data that is tracked throughout the project period, and implement a program that has been adapted from a promising practice or evidence-based model. The programs are innovative models that have been transitioned from a volume based system to a value based system; aligning with the new delivery system presented in the current healthcare landscape.

The programs are among the only non-categorical grants within HHS and that allows the grantees to determine the best way to meet local need. This flexibility in funding reflects the unique nature of health care challenges in rural communities and the need to allow communities to determine the best approach to addressing need. Each of the programs focus on making the initial investment in a rural area with the expectation that the community will continue to provide the services at the conclusion of the grant funding.

Sustainability continues to be a priority for the community-based programs. Since the grants are short-term programs, it is important that the emphasis of sustainability is focused on from year one. ORHP works in conjunction with the technical assistance provider and the grantee to help

them develop and implement a sustainability plan. The primary areas that are emphasized include leadership, organizational capacity and collaboration. Collaboration has been shown to be one of the most effective ways for a program to continue to provide services once federal funding has ended. ORHP community-based programs are required to develop a consortium or network of organizations that play a key role in helping the grant to sustain. Often times, the consortium or network provide resources (monetary, staffing, etc.) that help the program to sustain once federal funds have ended. In addition, in the network programs, studies show that network member fees are the primary way the grant sustains. Other ways the grants sustain include in-kind resources and third-party reimbursement.

Each year, different programs within the Outreach authority closes out and, therefore, sustainability is assessed on those respective programs. As a result, it should be expected that there may be significant variations in the results from one year to the next. The most recent cohort of community-based grantees that completed federal funding is the Small Health Care Provider Quality Improvement grant program. The FY 2012 results showed that 96 percent of the grantees will sustain either all or some of their programs, exceeding the target of 60 percent. The increase in sustainability can be attributed to increased technical assistance and emphasis around sustainability efforts.

In addition, ORHP has worked with The Lewin Group and The University of Washington Research Center to develop a generalizable formula which will allow rural communities to measure the economic impact their community investment makes. The tool will translate project specific impacts into community wide effects such as the number of jobs created, new spending and the impact of new and expanded services. The easy-to-use tool will assist rural programs in assessing their own performance and advocate for resources that contribute to the sustainability of programs and better health care for rural populations. A recent analysis of 59 Outreach grants, which completed the program in April, 2012, showed that for every HRSA dollar invested, approximately $1.50 was generated in the community.

Since 2004, ORHP has been working with the Center for Medicare and Medicaid Services (CMS) on two frontier demonstration: the Frontier Extended Stay Clinic (FESC) and the Frontier Community Health Integration Program (F-CHIP). The FESC demonstration is complete with a final evaluation report due in the coming year. The F-CHIP demonstration is in development, though the bulk of ORHP's work is complete. The Office supported initial information gathering and analysis to inform CMS in its development of the demonstration. ORHP is finishing up a pilot grant with some of the eligible hospitals that examines the use of community health workers to better manage chronic diseases. The evaluation for this program is expected to be complete in FY 2015.

ORHP's focus on the rural implications of health care reform and emerging demonstration and innovation activities will continue. In FYs 2012 - 2014, ORHP will support frontier and rural demonstrations through the Rural Health System Analysis and Technical Assistance (RHSATA) Cooperative Agreement, the purpose of which is to inform policy makers and rural health care providers about how changes in the health care delivery system may affect them, and to provide technical assistance to rural providers in identifying potential new approaches to health care delivery in their communities. The activity will continue to analyze lessons learned from the

FESC and F-CHIP demonstrations while also analyzing the viability of new and emerging care models such as accountable care organizations, shared savings and patient-centered medical homes for rural communities.

The Rural Health Care Services Outreach program legislation, as identified in the President's Budget through the "Improving Rural Health Care Initiative", includes five key programs:

Outreach Services Grants, which focus on improving access to care in rural communities through the work of community coalitions and partnerships. These grants often focus on disease prevention and health promotion but can also support expansion of services such as primary care, mental and behavioral health as well as oral health care services. This program is part of the 'Providing Direct Health Care Services' and 'Building an Evidence Base for Programs that Improve Rural Community Health' components of the "Improve Rural Health Care Initiative." In FY 2012, ORHP developed a new approach for the program, focused on demonstrating outcomes. Grantees were required to submit baseline data, which will be tracked throughout the project period, and also develop their program based on a promising practice or evidence-based model. The program will award 70 new grants in FY 2015.

Rural Network Development Grants, which support building regional or local partnerships among local hospitals, physician groups, long-term care facilities and public health agencies to improve management of scarce health care resources. This program is part of the 'Strengthening Rural Health Care Infrastructure' component of the "Improve Rural Health Care Initiative." The program expects to award 15 continuation awards in FY 2015. The approach will be geared towards demonstrating the health outcomes made by the network. In FY 2015, the program will also support 15 continuation grants for the Rural Health Information Technology (HIT) Workforce program, which involves increasing the number of qualified HIT professionals in rural communities.

Network Planning Grants Program, which began in 2004, provides funds to bring together key parts of a rural health care delivery system so they can work in concert to establish or improve local capacity and coordination of care. In addition, the program supports joint purchasing, bench-marking, and recruitment and retention efforts. This program is part of the 'Strengthening Rural Health Care Infrastructure' component of the "Improve Rural Health Care Initiative." The program will award approximately 15 new grants in FY 2015.

Small Health Care Provider Quality Improvement Grants, which began in 2006. These grants help to improve patient care and chronic disease outcomes by assisting rural primary care providers with the implementation of quality improvement initiatives using the Chronic Care Model and electronic patient registries. Specifically, the program focuses on addressing obesity, cardiovascular disease and diabetes given that rural residents tend to have higher rates of these diseases than their urban counterparts. In FY 2013, ORHP developed a new approach for the program so that it aligns with the current healthcare landscape. Grantees are required to have HIT implemented to track patient data, and are encouraged to explore other evidence-based models for patient self-management techniques. This program is part of the 'Improving the Quality of Health Care Services in Rural Areas' component of the "Improve Rural Health Care Initiative." The program expects to make 30 continuation awards in FY 2015.

The Delta States Network Grant Program, which began in 2001 and provides network development grants to the eight states in the Mississippi Delta for network and rural health infrastructure development. In addition, the program supports chronic disease management, oral health services, and recruitment and retention efforts. Unlike the programs mentioned above, this program is more geographically targeted given the health care disparities across this eight-state region. In FY 2013, ORHP developed a new approach for this program, focused on demonstrating outcomes. The program requires all grantees to support diabetes, cardiovascular disease and obesity, and to develop a program based on a promising practice or evidence-based model. The program will award 12 continuation grants in FY 2015.

Programs within the Rural Health Care Services Outreach Program authority provided either indirect or direct services for 2,451,969 individuals in FY 2009, which exceeded the target of 930,000. This was a substantial improvement from FY 2008 in which 828,360 individuals were served. This measure was revised in FY 2010 to examine the increase in the number of people receiving direct services through the ORHP Outreach grants. This measure focuses on only direct patient care such as screenings and treatment which is clearer, easier to interpret, easier to quantify, and, thus, more accurate. In FY 2010, 383,776 individuals were directly served, exceeding its target of 380,000. In FY 2011, 615,849 individuals were directly served, exceeding its target of 385,000. In FY 2012, 747,952 individuals were directly served, exceeding its target of 390,000. The increase in the number is a result of the Quality Program which had a dramatic increase for two reasons: 1) increased focus on the chronic care model and how to utilize it effectively which has led to an increased in the number of patients; and 2) the second year of the program is focused on seeing patients and conducting quality improvement activities with them.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2011	$55,658,000
FY 2012	$55,553,000
FY 2013	$52,093,000
FY 2014	$57,000,000
FY 2015	$57,000,000

Budget Request

The FY 2015 Budget Request is $57,000,000. The FY 2015 Request is equal to the FY 2014 Enacted level. This request will continue to support the five key activities for Rural Health Care Services Outreach, Network and Quality Improvement Grants Programs. In FY 2015, the program will support approximately 70 Outreach Services grants, 12 Delta grants, 15 Network

Development grants, 15 HIT Workforce grants, 30 Quality Improvement grants, and 15 Network Planning grants. ORHP expects that 405,000 people will receive direct services in FY 2015.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
29.IV.A.3. Increase the number of people receiving direct services through ORHP Outreach grants. [206] (Outcome)	FY 2012: 747,952 Target: 390,000 (Target Exceeded)	400,000	405,000	+5,000
29.IV.A.4: Percent of Outreach Authority grantees that will continue to offer services after the Federal grant funding ends.[207] (Outcome)	FY 2012: 96% Target: 60% (Target Exceeded)	60%	65%	+5% points

Grants Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	246	227	157
Average Award	$175,000	$175,000	$220,000
Range of Awards	$69,387-$350,000	$75,000-$350,000	$75,000-$350,000

[206] A new cohort of ORHP Outreach grants is awarded a 3-year project period. During the 1st year of the project period, the number of people receiving direct services through the ORHP Outreach grants tends to be lower due to program start up. The numbers generally increase throughout the project period as outreach efforts are implemented.

[207] The programs under the Outreach program authority have varying 3-year project periods. When sustainability data is captured at the end of a program project period, the result varies based on the program that closes out that particular project period.

Rural Access to Emergency Devices

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$2,340,000	$3,364,000	---	-$3,364,000
FTE	2	2	---	-2

Authorizing Legislation - Public Health Service Act, Section 313, and Section 413, P.L. 106-505 of the Public Health Improvement Act

FY 2015 Authorization – Rural Access to Emergency Devices.....Expired
FY 2015 Authorization – Public Access Defibrillation Demonstration.....Expired

Allocation Method.....Competitive Grants

Program Description and Accomplishments

The Rural Access to Emergency Devices (RAED) Grant Program began in 2002 and provides funds to community partnerships which then purchase and distribute automatic external defibrillators (AEDs) to be placed in rural communities. The grants also provide training in the use of AEDs by emergency first responders. For the first four years of this program, large grants were given to States through a competitive process and the States then worked with their rural communities to identify where to place the AEDs and how to conduct training in their use. In FY 2006, the program was restructured and began making direct grants to community partnerships.

In FY 2004, additional funding was allocated for the Public Access to Defibrillation Demonstration Projects (PADDP). The purpose of this program is to support grants to political subdivision of states, federally-recognized Native American Tribes, or Tribal Organizations to develop and implement innovative, comprehensive, community-based public access defibrillation demonstration projects. The intent of the grant program is to support projects that will increase public access to emergency medical devices and services.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and Health Resources and Services Administration's (HRSA) electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2011	$236,000
FY 2012	$1,100,000
FY 2013	$2,340,000
FY 2014	$3,364,000
FY 2015	---

Budget Request

There is no FY 2015 Budget Request for the Rural and Community Access to Emergency Devices program. The discontinuation of funding for this program reflects a reprioritization of these funds to other activities within the Office of Rural Health Policy. Activities related to access to emergency medical devices and training in FY 2015 may be addressed through other funding sources available to grantees, such as the Rural Outreach and Rural Network Development programs. Rural residents could use both of these program authorities to support projects that include the purchase of AEDs and training in their use. In FY 2009, the number of AEDs placed in rural communities was 681. In FY 2010, 1,000 AEDs were placed in rural communities. There were no awards made in FY 2011. In FY 2012, 182 AEDs were placed in rural communities. The decrease in AED placements is due to a decrease in the number of grantees over the years, from 19 grantees in FY 2009 to four grantees in FY 2012. Since the RAED Program was authorized in FY 2002, approximately $45,000,000 has been invested in rural communities to purchase, place and train providers to use AEDs.

Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	10	8	---
Average Award	$148,189	$100,000	---
Range of Awards	$98,944-$200,000	$63,000-$100,000	---

Rural Hospital Flexibility Grants

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$38,484,000	$40,609,000	$26,200,000	-$14,409,000
FTE	2	2	2	---

Authorizing Legislation - Social Security Act, Section 1820(j), as amended by sec. 4201(a), P.L. 105-33 and Section 405 (f), P.L. 108-173, as amended by Section 121, P.L. 110-275.

FY 2015 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Rural Hospital Flexibility activities are a component of the Office of Rural Health Policy (ORHP) and support a range of activities focusing primarily on Critical Access Hospitals (CAHs). There are two grant programs administered under this authority. These grant programs are also a part the "Improve Rural Health Care Initiative" to strengthen the regional and local partnerships among rural health care providers.

The Medicare Rural Hospital Flexibility (Flex) Grant Program targets funding to over 1,300 critical access hospitals in 45 states. The re-authorization of the Flex Program in 2008 took into account that most conversions of hospitals to critical access hospital status have taken place. The new focus of the program includes providing support for CAHs for quality improvement, quality reporting, performance improvements and benchmarking. This program is part of the Improving the Quality of Health Care Services in Rural Areas' component of the "Improve Rural Health Care Initiative." The Flex Program targets performance improvement and quality improvement activities within the CAH and the community through technical assistance and some direct support to hospitals.

In the past 13 years, the Flex Program and CAH designation has been instrumental in strengthening the infrastructure of these small rural hospitals, as evidenced in the trend of the operating margins improving from operating margins in negative double digits to close to zero. Economic viability is important in ensuring continued access to care, but quality improvement is now just as important. CAHs are not required to report to the Centers for Medicare and Medicaid Hospital Compare quality measures, but are encouraged to do so. The Flex Program includes a benchmarking and quality improvement project this grant cycle, expanding on the existing efforts to increase the percent of CAHs reporting on at least one measure to Hospital Compare, and making quality improvements around the measures reported.

The second program is the Flex Rural Veterans Health Access Program which began in 2010. This three-year program provides grants to three states with high percentage of veterans compared to the total population and focuses on increasing the delivery of mental health services or other health care services deemed necessary to meet the needs of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in rural areas. The program is targeting increased access for veterans through investments in telehealth and electronic health records for both access to needed services and continuity of care for veterans in rural communities. The first cohort of this program supported grantees in Alaska, Montana and Virginia from 2010 – 2013. A second cohort consisting of three grantees will be funded in September 2013 for another three-year project period.

Given the larger trends in health care, the Flex Program provides essential support to CAHs and help to prepare them to successfully navigate a future that will emphasize pay for performance and value based purchasing, while improving outcomes and managing growth in health care spending.

	FY 2013 Final	**FY 2014 Enacted**	**FY 2015 President's Budget**
Rural Hospital Flexibility (Flex) Grant Program	$22,644,000	$24,667,000	$25,200,000
Small Hospital Improvement Program (SHIP)	$14,840,000	$14,942,000	---
Flex Rural Veterans Health Access Program	$1,000,000	$1,000,000	$1,000,000

The Flex performance measures reflect efforts to increase CAH participation in reporting at least one measure to CMS's Hospital Compare. The data posted on the Hospital Compare Website is a key part of the Department's ongoing efforts to increase transparency in the health care system by measuring all hospitals. The FY 2006 baseline for this measure is 63.14 percent of CAHs voluntarily reporting at least one measure to Hospital Compare. Since FY 2006, there has been a steady progression each year of CAHs reporting at least one measure: 69 percent in FY 2007; 70 percent in FY 2008; 70.3 percent in FY 2009; 72.6 percent for FY 2010; and 79.7 percent in FY 2011.

Emergency medical services (EMS) are also an important part of the Flex Program and help to support quality and viability of rural communities across the continuum of care. The number of individuals trained in EMS leadership and/or trauma courses declined from 3,613 in FY 2008 to 3,002 in FY 2009. In FY 2010, 2,996 individuals were trained; and in FY 2011, 2,368 individuals were trained, not meeting its target. With the new focus on quality and performance improvement initiatives, the EMS components of the Flex program have moved from strict

investments in training to strategies linking EMS within the larger community for improved quality and performance.

Additionally, the Flex program has made programs on the work to get critical access hospitals to voluntarily participate in the HCAHPs patient satisfaction surveys. Participation has increased from the baseline in FY 2010 of 38 percent to 41.3 percent in FY 2011; with efforts in the past year get even greater involvement by hospitals.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and Health Resources and Services Administration's (HRSA) electronic handbook, follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2011	$41,118,000
FY 2012	$41,040,000
FY 2013	$38,484,000
FY 2014	$40,609,000
FY 2015	$26,200,000

Budget Request

The FY 2015 Budget Request is $26,200,000. The FY 2015 Request is $14,409,000 below the FY 2014 Enacted level. This request will continue to support 45 Flex grant programs to support critical access hospitals and 3 grants to support rural veterans. The FY 2015 request allows core activities to be targeted to the area of greatest need with a focused on Critical Access Hospitals (CAHs), the nation's smallest hospitals. CAHs will continue to receive support through the Flex grant with a focus on enhancing quality and patient outcomes as well as improving financial viability so that these hospitals can continue to ensure access to care for isolated Medicare beneficiaries. The activities supported through this funding will encourage hospitals to report quality data to Hospital Compare (FY 2015 target: 90 percent), engage in patient satisfaction surveys for quality and operational improvement (FY 2015 target: 70 percent), and to invest grant dollars in Emergency Medical Services (EMS) training and trauma system development (FY 2015 target: 2,995). The program will award 48 grants in FY 2015. Support for the Rural Veterans Health Access Program will allow for continued efforts to increase access for rural veterans to needed services. This program will support three grants in FY 2015.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
30.V.B.4: Increase the percent of Critical Access Hospitals reporting at least one measure to Hospital Compare. (Outcome)	FY 2011: 79.7% Target: 74% (Target Exceeded)	85%	90%	+5% points
30.V.B.5: Number of individuals trained in emergency medical services leadership and/or trauma courses. (Outcome)	FY 2011: 2,368 Target: 3,615 (Target Not Met)	2,995	2,995	Maintain
30.V.B.6: Increase the percent of Critical Access Hospitals participating in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey	FY 2011: 41.3% (Target Not in Place)	60%	70%	+10% points

Grants Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	48	48	48
Average Award	$490,000	$490,000	$550,000
Range of Awards	$256,000-$640,000	$256,000-$640,000	$300,000-$750,000

State Offices of Rural Health

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$9,411,000	$9,511,000	$9,511,000	---
FTE	---	1	1	---

Authorizing Legislation - Section 338J of the Public Health Service Act as amended by Section 301, P.L. 105-392.

FY 2015 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The State Offices of Rural Health (SORH) Grant Program is a key component of the Office of Rural Health Policy (ORHP). The SORH Program was created in 1992 to support rural health care in each of the 50 states by providing grants to states to establish and maintain SORHs. The grantees collect and disseminate health-related information in rural areas. They also provide technical and other assistance to rural health providers, including small rural hospitals. SORHs also help communities recruit and retain health professionals. Each dollar of Federal support for the program is matched by three state dollars. The SORH Program is part of the "Improve Rural Health Care Initiative" to strengthen the regional and local partnerships among rural health care providers and improve recruitment and retention of health care professionals in rural areas and falls under the Improve the Recruitment and Retention of Health Care Providers in Rural Areas component of the Initiative.

Two of the SORH measures reflect the technical assistance activities and focus on the number of technical assistance encounters provided directly to clients by SORHs as well as the number of clients (unduplicated) that receive technical assistance directly from SORHs. The number of technical assistance encounters provided directly to clients has continuously increased over the past few years: FY 2008-62,296[208]; FY 2009-63,701[2]; FY 2010-78,075[3]; and FY 2011-86,140. The number of technical assistance encounters for FY 2012 slightly decreased at 85,600; however, the target was exceeded. The number of clients receiving technical assistance directly; however, has varied, from 27,161[4] in FY 2008, decreasing in FY 2009 to 26,552[5], another decline in FY 2010 to 22,187[6], with increases to 25,441 in FY 2011 and 28,496 in FY 2012. Although there was a significant increase, the FY 2012 result did not meet the target. The third measure reflects the work facilitated by the SORHs through recruitment initiatives in the number of clinician placements. The FY 2008 baseline for this measure is 1,023 and the FY 2011 result is 1,767. This year we are working to improve the collection of information on the clinician

[208,2,3,4,5,6] These results differ from those shown in the FY 2013 Congressional Justification. They have been adjusted to reflect the accurate count of clients served based on updated information.

placements in rural areas. The SORHs have been instrumental in helping rural constituents to meet the challenges through sharing information and providing technical assistance around the changing environment that rural health providers face, both with the passage of meaningful use requirements under the American Recovery and Reinvestment Act and the Affordable Care Act.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2011	$10,005,000
FY 2012	$10,036,000
FY 2013	$9,411,000
FY 2014	$9,511,000
FY 2015	$9,511,000

Budget Request

The FY 2015 Budget Request is $9,511,000. The FY 2015 Request is equal to the FY 2014 Enacted level. This request will continue to support key activities for the State Offices of Rural Health Program and will support a grant award to each of the 50 states. The SORH program anticipates that it will provide 68,277 technical assistance encounters directly to clients in FY 2015. The program also expects that 22,632 clients will receive technical assistance directly from SORHs. Additionally, the program hopes to facilitate 1,260 clinician placements in FY 2015.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. (Outcome)	FY 2012: 85,600 Target: 66,269 (Target Exceeded)	67,601	68,277	+676
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs.	FY 2012: 28,496 Target: 30,826 (Target Not Met)	22,408	22,632	+224

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
(Outcome)				
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment initiatives. (Outcome)	FY 2011: 1,767 Target: 1,043 (Target Exceeded)	1,260	1,260	Maintain

Grants Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	50	50	50
Average Award	$178,000	$178,000	$178,000
Range of Awards	$160,000-$180,000	$160,000-$180,000	$160,000-$180,000

Radiation Exposure Screening and Education Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$1,815,000	$1,834,000	$1,834,000	---
FTE	1	1	1	---

Authorizing Legislation - Section 417C of the Public Health Service Act, as amended by Section 4, P.L. 106-245, as further amended by Section 103 and Section 104, P.L. 109-482.

FY 2015 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Radiation Exposure Screening and Education Program (RESEP), which began in 2002, 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.

The program measures the total number of individuals screened at RESEP centers each year and maintained the number of users over the past few years - FY 2010 (1,371), FY 2011 (1,366) and FY 2012 (1,567). Results in recent years were somewhat lower than the targets due to the rapidly aging former uranium mine worker population, in which potential patients have passed away as well as the relocation of this population from the original mining sites. However, current results are slightly higher due to increased outreach efforts in the community and collaboration with local organizations to expand screenings. The program partners with the Department of Justice to collect data in support of this measure and has adopted steps to ensure that grantees comply with uniform screening guidelines. In addition, the program has undertaken new outreach strategies to identify where this patient population has relocated and to make them aware of available screening sites.

The program also measures the average cost of the program per individual screened at RESEP Centers. These costs include all education and outreach efforts as well as the costs of the screening exams. In addition, the total number of individuals screened at RESEP centers each year greatly impacts the results for this measure. The results have shown higher costs in FY 2010 ($1,251) and FY 2011 ($1,093) than its targets; however, costs were lower in FY 2012 ($956), meeting the target.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2011	$1,939,000
FY 2012	$1,935,000
FY 2013	$1,815,000
FY 2014	$1,834,000
FY 2015	$1,834,000

Budget Request

The FY 2015 Budget Request is $1,834,000. The FY 2015 Request is equal to the FY 2014 Enacted level. This request will continue to support key activities for Radiation Exposure Screening and Education Program. The program will continue to support eight grantees in FY 2015, and the target for the number of individuals screened is 1,366.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
32.1: Percent of RECA successful claimants screened at RESEP centers.) [209] (Outcome)	FY 2008: 8.5% Target: N/A (3-year rolling baseline)	N/A	N/A	N/A
32.2: Percent of patients screened at RESEP clinics who file RECA claims that receive RECA benefits. [210] (Outcome)	FY 2008: 70% Target: N/A (Baseline)	N/A	N/A	N/A
32.I.A.1: Total number of individuals screened per year. (Output)	FY 2012: 1,567 Target: 1,400 (Target Exceeded)	1,400	1,366	-34

[209] This is a long-term measure with FY 2013 as a long-term target date.
[210] This is a long-term measure with FY 2013 as a long-term target date.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
32.E: Average cost of the program per individual screened (Efficiency)	FY 2012: $956 Target: $1,397 (Target Met)	$1,251	$1,093	$158

Grants Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	8	8	8
Average Award	$235,827	$235,827	$235,827
Range of Awards	$180,000-$279,000	$180,000-$279,000	$180,000-$279,000

Black Lung

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$6,695,000	$6,766,000	$6,766,000	---
FTE	---	---	---	---

Authorizing Legislation - Federal Mine, Health, and Safety Act of 1977, Section 427(a), P.L. 91-173 as amended by Section 5(6), P.L. 92-303 amended by Section 9, P.L. 95-239, as further amended by CFR Part 55A.

FY 2015 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Black Lung Program was established in 1980 and provides funds through project grants to public and private entities, including faith-based and community-based organizations, for the purpose of establishing and operating clinics that provide for the outreach and education, diagnosis, treatment, rehabilitation, and benefits counseling of active and retired coal miners and others with occupation-related respiratory and pulmonary impairments. Other patients include steel mill workers, agricultural workers, and others with occupationally-related respiratory and pulmonary disease. As persons with respiratory and pulmonary disease age, their disease severity progresses and their need for health care services increase along with the cost of those services.

In FY 2012, the program supported services to 12,586 miners, which fell below the target of 12,836 miners. The program also provided 19,880 medical encounters in FY 2012, which was below its target of 26,403. The decrease in miners served and medical encounters may be explained by staff turnover, leading to reduced clinical hours and outreach efforts. Several clinics also experienced challenges upgrading their electronic health record systems and incorporating telehealth into clinic activities, which ultimately had an impact on services to miners. The number of encounters per million dollars in Federal funding in FY 2012 was 8,514 which exceeded the target of 4,272. Data collected from the grantees shows that the cost per encounter per miner has increased in the last year, suggesting that the clinics are seeing miners with more significant medical issues.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2011	$7,153,000
FY 2012	$7,140,000
FY 2013	$6,695,000
FY 2014	$6,766,000
FY 2015	$6,766,000

Budget Request

The FY 2015 Budget Request is $6,766,000. The FY 2015 Request is equal to the FY 2014 Enacted level. This request will continue to support key activities for the Black Lung Program. The program expects to fund up to 15 awards in FY 2015 and meet the target of 13,000 miners served. In addition, the program expects to reach the target of 16,500 medical encounters in FY 2015.

Recent information from the Centers for Disease Control National Institute of Occupational Safety and Health (CDC/NIOSH) indicates that the prevalence of coal workers' pneumoconiosis (CWP), also known as black lung disease, is rising. In fact, a recent study of 2,000 coal miners from Utah to Pennsylvania showed five times as many miners have CWP than 10 years ago. Many miners are developing severe CWP before 50 years of age, and there is some evidence that this is being manifested as premature mortality. In addition, data from the U.S. Department of Labor show the number of federal black lung benefits claims has increased, suggesting that the disease is also leading to increased significant, long-term disability. ORHP plans to continue consulting with providers, experts, and federal partners in FY 2013 to thoroughly reassess the priorities and scope of the program, while taking into account regulatory requirements. It will also provide an opportunity to ensure funding levels as well as program resources are most effectively coordinated with other Federal efforts to address growing target population needs. This new approach will be implemented for the FY 2014 competitive cycle.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
33.I.A.1: Number of miners served each year. (Output)	FY 2012: 12,586 Target: 12,836 (Target Not Met)	12,840	13,000	+160
33.I.A.2: Number of medical encounters from Black Lung each year. (Output)	FY 2012: 19,880 Target: 26,403 (Target Not Met)	18,129	16,500	-1,629

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
33.E: Increase the number of medical encounters per $1 million in federal funding. (Efficiency)	FY 2012: 8,514 Target: 4,272 (Target Exceeded)	10,374	9,550	-824

Grants Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Final	FY 2015 President's Budget
Number of Awards	15	15	15
Average Award	$439,625	$381,562	$381,562
Range of Awards	$139,154 to 1,424,368	$116,742-$697,740	$116,742-$697,740

Telehealth

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$10,786,000	$13,900,000	$13,900,000	---
FTE	---	1	1	---

Authorizing Legislation: Section 330I of the Public Health Service Act; as amended by Public Law 107-251, as further amended by Public Law 108-163.

FY 2015 Authorization ..... Expired

Allocation Method ..... Competitive Grants/Cooperative Agreements and Contracts

Program Description and Accomplishments

The Office for the Advancement of Telehealth (OAT) administers three grant programs that support telehealth technologies:

- Telehealth Network Grant Program (TNGP), which includes funding projects that demonstrate the use of telehealth networks to improve healthcare services for medically underserved populations in rural and frontier communities. More specifically, the networks can be used to: (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. The primary objective of the TNGP is to help communities build the human, technical, and financial capacity to develop sustainable telehealth programs and networks.

- Telehealth Resource Center Grant Program (TRCGP), which provides technical assistance to communities wishing to establish telehealth services.

- Licensure Portability Grant Program (LPGP), which provides support for State professional licensing boards to carry out programs under which licensing boards cooperate to develop and implement State policies that will reduce statutory and regulatory barriers to telemedicine.

As of FY 2011[211], this cohort of TNGP grantees provided a total number of 151 clinical services, across 1155 sites in underserved rural communities for a total of 1,306 sites and services. When added to the FY 2008 baseline of 1,295, TNGP grantees supported 2,601 sites and services in these communities since FY 2005, exceeding the target for FY 2011. As a result, a gradual expansion of sites and/or services is evident across the three year project period (FY 2009-2012).

[211] OAT program's next set of results for FY 2012 will be available in March 2014.

In FY 2011, 310 communities had access to pediatric services and 304 communities had access to adult mental health services for which they otherwise would not have had access in the absence of the TNGP grants. Between FY 2010 and FY 2011, these results show a relative stability since new project period began in FY 2009.

In FY 2006, the Program began to collect data on a long-term measure to assess the program's impact on clinical outcomes in diabetic patients served by the grantees of the TNGP program, targeting control of hemoglobin A1c levels in patients. Since then, ideal glycemic control has been gradually achieved. As part of the FY 2009- FY 2012 cohort, 32 percent were able to achieve ideal glycemic control compared to a target of 21 percent in FY 2010. In FY 2011, 45 percent achieved ideal glycemic control, highlighting a continual upward trend.

The OAT Programs are an integral component of the "Improve Rural Health Care Initiative" to expand the use of telecommunications technologies that increase the access to and quality of health care provided to rural populations. The Telehealth Programs strengthen partnerships among rural health care providers, recruit and retain rural health care professionals, and modernize the health care infrastructure in rural areas. In FY 2012, HRSA supported networks in rural underserved communities that are experiencing severe shortages of health care professionals.

In FY 2013, OAT awarded a total of 26 telehealth network grants, 14 Telehealth Resource Center Grants, and two Licensure Portability Grant Program grants.

Table 1. Actual Grant Dollars to be awarded for grants

	FY 2013 Final	**FY 2014 Enacted**	**FY 2015 President's Budget**
Telehealth Network Grant Program	$4,909,383	$7,299,383	$7,299,383
Licensure Portability Grant Program	$700,000	$700,000	$700,000
Telehealth Resource Center Grant Program	$4,497,454	$5,147,454	$5,147,454
Contracts	$5,000	$5,000	$5,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and Health Resources and Services Administration's (HRSA) electronic handbook, and follow-up performance reviews, and Information Technology costs.

Funding History

FY	Amount
FY 2011	$11,524,000
FY 2012	$11,502,000
FY 2013	$10,786,000
FY 2014	$13,900,000
FY 2015	$13,900,000

Budget Request

The FY 2015 Budget Request is $13,900,000. The FY 2015 Level is equal to the FY 2014 Enacted level. The FY 2015 Budget Request will support: (1) TNGP grantees (20 grants); (2) TRCGP grantees (up to 14 grants); and (3) The Licensure Portability Grant Program (two grants). Through these programs, OAT hopes to increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program to 30 percent in FY 2015 (for the FY 2012-2015 cohort). Additionally, OAT anticipates that 315 communities will have access to adult mental health services and 320 communities will have access to pediatric and adolescent mental health services by FY 2015.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
34.II.A.1: Increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program with ideal glycemic control (defined as hemoglobin A1c at or below 7%). (Outcome)	FY 2011: 45% Target: 42% (Target Exceeded)	30%	30%	Maintain
34.1: The percent of TNGP grantees that continue to offer services after the	FY 2005: 100% (Baseline) Target: N/A (Target Not In Place)	N/A	N/A	Maintain

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
TNGP funding has ended. [212](Outcome)				
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. [213] (Outcome)	FY 2011: 2,601 Target: 2,537 (Target Exceeded)	2,579	2,675	+96
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. (Outcome)	FY 2011: 310 Target: 219 (Target Exceeded)	239	320	+81
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. (Outcome)	FY 2011: 304 Target: 186 (Target Exceeded)	204	315	+111

[212] This is a long-term measure with FY 2013 as a long-term target date.

[213] Please note: Because this is a demonstration program, every three years each cohort of TNGP grantees "graduates" from its three-year grant while a new cohort of grantees commences a new three-year cycle of grant-supported Telehealth activities. The data are calculated as a cumulative number. However, with each new cohort, the distribution of these services is uncertain. Therefore, the targets for FY 2015 may need to be revised if there is evidence of a significant increase in grantees that are providing mental health services.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
34.E: Expand the number of services and/ or sites provide access to health care as a result of the TNGP program per Federal program dollars expended.[214] (Efficiency)	FY 2011: 201 per Million $ Target: 199 per Million $ (Target Exceeded)	203 per Million $	204 per Million $	+1

Grants Awards Table
Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	36	42	42
Average Award	$280,745	$280,745	$280,745
Range of Awards	$250,000-$325,000	$250,000-$325,000	$250,000-$325,000

[214] This measure provides the number of sites and services made available to people who otherwise would not have access to them per million dollars of program funds spent. Every three years a new cohort of grantee commences.

Program Management

TAB

OTHER PROGRAMS

Program Management

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$151,450,000	$153,061,000	$157,061,000	+$4,000,000
FTE	867	867	867	---

Authorizing Legislation: Section 301 of the Public Health Service Act.

FY 2015 Authorization……...……Indefinite

Allocation Method……....Other

Program Description and Accomplishments

HRSA's Program Management activity operates programs budgeted in FY 2015 at more than $9 billion. HRSA's mission is to provide the National leadership, resources and services necessary to improve and expand access to quality healthcare for all Americans. To achieve its mission, HRSA requires qualified staff to operate at maximum efficiency. Program Management activity is the primary means of support for FTEs and overhead expenses such as rent, utilities and miscellaneous charges.

Program Management personnel plan, coordinate, and direct technical assistance and program guidance to clients of all of HRSA's authorized programs.

In addition, Program Management supports agency oversight of a broad variety of program operations funded from other sources, which include:

- National Practitioner Data Bank;
- Health Education Assistance Loan Program; and
- Vaccine Injury Compensation Program.

Significant progress has been made in a range of Program Management activities. The cybersecurity efforts to continuously improve and secure the Information Technology infrastructure include improving the perimeter protection through implementation of additional cybersecurity tools that provide HRSA with a state of the art Intrusion Detection System. This is happening while simultaneously reducing physical servers as part of ongoing virtualization and consolidation initiative.

HRSA has continued to mature the IT Investment governance and management processes through the continued implementation of the HRSA Enterprise Architecture and Capital Planning and Investment Control (CPIC) processes and the more recent implementation of an Enterprise Performance Life Cycle (EPLC) Framework. HRSA fully supports the Federal Information Technology Shared Services Strategy by consuming more than 35 shared services offered by other HHS Operating Divisions. By doing so, HRSA is able to drive down operating costs in support and commodity areas, improve return on investment and eliminate waste and duplication.

Funding for Program Management includes IT funding for the continued development, operations and maintenance of enterprise functionality of the HRSA Electronic Handbooks (EHBs). The EHBs is an IT Investment that supports the strategic and performance outcomes of the HRSA Programs and contributes to their success by providing a mechanism for sharing data and conducting business in a more efficient manner, while improving program integrity. The EHBs supports HRSA with program administration, grants administration and monitoring, management reporting, and performance measurement and analysis.

The HRSA Data Warehouse is the official repository for current HRSA data and promotes maximum operating efficiency through centralization, reconciliation, and standardization of data across HRSA's various transactional business systems. The Data Warehouse supports the Shared Services Strategy and is offered as a Shared Service to other HHS Operating Divisions. The Data Warehouse cleanses and standardizes data, applies established business rules to validate the data, and enriches and expands the data available from the sources. The Data Warehouse promotes "Open Data" by providing HRSA and the general public with a single source of HRSA programmatic information, related health resources, demographic, and statistical data for analyzing and reporting on HRSA activities with easily accessible, readily-available pre-designed tools, charts, maps, and reports. In FY 2013, the Data Warehouse released a mobile optimized customer-facing service.

Program Management also supports program integrity activities. Program Management intends to align HRSA's program integrity, performance, and strategic planning activities with the intent of reducing programmatic risk and improving performance. Through enhanced oversight of grant and contract recipients and other program integrity efforts, performance outcomes will improve and improper payments will be reduced.

Funding History

FY	Amount
FY 2011	$161,815,000
FY 2012	$159,894,000
FY 2013	$151,450,000
FY 2014	$153,061,000
FY 2015	$157,061,000

Budget Request

The FY 2015 Budget Request of $157,061,000 is an increase of $4,000,000 over the FY 2014 Enacted level. This increase will support a new consolidated facility that will improve efficiency over time.

HRSA is committed to improving the quality of output at a lower cost and improving the speed of government operations. HRSA is working towards its goal to reduce the IT network infrastructure and data center footprint by twenty percent. In addition, HRSA is reducing travel costs and supporting telework participation by increasing the agency-wide utilization of web collaboration tools by twenty- five percent, which will lead to greater business productivity.

HRSA has multiple data sets that reflect grantee performance, organizational dimensions, financial indicators, and grant compliance, that are not integrated and available for analytical purposes without a lot of manual effort. The data sets often reside in different systems. In addition, HRSA has a need to also train and develop staff in the use of data to guide their grants monitoring activities. The goal is that HRSA will be able to identify potential issues in the pre and post-award process and can therefore address the issues before they become audit finding. HRSA will be able to develop performance metrics based on historic audit findings and use this information to reduce the number of grantee audit issues and improve program performance.

<u>Planned use of program integrity funds:</u>

- Develop Statement of Work for contract support to conduct independent analysis, and then study and propose recommendations for solutions, and build an analytical tool using HRSA's electronic grants system, program data, Office of Federal Assistance Management data sources, HHS sources, and government-wide sources;

- Purchase training classes for OFAM staff on performing data analytics and classes in internal controls;

- Purchase training classes for Program staff on performance measure data analysis along with financial indicators;

- Develop virtual webinars specifically for HRSA grantees providing training on the top ten financial integrity challenges they face;

- Develop a new audit resolution module designed to electronically capture all of the A-133, OIG and OFAM audit information to retrieve audit related data that we would then be able to report on and do proactive reviews;

- Develop a new Financial Assessment functionality to allow us to search on the financial assessment data elements and be able to data mine on the financial assessment information for the Program Integrity Initiative;

- Pay the necessary fees to access the advanced search areas of Guidestar (financial data provider) and provide HRSA with the capability to mine data using the information;

- Undertake a broad technical assistance approach (not program by program) targeting all partners in the territory (community, local, hospitals, community health centers and other major organizations funded with HHS support;

- Establish systems for identifying high risk organizations for increased scrutiny.

HRSA's Office of Federal Assistance Management can fully use the ocean of data already available concerning our grantees, and can then ensure that without adding any additional burden on the grantee we fully use this information to monitor both compliance and performance. Also, building new and better data tools is only part of the answer. There has to be a focused and effective training effort to ensure that the agency has the internal capacity to digest and analyze data and then take appropriate actions on this information. By using the tools and data, HRSA can focus on a risk-based approach to grantee monitoring using the information and corresponding analysis to help staff spend their time on those grantees that show clear signs of the need for extra attention. Finally, this will enhance the capacity of HRSA grantees to be aware of, and avoid potential financial integrity challenges.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
35.VII.B.1.: Ensure Critical Infrastructure Protection: Security Awareness Training (Output)	FY 2013: Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security 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 role-based training for 100% of HRSA staff identified to have significant security and privacy responsibilities.	Full participation in Security and Privacy Awareness training by 100% of HRSA staff. Specialized role-based training for 100% of HRSA staff identified to have significant security and privacy responsibilities.	Maintain
35.VII.B.2: Ensure Critical Infrastructure Protection: Security Authorization to Operate (Output)	FY 2013: 100% of HRSA information systems have been Certified and Accredited and granted Authority to Operate. (ATO). (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
35.VII.B.3: Capital Planning and	FY 2013: 1) 100% of major investments received an IT	1) 100% of major investments will receive an IT	1) 100% of major investments will receive an IT	Maintain ___

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
Investment Control (Output)	Dashboard Overall Rating of "Green", which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers are in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM). (Target Met)	Dashboard Overall Rating of "Green", which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	Dashboard Overall Rating of "Green", which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	
35.VII.A.3: Strengthen Program Integrity (PI) Activities	FY 2013: (1) Reached staffing of 17 PI analysts (regions and HQ) to increase auditing/site visit capability. (2) HRSA PI Workgroup implemented and fully deployed two sections of the online PI toolkit. (Target Met)	1) Reach staffing of 20 PI analysts. 2) Operate and maintain PI toolkit and consider further expansion as needed.	1) Increase staffing to 22 analysts. 2) Operate and maintain PI toolkit and consider further expansion as needed.	1) + 2 PI analysts 2) Maintain

Family Planning

Tab

Family Planning

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$278,349,000	$286,479,000	$286,479,000	---
FTE	33	33	33	---

Authorizing Legislation: Title X of the Public Health Service Act
FY 2015 Authorization…….Indefinite
Allocation Method ..... Competitive Grant, Contract, Direct

Program Description and Accomplishments

The Title X Family Planning Program is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. Enacted in 1970 as part of the Public Health Service Act, the Title X Program is designed to provide access to contraceptive services, supplies and information to all who want and need them. By law, priority is given to persons from low-income families.

The public health value of family planning services is well documented. Cited by the CDC in 1999 as one of the greatest public health achievements of the 20th century, family planning services have been used by millions of individuals in the United States and around the world. In this spirit, the Title X Family Planning Program is committed to the delivery of high-quality family planning and reproductive health services to all women and men who want them. Guided by nationally recognized standards of care, all Title X funded family planning centers provide contraceptive methods, education and counseling, as well as related preventive health services to their clients.

The Title X Program has greatly contributed to decreasing unintended pregnancy among women and families, as well as significantly reducing unintended pregnancy rates among teens and young adults. According to the most recent data (CY 2012), of the more than 4.7 million individuals served in Title X clinics, approximately 20 percent were under 20 years of age and more than 2.23 million (51 percent) were in their 20s (2012 Family Planning Annual Report (FPAR)). By providing comprehensive family planning and related reproductive and preventive health services (e.g., STD and HIV prevention, education and screening), unintended pregnancy, infertility and related morbidity have been reduced for these populations.

In order to ensure that the Title X family planning program is responsive to the ever-changing needs of clients, and is adhering to the letter and spirit of the statute, the program commissioned a two-year independent evaluation by the Institute of Medicine (IOM), completed in May 2009.

Among the findings from the evaluation, it was noted that the Title X program is extremely resilient and valuable, especially in providing family planning services to its priority population – individuals from low-income families.

The Title X Program fulfills its mission through the award of competitive grants to public and private nonprofit organizations to support the provision of family planning services, information, and education. According to 2012 FPAR data, services were provided through 93 family planning service grants that support a nationwide network of 4,189 community-based sites that provide clinical and educational services to more than 4,700,000 persons annually. Grantees include state and local health departments, hospitals, community health centers, universities, Planned Parenthood centers, and other private nonprofit agencies. There is at least one Title X services grantee in every state and U.S. territory, including Pacific jurisdictions. Title X family planning program regulations require that projects provide a broad range of effective and acceptable family planning methods and related preventive health services.

A 2011 Guttmacher Institute publication indicated that for more than half of clients seen in publicly-funded family planning clinics, such as Title X, clients reported that the site was their "usual" or only continuing source of health care and/or health education. Historically, 90 percent of the clients served each year in Title X-funded sites have family incomes at or below 200 percent of the federal poverty level.

In addition to clinical services, the Title X Family Planning Program also supports three key functions aimed at assisting clinics in responding to clients' needs: (1) training for all levels of family planning agency personnel through a national training program; (2) information dissemination and community-based education and outreach activities; and (3) data collection and research to improve the delivery of family planning services. Each year the program establishes a set of program-wide priorities that provide guidance to grantees in an effort to ensure high-quality, responsive and appropriate family planning service delivery. In the past several years, the priorities have focused on building the program's capacity to address needs of clients and sustainability of the family planning network. Program priorities have stressed the need to expand access to a broad range of effective and acceptable family planning methods, including Long-Acting Reversible Contraceptives (LARCs).

Broader access to highly effective but relatively expensive methods of contraception has been recognized as a key strategy to reducing unplanned pregnancies. At the same time, clinics have been expected to provide a broader array of primary care services related to preventing unintended pregnancies or achieving health pregnancies. As a result, the ability of some providers to address the increasingly complex needs of clients served by Title X family planning centers has created added stress to the program. Since FY 2007, the program has focused on improving clinic efficiency in an effort to address the increasing cost of health care without sacrificing quality. Establishing clinic efficiency as a national training priority led to region-specific plans to address clinic efficiency through quality assurance/continuous quality improvement efforts and emphasis on implementing appropriate staffing patterns, purchasing strategies and other cost saving measures. These strategies and best practices were compiled in a national training compendium of clinic efficiency efforts with a focus on the best methods to address client needs and mitigate the effects of medical cost increases and have been made

available to providers and training centers to assist them with efficiency efforts. In FY 2013, the Family Planning National Training Center for Quality Assurance, Quality Improvement and Evaluation implemented a pilot program, directed at providing training and other resources to improve clinic efficiency. The results of this pilot are due in the spring of 2014, and it is anticipated that a broader roll-out of this program will begin shortly after.

In 2012, the most recent year for which final data are available, the program accomplished the following: Served over 4,763,000 clients, helping to avert an estimated 911,000 unintended pregnancies, approximately 178,000 of which were among teens. In addition, service sites provided approximately 1.25 million Chlamydia tests for15–24 year old females, preventing an estimated 1,472 cases of STD-related infertility. Targets were exceeded for the number of screenings for Chlamydia infection in females ages 15–24. This increase is most likely the result of increased adherence to CDC and other nationally recognized standards of care regarding screening for Chlamydia infection among females in this age group. Between 2011 and 2012, the number of total clients decreased 5.1 percent. This decrease was partly due to a decrease in funding, though significant policy changes at the state level, especially in states with large numbers of Title X clients, was a major driver in the overall decrease in clients. The decrease in overall clients, specifically female clients, resulted in the number of unintended pregnancies averted also decreasing.

Cervical cancer screenings also declined. While at first glance this may seem problematic, it likely reflects adherence to new recommendations from nationally recognized organizations such as the American College of Obstetricians and Gynecologists (ACOG), American Cancer Society (ACS), and US Preventive Services Task Force (USPSTF). These revised standards of care recommend that screening be initiated later in life and, for most women, performed less frequently. Currently, these organizations recommend that cervical cancer screening begin at age 21, and between ages 21–65, be performed every three years (beginning at age 30, in place of traditional cytology, screening through HPV co-testing may be performed every five years). As providers begin adopting the current screening recommendations, fewer cervical cancer screenings will be performed in all settings, including Title X clinics. FPAR data support this trend, with the latest data indicating that the proportion of women screened for cervical cancer in Title X family planning centers decreased from 52 percent in 2005 to 28 percent in 2012. This measure will be discontinued in FY 2015.

Despite the continued rise in medical care costs, the family planning program has historically been able to maintain the average cost per Title X client at or below the medical care rate of inflation. In 2012, the program continued to perform better than its projected target, and, the cost per client rose at a lower rate as compared with the Consumer Price Index (CPI) for medical care (3.26% versus 3.70%). Over the past 5 years (2008 to 2012), the program's average cost per client has risen 2.9 percent annually – lower than the medical CPI of 3.4 percent over the same period of time. Although some increase in the cost per client is expected and anticipated, the slower average growth (versus the CPI) over the past years is influenced by many factors, including investments Title X grantees and services sites have made in technology and other infrastructure advancements, such as incorporating electronic health records and implementing strategies to improve their ability to effectively leverage multiple sources of revenue.

Overall, the most significant challenge the program has encountered in recent years is the decrease in overall clients. The most significant decline has occurred with female clients, adding further difficulties in meeting performance targets, as targets are dependent on female oriented services. An important asset of the Title X program is its ability to leverage other sources of funding, often the major sources coming from state governments and Medicaid. In recent years, large states like Texas have decreased funding for family planning, in the case of Texas, this has resulted in Title X remaining as the only source of public funding for family planning services; this has resulted in fewer services sites and a decrease in the number of clients receiving services.

In order to improve overall program performance, the program is increasing training efforts around billing practices and other cost recovery methods. Grantees are being urged to implement more efficient administrative systems, such as health information technologies, electronic health records and payment management systems. Another trend, which the program believes will improve program performance, is increased competition and diversity in the types of grantees funded. Increased competition has led to more diversified grantees, leading to improved cost recovery methods and different administrative structures which it is anticipated will ultimately improve quality and service delivery.

Funding History

FY	Amount
FY 2011	$299,400,000
FY 2012	$293,870,000
FY 2013	$278,349,000
FY 2014	$286,479,000
FY 2015	$286,479,000

Budget Request

The FY 2015 President's Budget request of $286,479,000 is equal to the FY 2014 Enacted Level. The budget 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 2015 request is expected to support family planning services for approximately 4,307,000 persons, with approximately 90 percent having family incomes at or below 200 percent of the federal poverty level. These services include the provision of family planning methods, education, counseling, and related preventive health services. The performance of the program is reflected in the outcome measures developed during its performance assessment. These outcomes include preventing approximately 1,400 cases of infertility through Chlamydia screening of approximately 1,155,500 females ages 15-24, preventing 401 cases of invasive cervical cancer through cervical cancer screening, and preventing approximately 828,700 unintended pregnancies in FY 2015. The targets for FY 2015 are ambitious and assume that other sources of revenue that contribute to the family planning program at the grantee level will remain at historical proportions of the total Title X revenue.

As in the past, approximately 90 percent of the appropriation will be used for clinical family planning services. Those services will continue to include recommended Chlamydia screening, screening for undiagnosed cervical tissue abnormalities and providing a broad range of contraceptive methods and related education and counseling, thereby reducing the number of unintended pregnancies.

The program intends to publish new Title X Family Planning Services Guidelines during CY 2014. These new guidelines will reflect a foundation of empirical evidence and information supporting clinical practice and are intended to improve the provision of family planning and reproductive health services regardless of the service setting. The adoption of these guidelines and standards of care is expected to significantly improve the quality of care provided in Title X services sites and improve the program's performance trends.

The FY 2015 request will allow the program to provide additional training and support to Title X grantees, sub-recipients and service sites to facilitate full implementation of relevant provisions of the Affordable Care Act (ACA). The program will employ multiple strategies including training of staff and providers, coordination with other federal agencies and data collection reflecting impact. The program is anticipating that additional investment in billing 3rd parties, increasing 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 in need of family planning services.

Beginning in CY 2015, the program will be transforming its data collection system. Currently, FPAR data are reported in aggregate at the grantee level. This limits the amount and granularity of data that can be reported. Beginning in CY 2017, all grantees will be requested to submit encounter level data directly from service sites using electronic means. This will allow the program to collect specific information on patient characteristics that will allow the program to examine the impact of the ACA, as well as data on the quality of services provided, and patient outcomes. Collecting encounter level data represents a dramatic shift to the Title X data collection system and will require additional resources to each grantee so their service delivery sites can update Electronic Health Records (EHR) to collect and report required data elements. This effort will also require the creation of a centralized data center. In the long term, the investment in this data infrastructure will allow the program to monitor grantees in real time, as well as better assess the quality of services being provided to clients.

Outputs and Outcomes Tables

Long Term Objective: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals.

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2014 Target**	**FY 2015 Target**	**FY 2015 +/- FY 2014**
36.II.A.1: Total number of unduplicated clients served in Title X service sites. *(Outcome)Revised Measure*	FY 2012: 4,763,797 Target: 4,969,600 (Target not met)	4,461,000	4,307,000	-154,000
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 2012: 90% Target: 90% (Target Met)	90%	90%	-
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 2012: 910,779 Target: 949,300 (Target Not Met)	858,000	823,000	-29,300
36.II.A.4: Increase the proportion of female clients, using a method of	A: Baseline 2011: 8.8% B: Baseline 2011:70.1%		A: 9.7% B: 77.1%	

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
contraception, indicating the use of: A: Long Acting Reversible Contraceptive (LARC) as their primary method of contraception. And B: Highly or moderately effective methods of contraception as their primary method of contraception. (Outcome) New				

Long Term Objective: Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15 – 24.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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 2012: 1,247,525 Target: 1,296,300 (Target Not Met)	1,196,600	1,155,500	- 41,100
36.II.C.3: Increase the proportion of females ages 15 – 24 attending Title X family	FY 2011: Baseline: 57.8%		63%	

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
planning clinics screened for Chlamydia infection. *(Outcome)*				

Long Term Objective: Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
36.II.C.1: Increase the number of unduplicated female clients who receive a Pap test. *(Outcome)* Retired	FY 2012: 1,237,328 Target: 1,654,900 (Target Not Met)	1,215,000	Retire	
36.II.C.2: Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests. *(Outcome)* Retired	FY 2012: 408 Target: 546 (Target Not Met)	449	Reitre	

Efficiency Measure:

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014
36.E: Maintain the actual cost per Title X client below the medical care inflation rate. *(Efficiency)*	FY 2012: $264.54 Target: $280.66(Target Exceeded)	$283.85	$291.94	$8.09

Grant Awards Tables

Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	95	95	95
Average Award	$ 2,637,000	$ 3,014,700	$3,014,700
Range of Awards	$ 66,000- $19,500,000	$75,000 - $19,116,100	$75,000 - $19,116,100

Supplementary Tables Tab

Budget Authority by Object Class

PRIMARY HEALTH CARE

(Dollars in Thousands)

Object Class	FY 2014 Base	FY 2015 Request	Increase/Decrease
Full-time permanent (11.1)	14,409	8,210	-6,198
Other than full-time permanent (11.3)	633	353	-281
Other personnel compensation (11.5)	55	32	-23
Military personnel (11.7)	2,519	2,545	+ 25
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**17,617**	**11,140**	**-6,477**
Civilian benefits (12.1)	4,367	2,487	-1,880
Military benefits (12.2)	1,490	1,505	+ 15
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**23,474**	**15,132**	**-8,342**
Travel and transportation of persons (21.0)	652	652	-
Transportation of things (22.0)	34	34	-
Rental payments to GSA (23.1)	1,055	1,055	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	475	475	-
Printing and reproduction (24.0)	1	1	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	29,783	29,783	-
Purchase of goods and services from	-	-	-
government accounts (25.3)	43,564	43,564	-
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	4,916	4,916	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	106	106	-
Subtotal Other Contractual Services	**78,369**	**78,369**	**-**
Equipment (31.0)	450	450	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	1,340,210	853,321	-486,889
Insurance Claims and Indemnities (42.0)	50,556	50,551	-5
Total Non-Pay Costs	**1,471,802**	**984,908**	**-486,894**
Total Budget Authority by Object Class	**1,495,276**	**1,000,040**	**-**

HEALTH WORKFORCE

(Dollars in Thousands)

Object Class	FY 2014 Base	FY 2015 Request	Increase/Decrease
Full-time permanent (11.1)	7,676	7,581	-95
Other than full-time permanent (11.3)	429	344	-85
Other personnel compensation (11.5)	17	11	-6
Military personnel (11.7)	584	521	-63
Special personnel services payments (11.8)	73	-	-73
Subtotal personnel compensation	**8,779**	**8,457**	**-322**
Civilian benefits (12.1)	2,357	2,386	+ 29
Military benefits (12.2)	277	263	-14
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**1,413**	**11,106**	**-307**
Travel and transportation of persons (21.0)	164	112	-52
Transportation of things (22.0)	-	-	-
Rental payments to GSA (23.1)	988	797	-191
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	960	953	-7
Printing and reproduction (24.0)	102	76	-26
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	11,152	4,551	-6,601
Purchase of goods and services from government accounts (25.3)	- 22,620	- 12,820	- -9,800
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	1,728	578	-1,150
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	22	-	-22
Supplies and materials (26.0)	22	17	-5
Subtotal Other Contractual Services	**35,544**	**17,966**	**-17,578**
Equipment (31.0)	199	178	-20
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	684,867	445,952	-238,914
Insurance Claims and Indemnities (42.0)	0	0	-
Total Non-Pay Costs	**722,823**	**466,034**	**-256,789**
Total Budget Authority by Object Class	**734,236**	**477,140**	**-257,096**

MATERNAL AND CHILD HEALTH

(Dollars in Thousands)

Object Class	FY 2014 Base	FY 2015 Request	Increase/ Decrease
Full-time permanent (11.1)	5,600	5,656	+ 56
Other than full-time permanent (11.3)	31	32	-
Other personnel compensation (11.5)	38	38	-
Military personnel (11.7)	153	155	+ 2
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**5,822**	**5,881**	**+ 58**
Civilian benefits (12.1)	1,536	1,551	+ 15
Military benefits (12.2)	124	125	+ 1
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	7,483	7,557	+ 75
Travel and transportation of persons (21.0)	255	255	-
Transportation of things (22.0)	-	-	-
Rental payments to GSA (23.1)	226	226	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	724	724	-
Printing and reproduction (24.0)	6	6	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	6,377	6,377	-
Other services (25.2)	2,754	2,754	-
Purchase of goods and services from	-	-	-
government accounts (25.3)	10,579	10,579	-
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	2,610	2,610	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	23	23	-
Subtotal Other Contractual Services	22,344	22,344	-
Equipment (31.0)	15	15	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	814,965	814,890	-75
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**838,534**	**838,460**	**-75**
Total Budget Authority by Object Class	**846,017**	**846,017**	**-**

HIV/AIDS

(Dollars in Thousands)

Object Class	FY 2014 Base	FY 2015 Request	Increase/ Decrease
Full-time permanent (11.1)	14,886	14,689	-197
Other than full-time permanent (11.3)	243	186	-57
Other personnel compensation (11.5)	94	73	-21
Military personnel (11.7)	1,246	1,215	-31
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**16,469**	**16,163**	**-306**
Civilian benefits (12.1)	4,362	4,327	-36
Military benefits (12.2)	608	595	-13
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**21,439**	**21,085**	**-354**
Travel and transportation of persons (21.0)	255	244	-11
Transportation of things (22.0)	17	11	-6
Rental payments to GSA (23.1)	743	614	-129
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	674	570	-104
Printing and reproduction (24.0)	91	90	-1
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	14,440	12,761	-1,679
Purchase of goods and services from	-	-	-
government accounts (25.3)	59,761	58,311	-1,450
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	9,416	8,978	-438
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	68	43	-25
Subtotal Other Contractual Services	**83,685**	**80,094**	**-3,591**
Equipment (31.0)	1,763	1,517	-246
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	2,185,115	2,193,557	+ 8,442
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**2,272,342**	**2,276,696**	**+ 4,354**
Total Budget Authority by Object Class	**2,293,781**	**2,297,781**	**+ 4,000**

HEALTHCARE SYSTEMS

(Dollars in Thousands)

Object Class	FY 2014 Base	FY 2015 Request	Increase/ Decrease
Full-time permanent (11.1)	4,991	5,041	+ 50
Other than full-time permanent (11.3)	204	206	+ 2
Other personnel compensation (11.5)	355	358	+ 4
Military personnel (11.7)	902	911	+ 9
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**6,452**	**6,517**	**+ 65**
Civilian benefits (12.1)	1,669	1,685	+ 17
Military benefits (12.2)	354	357	+ 4
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**8,474**	**8,559**	**+ 85**
Travel and transportation of persons (21.0)	170	170	-
Transportation of things (22.0)	65	65	-
Rental payments to GSA (23.1)	162	162	-
Rental payments to Others (23.2)	726	726	-
Communication, utilities, and misc. charges (23.3)	1,014	1,014	-
Printing and reproduction (24.0)	67	67	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	3,889	3,889	-
Other services (25.2)	43,992	43,992	-
Purchase of goods and services from	-	-	-
government accounts (25.3)	2,967	2,967	-
Operation and maintenance of facilities (25.4)	187	187	-
Research and Development Contracts (25.5)	108	108	-
Medical care (25.6)	3,586	2,586	-1,000
Operation and maintenance of equipment (25.7)	124	124	-
Subsistence and support of persons (25.8)	36	36	-
Discounts and Interest (25.9)	0	0	-
Supplies and materials (26.0)	715	715	-
Subtotal Other Contractual Services	**55,603**	**54,603**	**-1,000**
Equipment (31.0)	253	253	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	36,659	38,040	+ 1,382
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**94,719**	**95,100**	**+ 381**
Total Budget Authority by Object Class	**103,193**	**103,659**	**+ 466**

RURAL
(Dollars in Thousands)

Object Class	FY 2014 Base	FY 2015 Request	Increase/Decrease
Full-time permanent (11.1)	879	858	-22
Other than full-time permanent (11.3)	98	67	-30
Other personnel compensation (11.5)	0	0	-
Military personnel (11.7)	79	80	+ 1
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**1,056**	**1,005**	**-51**
Civilian benefits (12.1)	310	247	-62
Military benefits (12.2)	42	43	-
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**1,408**	**1,295**	**-113**
Travel and transportation of persons (21.0)	159	159	-
Transportation of things (22.0)	-	-	-
Rental payments to GSA (23.1)	32	32	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	4	1	-3
Printing and reproduction (24.0)	-	-	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	4,736	4,595	-141
Purchase of goods and services from	-	-	-
government accounts (25.3)	2,952	2,851	-101
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	1,129	1,129	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	-	-	-
Subtotal Other Contractual Services	**8,817**	**8,575**	**-241**
Equipment (31.0)	-	-	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	131,914	114,498	-17,416
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**140,927**	**123,267**	**-17,660**
Total Budget Authority by Object Class	**142,335**	**124,562**	**-17,773**

FAMILY PLANNING

(Dollars in Thousands)

Object Class	FY 2014 Base	FY 2015 Request	Increase/Decrease
Full-time permanent (11.1)	6,122	6,184	+ 61
Other than full-time permanent (11.3)	195	197	+ 2
Other personnel compensation (11.5)	2	2	-
Military personnel (11.7)	781	788	+ 8
Special personnel services payments (11.8)	33	34	-
Subtotal personnel compensation	**7,133**	**7,204**	**+ 71**
Civilian benefits (12.1)	1,968	1,987	+ 20
Military benefits (12.2)	325	329	+ 3
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**9,426**	**9,520**	**+ 94**
Travel and transportation of persons (21.0)	122	122	-
Transportation of things (22.0)	2	2	-
Rental payments to GSA (23.1)	518	518	-
Rental payments to Others (23.2)	22	22	-
Communication, utilities, and misc. charges (23.3)	37	37	-
Printing and reproduction (24.0)	1	1	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	2,415	2,415	-
Other services (25.2)	145	145	-
Purchase of goods and services from government accounts (25.3)	8,891	8,891	-
Operation and maintenance of facilities (25.4)	36	36	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	-	-	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	4	4	-
Subtotal Other Contractual Services	**11,491**	**11,491**	-
Equipment (31.0)	2	2	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	264,857	264,762	-94
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**277,053**	**276,959**	**-94**
Total Budget Authority by Object Class	**286,479**	**286,479**	**-**

PROGRAM MANAGEMENT
(Dollars in Thousands)

Object Class	FY 2014 Base	FY 2015 Request	Increase/ Decrease
Full-time permanent (11.1)	79,753	80,550	+ 798
Other than full-time permanent (11.3)	3,492	3,527	+ 35
Other personnel compensation (11.5)	1,054	1,065	+ 11
Military personnel (11.7)	7,757	7,835	+ 78
Special personnel services payments (11.8)	279	281	+ 3
Subtotal personnel compensation	**92,335**	**93,258**	**+ 923**
Civilian benefits (12.1)	24,013	24,253	+ 240
Military benefits (12.2)	4,460	4,505	+ 45
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**120,808**	**122,016**	**+ 1,208**
Travel and transportation of persons (21.0)	64	64	-
Transportation of things (22.0)	234	234	-
Rental payments to GSA (23.1)	14,454	18,631	+ 4,177
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	640	640	-
Printing and reproduction (24.0)	164	164	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	1	1	-
Other services (25.2)	4,890	4,890	-
Purchase of goods and services from	-	-	-
government accounts (25.3)	5,509	4,321	-1,189
Operation and maintenance of facilities (25.4)	877	877	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	1,378	1,378	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	659	659	-
Subtotal Other Contractual Services	**13,314**	**12,126**	**-1,189**
Equipment (31.0)	517	517	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	2,867	2,671	-196
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**32,253**	**35,045**	**+ 2,792**
Total Budget Authority by Object Class	**153,061**	**157,061**	**+ 4,000**

DISCRETIONARY

Object Class	FY 2014 Base	FY 2015 Request	Increase/Decrease
Full-time permanent (11.1)	134,317	128,769	-5,548
Other than full-time permanent (11.3)	5,325	4,912	-414
Other personnel compensation (11.5)	1,615	1,579	-36
Military personnel (11.7)	14,022	14,050	+ 28
Special personnel services payments (11.8)	385	315	-70
Subtotal personnel compensation	**155,664**	**149,625**	**-6,039**
Civilian benefits (12.1)	40,581	38,924	-1,657
Military benefits (12.2)	7,680	7,722	+ 42
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**203,925**	**196,270**	**-7,654**
Travel and transportation of persons (21.0)	1,841	1,778	-63
Transportation of things (22.0)	353	346	-6
Rental payments to GSA (23.1)	18,180	22,036	+ 3,856
Rental payments to Others (23.2)	748	748	-
Communication, utilities, and misc. charges (23.3)	4,527	4,413	-113
Printing and reproduction (24.0)	431	404	-26
Other Contractual Services: 25.0	0	0	-
Advisory and assistance services (25.1)	12,682	12,682	-
Other services (25.2)	111,892	103,471	-8,420
Purchase of goods and services from government accounts (25.3)	156,842	144,303	-12,539
Operation and maintenance of facilities (25.4)	1,099	1,099	-
Research and Development Contracts (25.5)	108	108	-
Medical care (25.6)	3,586	2,586	-1,000
Operation and maintenance of equipment (25.7)	21,301	19,713	-1,587
Subsistence and support of persons (25.8)	36	36	-
Discounts and Interest (25.9)	23	1	-22
Supplies and materials (26.0)	1,598	1,568	-30
Subtotal Other Contractual Services	**309,167**	**285,568**	**-23,600**
Equipment (31.0)	3,199	2,932	-267
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	5,461,453	4,727,692	-733,761
Insurance Claims and Indemnities (42.0)	50,556	50,551	-5
Total Non-Pay Costs	**5,850,453**	**5,096,469**	**-753,985**
Total Budget Authority by Object Class	**6,054,378**	**5,292,739**	**-761,639**

MANDATORY Obligations

(Dollars in Thousands)

Object Class	FY 2014 Base	FY 2015 Request	Increase/Decrease
Full-time permanent (11.1)	33,611	40,062	+ 6,451
Other than full-time permanent (11.3)	993	1,000	+ 8
Other personnel compensation (11.5)	124	25	-99
Military personnel (11.7)	5,479	6,018	+ 539
Special personnel services payments (11.8)	58	59	+ 1
Subtotal personnel compensation	**40,264**	**47,164**	**+ 6,899**
Civilian benefits (12.1)	10,463	12,641	+ 2,179
Military benefits (12.2)	2,731	2,838	+ 106
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**53,458**	**62,643**	**+ 9,185**
Travel and transportation of persons (21.0)	347	713	+ 366
Transportation of things (22.0)	202	486	+ 284
Rental payments to GSA (23.1)	4,252	3,958	-294
Rental payments to Others (23.2)	5	5	-
Communication, utilities, and misc. charges (23.3)	1,226	2,904	+ 1,677
Printing and reproduction (24.0)	5	11	+ 7
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	16,181	-	-16,181
Other services (25.2)	21,282	31,450	+ 10,168
Purchase of goods and services from government accounts (25.3)	41,617	68,145	+ 26,528
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	3,832	5,584	+ 1,752
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	57	86	+ 29
Subtotal Other Contractual Services	**82,970**	**105,265**	**+ 22,295**
Equipment (31.0)	251	603	+ 352

MANDATORY Obligations

(Dollars in Thousands)

Object Class	FY 2014 Base	FY 2015 Request	Increase/Decrease
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	2,786,541	5,270,912	+ 2,484,372
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**2,875,798**	**5,384,857**	**+ 2,509,059**
Total Budget Authority by Object Class	**2,929,256**	**5,447,500**[215]	**+ 2,518,244**

[215] Includes transfer from the Medicare Hospital Insurance Trust Fund

Salaries and Expenses

(Dollars in Thousands)

DISCRETIONARY

Object Class	FY 2014 Base	FY 2015 Request	Increase/Decrease
Full-time permanent (11.1)	134,317	128,769	-5,548
Other than full-time permanent (11.3)	5,325	4,912	-414
Other personnel compensation (11.5)	1,615	1,579	-36
Military personnel (11.7)	14,022	14,050	+ 28
Special personnel services payments (11.8)	385	315	-70
Subtotal personnel compensation	**155,664**	**149,625**	**-6,039**
Civilian benefits (12.1)	40,581	38,924	-1,657
Military benefits (12.2)	7,680	7,722	+ 42
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**203,925**	**196,270**	**-7,654**
Travel and transportation of persons (21.0)	1,841	1,778	-63
Transportation of things (22.0)	353	346	-6
Rental payments to Others (23.2)	748	748	-
Communication, utilities, and misc. charges (23.3)	4,527	4,413	-113
Printing and reproduction (24.0)	431	404	-26
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	12,682	12,682	-
Other services (25.2)	111,892	103,471	-8,420
Purchase of goods and services from government accounts (25.3)	156,842	144,303	-12,539
Operation and maintenance of facilities (25.4)	1,099	1,099	-
Medical care (25.6)	3,586	2,586	-1,000
Operation and maintenance of equipment (25.7)	21,301	19,713	-1,587
Subsistence and support of persons (25.8)	36	36	-
Discounts and Interest (25.9)	23	1	-22
Supplies and materials (26.0)	1,598	1,568	-30
Subtotal Other Contractual Services	**314,017**	**290,278**	**-23,740**
Total Non-Pay Costs	**321,916**	**297,967**	**-23,949**
Total Budget Authority by Object Class	**525,841**	**494,238**	**-31,603**

Salaries and Expenses

(Dollars in Thousands)

MANDATORY Obligations

Object Class	FY 2014 Base	FY 2015 Request	Increase/Decrease
Full-time permanent (11.1)	33,611	40,062	+ 6,451
Other than full-time permanent (11.3)	993	1,000	+ 8
Other personnel compensation (11.5)	124	25	-99
Military personnel (11.7)	5,479	6,018	+ 539
Special personnel services payments (11.8)	58	59	+ 1
Subtotal personnel compensation	**40,264**	**47,164**	**+ 6,899**
Civilian benefits (12.1)	10,463	12,641	+ 2,179
Military benefits (12.2)	2,731	2,838	+ 106
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**53,458**	**62,643**	**+ 9,185**
Travel and transportation of persons (21.0)	347	713	+ 366
Transportation of things (22.0)	202	486	+ 284
Rental payments to Others (23.2)	5	5	-
Communication, utilities, and misc. charges (23.3)	1,226	2,904	+ 1,677
Printing and reproduction (24.0)	5	11	+ 7
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	16,181	-	-16,181
Other services (25.2)	21,282	31,450	+ 10,168
Purchase of goods and services from government accounts (25.3)	41,617	68,145	+ 26,528
Operation and maintenance of facilities (25.4)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	3,832	5,584	+ 1,752
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	57	86	+ 29
Subtotal Other Contractual Services	**84,201**	**108,180**	**+ 23,979**
Total Non-Pay Costs	**85,986**	**112,299**	**+ 26,313**
Total Budget Authority by Object Class	**139,444**	**174,942**	**+ 35,498**

Detail of Full-Time Equivalent Employment

Programs	FY 2013			FY 2014			FY 2015		
	Actual Civilian	Actual Military	Actual Total	Est. Civilian	Est. Military	Est. Total	Est. Civilian	Est. Military	Est. Total
Bureau of Primary Health Care:									
Direct:									
Health Centers/Tort	172	29	201	144	29	173	144	29	173
Free Clinics Medical Malpractice	2	-	2	2	-	2	2	-	2
Total, Direct	**174**	**29**	**203**	**146**	**29**	**175**	**146**	**29**	**175**
Mandatory:									
Community Health Center Fund	48	12	60	76	12	88	76	12	88
School-based Health Centers- Facilities	8		8	8		8	8		8
Total, Mandatory	**56**	**12**	**68**	**84**	**12**	**96**	**84**	**12**	**96**
Total FTE, BPHC	**230**	**41**	**271**	**230**	**41**	**271**	**230**	**41**	**271**
Health Workforce:									
Bureau of Clinician Recruitment & Service									
Direct:									
National Health Service Corps	-	-	-	-	-	-	15	-	15
Nurse Corps Scholarship & Loan Repayment Program	28	4	32	28	4	32	28	4	32
Total, Direct:	**28**	**4**	**32**	**28**	**4**	**32**	**43**	**4**	**47**
NHSC Fund::									
National Health Service Corps	192	37	229	200	37	237	200	37	237
National Health Service Corps (Proposed)	-	-	-	-	-	-	30	5	35
Total, Mandatory	**192**	**37**	**229**	**200**	**37**	**237**	**230**	**42**	**272**
Total FTE, BCRS	**220**	**41**	**261**	**228**	**41**	**269**	**273**	**46**	**319**

Programs	FY 2013			FY 2014			FY 2015		
	Actual Civilian	Actual Military	Actual Total	Est. Civilian	Est. Military	Est. Total	Est. Civilian	Est. Military	Est. Total
Bureau of Health Professions									
Direct:									
Centers for Excellence	1	-	1	1	-	1	1	-	1
Scholarships for Disadvantaged Students	4	-	4	4	-	4	4	-	4
Health Careers Opportunity Program	1	-	1	1	-	1	-	-	-
Health Care Workforce Assessment	6	1	7	6	1	7	6	1	7
Primary Care Training and Enhancement	5	-	5	5	-	5	5	-	5
Oral Health Training	2	-	2	2	-	2	2	-	2
Area Health Education Centers	2	-	2	2	-	2	-	-	-
Geriatric Programs	4	1	5	4	1	5	4	1	5
Mental and Behavioral Health	1	-	1	1	-	1	1	-	1
Clinical Training in Interprofessional Practice	-	-	-	-	-	-	2	-	2
Public Health/Preventive Medicine	2	-	2	4	-	4	4	-	4
Advanced Education Nursing Program	6	-	6	6	-	6	-	-	-
Nurse Workforce Diversity	1	-	1	1	-	1	1	-	1
Nurse Education, Practice & Retention	4	-	4	4	-	4	4	-	4
Nurse Faculty Loan Program	1	-	1	1	-	1	1	-	1
Comprehensive Geriatric Education	-	-	-	-	-	-	1	-	1
Children's Hospitals GME Program	18	-	18	18	-	18	-	-	-
HEAL	14	-	14	14	-	14	-	-	-
Total, Direct	**72**	**2**	**74**	**74**	**2**	**76**	**36**	**2**	**38**
Reimbursable:									
National Practitioner Data Bank	46	-	**46**	46	-	**46**	46	-	**46**
Advanced Education Nursing Program	-	-	-	-	-	-	6	-	6
Targeted Support for GME (Proposed)	-	-	-	-	-	-	26	-	**26**
Total, Reimbursable	**46**	**-**	**46**	**46**	**-**	**46**	**78**	**-**	**78**
Mandatory:									
GME Payments for Teaching Health Centers	4	2	**6**	4	2	**6**	4	2	**6**

Programs	FY 2013			FY 2014			FY 2015		
	Actual Civilian	Actual Military	Actual Total	Est. Civilian	Est. Military	Est. Total	Est. Civilian	Est. Military	Est. Total
Total, Mandatory	**4**	**2**	**6**	**4**	**2**	**6**	**4**	**2**	**6**
Total FTE, BHPr	**122**	**4**	**126**	**124**	**4**	**128**	**118**	**4**	**122**
Total FTE, Health Workforce	**342**	**45**	**387**	**352**	**45**	**397**	**391**	**50**	**441**
Maternal and Child Health Bureau:									
Direct:									
Maternal & Child Health Block Grant	29	2	31	29	2	31	29	2	31
Autism and Other Developmental Disorders	6	1	7	6	1	7	6	1	7
Traumatic Brain Injury	-	-	-	-	-	-	-	-	-
Sickle Cell Service Demonstrations	2	-	2	2	-	2	2	-	2
James T. Walsh Universal Newborn Hearing Screening	5	-	5	5	-	5	5	-	5
Emergency Medical Services for Children	4	-	4	4	-	4	4	-	4
Healthy Start	4	-	4	4	-	4	4	-	4
Heritable Disorders	3	-	3	4	-	4	4	-	4
Total, Direct:	**53**	**3**	**56**	**54**	**3**	**57**	**54**	**3**	**57**
Mandatory:									
Family to Family Health Info Centers	-	-	-	2	-	2	-	-	-
Maternal, Infant & Early Childhood Visitation	19	3	22	19	3	22	-	-	-
Maternal, Infant & Early Childhood Visitation (Proposed)							19	3	22
Total, Mandatory	**19**	**3**	**22**	**21**	**3**	**24**	**19**	**3**	**22**
Total FTE, MCHB	**72**	**6**	**78**	**75**	**6**	**81**	**73**	**6**	**79**
HIV/AIDS Bureau:									
Direct:									
Ryan White Part A	35	2	37	35	2	37	35	2	37

Programs	FY 2013			FY 2014			FY 2015		
	Actual Civilian	Actual Military	Actual Total	Est. Civilian	Est. Military	Est. Total	Est. Civilian	Est. Military	Est. Total
Ryan White Part B	55	2	57	55	2	57	55	2	57
Ryan White Part C	31	9	40	31	9	40	40	9	49
Ryan White Part D	13	-	13	13	-	13	-	-	-
Ryan White Part F	5	-	5	5	-	5	5	-	5
Ryan White Part F Dental	1	-	1	1	-	1	1	-	1
Total, Direct:	**140**	**13**	**153**	**140**	**13**	**153**	**136**	**13**	**149**
Reimbursable:									
OGAC Global AIDS	13	4	17	13	4	17	13	4	17
Total, Reimbursable	**13**	**4**	**17**	**13**	**4**	**17**	**13**	**4**	**17**
Total FTE, HAB	**153**	**17**	**170**	**153**	**17**	**170**	**149**	**17**	**166**
Healthcare Systems Bureau:									
Direct:									
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	3	-	3	4	-	4	4	-	4
340B Drug Pricing Program/Office of Pharmacy Affairs	1	2	3	1	2	3	1	2	3
Hansen's Disease Center	54	5	59	54	5	59	54	5	59
Covered Countermeasures Compensation	5	3	8	5	3	8	5	3	8
Vaccine	17	2	19	20	2	22	23	2	25
Total, Direct:	**89**	**13**	**102**	**93**	**13**	**106**	**96**	**13**	**109**
Reimbursable:									
340B Drug Pricing Program/Office of Pharmacy Affairs	-	-	-	-	-	-	4	-	4
Hansen's Disease Center	3	-	3	3	-	3	3	-	3
Total, Reimbursable	**3**	**-**	**3**	**3**	**-**	**3**	**7**	**-**	**7**
Total FTE, HSB	**92**	**13**	**105**	**96**	**13**	**109**	**103**	**13**	**116**

Programs	FY 2013			FY 2014			FY 2015		
	Actual Civilian	Actual Military	Actual Total	Est. Civilian	Est. Military	Est. Total	Est. Civilian	Est. Military	Est. Total
Office of Rural Health Policy:									
Direct:									
Rural Health Policy Development	1	-	1	1	-	1	1	-	1
Rural Health Outreach Grants	2	-	2	2	-	2	2	-	2
Rural & Community Access to Emergency Devices	2	-	2	2	-	2	-	-	-
Rural Hospital Flexibility Grants	2	-	2	2	-	2	2	-	2
State Offices of Rural Health	-	-	-	1	-	1	1	-	1
Radiation Exposure Screening & Education Program	-	1	1	-	1	1	-	1	1
Telehealth		-	-	1	-	1	1	-	1
Total, Direct	**7**	**1**	**8**	**9**	**1**	**10**	**7**	**1**	**8**
Total FTE, ORHP	**7**	**1**	**8**	**9**	**1**	**10**	**7**	**1**	**8**
Family Planning (Direct)	13	3	16	32	3	35	32	3	35
Program Management (Direct)	786	81	867	786	81	867	786	81	867
Subtotal Direct (non add)	1362	149	1511	1362	149	1511	1336	149	1485
Subtotal Reimbursable (non add)	62	4	66	62	4	66	98	4	102
Subtotal Mandatory (non add)	271	54	325	309	54	363	337	59	396
Total, Ceiling FTE	**1695**	**207**	**1902**	**1733**	**207**	**1940**	**1771**	**212**	**1983**

Average GS Grade	
FY 2011	12.5
FY 2012	12.5
FY 2013	12.5
FY 2014	12.5
FY 2015	12.5

Programs Proposed for Elimination

The following list shows the programs proposed for elimination or consolidation in the FY 2015 Budget Request. Termination of these programs frees up approximately $388 million (discretionary) and $2.5 million (mandatory) based on the FY 2014 levels for priority health programs that have demonstrated a record of success or that hold significant promise for increasing accountability and improving health outcomes. Following each program is a brief summary and the rationale for its elimination.

Program	FY 2014 Dollars in Millions
Discretionary	
Health Careers Opportunity Program	$ 14.2
Area Health Education Centers	$ 30.3
Children's Hospitals Graduate Medical Education Program	$265.0
Ryan White Women, Infants, Children and Youth – Part D	$75.1
Rural & Community Access to Emergency Devices	$ 3.4
Total Discretionary	**$ 388.0**
Mandatory	
Family to Family Health Information Centers	$ 2.5
Total Mandatory	**$ 2.5**

Program Descriptions

Discretionary

Health Careers Opportunity Program (-$14.2 million)
Although increasing diversity in the health professions is a high priority, the Budget includes funding directed to building the capacity and training of the primary care workforce.

Area Health Education Centers (-$30.3 million)
Although expanding the dispersal of health professions trainees is a high priority, the Budget includes $810 million to expand the National Health Service Corps..

Children's Hospitals Graduate Medical Education Program (-$265.0 million)
Children's hospitals will be eligible to compete for new mandatory Targeted Support for Graduate Medical Education funds. $100 million will be set-aside for children's hospitals in FY 2015 and FY 2016 to allow these entities to transition from the stand alone discretionary program to the competitive mandatory program.

Ryan White Children, Youth, Women & Families – Part D (-$75.1 million)
The Budget proposes the merger of the Part C and Part D grant programs. The merger will expand the focus on women, infants, children and youth across all the funded grantees in the Part C program.

Rural & Community Access to Emergency Devices (-$3.4 million)
Activities related to access to emergency medical devices and training may be addressed through other funding sources available to grantees, such as the Rural Outreach and Rural Network Development programs.

Mandatory

Family to Family Health Information Centers: (-$2.5 million)
Centers disseminating family based information may work through state and FQHCs to implement medical/health homes without separate Federal MCH funding.

FTE Funded by Mandatory Resources

	Section	FY 2013		FY 2014		FY 2015	
		Funding	FTE	Funding	FTE	Funding	FTE
Bureau of Primary Health Care:							
Community Health Center Fund	P.L. 111-152, Section 2303	1,465,397	60	2,144,716	88	3,600,000	88
School-based Health Centers- Facilities	P.L. 111-148, Section 4101(a)	47,450	8	-	8	-	8
Subtotal		**1,512,847**	**68**	**2,144,716**	**96**	**3,600,000**	**96**
Health Workforce:							
Bureau of Clinician Recruitment & Service							
National Health Service Corps	P.L. 111-148, Section 5207	284,700	229	283,040	237	310,000	237
National Health Service Corps (Proposed)			-		-	400,000	35
Subtotal		**284,700**	**229**	**283,040**	**237**	**710,000**	**272**
Bureau of Health Professions							
GME Payments for Teaching Health Centers	PHSA, Section 340H	-	6	-	6	-	6
Subtotal			**6**		**6**		**6**
Maternal and Child Health Bureau:							
Family to Family Health Info Centers	P.L. 111-148, Section 5507	4,745	-	2,500	2		-
Maternal, Infant & Early Childhood Visitation	P.L. 111-148, Section 2951	379,600	22	371,200	22		-
Maternal, Infant & Early Childhood Visitation (Proposed)						500,000	22
Subtotal		**384,345**	**22**	**373,700**	**24**	**500,000**	**22**
TOTAL		2,181,892	325	2,801,456	363	5,340,000	422

Physicians' Comparability Allowance (PCA) Worksheet

Table 1

		CY 2013 (Estimates)	BY 2014* (Estimates)	FY 2015 Request
1) Number of Physicians Receiving PCAs		42	44	44
2) Number of Physicians with One-Year PCA Agreements		3	1	1
3) Number of Physicians with Multi-Year PCA Agreements		39	43	43
4) Average Annual PCA Physician Pay (without PCA payment)		$145,000	$143,000	$143,000
5) Average Annual PCA Payment		$22,000	$21,000	$21,000
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	2	2	2
	Category II Research Position	0	0	0
	Category III Occupational Health	0	0	0
	Category IV-A Disability Evaluation	0	0	0
	Category IV-B Health and Medical Admin.	40	42	42

*FY 2014 data will be approved during the FY 2015 Budget cycle.

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

The necessity for an extra category is to render advice relating to patient care and community health programs to the HRSA Administrator.

	2013	2014	2015
Category IV – C	1	1	1

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

For each category, the amount of PCA given is to retain highly qualified medical officers that could potentially be compensated more in the private sector.
Category I - $28,000
Category IV – B - $30,000
Category IV – C - $30,000
Compensation reflects physician longevity and board certification. Physicians are also selecting multi year contracts, which provides allowances for mission specific factors. Compensating at these levels allows HRSA to compete with the private sector and to increase retention of HRSA physicians.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

PCA is used to recruit and retain highly qualified medical officers. It is difficult to compete with private industry salaries. If HRSA did not offer PCA, HRSA would not be able to attract potential candidates or maintain current HRSA medical officers who enhance HRSA mission and goals.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

HRSA had two medical officers who retired and two medical officers who resigned that were receiving PCA. HRSA has been able to retain a high rate of our medical officers using this mechanism. Of the remaining medical officers receiving PCA, the average years of service reflects nine years of service. The years of service range up to 20 years.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

N/A

Significant Items

Tab

SIGNIFICANT ITEMS FOR INCLUSION IN L-HHS APPROPRIATIONS COMMITTEE THE FY 2015 CONGRESSIONAL JUSTIFICATION

SENATE REPORT NO. 113-71 (July 11, 2013)

1. **The Committee continues to support the Centers of Excellence** program and the financial stability it has provided for the schools that participate. However, the Committee is concerned by reports that recent award amounts were based in large part on the amount of funding requested by each school, resulting in large, unexpected cuts for some of the schools and large increases for others. The Committee directs HRSA to institute an award review process that focuses more fully on the merits of the requested activities. The Committee expects HRSA to report back to the Committees on Appropriations of the House of Representatives and the Senate on the implementation of this process in the fiscal year 2015 budget justification. (Page 43)

   Action To Be Taken
   Appropriated funding for the Centers of Excellence (COE) program in FY 2013 necessitated reduction in funding for awardees relative to FY 2012 funding levels. The decisions regarding the appropriate funding level for each grantee were based on grants management principles that govern all Federal grant making. Factors included, but were not limited to, the amount of funding requested by each school, as well as statutory requirements, grantee progress, and the impact of funding reductions on the ability of the grantee to achieve the program's purpose. In response to the concerns raised by the Committee, HRSA is reviewing the process used to determine FY 2013 funding amounts and will identify improvements that could be applied in future funding cycles.

2. **Health Careers Opportunity Program** - The Committee encourages HRSA to refocus the program on reaching undergraduate and post-baccalaureate students. (Page 44)

   Action To Be Taken
   HRSA is interested in redesigning the Health Careers Opportunity Program (HCOP) program to better support program effectiveness and is currently discussing options for doing so. These discussions will include consideration of the Committee's recommendation to refocus the program on reaching undergraduate and post-baccalaureate students.

3. **Primary Care Training and Enhancement-** The Committee once again urges HRSA to prioritize the training of physician assistants and includes bill language allowing HRSA to increase funding for this activity. (Page 44)

   Action to be Taken
   The FY 2014 budget provided level funding for the Primary Care Training and Enhancement program. While HRSA will continue to support current grantees within the funding available, we are not able to support new grantees at this time.

4. **Pediatric Loan Repayment**- The Committee is concerned that shortages of child mental health providers and pediatric subspecialists are more severe than the shortages that exist for general pediatricians. Available fellowship positions are left unfilled because of the burden of student loans for specialty training. The Committee recommendation in this bill will fund 64 initial 2-year loan repayment awards for eligible providers working in underserved areas. The Committee urges HRSA to prioritize pediatric specialties aimed at mental and behavioral health services in implementing this program. (Page 44)

   Action To Be Taken
   The Patient Protection and Affordable Care Act provided, under Section 5203, for a loan repayment program by creating Section 775 of the Public Health Service Act: "Investments in Tomorrow's Pediatric Health Care Workforce." Subsection 775(e) authorizes $30,000,000 for loan repayment awards to pediatric medical subspecialists, and $20,000,000 for child and adolescent mental and behavioral specialists annually. To date, no appropriation has been made for this program.
   HRSA notes that the National Health Service Corps, through both the scholarship and loan repayment programs, has for many years supported pediatricians, pediatric nurse practitioners, pediatric dentists, and child psychiatrists to serve in health professional shortage areas.

5. **Training In Oral Health Care**- The Committee encourages HRSA to focus on training programs that target vulnerable populations in risk-based clinical disease management of all populations. (Page 44)

   Action To Be Taken
   HRSA encourages a focus on vulnerable populations through grant funding priorities within its Training in General, Pediatric, and Public Health oral health programs. Qualified applicants that have a record of training individuals who are from a rural or disadvantaged background, or from underrepresented minorities shall receive priority consideration. Training programs that have a high rate for placing graduates in practice settings that serve underserved areas or health disparity populations, or that establish formal relationships with Federally qualified health centers, rural health centers, or accredited teaching facilities would be considered.

   HRSA is also working collaboratively with other HHS agencies to develop the evidence base for risk assessment and chronic disease management of early childhood caries.

   Examples of current HRSA grantee activities focused on vulnerable populations and risk-based clinical disease management include:

   - The University of California-Los Angeles has partnered with a Federally Qualified Health Center to establish an infant oral health clinic rotation for its pediatric dental residency programs that follows a risk-based caries disease management model.

- Children's Hospital, Boston is enhancing pediatric dental residents and pediatric medical residents training by approaching caries in high risk populations using a chronic disease management approach.

6. **The Committee urges HRSA to work with CMS** on the evaluation of additional models for expanding access to oral healthcare. Such models should include emergency room diversion programs and efforts under State law to deploy and evaluate new provider types. (Page 45)

Action To Be Taken

HRSA, CMS, and CDC have been engaged in regularly scheduled meetings to discuss areas for interagency collaboration. Expanding access to oral health care has been a central theme and includes emergency room (ER) diversion programs. In addition, HRSA is supporting ER diversion programs through the following activities.

- HRSA awarded a State Oral Health Workforce grant to Alaska that includes activities to reduce in appropriate dental-related emergency room visits.

- HRSA's Area Health Education Centers (AHEC) Program works to enhance access to high quality, culturally competent health care through academic-community partnerships, by improving the distribution, diversity, and supply of the primary care health professions workforce who serve in rural and underserved areas. As part of the Western Maryland AHEC Center, HRSA funded the Allegany Health Right that established the Regional Oral Health Pathway (ROHP). ROHP has established unique compensation agreements with public health and private providers, as well as an Emergency Department diversion program.

- The following document and analysis was published with HRSA funding support: *Use of Emergency Departments for Conditions Related to Poor Oral Health Care*, http://www3.norc.org/NR/rdonlyres/DCBE76E8-3148-4085-9211-FB79AFD6BA51/0/OralHealthFinal2.pdf

7. **Area Health Education Centers**- The Committee is pleased by HRSA's collaboration with SAMHSA to develop and replicate community health worker programs that integrate primary care and behavioral health. HRSA should include in the fiscal year 2015 budget justification a report on progress made in this initiative. (Page 45)

Action To Be Taken

The Community Health Worker (CHW) Behavioral Health Integration into Primary Care – Pilot Project was awarded in September, 2012, to the University of Texas Medical Branch – Texas AHEC East. This is a one-time award with a four-year project period. The purpose of this project is to develop a behavioral health curriculum and train CHWs so that they can effectively enhance behavioral health services within the primary care

setting – particularly in medically underserved communities. This project is being implemented in multiple phases. In the initial phase, which ended September 30, 2013, the grantee worked with state and national subject matter experts and an experienced consultant in behavioral health and curriculum development to develop a behavioral health training curriculum to train community health workers (CHW). The current phase of the project, which will end on August 30, 2014, involves a small scale pilot in four community health centers where the CHWs will undergo specialized on-the-job training in behavioral health. Additionally, training is provided to the managers and supervisors of the CHWs at the community health centers to ensure that they are well-informed to work with the CHWs during their on-the-job training experience. The last phase of the project will involve broader dissemination including pilot sites in multiple states.

8. **Graduate Psychology Education**- The Committee supports the Secretary's initiative to increase the number of psychologists pursuing clinical work with high-need and high-demand populations. These populations are defined as rural, vulnerable, and/or underserved populations, as well as veterans, military personnel, and their families. While the Committee commends the emphasis on programs targeting veteran and military personnel population centers, the Committee is concerned that many service members reintegrate into civilian life in communities that are rural and far from military and veteran facilities. As such, the Committee encourages HRSA to maintain a strong commitment to underserved areas generally. (Pages 45-46)

Action To Be Taken

In FY 2013, HRSA funded 16 new grants totaling $2,452,002, through the Graduate Psychology Education (GPE). Rural and underserved populations, including veterans, military personnel, and their families, were identified as target populations in the Funding Opportunity Announcement for the program. Other underserved populations served by the GPE grantees include children and youths in urban and low-income settings, individuals with chronic illness, and lesbian, gay, bisexual and transgender (LGBT) individuals. HRSA will continue to monitor the inclusion of underserved communities during the implementation phase.

9. **Social Work Training Program**- The Committee recognizes the importance of social workers and their contribution to family planning and maternal and child health outcomes, particularly in low-income communities. The Committee intends the increase in this program to be used to continue and expand the Leadership Training in Social Work program, formerly funded in the Maternal Child Health Bureau of HRSA. This program annually funds three centers of excellence at schools of social work to help develop the next generation of social workers and provide critical leadership, resources, and training. The Leadership Training in Social Work program has successfully recruited many qualified minority candidates for long-term training, and graduates have taken faculty positions in schools of social work, pursued careers in policy and research, and become local leaders in direct service. The Committee directs the Bureau of Health Professions to work with the Maternal Child Health Bureau to ensure a smooth transition for grantees. (Page 46)

Action To Be Taken

The Bureau of Health Professions (BHPr) and the Maternal and Child Health Bureau (MCHB) have begun discussions about how to transfer the lessons learned from the Leadership Training in Social Work program, formerly funded in the MCHB, to the BHPr behavioral health programs. The ability to continue or expand the program will depend on funding availability. BHPr will also alert the Leadership Training grantees about the funding opportunities for which they are eligible to apply. MCHB staff and Leadership Training grantees can be a resource to other BHPr funded social work grantees so that the success from the program can be shared and replicated.

10. **Integrative Medicine**.--The Committee includes $3,502,000 for existing programs related to integrative medicine and $2,000,000 for a new competitive opportunity to improve residency programs in integrative medicine. The Committee intends the new funding to be used to award a national center of excellence on integrative primary care for the purpose of developing and disseminating best practices for integrative medicine training for physicians and nurses. HRSA should select a nonprofit entity with a strong record of leadership in the field of integrative medicine curriculum development, with experience in both publishing and working with residency programs. (Page 46-47)

Action To Be Taken

BHPr plans to continue to fund the twelve existing integrative medicine grantees so that they can build upon the work they have started. BHPr is also exploring options for supporting a national center of excellence on integrative primary care for the purpose of developing and disseminating best practices for integrative medicine training for physicians and nurses. Eligible entities for the national center of excellence would be nonprofit entities with a strong record of leadership in the field of integrative medicine curriculum development.

11. **Nursing Workplace Development Programs**- The Committee remains concerned that waiting lists for admission to nursing school are limiting our Nation's ability to address the nursing shortage. For that reason, the Committee continues to place a strong priority on filling vacant nursing faculty positions, the majority of which require either a Ph.D. or a doctorate of nursing practice. The Committee encourages the Division of Nursing to prioritize this level of training and create incentives for students to pursue teaching as a career. (Page 47)

Action To Be Taken

In FY 2013, the Nurse Faculty Loan Program (NFLP) consolidated 3 funding tiers to 2 to further prioritize doctoral students by placing both new and continuing doctoral students in the first tier funding priority. HRSA's Division of Nursing is also evaluating the feasibility of making programmatic changes in FY 2015. HRSA will work closely with current grantees to identify best practices and barriers for NFLP recipients to successfully move into faculty positions upon completion of their degrees, and will integrate appropriate changes into future annual funding opportunity announcements for the NFLP.

12. **Hemophilia**.--The Committee commends HRSA on its work to establish models of hemophilia care in a culturally sensitive, family-centered coordinated manner. The National Hemophilia Program is a model system for caring for high-cost, chronic conditions. The Committee encourages HRSA to share best practices with CMS, particularly those regarding transitioning care from adolescence to adulthood. (page 48)

    Action To Be Taken
    The Health Resources and Services Administration (HRSA) is committed to continuing support of the National Hemophilia Program through the eight (8) Regional Core grantees and the National Hemophilia Program Coordinating Center which helps coordinate Regional activities to evaluate and disseminate best practices nationally. Within the National Hemophilia Program all federally qualified Hemophilia Treatment Centers, including the HRSA Regional grantees, follow the National Hemophilia Foundation's Medical and Scientific Advisory Committee's (MASAC) Recommendation #132, Standards and Criteria for the Care of Persons with Bleeding Disorders which outlines comprehensive standards of care and services that should be provided by Hemophilia Treatment Centers (HTCs). Implementing and monitoring the medical, educational, and psychosocial transition needs of hemophilia patients is a key aspect in HTC's interactions with patients, families, and caregivers. In fact, the National Hemophilia Program was acknowledged in the 2011 American Academy of Pediatrics (AAP) / American Academy of Family Physicians (AAFP) / American College of Physicians (ACP) clinical report on transition, Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home, as a model program for implementing transition guidelines. Continual efforts to refine and enhance already existing HTC transition activities will be guided by HRSA's Center for Health Care Transition Improvement and evidence-based practices. HRSA is aware of CMS's efforts to finance transition services across different health care settings and will provide evidence from its programs on the benefits of financing transition services from pediatric to adult health care.

13. **Oral Health**- The Committee recognizes the key role that Maternal and Child Health Centers in Pediatric Dentistry provide in preparing dentists with dual training in pediatric dentistry and dental public health, fostering academic leadership, and developing expertise in the treatment of children with special healthcare needs. The Committee encourages HRSA to provide incentives for these centers to leverage resources to strengthen and expand their activities. (Page 48)

    Action To Be Taken
    HRSA's Maternal and Child Health Bureau will work closely with the Maternal and Child Health Centers in Pediatric Dentistry to make sure that they are aware of funding opportunities such as those provided by the Bureau of Health Professions to support pediatric dentistry education.

14. **Perinatal Hepatitis B**- The Committee is pleased at the progress that has been made in reducing perinatal hepatitis B transmission and commends HRSA for the ongoing review of best practices. The Committee notes that the 2010 rate of transmission was the lowest

on record and well below the Healthy People 2010 goal. However, given the availability of an effective post-exposure prophylaxis protocol, the Committee believes that the elimination of all perinatal transmission is a goal worth pursuing. In view of the large number of at-risk women being seen in HRSA-funded settings, the Committee urges HRSA to move expeditiously to integrate the best practices identified in the review into routine practice. In addition, HRSA is encouraged to validate further best practices to prevent perinatal hepatitis B transmission, particularly in high-risk ethnic communities disproportionately impacted by chronic hepatitis B. (Page 48)

Action To Be Taken
HRSA will continue to support the validation and promotion of best practices to prevent perinatal transmission of Hepatitis B among the nation's vulnerable populations.

15. **Social Work Training Program**- The Committee recognizes the importance of social workers and their contribution to family planning and maternal and child health outcomes, particularly in low-income communities. The Committee has included funding in the Bureau of Health Professions to continue and expand the Leadership Training Program in Social Work, which annually funds three centers of excellence at schools of social work to help develop the next generation of social workers and to provide critical leadership, resources, and training. The Committee directs the MCH Bureau to work with the Bureau of Health Professions to ensure a smooth transition for the program's grantees. 49

Action To Be Taken
HRSA's Maternal and Child Health Bureau will work closely with the Bureau of Health Professions to ensure a smooth transition for the Leadership Training Programs in Social Work, assuring that social workers are trained with the leadership and systems integration skills to best serve the needs of children and families.

16. **Autism and Other Developmental Disorders**- The Committee directs HRSA to fund research on evidence-based practices for interventions for individuals with autism and other developmental disabilities, for development of guidelines for those interventions, and for information dissemination at no less than fiscal year 2013 levels. (Page 49)

Action To Be Taken
HRSA's MCHB will continue to fund research on evidence-based practices for interventions for individuals with autism and other developmental disabilities, for development of guidelines for those interventions, and for information dissemination at no less than fiscal year 2013 levels.

17. **Leadership Education in Neurodevelopmental and Related Disabilities [LEND].**--The Committee directs that HRSA provide no less than the fiscal year 2013 level for LEND programs to maintain their capacity to train professionals to diagnose, treat, and provide interventions to individuals with autism spectrum disorders. (Page 49)

Action To Be Taken

HRSA's Leadership Education in Neurodevelopmental and Related Disabilities (LEND) grants provide interdisciplinary training to enhance the clinical expertise and leadership skills of professionals dedicated to caring for children with neurodevelopmental and other related disabilities and special health care needs. The 43 LEND training programs continue to address the shortage of trained professionals who can provide screening and diagnostic services for ASD and other DD. These programs span 39 States and their reach extends beyond those States as a result of partnerships formed and services provided across State lines. These programs have focused on 1) training health professionals to use valid, reliable screening and diagnostic tools and to provide evidence-based interventions for children with ASD or other DD; 2) providing continuing education to practicing health care providers; and 3) providing technical assistance to MCH Title V agencies, community-based organizations, and other entities that serve children with ASD and other DD and their families.

Each year, the LEND programs enroll long-term fellows that receive at least 300 hours of intensive didactic training and clinical experience working as part of a developmental screening or diagnostic team in hospitals, clinics, and community-based settings. In addition, the programs provide "medium-term" training to medical residents and practicing professionals who participate in 40–299 hours of training. Finally, the programs also reach a large number of "short-term trainees" every year who receive up to 40 hours of training. In fiscal year 2012, the LEND programs trained 9,361 short term trainees, 2,608 medium term trainees, and 1,420 long term trainees. By preparing these professionals to implement recommended screening practices and to use evidence-based screening tools such as the Modified Checklist for Autism in Toddlers (M-CHAT), the training programs are improving early identification of ASD and other DD.

Data collected from the LEND programs over the past 4 years show the direct impact of these investments on families with a child who screens positive for ASD. In 2010, LEND programs provided interdisciplinary diagnostic evaluations for more than 35,000 infants and children. With the expanded number of LEND grantees and trainees, the LEND programs provided interdisciplinary diagnostic evaluations for close to 56,000 infants and children in 2012. By continuing to meet the growing demand for these services, the LEND programs are reducing wait times for diagnostic evaluation and entry into intervention services. Moreover, because the LEND programs typically target underserved populations, their efforts are also helping to address disparities in early identification of ASD.

HRSA plans to fund LEND programs at no less than fiscal year 2013 levels.

18. **Public-Private Partnerships- Public-Private Partnerships.--**The Committee commends Healthy Start for engaging in public-private partnerships that identify best practices and lead to continuous quality improvement within the program. The Committee encourages HRSA to continue to evaluate rigorously the Healthy Start program and these partnerships. (Page 50)

Action To Be Taken

The purpose of the Healthy Start (HS) program is to improve perinatal health outcomes and reduce racial and ethnic disparities in perinatal health outcomes by using community-based approaches to service delivery, and to facilitate access to comprehensive health and social services for women, infants, and their families. HRSA/MCHB will continue to engage in public-private partnerships that identify best practices and lead to continuous quality improvement within the program. The Committee encourages HRSA to continue to evaluate rigorously the Healthy Start program and these partnerships.

HRSA/MCHB will support continuous quality improvement efforts in Healthy Start programs by supporting Healthy Start workforce development around core competencies, developing standardized curricula and interventions that are evidence-based or evidence-informed, and promoting continuous quality improvement activities to focus on prevention and health promotion (breastfeeding, immunization, safe sleep, family planning, smoking cessation). Systems and processes that will support the organization's quality improvement activities include selecting/defining a problem/issue appropriate for a QI project, setting an aim statement, deciding on a methodology to use, stating metrics for change, implementing the project, measuring progress through analysis, and then data reporting. HRSA/MCHB will also continue to support Healthy Start programs in implementing their local evaluation plan, as well as designing and developing a scientifically-rigorous national evaluation platform to demonstrate the impact of the Healthy Start program.

19. **Stillbirth and Sudden Unexpected Infant Deaths [SUIDs]-** The Committee notes that racial disparities in stillbirth and SUIDs persist and significantly contribute to the more than 25,000 stillbirths and over 4,000 SUIDs each year. HRSA is encouraged to support training and assistance that will enhance cooperative partnerships among local community health professionals, public health officers, community advocates, and consumers to address racial disparities in SUIDs and stillbirth. In addition, the Committee continues to support HRSA's efforts to review cases of stillbirth and SUIDs at a local level, especially to identify better ways to address racial disparities. (Page 50)

Action To Be Taken

Driving reductions in infant mortality, with an emphasis on increasing health equity, is central to the mission of HRSA's Maternal and Child Health Bureau. Sudden Unexpected Infant Death (SUID) remains the leading cause of death to infants 1 month to 1 year of age and is a significant contributor to the racial disparities present across infant mortality rates. Sleep-related deaths are a major category of deaths during the first year of life and thus HRSA has focused significant efforts on the promotion of protective safe sleep practices across many of its programs. Fostering public-private partnership, the MCHB Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality engages states to develop workgroups using a quality improvement model to use proven methods to decrease infant deaths including sleep-related deaths and measure the impact at the state level. To date, 19 states are actively involved in this initiative that brings various public and private sectors together including state government leaders, public health advocates and non-governmental organizations. Critical to the success of states is

the integration with other HRSA programs that intersect with the well-being of the family: Maternal and Child Health Block Grant, Healthy Start, and the Maternal, Infant and Early Childhood Home Visiting Program. Core to each of these programs is the goal to reduce infant mortality and decrease racial disparities. Each program engages community health professionals, public health officers, community advocates and consumers. In addition to these efforts, MCHB co-chairs the Federal SUID/SIDS Workgroup, a volunteer committee which strives to establish and enhance communication, coordination and collaboration among participating federal agencies with the ultimate goal of reducing SUID, including racial and ethnic disparities.

Once a death has occurred, understanding the contributing factors is essential to future prevention efforts. HRSA's work to review mortality cases is advanced through two unique approaches:

- The National Center for the Review and Prevention of Child Death provides training and technical assistance to state and local child death review (CDR) teams which perform in-depth analyses on child deaths, including SUIDs, to better understand the circumstances of these fatalities and to identify and advance data-driven pathways to prevention. The program hosts the CDR Case Reporting System which serves as the unified and uniform repository for all case review data. This Reporting System is the foundation of the Center for Disease Control and Prevention's SUID Case Registry pilot program.
- The National Fetal & Infant Mortality Review (FIMR) Resource Center provides training and technical assistance to local FIMR teams which work to determine the community-level factors associated with individual cases of fetal or infant death, with an ultimate goal of improving community resources and health service delivery systems for women, infants and families. Many FIMR teams work to promote safe infant sleep in their communities.

  HRSA is committed to supporting existing programs, as well as new and innovative concepts, to drive advancements in reducing SUID rates, including the racial disparities that persist.

20. **Emergency Medical Services for Children**- The Committee commends HRSA for initiating a demonstration project in fiscal year 2012 to support innovative models to increase pediatric care in rural and tribal communities. The Committee also applauds the EMSC program for its collaboration with other Federal agencies in order to achieve EMS systemwide improvements. Finally, the Committee remains strongly supportive of the Pediatric Emergency Care Applied Research Network. (Page 50)

Action To Be Taken
Emergency Medical Services for Children (EMSC) at HRSA continues to promote the development and dissemination of evidence-based practices for pediatric emergency care. To address the gap in evidence for pediatrics in the prehospital setting, EMSC recently (FY 2013) funded six innovation grants in the area of pediatric prehospital care. The initiative addresses two key issues: first, the feasibility of conducting pediatric prehospital research that replicates the Pediatric Emergency Care Applied Research Network and second, by supporting the development and use of evidence-based protocols in the prehospital setting. To ensure application of the evidence in the field, HRSA is working with other Federal agencies and health professional organizations to address the implementation of evidence-based prehospital care to promote quality care delivery throughout the United States.

21. **HIV Testing, Linkage, and Adherence**.--The Committee is aware that, despite the demonstrated success of treatment-as-prevention programs, less than half of all Americans with HIV are on antiretroviral treatment. The Committee believes that the key steps to ending the HIV/AIDS epidemic include finding those people who are unaware of their HIV-positive status, linking all Americans with HIV/AIDS to care and treatment, and retaining them in that care and treatment. The Committee urges HRSA within its Ryan White SPRANS portfolio to focus on the development of systemic approaches aimed at ensuring viral load suppression. (Page 51)

Action To Be Taken:
The Ryan White HIV/AIDS Program has viral suppression as a major goal of HIV care and treatment and will continue to increase efforts in the coming year. The HRSA HIV/AIDS Bureau's Special Projects of National Significance (SPNS) program funds demonstration project initiatives with a focus on promoting the development and evaluation of systemic and innovative approaches of HIV care delivery to vulnerable populations living with HIV. Through these demonstration projects, SPNS grantees implement a variety of community-level interventions gathering best practices and lessons learned on issues related to access, linkage, and retention of hard-to-reach populations, aimed at improving the health outcomes and viral load suppression of HIV-infected populations. SPNS initiatives continue to address the emerging needs of the most disenfranchised populations living with HIV including women of color, transgender people, homeless with multiply-diagnosed co-morbidities, Latinos, young men-who-have-sex with men, individuals with opioid abuse, and HIV/HCV co-infected persons, and actively promotes and evaluates state-wide innovative system strategies to reach people who are unaware of their HIV-positive status and out of care. All of the new SPNS initiatives in 2014 will focus in improving the care continuum with the goal of improving viral suppression.

22. **Emergency Assistance** - The Committee notes that the provision requiring HRSA to transfer funds from part A to part B of the Ryan White Care Act as a result of the four transitional grant areas that changed status in fiscal year 2011 has expired. Therefore, the Committee expects HRSA to transfer no funds in fiscal year 2014 related to transitional grant areas. (Page 51)

Action To Be Taken:
The only portion of the statute that is time-limited is Section 2610(c)(2)(B)(ii) of the PHS Act. This statutory provision is expressly not continued after FY 2013 as recognized above. However, for transitional grant areas (TGAs) that lose status after FY 2013, the statute in Section 2610(c)(2)(A) allows a one-time transfer of funds for the first such subsequent year from Part A to the Part B base only, with no funds going to the state in which the former TGA is located.

The Ponce, PR TGA is in precisely this position: it has been deemed ineligible for Part A funding in FY 2014. No authority is provided for funds to be transferred to the impacted state (the Commonwealth of Puerto Rico), although the statute continues to provide for a one-time transfer of funds from Part A to Part B in an amount equal to Ponce's FY 2013 formula award ($1,111,519) and $500,000, for a total of $1,611,519. These funds will be distributed through Part B base funding, without any particular amount directed to Puerto Rico.
Note that at this time, no TGAs are predicted to lose status in FY 2015 and therefore HRSA expects no funds will be transferred in FY 2015.

23. **Cell Transplantation Program**- The Committee continues to strongly support cell transplantation through the use of cord blood, bone marrow, peripheral blood stem cells, and other sources of stem cells that may be available in the future. The Committee appreciates HRSA's efforts to increase the diversity of the registry and the program's research efforts to improve the availability, efficiency, safety, and cost of transplants and the effectiveness of program operations. (Page 53)

Action To Be Taken
HRSA is committed to continuing the work of the C.W. Bill Young Cell Transplantation Program to increase the number of unrelated blood stem cell transplants for patients in need of such therapy. HRSA, along with its contractors, will continue to implement strategic programs and initiatives that will assist patients across the transplant continuum, from diagnosis through survivorship. HRSA will continue to support long-standing efforts of increasing the available adult volunteer donors and diverse, high-quality umbilical cord blood units available through the C.W. Bill Young Cell Transplantation Program, so that those resources represent the rich racial and ethnic diversity of the patients that rely on the registry for services. HRSA will also continue its work with the contractor**s** to ensure research efforts improve transplant outcomes, donor safety, operational efficiencies, (including cost of transplants), and effectiveness of program operations.

24. **Office of Pharmacy Affairs**- The Committee remains strongly committed to OPA's plans to develop a transparent system to verify the accuracy of the 340B ceiling price. Therefore, the Committee again includes a statutory provision, requested by the administration, to allow a nominal cost recovery fee to fund the implementation of program integrity provisions recommended by the inspector general and included in the ACA. The fee will be set at 0.1 percent for covered entities and is expected to generate

$6,000,000 in fiscal year 2014. The Committee expects HRSA to report the expected and actual amounts generated by the fee in HRSA's annual budget justification. (Page 53)

Action To Be Taken
The 340B cost recovery fee system will provide additional resources for operations, oversight and integrity of the 340B Drug Pricing Program. The cost recovery fee, in addition to OPA's line item budget, will support the natural growth of the 340B Program and fund new authority, responsibilities, and oversight. The cost recovery fee of 0.1 percent would be calculated on and added to the price of the 340B drug. Covered entities would have to pay the user fee to continue to participate in the 340B Program. The fee would be collected by the manufacturer (the manufacturer does not pay the fee) and submitted to the Treasury into an account that HRSA would use to operate the 340B Program and undertake program integrity activities. These activities include the development of the cost recovery system; development of an on-line, secure system to post 340B ceiling prices for access by participating covered entities; establishment of an administrative dispute resolution process for claims of overcharges; and establishment of civil monetary penalties for manufacturers who overcharge or covered entities who intentionally divert drugs to ineligible patients.

25. **OPA**- More than simply an individual discount program, the 340B program was designed to help safety net providers maintain, improve, and expand patient access to healthcare services generally. In establishing the program in 1992, Congress explicitly stated that the 340B program was intended to `enable entities to stretch scarce Federal resources as far as possible.' As OPA continues to improve and enhance oversight of the 340B program, the Committee urges OPA to implement policies that maximize the healthcare safety net and expand patient access to healthcare. (Page 53)

Action To Be Taken
The statute governing the 340B program does not specify how 340B Program savings must be used. The statute speaks only to covered entity eligibility and compliance requirements. Without specific statutory language, HRSA is unable to validate or measure how the savings are used in the 340B Program.

26. **340B Drugs**- The Committee continues to note that there is currently no way for eligible entities to know if they are paying manufacturers the correct prices for 340B drugs. The ACA requires HRSA to make 340B ceiling prices available to covered entities through a secure Web site. Given that the new cost recovery fee is being paid by 340B participating entities, the Committee directs HRSA to make this Web site the first activity funded by the fee. (Page 53)

Action To Be Taken
HRSA does not have an established date by which it is going to post the file to our website.

27. **Covered Outpatient Drug**- The Committee commends HRSA for delaying the enforcement of the group purchasing exclusion guidance promulgated on February 7,

2013, but remains concerned by HRSA's broad interpretation of the term `covered outpatient drug.' The Committee urges HRSA to create an understanding of the term that is more specific to the 340B program. This would allow 340B-participating entities to use other available purchasing methods to obtain access to non-340B drugs at a lower cost. (Page 54)

Action To Be Taken
The statute states that the term covered drug "means (A) covered outpatient drug (as defined in section 1927(k)(2) of the Social Security Act): and (B) includes, notwithstanding paragraph (3)(A) of section 1927(k) of such Act, a drug used in connection with an inpatient or outpatient service provided by a hospital described in subparagraph (L), (M), (N), or (O) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section.

28. **Poison Control Centers**- Poison control centers respond to nearly 4 million public and healthcare professional poisoning, toxic exposure, and adverse drug event emergency calls annually. It is estimated that the avoidance of these unnecessary hospitalizations save more than $1,200,000,000 in healthcare costs annually, of which nearly $700,000,000 of these savings accrue to the benefit of the Federal Medicare and Medicaid programs. The Committee believes these savings can be substantially increased through enhanced awareness of poison control centers by all Medicare and Medicaid participants. The Committee encourages the Secretary to engage in discussions with the Nation's poison control centers to develop a plan to achieve these possible additional Medicare and Medicaid cost savings. (Page 54)

Action To Be Taken
HRSA will engage the Nation's 56 poison control centers, the American Association of Poison Control Centers, Centers for Medicare and Medicaid Services, as well as other organizations that reach Medicare and Medicaid participants to develop a plan to increase awareness of the Poison Help line and the services poison centers provide in an effort to help affect possible additional Medicare and Medicaid cost savings.

29. **Office of Rural Health Policy**-The Committee commends ORHP for its increased collaboration with the Department of Veterans Affairs and other agencies of the Federal Government. ORHP has significant experience in the areas of information technology, workforce recruitment and retention, and improved access to care. The Committee urges ORHP to continue providing its expertise across the government in ways that improve healthcare delivery in rural areas. The Committee directs the Administrator to report to Congress in the fiscal year 2015 budget justification on ORHP's efforts in this area. (Page 55)

Action To Be Taken
Response: ORHP will gather information for the 2015 Budget Justification related to collaboration on our work with the Department of Veteran Affairs (VA). The Office has had an ongoing collaboration with the VA and its Office of Rural Health. We have also

examined strategies for targeting Veterans within our existing programs. For example, we are currently funding a three-year pilot program focused on creating Rural Health Information Technology Training Networks. This program seeks to increase the number of qualified HIT providers in rural communities. ORHP has placed an emphasis on recruiting, educating and training veterans, in an effort to provide them an opportunity to rejoin the workforce. In the funding opportunity, ORHP has encouraged applicants to reach out to veterans in their states. Moving forward, ORHP plans to provide resources from the Veteran's Affairs Office of Rural Health on ways the grantees can utilize existing resources within their state. ORHP also plans to hold a webinar featuring best practices programs that have successfully placed veterans in the workforce. These resources will then allow ORHP to work with the grantees to develop a plan on ways that they can proceed in recruiting veterans. Five of the 15 grantees have identified a range of strategies for identifying Veterans to enroll in the training programs. This includes the following:

- Collaborating with workforce development coordinators on state and county levels to incorporate suggested mechanisms for effectively recruiting and enrolling veterans into their programs;
- Organizing recruitment and screening processes for student enrollment around mechanisms tailored specifically to reaching out to potential veteran applicants;
- Utilizing program tools and resources available through hiring veteran programs; and
- Including veteran affiliated workforce development professionals on network boards and advisory committees in order to assist in leading veteran recruitment and training efforts within their programs.

ORHP has met and presented to the VA Office of Rural Health and their Rural Points of Contact in the field to bring them up to speed on key ORHP programs and opportunities for serving rural Veterans.

30. **Frontier Extended Stay Clinics-** The Committee is aware that the Frontier Extended Stay Clinic demonstration concluded in April 2013. The Committee urges HRSA to assist clinics in maintaining their infrastructure while they wait for CMS' evaluation of data from the demonstration. (Page 55)

Action To Be Taken

Response: We remain supportive of the FESC initiative. The CMS Medicare demonstration is complete and the CMS evaluation is also near completion. We continue to collaborate with the key partners as they work with Alaska Medicaid and Blue Cross Blue Shield on the next stage of the FESC model to determine the best approach.

31. **Native American Graduate Education-** The Committee is aware of significant needs in rural areas of the country for health professionals and in particular those areas that have significant populations of Native Americans. The Committee encourages HRSA to work with institutions in these areas to help them identify appropriate graduate health professions training programs for the need. (Page 55)

Action To Be Taken

HRSA is committed to working with tribes, tribal organizations and Native American communities to help meet their health workforce needs. Many Tribal Colleges and Universities do not meet the statutory accreditation requirements to receive direct funding from HRSA's health professions training and education programs. However, HRSA's Area Health Education Centers (AHEC) programs in regions that have significant Native American populations have established strong collaborations with Tribal Colleges, Universities and Native American communities. AHEC programs such as those in Arizona, New Mexico, Montana, North Dakota, and South Dakota, support Native American students in community-based clinical experiences for fellowships and residencies as well as provide continuing education programs to tribal community members. In addition, Tribal Colleges, Universities and other tribal institutions not statutorily eligible to apply directly to HRSA's COE program can become part of a consortium with eligible accredited health professions schools to collectively develop and implement a COE. At the University of North Dakota, the COE funds one program in Native Behavioral Health that is focused on the recruitment, retention, and successful completion of behavioral health career training by Native Americans. HRSA will continue to explore new opportunities for supporting tribal health workforce needs, within the constraints of existing funding and programmatic requirements.

32. **Oral Health**- The Committee remains concerned about the unnecessary use of hospital emergency rooms [ERs] for relief but not resolution of oral health maladies. The 2012 report `A Costly Dental Destination' estimates that 830,590 emergency room visits were made across the country in 2009 because of preventable dental problems. The Committee is aware of several successful community-wide programs that have effectively reduced ER visits for oral health patients. The Committee urges HRSA to compile best practices related to reductions in emergency dental care and disseminate that information to small and rural hospitals. In addition, HRSA is encouraged to work with CMS and AHRQ to identify gaps in knowledge related to these prevention initiatives. (Page 55-56)

Action To Be Taken

HRSA, CMS, and AHRQ have representation on the HHS Oral Health Coordinating Committee which meets monthly and has served as a venue to share knowledge, identify gaps and discuss strategies for addressing those gaps related to oral health promotion, including the reduction of ER visits for oral health patients.

HRSA's Bureau of Health Professions also collaborates with HRSA's Office of Rural Health Policy (ORHP) on multiple initiatives to improve oral health in rural areas that could help reduce inappropriate use of emergency rooms for oral health care. ORHP has funded rural communities to implement oral health programs as part of the 330A Outreach Authority program. This program focuses on reducing oral health care disparities and expanding health care services in rural areas. HRSA funded development of an Oral Health Toolkit that includes dissemination of rural health resources and promising practices.

- This evidence-based toolkit was developed through extensive literature reviews of models that have been proven to work and demonstrate outcomes

- Link: http://www.raconline.org/communityhealth/oral-health/

33. **Telehealth and Electronic Health Records**-The Committee commends HRSA for its work on telehealth and electronic health records in rural hospitals, with a focus on mental healthcare for veterans. The Committee modifies previous bill language to give HRSA flexibility to determine future needs in this area. (Page 56)

Action To Be Taken

Response: ORHP intends to continue its work in the area of health information technology (HIT) and telehealth. The Office is finishing up a three-year pilot in HIT that supported 41 grantees and focused on getting networks of rural health care providers adopt electronic health records. To date, 88% of grantees had all or some network members reach Meaningful Use (MU) Stage 1, and 93% had all or some network members receive incentive payments under Medicare and Medicaid. These grantees are currently working on their plan to achieve MU Stage 2.

ORHP is also in its first year of funding for the Rural HIT Workforce program, which was established to provide formal training programs to train HIT workforce in rural hospitals and clinics. By the end of this three-year program, each of the 15 projects will graduate its first class of HIT technicians and they will be ready to work in rural hospitals and clinics and help them maintain HIT systems, such as electronic health records, telehealth, home monitoring, mobile health technology, and meet EHR Meaningful Use Standards. In addition, each of the programs will then make their training curriculum available on-line so that other rural-serving community colleges can replicate the programs. ORHP is also continuing its support of the Telehealth Network Grant Program (TNGP), which currently supports 20 grantees for FY 2014, offering over 40 different type of services. Nine of these grantees focus solely on mental health.

As the Committee noted, we are also focusing on using HIT to enhance care for rural Veterans through the Rural Veterans Health Access Program (RVHAP). This program, which is done in coordination with the VA, provides approximately $1 million to support three pilot programs to examine ways to use telehealth and health information exchange to improve access to and the coordination of care for rural Veterans who receive care in their home communities and also in more distant VA facilities.

ORHP is also collaborating with its Federal partners on HIT activities. The HHS Office of the National Coordinator (ONC) for HIT, USDA Rural Development and the VA Office of Rural Health are all working together on several ongoing HIT initiatives. HHS and USDA launched a pilot project in the summer of 2013 to expand access to capital to support HIT in Iowa, Kansas, Texas, Illinois and Mississippi. Other key Federal and funding partners included the Appalachian Regional Commission and the Delta Regional Authority. Through this work, the hospitals in those states were able to compete for more than $38 Million in funding from USDA Rural Development to critical access hospitals and rural hospitals in Iowa, Kansas, Texas and Illinois. The Appalachian Regional Commission also provided over $578,000 in grant funding for rural health IT in Mississippi. ORHP collaborated on a larger effort led by ONC and the VA to support 10 pilot projects to help rural veterans gain access to their health information stored in the

VA system and then transmit this health information to their local non-VHA health care provider to enhance care coordination.

34. **Rural Access to Emergency Devices**- The Committee intends this appropriation to fund the rural program authorized in section 413 of the PHS Act and the community access demonstration authorized in section 313. Funding will be used to buy automated external defibrillators, put them in public areas where cardiac arrests are likely to occur, and train lay rescuers and first responders in their use. (Page 56)

Action To Be Taken

Response: ORHP is currently funding a total of 10 Rural Access to Emergency Devices (RAED) grants for a total of approximately $1,481,593. The purpose of the RAED program is to purchase and place AEDs, and train providers in the use of the AEDs. In FY 2012, 188 AEDs were purchased and approximately 940 lay persons and first responders received training in CPR and on the usage of the devices. One device, which was placed in a police vehicle, was reported to be used prior to the ambulance arriving on the scene. ORHP is currently working on revised performance measures that grantees will report on which will include specific outcome measures. These draft measures will include information on the number of times a device is used, who administered the device and the type of shock delivered by the device.

35. **Office for Advancement of Telehealth [OAT]-** The Committee commends OAT for expanding adult mental health services to 204 communities and pediatric/adolescent mental health services to 239 communities where access to such services did not exist prior to receiving Federal telehealth funding. The Committee remains strongly supportive of the emphasis OAT has placed on expanding access to mental health services. 57

Action To Be Taken

Response: The use of Telehealth technology to address mental health needs continues to grow. As noted in our performance table, the latest actual results are from FY 2011, and demonstrate an expansion of adult mental health services to 304 communities and pediatric/adolescent mental health services to 310 communities where access to such services did not exist prior to receive Federal telehealth funding. These are cumulative totals from both current and past grantees, and these numbers exceeded our targets for that year.

The FY 2014 planning target for the President's Budget is to expand adult mental health services to 204 communities and pediatric/adolescent mental health services to 239 communities. Please note that every three years each cohort of TNGP grantees "graduates" from its three-year grant while a new cohort of grantees commences a new three-year cycle of grant-supported Telehealth activities. The data are calculated as a cumulative number for only those grantees that are providing mental health services. Within its current cohort of grantees, OAT is currently supporting 20 TNGPs representing 191 service sites. The latest cohort of TNGP grantees will be providing their first data submission by April of 2014 for OAT to identify the precise number of

service sites that are providing mental health services including those that solely focus on pediatric and adolescent mental health issues.

36. **Tiered Subgranting-** The Committee is aware that some traditional grantees of the title X program are implementing newly tiered approaches which base subgranting decisions on criteria that are unrelated to the performance outcomes of the program. The Committee directs HRSA to give funding preference to applicants with plans that show that a wide range of providers are eligible for subgrants and that funding decisions will be made solely on the ability of a clinic to achieve the best possible outcomes for the population served. (Page 57-58)

Action Taken or To Be Taken

The Office of Population Affairs recognizes the seriousness of this issue, and has taken specific steps to address, particularly as family planning service areas become available for competition. The most recent Funding Opportunity Announcement (FOA) incorporates specific language to address the issue of "tiering" as well as excluding specific types of entities not related to their ability to provide the required services.

Funding Opportunity Description: *"Funding of applications that propose to rely on other entities to provide services will take into consideration the extent to which the applicant indicates it will be inclusive in considering all entities that are eligible to receive Federal funds to best serve individuals in need throughout the anticipated service area."*

Additionally, one of the criteria for assessing applications stipulates the following: *"For applicants that will not provide all services directly, the extent to which the applicant will consider all qualified entities eligible to receive federal funds in providing services throughout the service area."*

These factors are taken into consideration in the scoring of applications and subsequent funding decisions.

Health Education Assistance Loans

Tab

Health Education Assistance Loans

Table of Contents

FY 2015 Budget

Amounts Available for Obligation.....460

Summary of Changes.....462

Budget Authority by Activity.....463

Budget Authority by Object.....463

Salaries and Expenses.....464

Authorizing Legislation.....465

Appropriation History Tables.....466

Justification:

Health Education Assistance Loan Program Narrative.....468

Amounts Available for Obligation

Program and Financing Accounts

	FY 2013 Enacted	FY 2014 Enacted	FY 2015 PB
Balance, start of year	$49,475,220	$108,136,672	-
Appropriation	2,659,000	2,687,000	-
Appropriation Transfer to Department of Education		-671,750	
Total Appropriation	2,659,000	2,051,250	-
Collections:			
Upward Re-estimate	56,362,348		-
Downward Re-estimate		-43,360,879	
Interest	6,116,068		
FAI Adjustment	-861,350		
Repayments/Recoveries	6,401,750	2,915,491	-
Total collections	68,880,166	-40,445,388	
Borrowing Authority, Mandatory			
Total available	118,355,386	67,691,284	-
Claims:			
Death and disability	-1,633,791	-3,000,000	
Defaults	-7,947,018	-8,983,715	
Total claims	-9,580,809	-11,983,715	-
Principle Payments on Borrowing			
Administrative BA	-2,659,000	-2,015,250	
Ending balance	$108,136,672	$55,707,569	

Amounts Available for Obligation

Liquidating Account

	FY 2013 Enacted	FY 2014 Enacted	FY 2015 PB
Balance, start of year	---	---	---
Appropriation	$1,000,000	$1,000,000	-
Collections:			
Repayments/Recoveries	8,164,385	9,000,000	-
Total available	9,164,385	10,000,000	-
Total claims	-1,631,352	-2,722,456	-
Sweep-up to Treasury	$7,533,033	$6,277,544	-

Summary of Changes

Discretionary Appropriation:		
Increase:	**FTE**	**BA**
2014 HEAL Program Account	14	$2,687,000
2015 HEAL Program Account	-	-
Total Change	-14	-$2,687,000

Budget Authority by Activity

(Dollars in thousands)

	FY 2013 Enacted	**FY 2014 Enacted**	**FY 2015 PB**
Liquidating Account SLIA	$1,000,000	$1,000,000	-
HEAL Program Account:			
Administrative Expenses	$2,659,000	$2,687,000	-

Budget Authority by Object

Liquidating Account

Object Class (33.0)	**FY 2014 Enacted**	**FY 2015 PB**	**Increase or Decrease**
Investments and loans	$1,000,000	---	-$1,000,000

Budget Authority by Object

Program Account

	FY 2014 Enacted	FY 2015 Estimate	Decrease
Full-time equivalent employment	14	-	-
Average GS Grade	12.5	-	-
Average GS Salary	$84,800	-	-$84,800

	FY 2014 Enacted	FY 2015 Estimate	Decrease
Personnel compensation:			
Full-time permanent (11.1)	$1,339,000		-1,339,000
Other than full-time perm (11.3)			
Other personnel comp (11.5).			
Total personnel comp (11.9)	**$1,339,000**	**-**	**-$1,339,000**
Personnel benefits (12.1)	365,000		-365,000
Benefits for Former Personnel(13.1)			
Subtotal Pay Costs.	**$1,704,000**	**-**	**-$1,704,000**
Travel and transportation of Persons (21.0)			
Transportation of things (22.0)			
Rental payments to GSA (23.1)	139,000		-139,000
Printing (24.0)			
Other Contractual Services:			
Other services (25.2)	844,000		-844,000
Purchase of goods and services from other Government accounts (25.3)			
Operation and Maintenance of Equipment (25.7)			
Discounts and Interest (25.9)			
Supplies and Materials (26.0)			
Subtotal Other Contractual Services	**$844,000**		**-$844,000**
Equipment (31.0)			
Total Budget Authority by Object Class.	**$2,687,000**	**-**	**-$2,687,000**

Salaries and Expenses

	FY 2014 Enacted	FY 2015 Enacted	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$ 1,339,000		-1,339,000
Other than full-time perm (11.3)			
Other personnel comp (11.5).			
Total personnel comp (11.9)	**$1,339,000**	**-**	**-$1,339,000**
Personnel benefits (12.1)	365,000		-365,000
Benefits for Former Personnel(13.1)	-		-
Subtotal Pay Costs.	**$1,704,000**	**-**	**-$1,704,000**
Travel and transportation of persons (21.0)			
Transportation of things (22.0)			
Rental payments to GSA (23.1)	139,000		-139,000
Printing (24.0)			
Other Contractual Services:			
Other services (25.2)	844,000		-844,000
Purchase of goods and services from other Government accounts (25.3)			
Operation and Maintenance of Equipment (25.7)			
Discounts and Interest (25.9)			
Supplies and Materials (26.0)			
Subtotal Other Contractual Services	844,000	-	-844,000
			-
Subtotal Non-Pay Cost	**$983,000**	**-**	**-$983,000**
			-
Total Salaries and Expenses	**$2,687,000**	**-**	**-$2,687,000**

Authorizing Legislation

	FY 2013 Enacted	FY 2014 Amount Authorized	FY 2015 Pres. Budget
Health Education Assistance Loans and Student Loan Insurance Account:			
Appropriation:			
Liquidating Account (SLIA):			
PHS Act, Sec. 710	$1,000,000	---	---
Program Account:			
PHS Act, Secs. 709, 720	$2,659,000	SSAN	---
Borrowing authority (SLIA):			
PHS Act, Sec 710(b)	---	---	---

APPROPRIATION HISTORY
HEAL Program Account

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2005	3,270,000	3,270,000	3,270,000	3,270,000
Rescission				-26,000
2006	2,916,000	2,916,000	2,916,000	2,916,000
Rescission				-31,000
2007	2,887,000	2,887,000	2,887,000	2,898,000
2008	2,906,000	2,906,000	2,906,000	2,847,000
2009	2,847,000	2,847,000	2,847,000	2,847,000
2010	2,847,000	2,847,000	2,847,000	2,847,000
2011	2,841,000	2,841,000	2,841,000	2,841,000
2012	2,841,000	2,841,000	2,841,000	2,841,000
Rescission				-34,000
2013	2,807,000	-	2,807,000	2,853,000
Sequestration				-143,000
Transfer				-28,000
2014	2,687,000	-	2,687,000	2,687,000
Transfer				-672,000

Liquidating Account

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2002	10,000,000	10,000,000	10,000,000	10,000,000
2003	7,000,000	7,000,000	7,000,000	7,000,000
2004	4,000,000	4,000,000	4,000,000	4,000,000
2005	4,000,000	4,000,000	4,000,000	4,000,000
2006	4,000,000	4,000,000	4,000,000	4,000,000
2007	4,000,000	1,000,000	1,000,000	1,000,000
2008	1,000,000	1,000,000	1,000,000	1,000,000
2009	1,000,000	1,000,000	1,000,000	1,000,000
2010	1,000,000	1,000,000	1,000,000	1,000,000
2011	1,000,000			1,000,000
2012	1,000,000	1,000,000	1,000,000	1,000,000
2013	1,000,000	1,000,000	1,000,000	1,000,000
2014	1,000,000			1,000,000

Health Education Assistance Loans

	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Request	FY 2015 +/- FY 2014
Liquidating Account	$1,000,000	$1,000,000	---	-$1,000,000
HEAL Credit Reform-Direct Operations	$2,659,000	$2,687,000	---	-$2,687,000
FTE	14	14	---	-14

Authorizing legislation: Sections 701-720 of the Public Health Service Act
FY 2015 Authorization ..... Such Sums as Necessary
FY 2015 Authorization - Liquidating Account..... Such Sums as Necessary
Allocation Method .....Other

Program Goal and Description: The Health Education Assistance Loan (HEAL) Program insures loans made by participating lenders to eligible graduate students from 1978 through 1998. Authority to make new loans expired September 30, 1998 and refinancing ended September 30, 2004.

The Consolidated Appropriations Act of 2014 (P.L. 113-76) permanently transferred the authority to administer the HEAL program, including servicing, collecting, and enforcing any loans that were made under such program that remain outstanding from the Secretary of Health and Human Services to the Secretary of Education no later than June 30, 2014. An estimated X.X million is expected to be transferred to Department of Education.

Program Accomplishments: Between 1978 and 1998, the program provided $4 billion in loans to help 157,000 students of diverse socio-economic backgrounds pay for their health professions education. Approximately $2.2 billion in HEAL loans were refinanced.

The HEAL Program maintains, and updates quarterly, a list of defaulted HEAL borrowers on the internet. This site includes approximately 846 health professionals who owe the Federal Government approximately $105.5 million on their defaulted HEAL loans as of February 2014. Millions of dollars have been received from defaulters as a result of the activities associated with publicizing their names.

Funding History

FY	Amount	Liquidating Account
2011	$2,841,000	$1,000,000
2012	$2,807,000	$1,000,000
2013	$2,659,000	$1,000,000
2014	$2,687,000	$1,000,000
2015	---	---

Budget Request

No funding is requested for FY 2015 Budget Request. The FY 2015 Request is $2,687,000 below the FY 2014 Enacted level. The Budget reflects the transfer of the HEAL Program from the Department of Health and Human Services to the Department of Education in FY 2014.

The Health Education Assistance Loans Program investment in IT supports the strategic and performance outcomes of the program and contributes to its success by providing a system that enables the Program to ensure data integrity, monitor adherence to legislation, meet regulatory or policy requirements and pay claims in the proper amounts. This investment automates borrower, loan, litigation, claim, school, and lender information. The system allowed the HEAL program to automate a large portion of the claim review process including the calculation of time periods mandated in legislation and regulation and computation of penalty periods. Administratively, the system provides management with approximately 100 reports used to monitor lender/servicer activity.

Outcomes and Outputs Tables Measure	**Year and Most Recent Result /Target for Recent Result / (Summary of Result)**	**FY 2014 Target**	**FY 2015 Target**	**FY 2015 Target +/- FY 2014 Target**
9.VII.C.1: Conduct an orderly phase out of the outstanding loan portfolio, resulting in a reduction in the Federal liability associated with the HEAL Program (balance in the portfolio, dollars in millions). (Outcome)	FY 2013: $399	N/A[216]	N/A	N/A
9.E: Improve claims processing efficiency through implementation of an online processing system (HOPS). (Av. Number of days to process claims)(Efficiency)	FY 2013: 5 days	N/A[216]	N/A	N/A

[216] Measure has been discontinued in FY 2014 due to the program to being transferred to the Department of Education in FY 2014.

Vaccine Injury Compensation Program

TAB

Vaccine Injury Compensation Program
Table of Contents

FY 2015 Budget Page

Appropriation Language 472

Amounts Available for Obligation.....473

Budget Authority by Activity 473

Budget Authority by Object.....473

Authorizing Legislation 474

Appropriation History Table.....475

Justification:

A. Vaccine Injury Compensation Program.....476

Appropriations 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 [$6,464,000*]$7,500,000* shall be available from the Trust Fund to the Secretary.

Amounts Available for Obligation

	FY 2013 Final	FY 2014 Enacted	FY 2015 Estimate
Discretionary Appropriation:	$19,000,000	$19,000,000	$21,000,000
Mandatory Appropriation	235,000,000	235,000,000	235,000,000
Subtotal, adjusted appropriation……	$254,000,000	$254,000,000	$256,000,000
Spending Auth Offsets	1,000,000		
Budgetary Resources Available	**$255,000,000**	**$254,000,000**	**$256,000,000**
Administrative Expenses	19,000,000	19,000,000	21,000,000
Total Admin.DOJ/Claims Ct/HRSA	235,000,000	235,000,000	235,000,000
Reimbursable Program Activity (claims)	2,000,000		
Total New Obligations	**256,000,000**	**254,000,000**	**256,000,000**
Unobligated Balance	**1,000,000**	**-**	**-**

Budget Authority by Activity

	FY 2013 Final	FY 2014 Enacted	FY 2015 Pres. Budget
Trust Fund Obligations: Post-10/1/88 claims	$235,000,000	$235,000,000	$235,000,000
Administrative Expenses: HRSA Direct Operations	$6,464,000	$6,464,000	$7,500,000
Total Obligations	$241,464,000	$241,464,000	$242,500,000

Budget Authority by Object

	FY 2014 Enacted	FY 2015 Estimate	Increase or Decrease
Insurance claims and indemnities	$235,000,000	$235,000,000	-
Other Services (25.2)	$6,464,000	$7,500,000	$1,036,000
Total	$241,464,000	$242,500,000	$1,036,000

Authorizing Legislation

	FY 2013 Enacted	FY 2014 Amount Authorized	FY 2015 Pres. Budget
(a) PHS Act, Title XXI, Subtitle 2, Parts A and D:			
Pre-FY 1989 Claims	---	--	---
Post-FY 1989 Claims	SSAN	$235,000,000	$235,000,000
(b) Sec. 6601 (r)d ORBA of 1989 (P.L. 101-239):			
HRSA Operations	$6,464,000	$6,464,000	$7,500,000

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
2000	---	---	---	---
2001	---	---	---	---
2002	---	---	---	---
2003	---	---	---	---
2004	---	---	---	---
2005	---	---	---	---
2006	---	---	---	---
2007	---	---	---	---
2008	---	---	---	---
2009	---	---	---	---
2010	---	---	---	---
2011	----	----	---	----
2012	----	----	---	----
2013	----	----	----	----
2014	----	----	----	----
2015	----	----	----	----

Vaccine Injury Compensation Program

	FY 2013 Final	FY2014 Enacted	FY 2015 President's Budget	FY2015 +/- FY2014
Claims BA	$235,000,000	$235,000,000	$235,000,000	---
Admin BA	$6,464,000	$6,464,000	$7,500,000	+$1,036,000
Total BA	$241,464,000	$241,464,000	$242,500,000	+$1,036,000
FTE	19	22	25	+3

Authorizing Legislation – Public Health Service Act, Title XXI, Subtitle 2, Parts A and D, Sections 2110-19 and 2131-34.

FY 2015 Authorization ..... Indefinite

Allocation Method .....Other

Program Description and Accomplishments

The National Childhood Vaccine Injury Act of 1986 (the Act) established the National Vaccine Injury Compensation Program (VICP) to equitably and expeditiously compensate individuals, or families of individuals, who have been injured by childhood vaccines, and to serve as a viable alternative to the traditional tort system. The Health Resources and Services Administration (HRSA) administers the VICP in conjunction with the Department of Justice (DOJ) and the U.S. Court of Federal Claims (Court). HRSA has been delegated the authority to administer Parts A and D of Subtitle 2. Consistent with this delegation, HRSA:

- Receives petitions for compensation served on the Secretary of HHS (the Secretary);
- Arranges for medical review of each petition and supporting documentation by physicians with special expertise in pediatrics and adult medicine, and develops recommendations to the Court regarding the eligibility of petitioners for compensation;
- Publishes notices in the Federal Register of each petition received;
- Promulgates regulations to modify the Vaccine Injury Table;
- Provides administrative support to the Advisory Commission on Childhood Vaccines (ACCV), composed of nine voting members, including health professionals, attorneys,

and parents of children who have suffered a vaccine-related injury or death, and specified HHS agency heads (or their designees);

- Informs the public of the availability of the Program; and
- Processes award payments to petitioners and their attorneys for judgments entered by the Court, and informs the public of the availability of the VICP.

As of February 2014, over 3,500 families and individuals have been awarded compensation totaling over $2.85 billion since the Program's inception. FY 2008 through FY 2013 resulted in the largest outlays since VICP's inception, with over $1.05 billion in compensation awards to more than 1,320 families and individuals. The Program had 501 non-autism claims filed in FY 2013 (versus an average of 283 non-autism claims filed annually over the preceding ten years) and 375 families and individuals were awarded compensation totaling $276.4 million, which is approximately $198 million more than the average amount of outlays from FY's 2002-2009. (Yearly outlay totals include payments for attorneys' fees and costs.)

In 2012, the Institute of Medicine (IOM) released its third consensus report on the epidemiological, clinical, and biological evidence surrounding adverse events associated with 12 vaccines covered by the VICP. The vaccines are varicella zoster, influenza, hepatitis B, human papillomavirus, measles-mumps-rubella, hepatitis A, meningococcal and tetanus-containing vaccines such as diphtheria and tetanus toxoids and acellular pertussis vaccines. Two previous IOM reports published in 1991 and 1994 led to the Secretary adding injuries/conditions to the Vaccine Injury Table. The Table provides petitioners with a presumption of vaccine causation (and entitlement to compensation), if certain legal requirements are met. Since the last set of IOM report-related Table modifications in 1997, nine vaccines have been added to VICP, but there has been no independent examination of the adverse events associated with the use of these vaccines. As mandated under the Act, the Secretary must consult with the ACCV and seek public comment before any modifications to the Table are made. In December 2011 and March 2012, the ACCV unanimously approved proposals to add more injuries to the Table.

The VICP performance measures are focused on the timely adjudication of vaccine injury claims and monetary awards. From FY 2005-2012, the target for the percentage of eligible claimants who were awarded compensation, but opted to reject awards and elected to pursue civil action has been zero percent, and the VICP has met its target each of these fiscal years.

In FY 2007, the VICP did not meet its target of 1,213 days for the average time to process claims due to petitioner and Court-driven delays in adjudicating claims. For the time period of FY 2007, the performance outcome was 1,337 days. However, the VICP target average time to process claims was successfully met for FY 2006, FY 2008, FY 2009, FY 2010 and FY 2011, with the FY 2011 result being 993 days. The target average time to process a claim was not met in FY 2012, with a result of 1,309 days average compared with a target of 1,300 days. This outcome was due, in part, because six claims which were filed back in 1999 went to judgment and were paid in FY 2012, several of which were multi-million dollar awards. This indicates the complexity and difficulty in these cases in determining damages and the development of life care plans. FY 2013 target of 1,300 days was exceeded with a result of an average of 930 days.

The VICP has consistently exceeded its 86 percent target for the percentage of cases where the deadline for the Rule 4(b) report is met once the case has been deemed complete. In FY 2010, the Rule 4(b) report deadline was met for nearly 96 percent of the cases that were deemed complete (which is slightly more than in FY 2009), and performance remained steady once again in FY 2011 at 96.6 percent. FY 2012 results were 94.7 percent and the FY 2013 results are 95.2 percent, again exceeding the target of 86 percent.

Quickly and efficiently processing settlements is a top priority for the VICP. In FY 2011, the average time to process a settlement was 9.4 days, compared to the target of ten days. During FY 2012, the VICP received a 76 percent increase in the number of claims from the previous ten-year average (a 226 claim average to 398 claims filed in FY 2012) and processed twice as many negotiated settlements over the last three fiscal years. This level of filed claims and settlements is expected to continue to increase through FY 2014. Each DOJ settlement proposal requires the Office of the General Counsel (OGC) review and preparation of a legal opinion for VICP. In addition, consultation with DOJ attorneys to clarify or amend elements in the settlement proposal is often required during the approval process. The FY 2012 result was an average of 6.6 days, and the FY 2013 result was an average of 7.2 days, all exceeding the 10-day target.

In FY 2011, VICP paid lump sum only awards within an average of 4.9 days, exceeding the eight day performance target. The FY 2012 lump sum only award processing average was 3.6 days. Despite an unprecedented increase in compensation awards, the FY 2013 result was an average of 7.8 days, which exceeded the eight day target.

The percentage of cases in which settlements were completed by agreement among the parties by DOJ within 15 weeks has remained at 100 percent since FY 2008, exceeding the 92 percent target.

As outlined above, all targets were met, despite a significantly increased number of filings, number of compensation awards processed and amount of compensation paid by the Program.

Funding History

VICP Awards

FY	Amount
FY 2011	$234,991,887
FY 2012	$186,800,263
FY 2013	$277,087,363
FY 2014	$235,000,000
FY 2015	$235,000,000

Budget Request

The FY 2015 Claims Awards Budget Request is $235,000,000. The FY 2015 Request is equal to the FY 2014 Enacted level.

The FY 2015 Administrative Budget Request is $7,500,000. The FY 2015 Request is $1,036,000 above the FY 2014 Enacted level.

The FY 2015 Request will fund the following:

VICP Claims Awards - The VICP awards payments to individuals or families of individuals, who have thought to have been injured, or have died, as the result of receiving a vaccine(s) recommended by the Centers for Disease Control and Prevention (CDC) for routine administration to children. In FY 2015, HRSA estimates that $235,000,000 will be paid out of the Vaccine Injury Compensation Trust Fund (Trust Fund) for payment of Court-ordered awards for alleged vaccine-related injuries or deaths. These funding levels are necessary to account for potential outlays resulting from the processing of claims ordered by the Court that require medical reviews of increasing numbers of non-autism claims filed annually, medical reviews for certain autism claims, and compensation for injuries and attorneys' fees and costs. The significant increase in non-autism claims is primarily the result of the addition of the influenza vaccine to the VICP, which now accounts for approximately 50 percent of claims filed annually.

This Claims Award funding level will ensure adequate funds are available to pay awards allowing 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.

Administrative Expenses - HRSA anticipates using $7,500,000 from the Trust Fund for administrative expenses to cover costs associated with the internal medical review of claims, external medical review of claims by outside consultants (including, where warranted, expert testimony to the Court), professional and administrative support to the ACCV, meeting specific administrative requirements of the Act, processing award payments, maintaining necessary records, and informing the public of the availability of the VICP.

Non-autism claim filings have increased significantly since FY 2008, primarily due to the addition of influenza vaccines in 2005. Over 430 claims were filed in FY 2010, 382 claims were filed in FY 2011, 399 claims were filed in FY 2012, and 501 claims were filed in FY 2013 versus an average of 168 non-autism claims filed annually from FY 2000-2008. This upward trend is likely to continue with the February 2010 recommendation by CDC of universal use of influenza vaccines for all individuals over the age of six months. Further, claims alleging injury from the 2009 pandemic influenza H1N1 vaccine were initially filed with the Countermeasures Injury Compensation Program when it was a monovalent vaccine. However, starting with the 2010-2011 flu season, the H1N1 vaccine was made part of the seasonal influenza vaccine and now these claims are to be filed with the VICP.

The Administrative funding level will allow the utilization of medical experts to consult and provide testimony in defending claims on behalf of the Secretary before the U.S. Court of Federal Claims, targeting the number of claims compensated near FY 2011 levels.

Work on updating the Vaccine Injury Table following release in 2012 of the IOM's report on vaccines and adverse events has been initiated to keep the Vaccine Injury Table in line with

current science, a program objective that is included as a strategy in Goal 4 of the HHS' National Vaccine Plan. Work continues on updating the Table.

Beginning in 2001, parents began filing petitions under the VICP alleging autism (or autism spectrum disorder) from either measles-mumps-rubella (MMR) vaccine or thimerosal-containing vaccines, or from both. In 2002, the Chief Special Master of the Court created the Omnibus Autism Proceeding to adjudicate the thousands of claims that were expected. Over 5,600 cases were filed.

Omnibus hearings on entitlement to compensation for two theories of causation were held in 2007 and 2008. Three test cases were utilized for each theory and three special masters issued opinions on general causation, and causation in one of the three test cases for each theory. Theory 1 hearings looked at whether MMR vaccine, administered alone or in conjunction with thimerosal-containing vaccines, can cause autism or autism spectrum disorders, while the Theory 2 hearings determined whether thimerosol-containing vaccines can cause autism or autism spectrum disorders. Decisions in the six test cases in favor of the respondent were handed down by the U.S. Court of Federal Claims in 2009 and 2010. Appeals of the Theory 1 test cases were decided in favor of the respondent, and affirmed on appeal. Petitioners chose not to appeal the Theory 2 test case decisions.

In 2010, the Court began issuing orders to determine which petitioners want to pursue other theories of causation. Altogether, over 4,900 autism claims have been dismissed. Of the approximately 720 autism claims pending, it is uncertain how many will require medical reviews to determine if they were timely filed. Some petitioners are electing to pursue other theories, such as mitochondrial or metabolic disorders. Such claims will be tried on an individual basis and will require HRSA medical reviews and may require the use of medical experts for hearings.

The FY 2015 Request should allow the Program to maintain current staffing levels to meet and exceed VICP-specific performance goals, including: "Decrease the average time settlements are approved from the date of the receipt of the DOJ settlement proposal" and "Decrease the average time that lump sum only awards are paid from the receipt of all required documentation to make a payment." These measures have FY 2015 targets of 10 days and 8 days, respectively. These performance measures have been historically ambitious and appropriate funding levels are necessary for continued Program success in achieving these targets given the significant increase in claims filed annually and the increase of negotiated settlements.

Information Technology

The Vaccine Injury Compensation Program co-funds the HRSA - HSB Injury Compensation System IT Investment. The Injury Compensation System supports the strategic and performance outcomes of the both the VICP and Countermeasures Injury Compensation Program (CICP) by efficiently and effectively facilitating program administration, claims administration and monitoring, management reporting, and secure document management. The ICS will ensure there are not duplicate claims filed under both the VICP and CICP and will capture critical data on people adversely affected after receipt of vaccines or countermeasures. Funding for the Countermeasures Injury Compensation Program (CICP) comes from the Public Health and Social Services Emergency Preparedness Fund.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY2014
26.II.A.1: Percentage of cases in which judgment awarding compensation is rejected and an election to pursue a civil action is filed.	FY 2013: 0% Target: 0% (Target Met)	0%	0%	Maintain
26.II.A.2: Average claim processing time.	FY 2013: 930 days Target: 1,300 days (Target Exceeded)	1,300 days	1,300 days	Maintain
26.II.A.3: Percentage of cases where the deadline for the Rule 4(b) report is met once the case has been deemed complete.	FY 2013: 95.2% Target: 86% (Target Exceeded)	86%	86%	Maintain

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY2014
26.II.A.4: Decrease the average time settlements are approved from the date of receipt of the DOJ settlement proposal.	FY 2013: 7.2 days Target:10 days (Target Exceeded)	10 days	10 days	Maintain
26.II.A.5: Decrease the average time that lump sum only awards are paid from the receipt of all required documentation to make a payment.	FY 2013: 7.8 days Target: 8 days (Target Exceeded)	8 days	8 days	Maintain
26.E: Percentage of cases in which case settlements are completed within 15 weeks.	FY 2013: 100% Target: 92% (Target Exceeded)	92%	92%	Maintain