DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2020

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

MESSAGE FROM THE ADMINISTRATOR

As the Administrator of the Health Resources and Services Administration (HRSA), I present the fiscal year (FY) 2020 Budget for HRSA. HRSA is the primary Federal agency for improving access to health care for people who are geographically isolated, and economically or medically challenged. The FY 2020 Budget provides $10.7 billion to invest in programs that support direct heath care services to individuals who are medically underserved or face barriers to health care, and makes strategic investments in important health issues facing our country.

The FY 2020 Budget request:

- Provides new funding for the Ending the HIV Epidemic Initiative. HHS is proposing a once-in-a-generation opportunity to eliminate new HIV infections in our nation. The *Ending the HIV Epidemic: A Plan for America* will work to reduce new infections by 75 percent in the next five years and by 90 percent in the next ten years, averting more than 250,000 HIV infections in that span.

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

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

- Improves oversight over the 340B Drug Pricing Program, which requires drug manufacturers to provide discounts on outpatient prescription drugs to certain safety net providers

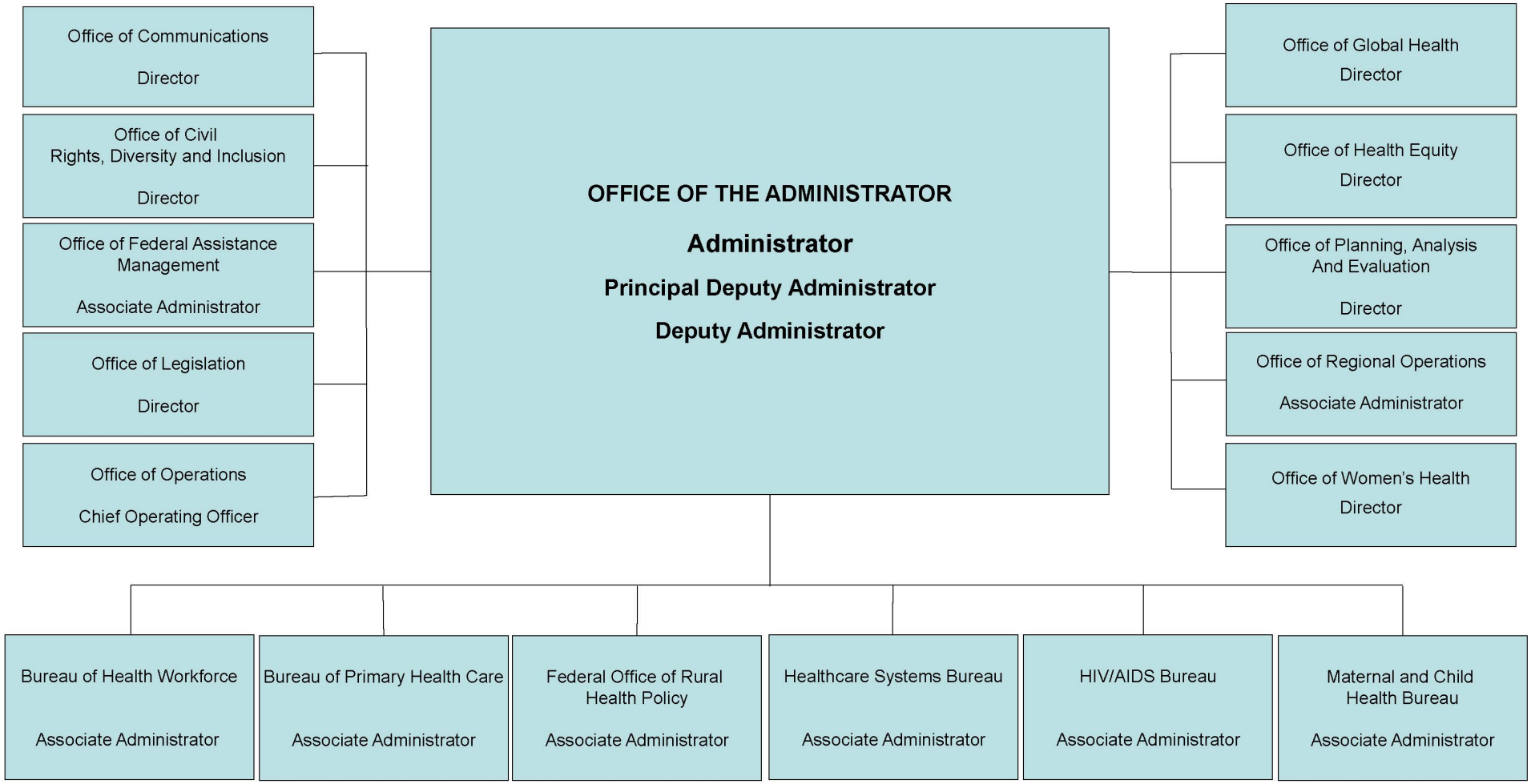
- Supports evidence-based interventions to address critical gaps in maternity care service delivery and reduce maternal mortality

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

George Sigounas, MS, Ph.D.
Administrator

Organizational Chart

Health Resources and Services Administration



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Executive Summary

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Introduction and Mission

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

HRSA supports programs and services that target, for example:

- Underserved persons who live in rural and poor urban neighborhoods where health care providers and services are scarce,
- Individuals who lack health insurance--many of whom are racial and ethnic minorities,
- African American infants who still are 2.2 times as likely as white infants to die before their first birthday[1,2],
- The more than 1.1 million people living with HIV infection[3],
- Persons affected by the national epidemic of opioid abuse and overdose,
- The more than 114,000 individuals who are waiting for an organ transplant[4].

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

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

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

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

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

Overview of Budget Request

The FY 2020 President's program level request is $10.7 billion for the Health Resources and Services Administration (HRSA). This level is $981 million below the FY 2019 enacted level, and provides investments to protect the health and well-being of the American people, while addressing the opioid crisis, promoting value-based care, and focusing on programs that provide direct health care. The Budget also proposes to extend mandatory funding for four critical programs.

Highlights of the major changes to programs are listed below:

Health Centers and Free Clinics: total program $5.6 billion – The Budget supports nearly 1,400 health centers, providing care to approximately 27.2 million patients. The Budget requests $4 billion in mandatory funding and proposes to extend funding through FY 2021, totaling $8 billion over the two-year period. Multi-year mandatory funding provides health centers, which depend on Federal resources to cover daily operational costs, with a stable source of funding with which to manage their operations.

In FY 2020, the Health Centers Program will allocate $50 million to support the HHS coordinated Ending the HIV Epidemic Initiative. The resources will support Pre-Exposure Prophylaxis (PrEP) and HIV/AIDS services through health centers as well as funding for outreach and care coordination in health centers.

This request also supports quality improvement and performance management activities at existing health center organizations, and ensure that current health centers can continue to provide essential primary health care services to their patient populations, including substance use disorder services focusing on the treatment, prevention, and/or awareness of opioid abuse.

Health Workforce: -$792.0 million; total program $760 million

- *National Health Service Corps (NHSC):-$15 million; total program $415 million.* The Budget supports loan repayment to improve access to quality primary care, dental, and behavioral health in underserved urban, rural, and tribal areas. The Budget includes $105 million specifically for opioid, and substance use disorder treatment. The request supports a field strength of 12,570 in FY 2020. The Budget also proposes to extend mandatory funding through FY 2021 for a total investment of $620 million for two years.

- *NURSE Corps: -$4.0 million; total program $83.1 million.* The Budget prioritizes nursing activities that provide nurse scholarships and nurse loan repayments in exchange for service in areas of the United States with health workforce shortages. This funding will allow the program to maintain its efforts to address the anticipated demand for access to services in Critical Shortage Facilities. Additionally, the funds will help increase the number of well-trained nurses available to provide mental/behavioral health services in communities experiencing a shortage in nurses. The Budget also includes a legislative proposal to expand tax-exempt status to include all components of the NURSE Corps Scholarship Program, Native Hawaiian Health Scholarship Program, and NURSE Corps Loan Repayment Program.

- *Teaching Health Centers Graduate Medical Education Program: total program $126.5 million.* The Budget includes $126.5 million in mandatory resources for residency training in primary care medicine and dentistry in community-based, ambulatory settings. In FY 2020, the program expects to support 750 resident full time equivalents (FTE). The Budget proposes to extend mandatory funding through FY 2021 for a total investment of $253 million for two years.

- *Children's Hospital Graduate Medical Education (GME) Program: -$325 million; total program $0.* The Budget proposes to consolidate Federal graduate medical education spending from Medicare, Medicaid, and the Children's Hospitals Graduate Medical Education program into a single grant program for teaching hospitals equal to the sum of Medicare and Medicaid's 2017 payments for graduate medical education, plus 2017 spending on children's hospitals graduate medical education, adjusted for inflation. This amount would then grow with inflation minus 1 percentage point each year. HRSA and the Centers for Medicare & Medicaid Services (CMS) would jointly determine program requirements and the formula for distribution. Payments would be distributed to hospitals based on the number of residents at a hospital (up to its existing cap) and the portion of the hospital's inpatient days accounted for by Medicare and Medicaid patients. The Secretary would have authority to modify the amounts distributed based on the proportion of residents training in priority specialties or programs and based on other criteria identified by the Secretary, including addressing health care professional shortages and educational priorities. This grant program would be funded out of the general fund of the Treasury.

- *Behavioral Health Training Programs: total program $111.9 million:* The Budget provides $111.9 million to support Behavioral Health Workforce Development programs. These funds will support multiple efforts to increase and develop the number of professionals and paraprofessionals who are trained to deliver integrated behavioral health and primary care services. This funding plays a critical role in addressing the opioid epidemic by training and developing the behavioral health workforce in underserved areas.

- *Workforce Training Programs: -$448.00 million; total program $23.5 million.* The Budget invests $4.7 million in the Health Care Workforce Assessment program to analyze health workforce data. HRSA is the primary Federal entity responsible for monitoring and analyzing the nation's health care workforce. The Budget also includes $18.8 million for the National Practitioner Data Bank (NPDB), a workforce tool that improves health care quality, promotes patient safety, and deters fraud and abuse in the health care system by providing information about past adverse actions of practitioners, providers, and suppliers to authorized health care entities and agencies. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals and eliminates funding for other health professions and nursing training programs.

<u>Maternal and Child Health (MCH): -$143.6 million; total program $1.2 billion –</u> The Budget provides $660.7 million for the MCH Block Grant program, a decrease of $17.0 million below the FY 2019 enacted level. The Block Grant serves an estimated 56 million people, including 86 percent of pregnant women, 99 percent of infants, and 55 percent of children nationwide. The

request also includes $122.5 million for the Healthy Start program to address maternal mortality by continuing to support the staffing of a maternal-child advance practice health professionals at Healthy Start sites. The Healthy Start program aims to serve approximately 70,000 participants with case managed services.

The Budget includes $400 million in mandatory resources for the Maternal, Infant, and Early Childhood Home Visiting program. This program provides at-risk families with voluntary, evidence-based home visiting services where nurses, social workers, and other professionals provide support for their children's health, development, and ability to learn. In addition, the Budget requests $6 million in mandatory funding for the Family-to-Family Health Information Centers Program. The Budget proposes to extend mandatory funding for this program through FY 2021 for a total investment of $12 million for two years.

HIV/AIDS: +$70.0 million; total program $2.4 billion – The Budget provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people living with HIV. The Budget provides an additional $70 million for the Ending the HIV Epidemic Initiative, a coordinated HHS effort, which will target resources to jurisdictions with the highest HIV incidence in order to decrease new cases through a strategy supporting HIV care and treatment services in the counties and states, evidence informed practices to link, engage, and retain people living with HIV, workforce capacity building, and technical assistance. In addition, to support the Initiative, the Budget also proposes to reauthorize the Ryan White HIV/AIDS Program to ensure Federal funds are allocated to target populations experiencing high or increasing levels of HIV infections and diagnoses while continuing to support Americans already living with HIV across the Nation.

Healthcare Systems: +$14.8 million; total programs $130.0 million –The Budget provides funding to support Poison Control Centers, organ and cell transplantation and the National Hansen's Disease Program. The request includes an additional $2 million to expand HRSA's financial support to living organ donors and increase awareness about living organ donation. The Budget includes resources and broad regulatory authority to support the 340B Drug Pricing Program, which requires drug manufacturers to provide discounts on outpatient prescription drugs to certain safety net providers. In addition, the Budget proposes to authorize and includes a new user fee on covered entities for the 340B program.

Rural Health: -$129.1 million; total program $188.6 million – The Budget provides $120 million for the Rural Communities Response Program (RCORP) to strengthen infrastructure and capacity within rural communities at high risk for substance abuse disorders. The resources will provide needed prevention, treatment, and recovery services to rural residents. The Budget request will provide RCORP funding to target specific initiatives, such as supporting medication-assisted treatment in rural hospitals, workforce development, maternal and child health, and telehealth activities focused on reducing opioid abuse. The Budget prioritizes funding for direct service programs, including the Radiation Exposure Screening Program, Black Lung Clinics, and Rural Health Outreach Services. The allocation includes funding for the Rural Health Policy program to support the Federal Office of Rural Health Policy's role to advise the Secretary on rural health issues, conduct and oversee research on rural health, and provide support for grant programs that enhance health care delivery in rural communities. Consistent with the FY 2019

Budget, no funding is requested for Rural Hospital Flexibility grants and State Offices of Rural Health.

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

Vaccine Injury Compensation Program: +$2 million; total program $11.2 million – The Budget requests additional administrative funding to support the significant rise in the number of claims filed largely due to claims for injuries from the influenza vaccine. The funding will support the additional costs of medical reviewers dedicated to evaluating the increased claims.

Overview of Performance

HRSA and its partners work to achieve the vision of "Healthy Communities, Healthy People." In pursuing this vision, HRSA's strategic goals are to: improve access to quality health care and services, strengthen the health workforce, build healthy communities, improve health equity, and strengthen program management and operations. The anticipated performance in FY 2020 of key HRSA programs is highlighted below, categorized by goal to indicate the close alignment of specific programmatic activities with broader HRSA priorities. The examples illustrate ways HRSA will continue to help states, communities and organizations provide essential health care and related services to meet the needs of medically underserved individuals, special needs populations, and many other Americans.

Highlights

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

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

- In FY 2020, the Health Center Program expects to support health centers' provision of affordable, accessible, quality and cost efficient care to 27.2 million patients.

- The Health Center Program projects that the low birthweight rate (LBW) among health center patients will be five percent below the national rate in FY 2020, an ambitious target given the many factors that predispose these patients to greater risk of LBW and adverse birth outcomes.

- HRSA expects to help states serve 58 percent of children through the Maternal and Child Health (MCH) Block Grant program in FY 2020, providing support to address states' highest MCH priorities.

- The MCH Block Grant program expects to contribute to the reduction of the national infant mortality rate from 5.8 per 1,000 in 2017 to 5.5 per 1,000 in 2020 by supporting state MCH activities to improve the health of mothers, children, and families, particularly those with low-income or limited availability of care.

- Grantees of the Maternal, Infant, and Early Childhood Home Visiting Program are expected to make 960,000 home visits to at-risk families in FY 2020, using evidence-based models of care to address children's health, development and well-being.

- By supporting the provision of HIV medications and related services to more than 266,000 persons in FY 2020 through the AIDS Drug Assistance Program, HRSA will continue its contribution to reducing AIDS-related mortality for low-income and uninsured people living with HIV/AIDS.

- In FY 2020, the Ryan White HIV Emergency Relief Grants (Part A) and HIV Care

Grants to States (Part B) are projected to support, respectively, 3.6 million visits and 3.4 million visits for health-related care.

- In FY 2020, 83% of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test are expected to be virally suppressed.

- To increase the number of patients from racially and ethnically diverse backgrounds able to find a suitably matched unrelated adult donor for their blood stem cell transplants, the C.W. Bill Young Cell Transplantation program projects that it will have more than 4.1 million adults on the donor registry in FY 2020 who self-identify as belonging to an underrepresented racial or ethnic group.

- HRSA's Organ Transplantation program projects that it will facilitate the transplantation of 32,000 deceased donor organs in FY 2020.

HRSA Goal: Strengthen the health workforce

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

- In FY 2020, approximately 12,500 primary care and other health practitioners will provide services in health professional shortage areas in rural, urban, and frontier communities in return for National Health Service Corps (NHSC) loan repayment or scholarship support.

- HRSA projects that in FY 2020 10,000 healthcare providers will be deemed eligible for Federal Tort Claims Act malpractice coverage through the Free Clinics Medical Malpractice program. The program encourages providers to volunteer their time at sponsoring free clinics, thereby expanding the capacity of the healthcare safety net.

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

Performance Management

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

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

Regular reviews of performance take place several times a year between Senior Staff and the Administrator/Deputy Administrator, including during regularly scheduled one-on-one meetings, mid-year and year-end Senior Staff performance reviews, and ad hoc meetings to address emerging issues and problems. Reviews focus on progress, challenges, and possible course corrections, with particular emphasis on root-causes of performance results.

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

All-Purpose Table
Health Resources and Services Administration

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final[5]	Enacted	President's Budget	FY 2020 PB +/- FY 2019 Enacted
PRIMARY CARE:				
Health Centers:				
Health Centers	1,486,816	1,505,522	1,505,522	-
Health Centers Loan Guarantee Program	20,000	-	-	-
Health Centers Mandatory	3,800,000	4,000,000		-4,000,000
Health Centers Proposed Mandatory	-	-	4,000,000	+4,000,000
Health Centers All of Us Research Program	25,000	-		-
Health Center Tort Claims	114,893	120,000	120,000	-
Subtotal, Health Centers	***5,446,709***	***5,625,522***	***5,625,522***	**-**
Free Clinics Medical Malpractice	1,000	1,000	1,000	-
Subtotal, Bureau of Primary Health Care (BPHC)	**5,447,709**	**5,626,522**	**5,626,522**	**-**
Subtotal, Mandatory BPHC (non-add)	*3,825,000*	*4,000,000*	*4,000,000*	-
Subtotal, Discretionary BPHC (non add)	*1,622,709*	*1,626,522*	*1,626,522*	-
				-
HEALTH WORKFORCE:				-
National Health Service Corps (NHSC):				-
NHSC	105,000	120,000	105,000	-15,000
NHSC Mandatory	310,000	310,000	-	-310,000
NHSC Proposed Mandatory	-	-	+310,000	+310,000
Subtotal, NHSC	***415,000***	***430,000***	***415,000***	***-15,000***
Loan Repayment/Faculty Fellowships	1,187	1,190	-	-1,190
Health Professions Training for Diversity:				-
Centers of Excellence	23,652	23,711	-	-23,711
Scholarships for Disadvantaged Students	48,705	48,970	-	-48,970
Health Careers Opportunity Program	14,154	14,189	-	-14,189
Subtotal, Health Professions Training for Diversity	***86,511***	***86,870***	**-**	***-86,870***
Health Care Workforce Assessment	5,663	5,663	4,663	-1,000
Primary Care Training and Enhancement	48,802	48,924	-	-48,924
Oral Health Training Programs	40,571	40,673	-	-40,673
Graduate Medical Education for Health Care Professionals	-	25,000	-	-25,000

[5] Reflects FY 2018 required and permissive transfers. Funding level does not include supplemental hurricane appropriations($60 million)

	FY 2018	FY 2019	FY 2020	
	Final[5]	Enacted	President's Budget	FY 2020 PB +/- FY 2019 Enacted
Interdisciplinary, Community-Based Linkages:				-
Area Health Education Centers	38,154	39,250	-	-39,250
Geriatric Programs	40,635	40,737	-	-40,737
Behavioral Health Workforce Development Programs[6]	111,766	111,916	111,916	-
Subtotal, Interdisciplinary, Community-Based Linkages	***190,555***	***191,903***	***111,916***	***-79,987***
Public Health Workforce Development:				-
Public Health/Preventive Medicine	17,000	17,000	-	-17,000
Nursing Workforce Development:				-
Advanced Nursing Education	74,311	74,581	-	-74,581
Nursing Workforce Diversity	17,300	17,343	-	-17,343
Nurse Education, Practice and Retention	41,733	41,913	-	-41,913
Nurse Faculty Loan Program	28,500	13,500	-	-13,500
NURSE Corps Scholarship and Loan Repayment Program	87,107	87,135	83,135	-4,000
Subtotal, Nursing Workforce Development	***248,951***	***234,472***	***83,135***	***-151,337***
Children's Hospital Graduate Medical Education[7]	314,213	325,000	-	-325,000
Teaching Health Center Graduate Medical Education (THCGME):				-
THCGME Mandatory	126,500	126,500	-	-126,500
THCGME Mandatory Proposed	-	-	126,500	+126,500
Subtotal, THCGME	***126,500***	***126,500***	***126,500***	**-**
National Practitioner Data Bank (User Fees)	*18,814*	*18,814*	*18,814*	-
Subtotal, Bureau of Health Workforce (BHW)	**1,513,767**	**1,552,009**	**760,028**	**-791,981**
Subtotal, User Fees BHW (non-add)	*18,814*	*18,814*	*18,814*	-
Subtotal, Discretionary BHW (non-add)	*1,058,453*	*1,096,695*	*304,714*	*-791,981*
Subtotal, Mandatory BHW (non-add)	*436,500*	*436,500*	*436,500*	-
				-
MATERNAL & CHILD HEALTH:				-
Maternal and Child Health Block Grant	650,194	677,700	660,700	-17,000
Autism and Other Developmental Disorders	48,899	50,599	-	-50,599
Sickle Cell Service Demonstrations	4,455	4,455	-	-4,455
James T. Walsh Universal Newborn Hearing Screening	17,818	17,818	-	-17,818

[6] Behavioral Health Workforce Development Programs includes Behavioral Health Workforce Education and Training program and Mental and Behavioral Health program.

[7] Discretionary funding for CHGME is discontinued in FY 2020. The Budget proposes to consolidate Federal graduate medical education spending from Medicare, Medicaid, and the Children's Hospitals Graduate Medical Education program into a single grant program for teaching hospitals.

	FY 2018	FY 2019	FY 2020	
	Final[5]	Enacted	President's Budget	FY 2020 PB +/- FY 2019 Enacted
Emergency Medical Services for Children	22,134	22,334	-	-22,334
Healthy Start	110,300	122,500	122,500	-
Heritable Disorders	15,788	16,383	-	-16,383
Pediatric Mental Health Care Access Grants	10,000	10,000	-	-10,000
Screening and Treatment for Maternal Depression	5,000	5,000	-	-5,000
Family-to-Family Health Information Centers:				-
Family-to-Family Health Information Centers Mandatory	6,000	6,000	-	-6,000
Family-to-Family Health Information Centers Proposed Mandatory	-	-	6,000	+6,000
Subtotal, Family-to-Family Health Information Centers	***6,000***	***6,000***	***6,000***	**-**
Maternal, Infant and Early Childhood Home Visiting Program Mandatory	400,000	400,000	400,000	-
Subtotal, Maternal and Child Health Bureau (MCHB)	**1,290,588**	**1,332,789**	**1,189,200**	**-143,589**
Subtotal, Discretionary MCHB (non-add)	*884,588*	*926,789*	*783,200*	*-143,589*
Subtotal, Mandatory MCHB (non-add)	*406,000*	*406,000*	*406,000*	-
				-
HIV/AIDS:				-
Emergency Relief - Part A	655,876	655,876	655,876	-
Comprehensive Care - Part B	1,309,251	1,315,005	1,315,005	-
AIDS Drug Assistance Program (non-add)	*-894,559*	*900,313*	*900,313*	-
Early Intervention - Part C	201,079	201,079	201,079	-
Children, Youth, Women & Families - Part D	75,088	75,088	75,088	-
AIDS Education and Training Centers - Part F	33,611	33,611	33,611	-
Dental Reimbursement Program Part F	13,122	13,122	13,122	-
Special Projects of National Significance (SPNS)	25,000	25,000	25,000	-
Ending the HIV Epidemic Initiative	-	-	70,000	+70,000
Subtotal, HIV/AIDS Bureau	**2,313,027**	**2,318,781**	**2,388,781**	**70,000**
				-
HEALTHCARE SYSTEMS:				-
Organ Transplantation	25,486	25,549	27,549	+2,000
National Cord Blood Inventory	15,236	16,266	12,266	-4,000
C.W. Bill Young Cell Transplantation Program	24,050	24,609	24,609	-
Poison Control Centers	20,785	22,846	22,846	-
340B Drug Pricing Program/Office of Pharmacy Affairs	10,210	10,238	10,238	-
340B Drug Pricing Program User Fees	-	-	*19,000*	*+19,000*

	FY 2018	FY 2019	FY 2020	
	Final[5]	Enacted	President's Budget	FY 2020 PB +/- FY 2019 Enacted
Hansen's Disease Center	13,665	13,706	11,653	-2,053
Payment to Hawaii	1,852	1,857	1,857	-
National Hansen's Disease Program - Buildings and Facilities	122	122	-	-122
Subtotal, Healthcare Systems Bureau (HSB)	**111,416**	**115,193**	**130,018**	**+14,825**
Subtotal, Discretionary HSB (non-add)	*111,416*	*115,193*	*111,018*	*-4,175*
Subtotal, User Fees HSB (non-add)	-	-	*19,000*	*+19,000*
				-
RURAL HEALTH:				-
Rural Health Policy Development	9,325	9,351	5,000	-4,351
Rural Health Outreach Grants	71,300	77,500	40,811	-36,689
Rural Hospital Flexibility Grants	49,470	53,609	-	-53,609
State Offices of Rural Health	10,000	10,000	-	-10,000
Radiation Exposure Screening and Education Program	1,834	1,834	1,834	-
Black Lung	10,000	11,000	11,000	-
Telehealth	23,434	24,500	10,000	-14,500
Rural Communities Opioid Response	100,000	120,000	120,000	-
Rural Residency	14,958	10,000	-	-10,000
Subtotal, Federal Office of Rural Health Policy	**290,321**	**317,794**	**188,645**	**-129,149**
				-
PROGRAM MANAGEMENT	154,615	155,250	151,993	-3,257
FAMILY PLANNING	285,768	286,479	286,479	-
Appropriation Table Match	**6,720,897**	**6,843,503**	**5,841,352**	**-1,002,151**
Funds Appropriated to Other HRSA Accounts:				
Vaccine Injury Compensation:				
Vaccine Injury Compensation Trust Fund (HRSA Claims)	227,083	280,000	285,600	+5,600
VICTF Direct Operations - HRSA	9,200	9,200	11,200	+2,000
Subtotal, Vaccine Injury Compensation	**236,283**	**289,200**	**296,800**	**+7,600**
Discretionary Program Level:				
HRSA	**6,739,711**	**6,862,317**	**5,879,166**	**-983,151**
Vaccine Direct Operations	9,200	9,200	11,200	+2,000
Total, HRSA Discretionary Program Level	**6,748,911**	**6,871,517**	**5,890,366**	**-981,151**

	FY 2018	FY 2019	FY 2020	
	Final[5]	Enacted	President's Budget	FY 2020 PB +/- FY 2019 Enacted
Mandatory Programs:	**4,667,500**	**4,842,500**	**4,842,500**	**-**
Total, HRSA Program Level	**11,416,411**	**11,714,017**	**10,732,866**	**-981,151**
Less Programs Funded from Other Sources:				
User Fees	*-18,814*	*-18,814*	*-37,814*	*-19,000*
Mandatory Programs	*-4,667,500*	*-4,842,500*	*-4,842,500*	*-*
Total, HRSA Discretionary Budget Authority	**6,730,097**	**6,852,703**	**5,852,552**	**-1,000,151**
Nonrecurring Expense Fund (notification amount)	*--*	*13,000*	*--*	*-13,000*

Budget Exhibits
TAB

Appropriations Language

PRIMARY HEALTH CARE

For carrying out titles II and III of the Public Health Service Act (referred to in this Act as the "PHS Act") with respect to primary health care and the Native Hawaiian Health Care Act of 1988, $1,626,522,000 [(in addition to the $4,000,000,000 previously appropriated to the Community Health Center Fund for fiscal year 2019)]: *Provided*, That no more than $1,000,000 shall be available until expended for carrying out the provisions of section 224(o) of the PHS Act: *Provided further*, That no more than $120,000,000 shall be available until expended for carrying out subsections (g) through (n) and (q) of section 224 of the PHS Act, and for expenses incurred by the Department of Health and Human Services (referred to in this Act as "HHS") pertaining to administrative claims made under such law.[: *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 2019, not less than $200,000,000 shall be obligated in fiscal year 2019 for improving quality of care or expanded service grants under section 330 of the PHS Act to support and enhance behavioral health, mental health, or substance use disorder services.]

HEALTH WORKFORCE

For carrying out titles III, VII, and VIII of the PHS Act with respect to the health workforce, sections 1128E and 1921 of the Social Security Act, and the Health Care Quality Improvement Act of 1986, [$1,096,695,000]*$304,714,000*: *Provided*, That sections 751[(j)(2)] and 762(k) of the PHS Act and the proportional funding amounts in paragraphs (1) through (4) of section 756(f) of the PHS Act shall not apply to funds made available under this heading:[*Provided further*, That for any program operating under section 751 of the PHS Act on or before January 1, 2009, the Secretary of Health and Human Services (referred to in this title as

the "Secretary") may hereafter waive any of the requirements contained in sections 751(d)(2)(A) and 751(d)(2)(B) of such Act for the full project period of a grant under such section: *Provided further*, That no funds shall be available for section 340G-1 of the PHS Act:] *Provided further*, That fees collected for the disclosure of information under section 427(b) of the Health Care Quality Improvement Act of 1986 and sections 1128E(d)(2) and 1921 of the Social Security Act shall be sufficient to recover the full costs of operating the programs authorized by such sections and shall remain available until expended for the National Practitioner Data Bank: *Provided further*, That funds transferred to this account to carry out section 846 and subpart 3 of part D of title III of the PHS Act may be used to make prior year adjustments to awards made under such section and subpart: *Provided further*, That $105,000,000 shall remain available until expended for the purposes of providing primary health services, assigning National Health Service Corps ("NHSC") members to expand the delivery of substance use disorder treatment services, notwithstanding the assignment priorities and limitations under sections 333(a)(1)(D), 333(b), and 333A(a)(1)(B)(ii) of the PHS Act, and making payments under the NHSC Loan Repayment Program under section 338B of such Act: [*Provided further*, That, in addition to amounts otherwise made available in the previous proviso, $15,000,000 shall remain available until expended for the purposes of making payments under the NHSC Loan Repayment Program under section 338B of the PHS Act to individuals participating in such program who provide primary health services in Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs (as those terms are defined by the Secretary), notwithstanding the assignment priorities and limitations under section 333(b) of such Act:]*Provided further,* That for purposes of the previous [two provisos] *proviso*, section 331(a)(3)(D) of the PHS Act shall be applied as if the term "primary health services" includes

clinical substance use disorder treatment services, including those provided by masters level, licensed substance use disorder treatment counselors.

[Of the funds made available under this heading, $25,000,000 shall remain available until expended for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions: *Provided*, That, in awarding such grants, the Secretary shall give priority to public institutions of higher education located in States with a projected primary care provider shortage in 2025, as determined by the Secretary: *Provided further*, That grants so awarded are limited to such public institutions of higher education in States in the top quintile of States with a projected primary care provider shortage in 2025, as determined by the Secretary: *Provided further*, That the minimum amount of a grant so awarded to such an institution shall be not less than $1,000,000 per year: *Provided further*, That such a grant may be awarded for a period not to exceed 5 years: *Provided further*, That such a grant awarded with respect to a year to such an institution shall be subject to a matching requirement of non-Federal funds in an amount that is not less than 10 percent of the total amount of Federal funds provided in the grant to such institution with respect to such year.]

MATERNAL AND CHILD HEALTH

For carrying out titles III, XI, XII, and XIX of the PHS Act with respect to maternal and child health, *and* title V of the Social Security Act, [and section 712 of the American Jobs Creation Act of 2004, $926,789,000] *$783,200,000*: *Provided*, That notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act, not more than [$109,593,000] *$92,593,*000 shall be available for carrying out special projects of regional and national significance pursuant to section 501(a)(2) of such Act and $10,276,000 shall be available for projects described in subparagraphs (A) through (F) of section 501(a)(3) of such Act.

RYAN WHITE HIV/AIDS PROGRAM

For carrying out title XXVI of the PHS Act with respect to the Ryan White HIV/AIDS program, [$2,318,781,000] *$2,388,781,000* [,]*;* of which $1,970,881,000 shall remain available to the Secretary through September 30, [2021]*2022*, for parts A and B of title XXVI of the PHS Act, [and] of which not less than $900,313,000 shall be for State AIDS Drug Assistance Programs under the authority of section 2616 or 311(c) of such Act; *and of which $70,000,000, to remain available until expended, shall be available to the Secretary for carrying out a program of grants and contracts under title XXVI or section 311(c) of such Act focused on ending the nationwide epidemic, with any grants issued under such section 311(c) administered in conjunction with title XXVI of the PHS Act, including the limitation on administrative expenses.*

HEALTH CARE SYSTEMS

For carrying out titles III and XII of the PHS Act with respect to health care systems, and the Stem Cell Therapeutic and Research Act of 2005, [$115,193,000] *$111,018,000*[, of which $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 appropriation and remain available until expended.*

RURAL HEALTH

For carrying out titles III and IV of the PHS Act with respect to rural health, section 427(a) of the Federal Coal Mine Health and Safety Act of 1969, and sections 711 and 1820 of the Social Security Act,[$317,794,000]*$188,645,000[*, of which $53,609,000 from general revenues, notwithstanding section 1820(j) of the Social Security Act, shall be available for carrying out the Medicare rural hospital flexibility grants program: *Provided*, That of the funds made available under this heading for Medicare rural hospital flexibility grants, $19,942,000 shall be available for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of health information technology and up to $1,000,000 shall be to 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, $10,000,000 shall be available for State Offices of Rural Health: *Provided further*, That $10,000,000 shall remain available through September 30, 2021, to support the Rural Residency Development Program: *Provided further*, That $120,000,000 shall be for the Rural Communities Opioids Response Program].

FAMILY PLANNING

For carrying out the program under title X of the PHS Act to provide for voluntary family planning projects, $286,479,000: *Provided*, That amounts provided to said projects under such title shall not be expended for abortions, that all pregnancy counseling shall be nondirective, and that such amounts shall not be expended for any activity (including the publication or

distribution of literature) that in any way tends to promote public support or opposition to any legislative proposal or candidate for public office.

PROGRAM MANAGEMENT

For program support in the Health Resources and Services Administration, [$155,250,000] *$151,993,000*: *Provided*, That funds made available under this heading may be used to supplement program support funding provided under the headings "Primary Health Care", "Health Workforce", "Maternal and Child Health", "Ryan White HIV/AIDS Program", "Health Care Systems", and "Rural Health".

GENERAL PROVISIONS

Sec. [206]*205*

In lieu of the timeframe specified in section 338E(c)(2) of the PHS Act, terminations described in such section may occur up to 60 days after the [execution] *effective date* of a contract awarded in fiscal year [2019] *2020* under section 338B of such Act, *or at any time if the individual who has been awarded such contract has not received funds due under the contract.*

Sec. 226 Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(a) in subsection (a)(5)(C)—

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

(2) by inserting at the end the following:

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

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

(b) by adding at the end the following new subsection: "(f) REGULATIONS.—The Secretary may promulgate such regulations as the Secretary determines necessary or appropriate to carry out the provisions of this section.".

Language Analysis

LANGUAGE PROVISION	EXPLANATION
[(in addition to the $4,000,000,000 previously appropriated to the Community Health Center Fund for fiscal year 2019)]	Language specific to FY 2019 removed.
[: *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 2019, not less than $200,000,000 shall be obligated in fiscal year 2019 for improving quality of care or expanded service grants under section 330 of the PHS Act to support and enhance behavioral health, mental health, or substance use disorder services.]	Language specific to FY 2019 removed.
Provided, That sections 751[(j)(2)] and 762(k) of the PHS Act and the proportional funding amounts in paragraphs (1) through (4) of section 756(f) of the PHS Act shall not apply to funds made available under this heading:[*Provided further*, That for any program operating under section 751 of the PHS Act on or before January 1, 2009, the Secretary of Health and Human Services (referred to in this title as the "Secretary") may hereafter waive any of the requirements contained in sections 751(d)(2)(A) and 751(d)(2)(B) of such Act for the full project period of a grant under such section: *Provided further*, That no funds shall be available for section 340G-1 of the PHS Act:]	Language and citation regarding the Area Health Education Centers is removed because funding is not requested for this program.
[*Provided further*, That, in addition to amounts otherwise made available in the previous proviso, $15,000,000 shall remain available until expended for the purposes of making payments under the NHSC Loan Repayment Program under section 338B of the PHS Act to individuals participating in such program who provide primary health services in Indian Health Service facilities,	Language specific to FY 2019 removed.

LANGUAGE PROVISION	EXPLANATION
Tribally-Operated 638 Health Programs, and Urban Indian Health Programs (as those terms are defined by the Secretary), notwithstanding the assignment priorities and limitations under section 333(b) of such Act:]	
Provided further, That for purposes of the previous [two provisos] proviso, section 331(a)(3)(D) of the PHS Act shall be applied as if the term "primary health services" includes clinical substance use disorder treatment services, including those provided by masters level, licensed substance use disorder treatment counselors.	Language amended to reflect removal of previous proviso.
[Of the funds made available under this heading, $25,000,000 shall remain available until expended for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions: *Provided*, That, in awarding such grants, the Secretary shall give priority to public institutions of higher education located in States with a projected primary care provider shortage in 2025, as determined by the Secretary: *Provided further*, That grants so awarded are limited to such public institutions of higher education in States in the top quintile of States with a projected primary care provider shortage in 2025, as determined by the Secretary: *Provided further*, That the minimum amount of a grant so awarded to such an institution shall be not less than $1,000,000 per year: *Provided further*, That such a grant may be awarded for a period not to exceed 5 years: *Provided further*, That such a grant awarded with respect to a year to such an institution shall be subject to a matching requirement of non-Federal funds in an amount that is not less than 10 percent of the total amount of Federal funds provided in the grant to such institution with respect to such year.]	Language regarding the Graduate Medical Education for Health Care Professionals program removed because funding is not requested for this program.

LANGUAGE PROVISION	EXPLANATION
For carrying out titles III, XI, XII, and XIX of the PHS Act with respect to maternal and child health, *and* title V of the Social Security Act, [and section 712 of the American Jobs Creation Act of 2004]	Language removed because the program was recently reauthorized under the PHS Act.
and of which $70,000,000, to remain available until expended, shall be available to the Secretary for carrying out a program of grants and contracts under title XXVI or section 311(c) of such Act focused on ending the nationwide epidemic, with any grants issued under such section 311(c) administered in conjunction with title XXVI of the PHS Act, including the limitation on administrative expenses.	Defines the authorization and appropriation for the RWHAP component of the Ending HIV Epidemic Initiative.
[of which $122,000 shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center.]	Language removed because funding is not requested for this program.
Provided, That the Secretary may collect a fee of 0.1 percent of each purchase of 340B drugs from entities participating in the Drug Pricing Program pursuant to section 340B of the PHS Act to pay for the operating costs of such program: Provided further, That fees pursuant to the 340B Drug Pricing Program shall be collected by the Secretary based on sales data that shall be submitted by drug manufacturers and shall be credited to this appropriation and remain available until expended.	Provision to authorize the Secretary to collect and spend user fees for the 340B Drug Pricing Program.
[of which $53,609,000 from general revenues, notwithstanding section 1820(j) of the Social Security Act, shall be available for carrying out the Medicare rural hospital flexibility grants program: *Provided*, That of the funds made available under this heading for Medicare rural hospital flexibility grants, $19,942,000 shall be available for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of	Language removed because funding is not requested for these programs.

LANGUAGE PROVISION	EXPLANATION
health information technology and up to $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, $10,000,000 shall be available for State Offices of Rural Health: *Provided further*, That $10,000,000 shall remain available through September 30, 2021, to support the Rural Residency Development Program:]	
[*Provided further*, That $120,000,000 shall be for the Rural Communities Opioids Response Program.]	Language regarding the Rural Communities Opioids Response Program is removed because a separate funding proviso is unnecessary and duplicative.
Sec. [206]*205* In lieu of the timeframe specified in section 338E(c)(2) of the PHS Act, terminations described in such section may occur up to 60 days after the [execution] *effective date* of a contract awarded in fiscal year [2019] *2020* under section 338B of such Act, *or at any time if the individual who has been awarded such contract has not received funds due under the contract*.	Provision to amend timeframe specified in section 338E(c)(2). Changed wording from "execution date" to "effective date" in order to allow participants more time to utilize the 60 day termination window. This additional flexibility will mitigate the administrative burdens, complications and potential legal challenges arising from the requirement to pursue damages in such cases.
Sec. 226 Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended— *(a) in subsection (a)(5)(C)—* *(1) by striking "A covered entity shall permit" and inserting "(i) DUPLICATE DISCOUNTS AND DRUG RESALE.—A covered entity shall permit" and;*	Provision to permit the Secretary to issue regulations on all aspects of the 340B Program and to require covered entities to report on the use of savings to ensure that net income from purchases under the 340B Drug Pricing Program benefit low-income and uninsured patients of the covered entities.

LANGUAGE PROVISION	EXPLANATION
(2) by inserting at the end the following: *"(ii) USE OF SAVINGS.—A covered entity shall permit the Secretary to audit, at the Secretary's expense, the records of the entity to determine how net income from purchases under this section are used by the covered entity.* *"(iii) RECORDS RETENTION.—Covered entities shall retain such records and provide such records and reports as deemed necessary by the Secretary for carrying out this subparagraph.".* *(b) by adding at the end the following new subsection: "(f) REGULATIONS.—The Secretary may promulgate such regulations as the Secretary determines necessary or appropriate to carry out the provisions of this section.".*	

Amounts Available for Obligation[8]

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
General Fund Discretionary Appropriation:			
Appropriation	$6,796,753,000	$6,843,503,000	$5,841,352,000
Real transfer to the Administration for Children and Families	-15,857,000		
Subtotal, adjusted general fund discretionary Appropriation	**$6,780,896,000**	**$6,843,503,000**	**$5,841,352,000**
Mandatory Appropriation:[9]			
Family to Family Health Information Centers	+6,000,000	+6,000,000	+6,000,000
Primary Health Care Access:			
Community Health Center Fund	+3,825,000,000	+4,000,000,000	+4,000,000,000
National Health Service Corps	+310,000,000	+310,000,000	+310,000,000
Subtotal Primary Health Care Access	**+4,135,000,000**	**+4,310,000,000**	**+4,310,000,000**
Maternal, Infant and Early Childhood Home Visitation	+400,000,000	+400,000,000	+400,000,000
Teaching Health Centers Graduate Medical Education	+126,500,000	+126,500,000	+126,500,000
Subtotal, adjusted mandatory appropriation	**4,667,500,000**	**4,842,500,000**	**4,842,500,000**
Subtotal, adjusted appropriation	**$11,448,396,000**	**$11,686,003,000**	**$10,683,852,000**
Offsetting Collections	+18,814,000	+18,814,000	+37,814,000
Subtotal Spending Authority from offsetting collections	**+18,814,000**	**+18,814,000**	**+37,814,000**
Unobligated balance, start of year	+322,768,000	+ 474,000,000	+ 331,000,000
Unobligated balance end of year	-474,000,000	-331,000,000	-312,000,000
Recoveries from prior year unpaid obligations	-78,589,000		
Unobligated balance, lapsing	-2,981,000	-	-
Total obligations	**$11,234,408,000**	**$11,847,817,000**	**$10,740,666,000**

[8] Excludes the following amounts for reimbursable activities carried out by this account: FY 2018 - 11,953,000 and 19 FTE; FY 2019 - $11,954,600 and 19 FTE; FY 2020 $11,954,600 and 19 FTE.

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

Summary of Changes

2019 Enacted	$6,843,503,000
(Obligations)	($6,843,503,000)
2020 Estimate	$5,841,352,000
(Obligations)	($5,841,352,000)
2019 Mandatory	$4,842,500,000
(Obligations)	($4,842,500,000)
2020 Mandatory	$4,842,500,000
(Obligations)	($4,842,500,000)
Net Change	**-$1,002,151,000**
(Obligations)	**+$1,002,151,000**

	FY 2019 Enacted		FY 2020 President's Budget		FY 2020 +/- FY 2019	
	FTE	**Budget Authority**	**FTE**	**Budget Authority**	**FTE**	**Budget Authority**
	2,044		**2,000**		**-44**	
		$ 316,194,153		$ 241,560,212		$ -74,633,941
		316,194,153		241,560,212		-74,633,941
		316,194,153		241,560,212		-74,633,941
		316,194,153		241,560,212		-74,633,941
Increases:						
A. Built in:						
1. January 2020 Civilian Pay Raise		-		-		-
2. January 2020 Military Pay Raise		+631,658		+562,950		-68,708
3. Civilian Annualization of Jan. 2019		+ 1,565,875		-		-1,565,875
4. Military Annualization of Jan. 2019		+ 170,062		+ 157,384		-12,678
Subtotal, built-in increases		**2,367,595**		**720,334**		**-1,647,261**
B. Program:						
Discretionary Increases						
Ending HIV Epidemic Initiative		-	30	70,000,000	+ 30	+70,000,000
Organ Transplantation	1	25,549,000	1	27,549,000	-	+2,000,000
Subtotal Discretionary Program Increases	**1**	**25,549,000**	**31**	**97,549,000**	+30	**+72,000,000**
Mandatory Increases						
Subtotal Mandatory Program Increases	**-**	**-**	**-**	**-**	-	-
Total Program Increases	**1**	**25,549,000**	**31**	**97,549,000**	+ 30	**+72,000,000**

	FY 2019 Enacted		FY 2020 President's Budget		FY 2020 +/- FY 2019	
	FTE	Budget Authority	FTE	Budget Authority	FTE	Budget Authority
Decreases:						
A. Built in:						
1. Pay Costs	**2,044**	**$ 316,194,153**	**2,000**	**$ 241,560,212**	-44	**$ -1,647,261**
B. Program:						
Discretionary Decreases						
National Health Service Corps	-	120,000,000	6	105,000,000	+ 6	-15,000,000
Loan Repayment/Faculty Fellowships		1,190,000		-	-	-1,190,000
Centers of Excellence	2	23,711,000		-	-2	-23,711,000
Scholarships for Disadvantaged Students	7	48,970,000		-	-7	-48,970,000
Health Careers Opportunity Program	2	14,189,000		-	-2	-14,189,000
Health Care Workforce Assessment	6	5,663,000	6	4,663,000	-	-1,000,000
Primary Care Training and Enhancement	7	48,924,000		-	-7	-48,924,000
Oral Health Training Programs	6	40,673,000		-	-6	-40,673,000
Graduate Medical Education for Health Care Professionals	1	25,000,000		-	-1	-25,000,000
Area Health Education Centers	4	39,250,000		-	-4	-39,250,000
Geriatric Programs	6	40,737,000		-	-6	-40,737,000
Public Health/Preventive Medicine	4	17,000,000		-	-4	-17,000,000
Advanced Nursing Education	11	74,581,000		-	-11	-74,581,000
Nursing Workforce Diversity	4	17,343,000		-	-4	-17,343,000
Nurse Education, Practice and Retention	5	41,913,000		-	-5	-41,913,000
Nurse Faculty Loan Program	4	13,500,000		-	-4	-13,500,000
NURSE Corps Scholarship and Loan Repayment Program	32	87,135,000	32	83,135,000	-	-4,000,000
Children's Hospital Graduate Medical Education	21	325,000,000		-	-21	-325,000,000
Maternal and Child Health Block Grant	53	677,700,000	53	660,700,000	-	-17,000,000
Autism and Other Developmental Disorders	7	50,599,000		-	-7	-50,599,000
Sickle Cell Service Demonstrations	2	4,455,000		-	-2	-4,455,000
James T. Walsh Universal Newborn Hearing Screening	4	17,818,000		-	-4	-17,818,000
Emergency Medical Services for Children	6	22,334,000		-	-6	-22,334,000
Heritable Disorders	4	16,383,000		-	-4	-16,383,000
Pediatric Mental Health Care Access Grants	2	10,000,000		-	-2	-10,000,000
Screening and Treatment for Maternal Depression	1	5,000,000		-	-1	-5,000,000
National Cord Blood Inventory	4	16,266,000	4	12,266,000	-	-4,000,000
Hansen's Disease Center	52	13,706,000	52	11,653,000	-	-2,053,000
National Hansen's Disease Program - Buildings and Facilities		122,000		-	-	-122,000
Rural Health Policy Development	3	9,351,000	3	5,000,000	-	-4,351,000
Rural Health Outreach Grants	9	77,500,000	9	40,811,000	-	-36,689,000
Rural Hospital Flexibility Grants	1	53,609,000	-	-	-1	-53,609,000
State Offices of Rural Health	1	10,000,000		-	-1	-10,000,000

	FY 2019 Enacted		FY 2020 President's Budget		FY 2020 +/- FY 2019	
	FTE	**Budget Authority**	**FTE**	**Budget Authority**	**FTE**	**Budget Authority**
Telehealth	**2**	24,500,000	+2	10,000,000	-	-14,500,000
Rural Residency	**2**	10,000,000	-	-	-2	-10,000,000
Program Management	**753**	155,250,000	+753	151,993,000	-	-3,257,000
Subtotal Discretionary Program Decreases	**1,028**	**2,159,372,000**	**+914**	**1,085,221,000**	**-114**	**-1,074,151,000**
<u>Mandatory Decreases</u>						
Subtotal Mandatory Program Decreases	**-**	**-**	**-**	**-**	**-**	**-**
Total Program Decreases	**1,028**	**2,159,372,000**	**+914**	**1,085,221,000**	**-114**	**-1,074,151,000**
Net Change Discretionary	**1,029**	**2,184,921,000**	**+945**	**1,182,770,000**	**-84**	**-1,002,151,000**
Net Change Mandatory	-	-	-	-		-
Net Change Discretionary and Mandatory	**1,029**	**$2,184,921,000**	**+945**	**$1,182,770,000**	**-84**	**-$1,002,151,000**

Budget Authority by Activity
(dollars in thousands)

	FY 2018	FY 2019	FY 2020
	Final[10]	**Enacted**	**President's Budget**
1. PRIMARY CARE:			
Health Centers:			
Health Centers	1,486,816	1,505,522	1,505,522
Health Centers Loan Guarantee Program	20,000	-	-
Health Centers Mandatory	3,800,000	4,000,000	
Health Centers Proposed Mandatory	-	-	4,000,000
Health Centers All of Us Research Program	25,000	-	
Health Center Tort Claims	114,893	120,000	120,000
Subtotal, Health Centers	***5,446,709***	***5,625,522***	***5,625,522***
Free Clinics Medical Malpractice	1,000	1,000	1,000
Subtotal, Bureau of Primary Health Care (BPHC)	**5,447,709**	**5,626,522**	**5,626,522**
2. HEALTH WORKFORCE:			
National Health Service Corps (NHSC):			
NHSC	105,000	120,000	105,000
NHSC Mandatory	310,000	310,000	-
NHSC Proposed Mandatory	-	-	+310,000
Subtotal, NHSC	***415,000***	***430,000***	***415,000***
Loan Repayment/Faculty Fellowships	1,187	1,190	-
Health Professions Training for Diversity:			
Centers of Excellence	23,652	23,711	-
Scholarships for Disadvantaged Students	48,705	48,970	-
Health Careers Opportunity Program	14,154	14,189	-
Subtotal, Health Professions Training for Diversity	***86,511***	***86,870***	**-**
Health Care Workforce Assessment	5,663	5,663	4,663
Primary Care Training and Enhancement	48,802	48,924	-
Oral Health Training Programs	40,571	40,673	-
Graduate Medical Education for Health Care Professionals	-	25,000	-

[10] Reflects FY 2018 required and permissive transfers. Funding level does not include supplemental hurricane appropriations($60 million)

	FY 2018	FY 2019	FY 2020
	Final[10]	Enacted	President's Budget
Interdisciplinary, Community-Based Linkages:			
Area Health Education Centers	38,154	39,250	-
Geriatric Programs	40,635	40,737	-
Behavioral Health Workforce Development Programs	111,766	111,916	111,916
Subtotal, Interdisciplinary, Community-Based Linkages	***190,555***	***191,903***	***111,916***
Public Health Workforce Development:			
Public Health/Preventive Medicine	17,000	17,000	-
Nursing Workforce Development:			
Advanced Nursing Education	74,311	74,581	-
Nursing Workforce Diversity	17,300	17,343	-
Nurse Education, Practice and Retention	41,733	41,913	-
Nurse Faculty Loan Program	28,500	13,500	-
NURSE Corps Scholarship and Loan Repayment Program	87,107	87,135	83,135
Subtotal, Nursing Workforce Development	***248,951***	***234,472***	***83,135***
Children's Hospital Graduate Medical Education	314,213	325,000	-
Teaching Health Center Graduate Medical Education (THCGME):			
THCGME	-	-	-
THCGME Mandatory	126,500	126,500	-
THCGME Mandatory Proposed	-	-	126,500
Subtotal, THCGME	***126,500***	***126,500***	***126,500***
National Practitioner Data Bank (User Fees)	*18,814*	*18,814*	*18,814*
Subtotal, Bureau of Health Workforce (BHW)	**1,513,767**	**1,552,009**	**760,028**
3. MATERNAL & CHILD HEALTH:			
Maternal and Child Health Block Grant	650,194	677,700	660,700
Autism and Other Developmental Disorders	48,899	50,599	-
Sickle Cell Service Demonstrations	4,455	4,455	-
James T. Walsh Universal Newborn Hearing Screening	17,818	17,818	-
Emergency Medical Services for Children	22,134	22,334	-
Healthy Start	110,300	122,500	122,500
Heritable Disorders	15,788	16,383	-
Pediatric Mental Health Care Access Grants	10,000	10,000	-
Screening and Treatment for Maternal Depression	5,000	5,000	-
Family-to-Family Health Information Centers:			
Family-to-Family Health Information Centers	-	-	-
Family-to-Family Health Information Centers Mandatory	6,000	6,000	-

	FY 2018	FY 2019	FY 2020
	Final[10]	**Enacted**	**President's Budget**
Family-to-Family Health Information Centers Proposed Mandatory	-	-	6,000
Subtotal, Family-to-Family Health Information Centers	***6,000***	***6,000***	***6,000***
Maternal, Infant and Early Childhood Home Visiting Program (MIECHV)			
MIECHV	-	-	-
MIECHV Mandatory	400,000	400,000	400,000
Subtotal, MIECHV	***400,000***	***400,000***	***400,000***
Subtotal, Maternal and Child Health Bureau (MCHB)	**1,290,588**	**1,332,789**	**1,189,200**
4. HIV/AIDS:			
Emergency Relief - Part A	655,876	655,876	655,876
Comprehensive Care - Part B	1,309,251	1,315,005	1,315,005
AIDS Drug Assistance Program (non-add)	*895,559*	*900,313*	*900,313*
Early Intervention - Part C	201,079	201,079	201,079
Children, Youth, Women & Families - Part D	75,088	75,088	75,088
AIDS Education and Training Centers - Part F	33,611	33,611	33,611
Dental Reimbursement Program Part F	13,122	13,122	13,122
Special Projects of National Significance (SPNS)	25,000	25,000	25,000
Ending HIV Epidemic Initiative	-	-	70,000
Subtotal, HIV/AIDS Bureau	**2,313,027**	**2,318,781**	**2,388,781**
5. HEALTHCARE SYSTEMS:			
Organ Transplantation	25,486	25,549	27,549
National Cord Blood Inventory	15,236	16,266	12,266
C.W. Bill Young Cell Transplantation Program	24,050	24,609	24,609
Poison Control Centers	20,785	22,846	22,846
340B Drug Pricing Program/Office of Pharmacy Affairs	10,210	10,238	10,238
340B Drug Pricing Program User Fees	-	-	*19,000*
Hansen's Disease Center	13,665	13,706	11,653
Payment to Hawaii	1,852	1,857	1,857
National Hansen's Disease Program - Buildings and Facilities	122	122	-
Subtotal, Healthcare Systems Bureau (HSB)	**111,416**	**115,193**	**130,018**
6. RURAL HEALTH:			
Rural Health Policy Development	9,325	9,351	5,000
Rural Health Outreach Grants	71,300	77,500	40,811
Rural Hospital Flexibility Grants	49,470	53,609	-

	FY 2018	FY 2019	FY 2020
	Final[10]	**Enacted**	**President's Budget**
State Offices of Rural Health	10,000	10,000	-
Radiation Exposure Screening and Education Program	1,834	1,834	1,834
Black Lung	10,000	11,000	11,000
Telehealth	23,434	24,500	10,000
Rural Communities Opioid Response	100,000	120,000	120,000
Rural Residency	14,958	10,000	-
Subtotal, Federal Office of Rural Health Policy	**290,321**	**317,794**	**188,645**
7. PROGRAM MANAGEMENT	154,615	155,250	151,993
8. FAMILY PLANNING	285,768	286,479	286,479
TOTAL, Discretionary Budget Authority	**6,720,897**	**6,843,503**	**5,841,352**
FTE (excludes Vaccine)	**2,090**	**2,112**	**2,075**

Authorizing Legislation

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
PRIMARY HEALTH CARE:				
Health Centers: Public Health Service (PHS) Act, Section 330, as amended by P.L. 111-148, Section 5601; as amended by P.L. 115-123, Section 50901	Authorized for FY 2018 (and each subsequent year), an amount equal to the previous year's funding adjusted for any increase in the number of patients served and the per-patient costs	$1,505,522,000	Authorized for FY 2019 (and each subsequent year), an amount equal to the previous year's funding adjusted for any increase in the number of patients served and the per-patient costs	$1,505,522,000
Health Centers (Mandatory): P.L. 111-148, Section 10503; as amended by P.L 111-152, Section 2303; as amended by P.L. 114-10, Section 221 [see 42 USC 254b-2 stand-alone provision—not in PHS Act], as amended by P.L. 115-96, Sec. 3101(a)(2)(F); as amended by P.L. 115-123, Section 50901	$4,000,000,000	$4,000,000,000	Expired	$4,000,000,000
Federal Tort Claims Act Coverage for Health Centers: PHS Act, Section 224, as added by P.L. 102-501; as amended by P.L. 103-183; P.L. 104-73; P.L. 108-163; and the 21st Century Cures Act, P.L. 114-255, Section 9025	$10,000,000 per fiscal year is authorized under Section 224; funding comes from the Health Center line	$120,000,000	$10,000,000 per fiscal year is authorized under Section 224; funding comes from the Health Center line	$120,000,000
Federal Tort Claims Act Coverage for Free Clinics: PHS Act, Section 224, as added to the PHS Act by P.L. 104-191, Section 194; as amended by P.L. 111-148, Section 10608	$10,000,000 per fiscal year is authorized	$1,000,000	$10,000,000 per fiscal year is authorized	$1,000,000
BUREAU OF HEALTH WORKFORCE:				
National Health Service Corps (NHSC): NHSC: PHS Act, Sections 331-338, and 338C-H as amended by the Health Care Safety Net Act of 2008, P.L. 110-355, Section 3(a)(1) and 3(c)-(d); as amended by P.L. 111-148, 10501(n)(1)-(3) and (5)	Authorized for FY 2018 (and each subsequent year), based on previous year's funding, subject to adjustment formula	$120,000,000	Authorized for FY 2019 (and each subsequent year), based on previous year's funding, subject to adjustment formula	$105,000,000

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
NHSC (Mandatory): P.L. 111-148, Section 10503(b)(2), as amended by P.L. 114-10, Section 221 [see 42 USC 254b-2 stand-alone provision—not in PHS Act] , as amended by P.L. 115-96, Sec. 3101(b)(3)(F); as amended by P.L. 115-123, Section 50901	$310,000,000	$310,000,000	Expired	$310,000,000
NHSC Scholarship Program: PHS Act, Sections 338A and 338C-H, as amended by the Health Care Safety Net Act of 2008, P.L. 110-355, Section 3(a)(2); as amended by the Patient Protection and Affordable Care Act P.L. 111-148, Sections 5207 NHSC Loan Repayment Program: PHS Act, Sections 338B and 338C-H, as amended by the Health Care Safety Net Act of 2008, P.L. 110-355, Section 3(a)(2); as amended by the Patient Protection and Affordable Care Act , P.L. 111-148, Sections 5207 and 10501(n)(4) Students to Service Loan Repayment Program: PHS Act, Section 338B State Loan Repayment Program (SLRP): PHS Act, Section 338I(a)-(i), as amended by P.L. 107-251, Section 315; as further amended by the Health Care Safety Net Act of 2008, P.L. 110-355, Section 3(a)(2)	Indefinite Expired (Note: The CHC/NHSC Fund (extended by MACRA) is used to make SLRP grants)		Indefinite Expired (Note: The CHC/NHSC Fund (extended by MACRA) was used to make SLRP grants	
Loan Repayments and Fellowships Regarding Faculty Positions (Faculty Loan Repayment): PHS Act, Section 738(a) and 740(b), as amended by P.L. 111-148, Sections 5402 and 10501(d)	Expired	$1,190,000	Expired	--
Centers of Excellence: Section 736, PHS Act, as amended by P.L. 111-148, Section 5401	SSAN	$23,711,000	SSAN	--
Scholarships for Disadvantaged Students: PHS Act, Section 737, as amended by P.L. 111-148, Section 5402(b), authorization of appropriations in Section 740(a)	Expired	$48,970,000	Expired	--
Health Careers Opportunity Program: PHS Act, Section 739, as amended by P.L. 111-148, Section 5402, authorization of appropriation in Section 740(c),	Expired	$14,189,000	Expired	--
National Center for Workforce Analysis: PHS Act, Section 761(b), as amended by P.L. 111-148, Section 5103	Expired	$5,663,000	Expired	4,663,000

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
Primary Care Training and Enhancement: PHS Act, Section 747, as amended by P.L. 111-148, Section 5301	Expired	$48,924,000	Expired	--
Oral Health Training Programs (Training in General, Pediatric, and Public Health Dentistry): PHS Act, Section 748, as added by P.L. 111-148, Section 5303	Expired (with provision for carryover funds for no more than 3 years)	$40,673,000	Expired (with provision for carryover funds for no more than 3 years)	--
Graduate Medical Education for Health Care Professionals: as added by P.L. 115-245	$25,000,000	$25,000,000	--	--
Interdisciplinary, Community-Based Linkages: Area Health Education Centers: PHS Act, Section 751, as amended by P.L. 111-148, Section 5403; as amended by P.L. 113-128, Section 512(z)(2)	Expired (with provision for carryover funds for no more than 3 years)	$39,250,000	Expired (with provision for carryover funds for no more than 3 years)	--
Behavioral Health Workforce Education and Training (BHWET): PHS Act, Sections 755 and 756; as amended by the 21st Century Cures Act, P.L. 114-255, section 9021 and the SUPPORT for Patients and Communities Act P.L. 115-271, section 7073	$50,000,000 for each of fiscal years 2018 through 2023	$75,000,000	$50,000,000	$75,000,000
Education and Training Related to Geriatrics: PHS Act, Section 753, as amended by P.L. 111-148, Section 5305	Expired	$40,737,000	Expired	--
Geriatric Academic Career Awards PHS Act, Section 753(c), as amended by P.L. 111-148, Section 5305(b)	Not Specified	--	Not Specified	--
Mental and Behavioral Health Education and Training Grants (MBHET): PHS Act, Section 756, as added by P.L. 111-148, Section 5306; as amended by the 21st Century Cures Act, P.L. 114-255, Section 9021	(through FY 2022) Subsection (a)(1) grants: $15,000,000 Subsection (a)(2) grants: $15,000,000 Subsection (a)(3) grants: $10,000,000 Subsection (a)(4) grants: $10,000,000	$36,916,000	21st Century CURES Act, Section 9021Subsection (a)(1)-- $15,000,000 Subsection (a)(2) $15,000,000; Subsection (a)(3): $10,000,000; Subsection (a)(4): $10,000,000	$36,916,000
Public Health /Preventive Medicine: PHS Act, Sections 765-768, as amended by P.L. 111-148, Section 10501	Expired	$17,000,000	Expired	--

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
Nursing Workforce Development: Advanced Education Nursing: PHS Act, Section 811, as amended by P.L. 111-148, Section 5308	Expired	$74,581,000	Expired	--
Nursing Workforce Diversity PHS Act, Section 821, as amended by P.L. 111-148, Sec. 5404	Expired	$17,343,000	Expired	--
Nurse Education, Practice, Quality and Retention : PHS Act, Section 831 and 831A, as amended by P.L. 111-148, Section 5309	Expired	$41,913,000	Expired	--
Nurse Faculty Loan Program: PHS Act, Section 846A, as amended by P.L. 111-148, Section 5311	Expired	$13,500,000	Expired	--
NURSE Corps (formerly Nursing Education Loan Repayment and Scholarship Programs): PHS Act, Section 846, as amended by P.L. 107-205, Section 103; and for NURSE Corps Loan Repayment only, as amended by P.L. 111-148, Section 5310(a)	Expired	$87,135,000	Expired	$83,135,000
Children's Hospitals Graduate Medical Education Program: PHS Act, Section 340E, as amended by P.L. 106-129, section 4; as amended by P.L. 106-310, section 2001; as amended by P.L. 108-490; as amended by P.L. 109-307; as amended by P.L. 113-98, as amended by P.L. 115-241, section 2	Direct GME: $105,000,000 Indirect Medical Education: $220,000,000	$325,000,000	Direct GME: $100,000,000 (through FY 2018) and Indirect Medical Education: $200,000,000 (through FY 2018)	--
Teaching Health Centers Graduate Medical Education Program: PHS Act, Section 340H, as added by P.L. 111-148, Section 5508; as amended by P.L. 114-10, Section 221; as amended by P.L. 115-63, Section 301(a) by the Disaster Tax Relief and Airport and Airway Extension Act of 2017 (included 3-month THCGME funding), as amended by P.L. 115-96 Sec. 3101(c)(2); as amended by P.L. 115-123, Section 50901	$126,500,000	$126,500,000	Expired	$126,500,000

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
National Practitioner Data Bank: (User Fees) *Title IV, P.L. 99-660, SSA, Section 1921; P.L. 100-508, SSA, Section 1128E* *(also includes: Health Care Integrity and Protection Data Bank (HIPDB), SSA, Section 1128E)*	*Not Specified*	*$18,814,000*	*Not Specified*	*$18,814,000*
Health Professional Shortage Areas PHS Act Section 332 as amended by the Improving Access to Maternity Care Act, Public Law 115-320, section 2—*added a new subsection (k) authority for "Maternity Care Health Professional Target Areas"*	--	--	--	--
Grants for Innovative Programs PHS Act Section 340G, as amended by the Action for Dental Health Act of 2018 P.L. 115-302, section 3	$13,903,000	--	$13,903,000	--
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant: Social Security Act, Title V	Indefinite at $850,000,000	$677,700,000	Indefinite at $850,000,000	$660,700,000
Autism Education, Early Detection and Intervention: PHS Act, Section 399BB, as added by P.L. 109-416, Section 2; reauthorized: P.L. 112-32, Section 2; reauthorized: P.L. 113-157, Section 4	Not Specified (sunset at end of FY 2019)	$50,599,000	Not Specified (sunset at the end of FY 2019)	--
Sickle Cell Service Demonstration Grants: American Jobs Creation Act of 2004, P.L. 108-357, Section 712(c), as amended by the Sickle Cell Disease and Other Heritable Blood Disorders Research, Surveillance, Prevention, and Other Treatment Act of 2018, P.L. 115-327, section 3	$4,455,000 (each of FY 2019 through FY 2023)	$4,455,000	$4,455,000	--
Universal Newborn Hearing Screening: PHS Act, Section 399M, as amended by P.L. 106-310, Section 702; as amended by P.L. 111-337, Section 2	Expired	$17,818,000	Expired	--

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
Emergency Medical Services for Children: PHS Act, Section 1910, as amended by P.L. 105-392, Section 415; as amended by P.L. 111-148, Section 5603; as amended by P.L. 113-180, Section 2	$20,213,000 (through FY 2019)	$22,334,000	$20,213,000	--
Healthy Start: PHS Act, Section 330H(a)-(d), as amended by P.L. 106-310, Section 1501; as amended by P.L. 110-339, Section 2	Expired	$122,500,000	Expired	$122,500,000
Heritable Disorders: PHS Act, Section 1109-1112 and 1114, as amended by P.L. 106-310, Section 2601; as amended by P.L. 110-204, Section 2; as amended by P.L. 110-237, Section 1; as amended by P.L. 113-240, Section 10 (see PHS Act, Section 1117-authorization levels)	$11,900,000 (Sections 1109-1112); $8,000,000 (Section 1113) (through FY 2019)	$16,383,000	$11,900,000 (Sections 1109-1112); $8,000,000 (Section 1113)	--
Pediatric Mental Health Care Access Grants: PHS Act, Section 330M, as added by P.L. 114-255, Section 10002	$9,000,000 (each of FY 2018 through FY 2022)	$10,000,000	$9,000,000	--
Screening and Treatment for Maternal Depression: PHS Act, Section 317L-1, as added by P.L. 114-255, Section 10005	$5,000,000 (each of FY 2018 through FY 2022)	$5,000,000	$5,000,000	--
Family to Family Health Information Centers: Social Security Act, Section 501(c)(1)(A), as amended by P.L. 109-171, Section 6064; reauthorized by P.L. 111-148, Section 5507(b), as amended by P.L. 112-240, Section 624; as amended by P.L. 113-67, Section 1203; as amended by P.L. 113-93, Section 207; as amended by P.L. 114-10, Section 216; as amended by P.L. 115-123, Section 50501	$6,000,000 (each of FY 2018 and FY 2019)	$6,000,000	Expired	$6,000,000

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
Maternal, Infant and Early Childhood Visiting Program: Social Security Act, Section 511, as added by P.L. 111-148, Section 2951; as amended by P.L. 113-93, Section 209; as amended by P.L. 114-10, Section 218; as amended by P.L. 115-123, Section 50601-50607	$400,000,000 (each of FY 2017 through FY 2022)	$400,000,000	$400,000,000	$400,000,000
HIV/AIDS:[11]				
Emergency Relief - Part A PHS Act, Sections 2601-10, as amended by P.L. 106-345; as amended by P.L. 109-415; as amended by P.L. 111-87	Expired	$655,876,000	Expired	$655,876,000
Comprehensive Care - Part B: PHS Act, Sections 2611-31, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	$1,315,005,000	Expired	$1,315,005,000
AIDS Drug Assistance Program (Non-Add) *PHS Act, Sections 2611-31 and 2616, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87*	*Expired*	*$900,313,000*	*Expired*	*$900,313,000*
Early Intervention Services – Part C: PHS Act, Sections 2651-67, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	$201,079,000	Expired	$201,079,000
Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D: PHS Act, Section 2671, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	7$5,088,000	Expired	$75,088,000
AIDS Education and Training Centers - Part F: PHS Act, Section 2692(a), as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	$33,611,000	Expired	$33,611,000

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

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
Dental Reimbursement Program - Part F: PHS Act, Section 2692(b), as amended by P.L. 106-345, as amended by P.L.109-415, as amended by P.L.111-87	Expired	$13,122,000	Expired	$13,122,000
Special Projects of National Significance - Part F: PHS Act, Section 2691, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	$25,000,000	Expired	$25,000,000
Ending HIV Epidemic Initiative: Section 311 of the Public Health Service Act and Title XXVI of the Public Health Service Act	Expired	--	Expired	$70,000,000
HEALTHCARE SYSTEMS:				
Organ Transplantation: 42 U.S.C. 273-274g, PHS Act, Sections 371-378, as amended by P.L. 108-216, P.L. 109-129, P.L. 110-144, P.L. 110-413, and P.L. 113-51	Expired	$25,549,000	Expired	$27,549,000
National Cord Blood Inventory: PHS Act, Section 379; as amended by P.L. 109-129, Section 3; as amended by P.L. 111-264; as amended by P.L. 114-104, Section 3	$23,000,000 (through FY 2020)	$16,266,000	$23,000,000	$12,266,000
C.W. Bill Young Cell Transplantation Program: PHS Act, Sections 379-379B, as amended by P.L. 109-129, Section 3; as amended by P.L. 111-264; as amended by P.L. 114-104, Section 2	$30,000,000 (through FY 2020)	$24,609,000	$30,000,000	$24,609,000
Poison Control: PHS Act, Sections 1271-1274, as amended by P.L. 108-194; as amended by P.L. 110-377; as amended by P.L. 113-77	Toll-free number: $700,000 Media campaign: $800,000 Grant program: $28,600,000	$22,846,000	Toll-free number: $700,000; Media Campaign: $800,000; Grant program: $28,600,000	$22,846,000
340B Drug Pricing Program: PHS Act, Section 340B, as added by P.L. 102-585, Section 602(a); as amended by P. L. 103-43, Section 2008(i)(1)(A); as amended by P.L. 111-148, Sections 2501(f)(1), 7101(a) –(d), 7102; as amended by P.L. 111-152, Section 2302; as amended by P.L. 111-309, Section 204(a)(1)	SSAN indefinitely	$10,238,000	SSAN	$29,238,000

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
National Hansen's Disease Program: PHS Act, Section 320, as amended by P.L. 105-78, Section 211; as amended by P.L. 107-220	Not Specified	$13,706,000	Not Specified	$11,653,000
Payment to Hawaii: PHS Act, Section 320(d), as amended by P.L. 105-78, Section 211	Not Specified	$1,857,000	Not Specified	$1,857,000
National Hansen's Disease - Buildings and Facilities: PHS Act, Section 320	Not Specified	$122,000	Not Specified	---
Countermeasures Injury Compensation Program: PHS Act, Sections 319F-3 and 319F-4, as added by P.L. 109-148, as amended by P.L. 113-5 (to Section 319F-3)	Not Specified	---	Not Specified	---
RURAL HEALTH:				
Rural Health Policy Development: Social Security Act, Section 711, and PHS Act, Section 301	Indefinite	$9,351,000	Indefinite	$5,000,000
Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement: PHS Act, Section 330A, as amended by P.L. 107-251, Section 201; as amended by P.L. 110-355, Section 4	Expired	$77,500,000	Expired	$40,811,000
Rural Hospital Flexibility Grants: SSA, Section 1820(j), as amended by P.L. 105-33, Section 4201(a) and Section 4002(f), and P.L. 108-173, Section 405(f), as amended by P.L. 110-275, Section 121; as amended by P.L. 111-148, Section 3129(a)	Expired	$53,609,000	Expired	---
State Offices of Rural Health: PHS Act, Section 338J, as amended by P.L. 105-392, Section 301, and the State Offices of Rural Health Reauthorization Act of 2018 [P.L. 115-XX]	12,500,000 for each of fiscal years 2018 through 2022	$10,000,000	12,500,000	---
Radiogenic Diseases (Radiation Exposure Screening and Education Program): PHS Act, Section 417C, as amended by P.L. 106-245, Section 4, as amended by P.L. 109-482, Sections 103, 104	Not Specified	$1,834,000	Not Specified	$1,834,000
Black Lung: Federal Mine Safety and Health Act 1977, P.L. 91-173, Section 427(a)	Not Specified	$11,000,000	$10,000,000	$11,000,000

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
Telehealth: PHS Act, Section 330I, as amended by P.L. 107-251, as amended by P.L. 108-163; as amended by P.L. 113-55, Section 103	Expired	$24,500,000	Expired	$10.000,000
Rural Communities Opioid Response: SSA Section 711, as added by P.L. 100-203, Section 4401; as amended by P.L. 100-360, Section 411(m)(1); as amended by P.L. 101-239, Section 6213(g); as amended by P.L. 108-173, Section 432	Not Specified	$120,000,000	Not Specified	$120,000,000
Rural Residency: SSA Section 711(b)(5), as added by P.L. 100-203, Section 4401; as amended by P.L. 100-360, Section 411(m)(1); as amended by P.L. 101-239, Section 6213(g); as amended by P.L. 108-173, Section 432	Not Specified	$10,000,000	Not Specified	$10,000,000
Rural Emergency Medical Services Training and Equipment Assistance Program PHS Act Section 330J as amended by the Agriculture Improvement Act of 2018, P.L. 115-XX, Section 12608	SSAN for each of fiscal years 2019 through 2023	---	SSAN	---
OTHER PROGRAMS:				
Family Planning: Grants: PHS Act Title X	Expired	$286,479,000	Expired	$286,479,000
Program Management	Indefinite	$155,250,000	Indefinite	$151,993,000
Vaccine Injury Compensation Program (VICP) (funded through the VICP Trust Fund): PHS Act, Title XXI, Subtitle 2, Sections 2110-34, as amended by P.L. 114-255, Section 3093(c).	Indefinite	$289,200,000	Indefinite	$296,800,000
UNFUNDED AUTHORIZATIONS:				
Health Center Demonstration Project for Individualized Wellness Plans PHS Act, Section 330(s), as added to PHS Act by P.L. 111-148, Section 4206	SSAN	--	SSAN	--
School Based Health Centers - Facilities Construction P.L. 111-148, Section 4101(a)	Expired (through FY 2013 and amounts remain available until expended)	--	Expired (through FY 2013 and amounts remain available until expended)	--

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
School Based Health Centers - Operations PHS Act, Section 399Z-1, as added by P.L. 111-148, Section 4101(b)	Expired	--	Expired	--
Health Information Technology Innovation Initiative PHS Act, Section 330(e)(1)(C), (Grants for Operation of Health Center Networks and Plans), as amended	SSAN	--	SSAN	--
Health Information Technology Planning Grants PHS Act, Section 330(c)(1)(B)-(C), as amended	SSAN	--	SSAN	--
Electronic Health Record Implementation Initiative PHS Act, Section 330(e)(1)(C), as amended	SSAN	--	SSAN	--
Native Hawaiian Health Scholarships: 42 USC 11709, as amended by P.L. 111-148, Section 10221 (incorporating Section 202(a) of title II of Senate Indian Affairs Committee-reported S. 1790)	SSAN (through FY 2019)	--	SSAN (through FY 2019)	--
Health Professions Education in Health Disparities and Cultural Competency PHS Act, Section 741, as amended by P.L. 111-148, Section 5307	Expired	--	Expired	--
Training Opportunities for Direct Care Workers PHS Act, Section 747A, as added by P.L. 111-148, Section 5302	Expired	--	Expired	--
Comprehensive Geriatric Education: PHS Act, Section 865, as re-designated by P.L. 111-148, Section 5310(b)	Expired	--	Expired	
Continuing Education Support for Health Professionals Serving in Underserved Communities PHS Act, Section 752, as amended by P.L. 111-148, Section 5403	SSAN	--	SSAN	--
Geriatric Career Incentive Awards PHS Act, Section 753(e), as amended by P.L. 111-148, Section 5305(a)	Expired	--	Expired	--
Rural Interdisciplinary Training (Burdick) PHS Act, Section 754	Not Specified	--	Not Specified	--
Grants for Pain Care Education & Training, PHS Act, Section 759, as added by P.L.111-148, Section 4305	Expired (through FY 2012 and amounts appropriated remain available until expended)	--	Expired (through FY 2012 and amounts appropriated remain available until expended)	--
Advisory Council on Graduate Medical Education PHS Act, Section 762, as amended by P.L. 111-148, Section 5103	Expired	--	Expired	--

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
Health Professions Education in Health Disparities and Cultural Competency PHS Act, Section 807, as amended by P.L. 111-148, Section 5307	Expired	--	Expired	--
Minority Faculty Fellowship Program PHS Act, Section 738 (authorized appropriation in PHS Act Section 740(b)), as amended by P.L.111-148, Sections 5402, 10501	Expired	--	Expired	--
State Health Care Workforce Development Grants and Implementation Grants [stand-alone 42 U.S.C. 294r (not as part of PHS Act)], as added by P.L. 111-148, Section 5102	SSAN	--	SSAN	--
Allied Health and Other Disciplines PHS Act, Section 755	Not Specified	--	Not Specified	--
Nurse Managed Health Clinics , PHS Act, Section 330A-1, as added by P.L. 111-148, Section 5208	Expired	--	Expired	--
Patient Navigator PHS Act, Section 340A, as added by P.L. 109-18, Section 2; as amended by P.L. 111-148, Section 3510	Expired	--	Expired	--
Teaching Health Centers Development Grants, PHS Act, Section 749A, as added by P.L. 111-148, Section 5508	SSAN	--	SSAN	--
Evaluation of Long Term Effects of Living Organ Donation, PHS Act, Section 371A, as added by P.L. 108-216, Section 7	Not Specified	--	Not Specified	--
Congenital Disabilities PHS Act, Section 399T, as added by P.L. 110-374, Section 3, as renumbered by P.L. 111-148, Section 4003	Not Specified	--	Not Specified	--
Pediatric Loan Repayment: PHS Act, Section 775, as added by P.L. 111-148, Section 5203	Expired	--	Expired	--
Clinical Training in Interprofessional Practice: PHS Act, Sections 755, 765, 831	Not Specified (Section 755) Expired (Sections 765 and 831)	--	Not Specified (Section 755) Expired (Sections 765 and 831)	--
Rural Access to Emergency Devices: PHS Act, Section 313 (Public Access Defibrillation Demo), and P.L. 106-505, Section 413 (Rural Access to Emergency Devices)	Expired	--	Expired	--

	FY 2019 Amount Authorized	FY 2019 Amount Appropriated	FY 2020 Amount Authorized	FY 2020 President's Budget
Training Demonstration Program: PHS Act, Section 760, as added by P.L. 114-255, the 21st Century Cures Act, Section 9022	$10,000,000 (for each of FY 2018-FY 2022)	--	$10,000,000 (for each of FY 2018-FY 2022)	--
Liability Protections for Health Professional Volunteers at Community Health Centers: PHS Act, Section 224(q), as added by P.L. 114-255, the 21st Century Cures Act, Section 9025	Not Specified	--	Not Specified	--

Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2011				
General Fund Appropriation:				
Base	7,473,522,000		7,491,063,000	6,274,790,000
Supplemental				
Transfers				
Across-the-board reductions				-12,549,000
American Recovery and Reinvestment Act				73,600,000
Subtotal	7,473,522,000		7,491,063,000	6,335,841,000
FY 2012				
General Fund Appropriation:				
Base	6,801,262,000			6,206,204,000
Advance				
Supplemental				
Rescissions				
Across-the-board reductions				-11,730,000
Transfers				11,277,000
Subtotal	6,801,262,000			6,205,751,000
FY 2013				
General Fund Appropriation:				
Base	6,067,862,000			6,194,474,000
Advance				
Supplemental				
Rescissions				-12,389,000
Transfers				-15,807,000
Sequestration				-311,619,000
Subtotal	6,067,862,000			5,854,664,000
FY 2014				
General Fund Appropriation:				
Base	6,015,039,000		6,309,896,000	6,054,378,000
Advance				
Supplemental				
Rescissions				
Transfers				-15,198,000
Subtotal	6,015,039,000		6,309,896,000	6,039,180,000

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2015				
General Fund Appropriation:				
Base	5,292,739,000		6,093,916,000	6,104,784,000
Advance				
Supplemental				
Rescissions				
Transfers				
Subtotal	5,292,739,000		6,093,916,000	6,104,784,000
FY 2016				
General Fund Appropriation:				
Base	6,217,677,000	5,804,254,000	5,987,562,000	6,139,558,000
Advance				
Supplemental				
Rescissions				
Transfers				
Subtotal	6,217,677,000	5,804,254,000	5,987,562,000	6,139,558,000
FY 2017				
General Fund Appropriation:				
Base	5,733,481,000	5,917,190,000	6,155,869,000	6,213,347,000
Advance				
Supplemental				
Rescissions				
Transfers				-14,100,000
Subtotal	5,733,481,000	5,917,190,000	6,155,869,000	6,199,247,000
FY 2018				
General Fund Appropriation:				
Base	5,538,834,000	5,839,777,000	6,217,794,000	6,736,753,000
Advance				
Supplemental				
Rescissions				
Transfers				-15,857,000
Subtotal	5,538,834,000	5,815,727,000	6,217,794,000	6,720,897,000

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2019				
General Fund Appropriation:				
Base	9,559,591,000	6,540,385,000	6,816,753,000	6,843,503,000
Advance				
Supplemental				
Rescissions				
Transfers				
Subtotal	9,559,591,000	6,540,385,000	6,816,753,000	6,843,503,000
FY 2020				
General Fund Appropriation:				
Base	5,841,352,000			
Advance				
Supplemental				
Rescissions				
Transfers				
Subtotal	5,841,352,000			

Appropriations Not Authorized by Law [12]

HRSA Program	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2019
School-Based Health Centers (Facilities Construction) –P.L. 111-148, Section 4101(a) School Based Health Centers - Operations PHS Act, Section 399Z-1, as added by P.L. 111-148, Section 4101(b)	2013	$50,000,000	47,450,000	--
NHSC – PHS Act, Sections 331-338 Authorization of appropriations ("Field"): Section 338(a)	2012	--	--	--
NURSE Corps (formerly Nursing Education Loan Repayment and Scholarship Programs) PHS Act, Section 846, as amended by P.L. 107-205, Section 103; and for NURSE Corps Loan Repayment only, as amended by P.L. 111-148, Section 5310(a) Authorization of appropriations: Section 846(i)(1)	2007	SSAN	31,055,000	87,135,000
Loan Repayments and Fellowships Regarding Faculty Positions (Faculty Loan Repayment) – PHS Act, Section 738(a) and 740(b), as amended by P.L. 111-148, Sections 5402 and 10501(d)	2014	5,000,000	1,187,000	1,190,000
Scholarships for Disadvantaged Students – PHS Act, program authorized by Section 737, authorization of appropriations in Section 740(a), as amended by P.L. 111-148, Section 5402(b)	2014	SSAN	44,857,000	48,970,000
Health Careers Opportunity Program – PHS Act, program authorized by Section 739, authorization of appropriation in Section 740(c), as amended by P.L. 111-148, Section 5402	2014	SSAN	14,153,000	14,189,000
National Center for Workforce Analysis – PHS Act, Section 761(b), authorization of appropriation in Section 760(e)(1)(A), as amended by P.L. 111-148, Section 5103	2014	7,500,000	4,651,000	5,663,000
Primary Care Training and Enhancement -- PHS Act, Section 747, as amended by P.L. 111-148, Section 5301	2014	SSAN	36,831,000	48,924,000
Area Health Education Centers PHS Act, Section 751, as amended by P.L. 111-148, Section 5403; as amended by P.L. 113-128, Section 512(z)(2)	2014	125,000,000	30,250,000	39,250,000

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

HRSA Program	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2019
Education and Training Relating to Geriatrics – PHS Act, Section 753, as amended by P.L. 111-148, Section 5305; as amended by P.L. 111-256, Section 2(f)(5) • Geriatric Workforce Development (authorization of appropriation in Section 753(d) (9)) • Geriatric Career Incentive Awards (authorization of appropriation in Section 753(e)(4)) • Geriatric Academic Career Awards PHS Act, Section 753(c), as amended by P.L. 111-148, Section 5305(b)	2014 2013	10,800,000 10,000,000	33,237,000	40,737,000
Nursing Workforce Development • Nurse Retention Grants – PHS Act, Section 831A; as amended by P.L. 111-148, Section 5309(a)	2012	SSAN	--	--
Nursing Workforce Development • Nurse Education, Practice, and Quality grants – PHS Act, Section 831; as amended by P.L. 111-148, Section 5311(a)	2016	SSAN	37,913,000	41,913,000
Nursing Workforce Development • Nurse Faculty Loan Program – PHS Act, Section 846A; as amended by P.L. 111-148, Sections 5305(c), 5310(b)(10)(A)	2014	SSAN	24,500,000	13,500,000
Nursing Workforce Development • Comprehensive Geriatric Education – PHS Act, Section 865	2014	SSAN	4,350,000	--
Healthy Start – PHS Act, Section 330H(a)-(d), as amended by P.L. 106-310, Section 1501; as amended by P.L. 110-339, Section 2	2013	Amount authorized for the preceding FY increased by formula	100,746,000	122,500,000
Emergency Relief - Part A – PHS Act, Sections 2601-10, as amended by P.L. 106-345; as amended by P.L. 109-415; as amended by P.L. 111-87	2013	789,471,000	649,373,000	655,876,000
Comprehensive Care - Part B – PHS Act, Sections 2611-31, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	1,562,169,000	1,314,446,000	1,315,005,000
Early Intervention Services – Part C – PHS Act, Sections 2651-67, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	285,766,000	205,544,000	201,079,000

HRSA Program	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2019
Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D – PHS Act, Section 2671, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	87,273,000	72,395,000	75,088,000
Special Projects of National Significance - Part F – PHS Act, Section 2691, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	25,000,000	25,000,000	25,000,000
AIDS Education and Training Centers - Part F – PHS Act, Section 2692(a), as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	42,178,000	33,275,000	33,611,000
Dental Reimbursement Program - Part F – PHS Act, Section 2692(b), as amended by P.L. 106-345, as amended by P.L.109-415, as amended by P.L.111-87	2013	15,802,000	12,991,000	13,122,000
Organ Transplantation – 42 U.S.C. 273-274g, PHS Act, Sections 371-378, as amended by P.L. 108-216, P.L. 109-129, P.L. 110-144, P.L. 110-413, and P.L. 113-51	Annual appropriations constitute authorizations (Section-specific appropriations for sections 377, 377A, and 377B expired September 30, 2009)	Section 377—5,000,000 Section 377A—SSAN Section 377B—SSAN	2,767,000	25,549,000
Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement – PHS Act, Section 330A, as amended by P.L. 107-251, Section 201; as amended by P.L. 110-355, Section 4	2012	45,000,000	55,553,000	77,500,000
Rural Hospital Flexibility Grants – SSA, Section 1820(j), as amended by P.L. 105-33, Section 4201(a) and Section 4002(f),, and P.L. 108-173, Section 405(f), as amended by, P.L. 110-275, Section 121; as amended by P.L. 111-148, Section 3129(a)	2012	SSAN	41,040,000	53,609,000
Telehealth – PHS Act, Section 330I, as amended by P.L. 107-251, as amended by P.L. 108-163; as further amended by P.L. 113-55, Section 103	2006	SSAN	6,814,000	24,500,000
Family Planning Grants – PHS Act, Title X	1985	158,400,000	142,500,000	286,479,000

Primary Health Care TAB

PRIMARY HEALTH CARE

Health Centers

	FY 2018 Final[13]	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$1,506,816,000	$1,505,522,000	$1,505,522,000	---
Current Law Mandatory Funding	$3,825,000,000	$4,000,000,000	---	-$4,000,000,000
Proposed Law Mandatory Funding	---	---	$4,000,000,000	+$4,000,000,000
FTCA Program	$114,893,000	$120,000,000	$120,000,000	---
Total	**$5,446,709,000**	**$5,625,522,000**	**$5,625,522,000**	---
FTE	500	500	500	---

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

FY 2020 Authorization: FY 2019 authorization level adjusted by the product of -
(i) one plus the average percentage increase in costs incurred per patient served; and
(ii) one plus the average percentage increase in the total number of patients served.

FY 2020 Community Health Center Fund Authorization.....$0

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

Program Description and Accomplishments

For more than 50 years, health centers have delivered affordable, accessible, quality, and cost-effective primary health care to patients regardless of their ability to pay. During that time, health centers have become an essential primary care provider for millions of people across the country. Health centers advance a model of coordinated, comprehensive, and patient-centered primary health care, integrating a wide range of medical, dental, mental health, substance use disorder, and patient services. Today, approximately 1,400 health centers operate nearly 12,000 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

[13] FY 2018 funding level does not include supplemental hurricane appropriations ($60 million).

In 2017, health centers served 27.2 million patients, one in every twelve people living in the United States, providing approximately 110 million patient visits, at an average cost of $942 per patient (including Federal and non-Federal sources of funding). In 2017, nearly half of all health centers served rural areas providing care to 8.9 million patients, about one in 5 people living in rural areas. Patient services are supported through Federal Health Center grants, Medicaid, Medicare, Children's Health Insurance Program (CHIP), other third party payments, self-pay collections, other Federal grants, and State/local/other resources.

Health centers deliver high quality and value-based care by using key quality improvement practices, including health information technology. Approximately 75 percent of health centers are currently recognized by national accrediting organizations as Patient Centered Medical Homes– an advanced model of patient-centered primary care that emphasizes quality and care coordination through a team-based approach to care. Despite treating a sicker, poorer, and more diverse population than other health care providers, health centers exceeded numerous national averages and benchmarks in 2017 including Healthy People 2020 goals for hypertension control and dental sealant services. Overall, 92 percent of health centers met or exceeded Healthy People 2020 goals for at least one clinical measure in 2017, and 99% of health centers improved in one or more clinical quality measures. Health centers also reduce costs to health systems; the health center model of care has been shown to reduce the use of costlier providers of care, such as emergency departments and hospitals[14].

Populations served: Health centers serve a diverse patient population. In 2017:

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

- People in poverty: Over 91 percent of health center patients are individuals or families living at or below 200 percent of the Federal Poverty Guidelines as compared to approximately 34 percent of the U.S. population as a whole.

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

- Special Populations: Some health centers receive specific funding to provide primary care services for certain special populations including individuals and families experiencing homelessness, agricultural workers, those living in public housing, and Native Hawaiians. Health centers served almost 1.4 million individuals experiencing homelessness, over 970,000 agricultural workers and their families, almost 3.5 million residents of public housing and nearly 14,000 Native Hawaiians.

[14] Nocon, Robert S. et al. "Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings" American Journal of Public Health, Nov 2016

- Health Care for the Homeless Program: Homelessness continues to affect rural as well as urban and suburban communities in the United States. According to the Department of Housing and Urban Development's 2016 Annual Homeless Assessment Report to Congress, over 1.4 million people experienced sheltered homelessness. In 2017, HRSA-funded health centers provided primary care services for nearly 1.4 million persons in supportive housing and/or experiencing homelessness. The Health Care for the Homeless Program supports coordinated, comprehensive, integrated primary care including substance abuse and mental health services for homeless persons in the United States, serving patients that live on the street, in shelters, or in transitional housing.

- Migrant Health Center Program: HRSA-funded health centers provided primary care services for over 970,000 migratory and seasonal agricultural workers and their families. It is estimated that there are approximately 2.8 million migratory and seasonal agricultural workers in the United States (2016 LSC Agricultural Worker Population Estimate Update). The Migrant Health Center Program supports comprehensive, integrated primary care services for agricultural workers and their families with a particular focus on occupational health and safety.

- Public Housing Primary Care Program: The Public Housing Primary Care Program increases access for residents of public housing to comprehensive, integrated primary care services. Health centers deliver care at locations on the premises of public housing developments or immediately accessible to residents. HRSA-funded health centers provided primary care services for nearly 3.5 million residents of public housing. The Public Housing Primary Care Program provides services that are responsive to identified needs of the residents and in coordination with public housing authorities.

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

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

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

Patient Care: Health centers continue to serve an increasing number of patients. The number of health center patients served in 2017 was 27.2 million; an increase of 11.1 million, or 69 percent, above the 16.1 million patients served in 2007. Of the 27.2 million patients served and for those for whom income status is known, over 91 percent were at or below 200 percent of the Federal poverty level and approximately 23 percent were uninsured. Success in increasing the number of patients served has been due in large part to the development of new health centers, new satellite sites, and expanded capacity at existing clinics.

Health centers focus on integrating care for their patients across the full range of services – not just medical but oral health, vision, behavioral health (mental health and substance use disorder services), and pharmacy. Health centers also deliver crucial services such as case management, transportation, and health education, which enable target populations to access care. Over 91 percent of health centers provide preventive dental services either directly or via contract. In 2017, health centers provided oral health services to over 6.1 million patients, an increase of 63 percent since 2010. In 2017, over 2.2 million people received behavioral health services at health centers, an increase of 64 percent from 2014 to 2017 due to significant Health Center Program investments in behavioral health services beginning in 2014.

From FY 2016 through FY 2019, HRSA has invested $544 million in targeted, ongoing annual grant funding for the expansion of substance use disorder (SUD) and mental health (MH) services in health centers. An additional $300 million has been invested in one-time health center infrastructure costs that support the expansion of services. These investments support health centers in implementing and advancing evidence-based strategies to expand access to quality integrated SUD prevention and treatment services, including those addressing opioid use disorder (OUD) and other emerging SUD issues, to best meet the health needs of the population served by each health center; and/or to expand access to quality integrated mental health services, with a focus on conditions that increase risk for, or co-occur with SUD, including OUD. Screening for substance use disorders has increased 42 percent since 2016 with the number of patients receiving screening, brief intervention, referral and treatment (SBIRT) increasing from 716,677 in 2016 to 1,017,249 in 2017. From 2016–2017, the number of health center providers eligible to prescribe MAT increased 75 percent (from 1,700 in 2016 to 2,973 in 2017) and the number of patients receiving MAT increased 64 percent (from 39,375 in 2016 to 64,597 in 2017).

Improving Quality of Care and Health Outcomes: Health centers continue to provide quality primary and related health care services, improving the health of the Nation's underserved communities and populations. HRSA-funded health centers are evaluated on a set of performance measures emphasizing health outcomes and the value of care delivered. These measures provide a balanced, comprehensive look at a health center's services toward common

conditions affecting underserved communities. Performance measures align with national standards and are commonly used by Medicare, Medicaid, and health insurance/managed care organizations. Benchmarking health center outcomes to national rates demonstrates how health center performance compares to the performance of the nation overall.

Timely entry into prenatal care is an indicator of both access to and quality of care. Identifying maternal disease and risks for complications of pregnancy or birth during the first trimester can also help improve birth outcomes. Results over the past few years demonstrate improved performance as the percentage of pregnant health center patients that began prenatal care in the first trimester grew from 57.8 percent in 2011 to 74.0 percent in 2017, exceeding the target of 70.0 percent.

Appropriate prenatal care management can also have a significant effect on the incidence of low birth weight (LBW), the risk factor most closely associated with neonatal mortality. Monitoring birth weight rates is one way to measure quality of care and health outcomes for health center female patients of childbearing age, approximately 29 percent of the total health center patient population served in 2017. In 2017, the health center rate was 8.0 percent, approximately 2 percentage points lower than the 2016 national rate of 8.2 percent, and has consistently been lower than the national rate during the past several years.

Health center patients, including low-income individuals, racial/ethnic minority groups, and persons who are uninsured, are more likely to suffer from chronic diseases such as hypertension and diabetes. Clinical evidence indicates that access to appropriate care can improve the health status of patients with chronic diseases and thus reduce or eliminate health disparities. The Health Center Program began reporting data from all grantees on the control of hypertension and diabetes via its Uniform Data System in 2008. In 2017, 63 percent of adult health center patients with diagnosed hypertension had blood pressure under adequate control (less than 140/90) compared to 57 percent nationally. Additionally in 2017, 67 percent of adult health center patients with type 1 or 2 diabetes had their most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent) compared to 60 percent nationally.

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

Health centers improve health outcomes by emphasizing the care management of patients with multiple health care needs and the use of key quality improvement practices, including health information technology. HRSA's Health Center Program Patient Centered Medical Home (PCMH) Initiative supports health centers to achieve national PCMH recognition, an advanced model of primary care using a team-based approach to improve quality through coordination of care and patient engagement. At the end of FY 2017, more than two-thirds of HRSA-funded

health centers were recognized as PCMHs, and currently over three-quarters of health centers are recognized as PCMHs. In addition, health centers have advanced quality and accountability by adopting Health Information Technology (HIT), including the use of certified Electronic Health Records (EHRs), telehealth and other technologies that advance and enable quality improvement. Over 99 percent of all health centers reported having an EHR in 2017.

Promoting Efficiency: Health centers provide cost-effective, affordable, quality primary health care services. The Program's efficiency measure focuses on maximizing the number of health center patient visits provided per dollar as well as keeping medical cost per medical visit below average annual national health care medical cost per medical visit while maintaining access to the full complement of high quality services (e.g., medical, dental, mental health, substance use disorder, pharmacy and patient support services) that make health centers a "health care home". In 2015, the medical cost per medical visit at health centers was $177, compared to the national cost of $187. In 2016, the medical cost per medical visit at health centers was $185, and in 2017 it was $192.

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

External Evaluation: In addition to internal monitoring of health center performance, peer reviewed literature and major reports continue to document that health centers successfully increase access to care, promote quality and cost-effective care, and improve patient outcomes, especially for traditionally underserved populations.

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

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

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

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

- Health centers demonstrate lower total costs for Medicare beneficiaries. Total median annual costs (at $2,370) for health center Medicare patients were lower by 10 percent compared to patients in physician offices ($2,667) and by 30 percent compared to patients in outpatient clinics ($3,580). (Dana B. Mukamel, Laura M. White, Robert S. Nocon, Elbert S. Huang, Ravi Sharma, Leiyu Shi and Quyen Ngo-Metzger; "Comparing the Cost of Caring for Medicare Beneficiaries in Federally Funded Health Centers to Other Care Settings" *Health Services Research*, Volume 51, No. 2, April 2016.

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

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

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

Federal Tort Claims Act (FTCA) Program: The Health Center Program administers the FTCA Program, under which participating health centers, their employees and eligible contractors may be deemed to be Federal employees qualified for medical malpractice liability protection under the FTCA. As Federal employees, they are immune from suit for medical malpractice claims while acting within the scope of their employment. The Federal Government assumes responsibility for such claims. In addition, the FTCA Program supports risk mitigation activities, including reviews of risk management plans and sites visits as well as risk management technical assistance and resources to support health centers. The enactment of the 21st Century Cures Act in December of 2016 extended liability protections for volunteers at deemed health centers under the FTCA Program. In accordance with the statute, HRSA implemented FTCA coverage for volunteers in FY 2017. More than 200 volunteers were covered under the FTCA Program in FY 2017. Overall, in FY 2015, 111 claims were paid totaling $93.8 million, in FY 2016, 134

claims were paid totaling $92.4 million, in FY 2017, 127 claims were paid totaling $119.7 million, and in FY 2018, 110 claims were paid totaling $109.3 million. Currently, there are over 800 FTCA Program claims outstanding. As the number of health center patients continues to grow, it is projected that the amount of claims paid will continue to increase in FY 2019.

Funding History

FY	Amount
FY 2016	$1,491,422,000
FY 2016 Mandatory	$3,600,000,000
FY 2017	$1,481,929,000
FY 2017 Mandatory[15]	$3,510,661,000
FY 2018	$1,621,709,000
FY 2018 Mandatory	$3,825,000,000
FY 2019	$1,625,522,000
FY 2019 Mandatory	$4,000,000,000
FY 2020	$1,625,522,000
FY 2020 Mandatory	$4,000,000,000

Budget Request

The FY 2020 Budget requests $1.6 billion in discretionary resources and includes $4 billion in mandatory funding, for a total request of $5.6 billion, which is equal to the FY 2019 Enacted level. In FY 2020, the Health Center Program will provide care for approximately 27.2 million patients. This request will also support quality improvement and value-based performance management activities at existing health center organizations, and ensure that current health centers can continue to provide essential primary health care services to their patient populations, including substance use disorder services focusing on the treatment, prevention, and/or awareness of opioid abuse. In FY 2020, the Health Centers Program will collaborate on the Ending the HIV Epidemic Initiative. As part of this effort, the Health Centers Program will provide Pre-Exposure Prophylaxis (PrEP) to people at high risk for HIV transmission and include outreach and care coordination services through new grant awards in targeted areas currently served by health centers. The FY 2020 Request also supports $120 million for the FTCA Program, which is equal to the FY 2019 Enacted level. The request also includes costs associated with the grant review and award process, operational site visits, information technology, and other program support costs.

This Budget requests $4 billion in annual mandatory funding for FY 2020 and FY 2021, totaling $8 billion over the two-year period. Multi-year mandatory funding would provide health centers, which depend on Federal resources to cover daily operational costs, with a stable source of funding with which to manage their operations.

[15] FY 2017 reflects the post-sequestered amount.

	FY 2020	FY 2021	Total Funding
Proposed Mandatory Funding	$4 billion	$4 billion	$8 billion

Health centers continue to be a critical element of the health system, largely because they can provide an accessible and dependable source of value-based primary health care services in underserved communities. In particular, health centers emphasize coordinated primary and preventive services that promote reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities, and other underserved populations. Health centers place emphasis on the coordination and comprehensiveness of care, the ability to manage patients with multiple health care needs, and the use of key quality improvement practices, including HIT. The health center model also overcomes geographic, cultural, linguistic, and other barriers through a team-based approach to care that includes physicians, nurse practitioners, physician assistants, nurses, dental providers, midwives, behavioral health care providers, social workers, and health educators. Health centers also reduce costs to health systems; the health center model of care has been shown to reduce the use of costlier providers of care, such as EDs and hospitals. In 2016, a study published in the American Journal of Public Health evaluated the total annual health care use and total health care spending of Medicaid (fee-for-service) patients seen at health centers versus those seen at non-health center settings.[16] This study found that patients seen at a health center had lower health care utilization and spending across all services when compared to non-health center patients. This included 33% lower spending on specialty care, 25% fewer inpatient admissions, and 24% lower total spending overall. Specifically, Medicaid FFS patients seen at a health center saved nearly $2,400 in total health care spending per year when compared to those seen in a non-health center setting. Health centers serve 4.2 million Medicaid FFS patients.

The FY 2020 Request supports the Health Center Program's achievement of its performance targets, including goals on access to affordable, accessible, quality, and cost-effective primary health care services, and the improvement of health outcomes and quality of care. The Health Center Program has established ambitious targets for FY 2020 and beyond. For low birth weight, the Program seeks to be below the national rate. This is ambitious because health centers continue to serve a higher risk prenatal population than represented nationally in terms of socio-economic, health status and other factors that predispose health center patients to greater risk for LBW and adverse birth outcomes. The FY 2020 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 2020 target for the program's diabetes management measure is 69 percent of adult patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent).

The Health Center Program will also continue to promote efficient, value-based care, and aims to keep the medical cost per medical visit below the average annual national medical visit costs.

[16] Nocon, Robert S. et al. "Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings" American Journal of Public Health, Nov 2016

By benchmarking the health center efficiency to national per capita medical visit costs, the measure takes into account changes in the healthcare marketplace while demonstrating the Program's continued ability to deliver services at a more cost-effective rate. The FY 2020 target is to keep the program's medical cost per medical visit below the 2020 national cost figure. By restraining increases in the medical cost per medical visit at health centers, the Health Center Program is able to demonstrate that it delivers its high-quality services at a more cost-effective rate.

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

To support quality improvement, the Program will continue to facilitate national and State-level technical assistance and training programs that promote quality improvements in health center data and quality reporting, clinical and quality improvement, and implementation of innovative value-based, quality activities. The Program continues to promote the integration of HIT into health centers through the Health Center Controlled Network Program to assure that key safety-net providers are able to advance their operations through enhanced technology and tele-health systems.

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

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

Funding would allow continued coordination and collaboration with related Federal, State, local, and private programs in order to further leverage and promote efforts to expand and improve health centers. The Health Center Program will continue to work with the CMS and the Office of the National Coordinator for Health Information Technology on HIT, and the Centers for Disease Control and Prevention to address HIV prevention and public health initiatives, and the

National Institutes of Health on clinical practice and precision medicine, among others. In addition, the Health Center Program will continue to coordinate with CMS to jointly review section 1115 Medicaid Demonstration Waivers. The Program will continue to work closely with the Department of Justice on the FTCA Program. Additionally, the proposed Budget supports coordination with programs in the Departments of Housing and Urban Development, Education, and Justice.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
1.I.A.1: Number of patients served by health centers (Output)	FY 2017: 27.2M Target: 25.7M (Target Exceeded)	27.2M	27.2M	Maintain
1.I.A.2.b: Percentage of grantees that provide the following services either on-site or by paid referral: (b) Preventive Dental Care (Output)	FY 2017: 91% Target: 90% (Target Exceeded)	90%	90%	Maintain
1.I.A.2.c: Percentage of grantees that provide the following services either on-site or by paid referral: (c) Mental Health/Substance Abuse (Output)	FY 2017: 90% Target: 86% (Target Exceeded)	88%	88%	Maintain
1.E.1: Medical cost per medical visit at health centers compared to the national cost.(Efficiency)	FY 2017: $192 Target: below national cost (not yet known)	Below national cost	Below national cost	Maintain

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
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 2017: 8.0%, Target: 5% below national rate (not yet known)	5% below national rate	5% below national rate	Maintain
1.II.B.3: Percentage of adult health center patients with diagnosed hypertension whose blood pressure is under adequate control (less than 140/90) (Outcome)	FY 2017: 63% Target: 63% (Target Met)	63%	63%	Maintain
1.II.B.4: Percentage of adult health center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent) (Outcome)	FY 2017: 67% Target: 69% (Target Not Met)	69%	69%	Maintain
1.II.B.1: Percentage of pregnant health center patients beginning prenatal care in the first trimester (Output)	FY 2017: 74% Target: 70% (Target Exceeded)	73%	73%	Maintain
1.II.A.1: Percentage of Health Center patients who are at or below 200 percent of poverty (Output)	FY 2017: 91% Target: 91% (Target Met)	91%	91%	Maintain
1.I.A.3: Percentage of health centers with at least one site recognized as a patient centered medical home (Outcome)	FY 2017: 67% Target: 65% (Target Exceeded)	65%	67%	Increase

Grants Awards Table

	FY 2018 Enacted	FY 2019 President's Budget	FY 2020 Request
Number of Awards	1,376	1,376	1,376
Average Award	$3.6 million	$3.7 million	$3.7 million
Range of Awards	$400,000 – $22.5 million	$400,000 – $22.5 million	$400,000 – $22.5 million

Free Clinics Medical Malpractice

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$1,000,000	$1,000,000	$1,000,000	---
FTE	---	---	---	

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

FY 2020 Authorization ..... Indefinite

Allocation Method ..... Other

Program Description and Accomplishments

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

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

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

Increasing Access: In FY 2017, 10,083 health care providers received Federal malpractice insurance through the Free Clinics Medical Malpractice Program, less than the Program target. In FY 2015, 237 clinics operated with FTCA deemed clinicians; in FY 2016, 243 clinics participated, and in FY 2017, 237 clinics participated.

Promoting Efficiency: The Free Clinics Medical Malpractice Program is committed to improving overall efficiency by controlling the Federal administrative costs necessary to deem each provider. By restraining these annual administrative costs, the Program is able to provide an increasing number of clinicians with malpractice coverage, thus building the free clinic workforce capacity nationwide and increasing access to care for the target populations served by these clinics. In FY 2015 the cost was $45 per provider, in FY 2016 the cost was $50 per provider, and in FY 2017 the cost was $7 per provider, which was unusually low due to no need to support system enhancement costs in FY 2017. Costs are expected to return to normal levels in FY 2018. In each year, the Program performance target has been exceeded.

To date, there has been 1 paid claim under the Free Clinics Medical Malpractice Program. There is 1 claim currently outstanding, and the Program Fund has a current balance of approximately $1.73 million.

Funding History

FY	Amount
FY 2016	$100,000
FY 2017	$1,000,000
FY 2018	$1,000,000
FY 2019	$1,000,000
FY 2020	$1,000,000

Budget Request

The FY 2020 Budget requests $1 million for the Free Clinics Medical Malpractice Program, which is to the same as the FY 2019 Enacted level. The request will support the Program's continued achievement of its performance targets addressing its goal of maintaining access and capacity in the health care safety net. The funding request also includes costs associated with information technology and other program support costs.

Targets for FY 2020 focus on maintaining FY 2019 target levels for the number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage at 10,000, while also maintaining the number of free clinics operating with FTCA deemed volunteer clinicians at 220. The Program will also continue to promote efficiency by restraining growth in the annual Federal administrative costs necessary to deem each provider, with a target of $75 administrative cost per provider in FY 2020.

The FY 2020 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 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
2.I.A.1: Number of free clinic health care providers deemed eligible for FTCA malpractice coverage (Outcome)	FY 2017: 10,083 Target: 11,500 (Target not Met)	10,000	10,000	Maintain
2.1: Patient visits provided by free clinics sponsoring FTCA deemed clinicians (Outcome)	FY 2017: 474,701 Target: 475,000 (Target Virtually Met)	475,000	475,000	Maintain
2.I.A.2: Number of free clinics operating with FTCA deemed clinicians (Output)	FY 2017: 237 Target: 220 (Target Exceeded)	220	220	Maintain
2.E: Administrative costs of the program per FTCA covered provider (Efficiency)	FY 2017: $7Target: $75 (Target Exceeded)	$75	$75	Maintain

HEALTH WORKFORCE

National Health Service Corps (NHSC)

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$105,000,000	$120,000,000	$105,000,000	-$15,000,000
Current Law Mandatory Funding	$310,000,000	$310,000,000	---	-$310,000,000
Proposed Law Mandatory Funding	---	---	$310,000,000	+$310,000,000
Total	$415,000,000	$430,000,000	$415,000,000	-$15,000,000
FTE	206	206	212	+6

Authorizing Legislation: Public Health Service Act, Sections 331-338H, as amended by Public Law 114-10
FY 2020 Authorization ..... Expires FY 2019

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

Program Description and Accomplishments:

Since its inception in 1972, the National Health Service Corps (NHSC) has worked to support qualified health care providers dedicated to working in underserved communities in urban, rural, and tribal areas. Across the nation, NHSC clinicians serve patients in Health Professional Shortage Areas (HPSAs) – communities with limited access to health care. As of September 30, 2018, there were 6,815 primary care HPSAs, 5,632 dental HPSAs, and 4,929 mental health HPSAs.

The NHSC seeks clinicians who demonstrate a commitment to serve the Nation's medically underserved populations at NHSC-approved sites located in HPSAs. NHSC-approved sites provide care to individuals regardless of ability to pay; currently, there are over 16,400 NHSC-approved sites. Eligible sites include Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes, American Indian and Native Alaska health clinics, rural health clinics, critical access hospitals and hospitals managed or owned by the Indian Health Service (IHS), school-based clinics, mobile units, free clinics, community mental health centers, state or local health departments, community outpatient facilities, federal facilities such as the Bureau of Prisons, U.S. Immigration and Customs Enforcement, IHS, and private practices.

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

As of September 30, 2018, there are 10,939 primary care medical, dental, and mental and behavioral health practitioners providing service nationwide in the following programs[17]:

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

NHSC Loan Repayment Program (LRP): The NHSC LRP offers fully trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service in a HPSA. In exchange for an initial two years of service, loan repayers receive up to $50,000 in loan repayment assistance. The NHSC LRP recruits clinicians as they complete training and are immediately available for service, as well as seasoned professionals seeking an opportunity to serve in the nation's underserved communities. In FY 2018, the NHSC LRP has added flexibility for NHSC clinicians to utilize telemedicine. Currently, less than 10 percent of NHSC applicants indicate that their site uses telemedicine.

NHSC LRP Substance Use Disorder (SUD) Expansion: The Consolidated Appropriations Act of 2018 and the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 appropriated funding to the NHSC for the express purpose of expanding and improving access to quality opioid and SUD treatment in rural and underserved areas nationwide. The primary purpose of this dedicated funding is to expand the availability of substance use disorder (SUD) treatment providers to include the SUD workforce and categories for outpatient services, including Opioid Treatment Programs, Office-based Opioid Treatment Facilities and Non-opioid Outpatient SUD facilities. The funding will support the recruitment and retention of health professionals needed in underserved areas to provide evidence-based SUD treatment and prevent overdose deaths. Providers will be given loan repayment to reduce their educational financial debt in exchange for a service commitment to work at SUD Treatment Facilities.

A portion of the FY 2018 and FY 2019 appropriations will fund the NHSC Rural Communities Opioid Response LRP; which will support the prevention and treatment of SUD, including

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

opioid abuse. As the needs in these counties are identified, loan repayment awards will be made beginning in FY 2019 through FY 2020.

Additionally, the FY 2019 appropriation includes funding to support loan repayment awards to both fully trained medical, nursing, dental and behavioral/mental health clinicians, and SUD providers, to deliver health care services in Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs. Federal Indian Health Service Clinics, Tribal Health Clinics, Urban Indian Health Clinics, and dually-funded Tribal Health Clinics/Community Health Centers are automatically designated as HPSAs. Additionally, these sites received NHSC placements before 2019.

SUD Providers include:

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

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

State Loan Repayment Program (SLRP): The SLRP is a federal-state partnership grant program that requires a dollar-for-dollar match from the state that enters into loan repayment contracts with clinicians who practice in a HPSA in that state. The program serves as a complement to the NHSC and provides flexibility to states to help meet their unique primary care workforce needs. States have the discretion to focus on one, some, or all of the eligible primary care disciplines eligible within the NHSC and may also include pharmacists and registered nurses. The program supported 37 states in FY 2017. In FY 2018, HRSA opened a new SLRP competition, expanding approved disciplines to include substance use disorder counselors, an additional 5 states and one territory received awards, for a total of 43 grantees.

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

NHSC Student Pipeline by Program as of 09/30/2018

Programs	**Students**
Scholarship Program	1,068
Students to Service Program	419
Total	**1,487**

NHSC Student Pipeline by Discipline as of 09/30/2018

Disciplines	Students
Allopathic/Osteopathic Physicians	1,020
Dentists	240
Nurse Practitioners	67
Physician Assistants	139
Certified Nurse Midwives	21
Total	**1,487**

NHSC Field Strength[18] by Program as of 09/30/2018

Programs	Clinicians
Scholarship Program Clinicians	463
Loan Repayment Program Clinicians	8,849
State Loan Repayment Program Clinicians	1,350
Student to Service Loan Repayment Program	277
Total	**10,939**

NHSC Field Strength by Discipline as of 09/30/2018

Disciplines	Clinicians
Allopathic/Osteopathic Physicians[19]	2,149
Dentists	1,364
Dental Hygienists	347
Nurse Practitioners	2,518
Physician Assistants	1,142
Nurse Midwives	170
Mental and Behavioral Health Professionals	3,168
Other State Loan Repayment Program Clinicians	81
Total	**10,939**

Average NHSC Award by Program as of 09/30/2018

Program	Average Award Amount
Scholarship Program	$212,280
Students to Service Loan Repayment Program	$108,780
Loan Repayment Program	$31,564

NHSC is committed to continuous performance improvement. Based on the most recent Participant Satisfaction Survey results, the short-term retention rate among respondents who

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

completed their NHSC service commitment in the past 2 years is 93 percent.[20] Applying the NHSC alumni retention rate among survey respondents to the 5,024 clinicians who successfully completed service in that period, NHSC estimates that more than 4,400 retained clinicians continue to provide primary care services to underserved communities within 2 years after completing their service commitment.

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

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

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

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

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

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[20] 2017 National Health Service Corps Participant Satisfaction Survey.

Funding History

FY	Amount
FY 2016	$310,000,000
FY 2017[21]	$288,610,000
FY 2018 Discretionary	$105,000,000
FY 2018 Current Law Mandatory	$310,000,000
FY 2019 Discretionary	$120,000,000
FY 2019 Current Law Mandatory	$310,000,000
FY 2020 Discretionary Request	$105,000,000
FY 2020 Proposed Law Mandatory	$310,000,000

Budget Request

The FY 2020 Budget Request for the NHSC Program of $415 million is $15 million below the FY 2019 Enacted level and includes $310 million in mandatory funding. The Budget proposes a two-year extension of mandatory funding through FY 2021 totaling $620 million. The FY 2020 Budget Request will fund 4,169 new and 2,350 continuation Loan Repayment awards, 150 new and 12 continuation Scholarship awards, 625 State Loan Repayment awards, and 167 Students to Service Loan Repayment awards. The FY 2019 appropriation includes funding to support loan repayment awards to both fully trained medical, nursing, dental and behavioral/mental health clinicians, and SUD providers, to deliver health care services in Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs. In FY 2020, funding will continue to be provided to clinicians delivering services in Indian Health Services, Tribally-Operated 638 Health Programs, and Urban Indian Health programs.

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

In FY 2020, HRSA will also look for opportunities to continue to enhance the ability of the NHSC to address the opioid epidemic. Included in the FY 2020 Budget request is $105 million for the NHSC LRP SUD Expansion to support approximately 1,880 of the projected 4,169 new loan repayment awards noted above to combat the substance use disorders and opioid use disorders.

In addition, the NHSC and Primary Care Training and Enhancement (PCTE) are coordinating to increase the number of PCTE graduates serving in HPSAs through the PCTE: Training Primary Care Champions program. The purpose of this program is to strengthen primary care and the workforce by establishing fellowship programs to train community-based practicing primary care physicians and/or physician assistant champions to lead health care transformation and enhance

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

teaching in community–based settings. HRSA made awards in FY 2018 to support the PCTE: Training Primary Care Champions program to give PCTE fellows experience and competency in areas that make them more likely to serve in underserved areas. Physicians and physician assistants who have completed PCTE fellowships will be afforded priority status when applying for NHSC LRP awards and continuation awards in FY 2020.

National Health Service Corps	2020	2021	Total Funding
NHSC Proposed Mandatory ($, millions)	$310	$310	$620

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
4.I.C.1: Number of individuals served by NHSC clinicians *(Outcome)*	FY 2018: 11.5 Million Target: 9.1 Million (Target Exceeded)	11.9 million	13.2 million	+1.3 million
4.I.C.2: Support field strength (participants in service) of the NHSC *(Outcome)*	FY 2018: 10,939[22] Target: 8,705 (Target Exceeded)	11,410	12,570	+1,160
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 2017: 93% Target: 80% (Target Exceeded)	80%	80%	Maintain
4.E.1: Default rate of NHSC Scholarship and Loan Repayment Program participants. *(Efficiency)* (Baseline: FY 2007 = 0.8%)	FY 2018: 1.2 % Target: ≤2.0% (Target Exceeded)	≤ 2.0%	≤ 2.0%	Maintain

[22] This measure reports on the number of people who received assistance through the NHSC scholarship and loan repayment programs who are currently in the field. NHSC field strength data include awards made from the FY 2017 Zika Supplemental, which supported providers in the U.S. territories.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
4.I.C.6: Number of NHSC sites *(Outcome)*	FY 2018: 16,430 Target: 14,000 (Target Exceeded)	16,000	16,000	Maintain

Loan Repayments/Scholarships Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Loan Repayments	$178,209,602	$277,000,000	$304,000,000
State Loan Repayments	$15,000,000	$15,000,000	$15,000,000
Scholarships	$47,126,164	$38,000,000	$38,000,000
Students to Service Loan Repayment	$19,317,715	$20,000,000	$20,000,000

NHSC Awards Table[23][24]

Program	2013	2014	2015	2016	2017	2018	2019	2020
Scholarships	180	190	196	205	181	222	155	150
Scholarship Continuation	16	7	11	8	7	7	18	12
Loan Repayment	2,106	2,775	2,934	3,079	2,554	3,262	3,817	4,169
Loan Repayment Continuations	2,399	2,105	1,841	2,111	2,259	2,384	2,196	2,350
State Loan Repayment	447	464	620	634	535	625	625	625
Students to Service Loan Repayment	78	79	96	92	175	162	167	167
Total Awards	**5,226**	**5,620**	**5,698**	**6,129**	**5,711**	**6,662**	**6,978**	**7,473**

[23] NHSC awards include those made from the FY 2017 Zika Supplemental.
[24] NHSC LRP awards include those made from the FY 2018 and FY 2020 BA appropriations

NHSC Field Strength Table as of 9/30/2018[25]

Program:	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Scholars	493	459	458	437	405	463	540	550
Loan Repayment	7,547	7,648	8,062	8,593	8,362	8,849	9,275	10,336
Students to Service Loan Repayment	753	1,135	1,136	1,378	179	277	345	434
State Loan Repayment	106	-	27	85	1,233	1,350	1,250	1,250
Total Field Strength	**8,899**	**9,242**	**9,683**	**10,493**	**10,179**	**10,939**	**11,410**	**12,570**

[25] Field Strength numbers for FY 2019- FY 2020 are projections.

Faculty Loan Repayment Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$1,187,000	$1,190,000	---	-$1,190,000
FTE	---	---	---	---

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

FY 2020 Authorization ..... Expired at the end of FY 2014

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

Program Description and Accomplishments:

The Faculty Loan Repayment Program (FLRP) provides loan repayment to health profession graduates from disadvantaged backgrounds who serve as faculty at eligible health professions colleges or universities for a minimum of two years. In return, the federal government agrees to pay up to $20,000 of the outstanding principal and interest on the individual's health professions education loans for each year of service. The employing institution must also make payments to the faculty member that match the amount paid by HRSA. In FY 2018, the FLRP made 23 new loan repayment awards. In FY 2019, FLRP anticipates making 21 new loan repayment awards.

Funding History

FY	Amount
FY 2016	$1,190,000
FY 2017	$1,187,000
FY 2018	$1,187,000
FY 2019	$1,190,000
FY 2020	---

Budget Request

The FY 2020 Budget Request for the Faculty Loan Repayment Program of $0 is $1.2 million below the FY 2019 Enacted level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Loans Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	23	21	---

Health Professions Training for Diversity

Centers of Excellence

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$23,652,000	$23,711,000	---	-$23,711,000
FTE	2	2	---	-2

Authorizing Legislation: Public Health Service Act, Section 736

FY 2020 Authorization ..... Such Sums as Necessary

Allocation Method ..... Competitive Grant

Program Description and Accomplishments:

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

In Academic Year 2017-2018, the COE Program supported 168 training programs and activities designed to prepare individuals either to apply to a health professions training program or to maintain enrollment in such programs during the academic year. These programs supported 1,191 trainees across the country with stipend support. Over 97 percent of the trainees were considered underrepresented minorities (URMs) in the health professions. In addition, 69 percent of the trainees were from financially and/or educationally disadvantaged backgrounds. Additional students participated in COE Programs throughout the academic year increasing total participation to 5,045 students of whom 3,025 completed their programs.

Grantees partnered with 271 health care delivery sites, to provide 3,935 clinical training experiences to health professions trainees. Nearly 44 percent of training sites used by COE grantees were primary care settings and 58 percent were in medically underserved communities.

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

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

Funding History

FY	Amount
FY 2016	$21,711,000
FY 2017	$21,659,000
FY 2018	$23,652,000
FY 2019	$23,711,000
FY 2020	---

Budget Request

The FY 2020 Budget Request for the Centers of Excellence Program of $0 is $23.7 million below the FY 2019 Enacted level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [26]	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
6.I.C.20: Percent of program participants who completed pre-health professions preparation training and intend to apply to a health professions degree program	FY 2017: 13% Target: 22% (Target Not Met)	13%	N/A	-13%

[26] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [26]	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
6.I.C.21: Percent of program participants who received academic retention support and maintained enrollment in a health professions degree program	FY 2017: 51% Target: 43% (Target Exceeded)	50%	N/A	-50%

Program Activity Data

COE Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Number of health professions students participating in research on minority health-related issues	FY 2017: 599	600	600	---
Number of faculty members participating in research on minority health-related issues	FY 2017: 544	500	500	---

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	19	19	---
Average Award	$1,165,025	$1,165,025	---
Range of Awards	$465,860-$3,177,641	$465,860-$3,177,641	---

Health Professions Training for Diversity

Scholarships for Disadvantaged Students

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$48,705,000	$48,970,000	---	-$48,970,000
FTE	7	7	---	-7

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

FY 2020 Authorization .....Expired at the end of FY 2014

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

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

In Academic Year 2017-2018, the SDS Program provided scholarships to 3,047 students from disadvantaged backgrounds, slightly below the FY 2017 target but an increase from the prior year of 2,811 scholarships. This was due in large part to fewer grants being awarded in FY 2016 as well as a significant increase in the scholarship limit per student (increased from $15,000 to $30,000), resulting in more substantial investments in fewer individuals. The adjustment to the scholarship cap was made to reflect the increasing costs of health professions education programs. The majority of students were considered under-represented minorities (URMs) in their prospective professions (64 percent).

Additionally, 1,051 students who received SDS-funded scholarships successfully graduated from their degree programs by the end of Academic Year 2017-2018. Upon graduation, 68 percent intended to work or pursue additional training in medically underserved communities, and 52 percent intended to work or pursue additional training in primary care settings.

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

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

Funding History

FY	Amount
FY 2016	$45,970,000
FY 2017	$45,859,000
FY 2018	$48,705,000
FY 2019	$48,970,000
FY 2020	---

Budget Request

The FY 2020 Budget Request for the Scholarships for Disadvantaged Students Program of $0 is $49 million below the FY 2019 Enacted level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals. While the SDS Program exposes students from disadvantaged backgrounds who have financial need to careers in the health professions, there are private scholarships and other Federal loan programs that can support student education.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[27]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.22: Number of disadvantaged students with scholarships	FY 2017: 3,047 Target: 3,185 (Target Not Met)	2,800	N/A	-2,800

Program Activity Data

SDS Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Number of URM students with scholarships	FY 2017: 1,945	1,800	1,800	---
Percent of students who are URMs	FY 2017: 64%	62%	62%	---

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	79	79	---
Average Award	$578,780	$578,780	---
Range of Awards	$28,000-$650,000	$28,000-$650,000	---

[27] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.

Health Professions Training for Diversity

Health Careers Opportunity Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$14,154,000	$14,189,000	---	-$14,189,000
FTE	2	2	---	-2

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

FY 2020 Authorization .....Expired at the end of FY 2014

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

The Health Careers Opportunity Program (HCOP) provides individuals from economically and educationally disadvantaged backgrounds an opportunity to develop the skills needed to successfully compete for, enter, and graduate from schools of health professions or allied health professions. In FY 2018, HRSA made awards for the National HCOP Academies. The National HCOP Academies provide a variety of academic and social supports to individuals from disadvantaged backgrounds through formal academic and research training, programming, and student enhancement or support services that can include counseling and mentoring services, student stipends, financial planning resources, and health care careers and training information.

The goal of this investment is to:

1) promote the recruitment of qualified individuals from disadvantaged backgrounds into the health professions, including allied health programs;
2) Improve retention, matriculation and graduation rates by implementing tailored enrichment programs designed to address the academic and social needs of disadvantaged students; and
3) Provide opportunities for community-based health profession training in primary care, emphasizing experiences in rural and underserved communities.

In Academic Year 2017-2018, HCOP supported 157 training programs and activities to promote interest in the health professions among prospective, disadvantaged students. In total, HCOP grantees reached 2,903 disadvantaged trainees across the country through structured programs. The establishment of National HCOP Academies is aimed at increasing the numbers of students in formal-structured programs in order to meet established targets.

In AY 2017-2018, the program fell short of its target of 3,500 disadvantaged students; however, the percentage of participants from disadvantaged backgrounds remained stable around 92

percent (as has been the case since FY 2013). HCOP grantees partnered with 140 sites to provide 3,893 clinical training experiences for HCOP student trainees (e.g., academic institutions, community-based organizations, and hospitals). Approximately 78 percent of these training sites were located in medically underserved communities and/or rural settings. Additional students participated in HCOP activities and programs as well bringing 5,017 total students into the health professions pipeline of whom 2,868 completed their training.

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

Funding History

FY	Amount
FY 2016	$14,189,000
FY 2017	$14,155,000
FY 2018	$14,154,000
FY 2019	$14,189,000
FY 2020	---

Budget Request

The FY 2020 Budget Request for the Health Careers Opportunity Program of $0 is $14.2 million below the FY 2019 Enacted level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[28]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.23: Total number of disadvantaged students in structured programs	FY 2017: 2,903 Target: 3,500 (Target Not Met)	N/A[29]	N/A	N/A

28 Most recent results are for Academic Year 2017-2018 and funded in FY 2017.
[29] This measure will be discontinued in FY 2019 as new measures will account for programmatic changes,

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[28]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.51: Number of HCOP trainees from disadvantaged backgrounds participating in academic programming, clinical training and/or student support services	---	TBD[30]	N/A	N/A
6.I.C.52: Percent of HCOP health professions program completers who intend to work in primary care settings	---	TBD[31]	N/A	N/A

Program Activity Data

HCOP Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Total number of students participating in all HCOP programs	FY 2017: 5,017	5,000	5,000	---
Total number of URM students participating in all HCOP programs	FY 2017: 3,597	2,700	2,700	---
Total number of URM students in all HCOP-Skills Training programs	FY 2017: 524	N/A[32]	---	---
Total number of students graduating from HCOP-Skills Training programs	FY 2017: 332	N/A[32]	---	---

[30] Baseline will be set for this measure in FY 2019 and reported in the FY 2022 Congressional Justification.
[31] Baseline will be set for this measure in FY 2019 and reported in the FY 2022 Congressional Justification.
[32] HCOP-Skills Training programs completed activities during FY 2017.

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	21	21	---
Average Award	$620,075	$620,075	---
Range of Awards	$442,220 – $640,000	$442,220 – $640,000	---

Health Care Workforce Assessment

The National Center for Health Workforce Analysis

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$5,663,000	$5,663,000	$4,663,000	-$1,000,000
FTE	6	6	6	---

Authorizing Legislation: Public Health Service Act, Sections 761, 792, and 806(f)
FY 2020 Authorization ..... Expired as of FY 2014

Allocation Method .....Competitive Grant/Contract

Program Description and Accomplishments:

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

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

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

NCHWA continues to model supply and demand of health professionals across a range of health occupations, and makes health workforce information available through reports and online databases. Several publications were released during Calendar Year 2018:

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

NCHWA also oversees seven Health Workforce Research Centers that perform and disseminate research and data analysis on health workforce issues of national importance, and provide technical assistance to regional and local entities on workforce data collection, analysis, and reporting.[33] In FY 2018, NCHWA partnered with the Substance Abuse and Mental Health Association (SAMHSA) to fund the Behavioral Health Workforce Research Center, which supports of the Administration's goal of combatting the opioid crisis and increasing access to behavioral health services. The Behavioral Health Workforce Center will improve behavioral health workforce training, planning, and policy to address severe substance use disorders (e.g., opioid addiction) through a better understanding of demographics, unemployment rates, unfilled jobs, and other socioeconomic factors. In addition, the Center will develop evidence-based strategies for strengthening the behavioral health workforce to provide care and treatment for individuals and populations with severe substance use disorders and mental illness.

Funding History

FY	Amount
FY 2016	$4,663,000
FY 2017	$4,652,000
FY 2018	$5,663,000
FY 2019	$5,663,000
FY 2020	$4,663,000

Budget Request

The FY 2020 Budget Request for the National Center for Health Workforce Analysis of $4.7 million is $1 million below the FY 2019 Enacted level. In FY 2020, NCHWA will continue to develop a projection model that allows a more sophisticated analysis and projection of health workforce supply and demand, taking into account changing national demographics, the demand for health care services, and the impact those changes have on the delivery of health care.

In FY 2020, NCHWA will continue to deliver reports and evaluation that support the Administration's goal of improving access to behavioral health services, including substance use treatment and prevention services. This includes collecting data and conducting studies on Medication-assisted treatment (MAT) as well as non-MAT opioid treatment to better understand recovery outcomes and treatment compliance.

[33] In FY 2018, two Health Workforce Resource Centers administered by NHCWA were funded from the Bureau of Primary Health Care and the Substance Abuse and Mental Health Administration.

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

Grants Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	5	5	5
Average Award	$589,951	$449,951	$449,951
Range of Awards	$549,795-$550,000	$449,795-$450,000	$449,795-$450,000

Primary Care Training and Enhancement Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$48,802,000	$48,924,000	---	-$48,924,000
FTE	7	7	---	-7

Authorizing Legislation: Public Health Service Act, Section 747

FY 2020 Authorization .....Expired at the end of FY 2014

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

Program Description and Accomplishments:

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

Program	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Primary Care Training and Enhancement[34]	$35,910,649	$36,197,888	---
Training Primary Care Champions	$7,746,209	$7,638,870	---
Academic Units for Primary Care Training and Enhancement	$5,154,142	$5,087,242	---

The PCTE Program includes three cohorts:

PCTE: The PCTE Program is designed to strengthen the primary care workforce by supporting enhanced training for future primary care clinicians, teachers, and researchers. The PCTE Program is focused on training for transforming health care systems, particularly enhancing the clinical training experience of trainees. The PCTE Program also supports the Primary Care Medicine and Dentistry Clinician Educator Career Development Awards, which support the

[34] The PCTE Program includes the Primary Care Medicine and Dentistry Clinician Educator Career Development Awards, which are jointly funded by PCTE and Oral Health Programs. The total is approximately $4 million, $2.9 million from PCTE and $1.1 million from Oral Health Programs.

development of future clinician educator faculty and leaders in primary care medicine and dentistry while also supporting innovative projects that involve the transformation of health care delivery systems. In FY 2018, HRSA provided $6 million in supplemental funding for PCTE awardees to meet the Administration's goals of addressing the opioid crisis to integrate substance use disorder training and treatment in primary care.

In Academic Year 2017-2018, the Primary Care Medicine and Dentistry Clinician Educator Career Development Award program supported 16 faculty, including 10 individuals from the field of medicine, 5 in dentistry, and 1 physician assistant. In addition, grantees developed or enhanced 31 curricula activities that were offered to 2,352 individuals. Grantees also offered 89 faculty development activities to 1,045 faculty members, and grant-funded faculty offered 24 courses to 1,687 students and advanced trainees.

Primary Care Training and Enhancement (PCTE): Training Primary Care Champions (TPCC): In FY 2018, HRSA established the PCTE: TPCC Program to strengthen primary care and the workforce by establishing fellowship programs to train community-based practicing primary care physician and/or physician assistant champions to lead health care transformation and enhance teaching in community-based settings. Applicants were encouraged to address the Administration's clinical priorities of opioid abuse and mental health through their training and fellows' health care transformation projects.

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

In Academic Year 2017-2018, PCTE grantees trained 2,404 primary care residents and fellows, 4,379 medical students, 1,190 students in physician assistant programs, 161 primary care medicine faculty, and 1,347 students from collaborating interprofessional disciplines (including pharmacy students, psychology students, dental and dental hygiene students, and nursing students) for a total of 9,481 trainees, 2,658 of whom completed their programs at the end of the academic year. PCTE grantees partnered with 903 health care delivery sites (e.g., physician's offices, hospitals, and ambulatory practice sites) to provide clinical training experiences to trainees. Over a third of the sites offered substance use treatment services. Approximately 64 percent of these sites were located in medically underserved communities, 30 percent were located in rural areas, and 63 percent were primary care settings.

With regard to the continuing education of the current workforce, PCTE grantees delivered 173 unique continuing education courses that focused on emerging issues in the field of primary care to 5,263 faculty members and current practicing providers. In addition, PCTE grantees developed or enhanced and implemented 955 different curricular activities, most of which were new academic courses, clinical rotations, and workshops for health professions students, residents and fellows that reached 29,944 trainees. PCTE grantees also supported 360 different

faculty-focused training programs and activities during the academic year, reaching 6,694 faculty-level trainees.

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

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

Funding History

FY	Amount
FY 2016	$38,924,000
FY 2017	$38,830,000
FY 2018	$48,802,000
FY 2019	$48,924,000
FY 2020	---

Budget Request

The FY 2020 Budget Request for the PCTE Program of $0 is $48.9 million below the FY 2019 Enacted level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table[35]

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[36]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.24: Number of physicians completing a Bureau of Health Workforce-funded residency or fellowship	FY 2017: 773 Target: 400 (Target Exceeded)	700	N/A	-700
6.I.C.25: Number of physicians graduating from a Bureau of Health Workforce-funded medical school	FY 2017: 1,081 Target: 400 (Target Exceeded)	1,000	N/A	-1,000
6.I.C.26: Number of physician assistants graduating from a Bureau of Health Workforce-funded program	FY 2017: 357 Target: 120 (Target Exceeded)	300	N/A	-300

Program Activity Data

PCTE Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Percent of physician and physician assistant trainees receiving at least a portion of their clinical training in an underserved area	FY 2017: 45%	50%	50%	---
Percent of physician and physician assistant graduates and program completers who are minority and/or from disadvantaged backgrounds	FY 2017: 34%	30%	30%	---

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

[36] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.

PCTE Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Number of physicians training in a Bureau of Health Workforce-funded residency or fellowship	FY 2017: 2,404	1,650	2,000	---
Number of medical students training in a Bureau of Health Workforce-funded medical school	FY 2017: 4,379	2,000	4,000	---
Number of physician assistant students training in a Bureau of Health Workforce-funded program	FY 2017: 1,190	700	1,000	---

Grant Awards Table[37]

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	109	109	---
Average Award	$411,600	$411,600	---
Range of Awards	$89,549-$799,802	$89,549-$799,802	---

[37] This table includes the PCTE portion of the 20 awards for the Primary Care Medicine and Dentistry Clinician Educator Career Development Program, which is co-funded by the Oral Health Programs. The award amount is approximately $4.4 million, $3.2 million from PCTE and $1.2 million from Oral Health Programs. This table includes the $3.2 million in PCTE funds; the Oral Health Program funds are accounted for in the Grants Award Table below.

Oral Health Training Programs

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$40,571,000	$40,673,000	---	-$40,673,000
FTE	6	6	---	-6

Authorizing Legislation: Public Health Service Act, Sections 748 and 340G[38]

FY 2020 Authorizations:.....Expired at the end of 2016

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

Program Description and Accomplishments:

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

Program	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene[39] and Dental Faculty Loan Repayment	$28,266,000	$28,531,000	---
State Oral Health Workforce Improvement Grant	$12,305,000	$12,142,000	---

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

[38] Public Law No: 115-302 extended the authorization for Section 340G until FY 2023.

[39] The Primary Care Medicine and Dentistry Clinician Educator Career Development Awards are jointly funded by PCTE and Oral Health Programs. The total funding is approximately $4.0 million, $2.9 million from PCTE and $1.1 million from Oral Health Programs.

Dentists, in particular, are in a position to meet the Administration's goal of addressing the opioid epidemic through better pain management, identifying substance abuse and referring patients for treatment, and providing quality oral health care that meets the needs of this vulnerable population. In FY 2018, HRSA made supplemental awards to the post-doctoral grants to train dental residents on appropriate opioid prescribing, to identify and refer patients with substance abuse disorders for treatment, and to provide oral health treatment for individuals with a history of substance abuse disorders.

In Academic Year 2017-2018, grantees of the Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program trained 9,562 dental and dental hygiene students in pre-doctoral training degree programs; 495 dental residents and fellows in advanced primary care dental residency and fellowship training programs; and 332 dental faculty members in faculty development activities and programs.

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

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

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

In Academic Year 2017-2018, the Dental Faculty Development and Loan Repayment Program provided financial support to 29 dental faculty and 2 residents: 18 individuals received a median loan repayment of $6,534, and 13 individuals received a median award of $1,673 in direct financial support. Grantees developed or enhanced 36 curricula that were offered to 4,665 individuals. In addition, grantees offered 31 faculty development programs to 332 dental faculty, missing the original target of 1,200 due to a programmatic change where the focus of the program was changed to loan repayment. Faculty funded through the Dental Faculty Development and Loan Repayment Program offered 41 courses to 2,513 advanced trainees from general dentistry (92 percent), pharmacy (4 percent), and pediatric dentistry (3 percent).

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

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

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

In Academic Year 2017-2018, the State Oral Health Workforce Improvement Grant Program continued to carry out community-based prevention activities authorized under statute. Grantees established 5 new oral health facilities for children with unmet needs in dental HPSAs, and expanded 23 oral health facilities in dental HPSAs to provide education, prevention, and restoration services to 90,480 patients. Grantees also supported 42 tele-dentistry facilities; replaced 34 water fluoridation systems to provide optimally fluoridated water to 3,007,100 individuals; provided dental sealants to 36,352 children; provided topical fluoride to 73,288 individuals; provided diagnostic or preventive dental services to 66,000 persons; and oral health education to 140,768 persons. The program provided direct financial support to 48 dental students and 5 residents. Of these 53 students and residents, approximately 25 percent reported coming from a rural background, 17 percent reported coming from a disadvantaged background, and 13 percent comprised an underrepresented minority group.

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

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

Funding History

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

Budget Request

The FY 2020 Budget Request for the Oral Health Programs of $0 is $40.7 million below the FY 2019 Enacted level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[40]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.27: Number of dental students trained	FY 2017: 9,562 Target: 1,600 (Target Exceeded)	9,500[41]	N/A	-9,500
6.I.C.28: Number of dental residents trained	FY 2017: 495 Target: 311 (Target Exceeded)	450[42]	N/A	-450
6.I.C.29: Number of faculty trained	FY 2017: 332 Target: 1,200 (Target Not Met)[43]	200[44]	N/A	-200

Program Activity Data

Oral Health Training and Workforce Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Percent of students and residents trained who are URMs	FY 2017: 21%	17%	20%	---
Number of dentists completing a Bureau of Health Workforce-funded dental residency or fellowship	FY 2017: 251	250	250	---
Number of dentists graduating from a Bureau of Health Workforce-funded dental school	FY 2017: 2,010	1,300	2,000	---

[40] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.
[41] Targets take into account attrition
[42] Targets take into account attrition
[43] A programmatic change occurred capping the amount awardees could devote to faculty development. This change caused the dramatic drop and necessitated the change in targets.
[44] Targets take into account attrition

Grant Awards Table – Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene[45]

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	52	52	---
Average Award	$414,250	$414,250	---
Range of Awards	$27,969-$812,803	$27,969-$812,803	---

Grant Awards Table – Dental Loan Repayment Programs

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	30	30	---
Average Award	$158,665	$158,665	---
Range of Awards	$40,500-$300,000	$40,500-$300,000	---

Grant Awards Table – State Oral Health Workforce Improvement Grant Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	33	33	---
Average Award	$338,100	$338,100	---
Range of Awards	$181,698-$407,722	$181,698-$407,722	---

[45] The Primary Care Medicine and Dentistry Clinician Educator Career Development Awards are jointly funded by PCTE and Oral Health Programs. The total funding is approximately $4.0 million, $2.9 million from PCTE and $1.1 million from Oral Health Programs. This awards table accounts for the $1.1 million in Oral Health Program funds only.

Graduate Medical Student Education Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 Request	FY 2020 Request +/- FY 2019 Enacted
BA	---	$25,000,000	---	-$25,000,000
FTE	---	1	--	-1

Authorizing Legislation: Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245)

FY 2020 Authorization .....Not Specified[46]

Allocation Method .....Grants

Program Description and Accomplishments:

The purpose of the Graduate Medical Student Education Program is to strengthen the primary care workforce by expanding or supporting training for medical students to become primary care clinicians. This program targets public institutions of higher education in states in the top quintile of states with projected primary care provider shortage in 2025[47] particularly in States that serve a high proportion of federally recognized Tribes. In these states, it is critical that medical schools are able to educate and train a workforce that is prepared to provide value-based care that improves health outcomes for individuals living on tribal reservations and in rural and underserved areas. The program will develop public-private partnerships between academia, federally-recognized tribes, tribal colleges, tribal organizations, primary care delivery sites or systems, and/or community-based organizations to educate and train medical students to provide value-based, high quality care that improves health outcomes for individuals living on tribal reservations and in rural and underserved communities.

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

[46] The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245) authorized $25 million in appropriations, to remain available until expended, funding for the Medical School Education Program.
[47] U.S. Department of Health and Human Services, Health Resources and Services Administration. HRSA, 2015. "National and Regional Projections of Supply and Demand for Primary Care Practitioners: 2013-2025. November 2016.

Funding History

FY	Amount
FY 2016	---
FY 2017	---
FY 2018	---
FY 2019	$25,000,000
FY 2020	---

Budget Request

The FY 2020 Budget Request for the Graduate Medical Student Education Program of $0 is $25 million less than the FY 2019 Enacted Budget. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Awards Table

	FY 2018 Final	**FY 2019** Enacted	**FY 2020** Request
Number of Awards	---	5	---
Average Award	---	$1,180,000	---
Range of Awards	---	$1,000,000 - $1,180,000	---

Interdisciplinary, Community-Based Linkages

Area Health Education Centers Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$38,154,000	$39,250,000	---	-$39,250,000
FTE	4	4	---	-4

Authorizing Legislation: Public Health Service Act, Section 751
FY 2020 Authorization ..... Expired at the end of FY 2014

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

Program Description and Accomplishments:

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

In Academic Year 2017-2018, the AHEC Program supported various types of pre-pipeline, pipeline, and continuing education training activities for thousands of trainees across the country. AHEC grantees implemented 1,915 unique continuing education courses that were delivered to 137,301 practicing professionals nationwide, 72,278 of whom were concurrently employed in medically underserved communities.

AHEC grantees partnered with 5,512 sites to provide 32,328 clinical training experiences to student trainees (e.g., ambulatory practice sites, physician offices, and hospitals). Approximately 60 percent of these training sites were primary care settings; 66 percent were located in medically underserved communities; and 45 percent were in rural areas.

In FY 2018, HRSA awarded over $7 million to AHEC grantees that focused on three priority areas:

1) Using telemedicine to increase access to behavioral health services;
2) Integration of behavioral health services and provider to provide team-base care with a focus on opioids; and
3) Training Community Health Workers on substance use disorder and pain management to decrease the risk opioid addiction.

In FY 2019, AHEC funding will continue to support AHEC Scholars and community-based experiential training.

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

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

Funding History

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

Budget Request

The FY 2020 Budget Request for the Area Health Education Centers Program of $0 is $39.3 million below the FY 2019 Enacted level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals. It is anticipated that the AHEC Program awardees can find other sources of funding to continue these activities.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[48]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.30: Percent of CE trainees who report being currently employed in medically underserved areas	FY 2017: 53% Target: 34% (Target Exceeded)	N/A[49]	N/A	N/A
6.I.C.31: Number of trainees receiving health career guidance and information from the AHEC Programs	FY 2017: 270,380 Target: 325,000 (Target Not Met)	N/A[50]	N/A	N/A
6.I.C.49: Number of AHEC scholars trained in medically underserved communities and/or rural areas.	---	TBD[51]	N/A	N/A
6.I.C.50: Percent of AHEC program completers practicing in medically underserved communities and/or rural areas.	---	TBD[52]	N/A	N/A

Program Activity Data

AHEC Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Number of medical students who participated in community-based clinical training	FY 2017: 13,090	17,000	13,000	---
Number of other health professions trainees who participated in community-based clinical training	FY 2017: 13,699	17,000	13,000	---

[48] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.
[49] Measure discontinued in FY 2019 as program was restructured.
[50] Measure discontinued in FY 2019 as program was restructured.
[51] Baseline for this measure will be set in FY 2019 and reported in the FY 2022 Congressional Justification.
[52] Baseline for this measure will be set in FY 2019 and reported in the FY 2022 Congressional Justification.

AHEC Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Number of trainees who received CE on topics including cultural competence, women's health, diabetes, hypertension, obesity, and health disparities	FY 2017: 137,301	175,000	130,000	---

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	49	49	---
Average Award	$735,056	$735,056	---
Range of Awards	$255,600-$1,912,000	$255,600-$1,912,000	---

Interdisciplinary, Community-Based Linkages

Geriatrics Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$40,635,000	$40,737,000	---	-$40,737,000
FTE	6	6	---	-6

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

FY 2020 Authorizations:.....Expired at the end of FY 2014

Allocation Method ..... Cooperative Agreement

Program Description and Accomplishments:

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

Program	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Geriatrics Workforce Enhancement Program	$40,635,000	$38,737,000	---
Geriatrics Academic Career Awards (GACA) Program	---	$2,000,000	---

In Academic Year 2017-2018, GWEP grantees provided training for 49,381 students and fellows participating in a variety of geriatrics-focused degree programs, field placements, and fellowships. Of these trainees, 26,966 graduated or completed their training during the current academic year. GWEP grantees partnered with 316 health care delivery sites (e.g., hospitals, long-term care facilities, and academic institutions) to provide clinical training experiences to trainees. Approximately 43 percent of these sites were located in medically underserved communities, and 53 percent were situated in primary care settings.

With regard to the continuing education of the current workforce, 212,444 faculty and practicing professionals participated in 1,564 unique continuing education courses offered by GWEP

grantees, 338 of which were specifically focused on Alzheimer's disease and related dementia, missing the target of 600. Because GWEP grantees create local partnerships to meet the needs of their particular communities, these partnerships may decide they need fewer but larger trainings to meet local needs resulting in fewer trainings overall. While the number of trainings has decreased slightly, the number of professionals participating in these trainings has increased by nearly 23 percent in the last two years. In addition, GWEP grantees developed or enhanced and implemented 3,339 different curricular activities. Most of these were new continuing education courses, academic courses, and workshops which together reached 140,320 people. Finally, with regard to faculty development, results showed that GWEP grantees supported 449 different faculty-focused training programs and activities during the academic year, reaching 8,868 faculty-level trainees.

The National and Regional Projections of Supply and Demand for Geriatricians: 2013-2025 report by HRSA's National Center for Health Workforce Analysis projected demand for geriatricians will exceed supply, resulting in a national shortage of 26,980 full time equivalent positions in 2025.[53] The report states all regions of the U.S. are projected to have a 2025 shortage of geriatricians, although the degree of shortage in each region is variable.[54] The education and training of health professionals in the area of geriatrics are hindered by a shortage of faculty, inadequate and variable academic curricula and clinical experiences, and a lack of opportunities for advanced training. In order to address these issues, faculty with expertise in geriatrics are needed to train the workforce to provide specialized care to improve health outcomes for older adults.

Consequently, in FY 2019, HRSA will fund the Geriatrics Academic Career Awards (GACA) Program to support the career development of junior faculty in geriatrics at accredited schools of allopathic medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, or allied health. Faculty with expertise in geriatrics are needed to train the workforce and provide specialized care to improve health outcomes for older adults. Under the GACA program, career development awards will be made to support individual junior faculty who will provide interprofessional clinical training and become leaders in academic geriatrics. The goals of the program are for the GACA candidate to develop the necessary skills to lead health care transformation in a variety of settings. These settings include rural and/or medically underserved settings, as well as age-friendly settings that provide interprofessional training in clinical geriatrics.

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

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

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

Funding History

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

Budget Request

The FY 2020 Request for the Geriatrics Program of $0, is $40.7 million below the FY 2019 Enacted level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Measures

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[55]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.12: Number of Bureau of Health Workforce-sponsored interprofessional continuing education sessions provided on Alzheimer's disease	FY 2017: 338 Target: 600 (Target Not Met)	300[56]	N/A	-300
6.I.C.13: Number of trainees participating in interprofessional continuing education on Alzheimer's disease	FY 2017: 55,057 Target: 51,000 (Target Exceeded)	51,000[57]	N/A	-51,000
6.I.C.32: Number of continuing education trainees in geriatrics programs	FY 2017: 212,444 Target: 100,000 (Target Exceeded)	100,000[58]	N/A	-100,000
6.I.C.33: Number of students who received geriatric-focused training in geriatric nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers	FY 2017: 48,819 Target: 17,000 (Target Exceeded)	17,000[59]	N/A	-17,000

Program Activity Data

Geriatrics Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Number of continuing education offerings delivered by grantees	FY 2017: 1,564	1,300	1,500	---
Number of faculty members participating in geriatrics trainings offered by grantees	FY 2017: 8,868	6,000	8,000	---

[55] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.
[56] Targets take into account attrition
[57] Targets take into account attrition
[58] Targets take into account attrition
[59] Targets take into account attrition

Geriatrics Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Number of individuals trained in new or enhanced curricula relating to the treatment of health problems of elderly individuals	FY 2017: 140,320	100,000	140,000	---
Number of individuals enrolled in geriatrics fellowships	FY 2017: 562	700	560	---
Number of advanced education nursing students enrolled in advanced practice adult-gerontology nursing programs	FY 2017: 84	75	80	---

GWEP Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	44	47	---
Average Award	$857,500	$517,000	---
Range of Awards	$589,616 - $881,825	$590,000-750,000	---

GACA Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	---	26	---
Average Award	---	$75,000	---
Range of Awards	---	$75,000	---

Interdisciplinary, Community-Based Linkages

Behavioral Health Workforce Development Programs

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA[1]	$111,766,000	$111,916,000	$111,916,000	---
FTE	13	13	13	---

1/Funding in FY 2018- FY 2020 combines appropriations for Mental and Behavioral Health Workforce (includes $36.916 million) and Training and Behavioral Health Workforce Education and Training ($75 million). Both appropriations support funding for the same authorizations and have been combined to eliminate confusion.

Authorizing Legislation: Public Health Service Act, Sections 750, 755, 756, 760, and 791
FY 2020 Authorization .....$50,000,000[60]

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

Program Description and Accomplishments:

The purpose of the Behavioral Health Workforce Development Programs are to develop and expand the behavioral health workforce serving populations across the lifespan, including in rural and medically underserved areas. Opioid use and its resulting deaths have impacted the lives of individuals and families, crippled communities, and depleted limited resources. Emergency departments treat over 1,000 people each day for misusing prescription opioids.[61] Over the past seven years, the number of opioid deaths have increased 137%, including a 200% increase in the rate of overdose deaths involving opioids pain relievers and heroin.[62] The effect is especially evident in geographical areas with large rural concentrations of the U.S., where nonmedical prescription opioid misuse remains a growing public problem.[63]

HRSA's 2016 National Behavioral Health Practitioner Projections Report estimated that by 2025, significant shortages of psychologists, social workers, school counselors and marriage and family

[60] The 21st Century Cures Act (P.L. 114-255) authorized $50 million through FY 2022.
[61] Substance Abuse and Mental Health Services Administration. Highlights of the 2011 Drug Abuse Warning Network (DAWN) findings on drug-related emergency department visits. The DAWN Report. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; 2013. Available at: http://www.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.htm.
[62] Rudd, R.A, Aleshire, N., Zibbell, J.E., Gladden, M. Increases in Drug and Opioid Overdose Deaths- United States, 2000-2014. American Journal of Transplantation 2016; 64(50):1378-1382. Available at: http://onlinelibrary.wiley.com/doi/10.1111/ajt.13776/full
[63] Keyes, K.M., Cerda, M., Brady, J.E., Havens, J.R., Galea, S. Understanding the Rural-Urban Differences in Nonmedical Prescription Opioid Use and Abuse in the United States. American Journal of Public Health 2014; 104(2): e52-e59. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3935688/.

therapists would equal approximately 41,340 FTEs.[64] HRSA uses projections data and other information about the behavioral health workforce to develop and adjust programs to ensure that they are responsive to the Nation's emerging needs.

The Behavioral Health Workforce Development Program has historically received appropriations through Mental and Behavioral Health Education and Training (MBHET) and Behavioral Health Workforce Education and Training (BWHET). Both sets of appropriations support the same authorizations. Therefore, the funding display combines these two sets of funding to eliminate confusion.

The Behavioral Health Workforce Development Programs increases the number of behavioral health workforce providers including psychiatrists, doctoral-level psychologists, psychiatric nurse practitioners, social workers, substance use counselors, marriage and family therapists, occupational therapists, school counselors, professional counselors, and behavioral health-related paraprofessionals.

The Behavioral Health Workforce Development Programs include the Behavioral Health Workforce Education and Training (BHWET) Program, which includes the Opioid Workforce Expansion Program (OWEP), and the Graduate Psychology Education (GPE) Program.

	FY 2018	**FY 2019**	**FY 2020**
Behavioral Health Workforce Development	$103.5 million	$93.9 million	$93.9 million
Graduate Psychology Education	$8.3 million	$18 million	$18 million
Total Behavioral Health Workforce Development Programs[1]	$111.8 million	$111.9 million	$111.9 million

1/Includes appropriations from both MBHET and BWHET.

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

In Academic Year 2017-2018, the BHWET Program supported training for 5,867 individuals. Of the total students supported, 3,333 graduate-level social workers, psychologists, school and clinical counselors, psychiatric nurse practitioners, and marriage and family therapists were

[64] Health Resources and Services Administration/National Center for Health Workforce Analysis; Substance Abuse and Mental Health Services Administration/Office of Policy, Planning, and Innovation. 2015. National Projections of Supply and Demand for Behavioral Health Practitioners: 2013-2025. Rockville, Maryland.

trained as well as 2,534 students training to become behavioral health paraprofessionals (such as community health workers, outreach workers, social services aides, mental health workers, substance abuse/addictions workers, youth workers, and peer paraprofessionals). Over fifty percent of the BHWET trainees received training in substance use treatment. By the end of the Academic Year, 3,395 students graduated from these degree and certificate-bearing programs and entered the behavioral health workforce. Upon program completion, 48 percent of students intended to pursue training and/or employment to serve at-risk children, adolescents, and transitional-aged youth. Further 61 percent of students intended to pursue training and/or employment in a medically underserved area and/or primary care setting.

BHWET grantees partnered with 2,244 training sites to provide 4,912 clinical training experiences for BHWET student trainees (e.g., hospitals, ambulatory practice sites, and academic institutions). Over 66 percent of these training sites were located in medically underserved communities where trainees provided over 1.1 million hours of behavioral health services to patients and clients. Over 20 percent of the sites offered opioid use treatment services and 48 percent of the sites offered substance use treatment services. Training at partnered sites incorporated interdisciplinary team-based approaches, where 15,419 students, residents and/or fellows from a variety of professions and disciplines were trained on teams with BHWET students. BHWET grantees used grant funds to develop, enhance, and implement nearly 1,200 behavioral health-related courses and training activities, reaching over 23,000 students and advanced trainees (i.e., psychology interns and fellows and psychiatry residents).

In FY 2019, HRSA will fund the Opioid Workforce Expansion Program to enhance the community-based experiential training focused on OUD and Substance Use Disorder (SUD) for students preparing to become behavioral health professionals and paraprofessionals, including social workers, psychologists, psychiatrists, psychiatric nurses, counselors, promotoras, peer support counselors, community health workers, etc.

GPE Program supports innovative doctoral-level health psychology programs that foster an integrated and interprofessional approach to addressing access of behavioral health and substance use prevention and treatment services in high need and high demand areas through academic and community partnerships. Through these efforts, the GPE Program transforms clinical training environments and is aligned with HRSA's mission to improve health and achieve health equity through access to quality services, a skilled workforce, and innovative programs.

In Academic Year 2017-2018, the GPE Program provided stipend support to 263 students participating in practica, internships, or post-doctoral residency programs in psychology. The majority of students who received a stipend were trained in medically underserved communities (94 percent) and/or a primary care setting (87 percent). Of the 254 students who completed GPE-supported programs, 75 percent intended to become employed or pursue further training in medically underserved communities and 58 percent intended to become employed or pursue further training in primary care settings.

GPE grantees partnered with 186 sites to provide 627 clinical training experiences for psychology graduate students (e.g., hospitals, ambulatory practice sites, and academic

institutions) as well as 3,140 interprofessional team-based care trainees who participated in clinical training along with the psychology graduate students. Approximately 88 percent of these training sites were located in medically underserved communities and 82 percent were primary care and/or rural settings. Approximately 48 percent of the sites offered substance use treatment services and 36 percent offered telehealth services.

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

Paraprofessionals: State-licensed behavioral paraprofessional certificate training programs and peer paraprofessional certificate training programs offered public or nonprofit private health professions schools (including universities, community colleges and technical schools).

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

Funding History

FY	Amount
FY 2016	$69,832,000
FY 2017	$69,784,000
FY 2018	$111,766,000
FY 2019	$111,916,000
FY 2020	$111,916,000

Budget Request

The FY 2020 Budget Request for the Behavioral Health Workforce Development Programs of $111.9 million is the same as the FY 2019 Enacted level. These funds will support multiple efforts to increase and develop the behavioral health workforce in order to improve access to high quality behavioral health care in underserved areas across the nation. These resources will prepare psychologists, psychiatrists, social workers, licensed professional counselors, occupational therapists, community health workers and peers to work in an environment that integrates behavioral health with primary medical care, focusing on underserved areas and

populations. These funds will enable HRSA to continue building a health workforce ready to address the Opioid epidemic by training professionals and paraprofessionals to provide team-based Opioid Use Disorder prevention, treatment and recovery services.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result[65]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.34: Number of students currently receiving training in behavioral health degree and certificate programs	FY 2017: 5,867 Target: 5,600 (Target Exceeded)	4,500	4,500	Maintain
6.I.C.35: Number of graduates completing behavioral health programs and entering the behavioral health workforce	FY 2017: 3,395 Target: 3,600 (Target Not Met)	3,000	3,000	Maintain
6.I.C.53: Number of OWEP trainees currently receiving training in opioid-related behavioral health degree and certificate programs	---	TBD[66]	TBD	---
6.I.C.54: Number of OWEP graduates completing opioid-related behavioral health programs and entering the behavioral health workforce	---	TBD[67]	TBD	---
6.I.C.36: Number of graduate-level psychology students supported in GPE program	FY 2017: 263 Target: 170 (Target Exceeded)	170	170	Maintain
6.I.C.37: Number of interprofessional students trained in GPE program	FY 2017: 3,140 Target: 1,900 (Target Exceeded)	1,900	1,900	Maintain

[65] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.

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

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

Program Activity Data

Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Number of GPE clinical training experiences that incorporated interprofessional team-based care training	FY 2017: 627	500	500	400

BHWET Grant Award Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	136	136	136
Average Award	$420,975	$370,000	$370,000
Range of Awards	$83,320 - $879,952	$83,320- $880,000	$83,320- $880,000

OWEP Grant Award Table

	FY 2018 Final[68]	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	---	62	34
Average Award	---	$1,100,000	$950,000
Range of Awards	---	$900,000-$1,350,000	$150,000-$1,350,000

GPE Grant Award Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	31	40	40
Average Award	$269,460	$450,000	$450,000
Range of Awards	$94,506-$350,000	$47,213-$450,000	$47,213-$450,000

[68] HRSA received a two-year appropriation in FY 2018 and anticipates making the OWEP awards in FY 2019.

Public Health Workforce Development

Public Health and Preventive Medicine Training Grant Programs

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$17,000,000	$17,000,000	---	-$17,000,000
FTE	4	4	---	-4

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

FY 2020 Authorization .....Expired at the end of FY 2015

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

Program Description and Accomplishments:

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

Program	FY 2018 Final	FY 2019 Enacted	FY 2020 Request
Public Health Training Centers Program	$9,842,742	$9,842,742	---
Preventive Medicine Residency Program	$7,157,258	$7,157,258	---

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

managers, and staff in other parts of the public health system. Beginning in Academic Year 2017-2018, the National Coordinating Center was discontinued.

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

In Academic Year 2017-2018, Regional PHTCs partnered with 190 sites to provide more than 239 clinical training experiences to student trainees (e.g., local health departments, academic institutions, and community-based organizations). Approximately 63 percent of these training sites were located in medically underserved communities and 22 percent were located in rural areas. With regard to the continuing education (CE) of the current workforce, PHTC grantees delivered 2,462 unique CE courses to 191,665 trainees during the academic year, approximately 28 percent of whom were practicing professionals concurrently employed in medically underserved communities. The total number of instructional hours for continuing education was 12,036 in current academic year.

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

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

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

In Academic Year 2017-2018, the PMR Program supported 130 residents, the majority of which

received clinical or experiential training in a primary care setting (76 percent) and/or a medically underserved community (77 percent). Approximately 39 percent of residents received training in substance use treatment. Of the 66 residents who completed their residency training programs during the academic year, 44 percent intended to pursue employment or further training in primary care. PMR grantees partnered with 231 sites to provide 620 clinical training experiences for PMR residents (e.g., academic institutions, ambulatory care sites, State and local health departments, and hospitals). Approximately 48 percent of these training sites were located in medically underserved communities and 39 percent were primary care settings. Nearly 36 percent of these training sites offered substance use treatment services.

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

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

Funding History

FY	Amount
FY 2016	$21,000,000
FY 2017	$16,949,000
FY 2018	$17,000,000
FY 2019	$17,000,000
FY 2020	---

Budget Request

The FY 2020 Budget Request for the Preventive Medicine and Public Health Training Grant Programs of $0 is $17 million below the FY 2019 Enacted level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[69]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.9: Number of trainees participating in continuing education sessions delivered by PHTCs	FY 2017: 191,665 Target: 23,000[70] (Target Exceeded)	190,000[71]	N/A	-190,000
6.I.C.18: Number of instructional hours offered by PHTCs	FY 2017: 12,036 Target: 9,320 (Target Exceeded)	12,000[72]	N/A	-12,000
6.I.C.19: Number of PHTC-sponsored public health students that completed field placement practicums in State, Local, and Tribal Health Departments	FY 2017: 182 Target: 150 (Target Exceeded)	180[73]	N/A	-180

Program Activity Data

PMR Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Number of preventive medicine residents participating in residencies	FY 2017: 130	75[74]	75	---
Number of preventive medicine residents completing training	FY 2017: 66	40	40	---
Percent of program completers who are URMs	FY 2017: 41%	20%	20%	---

[69] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.
[70] Target exceeded as grantees focused on delivery of archived and self-paced online delivery of continuing education courses rather than live, classroom-based classes
[71] Targets take into account attrition
[72] Targets take into account attrition
[73] Targets take into account attrition
[74] The PMR targets for number of residents decreased in FY 2017 due to a $4 million decrease in funding for Integrative Medicine residencies.

PMR Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Percent of preventive medicine resident program completers who intend to practice in primary care settings	FY 2017: 44%	40%	40%	---

Grant Awards Table – Public Health Training Centers Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 Request
Number of Awards	10	10	---
Average Award	$895,380	$895,380	---
Range of Awards	$767,470-$1,087,248	$767,470-$1,087,248	---

Grant Awards Table – Preventive Medicine Residency Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	17	17	---
Average Award	$382,975	$382,975	---
Range of Awards	$230,086-$400,000	$230,086-$400,000	---

Nursing Workforce Development

Advanced Nursing Education Programs

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$74,311,000	$74,581,000	---	-$74,581,000
FTE	11	11	---	-11

Authorizing Legislation: Public Health Service Act, Section 811

FY 2020 Authorization ..... Expired at the end of FY 2016

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

Program Description and Accomplishments:

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

Advanced Nursing Education Workforce (ANEW) Program: In FY 2018, the ANEW Program continues to support innovative academic-practice partnerships to prepare primary care advanced practice registered nursing students to practice in rural and underserved settings through academic and clinical training. The partnerships support traineeships as well as academic-practice program infrastructure funds to schools of nursing and their practice partners who deliver longitudinal primary care clinical training experiences with rural and/or underserved populations for selected students in primary care nurse practitioners (NP), primary care clinical nurse specialists (CNS), and/or nurse-midwives programs and facilitate program graduates' employment in those settings.

In Academic Year 2017-2018, grantees of the ANEW Program trained 3,787 nursing students and produced 934 graduates. Of the 1,142 students who were directly funded by ANEW, the majority received training in substance use treatment (57 percent) and/or opioid use treatment (51 percent). In addition, ANEW grantees supported 32 faculty and 11 preceptors. To provide clinical training experiences to nursing students, grantees partnered with 2,141 clinical training sites in primary care settings (78 percent), medically underserved communities (61 percent), and/or rural areas (32 percent). ANEW grantees developed or enhanced and offered 273 curricula, provided 90 continuing education courses to practicing professionals, and offered 119 faculty and preceptor development programs.

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

Advanced Nursing Education-Sexual Assault Nurse Examiners (ANE-SANE) Program: In FY 2018, HRSA established the ANE-SANE Program which supports partnerships that will recruit, train and retain nurses to conduct sexual assault forensic examinations which provide better physical and mental health care for survivors, better evidence collection, and leads to higher prosecution rates. The partnerships will have an infrastructure to provide didactic and clinical training, monitor and track experiential learning hours and SANE certificate completion. They will also provide support and resources to help improve the practice and retention of sexual assault nurse examiners.

Advanced Nursing Education (ANE)*:* In Academic Year 2017-2018, grantees of the ANE Program trained 3,649 nursing students and produced 1,319 graduates. Although the numbers of students trained and graduated were lower than the projected target, this was primarily related to the merger of the ANE and AENT programs to create the ANEW program where programs are more focused on infrastructure than student training. Further analysis showed that ANE grantees partnered with 1,923 health care delivery sites to provide clinical and experiential training to students. Approximately 41 percent of these sites were located in medically underserved communities, and 63 percent were in primary care settings.

Nurse Anesthetist Traineeships (NAT) Program: In Academic Year 2017-2018, grantees of the NAT Program provided direct financial support to 2,729 nurse anesthetist students. Students received clinical training in medically underserved communities (77 percent) and/or primary care settings (45 percent) during the academic year. More than 1,300 students graduated from their degree programs and entered the workforce. At the time of graduation, 54 percent of graduates intended to pursue employment or further training in medically underserved communities, and 21 percent planned to pursue employment or further training in a primary care setting.

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

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

Funding History

FY	Amount
FY 2016	$64,581,000
FY 2017	$64,425,000
FY 2018	$74,311,000
FY 2019	$74,581,000
FY 2020	---

Budget Request

The FY 2020 Budget Request for the Advanced Nursing Education program of $0 is $74.6 million below the FY 2019 Enacted level. The Request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[75]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.38: Number of students trained in advanced nursing degree programs	FY 2017: 3,649 Target: 7,000 (Target Not Met)[76]	3,700	N/A	-3,700

[75] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.
[76] The change in target reflects the old ANE program completing activities. We will begin reporting ANE-NPR activities and revise targets once that program has active grants. The new activity was the decision of program and is unrelated to meeting targets. We expect the new ANE-NPR program results to begin in FY 2020

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[75]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.39: Percent of students trained who are URMs and/or from disadvantaged backgrounds	FY 2017: 27% Target: 27% (Target Met)	27%	N/A	-27%
6.I.C.40: Number of graduates from advanced nursing degree programs	FY 2017: 1,319 Target: 1,800 (Target Not Met)	900[77]	N/A	-900

Program Activity Data

ANE Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Number of students supported in NAT program	FY 2017: 2,729	2,200	2,200	---
Number of graduates from NAT program	FY 2017: 1,347	1,000	1,000	---
Percent of NAT graduates who are minority and/or from disadvantaged backgrounds	FY 2017: 26%	30%	30%	---
Percent of graduates from NAT programs employed in underserved areas	FY 2017: 46%	40%	45%	---

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	171	179	---
Average Award	$407,725	$400,000	---
Range of Awards	$11,487-$867,588	$10,000-$1,000,000	---

[77] Targets modified to reflect programmatic changes. Targets take into account attrition

Nursing Workforce Development

Nursing Workforce Diversity

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$17,300,000	$17,343,000	---	-$17,343,000
FTE	4	4	---	-4

Authorizing Legislation: Public Health Service Act, Sections 821

FY 2020 Authorization .....Expired at end of FY 2016

Allocation Method .....Competitive Grant/Contract

Program Description and Accomplishments:

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

In Academic Year 2017-2018, the NWD Program supported 65 college-level degree programs as well as 164 training programs and activities designed to recruit and retain health professions students. These programs trained 6,549 students, including 2,886 students who graduated or completed their programs. Degree programs had 2,880 enrolled students this academic year, missing the target. This was primarily due to a new cohort of FY 2017 grantees being in a capacity-building year. In addition to providing support to students, NWD grantees partnered with 743 training sites during the academic year to provide 6,888 clinical training experiences to trainees across all programs. Approximately 48 percent of training sites were located in medically underserved communities and 33 percent were in primary care settings.

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

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

Funding History

FY	Amount
FY 2016	$15,343,000
FY 2017	$15,306,000
FY 2018	$17,300,000
FY 2019	$17,343,000
FY 2020	---

Budget Request

The FY 2020 Budget Request for the Nursing Workforce Diversity program of $0 is $17.3 million below the FY 2019 Enacted level. HRSA's nursing projections generally indicate that the supply of nurses will outpace demand at a national level in 2025. However, the distribution of nurses is estimated to be uneven with some areas of the country having an inadequate supply to meet the needs of their region, which is addressed by the NHSC, the NURSE Corps or other HRSA investments. The Request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[78]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.41: Percent of program participants who are URMs and/or from disadvantaged backgrounds	FY 2017: 100% Target: 95% (Target Exceeded)	95%[79]	N/A	-95%
6.I.C.42: Number of program participants who participated in academic support programs during the academic year	FY 2017: 3,669 Target: 2,900 (Target Exceeded)	3,300[80]	N/A	-3,300
6.I.C.43: Number of program participants who are enrolled in a nursing degree program	FY 2017: 2,880 Target: 4,000 (Target Not Met)	2,800[81]	N/A	-2,800

Program Activity Data

NWD Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Percent of URM students	FY 2017: 66%	60%[82]	65%[83]	---
Number of nursing students graduating from nursing programs	FY 2017: 2,886	500[84]	2,500	---

[78] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.
[79] Targets take into account attrition
[80] Targets take into account attrition
[81] Targets take into account attrition
[82] Targets take into account attrition
[83] Targets take into account attrition
[84] Targets take into account attrition

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	34	34	---
Average Award	$471,500	$471,500	---
Range of Awards	$245,100-$500,000	$245,100-$500,000	---

Nursing Workforce Development

Nurse Education, Practice, Quality and Retention Programs

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$41,733,000	$41,913,000	---	-$41,913,000
FTE	5	5	---	-5

Authorizing Legislation: Public Health Service Act, Sections 831 and 831A
FY 2020 Authorizations.....Expired at the end of FY 2016

Allocation Method .....Competitive Grant/Contract

Program Description and Accomplishments:

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

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

In Academic Year 2017-2018, IPCP grantees trained nearly 5,300 individuals. Grantees partnered with 150 clinical sites to provide interprofessional team-based training to 5,012 individuals. Approximately 61 percent of the clinical training sites were located in medically underserved communities, and 55 percent were in primary care settings. More than 58 percent of interprofessional trainees were nurses and nursing students, while 2,120 were trainees from other health care disciplines, including medical, dental, and behavioral health. Although targets were not met, this was primarily because the number of funded grantees was reduced.

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

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

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

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

Funding History

FY	Amount
FY 2016	$39,913,000
FY 2017	$39,817,000
FY 2018	$41,733,000
FY 2019	$41,913,000
FY 2020	---

Budget Request

The FY 2020 Budget request for the Nurse Education, Practice, Quality and Retention program of $0 is $41.9 million below the FY 2019 Enacted level. HRSA's nursing projections generally indicate that the supply of nurses will outpace demand at a national level in 2025. However, the distribution of nurses is estimated to be uneven with some areas of the country having an inadequate supply to meet the needs of their region, which is addressed by the NHSC, the NURSE Corps or other HRSA investments. The Request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[85]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.44: Number of trainees participating in interprofessional team-based care	FY 2017: 1,243 Target: 1,700 (Target Not Met)	N/A[86]	N/A	N/A
6.I.C.45: Number of nurses and nursing students trained in interprofessional team-based care	FY 2017: 2,928 Target: 3,000 (Target Not Met)	N/A[87]	N/A	N/A
6.I.C.57: Number of NEPQR nursing students trained in primary care	---	TBD[88]	N/A	N/A

[85] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.
[86] Measure discontinued in FY 2018 as program was restructured.
[87] Measure discontinued in FY 2018 as program was restructured.
[88] Baseline will be set for this measure in FY 2019 and reported in the FY 2022 Congressional Justification.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[85]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.58: Number of NEPQR trainees and professionals participating in interprofessional team-based care	---	TBD[89]	N/A	N/A

Program Activity Data

NEPQR Program Outputs	Year and Most Recent Result	FY 2018 Target	FY 2019 Target	FY 2020 Target
Total number of trainees and professionals participating in interprofessional team-based care	FY 2017: 5,012	N/A[90]	N/A	N/A
Number of veterans enrolled in baccalaureate (BSN) nursing programs	FY 2017: 993	N/A[91]	N/A	N/A
Number of veterans who graduate from baccalaureate (BSN) nursing programs	FY 2017: 266	N/A[91]	N/A	N/A

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	73	73	---
Average Award	$530,665	$530,665	---
Range of Awards	$131,830-$700,000	$131,830-$700,000	---

[89] Baseline will be set for this measure in FY 2019 and reported in the FY 2022 Congressional Justification.
[90] Measure discontinued in FY 2018 as program was restructured.
[91] Measures discontinued in FY 2018 as the VBSN program has completed activities.

Nursing Workforce Development

Nurse Faculty Loan Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$28,500,000	$13,500,000	---	-$13,500,000
FTE	4	4	---	-4

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

FY 2020 Authorization ..... Expired at the end of FY 2016

Allocation Method ..... Formula Grant

Program Description and Accomplishments:

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

In Academic Year 2017-2018, 80 schools received new NFLP awards. Awardees supported 2,172 nursing students pursuing graduate level degrees as nurse faculty. This outcome is slightly below the FY 2017 target of 2,200 students, primarily as a result of an increased focus on training doctoral students who are not as vast in number as master's students. In addition, with increasing tuition costs across schools, fewer individual awards are being made. The majority of students (84 percent) who received loans during the academic year were pursuing doctoral-level nursing degrees (e.g., PhD, DNP, DNSc/DNS, or EdD). By the end of the Academic Year, 800 trainees graduated, 94 percent of whom intended to teach nursing.

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

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

Funding History

FY	Amount
FY 2016	$26,500,000
FY 2017	$26,436,000
FY 2018	$28,500,000
FY 2019	$13,500,000
FY 2020	---

Budget Request

The FY 2020 Budget Request for the Nurse Faculty Loan Program of $0 is $13.5 million below the FY 2019 Enacted level. The request prioritizes funding for health workforce activities that provide scholarships and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[92]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.46: Number of graduate-level nursing students who received a loan	FY 2017: 2,172 Target: 2,200 (Target Not Met)	1,000[93]	N/A	-1,000

[92] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.
[93] Target change reflects decrease in FY 2019 funding.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[92]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.47: Number of loan recipients who graduated from an advanced nursing degree program	FY 2017: 800 Target: 400 (Target Exceeded)	400	N/A	-400

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	80	80	---
Average Award	$333,315	$159,000	---
Range of Awards	$16,380-$2,140,611	$7,750-1,014,000	---

Nursing Workforce Development

NURSE Corps

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$87,107,000	$87,135,000	$83,135,000	-$4,000,000
FTE	32	32	32	---

Authorizing Legislation: Public Health Service Act, Section 846

FY 2020 Authorization ..... Expired at the end of FY 2007

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

Program Description and Accomplishments:

HRSA's nursing and primary care projections generally indicate that the supply of nurses will outpace demand at a national level in 2025 and 2020, respectively. However, maldistribution of nurses is projected to be a continued problem. In addition, projections at the national-level mask a distributional imbalance of Registered Nurses (RN) at the state-level. Specifically, sixteen states are projected to experience a shortage of RNs by 2025.[94] Furthermore, as the Administration seeks to continue to address the opioid epidemic and other substance use disorders across the nation, the NURSE Corp program is critical to ensure access to high quality adequate behavioral health nursing workforce.

The NURSE Corps addresses (1) the distribution of nurses by supporting nurses and nursing students committed to working in communities with inadequate access to care; and (2) limited access to behavioral health services by increasing funding for scholarships for behavioral health training for Nurse Practitioners (NPs). In exchange for scholarships or educational loan repayment, NURSE Corps members fulfill their service obligation by working in Critical Shortage Facilities (CSFs) located in health professional shortage areas and medically underserved communities around the nation, which include rural communities and other identified geographic areas with populations that lack access to primary care and behavioral health services. As of September 30, 2018, over two-thirds of the NURSE Corps providers were serving in community-based settings and 19 percent served in rural communities.

The NURSE Corps Program includes:

NURSE Corps Loan Repayment Program (LRP): NURSE Corps LRP, which began in 1988, aims to assist in the recruitment and retention of professional RNs, including Advanced Practice

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

RNs (APRNs), (i.e., nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, clinical nurse specialists) who are dedicated to working in CSFs or as faculty in schools of nursing. The NURSE Corps LRP decreases the economic barriers associated with pursuing careers in CSFs or in academic nursing by repaying 60 percent of the principal and interest on nursing education loans in exchange for two years of full-time service at a CSF or in academic nursing.

***The NURSE Corps Scholarship Program (SP)*:** NURSE Corps SP, which began in 2002**,** awards scholarships to individuals who are enrolled or accepted for enrollment in an accredited school of nursing in exchange for a service commitment of at least two years in a CSF after graduation. The NURSE Corps SP awards reduce the financial barrier to nursing education for all levels of professional nursing students and increase the pipeline of nurses who will serve in CSFs.

The NURSE Corps performance measures gauge these programs' contribution towards improving access to health care and improving the health care systems through the recruitment and retention of nurses working in CSFs. In FY 2018, 54 percent of NURSE Corps LRP participants extended their service commitment for an additional year, exceeding the 52 percent target; and in FY 2018, 89.7 percent of NURSE Corps participants were retained in service at a CSF for up to two years beyond the completion of their NURSE Corps service commitment. In addition, in FY 2018, 97 percent of NURSE Corps SP awardees are pursuing their baccalaureate degree or advanced practice degree.

In FY 2019, HRSA directed up to 20 percent of scholarship awards to NPs specializing in Psychiatric-Mental Health with the goal of leveraging HRSA funding to address the opioid crisis.

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

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

Funding History

FY	Amount
FY 2016	$83,135,000
FY 2017	$82,935,000
FY 2018	$87,107,000
FY 2019	$87,135,000
FY 2020	$83,135,000

Budget Request

The FY 2020 Budget Request for the NURSE Corps Program of $83.1 million is $4 million below the FY 2019 Enacted level. This request will fund an estimated 197 scholarship (new and continuation) and 806 loan repayment (new and continuation) awards. This request will allow the program to maintain its efforts to address the anticipated demand for nurses in CSF. Additionally, the funds will help increase the number of well-trained nurses available to provide mental/behavioral health services in communities experiencing a shortage in nurses. In FY 2020, NURSE Corps will continue to drive funding to support the Administration's priorities to improve access to opioid treatment and prevention services through the Scholarship and LRP.

In fiscal year 2020 HRSA proposes to expand tax-exempt status under (1) 26 USC 117(c)(2) to the NURSE Corps Scholarship Program (SP) and Native Hawaiian Health Scholarship Program (NHHSP); and (2) 26 USC 108(f)(4) to the NURSE Corps Loan Repayment Program (LRP). The funding request includes operational, staffing, acquisition contracts, and costs associated with the award process, follow-up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
5.I.C.4: Proportion of NURSE Corps LRP participants who extend their service contracts to commit to work at a critical shortage facility for an additional year. *(Outcome)*	FY 2018: 54% 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 2018: 89,7% Target: 80% (Target Exceeded)	80%	80%	Maintain
5.I.C.7: Proportion of NURSE Corps SP awardees obtaining their baccalaureate degree or advanced practice degree in nursing. *(Outcome)*	FY 2018: 97% Target: 85% (Target Exceeded)	85%	85%	Maintain

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
5.E.1: Default rate of NURSE Corps LRP and SP participants. *(Efficiency)*	FY 2018: LRP: 2.8% Target: 3% (Target Exceeded) SP: 8.4% Target: 15% (Target Exceeded)	LRP: 3% SP: 15%	LRP: 3% SP: 15%	Maintain

NURSE Corps Loans/Scholarships Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Loans	$50,784,113	$50,784,113	$48,452,829
Scholarships	$25,013,070	$25,013,070	$23,864,826

NURSE Corps Awards

	2013	2014	2015	2016	2017	2018	2019	2020
Scholarships								
New Awards	239	242	257	230	198	215	198	193
Continuation Awards	21	13	12	12	14	4	6	4
Loan Repayment								
New Awards	580	667	590	518	501	544	500	510
Continuation Awards	606	412	319	365	340	279	310	296
Total	**1,446**	**1,334**	**1,178**	**1,125**	**1,053**	**1,042**	**1,014**	**1,003**

NURSE Corps Field Strength

	2013	2014	2015	2016	2017	2018	2019	2020
Scholarship	558	465	396	476	362	465	248	225
Loan Repayment	1,634	1,420	1,313	1,219	1,181	1,129	1,215	1116
Loan Repayment Nurse Faculty	367	318	321	321	331	271	123	123
Total	**2,559**	**2,203**	**2,030**	**2,016**	**1,874**	**1,865**	**1,586**	**1,464**

Children's Hospitals Graduate Medical Education Payment Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$314,213,000	$325,000,000	---	-$325,000,000
FTE	21	21	---	-21

Authorizing Legislation: Public Health Service Act, Section 340E
FY 2020 Authorization $325,000.000

Allocation Method ..... Formula Based Payment

Program Description and Accomplishments:

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

A sufficient and appropriate health workforce, efficient organization of health care teams, and training in value-based models of care are all critical components to supporting new models of care that drive value and quality throughout the entire system. In FY 2018, the CHGME initiated the Quality Bonus System (QBS), authorized by statute to allow the Secretary of HHS to distribute bonus payments to participating CHGME hospitals that meet quality standards specified by the Secretary. The goal of the QBS is to recognize and incentivize CHGME Payment Program awardees with high quality training to meet the pediatric workforce needs of the nation.

The CHGME QBS would be the first of its kind for any federal GME payment program and responds to changes occurring in the larger health care arena. In FY 2019, HRSA will implement a baseline phase for the CHGME QBS. Data collected in the baseline year will be used by HRSA for qualitative analysis to develop a core set of quality measures for the CHGME Payment Program. In order to qualify for a QBS payment, participating hospitals will need to submit data describing the hospital's initiatives, resident curriculum, and direct resident involvement in the following areas:

a. Integrated care models (e.g., integrated behavioral and mental health, care coordination across providers and settings);
b. Telehealth and/or Health Information Technology;
c. Population health;
d. Social determinants of health; and

e. Additional initiatives to improve access and quality of care to rural and/or underserved communities.

In FY 2018, 58 children's hospitals received CHGME funding. During FY 2017 (AY 2016-2017), the most recent year for which FTE information was reported, the CHGME hospitals trained 7,367 resident full-time equivalents (FTEs).[95] Among these FTEs, 40 percent were pediatric residents, 33 percent were pediatric subspecialty residents, and 27 percent were residents training in other primary disciplines such as family medicine.

During Academic Year 2016-2017, the most recent year for which performance information is available, CHGME-funded hospitals served as sponsoring institutions for 37 residency programs and 249 fellowship programs. In addition, they served as major participating rotation sites for 629 additional residency and fellowship programs. CHGME supported the training of 4,975 pediatric residents that included general pediatrics residents, as well as residents from five types of combined pediatrics programs (e.g., internal medicine/ pediatrics).

Additionally, 2,962 pediatric medical subspecialty residents, 348 pediatric surgical subspecialty residents, and 424 adult and pediatric dentistry residents were trained. CHGME funding was also responsible for the training of 3,571 adult medical and surgical specialty residents such as family medicine residents who rotate through children's hospitals for pediatrics training. During their training, these medical residents and fellows provided care during more than 1.7 million patient encounters in primary care settings in addition to providing 5.2 million patient contact hours in medically underserved communities. Of the full-time residents and fellows who completed their training during this Academic Year, approximately 54 percent of these CHGME-funded physicians chose to remain and practice in the state where they completed their residency training.

Eligible Entities: Freestanding children's teaching hospitals.

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

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

Funding History

FY	Amount
FY 2016	$295,000,000
FY 2017	$299,289,000
FY 2018	$314,213,000
FY 2019	$325,000,000
FY 2020	---

Budget Request

The FY 2020 Budget Request discontinues the discretionary CHGME program, which is $325 million below the FY 2019 Enacted level. The Budget proposes to consolidate Federal graduate medical education spending from Medicare, Medicaid, and the Children's Hospitals Graduate Medical Education program into a single grant program for teaching hospitals equal to the sum of Medicare and Medicaid's 2017 payments for graduate medical education, plus 2017 spending on children's hospitals graduate medical education, adjusted for inflation. This amount would then grow with inflation minus 1 percentage point each year. HRSA and the Centers for Medicare & Medicaid Services (CMS) would jointly determine program requirements and the formula for distribution. Payments would be distributed to hospitals based on the number of residents at a hospital (up to its existing cap) and the portion of the hospital's inpatient days accounted for by Medicare and Medicaid patients. The Secretary would have authority to modify the amounts distributed based on the proportion of residents training in priority specialties or programs and based on other criteria identified by the Secretary, including addressing health care professional shortages and educational priorities. This grant program would be funded out of the general fund of the Treasury.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[96]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
7.I.A.1: Maintain the number of FTE residents training in eligible children's teaching hospitals	FY 2017: 7,367 Target: 6,300 (Target Exceeded)	6,700	N/A	-6,700

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

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[96]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
7.VII.C.1: Percent of hospitals with verified FTE residents counts and caps	FY 2017: 100% Target: 100% (Target Met)	100%	N/A	-100%
7.E: Percent of payments made on time	FY 2017: 100% Target: 100% (Target Met)	100%	N/A	-100%

Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	58	58	---
Average Award	$5,074,270	$5,235,350	---
Range of Awards	$32,294-$21,826,750	$33,320-$22,519,650	---

Teaching Health Center Graduate Medical Education Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
Current Law Mandatory Funding	$126,500,000	$126,500,000	--	-$126,500,000
Proposed Law Mandatory Funding	---	---	$126,500,000	+$126,500,000
Total	$126,500,000	$126,500,000	$126,500,000	---
FTE	10	10	10	---

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

FY 2020 Authorization ..... Expired at the end of FY 2019

Allocation Method ..... Formula Based Payment

Program Description and Accomplishments:

Primary care physician shortages persist, particularly in rural and other underserved communities.[97] Access to high quality primary care is associated with improved health outcomes and lower costs.[98, 99] The Teaching Health Center Graduate Medical Education (THCGME) Program, established in 2010, increases the number of primary care physician and dental residents, increasing the overall number of these primary care providers. There is also evidence that physicians who receive training in community and underserved settings are more likely to practice in similar settings, such as health centers.[100, 101] Unlike most Federal funding for GME, payments support training in community-based ambulatory care settings, as opposed to in-patient care settings in hospitals.

[97] U.S. Department of Health and Human Services, Health Resources and Services Administration. HRSA, 2015. "National and Regional Projections of Supply and Demand for Primary Care Practitioners: 2013-2025. November 2016.
[98] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Quarterly. 2005; 83(3):457-502.
[99] Chang CH, O'Malley AJ, Goodman DC. Association between Temporal Changes in Primary Care Workforce and Patient Outcomes. Health Services Research 2017; 52:634–55.
[100] Phillips, RL; Petterson,S; Bazemore, A. Do Residents Who Train in Safety Net Settings Return for Practice? Academic Medicine: 2013; 88(12): 1934–1940.
[101] Goodfellow A, Ulloa J, Dowling P, Talamantes E, Chheda Somil, Bone C, Moreno G. Predictors of Primary Care Physician Practice Location in Underserved Urban or Rural Areas in the United States: A Systematic Literature Review. 2016, Academic Medicine.

Although health centers receive federal funding to improve access to care, they often have difficulty recruiting and retaining primary care professionals.[102] The THCGME Program is uniquely positioned to meet these recruitment and retention needs by providing funding to support residents training in underserved communities. Community health centers are generally smaller organizations with smaller operating margins compared to teaching hospitals. Without THCGME funding, these additional residency positions will cease to exist and the additional primary care physicians and dentists will not be available to rural and underserved communities.

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

Along with supporting the salaries and benefits of residents and faculty, THCGME funds are used to foster innovation and support curriculum concepts aimed at improving the quality of patient care, such as the Patient-Centered Medical Home model, Electronic Health Record utilization, population health, telemedicine, and healthcare leadership. These activities ensure residents receive high quality training and are well prepared to practice in community-based setting after graduation.

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

In Academic Year 2017-2018, the THCGME Program awarded 713 resident FTE slots that provided funding to 847 primary care medical and dental residents. While the number of FTE slots missed the target due to the unexpected loss of two grantees, the number of residents funded increased by 12 percent. Nearly all residents (over 99 percent) received training in a primary care setting, providing care during more than half a million patient encounters and accruing nearly 600,000 contact hours with these primary care patients. Additionally, most THCGME residents (82 percent) spent a significant part of their training in medically underserved and/or rural communities, providing over 950,000 hours of patient care. Approximately 18 percent of residents reported are coming from a financially or educationally disadvantaged background, while 25 percent of them are coming from a rural background.

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[102] National Association of Community Health Centers. Staffing the Safety Net: Building the Primary Care Workforce at America's Health Centers.2016

In addition to supporting training of individual residents, THCGME recipients also used funding to develop or enhance curricula on topics related to primary care. Programs developed or enhanced and implemented 1,203 courses and training activities during the academic year, impacting over 9,400 healthcare trainees. Nearly 13,000 students, residents, and other health care professionals from a variety of professions and disciplines trained alongside THCGME residents while participating in interprofessional team-based care.

Of the 248 residents who completed the program in Academic Year 2017-2018, approximately 55 percent reported intentions to practice in a primary care setting, while 65 percent intended to practice in a medically underserved and/or rural area. Employment status will be assessed for these individuals one year after program completion (during Academic Year 2018-2019). Of the 225 program completers from the prior academic year for whom employment data was available, most currently practice in a primary care setting (58 percent) and/or in a medically underserved community (43 percent).

Since the THCGME Program began, 880 new primary care physicians and dentists have graduated and entered the workforce. As the national average of physicians practicing primary care is approximately 33 percent, [103] the THCGME Program has evidenced much stronger results. Cumulative follow-up data indicates that 64 percent of graduates are currently practicing in a primary setting and approximately 58 percent of the graduating physicians and dentists are currently practicing in a medically underserved community and/or rural setting.

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

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

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

Funding History

FY	Amount
FY 2016	$60,000,000
FY 2017[104]	$55,860,000
FY 2018	$126,500,000
FY 2019	$126,500,000
FY 2020	$126,500,000

Budget Request

The FY 2020 Budget Request for the THCGME Program of $126.5 million is the same as the FY 2019 Enacted level. In Academic Year 2020-2021, the program expects to support approximately 800 resident FTEs.

	FY 2020	FY 2021	Total Funding
Proposed Mandatory Funding	$126.5 million	$126.5 million	$253 million

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[105]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.C.5: Number of resident positions supported by Teaching Health Centers (Cumulative)[106]	FY 2017: 713 Target: 760 (Target Not Met)	750	750	Maintain
6.I.C.48: Percent of THCGME-supported residents training in rural and/or underserved communities	FY 2017: 82% Target: 80% (Target Exceeded)	80%	80%	Maintain

[104] FY 2017 reflects the post-sequestration funding amount.
[105] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.
[106] Measure captures the number FTEs resident slots supported and not the number of individuals receiving direct financial support through the program. Awardees may use 1 FTE slot to fund two residents at 50 percent time, thus the FTE slot is not a one to one correspondence with number of individuals trained. Number of residents also does not equal the number of graduates as primary care residency programs require one year (Dental and Geriatrics), three years (Family Medicine, Internal Medicine, and Pediatrics), or four years (Ob-Gyn and Psychiatry) of training.

Program Activity Data

THCGME Program Outputs	Year and Most Recent Result
Number of primary care residents funded by THCGME residencies[107]	FY 2017: 847
Number of primary care residents completing training	FY 2017: 248
Percent of residents who are from a disadvantaged and/or rural background	FY 2017: 35%
Percent of primary care resident program completers who intend to practice in primary care settings	FY 2017: 55%

Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	57	57	62
Average Award	$2,045,725	$2,045,725	$1,938,306
Range of Awards	$326,914-$8,291,884	$326,914-$8,291,884	$300,550-7,623,184

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

National Practitioner Data Bank

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$18,814,000	$18,814,000	$18,814,000	---
FTE	34	34	34	---

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

FY 2020 Authorization ..... Indefinite

Allocation Method ..... User Fee Program

Program Description and Accomplishments:

The National Practitioner Data Bank (NPDB) is a workforce tool that improves health care quality, promotes patient safety, and deters fraud and abuse in the health care system by providing information about past adverse actions of practitioners, providers, and suppliers to authorized health care entities and agencies. With more than 1.4 million reports, the NPDB helps reduce health care fraud and abuse by collecting and disclosing information to authorized entities on health care-related civil judgments and criminal convictions, adverse licensure and certification actions, exclusions from health care programs, and other adjudicated actions taken against health care providers, suppliers, and practitioners. Authorized health care entities then use this information to make informed hiring, credentialing, and privileging decisions to ultimately determine whether, or under what conditions, it is appropriate for health care practitioners, providers, and suppliers to provide health care services.

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

- In FY 2018, the NPDB facilitated more than 8.3 million queries from the NPDB to authorized health care providers.
- DPDB has launched attestation initiatives for HRSA's community health centers, hospitals, and health plans. As of September 30, 2018, the attestation completion rate for selected health centers, hospitals, and health plans is over 90 percent. This multi-year compliance initiative will next focus on malpractice payers.

Funding History

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

FY	Amount
FY 2015	$20,159,152
FY 2016	$22,436,863
FY 2017	$18,814,000
FY 2018	$18,814,000
FY 2019	$18,814,000
FY 2020	$18,814,000

Budget Request

The FY 2020 Budget Request for the National Practitioner Data Bank of $18.8 million in user fees is the same as the FY 2019 Enacted level. This is based on HRSA's projections of 9.1 million queries on practitioners and organizations, and 165,000 self-queries, which yields estimated FY 2020 revenue projections similar to the level in FYs 2018 and 2019.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
8.III.B.5: Increase the number of practitioners enrolled in Continuous Query (which is a subscription service for Data Bank queries that notifies them of new information on enrolled practitioners within one business day)	FY 2018: 3,193,277 Enrolled Practitioners Target: 2,928,500 Enrolled Practitioners (Target Exceeded)	3,078,500	3,500,000	+200,000

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
8.III.B.7: Increase annually the number of disclosures of NPDB reports to health care organizations	FY 2018: 1,843,365 Disclosures Target: 1,750,000 (Target Exceeded)	1,850,000	1,880,000	+30,000

Health Workforce Cross-Cutting Performance Measures

The Bureau of Health Workforce (BHW) has tracked and reported on four cross-cutting measures for 27 of its programs that reported performance data during Academic Year 2017-2018. The cross-cutting measures focus specifically on the diversity of individuals completing specific types of health professions training programs;[108] the rate in which individuals participating in specific types of health professions training programs are trained in medically underserved communities;[109] the rate in which individuals who complete specific types of health professions training programs report being employed in a medically underserved community; and the rate in which clinical training sites provide interprofessional team-based care to patients. These measures do not currently include data from the Faculty Loan Repayment Program or the National Practitioner Data Bank.[110]

During Academic Year 2017-2018, results showed that 51 percent of graduates and program completers participating in BHW-supported health professions training and loan programs were underrepresented minorities (URMs) in the health professions and/or from disadvantaged backgrounds.[111]

With regard to the types of settings used to provide training, results showed that 60 percent of individuals participating in BHW-supported health professions training programs received at least a portion of their training in a medically underserved community surpassing the performance target of 55 percent. This is an improvement over last year's result of 56 percent and reflects the Bureau's programmatic changes aimed at increasing service and training in rural and underserved areas. As a result, more health professions trainees are being exposed to training and patient care in medically underserved communities than in prior years.

Results showed that 43 percent of individuals who graduated from or completed specific types of BHW-supported training programs reported working in medically underserved communities across the nation one year after graduation/completion.

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[108] BHW currently funds more than 35 health professions training and loan programs that have varying types of data reporting requirements based on the program's authorizing legislation. For the purposes of the cross-cutting measures, only programs that are required to report individual-level data are included in the calculation, as this ensures a higher level of accuracy and data quality, as well as consistency in the types of programs that are included in the calculation. Currently, 27 of the BHW-funded programs are required to report individual-level data and are included in these calculations. These programs are representative of the health professions and include oral health programs, behavioral health programs, medicine programs, nursing programs, geriatrics programs, and physician assistant programs, among others.

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

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

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

Lastly, the percent of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program was 59 percent, far exceeding the target of 19 percent. This result is significantly higher than last year's result due to a major shift in the programmatic emphasis of interprofessional training across programs in the Bureau.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [112]	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
6.I.B.1. Percentage of graduates and program completers of Bureau of Health Workforce-supported health professions training programs who are underrepresented minorities and/or from disadvantaged backgrounds.	FY 2017: 51% Target: 46% (Target Exceeded)	48%	TBD	TBD
6.I.C.1. Percentage of trainees in Bureau of Health Workforce-supported health professions training programs who receive training in medically underserved communities.	FY 2017: 60% Target: 55% (Target Exceeded)	57%	TBD	TBD
6.I.C.2. Percentage of individuals supported by the Bureau of Health Workforce who completed a primary care training program and are currently employed in underserved areas.[113]	FY 2017: 43% Target: 40% (Target Exceeded)	40%	TBD	TBD
6.I.1. Percent of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program.	FY 2017: 59% Target: 19% (Target Exceeded)	45%	TBD	TBD

[112] Most recent results are for Academic Year 2017-2018 and funded in FY 2017.

[113] Service location data are collected on students who have been out of the HRSA program for one year. The results are from programs that have the ability to produce clinicians with one-year post program graduation. Results are from Academic Year 2017-2018 based on graduates from Academic Year 2016-2017.

Maternal and Child Health

TAB

MATERNAL AND CHILD HEALTH

Maternal and Child Health Block Grant

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$650,194,233	$677,700,000	$660,700,000	-$17,000,000
FTE	49	53	53	---

Authorizing Legislation - Social Security Act, Title V

FY 2020 Authorization $850,000,000

Allocation Methods:

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

Program Description and Accomplishments

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

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

The MCH Block Grant program funding, combined with state investments, provides a significant funding source to improve access to and the quality of health care for mothers, children, and their families in all 50 states, the District of Columbia and the territories. The MCH Block Grant program enables each state to:

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

State MCH Block Grant Program

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

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

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

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

- **Reduce state burden** by streamlining the narrative reporting structure of the Five-Year Needs Assessment and Application/Annual Report, by reducing duplication in narrative reporting across multiple sections of the Application/Annual Report, and by pre-

populating performance and outcome measure data, as available, using national data sources.

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

MCHB works in partnership with the State MCH Block Grant programs to provide technical support, as requested by the state, for addressing their MCH priority needs as well as other performance and programmatic requirements of the MCH Block Grant program. HRSA makes key financial, program, performance, and health indicator data, as reported by states, available to the public at Explore the Title V Federal-State Partnership.

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

- An estimated 56 million pregnant women, infants and children, including children with special health care needs benefitted from a service supported by the State MCH Block Grant in FY 2017. This includes 86 percent of pregnant women, 99 percent of infants, and 55 percent of children nationwide.
- Access to health services for mothers has improved with support of the State MCH Block Grant program. The percentage of women who received early prenatal care in the first trimester of pregnancy increased from 71 percent in 2007 to 77 percent in 2017. Recognizing that improving maternal and child health in the United States will require, first of all, improving women's health before pregnancy, a total of 50 states and jurisdictions are now working to improve access to preventive and primary care for all women of childbearing age.
- The infant mortality rate is a widely used indicator of the nation's health. The State MCH Block Grant program has played a lead role in the 19 percent decline in U.S. infant mortality from 7.2 infant deaths per 1,000 live births in 1997 to 5.8 infant deaths per 1,000 in 2017. Efforts to reduce the overall infant mortality rate and its contributing factors continue.
- States are also working to reduce maternal mortality, which has been rising over the past two decades, through a range of approaches. For example, in 2018 37 State Title V programs provided funding to support comprehensive maternal mortality reviews to identify contributing factors, monitor trends, and initiate appropriate action to reduce such events in the future. An additional 14 states are in the planning process to use Title V funds to support maternal mortality reviews. In Kentucky, for example, the maternal mortality review team's findings led to the development of a patient "safety bundle" for obstetrical hemorrhage that provides standardized treatment protocols. California's MCH

Block Grant program supported the development and implementation of several maternal safety bundles to improve the quality and safety of maternity care in birthing hospitals, which coincided with a 60 percent reduction in maternal deaths in California between 2006 and 2012. New York is focusing on the "pre-hospital" antecedents of maternal mortality, which include promotion of women's health and wellness across the reproductive life course and early identification and coordinated management of high-risk pregnancies.

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

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

National Outcome or Performance Measures	Percent Change (1997 – 2017 unless otherwise noted)	Data Source
Infant Mortality Rate per 1,000 live births	19% decrease	National Vital Statistics System (NVSS)
Neonatal mortality rate per 1,000 live births	21% decrease	NVSS
Postneonatal mortality rate per 1,000 live births	24% decrease	NVSS
Perinatal mortality rate per 1,000 live births plus fetal deaths	18% decrease (1997-2016)	NVSS
Child mortality rate, ages 1 through 9 per 100,000	33% decrease	NVSS
Percent of 19-35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, & Hepatitis B	59% increase (2009-2017)	National Immunization Survey (NIS)
Percentage of children without health insurance	64% decrease	National Health Interview Survey (NHIS)
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates	12% increase (1997-2013)	Title V Information System
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	9% increase (2007-2017)	NVSS

Special Projects of Regional and National Significance (SPRANS)

HRSA awards SPRANS grants to 1) respond to legislative set-asides and directives, 2) address critical and emerging issues of regional and national significance in maternal and child health, and 3) support collaborative and innovative learning across states so programs can utilize existing best-practices and evidence. Of the $109.6 million for SPRANS in FY 2019, Congress set aside approximately 11 percent to address four specific priorities: oral health, epilepsy, sickle cell disease, and Fetal Alcohol Syndrome. In addition, approximately 42 percent of the total SPRANS budget supports specific directives highlighted in the authorizing language, including genetics, hemophilia, training, and research. The remaining approximately 47 percent addresses critical and emerging issues in maternal and child health such as maternal mortality and opioid abuse prevention, and supports collaborative learning across states.

Legislative Set-Asides

In FY 2019, Congressional appropriations directed approximately $12.4 million of SPRANS funding to four areas:

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

Legislative Directives

Topics outlined in the authorizing legislation for SPRANS include:

- *Genetics*—projects to improve access to genetic counseling and services for those at-risk of having a genetic condition and their families;
- *Hemophilia*—projects to improve the quality of care in 135 hemophilia treatment centers serving 33,000 patients with hemophilia and related blood disorders per year;
- *Training*—projects to support targeted interdisciplinary professional training in areas such as behavioral health, nutrition, public health, and adolescent health. In FY 2016, SPRANS projects trained 9,222 individuals across the country and provided continuing education to 73,548 practicing MCH professionals to improve care and outcomes for MCH populations, including state and local MCH professionals such as Title V leaders and staff, school nurses, and childcare providers;
- *Research and Data*— projects to support 1) translational research to advance MCH science and practice; 2) capacity-building to use data to drive improvements in state Title V programs and outcomes; and 3) The National Survey of Children's Health, which is the only source for annual national and state-by-state data for many Title V outcome and performance measures, as well as for 15 Healthy People Objectives.

Critical and Emerging Issues in Maternal and Child Health

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

- *Maternal mortality –*

- *AIM* - SPRANS supports the Alliance for Innovation in Maternal Health (AIM) to reduce maternal mortality in the United States. Building on the early successes in California, AIM is now working with 23 states and has implemented maternal safety bundles in more than 1,030 birthing hospitals across the country reaching nearly 2 million annual births or around half of all annual births in the United States. With additional funding provided in FY 2019, AIM will expand to all U.S. States, the District of Columbia, and U.S. territories, as well as tribal entities.
- *State Maternal Health Innovation Grants* – FY 2019 SPRANS funding will also support new State Maternal Health Innovation Grants that will support state-led demonstrations to implement evidence-based interventions to address critical gaps in maternity care service delivery and reduce maternal mortality.

- *Opioids* –SPRANS supported AIM to develop a safety bundle on the prevention and treatment of opioid abuse during pregnancy as well as neonatal abstinence syndrome.

Collaborative Learning across the States

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

- Provided a platform for the 13 states to share best practices and lessons learned with each other, and to learn from national content, methods, and data experts serving as improvement coaches for the states.
- Provided a virtual shared workspace for the states, as well as a data dashboard that provided real-time data to drive real-time improvements.
- Contributed, between 2011 and 2014, to a 30 percent reduction in early elective delivery across the 13 states, averting more than 85,000 early elective deliveries and saving state Medicaid programs hundreds of millions of dollars in unnecessary neonatal intensive care unit (NICU) stays; and a 12 percent reduction in smoking during pregnancy, translating to approximately 18,000 fewer pregnant women smoking across the South.

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

Community Integrated Service Systems (CISS)

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

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

MCH Activities	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
State MCH Block Grant Awards	$556,425	$557,831	$557,831
SPRANS	$83,493	$109,593	$92,593
CISS	$10,276	$10,276	$10,276
Total	**$650,194**	**$677,700**	**$660,700**

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

MCH SPRANS Set-Aside Programs	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
SPRANS – Other	$71,224	$97,224	$80,224
SPRANS - Oral Health	$5,210	$5,250	$5,250
SPRANS – Epilepsy	$3,622	$3,642	$3,642
SPRANS - Sickle Cell	$2,960	$3,000	$3,000
SPRANS - Fetal Alcohol Syndrome Demo	$477	$477	$477
Total SPRANS	**$83,493**	**$109,593**	**$92,593**
CISS	**$10,276**	**$10,276**	**$10,276**

Funding History

FY	Amount
FY 2016	$638,200,000
FY 2017	$641,700,000
FY 2018	$650,194,233
FY 2019	$677,700,000
FY 2020	$660,700,000

Budget Request

The FY 2020 President's Budget Request is $660.7 million, a $17 million decrease from the FY 2019 Enacted level. The funding will continue to prioritize support for State MCH Block Grant formula awards and CISS. Funding will also support efforts, through SPRANS, to address maternal mortality by expanding access to quality, evidence-based care for women of childbearing age through State Maternal Health Innovation grants and continued implementation of the Alliance for Innovation in Maternal Health Initiative maternal safety bundles in all 50 U.S. states, the District of Columbia, and the territories. HRSA will not fund new grants or re-compete SPRANS awards that are due for renewal in FY 2020. This will affect activities, including programs that support childhood obesity, early childhood development, access to genetics services, training to ensure an adequate maternal and child health workforce, and research to inform pregnancy-related care and maternal health, among other topics.

In addition, HRSA will continue to:

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

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

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
10.4: The percentage of children served by the Maternal and Child Health Block Grant[114]	FY 2017: Result: 57% Target: N/A[115]	55%	58%	+3 percentage points

[114] The term "children" includes both infants and children (0-21 years of age).
[115] This is a new performance measure for FY 2020.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
10.5: The percentage of pregnant women served by the Maternal and Child Health Block Grant	FY 2017: Result: 86% Target: N/A[116]	84%	87%	+3 percentage points
10.IV.B.1: Decrease the ratio of the Black infant mortality rate to the White infant mortality rate *(Output)*	FY 2017: 2.2 to 1[117,118] Target: 2.0 to 1 (Target Not Met)	2.0 to 1	2.0 to 1	Maintain
10.III.A.1: Reduce the infant mortality rate *(Outcome)*	FY 2017: 5.8 per 1,000[117] Target: 5.8 per 1,000 (Target Met)	5.5 per 1,000	5.5 per 1,000	Maintain
10.III.A.2: Reduce the incidence of low birth weight births *(Outcome)*	FY 2017: 8.3% Target: 7.8% (Target Not Met)	7.8%	8.0%	+ 0.2 percentage points
10.III.A.3: Increase percent of pregnant women who received prenatal care in the first trimester *(Outcome)*	FY 2017: 77%[118] Target: 76% (Target Exceeded)	79%	80%	+1 percentage points

[116] This is a new performance measure for FY 2020.
[117] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018.Data are from the Multiple Cause of Death Files, 1999-2017,as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html
[118] Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, Drake P. Births: Final data for 2017. National Vital Statistics Reports; vol 67 no 8. Hyattsville, MD: National Center for Health Statistics. 2018.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
10.3: Reduce the maternal mortality rate. (deaths/100,000 live births) *(Outcome)*[119]	FY 2014: 22.2 per 100,000 (baseline)[120] (Target Not in Place)	N/A[121]	N/A[121]	N/A

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

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

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

Grant Awards Table – Maternal and Child Health Block Grant

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	59	59	59
Average Award	$9,241,263	$9,242,754	$9,242,754
Range of Awards	$147,214 - $39,725,961	$147,238- $39,736,958	$147,238- $39,161,382

Grant Awards Table – SPRANS

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	255	253	209
Average Award	$291,506	$395,406	$397,310
Range of Awards	$11,672-$3,500,000	$11,672-$3,500,000	$11,672-$3,000,000

Grant Awards Table – CISS

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	14	14	14
Average Award	$665,487	$672,352	$672,352
Range of Awards	$275,000 - $2,700,000	$275,000-$2,700,000	$275,000- $2,700,000

State Table

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2018[122]	FY 2019[123]	FY 2020[124]	Difference +/- 2019
Alabama	11,411,388	11,413,002	11,448,395	35,393
Alaska	1,078,526	1,078,668	1,103,425	24,757
Arizona	7,407,455	7,409,669	7,395,161	(14,508)
Arkansas	6,972,695	6,973,734	6,940,338	(33,396)
California	39,725,961	39,736,958	39,161,382	(575,576)
Colorado	7,403,844	7,404,893	7,326,195	(78,698)
Connecticut	4,671,480	4,672,088	4,651,501	(20,587)
Delaware	1,993,981	1,994,181	2,023,201	29,020
District of Columbia	6,910,703	6,910,864	6,942,285	31,421
Florida	19,603,562	19,608,723	19,731,243	122,520
Georgia	17,153,951	17,157,394	17,054,439	(102,955)
Hawaii	2,160,950	2,161,183	2,139,043	(22,140)
Idaho	3,275,509	3,275,937	3,288,409	12,472
Illinois	21,241,852	21,245,056	21,108,918	(136,138)
Indiana	12,280,810	12,282,624	12,274,923	(7,701)
Iowa	6,508,785	6,509,382	6,507,569	(1,813)
Kansas	4,777,544	4,778,234	4,720,998	(57,236)
Kentucky	11,100,869	11,102,259	11,186,896	84,637
Louisiana	12,248,060	12,249,732	12,515,267	265,535
Maine	3,313,411	3,313,658	3,298,879	(14,779)
Maryland	11,762,222	11,763,180	11,829,459	66,279
Massachusetts	11,142,070	11,143,218	11,127,472	(15,746)
Michigan	18,871,595	18,874,318	18,837,589	(36,729)
Minnesota	9,104,300	9,105,262	9,088,379	(16,883)
Mississippi	9,235,413	9,236,649	9,252,780	16,131

[122] The poverty-based allocation for FY 18 uses 3-year poverty data from the American Community Survey, 2013-2015

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

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

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2018[122]	FY 2019[123]	FY 2020[124]	Difference +/- 2019
Missouri	12,202,566	12,204,137	12,209,488	5,351
Montana	2,301,521	2,301,757	2,277,248	(24,509)
Nebraska	4,026,912	4,027,334	4,021,231	(6,103)
Nevada	2,126,003	2,126,779	2,125,427	(1,352)
New Hampshire	1,973,578	1,973,740	1,953,243	(20,497)
New Jersey	11,650,677	11,652,411	11,643,660	(8,751)
New Mexico	4,130,727	4,131,531	4,170,776	39,245
New York	38,236,475	38,241,542	38,299,788	58,246
North Carolina	17,424,544	17,427,523	17,449,352	21,829
North Dakota	1,739,627	1,739,742	1,746,373	6,631
Ohio	22,104,518	22,107,662	22,142,432	34,770
Oklahoma	7,056,875	7,058,035	7,189,184	131,149
Oregon	6,268,884	6,269,853	6,188,443	(81,410)
Pennsylvania	23,748,778	23,751,574	23,868,653	117,079
Rhode Island	1,647,805	1,648,036	1,631,561	(16,475)
South Carolina	11,505,024	11,506,540	11,479,141	(27,399)
South Dakota	2,175,277	2,175,480	2,190,449	14,969
Tennessee	11,887,756	11,889,801	11,831,875	(57,926)
Texas	34,534,092	34,543,344	34,946,424	403,080
Utah	6,164,172	6,164,834	6,117,563	(47,271)
Vermont	1,649,612	1,649,708	1,651,030	1,322
Virginia	12,287,553	12,289,097	12,342,158	53,061
Washington	8,902,428	8,903,909	8,781,425	(122,484)
West Virginia	6,117,166	6,117,683	6,164,666	46,983
Wisconsin	10,923,868	10,925,098	10,844,449	(80,649)
Wyoming	1,195,544	1,195,641	1,203,472	7,831
SUBTOTAL	**525,338,918**	**525,423,657**	**525,423,657**	-
American Samoa	490,711	490,790	490,790	-
Guam	757,877	757,999	757,999	-
Marshalls	228,997	229,034	229,034	-

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2018[122]	**FY 2019[123]**	**FY 2020[124]**	**Difference +/- 2019**
Micronesia	517,973	518,057	518,057	-
Northern Marianas	463,450	463,525	463,525	-
Palau	147,214	147,238	147,238	-
Puerto Rico	15,800,897	15,803,445	15,803,445	-
Virgin Islands	1,488,491	1,488,731	1,488,731	-
SUBTOTAL	**19,895,610**	**19,898,819**	**19,898,819**	**-**
TOTAL Resources	**545,234,528**	**545,322,476**	**545,322,476**	**-**

Autism and Other Developmental Disabilities

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$48,899,000	$50,599,000	---	-$50,599,000
FTE	7	7	---	-7

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

FY 2020 Authorization ..... Expired

Allocation Methods:

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

Program Description and Accomplishments

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

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

Training Programs

The program has two main training components, the Leadership Education in Neurodevelopmental and Other Related Disabilities (LEND) program and the Developmental-Behavioral Pediatrics (DBP) Training program. LEND programs provide interdisciplinary training to enhance the clinical expertise and leadership skills of professionals dedicated to caring for children with neurodevelopmental and other related disabilities including autism. DBP trains the next generation of leaders in developmental-behavioral pediatrics and provides pediatric practitioners, residents, and medical students with essential biopsychosocial knowledge and clinical expertise. For the most recent evaluation period, FY 2014-FY 2016, the LEND and DBP programs collectively:

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

Research

To improve the health and well-being of children with ASD and other DDs, HRSA supports research networks, single investigator-led autism innovation projects, field-initiated research and secondary data analyses projects. HRSA supports research and development of reliable screening tools and guidelines for ASD and other developmental disabilities and the implementation of interventions to improve the physical and behavioral health of individuals with ASD and other DDs across the life course as well as research to address barriers to diagnosis and access to care for underserved populations. These research investments address the Interagency Autism Coordinating Committee Strategic Plan research questions around improving early identification and advancing effectiveness of interventions and services for children with ASD and other developmental disabilities. Recent accomplishments from FY 2014-FY 2016 include:

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

State Systems Grants

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

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

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

Funding History

FY	Amount
FY 2016	$47,099,000
FY 2017	$46,985,000
FY 2018	$48,899,000
FY 2019	$50,599,000
FY 2020	---

Budget Request

The FY 2020 President's Budget Request is $0. The FY 2020 President's Budget Request is a decrease of $50.6 million from the FY 2019 Enacted level. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2019 Target +/- FY 2020 Target
50.I.A.1 Percent of long-term trainees (LEND, DBP) working with underserved populations, 5 years post-training.	FY 2016[125]: LEND 74.7% DBP 100% (Target 0.5 percentage point increase from prior year - LEND: Target not met; DBP: Target exceeded)	Maintain FY 2018 Result[126]	N/A	N/A

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

[126] The FY2017 target for this measure is set at a 0.5 percentage point increase in the prior year. A continued increase is not anticipated in FY 2018 and therefore the target has been set to maintain the results that will be reported in FY2017.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2019 Target +/- FY 2020 Target
50.I.A.2 Percent of LEND long-term trainees who at 1, 5, and 10 years post-training, work in an interdisciplinary manner to serve the MCH population	FY 2016 Result: 1 year = 78.6 % 5 years = 76.4% (Target 0.25 percentage point increase from prior year - 1 year: Target exceeded; 5 years: Target not met)	Maintain FY 2018 Result[127]	N/A	N/A
50.I.A.3 Percent of MCHB Autism research programs supporting the production of scientific publications (*Developmental*)	Baseline data for FY 2017 will be available in 2019	N/A	N/A	N/A

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
LEND	$32,339,281	$33,500,000	---
DBP	$2,303,116	$2,278,982	---
Research	$7,510,047	$7,518,473	---
State Systems	$1,680,000	$1,860,000	---
Resource Centers	$1,076,000	$896,000	---
Number of Awards	78	83	**---**
Average Award	$575,749	$554,859	**---**

[127] The FY2017 target for this measure is set at a 0.25 percentage point increase in the prior year. A continued increase is not anticipated in in FY 2018 and therefore the target has been set to maintain the results that will be reported in FY2017.

Sickle Cell Disease Treatment Demonstration Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$4,455,000	$4,455,000	---	-$4,455,000
FTE	2	2	---	-2

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

FY 2020 Authorization .....Expired

Allocation Methods:

- Competitive cooperative agreement
- Contract

Program Description and Accomplishments

The Sickle Cell Disease Treatment Demonstration Program (SCDTDP) improves access to care and health outcomes for individuals with sickle cell disease, a genetic condition that results in abnormal red blood cells that can block blood flow to organs and tissues, causing anemia, periodic pain episodes, damage to tissues and vital organs, and increased susceptibility to infections and early death. While life expectancy of individuals with sickle cell disease has increased, affected populations have not benefitted equally from therapies. For example, hydroxyurea was approved by the FDA in 1998; however many patients who could benefit from hydroxyurea do not have access to it. Barriers to access include a lack of knowledge of the benefits and a limited number of providers prescribing hydroxyurea. SCDTDP grantees work to address these barriers and improve the prevention and treatment of the complications of sickle cell disease by:

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

In FY 2014-2016, the four SCDTDP grantees developed regional clinical networks, covering 25 states, Washington, DC, and 2 territories, to improve the delivery of care for patients with sickle

cell disease, primarily by training health professionals and supporting regional coordination for service delivery through telementoring, and improve data collection to inform the delivery of care. As a result, almost 11,000 patients with sickle cell disease received care through the four regional clinical networks. In FY 2017, the program was recompeted and five organizations received grants to develop Regional Coordinating Centers that cover the United States. The program supports at least 30 states where more than 50 percent of the 100,000 individuals with sickle cell disease live in the United States.

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

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

Funding History

FY	Amount
FY 2016	$4,455,000
FY 2017	$4,444,000
FY 2018	$4,455,000
FY 2019	$4,455,000
FY 2020	---

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2019 Target +/- FY 2020 Target
51.1: Number of sickle cell patients served by SCDTDP network providers in the past year (*Developmental*)	Baseline data for FY2018 will be available December 2019	N/A	N/A	---

Budget Request

The FY 2020 Budget requests $0, which is a decrease of $4.5 million from the FY 2019 Enacted level. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

Grant Awards Table

	FY 2018 Final	**FY 2019 Enacted**	**FY 2020 President's Budget**
Number of Awards	5	5	---
Average Award	$694,870	$714,993	---
Range of Awards	$347,436 - $1,042,304	$347,436-$1,042,304	---

James T. Walsh Universal Newborn Hearing Screening

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$17,818,000	$17,818,000	---	-$17,818,000
FTE	4	4	---	-4

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

FY 2020 Authorization $18,628,145

Allocation Methods:

- Competitive grant
- Cooperative agreement

Program Description and Accomplishments

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

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

The UNHS Program funds 59 competitive grants to states and territories to develop comprehensive and coordinated statewide EHDI systems of care as well as two technical resource centers that support these efforts in addition to empowering families to serve as leaders in the EHDI system. Funding also supports supplemental awards to 12 Leadership Education in Neurodevelopmental and Related Disabilities training programs supported by the Autism and Developmental Disabilities program to train future leaders in pediatric audiology. Since the program's inception, states and territories have had significant success in identifying newborns and infants with permanent hearing loss. In 2016, 98 percent of infants were screened for hearing loss. In addition, 62.7 percent of infants were diagnosed in accordance with expert

guidelines, compared to 60.7 percent in FY 2015. Additionally, the UNHS program continues to work with states to meet the Healthy People 2020 objectives of screening no later than one month of age, conducting audiologic evaluations no later than 3 months of age, and enrollment in early intervention services no later than 6 months of age (1-3-6 objectives). In 2016, 94.8% of infants were screened before one month of age, 75.9% were evaluated before 3 months of age, and 67.3% were enrolled in early intervention before six months of age. A lack of comprehensive data reporting requirements for service providers in states and variability across states in timely access to such providers, among other factors, continues to be a challenge.

The UNHS program continues to focus on supporting early screening and diagnosis as recommended by Healthy People 2020. Although the program did not meet the ambitious targets set for the 1-3-6 objectives for FY 2016, overall system improvements have led to more infants being screened and identified as deaf or hard of hearing and fewer infants being lost to follow-up (when an infant does not receive the recommended follow-up services) or lost to documentation (when an infant has received services, but results have not been reported to the EHDI program and, therefore, cannot be documented). In addition, the UNHS Program encourages grantees to develop an integrated EHDI health information system that allows communication and protected data sharing among health care providers to ensure that newborns and infants receive pertinent screenings and follow-up services.

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

Funding History

FY	Amount
FY 2016	$17,818,000
FY 2017	$17,775,000
FY 2018	$17,818,000
FY 2019	$17,818,000
FY 2020	---

Budget Request

The FY 2020 Budget requests $0, which is a decrease of $17.8 million from the FY 2019 Enacted level. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2019 Target +/- FY 2020 Target
13.2: Increase the percentage of infants with hearing loss enrolled in early intervention before six months of age. *(Output)*	FY 2016: 67.3% [128, 129] Target: 72% (Target Not Met)	72%	N/A	---
13.III.A.1: Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by three months of age. *(Output)*	FY 2016: 75.9128 Target: 77% (Target Not Met)	77%	N/A	---
13.III.A.3: Percentage of infants screened for hearing loss prior to one month of age. *(Output)*	FY 2016: 94.8% 128 Target 98% (Target Not Met)	95%	N/A	---
13.III.A.4 Percentage of families with deaf or hard of hearing newborns and infants that are active participants and leaders within their state/territory UNHS program and policy activities. (*Developmental*)	Baseline data for FY 2018 will be available in 2019	N/A	N/A	---

[128] 2016 CDC EHDI Hearing Screening & Follow-up Survey (HSFS); . The CDC has been collecting data annually since 2005. Baseline updated to reflect annual data collection. Previously, data was collected by the National Center for Hearing Assessment and Management.

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

Grant Awards Table[130]

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	59	59	---
Average Award	$226,139	$226,139	---
Range of Awards	$26,538-$250,000	$26,538-$250,000	---

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

Emergency Medical Services for Children

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$22,134,000	$22,334,000	$---	-$22,334,000
FTE	6	6	---	-6

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

FY 2020 Authorization .....Expired

Allocation Method

- Competitive grant/cooperative agreement
- Contract

Program Description and Accomplishments

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

Additionally, EMS agencies and hospital emergency departments often lack the necessary equipment to treat children adequately. The EMSC program works to ensure that ambulances and emergency rooms are equipped to deal with pediatric medical emergencies and trauma; EMS personnel receive appropriate training for pediatric emergencies; and guidelines and agreements are in place to ensure the safe and effective transfer of children from one hospital to another as necessary.

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

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

adverse events and improve the delivery of timely, effective care to children in a medical emergency.[131]

- Between 2006 and 2017, the number of states that established a pediatric medical recognition program more than doubled from four to 12. These 12 states established a state or regional entity to perform on-site assessments of hospital emergency departments to assure the presence of critical resources and protocols needed to manage pediatric medical emergencies.[132]

The EMSC program supports the Pediatric Emergency Care Applied Research Network (PECARN) Program, which enables rigorous clinical research using pooled samples of pediatric patients across institutions to advance EMSC science and clinical practice. For example, the Network examined the impact of giving fluids intravenously to children with diabetic ketoacidosis (DKA), a clinical intervention that was often avoided for fear of causing brain injury. The study found that fluid hydration can be safe for children with DKA, allowing clinicians to administer the fluids on an individualized basis, which may prevent cognitive impairment and decrease the risk of other complications in these children.[133] In addition, the EMSC program funds Targeted Issues grants, which support researchers to expand the evidence base in pediatric emergency medicine. For example, the Pediatric Evidence-Based Guidelines: Assessment of EMS System Utilization in States (PEGASUS) project developed four evidence-based guidelines to help prehospital health care providers deliver optimal care to children during airway management, allergic reactions, spinal care, and shock. The PEGASUS project then tested the application of these and five pre-existing guidelines in the management of pediatric asthma, bronchiolitis, croup, seizures, and pain in several states.[134]

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

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

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

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

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

Funding History

FY	Amount
FY 2016	$20,162,000
FY 2017	$20,113,000
FY 2018	$22,134,000
FY 2019	$22,334,000
FY 2020	---

Budget Request

The FY 2020 President's Budget Request is $0. The FY 2020 Request is a $22.3 million decrease from the FY 2019 Enacted Budget. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2019 Target +/- FY 2020 Target
14.3: The percentage of responding EMS agencies nationwide that have a designated individual who coordinates pediatric emergency care.	FY 2018: Result 23% Target: N/A (Baseline)[135]	N/A	N/A	---
14.4: Percent of responding hospitals nationwide that have written interfacility transfer guidelines that cover pediatric patients and that include specific components of transfer.	FY 2018: Result: 58% Target: N/A (Baseline)[136]	N/A	N/A	---
14.5: Number of children enrolled in Pediatric Emergency Care Applied Research Network (PECARN) studies.	FY 2017 Result: 117,995 Target: N/A (Baseline)[137]	N/A	N/A	---

[135] This is a new performance measure for FY 2020.
[136] This is a new performance measure for FY 2020.
[137] This is a new performance measure for FY 2020.

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	74	74	---
Average Award	$258,957	$255,263	---
Range of Awards	$130,000-$3,700,000	$130,000-$3,000,000	---

Healthy Start

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$110,300,000	$122,500,000	$122,500,000	---
FTE	15	15	15	---

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

FY 2020 Authorization ..... Expired

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

Program Description

The Healthy Start program provides grants to support community-based strategies to reduce disparities in infant mortality and improve perinatal outcomes for women and children in high-risk communities throughout the nation. Major and persistent racial and ethnic disparities exist for infant mortality, maternal mortality, and other adverse outcomes such as preterm birth and low birth weight.

Following a plateau between 2000 and 2005, the infant mortality rate declined 14 percent overall and 18 percent for non-Hispanic black infants between 2005 and 2016. However, the non-Hispanic black infant mortality rate continues to be more than twice that for non-Hispanic whites. The five leading causes of infant mortality include birth defects, preterm birth and low birthweight, Sudden Infant Death Syndrome, maternal pregnancy complications, and injuries. There is a potential for reducing each of these causes of death, particularly among low-income families and communities. Preterm birth (defined as birth at less than 37 completed weeks of gestation) is a key risk factor for infant death. More than two-thirds of all infant deaths occur among infants born preterm. After declining from 2007 to 2014, the U.S. preterm birth rate increased nearly 3 percent from 9.57 percent in 2014 to 9.85 percent in 2016. Non-Hispanic black women continue to be more likely to experience preterm birth than non-Hispanic white women (13.77 and 9.04 percent, respectively, in 2016). Greater rates of preterm birth and preterm-related infant deaths among non-Hispanic blacks account for over half of the infant mortality gap compared to non-Hispanic whites. Healthy Start aims to reduce these disparities by empowering high-risk women and their families to identify and access needed services to improve the health of mothers and children before, during, and after pregnancy.

In FY 2018, Healthy Start funded 100 competitive grants that reach 127 counties in 37 States and the District of Columbia. Healthy Start targets communities with infant mortality rates that are at

least 1½ times the U.S. national average and/or with high indicators of poor perinatal outcomes, particularly among non-Hispanic Black and other disproportionately affected populations. Grantees use five approaches to reduce infant mortality through individual services and community support to women, infants, and families:

1) Improve women's health before, during, and between pregnancies;
2) Promote quality services;
3) Strengthen family resilience;
4) Achieve collective impact, as a result of organizations from different sectors agreeing to solve a specific social problem using a common agenda, alignment of efforts, and use of common measures of success[138]; and
5) Increase accountability through ongoing quality improvement, performance monitoring, and evaluation.

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

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

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

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

[138] Kania J and Kramer M. Collective Impact. *Stanford Social Innovation Review*. 2011; 60.

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

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

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

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

Program Accomplishments

- HRSA transformed Healthy Start in 2014 to apply lessons from emerging research, act on national recommendations, and improve accountability. In 2016, grantees reported an overall infant mortality of 5.35 deaths per 1,000 live births, below the national average of

5.87 per 1,000 live births, despite serving communities that historically had very high rates of infant mortality.

- An important risk factor for infant mortality is the adequacy of prenatal care. Healthy Start facilitates access to prenatal care for disadvantaged and high-risk women. In 2016, 89 percent of Healthy Start participants initiated prenatal care during the first trimester, a notable increase from 68.3 percent in 2015.
- Low birth weight, or birth weight less than 2,500 grams, is a major contributor to infant mortality and has been reduced among Healthy Start participants. In 2016, 9.9 percent of infants born to Healthy Start participants were low birth weight, compared to 10.4 percent of births to Healthy Start participants in 2015.

Consistent with the commitment to data-driven and evidence-based decision-making, in 2017 the Healthy Start program initiated a rigorous impact evaluation plan to determine the effect of the program on changes in participant-level characteristics, including behaviors, service use, and health outcomes. By collaborating with the Centers for Disease Control and Prevention (CDC) and state vital records offices, the evaluation includes non-participant comparison groups through linked Vital Statistics and CDC Pregnancy Risk Assessment Monitoring System (PRAMS) data that will allow for rigorous assessments of program impact. Final results are expected in the Fall of 2019.

Funding History

FY	Amount
FY 2016	$103,500,000
FY 2017	$118,251,000[139]
FY 2018	$110,300,000
FY 2019	$122,500,000
FY 2020	$122,500,000

Budget Request

The FY 2020 Budget requests $122.5 million for the Healthy Start program, the same as the FY 2019 Enacted level. In FY 2020, the program will continue to serve women and families across the nation through the approximately 100 new grants awarded in the FY 2019 funding cycle. In addition, $12 million of the FY 2020 request will support efforts to address maternal mortality by continuing to support the staffing of a maternal-child advance practice health professional at Healthy Start sites to provide direct, on-site access to well woman care and maternity care services for high-risk clients. This support will help reduce barriers in access to care and better address health disparities among high-risk and underserved women. Healthy Start expects to serve at least 70,000 participants in FY 2020 with case managed services. Recognizing that improving birth outcomes begins with improving women's health before, during, and between pregnancies, funding will continue to strengthen services and supports to improve women's health.

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

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

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

Outcomes and Outputs Tables[140]

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2019 Target +/- FY 2020Target
12. III.A.1: The percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester. *(Outcome)*	FY 2016: 89%[141] Target: 75% (Target Exceeded)	80%	80%	Maintain
12.III.A.2. Percent of singleton births weighing less than 2,500 grams (low birth weight) (*Outcome*)	FY 2016: 9.9%[142] Target: 9.6% (Target not Met)	9.6%	9.6%	Maintain
12.E.2 The number of persons case managed in the Healthy Start Program[143]	FY 2016: 75,463 Target 63,000 (Target Exceeded)	69,000	70,000	+1,000

[140] There are limitations that should be considered when interpreting the estimates, such as these data are obtained by self-report and may be underreported or over reported.
[141] Note that the FY2016 result was reported as 80% in the FY2018 Congressional Justification. HRSA has updated this result to 89% based on more recent data.
[142] Note that the FY2016 result was reported as 10% in the FY2018 Congressional Justification. HRSA has updated this result to 9.9% to be more precise.
[143] This measure does not include clients served through Addressing and Preventing Lead Exposure through Healthy Start, the program to address lead exposure in Flint, MI.

Grant Awards Table[144]

	FY 2018 Final	FY 2019 Enacted[145]	FY 2020 President's Budget
Number of Awards	100	100	100
Average Award	$986,761	$1,070,000	$1,100,000
Range of Awards	$304,144 - $1,898,600	$1,070,000	$1,100,000

[144] Does not include grant offsets. Does not include amounts awarded for two technical assistance awards that are both approximately $2 million, the HS CoIIN and Supporting Healthy Start Performance Project.
[145] Does not include $4.9M for 13 awards, funded for 5 months, to get on cycle with remaining 87 awards in April.

Heritable Disorders in Newborns and Children

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$15,788,085	$16,383,000	---	-$16,383,000
FTE	4	4	---	-4

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

FY 2020 Authorization……Expired

Allocation Methods:

- Contract
- Competitive grant/cooperative agreement

Program Description and Accomplishments

The Heritable Disorders in Newborns and Children program focuses on reducing the morbidity and mortality caused by heritable disorders in newborns and children by supporting state and local public health agencies' ability to provide screening, counseling, and health care services. Four million newborns each year are screened for at least 29 of the 35 core conditions on the Recommended Uniform Screening Panel (RUSP), a list of conditions recommended by the Secretary of HHS for state newborn screening programs. Babies testing positive for one of these conditions receive early intervention and treatment to prevent serious problems such as brain damage, organ damage, and even death. Newborn screening saves or improves the lives of more than 12,000 babies in the United States each year. The Heritable Disorders in Newborns and Children program was authorized in 2000 and was reauthorized by the Newborn Screening Saves Lives Reauthorization Act of 2014.

The program is composed of six different projects.

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

- The **Quality Improvement in Newborn Screening Program** supports states to improve the outcomes of newborns with conditions identified through newborn screening by improving:
    - the amount of time it takes to identify infants at high risk for having one of these conditions;
    - the processes used for detecting out-of-range results; the procedures for reporting out-of-range results to providers; and
    - the methods state newborn screening programs use to confirm diagnoses.

  In addition, the program addresses emerging issues, or any other newborn screening process or procedure that could negatively affect the quality, accuracy, or timeliness of newborn screening. The program supports 30 states to use quality improvement methodology to improve the newborn screening system.
- The **Newborn Screening Family Education Program** seeks to increase awareness, knowledge, and understanding of newborn screening for parents, families, patient advocacy and support groups, as well as the public at large. The purpose of this program is to develop and deliver educational programs about newborn screening, counseling, testing, follow-up, treatment, and specialty services to parents, families, patient advocacy and support groups.
- The **Regional Genetics Networks** address the challenges of enhancing, improving, or expanding access to screening, counseling, and health care services for newborns and children having or at risk for genetic disorders. The networks link patients to genetic services and provide resources to genetic service providers, public health officials and families.
- **Severe Combined Immunodeficiency (SCID) Implementation Program**: SCID is a primary immune deficiency characterized by the lack of a functioning immune system that, if untreated, leads to death in infancy. The program works to increase awareness and knowledge about SCID and newborn screening for SCID among parents, families, health care providers, public health professionals, and the public; provide education, training, and support for newborn screening programs; link children with SCID and their families to clinical services; and improve clinical care through education and training for providers caring for individuals with SCID.
- The **Newborn Screening State Evaluation Program** supports state newborn screening programs to use newborn screening quality indicator information to evaluate the effectiveness of their state newborn screening systems in reducing morbidity and mortality caused by heritable disorders. Newborn screening quality indicators provide longitudinal comparisons within newborn screening programs and allow data to be aggregated at a national level. Quality indicators cover actions within the newborn screening system including assessing borderline results, eligible newborns, specimen collection, improper transport, and time of medical intervention.

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

recommend updates to the RUSP, and considers ways to ensure state and territory capacity to screen for RUSP conditions.

Since 2009, the program also supports the Clearinghouse of Newborn Screening Information as a central source of current educational and family support information, materials, resources, research, and data on newborn screening. The Clearinghouse is interactive and contains links to various resources including government-sponsored, non-profit organizations, laboratories, and other organizations with expertise in newborn screening; research-based information on newborn screening tests currently available throughout the United States; and information about newborn conditions and screening services available in each state.

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

Funding History

FY	Amount
FY 2016	$13,883,000
FY 2017	$13,850,000
FY 2018	$15,788,085
FY 2019	$16,383,000
FY 2020	---

Budget Request

The FY 2020 Budget requests $0, which is a decrease of $16.4 million from the FY 2019 Enacted level. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	15	26	---
Average Award	$822,667	$522,864	---
Range of Awards	$59,939-$3,300,000	$150,000-$3,300,000	---

Pediatric Mental Health Care Access

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$10,000,000	$10,000,000	---	-$10,000,000
FTE	1	2	---	-2

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

FY 2020 Authorization……...$9,000,000

Allocation Method

- Competitive cooperative agreement

Program Description and Accomplishments

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

A total of 13–20 percent of children living in the United States experience a mental disorder in a given year, and surveillance during 1994–2011 has shown the prevalence of these conditions to be increasing.[146] However, between 2010 and 2012, the percent of youth receiving any outpatient mental health service was estimated to be 13.3 percent.[147]

Compounding this, 33.6 percent of the U.S. population lives in a designated Mental Health Professional Shortage Area (population of designated MH HPSAs/U.S. population as of

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

September 30, 2018) and only 25.6 percent of the need for mental health care in these Mental Health Professional Shortages Areas has been met.[148] Primary care physicians in these areas are often the first to identify behavioral health disorders and provide services. These primary care providers are able to identify severe behavioral health problems, but often have difficulty in identifying milder cases. This under-identification and lack of access to needed services may lead to conditions severe enough to impair child, adolescent, and family functioning, school performance, and safety.

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

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

Funding History

FY	Amount
FY 2018	$10,000,000
FY 2019	$10,000,000
FY 2020	---

Budget Request

The FY 2020 President's Budget requests $0 for the Pediatric Mental Health Care Access Program, which is a decrease of $10 million from the FY 2019 Enacted level. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

[148] Health Resources and Services Administration. Bureau of Health Workforce. Designated Health Professional Shortage Areas Statistics (2018). Retrieved 10/2018.

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	18	21	---
Average Award	$439,658	$438,850	---
Range of Awards	$378,794 – $445,000	$378,794 – $445,000	---

Screening and Treatment for Maternal Depression and Related Behavioral Disorders

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$5,000,000	$5,000,000	---	---
FTE	0	1	0	-1

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

FY 2020 Authorization……...……..$5,000,000

Allocation Method

- Competitive cooperative agreement

Program Description and Accomplishments

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

This program improves the mental health and well-being of pregnant and postpartum women and the social and emotional development of their infants. Experienced by one in seven women,[149] depression is the most common complication of pregnancy and within the first year of delivery.[150] Additionally, substance use can co-occur with mental disorders and is at least as common as many of the medical conditions typically screened for and managed during pregnancy.[151] These issues affect not only the mother, but can also affect the child's cognitive and emotional development. Intervening early and offering integrated services and support can prevent or reverse these affects.

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

Despite the importance of screening and early intervention, these services are often unavailable for front-line health care providers. A nationwide shortage of psychiatrists, especially perinatal psychiatrists, compounds this issue. Women in rural and medically underserved areas are especially vulnerable to these shortages and experience poorer health outcomes than urban women[152] [153].

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

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

Funding History

FY	Amount
FY 2018	$5,000,000
FY 2019	$5,000,000
FY 2020	---

Budget Request

The FY 2020 Budget requests $0 for the Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program, which is a decrease of $5 million from the FY 2019 Enacted level. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

[152] Alliance for Health Policy. 2017. *The Sourcebook: Essentials of Health Policy. Ch. 8- Mental Health and Substance Abuse*. Retrieved 12/2017

[153] The American College of Obstetricians and Gynecologists 2014 Committee Opinion (Reaffirmed 2018), Health Disparities in Rural Women. Retrieved 5/2018.

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	7	7	---
Average Award	$645,299	$646,210	---
Range of Awards	$627,525-$650,000	$627,525-$650,000	---

Family-To-Family Health Information Centers

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
Current Law Mandatory Funding	$6,000,000	$6,000,000	---	-$6,000,000
Proposed Law Mandatory Funding	---	---	$6,000,000	+$6,000,000
Total	$6,000,000	$6,000,000	$6,000,000	---
FTE	1	1	1	---

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

FY 2020 Authorization……...Expired

Allocation Method ..... Competitive grants

Program Description and Accomplishments

The Family-to-Family Health Information Centers (F2F HICs) Program assists families of children and youth with special health care needs (CYSHCN) to be partners in health care decision making. Staffed by family members who have first-hand experience using health care services and programs for CYSHCN, F2F HICs promote cost-effective, quality health care by providing patient-centered information, education, technical assistance, and peer support to families of CYSHCN and health professionals. Initially authorized by the Deficit Reduction Act of 2005, the program funded one health information center in each of the 50 states and the District of Columbia. Most recently, the Bipartisan Budget Act of 2018 reauthorized the program for FY 2018 and FY2019 at $6 million per year and added the requirement that F2F HICs be developed in all territories and at least one such center be developed for Indian tribes.

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

- Helping families gain the knowledge and skills to make informed health care choices that promote good treatment decisions, cost effectiveness, and improved health outcomes;
- Developing models for building working relationships between families and health professionals to assist in providing appropriate services and information;
- Providing training and guidance to health professionals on the care of CYSHCN;

- Conducting outreach activities to families, health professionals, schools, and other appropriate entities to increase their knowledge of F2F HICs and the resources available for CYSHCN and their families; and
- Enlisting families of CYSHCN and health professionals to staff these efforts.

Research supports the effectiveness of the F2F HIC strategy.[154] Evidence shows CYSHCN experience improved health outcomes and cost-savings when families are empowered to make informed choices about their care and partner with health professionals.[155] Documented outcomes include:

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

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

FY 2018 data will be reported in late 2019.

Funding History

FY	Amount
FY 2016	$5,000,000
FY 2017[156]	$4,655,000
FY 2018	$6,000,000
FY 2019	$6,000,000
FY 2020	$6,000,000

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

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

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

Budget Request

The FY 2020 President's Budget requests $6 million in annual mandatory funding for FY 2020 and FY 2021, totaling $12 million over the two-year period, for the Family-to-Family Health Information Centers (F2F HICs). The FY 2020 President's Budget is the same as the FY 2019 Enacted Level.

	FY 2020	FY 2021	Total Funding
Proposed Mandatory Funding	$6 million	$6 million	$12 million

FY 2020 funding will support 59 F2F HIC grants to enable families of CYSHCN to partner in health care decision making at all levels to improve health outcomes for CYSHCN and achieve cost-savings for families. The FY 2020 funding will help ensure continued delivery of patient-centered information, education, technical assistance, and peer support to families of CYSHCN. These family-staffed centers will provide other enabling support to families and health professionals serving them including training and guidance to health professionals on the care of CYSHCN and building joint working relationships between families and health professionals to improve delivery of appropriate care.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2019 Target +/- FY 2020 Target
15.III.C.1: Number of families with CYSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers (*Output*)	FY2017: 184,002 Target: 166,000 (Target Exceeded)	174,300	184,250	+9,950

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2019 Target +/- FY 2020 Target
15.III.C.2: Number of professionals who serve CYSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers (*Developmental*)	FY 2018 Baseline data available December 2019	N/A	N/A	---
15.III.C.3: Percentage of families with CYSHCN served who report that the information or services received from Family-to-Family Health Information Centers helped prepare them to work with those who serve their children (*Developmental*)	FY 2018 Baseline data available December 2019	N/A	N/A	---
15.III.C.4: Percentage of professionals served who reported the information or services received from the Family-to-Family Health Information Centers helped prepare them to work better with families of CYSHCN and/or others who serve CYSHCN (*Developmental*)	FY 2018 Baseline data available December 2019	N/A	N/A	---

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	59	59	59
Average Award	$96,750	$96,750	$96,750
Range of Awards	$96,750	$96,750	$96,750

Maternal, Infant, and Early Childhood Home Visiting Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 Request +/- FY 2019 President's Budget
Current Law Mandatory Funding	$400,000,000	$400,000,000	$400,000,000	---
Total	$400,000,000	$400,000,000	$400,000,000	---
FTE	42	42	42	---

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

FY 2020 Authorization $400,000,000

Allocation Methods:

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

Program Description

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

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

By providing necessary resources and supports, home visiting empowers families. Evidence-based home visiting can be cost-effective in the long term, with the largest benefits coming through reduced spending on government programs and increased individual earnings.[157]

[157] Michalopoulos, C, et. al. (2017). Evidence on the Long-Term Effects of Home Visiting Programs: Laying the Groundwork for Long-Term Follow-Up in the Mother and Infant Home Visiting Program Evaluation (MIHOPE). OPRE Report 2017-73.

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

- Premature birth, low birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;
- Poverty;
- Crime;
- Domestic violence;
- High rates of high school drop-outs;
- Substance abuse;
- Unemployment; or
- Child maltreatment.[158]

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

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

MIECHV grantees have the flexibility to tailor the program to serve the specific needs of their states and at-risk communities. In order to meet those needs, grantees conduct needs assessments, which will be updated by October 1, 2020, as required under the Bipartisan Budget Act of 2018, to identify eligible at-risk communities, determine priority populations, and choose which approved evidence-based models or promising approaches for home visiting will be used. Grantees work with local implementing agencies to:

- Build infrastructure for implementation of home visiting programs;
- Train a high-quality home visiting workforce;

[158] 42 U.S.C. § 711(b)(1)(A).

- Provide home visiting services to eligible families;
- Establish data reporting, performance measurement, continuous quality improvement, and financial accountability systems; and
- Develop referral networks to enroll families and facilitate service coordination in local communities.

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

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

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

Formula grants to states and territories

In FY 2018, HRSA awarded $361 million in MIECHV formula grants to 56 states, territories, and nonprofit organizations. Grants are generally administered by the lead state agency for home visiting designated by the Governor or can be competitively awarded to a nonprofit organization in those states or territories that opted not to participate in the grant program.

By law, state and territory grantees must spend the majority of their MIECHV funds to implement evidence-based home visiting models, with up to 25 percent of funding available to implement promising approaches for home visiting that undergo rigorous evaluation. In FY 2018, four states implemented and evaluated four promising approaches to better address the needs of their communities.

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

Three percent of funding is set aside for five-year competitive awards available to tribal entities. As of FY 2018, 29 tribal entities had received funding through the Tribal Home Visiting program, administered by ACF. There are currently 23 Tribal Home Visiting program grantees. The Tribal Home Visiting Program is designed to:

- Develop and strengthen tribal capacity to support and promote the health and well-being of American Indian and Alaska Native families through home visiting programs;
- Expand the evidence base around home visiting in tribal communities; and
- Support and strengthen cooperation and linkages between programs that serve Native children and their families.

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

Competitive Innovation Awards

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

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

Program Accomplishments

MIECHV state and territory grantees provided 5.2 million visits from FY 2012 through FY 2018. In FY 2018 states reported serving more than 150,000 parents and children in 888 counties across all 50 states, the District of Columbia, and five territories.[159] This is a 340 percent increase in the number of participants served since FY 2012 (see Tables 1 and 2 below). There was a slight decrease in participants and home visits from FY 2017. This reduction may be due, in part, to transitions in the models being implemented in several states as well as not receiving data from the Commonwealth of the Northern Mariana Islands following reporting delays due to Super Typhoon Yutu. In addition, data from grantees indicate reductions in staffing over the past several years. Staffing reductions in turn reduce the number of participants home visiting programs are able to serve. Tribal grantees provided over 72,000 home visits from FY 2012 to FY 2017 and served over 3,500 parents and children in FY 2017.[160]

[159] FY 2018 data does not include figures for the Commonwealth of the Northern Mariana Islands due to reporting delays related to the impact of Super Typhoon Yutu .

[160] FY 2017 is the most recently available data for Tribal grantees.

Table 1: Number of State/Territory Participants (FY 2012 – FY 2018)[161]

Fiscal Year	Number of Participants
2012	34,180
2013	75,970
2014	115,545
2015	145,561
2016	160,374
2017[162,163]	156,297
2018[164]	150,291

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

Fiscal Year	Number of Home Visits
2012	174,257
2013	489,363
2014	746,303
2015	894,347
2016	979,521
2017[165,166]	942,676
2018[167]	930,595

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

[161] Data in Tables 1 and 2 represent the number of participants and home visits provided by state and territory grantees (does not include tribal data).
[162] Reflects changes HRSA made to reporting definitions beginning in FY 2017clarifying that only participants whose services were directly supported with federal funds should be included in MIECHV reports.
[163] Does not include data from Puerto Rico and the U.S. Virgin Islands due to reporting delays caused by Hurricanes Maria and Irma.
[164] Does not include data from the Commonwealth of the Northern Mariana Islands due to reporting delays caused by Super Typhoon Yutu.
[165] Reflects changes HRSA made to reporting definitions beginning in FY 2017 clarifying that only participants whose services were directly supported with federal funds should be included in MIECHV reports.
[166] Does not include data from Puerto Rico and the U.S. Virgin Islands due to reporting delays caused by Hurricanes Maria and Irma.
[167] Does not include data from the Commonwealth of the Northern Mariana Islands due to reporting delays caused by Super Typhoon Yutu.

MIECHV serves many at-risk families. In FY 2018:

- 71 percent of participating families had household incomes at or below 100 percent of the federal poverty guidelines ($25,100 for a family of four), and 42 percent were at or below 50 percent of those guidelines;
- 27 percent of adult program participants had less than a high school education, and 38 percent had only a high school degree or equivalent; and
- 13 percent of households included pregnant teens; 19 percent of households reported a history of child abuse and maltreatment; and 13 percent of households reported substance abuse.

Performance data collected to fulfill the statutory requirement of a three-year assessment of improvement[168] were most recently updated in FY 2016. These data indicate state, territory, and non-profit grantees demonstrated 98 percent improvement in at least four of the six benchmark areas for demonstrating program improvements as outlined in the legislation:

- Improving maternal and newborn health;
- Preventing child injuries, maltreatment, and emergency department visits;
- Improving school readiness and achievement;
- Reducing crime or domestic violence;
- Improving family economic self-sufficiency; and
- Improving service coordination and referrals for other community resources and supports.

Following a redesign of the MIECHV performance measurement system, awardees began reporting on 19 standardized performance indicators and systems outcome measures in FY 2017. These new performance measures allow grantees to more effectively monitor and understand program performance, and implement continuous quality improvements in home visiting.

The statute requires an evaluation of the MIECHV Program. To fulfill this requirement, the Mother and Infant Home Visiting Program Evaluation (MIHOPE) was initiated in 2011. In February 2015, HHS delivered a Report to Congress that presented the first findings from the study, including an analysis of the states' needs assessments and baseline characteristics of families, staff, local programs, and models participating in the study. MIHOPE found that women enrolled in the evaluation face multiple risk factors that can lead to adverse outcomes for themselves and their children. The study also found that local programs' infrastructure aligns with MIECHV Program expectations and supports quality service delivery for these families. Released in November 2018, findings from the MIHOPE Implementation Report include: that the local programs that participated in MIHOPE served eligible families in disadvantaged communities with high levels of socioeconomic risk; most home visitors were well educated and experienced; local programs focused on improving parenting and child development outcomes; and the tailoring of services to families' needs was especially evident in areas of substance use,

[168] Performance data represent data submitted after three years of program implementation is required per Social Security Act, Title V, § 511(d)(1)(B).

mental health, and intimate partner violence. The MIHOPE Impact Report, released in January 2019, presents evidence that MIECHV funded home visiting services had positive effects for the families that participated in services. The study provides evidence that differences in effects among the evidence-based models are generally consistent with the models' focuses.

Funding History

FY	Amount
FY 2016	$400,000,000
FY 2017[169]	$372,400,000
FY 2018	$400,000,000
FY 2019	$400,000,000
FY 2020	$400,000,000

Budget Request

The Maternal, Infant, and Early Childhood Home Visiting Program is funded at $400 million for each fiscal year through FY 2022. FY 2020 funding will support the state, territory, and tribal administration of locally run voluntary, evidence-based home visiting services for at-risk families that have been proven to prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. This level of funding will provide:

- Awards to 53 state and territory grantees and three non-profit organizations;
- Awards 23 to tribal entities; and
- Support for research, evaluation, and technical assistance for both corrective action and program improvement for state, territory, and tribal MIECHV grantees.

Funds will continue to support the statutory directive for an ongoing portfolio of research and evaluation on home visiting, which includes the MIHOPE Long-Term Follow-Up evaluation, the Home Visiting Research and Development Platform, the Home Visiting Collaborative Improvement and Innovation Network, a study of the home visiting workforce, a multi-site implementation study of Tribal Home Visiting, and a tribal early childhood research center.

Technical assistance to grantees is of vital importance to ensure that home visiting services are provided with quality and fidelity to evidence-based and promising approach home visiting service delivery models. The funding will support contracts for technical assistance to state, territory, and tribal grantees for performance measurement, implementation, data systems, quality improvement, and research and evaluation to help grantees enhance the efficiency and effectiveness of their home visiting programs.

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

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

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2019 Target +/- FY 2020 Target
37.1: Number of home visits to families receiving services under the MIECHV Program.[170] (*Output*)	State/ Territory/ Tribal: FY 2018[171]: 948,120 Target: 960,000 (Target Not Met)	State/ Territory/ Tribal: 960,000	State/ Territory/ Tribal: 960,000	Maintain
37.2: Number and percent of grantees that meet benchmark area data requirements for demonstrating improvement. (*Outcome)*	State/Territory: FY 2016: 55 (98%)[172] Target: 53 (95%) (Target Exceeded) Tribal: FY 2017 24 (96%) Target: 20 (80%) (Target Exceeded)	State/ Territory: 55 (98%) Tribal: 22 (88%)	State/Territory: 55 (98%) Tribal: 22 (88%)	State/Territory: Maintain Tribal: Maintain
37.3: Number of participants served by the MIECHV Program (*Output)*	State/ Territory/Tribal: FY 2018[173]: 153,834 Target: 160,000 (Target Not Met)	State/ Territory/ Tribal: 160,000	State/ Territory/ Tribal: 160,000	Maintain

[170] A home visit is the service provided by qualified professionals, delivered over time within the home to build relationships with the enrolled caregiver and the index child to achieve improved child and family outcomes. The number of "home visits" demonstrates the level of effort and service utilization for all enrollees and index children participating in the MIECHV Program.

[171] Results reflect the most recent data available, which include FY 2018 data for state and territory grants and FY 2017 data for Tribal grants.

[172] Per statute, an initial assessment of improvement occurred after three years of program implementation. Current statute requires the next assessment of improvement following FY2020, and every 3 years thereafter.

[173] Results reflect the most recent data available, which includes FY 2018 data for state and territory grants and FY 2017 data for Tribal grants.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2019 Target +/- FY 2020 Target
37.4: Percent of children enrolled in MIECHV who received daily early language and literacy support from a family member *(Developmental)*	FY 2018: 65.4%[174] (Baseline) (Target Not in Place)	N/A	N/A	---
37.5: Percent of parents enrolled in MIECHV who were screened for depression after enrollment or after giving birth *(Developmental)*	FY 2018: 76.5%[175] (Baseline) (Target Not in Place)	N/A	N/A	---

Grant Awards Tables[176]

	FY 2018 Final[177]	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	79	79	79
Average Award	$4,721,459	$4,594,937	$4,594,937
Range of Awards	$300,000-$21,384,282	$300,000-$21,384,282	$300,000-$21,384,282

[174] Results reflect state and territory grants only and reflect a two-year average from FY 2017 and FY 2018.
[175] Results reflect state and territory grants only and reflect a two-year average from FY 2017 and FY 2018.
[176] Does not include carryover funding.
[177] Includes funding to conduct the statutorily required update to the needs assessment.

Ryan White HIV/AIDS TAB

RYAN WHITE HIV/AIDS

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) funds and coordinates with cities, states, and local clinics/community-based organizations to deliver efficient and effective HIV care, treatment, and support to low-income people living with HIV (PLWH). Nearly two-thirds of clients (patients) live at or below 100 percent of the Federal poverty level and approximately three-quarters of RWHAP clients are racial/ethnic minorities. The RWHAP statute indicates that the program is the "payor of last resort," meaning RWHAP funds can only be used for allowable services not covered by other Federal or state programs, or private insurance. Since 1990, RWHAP has developed a comprehensive system of safety net providers who deliver high quality direct health care and support services to over half a million people living with HIV (PLWH)[178] – more than 50 percent of all people living with diagnosed HIV in the United States.[179]

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

The RWHAP provides HIV care and treatment services to a significantly higher proportion of certain HIV-positive populations than their representation in the epidemic nationally. For example, according to the most recent Centers and Disease Control Prevention (CDC) data, 70 percent of people living with diagnosed HIV in the United States are racial/ethnic minorities, while 73 percent of RWHAP clients are racial/ethnic minorities, exceeding the target by 3 percentage points.[180] Similarly, 24 percent of people living with diagnosed HIV in the United States are women, while 27 percent of RWHAP clients are women, exceeding the target by 3 percentage points.

The RWHAP is critical to ensuring that individuals with HIV are linked to care, retained in care, able to adhere to medication regimens, and ultimately, achieve viral suppression. These steps are not only crucial to ensuring the health outcomes of PLWH but to preventing further transmission of the virus, which furthers the public health goal of ending the HIV epidemic in the United

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[178] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2017. Published December 2017. Accessed December , 2017.
[179] Centers for Disease Control and Prevention. HIV Surveillance Report, 2017; vol. 29. Published November 2018. Accessed November 19, 2018
[180] Centers for Disease Control and Prevention. HIV Surveillance Report, 2017; vol. 29. Published November 2018. Accessed November 19, 2018

States.[181] Research studies demonstrate that PLWH who take HIV medications daily as prescribed, and achieve and then maintain an undetectable viral load, have effectively no risk of sexually transmitting the virus to an HIV-negative partner.[182,183] In the RWHAP, 86 percent of patients receiving RWHAP medical care are virally suppressed[184] compared to the general population of people diagnosed with HIV which have a viral suppression rate of 59.8 percent[185,186] - an outcome measure that demonstrates the success of the program and results in major public health benefits.

According to a *Clinical Infectious Diseases* study, clients receiving care and support at RWHAP-funded facilities are associated with improved outcomes (such as viral suppression), compared to others.[187] Furthermore, RWHAP patients who are receiving medical visits are more likely to reach viral suppression regardless of other health care coverage (e.g. uninsured, Medicaid, Medicare, or private insurance). Improved viral suppression rates reduce the transmission of HIV and result in significant cost-savings to the health care system.[188]

The RWHAP has made tremendous progress toward ending the HIV epidemic in the United States: from 2010 to 2017, HIV viral suppression among RWHAP patients has increased from 70 percent to 86 percent, and racial/ethnic, age-based, and regional disparities have decreased.[189] However, even with these positive outcomes, fully addressing the HIV epidemic domestically continues to be a challenge as the CDC estimates more than 1.1 million people in the United States are living with HIV infection, and almost 1 in 6 are unaware of their HIV infection.[190] In addition, approximately 40,000 new HIV infections occur every year.[191]

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[181] The goal of HIV treatment is to decrease viral load in PLWH, ideally to an undetectable level, known as viral suppression. When viral suppression is achieved and maintained, the risk of transmitting HIV is reduced.
[182] National Institute of Allergy and Infectious Disease (NIAID). Preventing Sexual Transmission of HIV with Anti-HIV Drugs. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000- [cited 2016 Mar 29]. Available from: http://clinicaltrials.gov/show/ NCT00074581 NLM Identifier: NCT00074581.
[183] Rodger AJ et al for the PARTNER study group. Sexual activity without condoms and risk of HIV transmission in serodifferent couples when the HIV-positive partner is using suppressive antiretroviral therapy. JAMA, 2016;316(2):1-11. DOI: 10.1001/jama.2016.5148. (12 July 2016). Full free access.
[184] HIV viral suppression was based on data for RWHAP clients who had at least 1 outpatient ambulatory medical care visit during the measurement year and one viral load measurement and whose most recent viral load test result was <200 copies/mL.
[185] Centers for Disease Control and Prevention. Social determinants of health among adults with diagnosed HIV infection, 2016. Part B: County-level social determinants of health and selected care outcomes among adults with diagnosed HIV infection—39 states and the District of Columbia. HIV Surveillance Supplemental Report 2018;23(No. 6, Part B, Table 9). Published October 2018. Accessed November 19, 2018.
[186] Based on data reported by 39 States and the District of Columbia.
[187] Bradley H, Viall AH, Wortley PM, Dempsey A, Hauck H, Skarbinski J. Ryan White HIV/AIDS Program Assistance and HIV Treatment Outcomes. *Clin Infect Dis.* (2016) 62 (1): 90-98.
[188]The lifetime cost of medical care and medications for a PLWH is $380,000. Schackman et al. The lifetime cost of current human immunodeficiency virus care in the United States. Med Care 2006; 44(11):990-997.
[189] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2016. Published November 2017. Accessed July 20, 2018.
[190] Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2010–2015. HIV Surveillance Supplemental Report 2018;23(No. 1). Published March 2018. Accessed November 18, 2018.
[191] Centers for Disease Control and Prevention. HIV Surveillance Report, 2017; vol. 29. Published November 2018. Accessed November 19, 2018.

Focused Public Health Response

The FY 2020 Budget provides $70 million in increased resources through HRSA's RWHAP for the Ending the HIV Epidemic Initiative, the first year of a ten year initiative. HHS is proposing a once-in-a-generation opportunity to eliminate new HIV infections in our nation. *Ending the HIV Epidemic*: *A Plan for America* will work to reduce new infections by 75 percent in the next five years and by 90 percent in the next ten years, averting more than 250,000 HIV infections in that span. The multi-year program will infuse 48 counties, Washington, D.C., San Juan, Puerto Rico, as well as 7 states that have a substantial rural HIV burden with the additional expertise, technology, and resources needed to end the HIV epidemic in the United States. HHS's four strategies – diagnose, treat, protect, and respond – will be implemented across the entire U.S. within 10 years. Without this new intervention, new infections will continue and could increase, costing more lives and the U.S. government more than $200 billion in direct lifetime medical costs for HIV prevention and medication.

This RWHAP funding will target 48 counties, Washington, D.C., San Juan, Puerto Rico, and seven states that have more than 50% of new HIV infections. Strategies for implementation are:

- Implementing evidence-informed practices shown to increase linkage, engagement, and retention in care targeted to those not yet diagnosed or out of care;
- Expanding HIV care, treatment and support services to people with HIV who are not currently in care; and
- Providing technical assistance to the 48 counties, Washington, D.C., San Juan, Puerto Rico, and seven states to support effective strategic plans and activities to successfully implement the new initiative.

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

In FY 2020, the HRSA RWHAP program will also ensure effective use of resources and a coordinated and focused public health response to HIV. Meanwhile, HRSA will continue to coordinate and collaborate with other federal, state, and local entities as well as national AIDS organizations to further leverage and promote efforts to address the unmet care and treatment needs of PLWH who are uninsured and underserved. These efforts help to align priorities, policies, and activities in sustaining a multi-faceted and comprehensive Federal response to the HIV epidemic. Federal partners include the Office of the Assistant Secretary for Health (OASH), the CDC, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS), the Indian Health Service (IHS), the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), the Department of Housing and Urban Development (HUD), the Department of Veterans Affairs (VA), and the Department of Justice (DOJ) as well as other HRSA-funded programs, such as the Health Center Program.

Additionally, the Administration looks forward to working with the Congress to reauthorize the RWHAP to ensure that the allocation of Federal funds address the changing landscape of HIV across the United States. The FY 2020 Budget Request includes the following proposed statutory

changes through the RWHAP authorization which will also help support the Ending the HIV Epidemic Initiative:

> *RWHAP Part A and B Supplemental Funding Methodologies:* Reauthorization of the RWHAP should include changes to the funding methodologies for Parts A and B Supplemental funding to ensure that funds may be allocated to target populations experiencing high or increasing levels of HIV infections/diagnoses, such as minority populations, while continuing to support Americans that are already living with HIV across the nation. African Americans, for example, account for a higher proportion of new HIV diagnoses, those living with HIV, and those ever diagnosed with AIDS, compared to other races/ethnicities. This data-driven approach would reduce burden for recipients and increase HHS's ability to effectively focus resources for HIV care, treatment, and support needs in states and eligible metropolitan areas based on metrics of need, geography, data quality, and performance.
>
> *Simplification and Modernization:* The proposed changes would simplify, modernize and standardize certain statutory requirements and definitions for consistency across RWHAP Parts. This would reduce burden, align and consolidate the differing provisions, eliminate those provisions in the statute that are no longer current as well as update certain provisions to make the statute more consistent with the current state of the US epidemic and better direct resources to the jurisdictions where clients are currently residing.

Additional Current Priorities and Collaborative Efforts

The National HIV/AIDS Strategy (NHAS) 2020: The *National HIV/AIDS Strategy for the United States* provides a roadmap for federal, state, and local governments, national and community based organization, health care providers, PLWH, and others to work together to address four primary goals:

1) Reducing new HIV infections;
2) Increasing access to care and improving health outcomes for PLWH;
3) Reducing HIV-related health disparities and health inequities; and
4) Achieving a more coordinated national response to the HIV epidemic.

The NHAS also includes 10 quantitative indicators to monitor progress. The RWHAP will continue to coordinate with other Federal partners, grant recipients, and other partners to work towards achieving these four goals.

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

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

Measuring Future Performance

Together, in FY 2020 RWHAP Parts A-D programs are anticipated to achieve the following performance goals:

- In FY 2020, the RWHAP will serve racial/ethnic minorities at a proportion not lower than 3 percentage points of national HIV prevalence data as reported by CDC.
- In FY 2020, the RWHAP will serve women at a proportion that is not lower than 3 percentage points of national HIV prevalence data as reported by CDC.
- In FY 2020, at least 83 percent of all patients receiving HIV medical care and at least one viral load test will be virally suppressed.

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

Outcomes and Outputs Table for Over-Arching Performance Measures

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2019 +/- FY 2020
16.I.A.1: Percentage of people living with HIV served by the Ryan White HIV/AIDS Program who are racial/ethnic minorities.*(Outcome)*	2017: 73% Target: Within 3 percentage points of CDC data (CDC data not available) 2016: 73% Target: Within 3 percentage points of CDC data or 70% (Target Exceeded)	Not lower than 3 percentage points of CDC data	Not lower than 3 percentage points of CDC data	Maintain
16.I.A.2: Percentage of people living with HIV served by the Ryan White HIV/AIDS Program who are women.*(Outcome)*	2017: 27% Target: Within 3 percentage points of CDC data (CDC data not available) 2016: 27% Target: Within 3 percentage points of CDC data or 24% (Target Exceeded)	Not lower than 3 percentage points of CDC data	Not lower than 3 percentage points of CDC data	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2019 +/- FY 2020
16.III.A.4: Percentage of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test who are virally suppressed.	2017: 86% (Target not in place) 2015 Baseline: 83%	83%	83%	Maintain

RWHAP Part A - Emergency Relief Grants

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$655,876,000	$655,876,000	$655,876,000	---
MAI (non add)	$54,105,000	$54,105,000	$54,105,000	---
Total Funding	$655,876,000	$655,876,000	$655,876,000	---
FTE	47	47	47	---

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

FY 2020 Authorization…….……..…….Expired

Allocation Method:

- Formula Grants
- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

Ryan White HIV/AIDS Program (RWHAP) Part A provides grants to cities with a population of at least 50,000, which are areas severely affected by the HIV epidemic. These jurisdictions are funded as either an Eligible Metropolitan Area (EMA) or a Transitional Grant Area (TGA), depending on the severity of the epidemic in their jurisdiction. Seventy-two percent of all people living with diagnosed HIV reside in a RWHAP Part A EMA or TGA. [192,193]

Formula and supplemental grants assist eligible areas in developing and enhancing access to a comprehensive continuum of high quality, community-based care for low-income people living with HIV (PLWH). The RWHAP requires EMAs and TGAs to utilize local needs assessments and planning processes to develop coordinated systems of HIV care in order to improve health outcomes for low-income PLWH, thereby reducing transmission of HIV.

RWHAP Part A prioritizes primary medical care, access to antiretroviral treatment, and other core medical and supportive services in order to engage and retain PLWH in care. The grants

[192] Centers for Disease Control and Prevention. HIV Surveillance Report, 2017; vol. 29. Published November 2018. Accessed November 19, 2018

[193] Centers for Disease Control and Prevention. HIV/AIDS data through December 2017 provided for the Ryan White HIV/AIDS Program, for fiscal year 2018. *HIV Surveillance Supplemental Report 2018*;29(No. 7). Published December 2018. Accessed December, 2018.

fund systems of care to provide services for PLWH in 24 EMAs, which are jurisdictions with 2,000 or more AIDS cases over the last five years, and 28 TGAs, which are jurisdictions with at least 1,000 but fewer than 2,000 AIDS cases over the last five years as reported to the Centers for Disease Control and Prevention. Two-thirds of the funds available for EMAs and TGAs are awarded according to a formula, based on the number of living cases of HIV in the EMAs and TGAs.

The remaining funds are awarded as discretionary supplemental grants based on the demonstration of additional need by the eligible EMAs and TGAs, and as Minority AIDS Initiative (MAI) grants. The MAI funds are a statutory set-aside funding component for RWHAP Parts A – D, and Part F AIDS Education and Training Center programs to evaluate and address the disproportionate impact of HIV on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. MAI funds are also awarded based on a formula utilizing the number of minorities living with HIV and AIDS in a jurisdiction and support HIV care, treatment, and support services to racial/ethnic minorities.

The RWHAP Part A funds are awarded to the Chief Elected Official who is required to establish a local Planning Council/Body that determines the allocation of RWHAP resources based on local needs assessments. Seventy-five percent of RWHAP Part A funds must be used to support core medical services. Eligible subrecipients are community health centers, health departments, ambulatory care facilities, and other non-profit organizations providing services for PLWH.

In 2017, 77 percent of RWHAP Part A clients were racial/ethnic minorities and 26 percent were women. In 2017, RWHAP Part A funded sites provided 3.6 million core medical service visits for health-related care utilizing a combination of RWHAP Parts A, B, C, and D funding. The number of visits for health-related services demonstrates the scope of RWHAP Part A in delivering primary care and related services for PLWH by increasing the availability and accessibility of care.

RWHAP Part A Funding History

FY	Amount
FY 2011	$672,529,000
FY 2012	$666,071,000
FY 2013	$624,262,000
FY 2014	$649,373,000
FY 2015	$655,220,000
FY 2016	$655,876,000
FY 2017	$654,296,000
FY 2018	$655,876,000
FY 2019	$655,876,000
FY 2020	$655,876,000

Budget Request

The FY 2020 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part A of $655.9 million is equal to the FY 2019 Enacted level. The request will fund RWHAP activities and services for people living with HIV (PLWH) in the 24 EMAs and 28 TGAs.

The FY 2020 Request proposes statutory changes through RWHAP authorization to the RWHAP Part A Supplemental funding methodology. These changes would allow HRSA to utilize a data driven framework developed by the Secretary to distribute RWHAP Part A Supplemental funding. This would ensure the allocation of funds to areas experiencing high or increasing of need while continuing to support Americans that are already living with HIV across the nation. This approach would reduce burden for recipients and increase HHS's ability to effectively focus resources for HIV care, treatment, and support in funded cities based on need, geography, data quality, and performance.

In FY 2017, 67 percent of all RWHAP clients were served by one of the 52 metropolitan areas funded under the RWHAP Part A. Approximately 72 percent of all people living with diagnosed HIV reside within these metropolitan areas. The RWHAP serves populations that are diverse and challenging in terms of service delivery (e.g., PLWH at or below 100 percent Federal Poverty Level and/or those who are homeless). As indicated previously, ongoing and effective treatment not only enhances the quality and length of life but also achieves viral suppression, which reduces new HIV infections. Thus, the RWHAP Part A, which focuses on areas with concentrated cases of HIV, has a significant public health impact on HIV incidence.

In FY 2020, RWHAP Part A grant recipients will continue to provide core medical and support services, which are essential to providing quality comprehensive HIV care, such as case management and care coordination services, and linking PLWH into care in a timely manner, initiating antiretroviral treatment as early as possible, and retaining them in ongoing care.

The FY 2020 Request will support the RWHAP Part A in achieving its target of providing 3.6 million core medical service visits for health-related care. RWHAP Part A jurisdictions are experienced in data-driven, community-based needs assessment, responsive procurement of a variety of direct medical and supportive services, working across service providers to develop and maintain a system of services, and serving diverse populations. RWHAP Part A funding will also contribute to achieving the FY 2020 targets for performance goals that relate to cross-cutting activities, such as the percentage of racial/ethnic minorities and women served, percentage of clients who achieved viral suppression, and percentage of HIV-positive pregnant women served by RWHAP who receive antiretroviral medications.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
17.I.A.2: Number of RWHAP Part A visits for health-related care.[194] *(Output)*	2017: 3.6M (Target not in place) 2015 Baseline: 3.7 M	3.6M	3.6M	Maintain

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	52	52	52
Average Award	$12,006,679	$12,006,679	$12,006,679
Range of Awards	$2,180,586 - $95,799,060	$2,180,586 - $95,799,060	$2,180,586 - $95,799,060

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

RWHAP Part A – FY 2018 Formula, Supplemental & MAI Grants[195]

Table 1. Eligible Metropolitan Areas

EMAs	Formula[196]	Supplemental	MAI	Total
Atlanta, GA	$16,063,332	$7,813,134	$2,474,045	$26,350,511
Baltimore, MD	9,837,719	5,328,626	1,615,252	16,781,597
Boston, MA	9,249,812	4,310,735	1,020,308	14,580,855
Chicago, IL	16,679,635	8,591,207	2,386,330	27,657,172
Dallas, TX	10,843,682	5,221,440	1,388,506	17,453,628
Detroit, MI	5,743,402	3,017,900	827,236	9,588,538
Ft. Lauderdale, FL	9,604,765	4,912,130	1,258,648	15,775,543
Houston, TX	14,342,204	7,056,740	2,166,944	23,565,888
Los Angeles, CA	26,771,869	13,090,360	3,576,622	43,438,851
Miami, FL	15,498,036	8,439,212	2,633,946	26,571,194
Nassau-Suffolk, NY	3,353,911	1,848,690	442,201	5,644,802
New Haven, CT	3,298,171	1,840,184	451,274	5,589,629
New Orleans, LA	4,643,311	2,545,175	637,087	7,825,573
New York, NY	56,066,796	30,828,166	8,904,098	95,799,060
Newark, NJ	7,307,299	3,988,141	1,248,768	12,544,208
Orlando, FL	6,151,467	2,992,974	792,251	9,936,692
Philadelphia, PA	13,249,475	7,318,490	1,972,662	22,540,627
Phoenix, AZ	5,894,323	2,897,791	559,254	9,351,368
San Diego, CA	7,159,533	3,254,167	730,044	11,143,744
San Francisco, CA	9,419,663	5,243,779	767,247	15,430,689
San Juan, PR	6,296,077	3,422,947	1,206,322	10,925,346
Tampa-St. Petersburg, FL	6,230,345	3,387,211	665,216	10,282,772
Washington, DC-MD-VA-WV	18,816,715	10,306,923	2,944,677	32,068,315
West Palm Beach, FL	4,379,857	2,395,700	649,892	7,425,449
Subtotal EMAs	**$286,901,399**	**$150,051,822**	**$41,318,830**	**$478,272,051**

[195] Awards to EMAs and TGAs include prior year unobligated balances.
[196] Hold Harmless expired in FY 2014.

Table 2. Transitional Grant Areas

TGAs	Formula	Supplemental	MAI	Total
Austin, TX	$3,100,713	$1,479,241	$340,775	$4,920,729
Baton Rouge, LA	2,771,551	1,353,901	445,024	4,570,476
Bergen-Passaic, NJ	2,459,938	1,283,662	350,655	4,094,255
Charlotte-Gastonia, NC-SC	3,857,412	1,816,840	564,799	6,239,051
Cleveland, OH	2,919,913	1,436,973	372,130	4,729,016
Columbus, OH	2,957,669	1,441,290	281,190	4,680,149
Denver, CO	4,892,225	2,351,906	372,332	7,616,463
Fort Worth, TX	2,858,229	1,312,832	354,285	4,525,346
Hartford, CT	1,927,111	1,022,385	260,117	3,209,613
Indianapolis, IN	2,726,351	1,314,065	283,206	4,323,622
Jacksonville, FL	3,633,008	1,749,255	501,080	5,883,343
Jersey City, NJ	2,989,574	1,608,939	460,651	5,059,164
Kansas City, MO	2,685,406	1,252,009	267,276	4,204,691
Las Vegas, NV	3,964,829	1,890,495	430,606	6,285,930
Memphis, TN	4,053,101	2,020,439	670,963	6,744,503
Middlesex-Somerset-Hunterdon, NJ	1,678,777	899,316	232,493	2,810,586
Minneapolis-St. Paul, MN	3,697,352	1,806,705	358,822	5,862,879
Nashville, TN	2,777,933	1,273,741	298,732	4,350,406
Norfolk, VA	3,617,055	1,754,162	529,814	5,901,031
Oakland, CA	4,369,501	2,136,888	551,188	7,057,577
Orange County, CA	3,919,629	1,870,697	425,767	6,216,093
Portland, OR	2,607,768	1,283,616	135,705	4,027,089
Riverside-San Bernardino, CA	4,891,692	2,259,968	502,693	7,654,353
Sacramento, CA	2,142,475	1,042,976	192,064	3,377,515
Saint Louis, MO	3,902,081	1,923,817	464,482	6,290,380
San Antonio, TX	3,324,054	1,498,369	497,450	5,319,873
San Jose, CA	1,944,659	953,638	226,141	3,124,438
Seattle, WA	4,527,434	2,128,368	340,876	6,996,678
Subtotal TGAs	**$91,197,440**	**$44,166,493**	**$10,711,316**	**$146,075,249**
Subtotal EMAs/TGAs	**$378,098,839**	**$194,218,315**	**$52,030,146**	**$624,347,300**

RWHAP Part B - HIV Care Grants to States

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$1,309,251,000	$1,315,005,000	$1,315,005,000	---
MAI (non add)	$10,145,000	$10,145,000	$10,145,000	---
ADAP (non add)	$894,559,000	$900,313,000	$900,313,000	---
Total Funding	$1,309,251,000	$1,315,005,000	$1,315,005,000	---
FTE	59	59	59	---

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

FY 2020 Authorization……Expired

Allocation Method:

- Formula Grants
- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part B is the largest RWHAP Part and provides grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and five Associated Pacific Jurisdictions to provide services for people living with HIV (PLWH). RWHAP Part B grants support outpatient ambulatory medical care, HIV-related prescription medications, case management, oral health care, health insurance premium and cost-sharing assistance, mental health and substance abuse services, and support services.

RWHAP Part B funds are distributed through base and supplemental grants, AIDS Drug Assistance Program (ADAP) base and ADAP supplemental grants, Emerging Communities (ECs) grants, and Minority AIDS Initiative (MAI) grants. The base awards are distributed by a formula based on a state or territory's living HIV/AIDS cases weighted for cases outside of the jurisdictions that receive RWHAP Part A funding. The ECs are metropolitan areas that do not qualify as RWHAP Part A EMAs or TGAs but have 500-999 cumulative reported AIDS cases over the last five years. States apply on behalf of the ECs for funding through the RWHAP Part B base grant application. RWHAP Part B Supplemental grants are available through a competitive process to eligible states with demonstrated need.

A portion of the RWHAP Part B appropriation supports ADAP, which supports the provision of HIV medications and related services, including health insurance premium and cost-sharing assistance. These funds are distributed by a formula based on living HIV/AIDS cases. In addition, ADAP supplemental funds are a five percent set aside for states with severe need. ADAP provides FDA-approved prescription medications for PLWH who cannot afford HIV medications. ADAP is instrumental in efforts to end the HIV epidemic across the nation. ADAP provides the access to medications and insurance necessary for PLWH to achieve optimal health outcomes and viral suppression. Individual ADAPs operate in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, the Republic of Palau, and the Republic of the Marshall Islands.

The MAI funds are a statutory set-aside funding component for RWHAP Parts A – D and Part F AIDS Education and Training Center programs to evaluate and address the disproportionate impact of HIV on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. The RWHAP Part B MAI funding is statutorily required to specifically support education and outreach services to increase the number of eligible racial/ethnic minorities who have access to the RWHAP Part B ADAP.

In 2017, 69 percent of RWHAP Part B clients were racial/ethnic minorities, and 27 percent were women. Seventy-five percent of RWHAP Part B funds must be used to support core medical services and in 2017, RWHAP Part B funded sites provided 3.4 million core medical service visits for health-related care utilizing RWHAP Parts A, B, C, and D funding. The number of visits for health-related services demonstrates the scope of RWHAP Part B in delivering primary care and related services for PLWH by increasing the availability and accessibility of care.

AIDS Drug Assistance Program

The RWHAP Part B has been successful in helping to ensure that PLWH have access to the care and treatment services they need to live longer, healthier lives. According to the RWHAP ADAP Report, ADAPs, which are run by states and territories, continue to provide robust formularies of antiretroviral medications to treat HIV infection, prevent and treat opportunistic infections, manage side effects, and treat co-morbidities. Recent studies have demonstrated that individuals with HIV on antiretroviral medications who achieve viral suppression are not at risk to transmit HIV to others. The RWHAP provides the care and treatment services that support the achievement of viral suppression and therefore, has a significant public health impact on HIV incidence as well. These efforts demonstrate the central role of the RWHAP in ending the HIV epidemic by ensuring that PLWH have access to regular care, are started on, and adhere to, their antiretroviral medications.

According to the RWHAP ADAP Data Report, the number of PLWH receiving ADAP services has grown 28% over the last seven years from 208,809 clients in 2010, to 268,174 clients in 2017, exceeding the FY 2017 target by 61,869. In FY 2017, the RWHAP Part B ADAP provided medication and health care coverage assistance for 27% of people diagnosed with HIV in the United States and 69 percent of the clients served by ADAPs were racial/ethnic minorities.

Nationally, 74 percent of ADAP clients had incomes at or below 200 percent of the Federal poverty level.

ADAP Cost Containment: Increased demand for RWHAP Part B services in recent years has led a number of States to implement cost-containment measures for their RWHAP Part B ADAPs. Cost-containment measures include using drug-purchasing strategies such as cost recovery through drug rebates and third party billing; directly negotiating pharmaceutical pricing; reducing ADAP formularies, capping enrollment, lowering financial eligibility levels, and implementing waiting lists for people to enroll in their ADAP. In addition, states implemented cost-savings strategies such as recovering costs when another payor was primary, coordinating benefits with Medicare Part D, and improving drug-purchasing models. ADAPs have reported significant savings by participating in manufacturer rebate programs and recovering costs through insurance reimbursement.

Across the RWHAP, grant recipients are encouraged to maximize resources and leverage efficiencies. One example of this is within RWHAP Part B, where ADAPs use a variety of the above-mentioned strategies to maximize resources, which result in effective funds management, enabling ADAPs to serve more people. In 2017, ADAPs participating in cost-savings strategies on medications saved $2.15 billion, exceeding the FY 2017 performance target by more than $1 billion. Over the last 5 years, ADAPs participating in medication cost-savings strategies saved $6.22 billion.

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

In FY 2020, HRSA will continue the use of RWHAP Part B ADAP Emergency Relief Funds (ERF) through "311 authority" in order to maintain infrastructure in the states and territories that had previously imposed waiting lists and to ensure that no new waiting lists are established. This funding also addresses the gaps in access created by ongoing cost-containment measures in many ADAPs such as HIV medication formulary reductions, lower client financial eligibility levels, and capped enrollment. However, with no individuals on the ADAP waiting lists, states requested and HRSA distributed $53.77 million in ERF funding in FY 2018. These funds are required to be used for ADAP services, including the purchase of medications, insurance premium assistance, and medication copay assistance. States that developed need through unforeseen events had the ability to request RWHAP Part B supplemental funds to assist in meeting shortfalls.

Due to availability of effective HIV medications, mother-to-child transmission in the United States has decreased dramatically since its peak in 1992 due to 1) an increased focus on HIV testing for all pregnant women; and 2) the use of antiretroviral therapy, which significantly reduces the risk of HIV transmission from the mother to her baby. In 2017, 98 percent of HIV-positive pregnant women served by the RWHAP were prescribed antiretroviral therapy to

prevent maternal-to-child transmission of HIV, exceeding the FY 2017 performance target by 8 percentage points. The RWHAP Part B ADAP plays a crucial role that ensures access to HIV medications for pregnant women.

Funding History

FY	Amount	ADAP (Non-Add)
FY 2011	$1,308,141,000	($885,000,000)
FY 2012	$1,360,827,000	($933,299,000)
FY 2013	$1,287,535,000	($886,313,000)
FY 2014	$1,314,446,000	($900,313,000)
FY 2015	$1,315,005,000	($900,313,000)
FY 2016	$1,315,005,000	($900,313,000)
FY 2017	$1,311,837,000	($900,313,000)
FY 2018	$1,309,251,000	($894,559,000)
FY 2019	$1,315,005,000	($900,313,000)
FY 2020	$1,315,005,000	($900,313,000)

Budget Request

The FY 2020 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part B of $1.3 billion is equal to the FY 2019 Enacted level. The request includes $900.3 million for RWHAP Part B ADAPs to provide access to life saving HIV related medications and direct health care services to people living with HIV (PLWH) in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam and five Associated Pacific Jurisdictions. HRSA will continue to utilize the 311 authority to implement the Emergency Relief Fund to prevent, reduce, or eliminate ADAP waiting lists through cost containment and/or cost savings measures.

The FY 2020 Request proposes statutory changes through the RWHAP authorization to the RWHAP Part B Supplemental funding methodology. These changes would allow HRSA to utilize a data driven framework developed by the Secretary to distribute RWHAP Part B Supplemental funding. This would ensure the allocation of funds to areas experiencing high or increasing of need while continuing to support Americans that are already living with HIV across the nation. This approach would reduce burden for recipients and increase HHS's ability to effectively focus resources for HIV care, treatment, and support services based on need, geography, data quality, and performance.

As part of the program's efforts to continue to provide access to life-saving medications and related services for low-income PLWH, the RWHAP has established a target for FY 2020 of serving at least 266,000 RWHAP Part B ADAP clients. This target is based on anticipated steady funding - not demand. While the number of ADAP clients is projected to remain constant in future years with anticipated steady funding, health care coverage and costs related to co-pays, co-insurance, premiums, etc., are difficult to anticipate. The increased demand for ADAP services in recent years has required many states to recover costs when possible by coordinating benefits with Medicare Part D or exhausting all coverage options, participating in rebate programs, and improving drug-purchasing models.

An important contributing factor to the demand for services for RWHAP Part B ADAP continues to be access to HIV medications and high cost-sharing requirements for these medications. In order to meet this demand, the number of ADAPs participating in cost-savings strategies on medications will need to remain steady (the FY 2020 target is to maintain the previous year's output measure).

The funding request will support the RWHAP Part B in achieving its target of providing 3.4 million core medical service visits for health-related care. RWHAP Part B/ADAP grant recipients will continue to work directly with uninsured PLWH to ensure access to health care coverage and will continue to support HIV medications not on health plan formularies and the cost sharing required by health coverage plans. ADAP resources will also support:

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

HRSA and the CDC continue to collaborate to accelerate the elimination of perinatal HIV transmission in the United States. The FY 2020 Request will support RWHAP Part B ADAP to ensure that at least 96% of HIV-positive pregnant women served by the RWHAP will receive antiretroviral medications. RWHAP Part B/ADAP funding will also contribute to achieving the FY 2020 targets for performance goals that related to cross-cutting activities, such as the percentage of racial/ethnic minorities and women served, and percentage of clients who achieved viral suppression.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
18.I.A.2: Number of RWHAP Part B visits for health-related care.[197] *(Output)*	2017: 3.4M (Target not in place) 2015 Baseline: 3.6M	3.4M	3.4M	Maintain

[197] This measure reports on core medical services. It replaces measure 18.I.A.1 that reported on only a subset of core medical services. The first target is set for 2018.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
16.II.A.1: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. *(Output)*	2017: 268,174 Target: 206,305 (Target Exceeded)	259,531	266,000	+6,469
16.E: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. *(Containing Costs)*	2017: $2.15B Target: $1.14B (Target Exceeded)	Sustain Prior Year Results	Sustain Prior Year Results	Maintain
16.II.A.3: Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive antiretroviral medications.[198] *(Output)*	2017: 98% Target: 90% (Target Exceeded)	96%	96%	Maintain

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	59	59	59
Average Award	$23,539,326	$23,539,326	$23,539,326
Range of Awards	$24,596-$169,443,389	$50,000-$169,443,389	$50,000-$169,443,389

RWHAP Part B – FY 2018 State Table[199]

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Alabama	$8,060,177	$12,335,911	$10,594,199	$317,008	$150,294	$31,457,589
Alaska	500,000	425,451	580,102	0	0	1,505,553
American	32,093	0	815	0	0	32,908
Arizona	4,113,644	0	12,000,459	0	0	16,114,103
Arkansas	3,374,295	0	4,552,010	0	49,769	7,976,074
California	33,135,968	23,765,871	116,659,276	163,387	1,239,593	174,964,095

[198] This RWHAP overarching performance measure applies to RWHAP Parts A, B, C, and D and is not Part B specific.
[199] Awards include prior year unobligated balances.

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Colorado	3,362,667	0	9,768,043	0	75,999	13,206,709
Connecticut	2,728,988	0	8,869,373	0	0	11,598,361
Delaware	2,027,597	0	2,665,049	193,887	37,705	4,924,238
Dist. of	3,718,903	0	6,300,456	0	211,744	10,231,103
F States	50,000	0	815	0	0	50,815
Florida	30,367,329	20,900,239	89,515,812	473,831	1,266,095	142,523,306
Georgia	13,986,055	2,060,818	51,830,597	169,311	591,741	68,638,522
Guam	200,000	0	65,180	0	0	265,180
Hawaii	1,640,178	0	2,155,830	0	21,912	3,817,920
Idaho	577,100	2,934,719	2,448,828	0	0	5,960,647
Illinois	9,546,822	0	33,003,927	0	426,706	42,977,455
Indiana	3,609,343	11,509,813	11,364,704	0	0	26,483,860
Iowa	1,438,100	10,760,441	1,890,221	0	0	14,088,762
Kansas	1,095,007	0	2,539,577	0	0	3,634,584
Kentucky	4,092,386	0	5,378,982	274,340	45,753	9,791,461
Louisiana	6,476,557	0	17,387,588	0	256,397	24,120,542
Maine	786,616	1,627,018	1,033,918	0	0	3,447,552
Marshall	26,206	0	815	0	0	27,021
Maryland	7,975,128	0	26,740,923	0	450,180	35,166,231
Massachusetts	5,204,324	5,104,136	16,095,394	0	184,732	26,588,586
Michigan	5,067,469	0	13,579,445	0	178,963	18,825,877
Minnesota	2,043,212	2,269,463	6,444,676	0	64,031	10,821,382
Mississippi	5,778,432	3,510,443	7,819,160	278,823	124,270	17,511,128
Missouri	3,486,897	589,105	10,281,335	0	107,872	14,465,209
Montana	500,000	566,491	1,259,478	0	0	2,325,969
N. Marianas	50,000	10,478	4,074	0	0	64,552
Nebraska	1,242,221	1,317,007	1,632,760	0	0	4,191,988
Nevada	2,187,045	0	6,855,310	0	74,342	9,116,697
New	500,000	0	978,515	0	0	1,478,515
New Jersey	10,105,758	754,999	30,505,884	0	478,897	41,845,538
New Mexico	1,848,454	0	2,429,586	0	0	4,278,040
New York	34,111,900	26,333,142	106,716,823	609,440	1,672,084	169,443,389
North Carolina	11,495,064	2,612,392	26,827,375	305,000	353,336	41,593,167
North Dakota	500,000	161,348	240,351	0	0	901,699
Ohio	7,122,704	0	17,420,178	329,576	0	24,872,458
Oklahoma	3,598,969	0	4,730,441	227,269	0	8,556,679
Oregon	1,145,186	0	4,891,761	0	0	6,036,947

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Pennsylvania	10,617,820	0	28,064,078	272,819	383,647	39,338,364
Puerto Rico	5,757,976	14,277,230	30,232,579	0	298,213	50,565,998
Republic of	20,449	0	4,147	0	0	24,596
Rhode Island	1,525,502	2,505,974	2,005,101	192,766	21,625	6,250,968
South Carolina	10,170,016	12,038,386	13,616,923	558,047	205,258	36,588,630
South Dakota	500,000	0	439,965	0	0	939,965
Tennessee	5,053,896	0	23,041,408	0	178,772	28,274,076
Texas	23,581,066	1,884,208	68,823,596	0	978,495	95,267,365
Utah	1,720,141	1,999,675	3,751,641	0	15,442	7,486,899
Vermont	500,000	0	407,375	0	0	907,375
Virgin Islands	500,000	650,838	517,367	0	9,259	1,677,464
Virginia	7,068,769	0	29,646,378	375,366	259,185	37,349,698
Washington	3,612,726	0	10,180,306	0	78,055	13,871,087
West Virginia	1,008,638	0	1,442,108	0	0	2,450,746
Wisconsin	3,588,620	2,509,106	4,741,847	259,130	52,526	11,151,229
Wyoming	500,000	0	253,387	0	0	753,387
Total	**$314,634,413**	**$165,414,702**	**$893,228,251**	**$5,000,000**	**$10,542,892**	**$1,388,820,258**

RWHAP Part C - Early Intervention Services

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$201,079,000	$201,079,000	$201,079,000	---
MAI (non add)	$71,012,000	$71,012,000	$71,012,000	---
Total Funding	$201,079,000	$201,079,000	$201,079,000	---
FTE	54	54	54	---

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

FY 2020 Authorization……..……..…….…...Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

HRSA's Ryan White HIV/AIDS Program (RWHAP) Part C provides grants directly to community and faith-based organizations, health centers, health departments, and university or hospital-based clinics in 49 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. RWHAP Part C supports comprehensive primary health care and support services in an outpatient setting for low-income, uninsured, and underserved people living with HIV (PLWH).

Minority AIDS Initiative (MAI) funds are a statutory set-aside funding component for RWHAP Parts A – D, and Part F AIDS Education and Training Center programs to evaluate and address the disproportionate impact of HIV on, racial and ethnic minorities. RWHAP Part C MAI funding supports HIV care, treatment, and support services to racial/ethnic minorities. RWHAP Part C is also authorized to fund capacity development grants that strengthen organizational development and infrastructure, resulting in a more effective delivery of HIV care and services.

The RWHAP Part C provides services for PLWH disproportionately affected by the HIV epidemic and who have poor health outcomes, including ethnic and minority populations and youth. In 2017, RWHAP Part C funded sites served over 300,000 clients utilizing a combination of RWHAP Parts A, B, C, and D funding. Of the total clients served, 72 percent were racial/ethnic minorities and 27 percent were female.

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

expertise and cultural competency to provide quality care and treatment to low-income, diverse PLWH. In 2017, RWHAP Part C funded sites provided 2.4 million medical service visits for health-related care utilizing a combination of RWHAP Parts A, B, C, and D funding. The number of visits for health-related services demonstrates the scope of RWHAP Part C in delivering primary care and related services for PLWH by increasing the availability and accessibility of care.

Funding History

FY	Amount
FY 2011	$205,564,000
FY 2012[200]	$215,086,000
FY 2013	$194,444,000
FY 2014	$205,544,000
FY 2015	$204,179,000
FY 2016	$205,079,000
FY 2017	$200,585,000
FY 2018	$201,079,000
FY 2019	$201,079,000
FY 2020	$201,079,000

Budget Request

The FY 2020 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part C of $201.1 million is equal to the FY 2019 Enacted level. In FY 2020, RWHAP Part C grant recipients' clients will continue to achieve improved health outcomes resulting from the comprehensive array of direct medical and supports services that are essential in addressing the HIV epidemic.

RWHAP Part C supports direct health care services for low income PLWH who are uninsured or underserved. These services are considered essential to improving health outcomes and are a crucial part of the care network that links and retains PLWH into health care. Such critical health care services include intensive case management and care coordination services, linking and retaining PLWH into care, and getting them on antiretroviral medications as early as possible.

The funding request will support the RWHAP Part C in achieving its target of providing 2.3 million visits for health-related care in FY 2020. RWHAP Part C funding will also contribute to achieving the FY 2020 targets for performance goals that relate to cross-cutting activities, such as percentage of racial/ethnic minorities and women served, percentage of clients who achieved viral suppression, and percentage of HIV-positive pregnant women served by the RWHAP who receive antiretroviral medications.

[200] Reflects Ryan White Budget Authority only (does not include $5.089 million in Health Center Program Budget Authority for RWHAP Part C grant recipients in FY 2012).

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
19.II.A.3: Number of RWHAP Part C visits for health-related care.[201] *(Output)*	2017: 2.4M (Target not in place) 2016 Baseline: 2.3M	2.3M	2.3M	Maintain

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	351	351	351
Average Award	$518,167	$518,167	$518,167
Range of Awards	$92,999 - $1,507,775	$92,999 - $1,507,775	$92,999 - $1,507,775

[201] This measure reports on core medical services. It replaces measure 19.II.A.2 that reported on only a subset of core medical services. The first target is set for 2018. The 2015 baseline and FY 2019 target was reported incorrectly in the FY 2019 Congressional Justification and has been corrected.

RWHAP Part D - Women, Infants, Children and Youth

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$75,088,000	$75,088,000	$75,088,000	---
MAI (non add)	$23,671,000	$23,671,000	$23,671,000	---
Total Funding	$75,088,000	$75,088,000	$75,088,000	---
FTE	12	12	12	---

Authorizing Legislation: Public Health Service Act, Section 2671, as amended by Public Law 111-87

FY 2020 Authorization……Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part D provides grants directly to public or private community-based organizations, hospitals, and State and local governments. In FY17, there were 115 RWHAP Part D grant recipients located in 40 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. The RWHAP Part D focuses on providing access to coordinated, comprehensive, culturally and linguistically competent, family-centered HIV primary medical care and support services. RWHAP services focus on low-income, uninsured, and underserved women, infants, children, and youth living with HIV and their affected[202] family members. RWHAP Part D also funds essential support services, such as case management and transportation that help clients' access medical care and stay in care.

Minority AIDS Initiative Funds (MAI) funds are a statutory set-aside funding component for RWHAP Parts A – D, and Part F AIDS Education and Training Center programs to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. RWHAP Part D MAI funding supports HIV care, treatment, and support services to racial/ethnic minorities. In 2017, RWHAP Part D funded sites provided over 1.7M visits for health-related care and support services utilizing a combination of RWHAP Parts A, B, C, and D funding.

[202] Support services are available for family members not living with HIV. Some examples are family-centered case management, childcare services during medical appointment attendance, and psychosocial support services that focus on equipping affected family members, and caregivers, to manage the stress associated with HIV.

The RWHAP Part D serves women, infant, children, and youth – populations disproportionately affected by HIV epidemic that have poor health outcomes. In 2017, RWHAP Part D funded sites served 223,791 clients utilizing a combination of RWHAP Parts A, B, C, and D funding. Of the total clients served, 75 percent were racial/ethnic minorities and 29 percent were female. RWHAP Part D providers have the clinical expertise and cultural competency to provide quality care and treatment to low-income, diverse women, infant, children, and youth living with HIV.

Funding History

FY	Amount
FY 2011	$77,313,000
FY 2012	$77,167,000
FY 2013	$72,361,000
FY 2014	$72,395,000
FY 2015	$73,008,000
FY 2016	$75,088,000
FY 2017	$74,907,000
FY 2018	$75,088,000
FY 2019	$75,088,000
FY 2020	$75,088,000

Budget Request

The FY 2020 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part D of $75.1 million is equal to the FY 2019 Enacted level. In FY 2020, RWHAP Part D grant recipients' clients will continue to achieve improved health outcomes resulting from the comprehensive array of medical and supports services that are essential in addressing the HIV epidemic.

RWHAP Part D supports health care services for low income PLWH who are uninsured or underserved. These services are considered essential to improving health outcomes and are a crucial part of the care network that links and retains PLWH into health care, especially for women, infants and children and youth. Such critical health care services include intensive case management and care coordination services, linking and retaining PLWH into care, and getting them on antiretroviral medications as early as possible.

The funding request will support the RWHAP Part D in achieving its target of providing at least 1.7 million health-related care and support service visits in FY 2020. RWHAP Part D funding will also contribute to achieving the FY 2020 targets for performance goals that relate to cross-cutting activities, such as the percentage of racial/ethnic minorities and women served, percentage of clients who achieved viral suppression, and percentage of pregnant women living with HIV served by the RWHAP who receive antiretroviral medications.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
20.II.A.2 Number of RWHAP Part D visits for health-related care and support services[203]	2017: 1.7M (Target not in place) 2015 Baseline: 1.8M	1.7M	1.7M	Maintain

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	115	115	115
Average Award	$583,894	$583,894	$583,894
Range of Awards	$113,823 - $2,185,691	$113,823 - $2,185,691	$113,823 - $2,185,691

[203] The 2015 baseline was reported incorrectly in the FY 2019 Congressional Justification and has been corrected.

RWHAP Part F - AIDS Education and Training Programs

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$33,611,000	$33,611,000	$33,611,000	---
MAI (non add)	$10,144,000	$10,144,000	$10,144,000	---
Total Funding	$33,611,000	$33,611,000	$33,611,000	---
FTE	5	5	5	---

Authorizing Legislation: Public Health Service Act, Sec. 2692(a), as amended by Public Law 111-87.

FY 2020 Authorization……...….Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part F AIDS Education and Training Center (AETC) program supports a network of regional centers and two national centers that conduct targeted, multidisciplinary education and training programs for health care providers serving people living with HIV (PLWH) in all states, DC, Puerto Rico, the U.S. Virgin Islands, and the Associated Jurisdictions. The RWHAP AETC improves the quality of life of persons living with or at-risk of HIV through the provision of specialized professional education and training. The program uses a strategy of implementation of multidisciplinary education and training programs for health care providers in the prevention and treatment of HIV.

The RWHAP AETCs target training to health care providers who serve minority populations, the homeless, rural communities, incarcerated persons, federally qualified community and migrant health centers, and RWHAP sites. In addition, nearly half the providers themselves are racial/ethnic minorities. In 2016-2017, the proportion of racial/ethnic minority health care providers participating in RWHAP AETC training intervention programs was 46 percent, exceeding the most recent performance target by 3 percentage points.[204]

[204] Due to changes in the reporting instrument, an estimated proportion of racial/ethnic minority providers was calculated using data from the past three reporting years. This performance measure is scheduled to be replaced with a more meaningful measure in subsequent reports.

RWHAP AETCs currently train providers through a variety of training modalities, including didactics, clinical preceptorships, self-study, clinical consultation, communities of practice and distance-based technologies. A variety of educational formats are used including skills building workshops, hands-on preceptorships and mini-residencies, on-site training, tele-education, and technical assistance. For example, the RWHAP AETC implemented an online interactive platform that hosts an HIV care and treatment curriculum targeted to health care professionals. Clinical faculty also provides timely clinical consultation in person or via the telephone or internet.

Funding History

FY	Amount
FY 2011	$34,607,000
FY 2012	$34,542,000
FY 2013	$32,390,000
FY 2014	$33,275,000
FY 2015	$33,349,000
FY 2016	$33,611,000
FY 2017	$33,530,000
FY 2018	$33,611,000
FY 2019	$33,611,000
FY 2020	$33,611,000

Budget Request

The FY 2020 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part F-AETC of $33.6 million is equal to the FY 2019 Enacted level. The budget will support targeted, multidisciplinary education and training programs for novice and experienced health care providers treating people living with HIV (PLWH) in order to assure access to high quality HIV care delivered by competent providers. The RWHAP AETC program also provides expert advice to providers across the country on HIV treatment, post-exposure prophylaxis after needle sticks and other occupational exposures, and expert advice in the treatment of pregnant women with HIV and their newborns to prevent mother-to-child transmission.

The RWHAP AETC program funds a national curriculum for medical providers on HIV care and treatment to assure continued training of providers from medical/nursing school through in-service training. The central focus of RWHAP AETC training is to ensure high quality care and good patient outcomes through HIV care and treatment that is consistent with established treatment guidelines and reflects current research. This is increasingly important as PLWH are living longer. In addition, the number of experienced HIV care professionals is projected to decrease as many of those who have worked in the epidemic since its inception reach retirement age. Training an expanded cadre of culturally competent, high quality providers is vital to increasing access to quality HIV care and treatment and improving health outcomes for PLWH.

HRSA will continue to prioritize interactive training and technical assistance that result in health system strengthening and transformation. Focus will be on training health care providers,

particularly racial/ethnic minority providers, to deliver high quality HIV care and treatment services in primary care settings – settings that have typically not provided services to PLWH.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2019 +/- FY 2020
21.V.B.1: Proportion of RWHAP AETC training intervention participants that are racial/ethnic minorities. *(Output)*[205]	FY 2016: 46% Target: 43% (Target Exceeded)	N/A	N/A	N/A

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	13	14	14
Average Award	$2,154,385	$2,000,500	$2,000,500
Range of Awards	$300,000 - $3,858,166	$300,000 - $3,858,166	$300,000 - $3,858,166

[205] Data relating to this target is no longer being collected. This performance measure will be retired and replaced by a new measure in subsequent reports.

RWHAP Part F - Dental Programs

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$13,122,000	$13,122,000	$13,122,000	---
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 2692(b) as amended by Public Law 111-87

FY 2020 Authorization…….…….…..Expired

Allocation Method:

- Competitive Grants
- Formula Grants
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part F funding supports two dental programs: 1) HIV/AIDS Dental Reimbursement Program (DRP); and 2) Community-Based Dental Partnership Program (CBDPP).

The RWHAP DRP ensures access to oral health care for low-income people living with HIV (PLWH) by reimbursing dental education programs for the non-reimbursed costs they incur providing such care. By offsetting the costs of non-reimbursed HIV care in accredited dental education institutions, the RWHAP DRP improves access to oral health care for low-income, PLWH and ensures quality services by dental students, dental hygiene students, and dental residents for providing oral health care services to PLWH. The care provided through the program includes a full range of diagnostic, preventive, and treatment services, including oral surgery, as well as oral health education and health promotion. Dental schools, post-doctoral dental education programs, and dental hygiene education programs accredited by the Commission on Dental Accreditation that have documented non-reimbursed costs for providing oral health care to PLWH are eligible to apply for reimbursement. Funds are then distributed to eligible organizations taking into account the number of people served and the cost of providing care.

In FY 2017, the RWHAP DRP awards were able to provide 27 percent of the total non-reimbursed costs requested by 56 participating institutions in support of oral health care. These institutions reported providing care to 37,370 HIV-positive individuals, 18,797 for whom no other funded source was available, missing the FY 2017 performance target by 1,768 individuals or less than 5 percentage points. In FY 2017, the demographic characteristics of patients who

were cared for by institutions participating in the RWHAP DRP were 55 percent minority and 31 percent women.

The RWHAP CBDPP supports collaborations between dental education programs and community-based partners to deliver oral health services in community settings while supporting students and residents enrolled in accredited dental educations programs. In FY 2017, RWHAP CBDPP funded 12 partnership grants to support collaboration and coordination between the dental education programs and the community-based partners in the delivery of oral health services.

Programs	FY 2018	FY 2019	FY 2020
RWHAP Dental Reimbursement Program	$8,891,572	$8,891,572	$8,891,572
RWHAP Community-Based Dental Partnership Program	$3,475,673	$3,475,673	$3,475,673

Funding History

FY	Amount
FY 2011	$13,511,000
FY 2012	$13,485,000
FY 2013	$12,646,000
FY 2014	$12,991,000
FY 2015	$13,020,000
FY 2016	$13,122,000
FY 2017	$13,090,000
FY 2018	$13,122,000
FY 2019	$13,122,000
FY 2020	$13,122,000

Budget Request

The FY 2020 Budget Request for the Ryan White HIV/AIDS (RWHAP) Part F Dental Programs of $13.1 million is equal to the FY 2019 Enacted level. The request will support oral health care for PLWH. This Request supports the reimbursement of applicant institutions through the RWHAP DRP and funding of the RWHAP CBDPP.

The FY 2020 Request will support RWHAP target for reimbursing at least 37,370 PLWH for a portion of their unreimbursed oral health costs through the RWHAP Dental Reimbursement Program.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
22. I.D.1: Number of persons for whom a portion/percentage of their unreimbursed oral health costs were reimbursed. *(Output)*	2017: 37,370 Target: 39,138 (Target Not Met)	36,232	37,370	Maintain

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	63	63	63
Average Award	$196,305	$196,305	$196,305
Range of Awards	$6,195 - $1,545,922	$6,195 - $1,545,922	$6,195 - $1,545,922

RWHAP Part F - Special Projects of National Significance

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$25,000,000	$25,000,000	$25,000,000	---
FTE	3	3	3	---

Authorizing Legislation: Public Health Service Act, Section 2691, as amended by Public Law 111-87

FY 2020 Authorization…….…….…..Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part F Special Projects of National Significance (SPNS) supports the development, evaluation, and dissemination of innovative interventions, models and strategies for HIV care to improve the retention and health outcomes of RWHAP clients. As healthcare systems work under increasingly dynamic conditions, evidence-based strategies are essential in order to ensure that research investments maximize healthcare value and improve public health. Implementation science plays a critical role in supporting these efforts. RWHAP SPNS-funded projects use implementation science - the scientific study of methods to promote the systematic uptake of research findings into routine practice - to improve the quality and effectiveness of health services, maximize resources, and improve health outcomes for PLWH.

The RWHAP SPNS evaluates the effectiveness of various models, interventions, strategies, implementation, utilization, cost, and health related outcomes, while promoting the dissemination and replication of successful models. Through these special projects, RWHAP SPNS grant recipients implement a variety of promising interventions gathering evidence-informed practices and lessons learned to improve treatment outcomes and avert new HIV infections. RWHAP SPNS initiatives address the emerging needs of the most disproportionately impacted populations living with HIV.

Through its demonstration projects, RWHAP SPNS models, interventions, and strategies contribute to the advancement of public health knowledge and help move toward the elimination of HIV in the United States by promoting models that focus on expanding linkage to HIV medical care, improving lifelong retention in HIV medical care, the delivery of antiretroviral therapy (ART), and ultimately achieving HIV viral suppression among people living with HIV.

Of the 77 currently funded FY 2018 Ryan White HIV/AIDS Program SPNS grant recipients: 22 percent are community-based/AIDS services organizations; 19 percent are state/county/local departments of health; 26 percent are community health centers; 10 percent are academic-based clinics; and 23 percent are universities/evaluation and technical assistance providers.

Currently funded projects include: use of social media to improve engagement, retention, and health outcomes; addressing HIV care and housing coordination improve health outcomes; workforce capacity building for integrating HIV primary care in community health care settings; outreach, access, and retention among Latino(a) populations; improving sexually transmitted infection screening and treatment; and using evidence-informed interventions through an implementation science framework, to improve health outcomes among people living with HIV.

Funding History

FY	Amount
FY 2011	$25,000,000
FY 2012	$25,000,000
FY 2013	$25,000,000
FY 2014	$25,000,000
FY 2015	$25,000,000
FY 2016	$25,000,000
FY 2017	$24,940,000
FY 2018	$25,000,000
FY 2019	$25,000,000
FY 2020	$25,000,000

Budget Request

The FY 2020 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part F Special Projects of National Significance (SPNS) of $25 million equal to the FY 2019 Enacted level. The Budget will support the continued development of innovative models of HIV care and treatment for populations that are significantly difficult to engage in continuous care and achieve viral suppression. In FY 2020, there is a decrease in the number of RWHAP SPNS awards because the program is now using more funding to evaluate the implementation of several different evidence informed interventions to assess impact on outcomes across populations and clinical settings.

Through its funded demonstration projects, RWHAP SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models, interventions, and strategies, while promoting the dissemination and replication of successful ones. RWHAP SPNS funding also supports projects to build capacity in the health information technology (HIT) systems of RWHAP grant recipients and provider organizations to report client-level data and to improve health outcomes.

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

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	37	28	25
Average Award	$620,029	$799,896	$895,883
Range of Awards	$143,286 - $5,317,392	$145,304 - $5,322,371	$296,596 - $5,324,435

RWHAP – Ending the HIV Epidemic Initiative

	FY 2018 Final	FY2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	—	—	$70,000,000	+$70,000,000
FTE	—	—	30	+30

Authorizing Legislation: Section 311 of the Public Health Service Act and Title XXVI of the Public Health Service Act

FY 2018 Authorization…….……..…….Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description

HHS is proposing a once-in-a-generation opportunity to eliminate new HIV infections in our nation. Ending the HIV Epidemic*: A Plan for America* will work to reduce new infections by 75 percent in the next five years and by 90 percent in the next ten years, with the goal of averting more than 250,000 HIV infections in that span. The multi-year program will infuse 48 counties, Washington, D.C., San Juan, Puerto Rico, as well as 7 states that have a substantial rural HIV burden with the additional expertise, technology, and resources needed to end the HIV epidemic in the United States. This Initiative will be coordinated across HHS, with efforts from HRSA, the Centers for Disease Control and Prevention (CDC), the Indian Health Service (IHS), and the National Institutes of Health (NIH). HHS is focused on four strategies – diagnose, treat, protect, and respond.

Through expanded HIV care and treatment utilizing the existing RWHAP infrastructure, HRSA proposes to contribute to efforts to end the U.S. HIV epidemic by increasing viral suppression among people living with HIV (PLWH) through engaging those PLWH currently not in care and those newly diagnosed with HIV. Research studies demonstrate that PLWH who take HIV medications daily as prescribed, and achieve and then maintain an undetectable viral load, have effectively no risk of sexually transmitting the virus to an HIV-negative partner.[206,207] The RWHAP plays a key role in increasing viral suppression rates nationally. The RWHAP provides

[206] National Institute of Allergy and Infectious Disease (NIAID). Preventing Sexual Transmission of HIV with Anti-HIV Drugs. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000- [cited 2016 Mar 29]. Available from: http://clinicaltrials.gov/show/ NCT00074581 NLM Identifier: NCT00074581.
[207] Rodger AJ et al for the PARTNER study group. Sexual activity without condoms and risk of HIV transmission in serodifferent couples when the HIV-positive partner is using suppressive antiretroviral therapy. JAMA, 2016;316(2):1-11. DOI: 10.1001/jama.2016.5148. (12 July 2016). Full free access.

services to over half a million people, over half of all people with diagnosed HIV in the U.S.[208] In the RWHAP, 85.9 percent of patients receiving RWHAP medical care are virally suppressed[209] compared to the general population of people diagnosed with HIV which have a viral suppression rate of 59.8 percent[210,211] - an outcome measure that demonstrates the success of the program and is critical to efforts to end the HIV epidemic.

The Ending the HIV Epidemic Initiative is a close collaboration with the HRSA Health Center Program to expand HIV care and treatment capacity, with CDC efforts to test and refer people who are not aware of their HIV diagnosis or to bring into care PLWH who have not been engaged in HIV care and treatment, and IHS and NIH efforts. Nationally, CDC estimates that out of the 1.1 million PLWH, an estimated 418,000 are either not yet diagnosed or are not receiving HIV care and treatment. The goal of the 10 year initiative is to engage, retain, and provide care and treatment to PLWH who are diagnosed but not in care and those newly diagnosed with HIV.

HRSA's RWHAP efforts will focus on implementing evidence-informed practices shown to increase linkage, engagement, and retention in care; capacity development; HIV care and treatment services, including medication services; and on technical assistance in the 48 counties, Washington, D.C., San Juan, Puerto Rico, and seven states that contain more than 50% of new HIV infections. Through these efforts, HRSA anticipates that an additional approximately 18,200 PLWH will be served by the RWHAP in the first year (FY2020).

HRSA will distribute funding to the RWHAP Part A and B jurisdictions in the 48 counties, Washington, D.C., San Juan, Puerto Rico, and 7 states. These jurisdictions will utilize the funding to implement evidence informed practices shown to increase linkage, engagement, and retention in care. These would include practices such as data to care efforts; using acuity tools and clinics to identify and provide care for the most challenging to engage patients; rapid engagement and medication initiation protocols; and others that have been successful in the field.

As patients are linked and retained in care, the jurisdictions will support the HIV care and treatment needs of the newly identified and re-engaged PLWH. The HRSA funded jurisdictions will work with their respective AIDS Drug Assistance Program (ADAPs) to ensure necessary resources are available to provide assistance for medications and health care coverage premiums and cost-sharing for PLWH newly diagnosed or re-engaged in care through the initiative.

Funding would also be provided to expand capacity, and to provide technical assistance to jurisdictions to build capacity to implement evidence-informed interventions to achieve the goals

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[208] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2017 Accessed December 11, 2018.

[209] HIV viral suppression was based on data for RWHAP clients who had at least 1 outpatient ambulatory medical care visit during the measurement year and one viral load measurement and whose most recent viral load test result was <200 copies/mL. Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2017. Accessed December 11, 2018.

[210] Table 5a. HIV viral suppression during 2015 among persons aged >=13 years with HIV infection diagnosed by year-end 2014 and alive at year-end 2015 – 39 states and the District of Columbia. Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2016. *HIV Surveillance Supplemental Report* 2018;23(No. 4). Published June 2018. Accessed July 16,, 2018.

[211] Based on data reported by 39 States and the District of Columbia.

of the initiative. HRSA will utilize initiative funds for internal infrastructure to implement the initiative, including data systems to provide timely monitoring of the initiative.

Budget Request

The FY 2020 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) component of the Ending HIV Epidemic Initiative is $70 million. This funding will support HIV care and treatment services in the counties and states, evidence informed practices to link, engage, and retain PLWH, capacity building, technical assistance, and HRSA infrastructure for program implementation and oversight.

In FY 2020, the HRSA will direct RWHAP funding to the 48 counties, DC, San Juan, and seven states that contain more than 50% of new HIV infections. Funding will be awarded to the current RWHAP Part As that contain one or more of the counties and relevant states for counties located outside of the eligible metropolitan areas. Funding for the 7 initiative states will be awarded to the current RWHAP Part B recipients. HRSA will require coordination with the respective AIDS Drug Assistance Program (ADAPs) to ensure necessary resources are available to provide assistance for medications and health care coverage premiums and cost-sharing for PLWH newly diagnosed or re-engaged in care through the initiative. The RWHAP's comprehensive system of HIV care and support services and effective system for medication delivery creates a very efficient and effective service delivery mechanism for this initiative.

In FY 2020, funding will be proportionally distributed between the jurisdictions based on the estimated number of people living with HIV (PLWH) who are out of care or undiagnosed in each area as determined by the CDC.

Starting in FY 2020, HRSA will fund activities to increase the capacity within the RWHAP and the HRSA Health Center Program to provide services to the increased number of PLWH and for the provision of PrEP services.

The RWHAP will direct funding to support technical assistance, evaluation, and clinical quality improvement efforts for the initiative. These funds will be used to enhance the current RWHAP data collection systems to provide timely monitoring of the initiative; to support dissemination of effective interventions to increase the number of PLWH served by the initiative; to provide additional technical assistance to jurisdictions to identify and link and retain.

Grants Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	—	—	48
Average Award	—	—	1,126,036
Range of Awards	—	—	N/A

Healthcare Systems TAB

HEALTHCARE SYSTEMS

Organ Transplantation

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$25,486,000	$25,549,000	$27,549,000	+$2,000,000
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Sections 371-378, as amended by Public law 108-216, Public Law 109-129, Public Law 110-144, Public Law 110-413, and Public Law 113-51

FY 2020 Authorization……..…….…..……..... Expired

Allocation Method:
- Contracts
- Competitive Grants/Co-operative Agreements
- Other (Interagency Support)

Program Description

The Organ Transplantation Program extends and enhances the lives of individuals with end-stage organ failure for whom an organ transplant is the most appropriate therapeutic treatment. HRSA oversees a national system, the Organ Procurement and Transplantation Network (OPTN), to allocate and distribute donor organs to individuals waiting for an organ transplant. Organ allocation is guided by OPTN policies informed by analytic support from the Scientific Registry of Transplant Recipients (SRTR). HRSA also invests in public education and outreach to increase the supply of deceased donor organs available for transplant and to ensure the safety of living organ donors.

The OPTN is a critical system that facilitates matching donor organs to individuals needing organ transplants. Given the great demand for and limited supply of organs, OPTN policies are under continual review and refinement to achieve the best outcomes for patients, attain the maximum benefit for the maximum number of waitlist candidates, make the best use of donor organs, and align with policy development requirements of the OPTN final rule (42 CFR 121). OPTN operating costs are covered by appropriated funds and revenues generated by registration fees paid by transplant centers for each transplant candidate placed on the waiting list. The OPTN collects fees under the authority of 42 CFR 121.5(c).

The OPTN final rule (42 CFR §121.12) established the Advisory Committee on Organ Transplantation (ACOT), which is composed of experts in the field of organ transplantation, to

provide recommendations to the Secretary on issues related to organ donation and transplantation. HRSA provides logistics and analytic support for periodic ACOT meetings. HRSA also engages in interagency activities that support organ donation and transplantation.

The SRTR provides analytic support to the OPTN in the development of organ allocation policies and performance evaluation. Additionally, the SRTR provides analytic support to HHS, including the ACOT. SRTR shares information publicly about the performance of transplant programs and organ procurement organizations at https://www.srtr.org/. It publishes online transplant program risk-adjusted patient and graft outcomes data as well as organ procurement organization risk-adjusted data on organs procured per donor. SRTR also publishes online a comprehensive Annual Data Report that includes the most current ten years of data on waitlist, transplant, and deceased donor organ donation.

HRSA collaborates with the organ donation and transplantation community on efforts to promote awareness of the need for donated organs and to encourage public enrollment on organ donor registries (state or national). Outreach activities include:

- Public service announcement campaigns for radio, TV stations, and publications nationwide
- Educational web videos for reposting, download, and social media
- Radio Ad Spotlights during high traffic drive-time hours in designated markets with the highest numbers of African Americans, Asians, Hispanics or Latinos, and people 50 years and older. Data reveals gaps between the numbers of patients waiting for an organ and numbers of donors from these groups.
- Print ads in widely circulated publications such as major sporting event program guides
- Organ donation and transplantation related articles for newspapers and journals
- Downloadable print materials on a variety of topics for multiple audiences
- HRSA's organ donation sites: www.organdonor.gov and https://donaciondeorganos.gov
- Social media outreach
- Grant projects to test approaches to promote public awareness of the need for organ donation and increase registration in donor registries

Through a cooperative agreement, HRSA provides reimbursement of travel and subsistence expenses to living organ donors who are not able to receive such support: (1) under any state compensation program, insurance policy, or under any Federal or state health benefits program; (2) by an entity that provides health services on a prepaid basis; or (3) from an organ recipient. In addition, HRSA is supporting a three-year demonstration project, through a separate FY 2019 cooperative agreement, to assess the impact of reimbursement of lost wages on individuals' willingness to become living organ donors.

Program Accomplishments

One of HRSA's primary goals for the Organ Transplantation Program is to increase the annual number of deceased donor organs transplanted. In CY 2017, the number of deceased organ transplanted was 31,608, which is a 7 percent increase over the CY 2016 total of 29,497. HRSA experienced record-breaking numbers of organ transplants in 2015, 2016, and 2017.

Another important program goal is to increase the organ donor conversion rate, which is the rate potential organ donors become actual organ donors after death. The conversion rate has been a key performance metric and a priority for the Organ Transplantation Program since 2003. The conversion rate remained steady at approximately 72 percent in CY 2015 and CY 2016, but declined to 70 percent in CY 2017. HRSA will continue to monitor conversion rates and assess potential next steps.

The organ donor conversion rate is based on potential "eligible deaths," which includes potential donors aged 75 or below who are legally declared dead by neurologic criteria (brain death) and not excluded for other defined reasons related to certain risk factors. The number of "eligible deaths" does not include: (1) donors declared dead by circulatory determination of death (cardiac death) rather than neurologic criteria and (2) donors whose organs were transplanted despite donor ages or other risk factors that may have excluded them from being counted as "eligible deaths."

Table 1. Conversion Rates and Eligible Deaths 2013-2017

Year	Number of Donors	Number of Eligible Deaths	Conversion Rate (%)	Change in Eligible Deaths (%)
2013	6,530	9,173	71.2	2.5
2014	6,821	9,259	73.7	0.9
2015	7,053	9,781	72.1	5.6
2016	7,753	10,706	72.4	9.5
2017	8,104	11,653	69.5	8.8

Funding History

FY	Amount
FY 2016	$23,549,000
FY 2017	$23,492,000
FY 2018	$25,486,000
FY 2019	$25,549,000
FY 2020	$27,549,000

Budget Request

The FY 2020 Budget requests for the Organ Transplantation Program of $27.5 million is $2.0 million above the FY 2019 Enacted level. HRSA will use the additional funding to expand HRSA's financial support to living organ donors and increase awareness about living organ donation. The Budget request will provide $18.1 million for the OPTN, SRTR, and public and professional education efforts to increase public awareness about the need for organ donation. HRSA will also invest $6.5 million for efforts to support living organ donors, which include reimbursement of lost wages and travel and subsistence expenses, and $2.9 million for activities

related to the Advisory Committee, interagency agreements, and other internal support and Program-related activities.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, information technology and other program support costs. Additionally, the request covers IT investment costs to support performance outcomes and to enhance data sharing.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
23.II.A.1: Annual number of deceased donor organs transplanted.	FY 2017: 31,608 Target: 26,202 (Target Exceeded)	26,555	32,010	+5,455
23.II.A.8: Annual conversion rate of eligible donors.	FY 2017: 69.50% Target: 74.0% (Target Not Met)	74.50%	74.50%	Maintain

Grants Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	12	8	9
Average Award	$593,813	$939,443	882,077
Range of Awards	$301,992-$2,744,196	$299,274--$3,250,000	$300,000-$3,250,000

National Cord Blood Inventory

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$15,236,000	$16,266,000	$12,266,000	-$4,000,000
FTE	4	4	4	---

Authorizing Legislation: Public Health Service Act, Section 379, as amended by Public Law 114-104

FY 2020 Authorization…….....$23,000,000

Allocation Method…….…….....……Contract

Program Description

The National Cord Blood Inventory (NCBI) Program is charged with building a genetically and ethnically diverse inventory of at least 150,000 new units of high-quality umbilical cord blood for transplantation. These cord blood units (CBUs), as well as other cord blood units in the inventories of participating cord blood banks, are made available to patients for blood stem cell transplants through the C.W. Bill Young Cell Transplantation Program (CWBYCTP). Cord blood banks participating in the NCBI program also make cord blood units not suitable for transplantation available for preclinical and clinical research.

Blood stem cell transplantation is potentially a curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year, nearly 18,000 people in the U.S. are diagnosed with illnesses for which blood stem cell transplantation from matched donors is their best treatment option. Often, the first-choice donor is a sibling, but only 30 percent of people have a fully tissue-matched brother or sister. The other 70 percent, or approximately 12,600 people, often search for a matched, unrelated adult donor or a matched umbilical cord blood unit.

Tissue types of blood stem cell donors must closely match their recipients for transplants to be successful. Since tissue types are inherited, patients are more likely to find closely matched donors within their own racial and ethnic groups. Due to the high rate of diversity in tissue types of underrepresented racial and ethnic populations, especially African-Americans, underrepresented racial and ethnic populations are less likely to find suitably matched adult marrow donors on the CWBYCTP Registry. Because umbilical cord blood can be used with a less stringent match in tissue types between donor and recipient than is the case for adult marrow donors, umbilical cord blood offers a chance of survival for patients who lack suitably matched related or unrelated adult donors, particularly those from racially and ethnically diverse populations. For this reason, HRSA's NCBI policy continues to emphasize increasing the number of CBUs collected from diverse populations.

The NCBI provides funds through competitive contracts for the collection and storage of qualified CBUs by a network of cord blood banks in the U.S. The NCBI program selects cord blood banks based on assessment of technical merit, overall quality, geographic dispersion of collection and storage sites, evaluation of past performance, and evaluation of proposed costs. Additionally, HRSA prioritizes demonstrated ability of cord blood banks to collect and bank significant numbers of CBUs from racially and ethnically diverse populations.

Program Accomplishments

Currently, thirteen cord blood banks hold NCBI contracts. As of September 30, 2017, the cumulative number of NCBI CBUs available through the Program was 92,546 (Table 1). HRSA estimates that approximately 3,000 additional units will be collected and made available for patient searches in FY 2020. The number of units collected varies from year to year based on funding levels, contractor's ability to collect and store units from diverse populations, and contractor's licensure status.

Table 1. Cord Blood Collections

Fiscal Year	Number of Units Contracted	NCBI Cord Blood Units Collected and Made Available[1] for Patient Searches	Cumulative Units Made Available[212]
2013	7,900	7,640	61,249
2014	7,469	8,654	69,903
2015	6,469	9,373	79,276
2016	5,840	6,167	85,443
2017	6,369	7,103	92,546

The availability of umbilical cord blood has increased access to blood stem cell transplantation, particularly for patients who would not otherwise have well-matched adult donors. The NCBI further increases access to transplantation compared to non-NCBI CBUs, because NCBI CBUs are more genetically diverse and contain higher cell counts. Higher cell counts reflect more blood stem cells available for infusion into a transplant patient, which can benefit larger patients and assist with improving outcomes. NCBI units released for transplantation have cell counts well above the levels generally available prior to implementation of the NCBI Program.

As shown in Table 2, the number of NCBI cord blood units released for transplants fell below the FY 2017 target of 535 due to the increasing use of alternative therapies. In particular, haploidentical transplants, use of blood stem cells from a donor who is biologically related to the recipient-patient, are on the rise. Despite this recent trend, NCBI units remain key in servicing a

[212] Due to the lag between when cord blood units are collected and when they have been fully tested and qualified for listing on the public registry, not all of the units collected with funds from a given fiscal year will be available on the registry during that same fiscal year.

diverse population. As the NCBI's diverse inventory of cord blood units grows, it will continue to serve an increasing number of patients. Underrepresented racial and ethnic populations account for over 60 percent of the cord blood units collected. HRSA will continue to monitor and assess trends in cord blood transplantation and will adjust transplant targets accordingly.

Table 2. Cord Blood Units Released for Transplantation

Fiscal Year	NCBI Units Released for Transplantation	Total Cord Blood Units (NCBI and Non-NCBI) released for Transplantation through the C.W. Bill Young Cell Transplantation Program
2013	714	1,102
2014	544	1,359
2015	609	1,393
2016	529	1,154
2017	494	1,050

In addition to directly growing the NCBI inventory, resources provided to NCBI-contracted banks have played an important role in stimulating the collection and banking of many other non-NCBI units. These CBUs may not meet minimum cell content thresholds established for the NCBI, but may be suitable sources of blood stem cells for smaller patients where acceptable cell doses can still be achieved using smaller units. Additionally, NCBI banks have provided researchers more than 93,844 cord blood units that are not be suitable for clinical transplantation but serve a wide variety of research purposes.

Funding History

FY	Amount
FY 2016	$11,266,000
FY 2017	$12,239,000
FY 2018	$15,236,000
FY 2019	$16,266,000
FY 2020	$12,266,000

Budget Request

The FY 2020 Budget requests for the National Cord Blood Inventory Program of $12.3 million is $4 million below the FY 2019 Enacted level. This Budget request supports continued progress toward the statutory goal of building a genetically diverse inventory of at least 150,000 new units of high-quality cord blood for transplantation. This request will also increase the number of patients in all population groups who are able to obtain life-saving transplants. Cell dose and degree of match between patient and cord blood unit are both strongly associated with positive transplant outcomes. Therefore, a larger inventory of publicly available CBUs will contribute to

improved patient survival after transplant because a growing inventory of high cell count CBUs will allow access to higher cell doses and better tissue matches for patients.

The FY 2020 Budget request supports collecting and banking approximately 3,000 additional CBUs and projects an average price of $3,000 per CBU, which includes an anticipated price increase of $1,000 per CBU. HRSA expects the significant CBU price increase based on a RAND Study published in September 2017 that discussed generally increasing costs of cord blood banking and, more specifically, the costs in building a racially and ethnically diverse inventory.[213] HRSA anticipates continued NCBI CBUs prices increases since cord blood banks are no longer financially positioned to offer the government significant discounts as provided previously. However, HRSA will continue to seek substantial discounts for each cord blood unit through competitive contracting.

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

[213] Kapinos, Kandice A. et al. *Challenges to the Sustainability of the U.S. Public Cord Blood System*. Santa Monica, CA: RAND Corporation, 2017. Full document is available online.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
40.II.A.1: The cumulative number of cord blood units from underrepresented racial and ethnic populations available through the C.W. Bill Young Cell Transplantation Program (NCBI & non-NCBI)[214]	FY 2017: 142,721 Target: 78,809 (Target Exceeded)	83,809	145,721	+61,912
40.II.A.2: The size of the National Cord Blood Inventory (cumulative # of units banked and available through the C.W. Bill Young Cell Transplantation Program)	FY 2017: 92,546 Target: 88,000 (Target Exceeded)	96,000	99,000	+3,000
40.II.A.3: The annual number of NCBI cord blood units released for transplant[215]	FY 2017: 494 Target: 535 (Target Not Met)	500	500	Maintain

Contracts Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Contracts	4	6	6
Average Contract	$2,265,827	$2,366,667	$1,888,189
Range of Contracts	$500,000-5,000,000	$500,000-5,000,000	$500,000-$5,000,000

[214] Data shows there are over 20,000 cord blood units designated as "unknown race/ethnicity" as not every cord blood bank requires donors to provide the information. Inability to properly categorize these units subsequently impacts tracked data. The 20,000 cord blood units are not included in this measure but are included in the total number of cord blood units available through the CWBYCTP.

[215] Due to advances in the field, the number of unrelated blood stem cell transplants using cord blood has been on the decline, which may impact established targets.

C.W Bill Young Cell Transplantation Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$24,050,000	$24,609,000	$24,609,000	---
FTE	7	7	7	---

Authorizing Legislation: Public Health Service Act, Sections 379-379B, as amended by Public Law 114-104

FY 2020 Authorization…….…….$30,000,000

Allocation Method…….…….…….Contract

Program Description

The primary goal of the C.W. Bill Young Cell Transplantation Program (CWBYCTP) is to increase the number of transplants for recipients suitably matched to biologically unrelated bone marrow[216] and umbilical cord blood donors. HRSA achieves this goal by: (1) providing a national system for recruiting potential bone marrow donors; (2) tissue typing potential donors; (3) coordinating the procurement of bone marrow and umbilical cord blood units for transplantation; (4) offering patient and donor advocacy services; (5) providing public and professional education; and (6) collecting, analyzing, and reporting data on transplant outcomes.

Blood stem cell transplantation, which includes bone marrow and cord blood, is a potentially curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year nearly 18,000 people in the U.S. are diagnosed with life-threatening illnesses where blood stem cell transplantation from matched donors is the best treatment option. Often, the ideal donor is a suitably matched family member, but only 30 percent of people have a fully matched relative. The other 70 percent, or approximately 12,600 people, often search for a matched unrelated adult donor or umbilical cord blood unit.

The CWBYCTP is the successor to the National Bone Marrow Donor Registry. While the current scope of the CWBYCTP is similar to that of its predecessor, HRSA expanded responsibility for collecting, analyzing, and reporting data on transplant outcomes, to include all allogeneic (from a genetically similar, but not identical, donor) blood stem cell transplants as well as other therapeutic uses of blood stem cells. The CWBYCTP operates through three major contracts that require close coordination and oversight and supports an Advisory Council that

[216] Public Health Service Act, Sections 379-379B, as amended by P.L. 114-104 states that the term 'bone marrow' means the cells found in the adult bone marrow and peripheral blood.

provides recommendations to the HHS Secretary and HRSA on activities related to the CWBYCTP. The major components of the CWBYCTP are:

- The combined Single Point of Access – Coordinating Center (SPA-CC) maintains a system for health care professionals and physicians, searching on behalf of patients, to search electronically for cells derived from adult marrow donors and cord blood units through a single point of access and supports coordination activities for bone marrow and cord blood.

- The Office of Patient Advocacy (OPA) maintains a system for patient advocacy, which provides individualized patient services for ongoing searches for bone marrow donors or cord bloods. The OPA also assists patients with information regarding treatment options and payment matters.

- The Stem Cell Therapeutic Outcomes Database (SCTOD) provides an electronic outcomes blood stem cell transplantation database for use by researchers and health care professionals. The SCTOD also provides a repository that stores donor and recipient samples for research and the collection and analysis of data on the clinical outcomes of blood stem cell transplants.

Performance measures are incorporated into contracts and monitored quarterly to ensure the CWBYCTP meets its long-term goals for: (1) number of blood stem cell transplants facilitated annually; (2) number of transplants facilitated annually for minority patients; (3) number of domestic transplants facilitated annually; and (4) one-year post-transplant patient survival. The CWBYCTP also relies on two annual performance measures: (1) number of adult volunteer potential donors from underrepresented racial and ethnic populations listed on the CWBYCTP's registry; and (2) per unit cost for human leukocyte antigen (HLA) tissue typing needed to match patients and donors. Additional performance standards are developed and monitored under each contract.

Program Accomplishments

The CWBYCTP continues to serve a diverse patient population, with umbilical cord blood playing a vital role in expanding access to transplants for patients from underrepresented racial and ethnic populations. Increasing the number of blood stem cell transplants facilitated for patients from racially and ethnically diverse backgrounds addresses the statutory aim of ensuring comparable access to transplantation for patients from all populations. Adding to the pool of potential adult volunteer blood stem cell donors also helps achieve this aim. As of the end of FY 2017, more than 19.3 million potential adult volunteer donors were listed on the CWBYCTP's registry. More than 3.7 million, or 19 percent, self-identify as belonging to an underrepresented racial or ethnic population. The CWBYCTP expects the registry will list 4.1 million adult donors who self-identify as belonging to an underrepresented racial or ethnic population in FY 2020.

The cost of tissue typing per donor strongly influences the number of potential volunteer donors recruited for the Program's registry. The FY 2020 cost for each donor's tissue typing will remain at $58.00, the same cost as in FY 2017. Tissue typing identifies genetic markers that assist physicians in conducting donor searches on behalf of patients. Continued advances in tissue

typing technology facilitate more efficient matching between potential donors and searching patients and allow patients to move more rapidly toward transplantation.

Funding History

FY	Amount
FY 2016	$22,109,000
FY 2017	$22,056,000
FY 2018	$24,050,000
FY 2019	$24,609,000
FY 2020	$24,609,000

Budget Request

The FY 2020 Budget request for the C.W Bill Young Cell Transplantation Program of $24.6 million is the same as the FY 2019 Enacted level. This Budget request supports the Program's FY 2020 performance target of 4.1 million adult volunteer donors from underrepresented racial and ethnic populations listed on the CWBYCTP's registry.

The Budget request prioritizes recruiting and tissue-typing new donors and continues the following activities: (1) collecting comprehensive outcomes data on both related and unrelated-donor blood stem cell transplants; (2) assessing quality of life for transplant recipients; (3) working with foreign transplant centers to obtain data on U.S. stem cell products provided to them for transplant; and (4) collecting data on emerging therapies using cells derived from bone marrow and umbilical cord blood. Additionally, the FY 2020 Budget request allows the CWBYCTP to continue critical planning in collaboration with HHS on a response to a national radiation or chemical emergency. In such an event, casualties could involve temporary or permanent marrow failure and may possibly require emergency transplants for individuals unable to recover marrow function.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
24.II.A.2: The number of adult volunteer potential donors of blood stem cells from minority race and ethnic groups (Outcomes)	FY 2017: 3.70M Target: 3.74M (Target Not Met)	4.08M	4.13M	+0.05M
24.1: The number of blood stem cell transplants facilitated by the Program [217] (Outcome)	FY 2017: 5,994 Target: 6,960 (Target Not Met)	N/A	N/A	N/A
24.2: The number of blood stem cell transplants facilitated for minority patients by the Program [218] (Outcome)	FY 2017: 875 Target: 1,150 (Target Not Met)	N/A	N/A	N/A
24.3: The rate of patient survival at one year, post- transplant [219] (Outcome)	FY 2013: 71% Target: 69% (Target Exceeded)	N/A	N/A	N/A
24.4: The number of blood stem cell transplants facilitated for domestic patients by the Program [220] (Outcome)	FY 2017: 4,835 Target: 5,135 (Target Not Met)	N/A	N/A	N/A
24.E: The unit cost of human leukocyte antigen (HLA) typing of potential donors (Efficiency)	FY 2017: $58.00 Target: $58.00 (Target Met)	$58.00	$58.00	Maintain

[217] "This is a long-term measure. The next target will be set for FY 2022.
[218] "This is a long-term measure. The next target will be set for FY 2022.
[219] "This is a long-term measure. The 2017 target for this measure, set at 69%, will be compared to actuals once available. The next target will be set for FY 2022.
[220] "This is a long-term measure. The next target will be set for FY 2022.

Contracts Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	3	3	3
Average Award	$7,453,761	$7,415,731	$6,794,476
Range of Awards	$851,741-$17,141,120	$877,293-$16,900,000	$877,293-$16,900,000

Poison Control Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$20,810,000	$22,846,000	$22,846,000	---
FTE	3	3	3	---

Authorizing Legislation: Public Health Service Act, Sections 1271-1274, as amended by Public Law 113-77

FY 2020 Authorization .....Expired

Allocation Method:

- Contracts
- Competitive Grants/Co-operative Agreements

Program Description and Accomplishments

The Poison Control Program (PCP) was established in 2000 and is legislatively mandated to: fund poison centers; establish and maintain a single, national toll-free number (800-222-1222) to ensure universal access to poison center services; connect callers to the poison centers serving their areas; and implement a nationwide media campaign to educate the public and health care providers about poison prevention, poison center services, and the 800 number.

The PCP grant program supports poison control centers' (PCCs) efforts to: 1) prevent and provide treatment recommendations for poisonings; 2) comply with operational requirements to sustain accreditation and or achieve accreditation; and 3) improve and enhance communications and response capability and capacity. Funds may also be used to improve the quality of data uploaded from poison centers to the National Poison Data System (NPDS) in support of national toxic surveillance activities conducted by the Centers for Disease Control and Prevention (CDC).

The national toll-free Poison Help Line, was established in 2001 to ensure universal access to PCC services. Individuals can call from anywhere in the United States (U.S.) and its territories and connect to the poison centers that serve their respective areas. The PCP maintains the number, provides translation services in over 150 languages, and offers services for the hearing impaired.

Today, a network of 55 PCCs supported by 52 grant awards, provides cost effective, quality health care advice to the general public and health care providers across the U.S., including American Samoa, the District of Columbia, the Federated States of Micronesia, Guam, Puerto Rico, and the U.S. Virgin Islands. Twenty-four hours a day, seven days a week, health care providers and other specially trained poison experts provide poisoning triage and treatment

recommendations at no cost to callers. A hallmark of poison center case management is the use of follow up calls to monitor case progress and medical outcomes. Poison centers are not only consulted when children get into household products, but also when seniors and people of all ages mismanage medicine or when workers are exposed to harmful substances on the job. Emergency 911 operators refer poison-related calls to PCCs, and health care professionals regularly consult PCCs for expert advice on complex cases. PCCs are a critical resource for emergency preparedness and response as well as for other public health emergencies.

According to the American Association of Poison Control Centers (AAPCC), poison centers managed 2.7 million calls in 2016, an average of 7,446 calls per day. Of the approximate 2.1 million human exposure poisonings reported in FY 2016, PCCs managed nearly 67 percent at the site of exposure, avoiding unnecessary visits to emergency departments and reducing health care costs. Health care facilities represented less than one percent of exposures, but made approximately 23 percent of poison control calls.[221] Multiple studies have demonstrated that poison centers' accurate assessments and triage of poison exposures save dollars by reducing severity of illness and death, and by eliminating or reducing the expense of unnecessary trips to emergency departments. Poison center consultations also decrease patients' lengths of stay in hospitals and decrease hospital costs. Health care facilities' use of poison centers continues to increase, indicating an increase in severity of poisonings and the need for toxicological expertise in clinical settings. Every dollar invested in the poison center system is estimated to save $13.39 in medical costs and lost productivity, for a total savings of more than $1.8 billion every year. Of the $1.8 billion saved, the Federal Government saves approximately $662.8 million in medical care costs and lost productivity.[222]

In FY 2017, the PCP conducted a retrospective study to determine the impact of PCC consultations on the length of inpatient hospital stays related to poisonings for Medicare beneficiaries and any associated cost savings. The study found that PCC consultations with Medicare beneficiaries resulted in a reduction of more than 15,000 hospital days and cost savings of $16 million annually. The study also found that PCC consultations for all beneficiaries, regardless of payer, resulted in an estimated reduction of 90,000 hospital days and cost savings of $201 million annually.[223]

Through the nationwide Poison Help media campaign, the PCP has been educating the public about the toll-free number and increasing awareness of poison center services. In FY 2018, the Poison Help media campaign included an initial investment of $320,442. Based on over 485 million media impressions through television, radio, and social media, the PCP was able to leverage an advertising return on investment of nearly $5.5 million. The number of media impressions for FY 2018 increased 61 percent over FY 2017.

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[221] David D. Gummin, James B. Mowry, Daniel A. Spyker, Daniel E. Brooks, Michael O. Fraser & William Banner: 2016 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 34th Annual Report, Clinical Toxicology.

[222] Value of the Poison Center System: Lewin Group Report for the American Association of Poison Control Centers. 2011

[223] The Value of Poison Control Centers for Medicare Beneficiaries: Measuring the Impact of Poison Center Intervention. 2017

In addition to providing the public and health care providers with treatment advice on poisonings, a second critical function of the PCCs is the collection of poison exposure and surveillance data. Multiple Federal agencies, including the CDC, Consumer Product Safety Commission, Environmental Protection Agency, Food and Drug Administration, and Substance Abuse and Mental Health Services Administration, use these data for public health surveillance, including timely identification, characterization, or ongoing tracking of occurrences and other public health threats. In addition, many state health departments collaborate directly with poison centers within their jurisdictions. For example, states and Federal agencies use data from PCCs to monitor exposures to e-cigarette devices and liquid nicotine, synthetic cathinones and cannabinoids, opioids, hand sanitizer, and laundry detergent packets. In another example, PCCs are on the frontline of the opioid epidemic handling opioid-related calls every day, resulting in 55,000 opioid misuse and abuse cases per year.

According to the CDC, in 2016, the most recent year for which data are available, unintentional poisoning continues to be the leading cause of unintentional injury deaths. Prescription drugs, primarily opioid analgesics, were responsible for 91 percent of unintentional poisonings. The rate of drug poisoning deaths involving opioid analgesics nearly quadrupled over a 14-year period. PCCs play a critical role in combatting opioid drug-related abuse and misuse, from helping to define and trace the problem within a local and national context to responding to calls from health care providers seeking treatment advice for patients.

PCCs also provide public and health care provider education and actively seek to change behaviors to reduce poisonings and promote awareness and utilization of poison center services. Education efforts include: partnering with health departments, education departments, and other state agencies; promoting safe prescription medication use and storage; messaging at health fairs and community events; and collaborating to develop media campaigns focused on preventing poisonings. Additionally, PCCs participate in National Prescription Drug Take Back events sponsored by the Drug Enforcement Agency to provide a safe, convenient, and responsible means of prescription drug disposal, while also educating the public about potential medication abuses.

Funding History

FY	Amount
FY 2016	$18,846,000
FY 2017	$18,846,000
FY 2018	$20,810,000
FY 2019	$22,846,000
FY 2020	$22,846,000

Budget Request

The FY 2020 Budget Request is $22.8 million, which is the same as the FY 2019 Enacted level. This request will support the PCCs' infrastructure and core triage and treatment services. PCCs predominantly rely on state and local funding, as Federal funding accounts for approximately 13 percent of total PCC funding. While PCCs have innovatively secured funding from a variety of local sources, including philanthropic organizations, their financial stability is tenuous. Federal funding helps reinforce the nationwide PCC infrastructure, enabling PCCs to sustain their public health and toxic surveillance efforts.

In FY 2020, the PCP plans to issue grant awards to 52 recipients, with a five-year project period from FY 2020 to FY 2024. The National Toll-Free Hotline Services and Promotion of Number and Services will ensure access to PCCs through the national toll-free Poison Help hotline, 24 hours a day, every day of the year and will also support translation services for non-English speaking callers.

The Nationwide Media Campaign will continue to educate the public and health care providers about the national toll-free number and build upon the existing national public awareness campaign, Poison Help, to highlight the role of PCCs in the public health system with a focus on Medicare and Medicaid beneficiaries. The goals of the campaign include, increasing public awareness of the national Poison Help toll-free number; educating Medicare and Medicaid beneficiaries about poisoning risk and prevention; and showcasing the role of the national network of PCCs and the services they provide. The PCP will also continue to promote the hotline to the public and health care providers as well as engage other Federal partners, including Medicare and Medicaid recipients, community health centers, 340B Drug Pricing Program participants, geriatric education centers, rural health associations, Ryan White Program providers, and Head Start programs.

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

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
25.III.D.3: Percent of inbound volume on the toll-free number. (Output)	FY 2018: 85.9% Target: 83.0% (Target Exceeded)	83%	83%	Maintain

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
25. III.D.4: Percent of national survey respondents who are aware that calls to poison control centers are handled by health care professionals. (Outcome) [224]	FY 2012: 25% Baseline (Target Not in Place)	N/A	N/A	N/A
25. III.D.5: Percent of human poison exposure calls made to PCCs that were managed by poison centers outside of a healthcare facility. (Output)	FY 2016: 66.6% Target: 71% (Target Not Met)	65%	65%	Maintain

Grants Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards [225]	52	52	52
Average Awards	$327,275	$329,635	$329,635
Range of Award	$12,466-$2,006,384	$12,466-$2,013,447	$12,466-$2,185,501
Range of Contracts	$10,168-$511,000	$320,443-$511,000	$320,443-$511,000

[224] This is a long-term measure based on periodic survey data, reported about every 5 years. FY 2017 is the first year for which there is a target; the FY 2017 target is 25%. The 2017 results are expected in 2019 once a final report is approved by HRSA. The next year for which a target will be set is FY 2022.

[225] There are 55 PCCs across the Nation. Fifty-two awards were made in FY 2018 and are anticipated in FY 2019 and FY 2020 under the Poison Center Network Grant Program, representing all of the poison centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, while it encompasses four California poison centers.

Office of Pharmacy Affairs/340B Drug Pricing Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$10,210,000	$10,238,000	$10,238,000	---
User Fees	---	---	$19,000,000	+$19,000,000
Total	$10,210,000	$10,238,000	$29,238,000	+$19,000,000
FTE	22	22	38	+16

Authorizing Legislation: Public Health Service Act, Section 340B, as amended by Public Law 111-309, Section 204

FY 2020 Authorization…….…….…….…….....SSAN

Allocation Method……...…….……..….Contract

Program Description and Accomplishments

Administered by HRSA's Healthcare Systems Bureau Office of Pharmacy Affairs (OPA), the 340B Program requires drug manufacturers to provide discounts on outpatient prescription drugs to certain safety net health care providers specified in statute, known as covered entities. These include Federally Qualified Health Centers, AIDS Drug Assistance Programs, and certain disproportionate share hospitals. The 340B Program helps these designated hospitals and clinics provide more care to additional patients.

The 340B ceiling price – the maximum amount a drug manufacturer can charge a covered entity for a given drug – is equal to the Average Manufacturer Price (AMP) minus the Unit Rebate Amount, both set by the Centers for Medicare & Medicaid Services (CMS). Covered entities purchase 340B drugs that are at least 23.1 percent below AMP for brand name drugs; 13 percent below AMP for generic drugs; and 17.1 percent below AMP for clotting factor and pediatric drugs. In 2017, total sales in the 340B Program were approximately $19 billion. Covered entities saved between 25 to 50 percent on what they would have otherwise paid for covered outpatient drugs. OPA estimates 340B sales are approximately 4.3 percent of the total U.S. drug market.

HRSA places a high priority on the integrity of the 340B Program and continually works to improve Program oversight. OPA conducts the following activities to ensure both covered entities and manufacturers are in compliance with program requirements:

- Performs initial eligibility checks of all entities seeking to register with the Program.

- Recertifies covered entities annually including an attestation to compliance with all Program requirements.
- Performs audits of covered entities to assure compliance within the Program. Since FY 2012, OPA completed 1,090 covered entity audits, which included review of 15,144 offsite outpatient facilities and 22,867 contract pharmacies. Final audit results, including statuses of corrective actions, are available on HRSA's website. As of November 30, 2018, OPA closed out and finalized 1,006 of the 1,090 audits conducted, with 39 percent of findings related to diversion and 26 percent related to duplicate discount.
- Reviews every non-compliance allegation received through targeted communication and, if necessary, performs on-site audits.
- Performs audits of manufacturers.
- Provides assistance to covered entities that self-disclose compliance issues, including developing corrective action plans and working with affected manufacturers.
- Supports an integrated system of compliance tracking for covered entities and manufacturers, enabling enhanced communication across the Office of Pharmacy Affairs to ensure that all covered entities and manufacturers are in compliance with 340B program requirements.

The 340B Program includes the establishment of a Prime Vendor Program (PVP) to develop, maintain, and coordinate a program capable of facilitating distribution of covered outpatient drugs. By the end of 2017, the PVP had nearly 7,800 products available to participating entities below the 340B ceiling price, including 3,760 covered outpatient drugs with an estimated average savings of 10 percent below the 340B ceiling price. From 2009 to 2017, the PVP contracts provided over $723 million in additional sub-ceiling savings for covered entities.

Funding History

FY	Budget Authority	User Fees
FY 2016	$10,238,000	---
FY 2017	$10,213,000	---
FY 2018	$10,210,000	---
FY 2019	$10,238,000	---
FY 2020	$10,238,000	$19,000,000

Budget Request

The FY 2020 Budget Request is $10.2 million, which is the same as the FY 2019 Enacted level. Additionally, the FY 2020 Budget Request includes $19 million from user fees as a new revenue source. In FY 2020, HRSA will begin the development of a multi-functional web-based user fee system that will calculate user fees based on required manufacturer and covered entity sales data, collect user fees from covered entities, and verify payments. HRSA bases revenue projections on collecting a 0.1 percent (or one dollar for every thousand dollars) of the total 340B drug purchases paid by participating covered entities. Both appropriated resources and user fee revenue will support implementation of 340B Program statutory obligations, oversight of

participating manufacturers and covered entities, operational improvements, and increased efficiencies using information technology.

The FY 2020 President's Budget also proposes to reform the 340B Program through a General Provision in the Labor and Health and Human Services Appropriations Act that would require covered entities to report both savings and their uses to HRSA, and provide HRSA with general regulatory authority. General regulatory authority over the 340B Program would allow HHS to set clear enforceable standards of participation on all aspects of 340B program and will help ensure compliance with 340B Program requirements. Currently, hospitals participating in 340B are not required to report on 340B savings or how these savings are used to benefit patient populations. In addition, the Budget includes a legislative proposal to amend the 340B statute to improve program integrity and ensure that the program benefits patients, especially low-income and uninsured patients. These reforms would ensure low income and uninsured patients benefit from the Program, as intended, and strengthen program integrity and oversight activities. The Budget also seeks authorization of the proposed user fee.

FY 2020 Budget Authority

The FY 2020 Budget request provides resources for the 340B Program to educate participating covered entities and prospective sites on compliance with statutory requirements. For participating covered entities, HRSA will continue to expand its oversight activities, producing a sentinel effect of increased compliance. PVP data shows education based on oversight measures reduces the risk of future compliance issues. HRSA will conduct audits of manufacturers, which should not only increase compliance, but also provide greater insight into the tools and mechanisms used by companies to comply with 340B statutory requirements and guide future technical assistance.

The request supports facilitation of refunds and credits to entities that are overcharged by participating manufacturers as well as enhancements to the pricing system whereby covered entities access 340B ceiling price information via a secure website. System implementation began in the first two quarters of calendar year 2019, with manufacturers reporting data during the first quarter and prices being available to covered entities, after review and validation, on April 1, 2019.

In addition, GAO recommended that HRSA clarify the definition of a patient eligible to receive 340B drugs, eligibility of certain hospitals that participate as covered entities, prevention of duplicate discounts, and clarity related to audit expectations. HRSA prioritizes developing and providing clear policies to stakeholders through regulations and guidance.

The FY 2020 Request for budget authority includes costs associated with contract award processes, follow-up reviews, information technology, and other program support costs.

FY 2020 User Fees

In FY 2020, HRSA will begin user fee implementation. Revenue collected from user fees, once fully implemented, will support improvements to the 340B public database, program audits, and improve the Program's automated compliance management tool.

The Office of Pharmacy Affairs Information System (OPAIS) is a multi-function web-based database system that provides information on covered entities, contract pharmacy arrangements, and participating manufacturers. External stakeholders use the database to verify eligible entities and their associated sites, confirm manufacturer participation, and prevent statutorily prohibited duplicate discounts. Integrity of the 340B database requires ongoing maintenance and development. User fees would provide the additional resources needed to improve the integrity, transparency, security, and reliability of the OPAIS and ensure that the database continues to meet the needs of external stakeholders.

OPA plans to continue random and targeted audits of covered entities and manufacturers, as well as publish audit report summaries on the HRSA website to expand the 340B Program's compliance reach while managing program risk. User fees would provide the additional funding needed to hire and train staff to expand OPA's capacity to conduct additional covered entity audits in the future, conduct five manufacturer audits, write reports, work with entities and manufacturers through the notice and hearing process, and finalize information for public dissemination.

Performance Measures

OPA measures 340B Program performance by two key metrics: numbers of covered entities and manufacturers audits.

As of October 1, 2018, participation levels included 12,807 covered entities and 31,906 associated sites participating in the 340B Program, for a total of 44,713 registered sites. Twenty-seven percent of the 44,713 covered entity sites have contract pharmacy arrangements that support 22,101 unique pharmacy locations registered in the 340B database.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
39.I.A.1: Covered Entity Audits Conducted	FY 2018: 200 Target: 200 (Target Met)	200	200	Maintain
39.I.A.2: Manufacturer Audits Conducted	FY 2018>: 5 Target: 5 (Target Met)	5	5	Maintain

Contracts Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Contracts	3	3	3
Average Contract	$2,766,666	$3,000,000	$3,000,000
Range of Contracts	$1,500,000 - $3,900,000	$1,000,000 - $4,000,000	$1,000,000 - $4,000,000

National Hansen's Disease Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$13,650,000	$13,706,000	$11,653,000	-$2,053,000
FTE	54	54	54	---

Authorizing Legislation: Public Health Service Act, Section 320, as amended by Public Law 105-78, Section 211

FY 2020 Authorization .....Indefinite

Allocation Methods:
- Direct Federal/Intramural
- Contract

Program Description and Accomplishments

The National Hansen's Disease Program (NHDP) provides medical care, education, and research for Hansen's disease (HD, leprosy) and related conditions as authorized since 1921. Medical care includes providing direct patient care (diagnosis, treatment and rehabilitation), HD drug regimens at no cost to patients, consultations, laboratory services and outpatient referral services to any patient living in the United States (U.S.) or its territories. The Program strengthens the safety net infrastructure for patients with this rare disease by focusing on case management, patient compliance, and clinical training on the diagnosis and management of Hansen's disease. The Program makes specific outreach efforts to health care providers who are likely to encounter and treat patients in geographic areas most impacted by the disease. The more complicated HD cases are treated as short-term referrals in the NHDP clinic in Baton Rouge, Louisiana.

Ninety-five percent of the human population is not susceptible to infection with *M. leprae,* the bacteria that causes leprosy. Hansen's disease is also not highly transmissible, is very treatable, and, with early diagnosis and treatment, is not disabling. Treatment with standard antibiotic drugs is very effective, and patients become noninfectious after taking only a few doses of medication and need not be isolated from family and friends. However, diagnosis in the U.S. is often delayed because many health care providers are unaware of Hansen's disease and its symptoms. Early diagnosis and treatment prevents nerve involvement, the hallmark of Hansen's disease, and the disability it causes. People with leprosy can generally continue their normal work and other activities uninterrupted while they are under treatment, which may last several years.

Increasing Quality of Care: Increasing health care provider knowledge about Hansen's disease will lead to earlier diagnosis and treatment, which are key to blocking or arresting the trajectory of Hansen's disease-related disability and deformity. The Program facilitates outpatient

management of leprosy by providing additional laboratory, diagnostic, consultation, and referral services to private sector physicians. NHDP increases U.S. health care providers' knowledge by serving as an education and referral center.

The NHDP outpatient care is comprehensive and includes treatment protocols for multi-drug therapy, diagnostic studies, provider consultations, ancillary medical services, clinical laboratory analysis, hand and foot rehabilitation, leprosy surveillance, and patient transportation for indigent patients.

Improving Health Outcomes: Hansen's disease is a life-long chronic condition, which left untreated and unmanaged usually progresses to severe deformity. Through a focus on early diagnosis and treatment, NHDP measures its impact on improving health outcomes for Hansen's disease patients by reducing the percentage of patients with grades 1 or 2 disability/deformity.[226] The percentage of patients presenting with disability fluctuates due to several variables, including migration, immigration, and disease stigma. However, fluctuations in disability are primarily attributed to delays in diagnosis

The Program has also been improving health outcomes through research. With advanced scientific knowledge and breakthroughs in genomics and molecular biology, the Program has been advancing the standard-of-care for leprosy. Currently, lab research is using rapid assessment of drug resistance and strain typing of leprosy bacilli to determine the origins of individual infections and the likelihood of severe pathological reactions.

Fostering Collaboration: NHDP is the sole worldwide provider of reagent grade viable leprosy bacilli and collaborates with researchers across the globe to further scientific investigations and advances related to the disease. NHDP coordinates and collaborates with Federal, state, local, and private programs to further leverage and promote efforts to improve quality of care and health outcomes related to Hansen's disease.

Funding History

FY	Amount
FY 2016	$15,206,000
FY 2017	$15,169,000
FY 2018	$13,650,000
FY 2019	$13,706.000
FY 2020	$11,653,000

[226] 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.

Budget Request

The FY 2020 Budget request for the National Hansen's Disease Program of $11.7 million is $2.0 million below the FY 2019 Enacted level. This request supports the Program's primary focus on direct patient care activities and improving health outcomes for Hansen's disease patients. The reduced funding level also reflects a declining inpatient beneficiary population and improvements in health outcomes through research and health care provider education.

In FY 2020, NHDP will fund eleven ambulatory care contracts with continuing efforts to align resources with levels of care. Hansen's disease patients with severe complications, either who are advanced on the HD spectrum or who have HD related disabilities, may be referred to the primary clinic in Baton Rouge free of charge. The National Hansen's Disease Program provides HD medication free of charge to all providers upon request for the care and treatment of HD patients.

The FY 2020 budget request will support NHDP's move to a new facility in Baton Rouge that will accommodate administrative and clinical activities. The new facility will be designed to support patient care delivery with patient exam rooms, a pharmacy, rehabilitation therapy space, and medical records storage. The NHDP is working with the General Services Administration (GSA) to locate a new facility and complete a lease agreement. NHDP anticipates receiving information on facility location and related leasing and construction expenses during FY 2019. Initial GSA estimates are significantly higher than current lease costs.

NHDP plans to continue investing resources in FY 2020 in a new Electronic Health Record system to capture patient care data, improve care coordination, and increase communication among staff and providers. The investment will include implementation and staff training costs. In FY 2020, the NHDP also plans to expand and enhance outreach and training for providers in order to provide early diagnosis and reduce permanent disability in patients.

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

Outputs and Outcomes Table

Measure	Year and Most Recent Result/Target for Recent Result/ (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
3.E.: Maintain the increase in the cost per outpatient served below the medical inflation rate (Efficiency)	FY 2018: -6.59% Target: Below national medical inflation rate Target: 4.11 % (Target Met)	Maintain below national medical inflation rate	Maintain below national medical inflation rate	Maintain
3.II.A.4.: Number of health care providers who have received training from NHDP (Output)	FY 2018: 661 Target 550 (Target Exceeded)	600	650	+50
3.II.A.1.: Percentage of patients at Grade 1 or 2 disability (Outcome)	FY 2018: 36% Target: Less than or equal to 50% (Target Met)	Less than or equal to 50%	Less than or equal to 50%	Maintain

Program Indicators

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Resident Population: Inpatients	1	1	1
Baton Rouge Clinic: Outpatients	194	194	194
Baton Rouge Clinic: Outpatient Visits	2,031	2,031	2,031
Ambulatory Care Program (ACP) Contracts	11	11	11
ACP Clinic: Outpatients	652	652	652
ACP Clinic: Outpatient Visits	1,770	1,770	1,770

National Hansen's Disease Program – Buildings and Facilities

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$122,000	$122,000	---	-$122,000
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 320 and 321(a)

FY 2020 Authorization .....Indefinite

Allocation Method ..... Direct Federal

Program Description and Accomplishments

This activity provides for renovation and modernization of buildings at the Gillis W. Long Hansen's Disease Center at Carville, Louisiana, to eliminate structural deficiencies under applicable laws in keeping with accepted standards of safety, comfort, human dignity, efficiency, and effectiveness. Projects assure a safe facility and functional environment for the delivery of patient care and training activities, while meeting requirements to preserve the Carville historic district under the National Historic Preservation Act.

Funding History

FY	Amount
FY 2016	$122,000
FY 2017	$122,000
FY 2018	$122,000
FY 2019	$122,000
FY 2020	$---

Budget Request

There is no request in FY 2020 for Building and Facilities. Sufficient funds are available to continue renovation and repair work on patient and clinic areas and to complete minor renovation work at the Carville facilities.

Payment to Hawaii

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$1,852,000	$1,857,000	$1,857,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Section 320(d), as amended by Public Law 105-78, Section 211

FY 2020 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 2016	$1,857,000
FY 2017	$1,853,000
FY 2018	$1,852,000
FY 2019	$1,857,000
FY 2020	$1,857,000

Budget Request

The FY 2020 Budget requests $1.9 million, which is the same as the FY 2019 Enacted level. This request supports the payment made to the State of Hawaii for the medical care and treatment of persons with HD. It also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology, and other program support costs.

Rural Health Policy TAB

FEDERAL OFFICE OF RURAL HEALTH POLICY

Rural Health Policy Development

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$9,325,000	$9,351,000	$5,000,000	-$4,351,000
FTE	1	3	3	---

Authorizing Legislation: Social Security Act, Section 711

FY 2020 Authorization ..... Indefinite

Allocation Method ..... Competitive Cooperative Agreements

Program Description and Accomplishments

The Federal Office of Rural Health Policy (FORHP) is charged with advising the HHS Secretary on how rural health care is affected by current policies as well as proposed statutory, regulatory, administrative, and budgetary changes in the Medicare, Medicaid and other key HHS programs. The authorizing legislation requires FORHP to advise on: (1) the financial viability of small rural hospitals; (2) the ability of rural areas (particularly rural hospitals) to attract and retain physicians and other health professionals; and (3) access to and quality of health care in rural areas. FORHP is also charged with overseeing compliance, per the requirements of section 1102(b) of the Social Security Act, related to assessing the impact of key regulations affecting a substantial number of small rural hospitals. To support these advisory and compliance roles, FORHP maintains clearinghouses for collecting and disseminating information on rural health care issues, promising approaches to improving and enhancing health care delivery in rural communities, and policy-relevant research findings addressing rural health care delivery.

FORHP provides funding for the only federal research programs specifically designed to provide publically available, policy relevant studies on rural health issues. The Rural Health Research Center (RHRC) Program funds seven research centers to conduct policy-oriented health services research. The RHRCs produce policy briefs and peer-reviewed journal manuscripts and make their publications available to policy makers and other rural stakeholders at both the federal and state levels. The RHRC publications also align with Administration priorities, such as addressing opioid abuse. The Rapid Response Rural Data Analysis and Issue Specific Rural Research Studies Program supports one award to conduct rapid data analyses and short-term rural research studies. The Rural Health Research Dissemination Cooperative Agreement disseminates and markets FORHP funded rural health services research to stakeholders at the national, state, and community levels with the goal of informing and raising awareness of key policy issues

important to rural communities. In FY 2018, these programs conducted and disseminated 67 research reports, including policy briefs posted on the Rural Health Research Gateway website and manuscripts published in peer-reviewed journals. FORHP will provide base-level support to these programs in FY 2020.

Rural Health Policy Development supports the Rural Assistance Center Cooperative Agreement that serves as a clearinghouse for information on rural health, including HRSA's rural health programs, for residents of rural areas in the United States and other rural health stakeholders. The FY 2020 budget will provide base-level support for this program.

Rural Health Policy Development also supports the staffing for the National Advisory Committee on Rural Health and Human Services (NACRHHS), which advises the HHS Secretary on rural health and human service programs and policies, produces policy briefs, and makes recommendations on emerging rural policy issues. In addition, HRSA continues to monitor and track the number of rural hospitals that have closed across the country. From January 1, 2010 to November 30, 2018, ninety rural hospitals have closed. FORHP has funded a number of grants that focus on addressing hospital closures, particularly mitigating the loss of services due to hospitals closing or facing financial distress.

Funding History

FY	Amount
FY 2016	$9,351,000
FY 2017	$9,351,000
FY 2018	$9,325,000
FY 2019	$9,351,000
FY 2020	$5,000,000

Budget Request

The FY 2020 Budget requests $5.0 million for Rural Health Policy Development, which is $4.4 million below the FY 2019 Enacted level. This request will maintain base-level support for the following activities: Rural Health Research Center Cooperative Agreement; Rapid Response Rural Data Analysis and Issue Specific Rural Research Studies Program; Rural Health Research Dissemination Cooperative Agreement; Rural Assistance Center Cooperative Agreement; and the National Advisory Committee on Rural Health and Human Services. The Rural Health Research Center program will produce 14 rural policy briefs in FY 2020.

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

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Outcome)	FY 2018 : 67 Target: 14 (Target Exceeded)	39	14	-25

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	13	14	10
Average Award	$746,911	$745,357	$342,864
Range of Awards	$100,000-$2,100,000	$100,000-$2,3000,000	$46,000-$2,254,000

Rural Health Care Services Outreach, Network and Quality Improvement Grants

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$71,300,000	$77,500,000	$40,811,000	-$36,689,000
FTE	9	9	9	---

Authorizing Legislation: Public Health Service Act, Section 330A, as amended by Public Law 110-355, Section 4

FY 2020 Authorization ..... Expired

Allocation Method ..... Competitive Grants and Cooperative Agreements

Program Description and Accomplishments

The Rural Health Care Services Outreach, Network and Quality Improvement Grants (Outreach programs) improve rural community health by focusing on quality improvement, increasing health care access, coordination of care, and integration of services.

Outreach grant programs support collaborative models to deliver basic health care services to rural areas and are uniquely designed to meet rural needs. The grants allow rural communities to compete for funding against other rural communities, rather than competing against larger metropolitan communities with greater resources. The Outreach programs are among the only non-categorical grants within HHS, allowing grantees to determine the best ways to meet local needs. This flexibility responds to the unique health care challenges in rural communities and enables communities to determine the best approaches for addressing needs.

- Rural Health Care Services Outreach Grants focus on improving access to health care in rural communities through community coalitions and evidence based and promising practice models. These grants focus on disease prevention, health promotion, and can support the expansion of services around primary care, opioid use disorder treatment and prevention, behavioral health, and oral health care. Additionally, through the introduction of the Health Improvement Special Project track, a cohort of grantees within the Outreach Program have a specific focus on addressing cardiovascular disease risk through use of the Centers for Disease Control and Prevention (CDC) Heart Age Calculator. Grantees are required to submit and track baseline data throughout their project periods and to develop their programs based on promising practices or evidence-based models. HRSA expects to continue to award 60 grants in FY 2020.

- Rural Health Opioid Program promotes rural health care services outreach by expanding the delivery of opioid related health care services to rural communities through broad

community consortiums focused on treatment, care coordination to organize patient care activities, and support to individuals in recovery through behavioral counselling and peer support activities. The program brings together non-profit entities such as hospitals, primary care practices, substance abuse treatment centers, social service organizations, and other community groups to respond with a multifaceted approach to the opioid epidemic in a rural community. HRSA expects to continue to award 26 grants in FY 2020.

- Rural Health Network Development Grants support formalized partnerships among health care providers and social and community service organizations collaborating to improve access and enhance the quality of healthcare in rural areas. The program focuses on demonstrating improved health outcomes resulting from network collaboration, as well as positioning healthcare networks and their products and services to be sustainable as the health care landscape continues to evolve. Grantees under this program are likely to focus on improving health outcomes, enhancing health care quality, and increasing services provided by the network. HRSA does not plan to make new grant awards in FY 2020.

- Rural Network Development Planning Grants assists in the development of integrated healthcare networks to address local health care challenges. The Network Planning program provides an opportunity for grantees to work on priority and emerging local public health issues, such as care coordination, patient engagement, rural hospital closure/conversion, telehealth, mental health, and substance use (particularly opioid use disorder). HRSA does not plan to make new grant awards in FY 2020.

- Small Health Care Provider Quality Improvement Grants help improve patient care and chronic disease outcomes by assisting rural primary care providers with the implementation of quality improvement activities. Specifically, program objectives include increased care coordination, enhanced chronic disease management, and improved health outcomes for patients. An additional program goal is to prepare rural health care providers for quality reporting and pay-for-performance programs. HRSA expects to continue 32 awards in FY 2020.

- The Delta States Network Grant Program provides network development grants to the eight states in the Mississippi Delta for network and rural health infrastructure development. This program is geographically targeted, given the health care disparities across this eight-state region. The program supports chronic disease management, oral health services, and recruitment and retention efforts for health professionals. The program requires grantees to focus on diabetes, cardiovascular disease, and obesity and to develop programs based on promising practices or evidence-based models. HRSA does not plan to make new grant awards in FY 2020.

- Delta Region Community Health Systems Development Program helps rural communities address their health care needs in a targeted manner and assists small rural hospitals and clinics improve their financial and operational performances. The program started with one cohort of nine rural communities and their hospitals in FY 2017. The

program expanded to include a second cohort of two rural communities and their hospitals in FY 2018 and a third new cohort of eight rural communities and their hospitals in FY 2019. HRSA will close out the first cohort and continue the new cohorts in FY 2020. HRSA developed this program in FY 2017 in coordination with the Delta Regional Authority. HRSA expects to continue the Delta Region Community Health Systems Development award in FY 2020.

The Outreach programs continue to conduct program evaluations and build evidence-based models for new ways to improve health care in rural communities. Evaluations focus on measuring program impact on the health status of rural residents with chronic conditions and economic impact of the federal investment in rural communities. Grantees use the Rural Health Information (RHI) Hub's Economic Impact Analysis[227] tool to assess the economic impact of federal investments. The tool translates project impacts into community-wide benefits, such as number of jobs created, new spending, and impacts of new and expanded services.

Grantees are also required to demonstrate program impact through outcome-focused measures. Grantees track and submit to HRSA baseline data throughout their project periods and implement programs that are adapted from promising practices or evidence-based models. The programs support innovative models that offer rural communities the tools and resources to enhance health care services and ease the transition to health care models focusing on improved quality and value.

While making the initial federal investment in a rural area, each of the grant programs expects the communities to continue providing the services at the conclusion of the grant funding. As each project periods end, the Outreach programs continually assess program sustainability. While sustainability rates may vary across grantee cohorts, HRSA expects the majority of projects to continue after federal funding.

Across the investments made in the Outreach programs, findings and key lessons learned from evaluations and case studies are gathered and made available on the RHI Hub's Community Health Gateway[228] so that rural communities from across the country can benefit from Outreach program investments and results.

Funding History

FY	Amount
FY 2016	$63,500,000
FY 2017	$65,500,000
FY 2018	$71,300,000
FY 2019	$77,500,000
FY 2020	$40,811,000

[227] Economic Impact Analysis Tool
[228] Rural Community Health Gateway

Budget Request

The FY 2020 Budget requests $40.8 million for the Rural Health Care Services Outreach, Network, and Quality Improvement Grants, which is $36.7 million below the FY 2019 Enacted level. The budget request supports the continuation of 119 existing grantees that will positively affect health care service delivery for 200,000 people and does not fund any new competitive grants in FY 2020.

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

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
29.IV.A.3. Track number of unique individuals who received direct services through FORHP Outreach grants, subject to availability of resources. (Outcome)	FY 2017: 704,700 Target: 415,000 (Target Exceeded)	425,000	200,000	-225,000
29.IV.A.4: Percent of Outreach Authority grantees that will continue to offer services after the federal grant funding ends.[229] (Outcome)	FY 2017: 100% Target: 70% (Target Exceeded)	75%	75%	Maintain

[229] Outreach programs have varying three-year project periods. When sustainability data is captured at the end of a program project period, sustainability rates may vary based on the nature of the program ending.

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	228	217	119
Average Award	$261,823	$301,848	$279,508
Range of Awards	$74,515 - $4,000,000[230]	$94,698 - $8,000,000[231]	$145,000 - $8,000,000[232]

[230] This represents one cooperative agreement worth up to $4,000,000 for the Delta Region Community Health Systems Development Cooperative Agreement.
[231] This represents one cooperative agreement worth up to $8,000,000 for the Delta Region Community Health Systems Development Cooperative Agreement.
[232] This represents one cooperative agreement worth up to $8,000,000 for the Delta Region Community Health Systems Development Cooperative Agreement.

Rural Hospital Flexibility Grants

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$49,470,000	$53,609,000	---	-$53,609,000
FTE	1	1	---	-1

Authorizing Legislation: Social Security Act, Section 1820(j), as amended by Public Law 105-33, Section 4201(a), and Public Law 108-173, Section 405 (f), as amended by Section 121, Public Law 110-275

FY 2020 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Rural Hospital Flexibility Grants are offered through three grant programs:

- Medicare Rural Hospital Flexibility Grant (Flex) Program supports a partnership between 45 states and more than 1,300 Critical Access Hospitals (CAHs) to work on quality and performance improvement activities, as well as help eligible rural hospitals convert to CAH status and enhance CAH-related emergency medical services. The Flex Program's goal is to help CAHs maintain high-quality and economically viable facilities to ensure that rural community residents, particularly Medicare beneficiaries, have access to high-quality health care services. States use Flex resources to address identified CAH needs and to achieve improved and measurable outcomes in each selected program area. In FY 2018, HRSA received an increase in appropriated funds for the Flex Program and allocated an additional $3 million across the 45 states to support ongoing efforts and ensure the program is meeting the goal of improving the financial viability of hospitals. With the increase in FY 2018 funds, HRSA targeted $2 million for a new one-year initiative supporting emergency medical services (EMS) across 39 interested states and focusing on quality and operational improvement initiatives.

  The Flex Program plays a key role in ensuring that CAHs are aligned with certain Medicare Program quality initiatives. All prospective payment system hospitals (PPS) are required to submit quality data to the Centers for Medicare & Medicaid Services (CMS) to receive a full Medicare payment update. While not subject to this CMS requirement, CAHs, through this program, can elect to submit quality data to CMS to demonstrate areas of high quality while also identifying areas for improvement. This provides an avenue for ensuring that CAH quality efforts are aligned with broader Medicare quality

initiatives. As a result of the Flex Program's Medicare Beneficiary Quality Improvement Project (MBQIP), ninety-six percent[233] of CAH's are reporting quality data to CMS.

Small Rural Hospital Improvement Program (SHIP) provides support to rural hospitals with fewer than 50 beds to enhance their administrative capabilities in meeting information technology and reporting requirements under value-based care through awards to 46 states with eligible hospitals. SHIP provides funding for equipment and training to upgrade billing requirements, such as incorporating new ICD-10 standards, and for software that captures patient satisfaction data.

- Flex Rural Veterans Health Access Program focuses on increasing the delivery of mental health services or other health care services to meet the needs of Operation Iraqi Freedom and Operation Enduring Freedom veterans living in rural areas. Grantees focus on investments in telehealth and health information exchange technologies to improve veteran access to needed services and to provide veterans greater continuity of care.

Additionally, HRSA developed a new initiative in FY 2018 in response to rural hospital closures. This project supports targeted assistance to hospitals and communities at risk of losing a hospital with the goal of keeping key health care services available locally.

Funding History

FY	Amount
FY 2016	$41,609,000
FY 2017	$43,609,000
FY 2018	$49,470,000
FY 2019	$53,609,000
FY 2020	---

Budget Request

The FY 2020 Budget requests $0 for Rural Hospital Flexibility Grants, which is $53.6 million below the FY 2019 Enacted level. The Budget prioritizes programs that provide direct health care services.

[233] Results based on the Flex Monitoring Team analysis of the 2016 CMS data.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
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 2016: 81.2% Target: 72% (Target Exceeded)	82%	N/A	---
30. V.B.7a: Percent of CAHs participating in one or more Flex-funded required quality improvement initiatives that showed improvement in one or more specified quality domains. (Developmental)[234]	FY 2016: 76% (Target Not in Place)	70%	N/A	---
30. V.B.7b: Percent of CAHs participating in one or more Flex-funded optional quality improvement initiatives that showed improvement in one or more specified quality domains. (Developmental) [235]	FY 2016: 49% (Target Not in Place)	47%	N/A	---

[234] FY 2015 was the first year of data for this measure. Targets will be set after two years of results.
[235] FY 2015 was the first year of data for this measure. Targets will be set after two years of results.

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	94	94	---
Average Award	$565,000	$570,308	---
Range of Awards	$18,000-$945,000	$20,340-$1,118,700	---

State Offices of Rural Health

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$10,000,000	$10,000,000	---	-$10,000,000
FTE	1	1	---	-1

Authorizing Legislation: Section 338J of the Public Health Service Act, as amended by Public Law 105-392, Section 301

FY 2020 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

This grant program provides funding to establish and maintain a State Office of Rural Health (SORH) within states to strengthen rural health care delivery systems. Every dollar of federal support is matched by three state dollars. SORHs serve as focal points and clearinghouses for the collection and dissemination of information on rural health issues, research findings, innovative approaches, and best practices pertaining to the delivery of health care in rural areas.

As the state's rural institutional framework, SORHs help link rural communities with state and federal resources to develop long-term solutions to rural health problems. SORHs form collaborative partnerships to better coordinate rural health activities, maximize limited resources, and avoid duplication of effort and activities. SORHs facilitate clinical placements through recruitment initiatives and help rural constituents meet recruitment challenges by sharing information. SORHs identify federal, state, and nongovernmental programs and funding opportunities and provide technical assistance to public and nonprofit private entities regarding participation in rural health programs.

Funding History

FY	Amount
FY 2016	$9,511,000
FY 2017	$10,000,000
FY 2018	$10,000,000
FY 2019	$10,000,000
FY 2020	---

Budget Request

The FY 2020 Budget requests $0 for State Office of Rural Health, which is $10.0 million below the FY 2019 Enacted level. The Budget prioritizes programs that provide direct health care services.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. (Outcome)	FY 2017: 69,303 Target: 82,549 (Target Not Met)	69,996	N/A	---
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. (Outcome)	FY 2017: 22,467 Target: 26,574 (Target Not Met)	22,691	N/A	---
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment initiatives. (Outcome)	FY 2016: 2,380 Target: 1,260 (Target Exceeded)	1,260	N/A	---

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	50	50	---
Average Award	$179,871	$179,871	---
Range of Awards	$165,521-$179,871	$165,521- $179,871	---

Radiation Exposure Screening and Education Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$1,834,000	$1,834,000	$1,834,000	---
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 417C, as amended by Public Law 109-482, Sections 103 and 104

FY 2020 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Radiation Exposure Screening and Education Program (RESEP) provides grants to states, local governments, and appropriate health care organizations to support programs for cancer screening for individuals adversely affected by the mining, transport and processing of uranium and the testing of nuclear weapons for the Nation's weapons arsenal. The RESEP grantees also help clients with appropriate medical referrals, engage in public information development and dissemination, and facilitate claims documentation to aid individuals who may wish to apply for support under the Radiation Exposure Compensation Act. In FY 2017, the number of individuals screened at RESEP was 1,359 and the average screening cost per individual was $1,177.

Funding History

FY	Amount
FY 2016	$1,834,000
FY 2017	$1,834,000
FY 2018	$1,834,000
FY 2019	$1,834,000
FY 2020	$1,834,000

Budget Request

The FY 2020 Budget requests $1.8 million for Radiation Exposure Screening and Education, which is the same as the FY 2019 Enacted level. This request will continue to support activities such as: implementing cancer screening programs; developing education programs; disseminating information on radiogenic diseases and the importance of early detection; screening eligible individuals for cancer and other radiogenic diseases; providing appropriate

referrals for medical treatment; and facilitating documentation of Radiation Exposure Compensation Act (RECA) claims.

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

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
32.1: Percent of RECA successful claimants screened at RESEP centers. (Outcome)	FY 2017: 20 % Target: 8.8% (Target Exceeded)	13%	13%	Maintain
32.2: Percent of patients screened at RESEP clinics who file RECA claims that receive RECA benefits. (Outcome)	FY 2017: 83.7% Target: 72% (Target Exceeded)	77%	77%	Maintain
32.I.A.1: Total number of individuals screened per year. (Output)	FY 2017: 1,359 Target: 1,200 (Target Exceeded)	1,300	1,300	Maintain

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	8	8	8
Average Award	$200,486	$200,590	$200,590
Range of Awards	$98,392-$245,156	$100,995-$242,525	$100,995-$242,525

Black Lung

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$10,000,000	$11,000,000	$11,000,000	---
FTE	---	---	1	+1

Authorizing Legislation: Federal Mine, Health, and Safety Act of 1977, Public Law 91-173, Section 427(a), as amended by Public Law 95-239, Section 9

FY 2020 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants and Cooperative Agreement

Program Description and Accomplishments

The Black Lung Clinics Program (BLCP) funds eligible public, private, and state entities that provide medical, outreach, educational, and benefits counseling services to active, inactive, retired, and disabled coal miners throughout the United States with the goal of reducing the morbidity and mortality associated with occupationally related coal-mine dust lung disease. To support the longer-term need faced by miners with severe disability due to black lung disease, grantees may also assist coal miners and their families in preparing the detailed application for federal Black Lung benefits from the Department of Labor (DOL).

In FY 2017, the program supported 18,402 medical encounters with black lung disease patients, which fell just below the target of 20,000 medical encounters. This measure reflects only one encounter per day and often miners will have multiple visits with different specialists during a single trip to a clinic, so this measure is likely an underrepresentation of medical encounters.

Recent data highlights the continued need for black lung services. The National Institute of Occupational Safety and Health (NIOSH) identified a cluster of 60 progressive massive fibrosis (PMF) cases among current and former Appalachian coal miners at a single eastern Kentucky radiology practice from January 2015 to August 2016. This figure exceeded the 19 PMF cases in Kentucky detected by NIOSH's National Coal Workers' Health Surveillance Program between August 2011 to July 2016.[163] The current prevalence of CWP among underground coal miners with 25 years or more of underground mining tenure in central Appalachia (Kentucky, Virginia, West Virginia) is 20.6 percent and the national prevalence is over 10 percent.

Funding History

FY	Amount
FY 2016	$6,766,000
FY 2017	$7,250,000
FY 2018	$10,000,000
FY 2019	$11,000,000
FY 2020	$11,000,000

Budget Request

The FY 2020 Budget requests $11.0 million for the Black Lung Clinics Program, which is equal to the FY 2019 Enacted level. HRSA will continue to fund 15 Black Lung Clinic Program awards that provide primary care and other services to coal miners and a cooperative agreement with one Black Lung Center of Excellence (BLCE) to enhance the quality of services provided by BLCP grantees. The BLCE cooperative agreement recipient will work closely with HRSA to strengthen the quality of data collection and analysis.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
33.I.A.1: Number of miners served each year. (Output)	FY 2017: 12,838 Target: 13,800 (Target Not Met)	13,800	13,800	Maintain
33.I.A.2: Number of medical encounters from Black Lung each year. (Output)	FY 2017: 18,402 Target: 20,000 (Target Not Met)	19,000	19,000	Maintain
33.E.1:The number of miners served per $1 million in HRSA Black Lung Clinics Program funding.(Efficiency)	FY 2017: 1,314[236] (Target Not in Place)	1,900	1,300	-600

[236] HRSA introduced this measure in the FY 2019 President's Budget, with targets identified for FY 2018 and FY 2019. FY 2017 results will serve as baseline results for this measure.

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	16	16	16
Average Award	$618,463	$618,463	$618,463
Range of Awards	$125,000-$1,786,069	$125,000-$1,786,069	$125,000-$1,786,069

Telehealth

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$23,434,000	$24,500,000	$10,000,000	-$14,500,000
FTE	2	2	2	---

Authorizing Legislation: Public Health Service Act, Section 330I

FY 2020 Authorization ..... Expired

Allocation Method ..... Competitive Grants/Cooperative Agreements

Program Description and Accomplishments

The Office for the Advancement of Telehealth (OAT) promotes the use of telehealth technologies for health care delivery, education, and health information services. OAT administers the following grant programs:

The Telehealth Network Grant Program (TNGP) supports the use of telehealth networks to improve health care services for medically underserved populations in urban, rural, and frontier communities. More specifically, the networks: (a) expand access to, coordinate, and improve the quality of health care services; (b) improve and expand the training of health care providers; and/or (c) expand and improve the quality of health information available to health care providers, patients, and their families.

This program funds different cohorts of grantees, usually with unique clinical or population focus areas, although grantees can also provide other clinical services in their projects. All TNGP grantee cohorts focus on using telehealth technology to expand access to services. In addition, the program conducts project evaluations to establish an evidence-base assessing the effectiveness of telehealth care for patients, providers, and payers. In FY 2020, FORHP will support a new TNGP cohort focused on improving access to health care services, including behavioral health care services, in rural and underserved communities.

In FY 2016 (the most recent year data is available), TNGP grantees provided 88 clinical services across 165 telehealth sites in underserved rural communities. There was a shift to school-based clinical services from the previous year due to the start of a new cohort currently building capacity to provide services in school-based settings. Of the 165 telehealth sites, 9 sites offered pediatric mental health services and 43 offered adult mental health services.

Evidence-Based Tele-Behavioral Health Network Program increases access to behavioral health care in rural and frontier communities by using telehealth technologies, given the shortage of mental health providers in many rural and underserved communities. The emphasis on data collection and research to further the telehealth evidence base separates this program from other

Telehealth Network Grants in OAT. HRSA expects to continue to support 14 grantees in FY 2020.

Telehealth Resource Center (TRC) Program provides expert and customizable telehealth technical assistance across the country. The TRCs provide training and support, disseminate information and research findings, promote effective collaboration, and foster the use of telehealth technologies to provide health care information and education for providers who serve rural and medically underserved areas and populations. In FY 2020, HRSA anticipates re-competing this program and funding 12 regional and two national TRCs.

Telehealth Center of Excellence program examines the efficacy of telehealth services in rural and urban areas and serves as a national clearinghouse for telehealth research and resources. HRSA anticipates re-competing this program in FY 2020.

The Telehealth Focused Rural Health Research Center conducts policy-relevant and clinically informed telehealth research. As part of its research, the Rural Health Research Center works with Telehealth Network Grant Program grantees, helping them quantify and analyze their results and preparing summaries and publications of TNGP's clinical impact. HRSA anticipates making one award in FY2020.

Licensure Portability Grant Program provides support to state professional licensing boards to carry out programs under which the boards cooperate to develop and implement state policies that will reduce statutory and regulatory barriers to telemedicine. HRSA will continue funding two awards for this program in FY 2020.

Funding History

FY	Amount
FY 2016	$17,000,000
FY 2017	$18,500,000
FY 2018	$23,434,000
FY 2019	$24,500,000
FY 2020	$10,000,000

Budget Request

The FY 2020 Budget requests $10 million for the Telehealth program, which is $14.5 million below the FY 2019 Enacted level. This Budget request supports core telehealth programs, including the Telehealth Network Grant Program, Telehealth Resource Center Program, and the Telehealth Center of Excellence Program. Funding also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure[237]	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
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) [238]	FY 2016: 22% Target: 20% (Target Exceeded)	25%	N/A	N/A
34.1: The percent of TNGP grantees that continue to offer services after the TNGP funding has ended. [239](Outcome)	FY 2015: 100% Target: 95%	N/A	95%	N/A
34.III.D.2: Expand the number of telehealth services (e.g., dermatology, cardiology) and the number of sites where services are available as a result of the TNGP program. (Outcome)[240]	FY 2016: 3,223 Target: 2,700 (Target Exceeded)	2,750	2,775	+25

[237] The Telehealth Network Grant Program (TNGP) is a demonstration program. Every three to four years, each cohort of TNGP grantees completes its project period, while a new cohort of grantees commences a new cycle of grant-supported Telehealth activities. The data is calculated as a cumulative number, and with each new cohort, the distribution of these services is uncertain. Therefore, the targets may need to be revised if there is evidence of a significant increase in grantees that are providing mental health services.

[238] Under reduced FY 2020 funding, no grantees will be expected to participate in telediabetes case management, so this measure will be unassessable.

[239] This is a long-term measure based on the end date of the current cohort of grantees. The target date for this measure is FY 2020.

[240] This is a demonstration program. Every three to four years, each cohort of TNGP grantees "graduates" from the program while a new cohort of grantees begin a new multi-year cycle of grant-supported telehealth activities. This measure is calculated as a cumulative number of total services by site. With each new cohort, the distribution of telehealth service types and the number of sites delivering one or more services may change. Therefore, the targets may need to be revised if there is evidence of a significant increase or decrease in the number of sites or services that new grantees select to provide.

Measure[237]	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
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.[241] (Outcome)	FY 2016: 497 Target: 325 (Target Exceeded)	335	340	+5
34.III.D.1.1: Increase the number of communities that have access to adult mental health services where access did not exist in the community prior to the TNGP grant.[242] (Outcome)	FY 2016: 554 Target: 320 (Target Exceeded)	340	350	+10
34.E: Expand the number of services and/or sites providing access to health care as a result of the TNGP program per federal program dollars expended.[243] (Efficiency)	FY 2016: 20 per Million $ Target: 106 per Million $ (Target Not Met)	65 per Million $	65 per Million $	Maintain

[241] This is a demonstration program. Every three to four years, each cohort of TNGP grantees "graduates" from the program while a new cohort of grantees begins a new multi-year cycle of grant-supported telehealth activities. This measure is calculated as a cumulative number. With each new cohort, the distribution of telehealth service types which grantees select to provide may change. Therefore, the targets may need to be revised if there is evidence of a significant increase or decrease in grantees that are providing mental health services.
[242] Ibid.
[243] This measure provides the number of sites and services made available to people who otherwise would not have access to them per million dollars of program funds spent. Every three to four years a new cohort of grantee begins a new three- or four-year cycle of grant-supported activities, with grantees gradually expanding sites and services per dollar invested. With each new cohort, there is a start-up period where services are put in place but are not yet necessarily implemented, which increases the cost per site or service type. OAT has refined programs to focus on specific uses and users like school-based health clinics. The focus on innovation in the use of telehealth services rather than volume of telehealth services has increased cost per site or service type. As OAT seeks to focus telehealth funding on special areas, it will reexamine the target baseline for cost per site or service.

Grant Awards Table

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	57	57	39
Average Award	$381,579	$372,807	$256,154
Range of Awards	$250,000 - $2,000,000	$250,000 - $2,000,000	$97,500 – $600,000

Rural Residency Planning and Development

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$14,958,000	$10,000,000	---	-$10,000,000
FTE	---	2	---	-2

Authorizing Legislation: Social Security Act, Section 711

FY 2020 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants/Cooperative Agreement

Program Description and Accomplishments

The Rural Residency Planning and Development Program seeks to expand the number of rural residency training programs and subsequently increase the number of physicians choosing to practice in rural areas. For the purpose of this program, rural residencies are allopathic and osteopathic physician residency training programs that primarily train in rural communities. This includes Rural Training Tracks (RTTs), a specific model of rural residency training in which residents receive more than 50 percent of their training in a rural location after spending their initial year in a larger, often urban, residency setting. Research has shown that residents often practice near where they complete their residency training. RTT graduates are twice as likely to practice family medicine in a rural setting as compared to family medicine residents trained in an urban program. The Rural Residency Program seeks to expand the number of rural residency training programs to increase the number of physicians who practice in rural locations. The Federal Office of Rural Health Policy collaborates with HRSA's Bureau of Health Workforce (BHW) to fund two rural residency programs:

- Rural Residency Planning and Development (RRPD) creates new physician residency training programs that support physician workforce expansion in rural areas and that are sustainable beyond the grant performance period through public (i.e., Medicare or Medicaid), other state or private funding. Grantees may use funds to cover planning and development costs incurred while achieving program accreditation through the Accreditation Council for Graduate Medical Education (ACGME).

- Rural Residency Planning and Development Technical Assistance (RRPD-TA) funds a cooperative agreement that serves as a technical assistance center to support RRPD awardees.

Funding History

FY	Amount
FY 2016	---
FY 2017	---
FY 2018	$14,958,000
FY 2019	$10,000,000
FY 2020	---

Budget Request

The FY 2020 Budget requests $0 for the Rural Residency Planning and Development Program, which is $10.0 million below the FY 2019 Enacted level. In FY 2020, HRSA's previously funded Rural Residency awards will remain active and continue to provide assistance to rural entities seeking to establish new rural residency programs and develop accredited residencies.

Grant Awards Table

	FY 2018 Final[244]	FY 2019 Enacted[245]	FY 2020 President's Budget
Number of Awards	16	13	---
Average Award	$853,125	$750,000	---
Range of Awards	$750,000-$2,400,000	$750,000	---

[244] Data represents a three-year RRPD-TA award funded fully at the beginning of the FY 2018 project period, as well as, 15 three-year RRPD awards funded fully at the beginning of the FY 2019 project period, using multi-year funding appropriated in FY 2018.
[245] Thirteen three-year RRPD awards were fully funded at the beginning of the FY 2019 project period, using multi-year funding appropriated in FY2019.

Rural Communities Opioid Response

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$100,000,000	$120,000,000	$120,000,000	---
FTE	1	12	12	---

Authorizing Legislation: Social Security Act, Section 711

FY 2020 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants/Cooperative Agreement

Program Description and Accomplishments

The Rural Communities Opioid Response Program (RCORP) supports treatment and prevention of substance use disorder, including opioid abuse, in rural communities at the highest risk for substance use disorder. The program goal is to reduce the morbidity and mortality associated with opioid overdoses in rural communities through the strengthening of the organizational and infrastructural capacity of multi-sector consortiums. These consortiums address one or more of the following focus areas at the community, county, state, and/or regional levels:

1. Prevention: reducing the occurrence of opioid addiction among new users and those at-risk as well as reducing the occurrence of fatal opioid-related overdoses, through community and provider education and harm reduction measures including the strategic placement of overdose reversing devices, such as Naloxone;
2. Treatment: implementing or expanding access to evidence-based practices for opioid use disorder (OUD) treatment such as medication-assisted treatment (MAT); and
3. Recovery: expanding peer recovery and treatment options that help people start and stay in recovery.

The RCORP initiative is currently composed of two competitive grant programs and two cooperative agreements that provides technical assistance coordination and program evaluation.

- RCORP-Planning provides one year of support to rural communities to identify opioid use disorder issues in their communities and develop plans to resolve these issues. Based on HRSA's experience administering other rural grant programs, the one-year planning grant provides sufficient time and resources for communities to form partnerships with other entities, conduct needs assessments, and plan ways to address specific issues being faced by the communities. HRSA awarded 95 Planning grants in FY 2018.
- RCORP-Implementation provides multi-year support to rural communities to yield large-scale organizational and infrastructural improvements at the regional and state levels to address opioid use disorder, with a particular focus on treatment and recovery. HRSA plans to make awards in FY 2019 and in FY 2020.

In FY 2019, HRSA will develop a Rural Centers of Excellence on Substance Use Disorders program that will support the dissemination of best practices related to the treatment for and prevention of substance use disorders within rural communities, with a focus on the current opioid crisis. These new opioid response activities will continue in FY 2020.

The Rural Communities Opioid Response initiative reflects the high level of interest in and continued need for rural-focused funding to build robust opioid prevention, treatment, and recovery infrastructure and capacity in rural communities. HRSA will utilize stakeholder feedback, results from prior investments, and data about the evolving opioid epidemic to make informed decisions on how to further strengthen rural communities' ability to respond to the opioid crisis. HRSA will also engage in partnerships with other federal agencies to promote a coordinated approach to combatting this devastating epidemic.

Funding History

FY	Amount
FY 2016	$---
FY 2017	$---
FY 2018	$100,000,000
FY 2019	$120,000,000
FY 2020	$120,000,000

Budget Request

The FY 2020 Budget requests $120 million for the Rural Communities Opioid Response Program, which is equal to the FY 2019 Enacted level. HRSA will continue support for RCORP programs to strengthen the infrastructure and capacity within rural communities at high risk for substance abuse disorders and provide needed prevention, treatment, and recovery services to rural residents. The Budget request will provide RCORP funding to target specific initiatives, such as supporting medication-assisted treatment in rural hospitals, workforce development, maternal and child health, and telehealth activities focused on reducing opioid abuse.

HRSA recognizes the importance of remaining flexible to meet the needs of the evolving opioid epidemic and will utilize stakeholder feedback and input through focus groups and other means to consider additional activities. HRSA will consider new pilot programs to respond to specific substance use disorder issues within rural communities; utilizing telehealth to provide treatment, prevention, and recovery services; and increasing the availability of rural opioid data and research.

Grant Awards Table

	FY 2018 Final[246]	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	182	188	188
Average Award	$521,978	$622,340	$622,340
Range of Awards	$200,000-$3,000,000	$200,0000-$6,666,666	$200,000-$6,666,666

[246] Data represents awards funded for FY 2018, FY 2019, and FY 2020 project periods, using multi-year funds appropriated in FY 2018.

Program Management TAB

Program Management

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$154,615,000	$155,250,000	$151,993,000	-$3,257,000
FTE	753	753	753	---

Authorizing Legislation: Public Health Service Act, Section 301

FY 2020 Authorization……...……Indefinite

Allocation Method……....Other

To achieve its mission, HRSA requires qualified staff to operate at maximum efficiency. One of HRSA's goals is to strengthen program management and operations by improving program customer satisfaction, increasing employee engagement, and implementing organizational improvements and innovative projects. Program Management is the primary means of support for staff, business operations and processes, information technology and overhead expenses such as rent, utilities, and miscellaneous charges, for HRSA.

Improving Processes and Business Operations

HRSA continues to improve operational planning processes to foster cross-agency collaboration. HRSA has automated its contracting process to operate in a totally paperless environment, including the receipt of committed funds, the obligation of funds, and the generation and storage of contract documents. Over the past several years, HRSA has reduced travel costs and supported telework participation by increasing the agency-wide utilization of real-time web collaboration tools. Real-time collaboration is accomplished using automated tools that support a full range of requirements from one-on-one for teleworkers to web-based meetings supporting as many as 500 participants.

Developing a 21st Century Workforce

Numerous efforts are underway to enhance efficiency and effectiveness of the agency and to ensure the workforce is positioned to succeed in the 21st century. The hiring process has been improved, reducing the time it takes to complete the hiring cycle from recruitment to onboarding.

HRSA is focused on intense employee engagement improvement efforts. The agency had over an 82% participant rate in the 2018 Federal Employee Viewpoint Survey (FEVS). HRSA performs custom analysis and consultations with organizations at all levels to inform improvement strategies.

Maintaining a skilled workforce is a top priority. In 2017, The HRSA Learning Institute (HLI) delivered more than 200 instructor-led courses. More than 1,200 HRSA employees participated in at least one instructor-led class, an increase of 13 percent compared to 2016. HLI received

and assisted agency staff on requests for organizational development facilitation services, and collaborated with the Bureaus/Offices to create custom training curriculum.

Sharing Quality Services

HRSA relies on HHS-provided shared services for many of the services represented in this CAP goal, such as human resources, financial management, grants, and procurement. HRSA actively seeks out and deploys shared services to improve and simplify processes, and to maximize the efficiency of shared services with other components of HHS.

Creating a Culture of Program Integrity

Program Management also supports Enterprise Risk Management (ERM) activities that align with core principles and performance and strategic planning activities to reduce programmatic risk and improve performance. HRSA has established a HRSA-wide governance structure for enterprise-wide business operations and risk management activities to ensure a proactive and customer-focused suite of business operation services and risk management functions.

HRSA is currently engaged in ERM implementation strategies aligned with the revised OMB Circular A-123. Recent revisions to the circular's Appendices A and C, respectively, include prioritizing risk based assessments and a focus on fraud identification and prevention activities. HRSA's ERM efforts include Governance and Process support for the promotion of a risk-aware organizational culture, the creation of a comprehensive view of risks to drive strategic decision making and the establishment and communication of risk appetite

Funding History

FY	Amount
FY 2016	$154,000,000
FY 2017	$153,629,000
FY 2018	$154,615,000
FY 2019	$155,250,000
FY 2020	$151,993,000

Budget Request

The FY 2019 Budget requests $152 million, which is $3.3 million below FY 2019 Enacted. This funding level supports program management activities to effectively and efficiently support HRSA's operations.

HRSA is committed to improving quality at a lower cost and improving the effectiveness and efficiency of government operations. HRSA continues to reduce travel costs and support telework participation by increasing the agency-wide utilization of web collaboration tools, which have led to greater business productivity.

HRSA also continues to enhance its program integrity activities by supporting analytical tools using HRSA's electronic grants system, program data, Office of Federal Assistance Management data sources, HHS sources, and government-wide sources. The goal is for HRSA to identify

potential issues in the pre- and post-award processes and to address issues before they become audit findings. HRSA plans to focus on a risk-based approach to grantee monitoring using the information and corresponding analysis to help staff spend their time on grantees at risk of noncompliance. HRSA will also continue to provide training for grants management and program staff to support the alignment of program integrity initiatives with planning and performance activities. These efforts will enhance HRSA grantees awareness and ability to avoid potential financial integrity issues.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
35.VII.B.1.: Ensure Critical Infrastructure Protection: Security Awareness Training (Output)	FY 2018: Full participation in Security and Privacy Awareness training by 100% of HRSA staff. specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities, and participation in Executive Awareness training by 100% of HRSA executive staff (Target Met)	Full participation in Security and Privacy Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities, and participation in Executive Awareness training by 100% of HRSA executive staff	Full participation in Security and Privacy Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities, and participation in Executive Awareness training by 100% of HRSA executive staff	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
35.VII.B.2: Ensure Critical Infrastructure Protection: Security Authorization to Operate (Output)	FY 2018: 100% of HRSA information systems will be assessed and authorized to operate (ATO). In addition, all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner. (Target Met)	100% of HRSA information systems will be assessed and authorized to operate (ATO). In addition all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner	100% of HRSA information systems will be assessed and authorized to operate (ATO). In addition all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner	Maintain
35.VII.B.2a: Ensure Critical Infrastructure Protection: Security HSPD-12 Privilege and Non-Privilege	FY 2018: Privacy - 100% of HRSA staff (federal and contractor) accessing the HRSA network with Privileged accounts must use PIV cards or other 2-factor authentication (Target Met)	Privacy - 95% of HRSA staff (federal and contractor) accessing the HRSA network with Privileged accounts must use PIV cards or other 2-factor authentication	Privacy - 95% of HRSA staff (federal and contractor) accessing the HRSA network with Privileged accounts must use PIV cards or other 2-factor authentication	Maintain
35.VII.B.2b: Ensure Critical Infrastructure Protection: Security Cyber Sprint	FY 2018: Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 days (Target Met)	Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 days	Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 days	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
35.VII.B.2c: Ensure Critical Infrastructure Protection: Security Privacy Impact Assessment (PIA) Or Privacy Threshold Assessment (PTA)	FY 2018: Identify 90% of systems that require a PIA or a Privacy Threshold Assessment (PTA) (Target Met)	Identify 90% of systems that require a PIA or a Privacy Threshold Assessment (PTA)	Identify 90% of systems that require a PIA or a Privacy Threshold Assessment (PTA)	Maintain
35.VII.B.2d: Ensure Critical Infrastructure Protection: Security Phishing	FY 2018: 17 Phishing Campaigns completed (Target Exceeded)	6 Phishing Campaigns completed	12 Phishing Campaigns completed	+6 Phishing Campaigns
35.VII.B.3: Capital Planning and Investment Control (Output)	FITARA score of "A" for IT Portfolio; 2) **75%** of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM). (Target Met)	1) Receiving FITARA score of "A" for IT Portfolio; 2) 75% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	1) Receiving FITARA score of "A" for IT Portfolio; 2) 75% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/- FY 2019 Target
35.VII.B.4: Enterprise Architecture	FY 2018: Enterprise Architecture: 90% of IT investments reported to OMB with mapping to at least one HHS segment and domain (Target Met)	Enterprise Architecture: 90% of IT investments reported to OMB with mapping to at least one HHS segment and domain	Enterprise Architecture: 90% of IT investments reported to OMB with mapping to at least one HHS segment and domain	Maintain
35.VII.A.4: Implement Enterprise Risk Management (ERM)	FY 2018: HRSA conducted a grants risk management study and continued to engage governance boards in ERM, per revised OMB circular A-123 (Target Met)	Assess HRSA's ERM implementation efforts, including alignment with revised OMB Circular A-123	Assess HRSA's ERM implementation efforts, including alignment with revised OMB Circular A-123 and Appendices A (reporting) and C (improper payments)	N/A

Family Planning TAB

Family Planning

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
BA	$286,479,000	$286,479,000	$286,479,000	---
FTE	11[247]	11[247]	35	24

Authorizing Legislation: ……Title X of the Public Health Service Act

FY 2019 Authorization…….…....Indefinite

Allocation Method…….…....Direct Federal, Contract, Competitive Grant

Program Description and Accomplishments

The Title X Family Planning Program is the only federal grant program dedicated to providing individuals with comprehensive family planning and related health services. Enacted in 1970 as part of the Public Health Service Act, the mission of the Title X Program is to assist individuals and families in determining the number and spacing of children and to provide access to voluntary family planning methods, services, and information to all who want and need them. Title X authorizing legislation requires that projects provide a broad range of effective and acceptable family planning methods and services, including fertility awareness-based methods, infertility services and services for adolescents. By law, priority is given to persons from low-income families.

The Title X Program fulfills its mission through awarding competitive grants to public and private nonprofit organizations. According to the 2017 Family Planning Annual Report (FPAR) data (the most recent data available), services were provided through 89 family planning service grants that supported a nationwide network of 3,858 community-based sites that provided clinical and educational services to more than 4,004,200 persons. There is at least one Title X services grantee in every state, the District of Columbia, and in each of the U.S. territories, including the six Pacific jurisdictions.

The Title X program was responsible for the prevention of approximately 885,300 unintended pregnancies through the provision of family planning methods, counseling and education, and other clinical services. In 2017, OPA clinics and grantees were also involved in Chlamydia screening for approximately 925,000 females ages 15-24. This screening resulted in the prevention of approximately 214 cases of invasive cervical cancer. Approximately 1.2 million confidential HIV tests were administered with 2,195 diagnosed as HIV positive.

[247] Due to coding error, FTE in FY 2018 and FY 2019 is reporting lower than actual 35 FTE

In addition to providing grants to clinical service providers, the Title X Family Planning program supports the US Department of Health and Human Services, and the Office of the Assistant Secretary for Health's initiative to identify and provide solutions to reduce substance use disorders (SUD) and the impact that they have on future health outcomes. In 2018, the Title X program held an expert work group to assist with the identification of interventions to better incorporate and link SUD screening, referral, and treatment with Title X family planning centers. OPA plans on holding a follow up to this expert work group in the spring/summer of 2019. The program also collaborates with SAMHSA's Addiction Technology Transfer Centers (ATTCs) in order to improve counseling, screening and referral for treatment services at Title X service sites.

In FY 2019, the program will explore innovative ways to increase access to Title X family planning services, including services which help support individuals impacted by SUDs. Additionally, in FY 2019, the program will be completing a 3-year initiative to improve the ability of Title X family planning projects to provide PrEP (Pre Exposure Prophylaxis) services on-site or by referral. This initiative included the development of a comprehensive tool, guidance and technical assistance for Title X family planning projects interested in providing PrEP services to reduce the risk of HIV infection. While the audience of this tool is Title X family planning service providers, it can also be used by other clinical care providers, including but not limited to STD clinics and other service sites which provide family planning and related preventive health services. At the completion of this initiative, it is expected that Title X clinics will be better prepared to offer PrEP services.

The Title X program will continue to assist in the Government response to infectious disease outbreaks that impact the ability of individuals to achieve healthy pregnancies, like the Zika Virus. Though the response will be directed by the epidemiology of the disease, the program will build upon its expertise in providing training for all levels of family planning personnel to disseminate information, collect data and research improved delivery mechanisms for family planning services. Title X will work with other HHS OPDIVs to update clinical guidance and recommendations to ensure that high-quality counseling, education and family planning services are available to clients and providers.

Each year, the program provides guidance to grantees by setting program priorities. The program will continue to emphasize the importance of making the broad range of family planning methods and services available at Title X family planning centers, including promoting clinical counseling and education of fertility awareness-based methods. Supporting the overall health of clients will continue to be an important focus of the program. Therefore, each Title X project should ensure that access to primary health care services, either onsite or by referral is encouraged and, at a minimum, supported through robust referral linkages.

In order to improve overall program performance, the program is increasing the emphasis on financial and program management by providing training around billing practices, including billing all appropriate third-party payers, and other cost recovery methods through the Title X National Training Center. In addition, grantees are urged to implement more efficient administrative systems, such as health information technologies, electronic health records, and payment management systems. Focusing on these areas will also assist in better data collection

and increase the ability to report on the outputs and outcomes of Title X projects and the program.

Another trend, which the program believes will improve program performance, is increasing competition and the diversity in the types of grantees funded. Increased competition has led to more diversified grantees, improved cost recovery methods and different administrative structures, which, it is anticipated, will ultimately improve quality and service delivery.

In 2018, OASH began the process of updating regulations surrounding the Title X program. A proposed rule was published in the Federal Register, which began the process to ensure statutory compliance. A final rule was released in 2019.

Funding History

FY	Amount
FY 2016	$286,479,000
FY 2017	$286,479,000
FY 2018	$286,479,000
FY 2019	$286,479,000
FY 2020	$286,479,000

Budget Request

The FY 2020 Budget Request for Family Planning of $286.5 million is equal to the FY 2019 Enacted level.

The FY 2020 Budget Request is expected to support family planning for approximately 3,965,000 persons, with approximately 90 percent having family incomes at or below 200 percent of the federal poverty level. The FY 2020 request will also allow the program to continue supporting the operation of Family Planning National Training Centers. These training centers focus on improving grantee capacity and skills of clinical providers in Title X service grant projects service providers in order to increase access and the quality of services for all individuals seeking Title X family planning services.

The targets for FY 2020 assume other sources of revenue that contribute to the family planning program at the grantee level will remain at current levels, including Medicaid, state and local government programs, other federal, state, and private grants, and private insurance.

OPA's clinical service grantees will continue to include recommended chlamydia screening, screening for undiagnosed cervical tissue abnormalities, preconception care and counseling, basic infertility services, pregnancy testing and counseling, natural family planning methods, contraceptives, adolescent services and related education and counseling. These services, along with community-based education and outreach, assist individuals and families with effective family planning services, whether it be to prevent or achieve pregnancy. To the extent practicable, Title X clinics also encourage family participation when delivering such services.

OPA will also coordinate with other federal agencies, and with other data collection efforts reflecting performance and impact. The program is anticipating that additional investment in third party billing, an increase in the proportion of clients who have health insurance, and better adoption of electronic health records and related health IT systems, will increase revenue and allow the Title X program to reach more of the population it is intended to serve. In addition, the program is assessing traditional and innovative ways to increase access to family planning and related preventive health services, specifically in rural and hard to reach areas.

In FY 2019 and continuing into FY 2020, the Title X family planning program will develop and recommend additional performance measures for the program. These measures will include: (1) Increasing the number of unduplicated clients that receive the HPV (human papillomavirus) vaccine at Title X family planning centers; (2) Increasing the number of clients screened for substance use disorders; and (3) re-emphasizing the importance of screening for Chlamydia infection in females ages 15 – 24. Baseline data will be collected and targets established for these measures in to prepare for implementation in FY 2020.

Outputs and Outcomes Tables

Long Term Objective: Increase awareness of voluntary family planning resources and methods by providing Title X family planning services, education and research, with priority for services to low-income individuals.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
36.II.A.1: Total number of unduplicated clients served in Title X service sites. *(Outcome)*	FY 2017: 4,004,246 Target: 4,259,000 (Target Not Met)	3,991,000	3,965,000	-26,000
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 2017: 90% Target: 90% (Target Met)	90%	90%	Maintain
36.II.A.3: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals. *(Outcome)*	FY 2017: 885,309 Target: 977,400 (Target Not Met)	903,000	912,000	+9,000

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
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 2017: 925,121 Target: 1,032,500 (Target Not Met)	1,218,000	1,030,000	-188,000
36.II.C.3: Increase the proportion of females' ages 15 – 24 attending Title X family planning clinics screened for Chlamydia infection. *(Outcome)*	FY 2017: 62.04% Target: 64.4% (Target Not Met)	64.4%	85.0%	+20.6 points

Efficiency Measure

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
36.E: Maintain the actual cost per Title X client below the medical care inflation rate. *(Efficiency)*	FY 2017: $324.06 Target: $328.21 (Target Exceeded)	$345.11	$364.21	+$19.10

Grant Awards Tables

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Number of Awards	96	95	95
Average Award	$2,687,500	$2,867,000	$2,715,000
Range of Awards	$131,000 - $20,500,000	$130,000 - $20,000,000	$130,000 - $20,000,000

Performance Analysis

The Program currently has six performance measures that focus on increasing access and serving individuals and families from underserved, vulnerable and low-income populations. Three measures gauge the extent to which the Program expands the availability of healthcare to the

public and three measures assess the quality of health care serviced delivered and the extent to which preventive healthcare and chronic disease management services are utilized. Each of the performance measures and the efficiency measure guide Program strategies; establish directions for technical assistance, and direct revisions to program policies. This enables the Program to better address program performance and facilitates methods to increase efficiency in the delivery of preventive healthcare services.

The Program's major challenge to meeting its targets and maintaining a high-level of service delivery is the continued increase in medical care prices, which ultimately affects the number of clients that clinics are able to serve. The Program addresses this issue primarily using the strategy of employing focused training efforts. This includes providing targeted funding for a national training priority that addresses clinic efficiency, quality assurance, staffing pattern strategies and other areas related to improved clinic management, cost reduction and resource allocation.

For 2017, the most recent performance data available, the program did not meet several of the targets for its performance measures. While the number of unduplicated clients did not meet the target, the program appears to be leveling off the decline in the number of unduplicated clients receiving Title X family planning services. This may be a result of the improvement in the capacity of Title X service sites to bill third-party payers and ultimately increase revenue, and therefore improving access and capacity. Another target that was not met was the number of unintended pregnancies averted and number of females screened for Chlamydia infection also failed to meet their targets as these targets and measures are driving by client volume. However, the program improved on this measure (proportion screened), up from 2016. In FY2019 and FY2020, OPA has a specific focus on improving Chlamydia screening among all Title X clients, with specific emphasis on females within this age range.

After added program emphasis in 2017, 90% of all clients served within the Title X program had incomes at or below 200% of the Federal Poverty Level, meeting the target and again reflecting the priority of providing services to low income individuals. Another improvement was the Program's efficiency measure – meeting the objective, as our costs were less than target.

Nonrecurring Expenses Fund TAB

Nonrecurring Expenses Fund

Budget Summary
(Dollars in Thousands)

Notification[248]	FY 2018[249]	FY 2019	FY 2020[250]
HRSA Investments	--	$13,000	TBD

Authorizing Legislation:

Authorization…….Section 223 of Division G of the Consolidated Appropriations Act, 2008

Allocation Method……..Direct Federal, Competitive Contract

Program Description and Accomplishments

The Nonrecurring Expenses Fund (NEF) permits HHS to transfer unobligated balances of expired discretionary funds from FY 2008 and subsequent years into the NEF account. Congress authorized use of the funds for capital acquisitions necessary for the operation of the Department, specifically information technology (IT) and facilities infrastructure acquisitions.

Budget Allocation

HRSA received $13.0 million to support five FY 2019 NEF proposals that will improve HRSA operations, strengthen the security of HRSA's data, and support the President's Management Agenda. HRSA will expand Electronic Handbooks (EHBs) modernization efforts, enhance EHBs security features, and support cloud migration activities. HRSA will also invest in security operations upgrades that will identify and mitigate open source security risks across application portfolios and will resolve minor cybersecurity events through tool automation and orchestration. A final project focuses on developing dashboards that leverage internal and external health workforce data sets to enable HRSA to prioritize funding strategies to target specific areas of workforce need.

[248] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.
[249] There was no Congressional notification for the planned uses of NEF funds in FY 2018.
[250] This represents the total amount to be notified as a planned use of funds in a FY 2020 notification letter.

3

Supplementary Tables TAB

Object Class Tables
(dollars in thousands)

DISCRETIONARY

OBJECT CLASS	2018 Actual	FY 2019	FY 2020 President's Budget	FY 2020 +/- FY 2019
Full-time permanent (11.1)	$152,333	$155,567	$151,909	$-3,658
Other than full-time permanent (11.3)	5,545	5,546	5,224	-322
Other personnel compensation (11.5)	3,555	3,576	3,285	-291
Military personnel (11.7)	15,834	16,226	15,778	-448
Special personnel services payments (11.8)	16	17	13	-4
Subtotal personnel compensation	**177,283**	**180,932**	**176,209**	**-4,723**
Civilian benefits (12.1)	49,964	50,962	49,917	-1,045
Military benefits (12.2)	8,465	8,749	8,521	-228
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$235,712**	**$240,643**	**$234,647**	**$-5,996**
Travel and transportation of persons (21.0)	2,862	2,826	2,699	-127
Transportation of things (22.0)	167	177	119	-57
Rental payments to GSA (23.1)	22,937	22,865	15,704	-7,161
Rental payments to Others (23.2)	695	695	704	+9
Communication, utilities, and misc. charges (23.3)	2,689	3,333	4,580	+1,247
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	102	102	84	-18
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	15,917	14,681	10,882	-3,800
Other services (25.2)	209,833	211,917	188,402	-23,515
Purchase of goods and services from government accounts (25.3)	179,504	298,336	156,491	-141,845
Operation and maintenance of facilities (25.4)	634	753	854	+101
Research and Development Contracts (25.5)	205	205	16	-190
Medical care (25.6)	2,684	3,255	1,860	-1,395
Operation and maintenance of equipment (25.7)	6,283	6,050	3,671	-2,380
Subsistence and support of persons (25.8)	25	25	30	+5
Discounts and Interest (25.9)	20	20	-	-20
Supplies and materials (26.0)	802	807	1,109	+303
Subtotal Other Contractual Services	**415,908**	**536,049**	**363,313**	**-172,736**
Equipment (31.0)	3,694	3,812	4,198	+385
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	5,926,549	5,923,766	5,106,124	-817,642
Insurance Claims and Indemnities (42.0)	109,581	109,235	109,180	-54
Total Non-Pay Costs	**6,485,185**	**6,602,860**	**5,606,705**	**-996,155**
Total Budget Authority by Object Class	**$6,720,897**	**$6,843,503**	**$5,841,352**	**$-1,002,151**

PRIMARY HEALTH CARE

OBJECT CLASS	2018 Actual	FY 2019	FY 2020 President's Budget	FY 2020 +/- FY 2019
Full-time permanent (11.1)	$ 24,337	$ 24,476	$24,476	-
Other than full-time permanent (11.3)	707	711	711	-
Other personnel compensation (11.5)	443	446	446	-
Military personnel (11.7)	3,977	4,075	4,196	+121
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**29,465**	**29,709**	**29,830**	**+121**
Civilian benefits (12.1)	8,069	8,115	8,115	-
Military benefits (12.2)	2,099	2,151	2,215	+64
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$39,632**	**$39,974**	**$40,160**	**$+185**
Travel and transportation of persons (21.0)	1,091	1,091	1,091	-
Transportation of things (22.0)	5	5	5	-
Rental payments to GSA (23.1)	2,899	2,899	2,899	-
Rental payments to Others (23.2)	2	2	2	-
Communication, utilities, and misc. charges (23.3)	374	374	374	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	86,734	86,734	86,734	-
Purchase of goods and services from government accounts (25.3)	45,723	45,723	45,723	-
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	818	818	818	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	115	115	115	-
Subtotal Other Contractual Services	**$133,389**	**$133,389**	**$133,389**	**-**
Equipment (31.0)	817	817	817	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	1,334,972	1,338,789	1,338,608	-181
Insurance Claims and Indemnities (42.0)	109,528	109,181	109,178	-4
Total Non-Pay Costs	**1,583,077**	**1,586,548**	**1,586,362**	**-185**
Total Budget Authority by Object Class	**$1,622,709**	**$1,626,522**	**$1,626,522**	**-**

HEALTH WORKFORCE

OBJECT CLASS	2018 Actual	FY 2019	FY 2020 President's Budget	FY 2020 +/- FY 2019
Full-time permanent (11.1)	$11,820	$11,888	$5,331	$-6,557
Other than full-time permanent (11.3)	327	329	106	-222
Other personnel compensation (11.5)	285	287	83	-204
Military personnel (11.7)	1,302	1,334	600	-733
Special personnel services payments (11.8)	4	4	-	-4
Subtotal personnel compensation	**13,737**	**13,841**	**6,120**	**-7,720**
Civilian benefits (12.1)	3,946	3,969	1,877	-2,091
Military benefits (12.2)	676	693	313	-380
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$18,359**	**$18,502**	**$8,311**	**$-10,191**
Travel and transportation of persons (21.0)	176	162	19	-143
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	1,348	1,221	331	-890
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	906	1,012	1,111	+99
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	0.17	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	15,690	15,993	3,870	-12,123
Purchase of goods and services from government accounts (25.3)	23,384	142,693	5,717	-136,976
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	1,010	1,078	131	-946
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	-	-	-	-
Subtotal Other Contractual Services	**40,084**	**159,764**	**9,718**	**-150,046**
Equipment (31.0)	196	196	19	-176
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	997,385	915,838	285,205	-630,633
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**1,040,094**	**1,078,193**	**296,403**	**-781,790**
Total Budget Authority by Object Class	**$1,058,453**	**$1,096,695**	**$304,714**	**$-791,981**

MATERNAL AND CHILD HEALTH

OBJECT CLASS	2018 Actual	FY 2019	FY 2020 President's Budget	FY 2020 +/- FY 2019
Full-time permanent (11.1)	$ 8,607	$9,332	$ 6,555	$-2,776
Other than full-time permanent (11.3)	356	358	287	-70
Other personnel compensation (11.5)	165	166	90	-76
Military personnel (11.7)	495	507	448	-59
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**9,623**	**10,362**	**7,381**	**-2,982**
Civilian benefits (12.1)	2,870	3,111	2,195	-916
Military benefits (12.2)	242	248	207	-41
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$12,735**	**$13,722**	**$9,783**	**$-3,938**
Travel and transportation of persons (21.0)	456	434	353	-81
Transportation of things (22.0)	1	10	10	-
Rental payments to GSA (23.1)	586	640	453	-187
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	42	580	344	-235
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	10,026	8,790	5,977	-2,813
Other services (25.2)	4,815	4,589	3,892	-698
Purchase of goods and services from government accounts (25.3)	13,595	15,426	11,535	-3,891
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	725	423	277	-146
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	1	6	5	-1
Subtotal Other Contractual Services	**29,162**	**29,234**	**21,686**	**-7,548**
Equipment (31.0)	229	462	345	-117
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	841,378	881,707	750,224	-131,483
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**871,853**	**913,067**	**773,417**	**-139,651**
Total Budget Authority by Object Class	**$884,588**	**$926,789**	**$783,200**	**$-143,589**

HIV/AIDS

OBJECT CLASS	2018 Actual	FY 2019	FY 2020 President's Budget	FY 2020 +/- FY 2019
Full-time permanent (11.1)	$15,952	$16,043	$19,418	$+3,375
Other than full-time permanent (11.3)	116	117	117	-
Other personnel compensation (11.5)	296	298	298	-
Military personnel (11.7)	2,763	2,831	2,832	+1
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**19,127**	**19,289**	**22,665**	**+3,376**
Civilian benefits (12.1)	4,896	4,924	6,049	+1,125
Military benefits (12.2)	1,498	1,535	1,581	+46
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$25,521**	**$25,748**	**$30,294**	**$+4,547**
Travel and transportation of persons (21.0)	422	422	583	+160
Transportation of things (22.0)	1	1	1	-
Rental payments to GSA (23.1)	2,468	2,468	2,122	-347
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	142	142	811	+669
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	30,845	30,845	26,271	-4,574
Purchase of goods and services from government accounts (25.3)	61,794	61,794	59,046	-2,748
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	3,415	3,415	1,531	-1,884
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	32	32	29	-3
Subtotal Other Contractual Services	96,086	96,086	86,877	-9,209
Equipment (31.0)	1,277	1,277	2,108	+831
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	2,187,106	2,192,633	2,265,982	+73,350
Insurance Claims and Indemnities (42.0)	3	3	3	-
Total Non-Pay Costs	**2,287,506**	**2,293,033**	**2,358,487**	**+65,453**
Total Budget Authority by Object Class	**$2,313,027**	**$2,318,781**	**$2,388,781**	**$+70,000**

HEALTHCARE SYSTEMS

OBJECT CLASS	2018 Actual	FY 2019	FY 2020 President's Budget	FY 2020 +/- FY 2019
Full-time permanent (11.1)	7,808	7,853	7,853	-
Other than full-time permanent (11.3)	311	313	313	-
Other personnel compensation (11.5)	293	295	295	-
Military personnel (11.7)	1,389	1,423	1,465	+42
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**9,801**	**9,884**	**9,926**	**+42**
Civilian benefits (12.1)	2,667	2,683	2,683	-
Military benefits (12.2)	652	668	688	+20
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**13,121**	**13,234**	**13,297**	**+62**
Travel and transportation of persons (21.0)	277	277	245	-31
Transportation of things (22.0)	129	129	78	-50
Rental payments to GSA (23.1)	1,197	1,197	392	-804
Rental payments to Others (23.2)	692	692	687	-6
Communication, utilities, and misc. charges (23.3)	226	226	1,097	+871
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	0	0	0	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	838	838	463	-375
Other services (25.2)	55,992	59,658	53,927	-5,731
Purchase of goods and services from government accounts (25.3)	3,612	3,612	4,534	+921
Operation and maintenance of facilities (25.4)	48	167	69	-98
Research and Development Contracts (25.5)	205	205	16	-190
Medical care (25.6)	2,684	3,255	1,860	-1,395
Operation and maintenance of equipment (25.7)	270	270	329	+59
Subsistence and support of persons (25.8)	25	25	30	+5
Discounts and Interest (25.9)	19	19	-	-19
Supplies and materials (26.0)	382	382	689	+307
Subtotal Other Contractual Services	**64,074**	**68,432**	**61,915**	**-6,516**
Equipment (31.0)	517	517	406	-111
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	31,183	30,489	32,900	+2,411
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**98,295**	**101,959**	**97,721**	**-4,237**
Total Budget Authority by Object Class	**111,416**	**115,193**	**111,018**	**-4,175**

RURAL HEALTH POLICY

OBJECT CLASS	2018 Actual	FY 2019	FY 2020 President's Budget	FY 2020 +/- FY 2019
Full-time permanent (11.1)	1,445	3,141	2,741	-400
Other than full-time permanent (11.3)	111	82	53	-29
Other personnel compensation (11.5)	34	34	23	-11
Military personnel (11.7)	72	74	76	+2
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**1,663**	**3,331**	**2,893**	**-438**
Civilian benefits (12.1)	489	979	916	-63
Military benefits (12.2)	42	118	82	-36
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**2,194**	**4,428**	**3,891**	**-538**
Travel and transportation of persons (21.0)	230	230	195	-35
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	295	295	186	-109
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	88	88	87	-1
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	7,950	7,950	7,178	-772
Purchase of goods and services from government accounts (25.3)	2,413	2,413	2,164	-249
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	37	37	37	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	-	-	-	-
Subtotal Other Contractual Services	**10,400**	**10,400**	**9,380**	**-1,020**
Equipment (31.0)	89	89	44	-45
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	277,024	302,263	174,861	-127,402
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**288,127**	**313,366**	**184,754**	**-128,611**
Total Budget Authority by Object Class	**290,321**	**317,794**	**188,645**	**-129,149**

PROGRAM MANAGEMENT

OBJECT CLASS	2018 Actual	FY 2019	FY 2020 President's Budget	FY 2020 +/- FY 2019
Full-time permanent (11.1)	$78,483	$78,933	$78,933	-
Other than full-time permanent (11.3)	3,542	3,562	3,562	-
Other personnel compensation (11.5)	1,776	1,786	1,786	-
Military personnel (11.7)	4,959	5,082	5,233	+151
Special personnel services payments (11.8)	13	13	13	-
Subtotal personnel compensation	**88,773**	**89,376**	**89,527**	**+151**
Civilian benefits (12.1)	25,735	25,882	25,882	-
Military benefits (12.2)	2,792	2,861	2,946	+85
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$117,300**	**$118,119**	**$118,355**	**+236**
Travel and transportation of persons (21.0)	127	127	95	-32
Transportation of things (22.0)	31	31	23	-8
Rental payments to GSA (23.1)	12,681	12,681	8,798	-3,883
Rental payments to Others (23.2)	0	0	-	-
Communication, utilities, and misc. charges (23.3)	746	746	703	-44
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	100	100	82	-18
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	5,906	5,906	6,478	+572
Purchase of goods and services from government accounts (25.3)	16,273	16,204	15,457	-747
Operation and maintenance of facilities (25.4)	553	553	735	+181
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	9	9	547	+538
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	269	269	266	-2
Subtotal Other Contractual Services	**23,010**	**22,941**	**23,483**	**-22,675**
Equipment (31.0)	568	454	454	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	-	-	-	-
Insurance Claims and Indemnities (42.0)	50	50	-	-50
Total Non-Pay Costs	**37,315**	**37,131**	**33,638**	**-3,493**
Total Budget Authority by Object Class	**$154,615**	**$155,250**	**$151,993**	**$-3,257**

FAMILY PLANNING

OBJECT CLASS	2018 Actual[251]	FY 2019[251]	FY 2020 President's Budget	FY 2020 +/- FY 2019
Full-time permanent (11.1)	$3,880	$3,902	$6,602	$+2,700
Other than full-time permanent (11.3)	74	74	74	-
Other personnel compensation (11.5)	263	264	264	-
Military personnel (11.7)	878	900	926	+27
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**5,095**	**5,140**	**7,867**	**+2,727**
Civilian benefits (12.1)	1,292	1,300	2,200	+900
Military benefits (12.2)	464	475	489	+14
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$6,851**	**$6,915**	**$ 10,556**	**$+3,641**
Travel and transportation of persons (21.0)	84	84	117	+34
Transportation of things (22.0)	-	-	1	+1
Rental payments to GSA (23.1)	1,464	1,464	523	-941
Rental payments to Others (23.2)	-	-	15	+15
Communication, utilities, and misc. charges (23.3)	165	165	53	-113
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	1	1	2	+1
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	5,054	5,054	4,442	-612
Other services (25.2)	241	241	51	-190
Purchase of goods and services from government accounts (25.3)	10,471	10,471	12,315	+1,843
Operation and maintenance of facilities (25.4)	33	33	50	+18
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)	1	1	-	-1
Supplies and materials (26.0)	4	4	6	+2
Subtotal Other Contractual Services	**$15,805**	**$15,805**	**$16,865**	**$+1,061**
Equipment (31.0)	-	-	4	+4
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	261,399	262,045	258,342	-3,703
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**278,917**	**279,564**	**275,923**	**-3,641**
Total Budget Authority by Object Class	**$285,768**	**$286,479**	**$286,479**	**-**

[251] Due to coding error, FTE in FY 2018 and FY 2019 is reporting lower than actual 35 FTE.

MANDATORY

OBJECT CLASS	2018 Actual	FY 2019	FY 2020 President's Budget	FY 2020 +/- FY 2019
Full-time permanent (11.1)	$48,552	$48,811	$49,824	$+1,013
Other than full-time permanent (11.3)	922	928	926	-2
Other personnel compensation (11.5)	1,119	1,124	1,124	-
Military personnel (11.7)	5,308	5,435	5,203	-232
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**55,901**	**56,298**	**57,076**	**+778**
Civilian benefits (12.1)	16,037	16,122	16,460	+338
Military benefits (12.2)	2,907	2,980	2,859	-122
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$74,845**	**$75,401**	**$76,395**	**$+994**
Travel and transportation of persons (21.0)	306	316	352	+36
Transportation of things (22.0)	1	1	1	+
Rental payments to GSA (23.1)	7,631	7,556	8,211	+655
Rental payments to Others (23.2)	25	25	25	-
Communication, utilities, and misc. charges (23.3)	1,865	1,866	1,887	+22
GSA Reimbursement Transaction Charge (23.5)	-	-	-	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	1	1	1	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	4,735	4,735	18,903	+14,167
Other services (25.2)	42,658	38,610	36,546	-2,064
Purchase of goods and services from government accounts (25.3)	118,905	118,851	118,004	-847
Operation and maintenance of facilities (25.4)	209	209	209	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	388	388	388	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	4	4	6	+2
Subtotal Other Contractual Services	**$166,899**	**$162,798**	**$174,056**	**$+11,258**
Equipment (31.0)	525	525	436	-89
Grants, subsidies, and contributions (41.0)	4,415,403	4,594,012	4,581,136	-12,876
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**4,592,655**	**4,767,099**	**4,766,105**	**-994**
Total Budget Authority by Object Class	**$4,667,500**	**$4,842,500**	**$4,842,500**	**-**

Salaries and Expenses
(dollars in thousands)

DISCRETIONARY

OBJECT CLASS	2018 Actual	FY 2019	FY 2020 President's Budget	FY 2020 +/- FY 2019
Full-time permanent (11.1)	$152,333	$155,567	$151,909	$-3,658
Other than full-time permanent (11.3)	5,545	5,546	5,224	-322
Other personnel compensation (11.5)	3,555	3,576	3,285	-291
Military personnel (11.7)	15,834	16,226	15,778	-448
Special personnel services payments (11.8)	16	17	13	-4
Subtotal personnel compensation	**177,283**	**180,932**	**176,209**	**-4,723**
Civilian benefits (12.1)	49,964	50,962	49,917	-1,045
Military benefits (12.2)	8,465	8,749	8,521	-228
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$235,712**	**$240,643**	**$234,647**	**$-5,996**
Travel and transportation of persons (21.0)	2,862	2,826	2,699	-127
Transportation of things (22.0)	167	177	119	-57
Rental payments to Others (23.2)	695	695	704	+9
Communication, utilities, and misc. charges (23.3)	2,689	3,333	4,580	+1,247
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	102	102	84	-18
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	15,917	14,681	10,882	-3,800
Other services (25.2)	209,833	211,917	188,402	-23,515
Purchase of goods and services from government accounts (25.3)	179,504	298,336	156,491	-141,845
Operation and maintenance of facilities (25.4)	634	753	854	+101
Medical care (25.6)	2,684	3,255	1,860	-1,395
Operation and maintenance of equipment (25.7)	6,283	6,050	3,671	-2,380
Subsistence and support of persons (25.8)	25	25	30	+5
Discounts and Interest (25.9)	20	20	-	-20
Supplies and materials (26.0)	802	807	1,109	+303
Subtotal Other Contractual Services	415,703	535,844	363,298	-172,546
Total Non-Pay Costs	**$422,218**	**$542,977**	**$371,484**	**$-171,493**
Total Budget Authority by Object Class	**$657,930**	**$783,620**	**$606,131**	**$-177,489**

Salaries and Expenses
(dollars in thousands)

MANDATORY

OBJECT CLASS	2018 Actual	FY 2019	FY 2020 President's Budget	FY 2020 +/- FY 2019
Full-time permanent (11.1)	$48,552	$48,811	$49,824	$+1,013
Other than full-time permanent (11.3)	922	928	926	-2
Other personnel compensation (11.5)	1,119	1,124	1,124	-
Military personnel (11.7)	5,308	5,435	5,203	-232
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**55,901**	**56,298**	**57,076**	**+778**
Civilian benefits (12.1)	16,037	16,122	16,460	+338
Military benefits (12.2)	2,907	2,980	2,859	-122
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$74,845**	**$75,401**	**$76,395**	**$+994**
Travel and transportation of persons (21.0)	306	316	352	+36
Transportation of things (22.0)	1	1	1	+
Rental payments to Others (23.2)	25	25	25	-
Communication, utilities, and misc. charges (23.3)	1,865	1,866	1,887	+22
GSA Reimbursement Transaction Charge (23.5)	-	-	-	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	1	1	1	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	4,735	4,735	18,903	+14,167
Other services (25.2)	42,658	38,610	36,546	-2,064
Purchase of goods and services from government accounts (25.3)	118,905	118,851	118,004	-847
Operation and maintenance of facilities (25.4)	209	209	209	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	388	388	388	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	4	4	6	+2
Subtotal Other Contractual Services	166,899	162,798	174,056	+11,258
Total Non-Pay Costs	**169,096**	**165,006**	**176,323**	**+11,316**
Total Budget Authority by Object Class	**$243,941**	**$240,407**	**$252,717**	**$+12,310**

Detail of Full-Time Equivalent Employment

Programs	2018 Actual			2019 Enacted			2020 Budget		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Bureau of Primary Health Care									
Direct:									
Health Centers/Tort	263	54	317	263	54	317	263	54	317
Free Clinics Medical Malpractice			-	-	-	-	-	-	-
Total, Direct:	**263**	**54**	**317**	**263**	**54**	**317**	**263**	**54**	**317**
Mandatory:									
Health Centers	161	13	174	161	13	174	170	13	183
School-based Health Centers- Facilities (ACA)	9		9	9	-	9	-	-	-
Total, Mandatory	**170**	**13**	**183**	**170**	**13**	**183**	**170**	**13**	**183**
Total FTE, BPHC	**433**	**67**	**500**	**433**	**67**	**500**	**433**	**67**	**500**
Health Workforce:									
Direct:									
National Health Service Corps	-	-	-	-	-	-	6	-	6
NURSE Corps Loan Repayment & Scholarship	27	5	32	27	5	32	27	5	32
Centers for Excellence	2	-	2	2	-	2	-	-	-
Scholarships for Disadvantaged Students	7	-	7	7	-	7	-	-	-
Health Careers Opportunity Program	-	2	2	-	2	2	-	-	-
Health Care Workforce Assessment	6	-	6	6	-	6	6	-	6
Primary Care Training and Enhancement	6	1	7	6	1	7	-	-	-
Oral Health Training	5	1	6	5	1	6	-	-	-
Area Health Education Centers	4	-	4	4	-	4	-	-	-
Geriatric Programs	4	2	6	4	2	6	-	-	-
Behavioral Health Workforce Development Programs	12	1	13	12	1	13	12	1	13
Public Health/Preventive Medicine	4	-	4	4	-	4	-	-	-
Advanced Education Nursing Program	11	-	11	11	-	11	-	-	-

Programs	2018 Actual			2019 Enacted			2020 Budget		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Nurse Workforce Diversity	3	1	4	3	1	4	-	-	-
Nurse Education, Practice & Retention	4	1	5	4	1	5	-	-	-
Nurse Faculty Loan Program	3	1	4	3	1	4	-	-	-
Children's Hospitals GME Program	20	1	21	20	1	21	-	-	-
Graduate Medical Education for Health Care Professionals	-	-	-	1	-	1	-	-	-
Total, Direct	**118**	**16**	**134**	**119**	**16**	**135**	**51**	**6**	**57**
Reimbursable:									
National Practitioner Data Bank	33	1	34	33	1	34	33	1	34
Total, Reimbursable:	**33**	**1**	**34**	**33**	**1**	**34**	**33**	**1**	**34**
Mandatory:									
National Health Service Corps	185	21	206	185	21	206	185	21	206
Teaching Health Center Graduate Medical Education	9	1	10	9	1	10	9	1	10
Total, Mandatory	**194**	**22**	**216**	**194**	**22**	**216**	**194**	**22**	**216**
Total FTE, Health Workforce	**345**	**39**	**384**	**346**	**39**	**385**	**278**	**29**	**307**
Maternal and Child Health Bureau:									
Direct:									
Maternal & Child Health Block Grant	48	1	49	52	1	53	52	1	53
Autism and Other Developmental Disorders	6	1	7	6	1	7	-	-	-
Sickle Cell Service Demonstrations	2	-	2	2	-	2	-	-	-
James T. Walsh Universal Newborn Hearing Screening	4	-	4	4	-	4	-	-	-
Emergency Medical Services for Children	6	-	6	6	-	6	-	-	-
Healthy Start	12	3	15	12	3	15	12	3	15
Heritable Disorders	4	-	4	4	-	4	-	-	-
Pediatric Mental Health Care Access Grants	1	-	1	2	-	2	-	-	-
Screening and Treatment for Maternal Depression	-	-	-	1	-	1	-	-	-
Total, Direct:	**83**	**5**	**88**	**89**	**5**	**94**	**64**	**4**	**68**

Programs	2018 Actual			2019 Enacted			2020 Budget		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Mandatory									
Family to Family Health Info Centers	-	1	1	-	1	1	-	1	1
Home Visiting	39	3	42	39	3	42	39	3	42
Total, Mandatory	**39**	**4**	**43**	**39**	**4**	**43**	**39**	**4**	**43**
Total FTE, MCHB	**122**	**9**	**131**	**128**	**9**	**137**	**103**	**8**	**111**
HIV/AIDS Bureau:									
Direct:									
Ryan White Part A	42	5	47	42	5	47	42	5	47
Ryan White Part B	52	7	59	52	7	59	52	7	59
Ryan White Part C	41	13	54	41	13	54	41	13	54
Ryan White Part D	9	3	12	9	3	12	9	3	12
Ryan White Part F	4	1	5	4	1	5	4	1	5
Ryan White Part F Dental	1	-	1	1	-	1	1	-	1
Special Project of National Significance (SPNS)	3	-	3	3	-	3	3	-	3
Ending HIV/AIDS	-	-	-	-	-	-	30	-	30
Total, Direct:	**152**	**29**	**181**	**152**	**29**	**181**	**182**	**29**	**211**
Reimbursable:									
OGAC Global AIDS	16	1	17	16	1	17	16	1	17
Secretary's Minority AIDS Initiative			-	-	-	-	-	-	-
Total, Reimbursable	**16**	**1**	**17**	**16**	**1**	**17**	**16**	**1**	**17**
Total FTE, HAB	**168**	**30**	**198**	**168**	**30**	**198**	**198**	**30**	**228**
Healthcare Systems Bureau:									
Direct:									
Organ Transplantation	1		1	1	-	1	1	-	1
National Cord Blood Inventory	3	1	4	3	1	4	3	1	4
C.W. Bill Young Cell Transplantation Program	7		7	7	-	7	7	-	7
Poison Control Centers	2	1	3	2	1	3	2	1	3

Programs	2018 Actual			2019 Enacted			2020 Budget		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
340B Drug Pricing Program/Office of Pharmacy Affairs	16	6	22	16	6	22	16	6	22
Hansen's Disease Center	47	5	52	47	5	52	47	5	52
Covered Countermeasures Compensation	4	2	6	4	2	6	4	2	6
Vaccine	14	4	18	14	4	18	20	4	24
Total, Direct:	**94**	**19**	**113**	**94**	**19**	**113**	**100**	**19**	**119**
Reimbursable:									
Hansen's Disease Center	2		2	2	-	2	2	-	2
340B			-	-	-	-	16	-	16
Total, Reimbursable	**2**	**-**	**2**	**2**	**-**	**2**	**18**	**-**	**18**
				-	**-**	**-**	**-**	**-**	**-**
Total FTE, HSB	**96**	**19**	**115**	**96**	**19**	**115**	**118**	**19**	**137**
Federal Office of Rural Health Policy:									
Direct:									
Rural Health Policy Development	1	-	1	3	-	3	3	-	3
Rural Health Outreach Grants	8	1	9	8	1	9	8	1	9
Rural Hospital Flexibility Grants	1	-	1	1	-	1	-	-	-
State Offices of Rural Health	1	-	1	1	-	1	-	-	-
Radiation Exposure Screening & Education Program	1	-	1	1	-	1	1	-	1
Black Lung	-	-	-	-	-	-	1	-	1
Telehealth	2	-	2	2	-	2	2	-	2
Rural Communities Opioid Response	1	-	1	12	-	12	12	-	12
Rural Residency	-	-	-	2	-	2	-	-	-
Total FTE, FORHP	**15**	**1**	**16**	**30**	**1**	**31**	**27**	**1**	**28**
Family Planning (Direct)*	10	1	11	10	1	11	34	1	35
Program Management (Direct)	707	46	753	707	46	753	707	46	753

Programs	2018 Actual			2019 Enacted			2020 Budget		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Subtotal Direct (non add)	1,442	171	1,613	1,464	171	1,635	1,428	160	1,588
Subtotal Reimbursable (non add)	51	2	53	51	2	53	67	2	69
Subtotal Mandatory (non add)	403	39	442	403	39	442	403	39	442
Total, Ceiling FTE	**1,896**	**212**	**2,108**	**1,918**	**212**	**2,130**	**1,898**	**201**	**2,099**

***Due to coding error, FTE in FY18 and FY19 is reporting lower than actual 35 FTE.**

FTEs Funded by P.L. 111-148 and Any Supplementals

(*Dollars in Thousands)*

		FY 2011		FY 2012		FY 2013		FY 2014		FY 2015		FY 2016		FY 2017		FY 2018[252]		FY 2019		FY 2020	
Program	**Section**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**
Community Health Center Fund:																					
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(1)	1,000,000	56	1,200,000	47	1,500,000	60	2,144,716	95	3,509,111	122	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	-	-	-	-	3,600,000	240	3,510,661	225	3,800,000	174	4,000,000	174	4,000,000	183
Health Centers - Facilities Construction	H.R. 3590, Section 10503(c)	1,500,000	20	-	19	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
School-Based Health Centers-Facilities	H.R. 3590, Section 4101	50,000	9	50,000	5	47,500	8	-	9	-	7	-	7	-	9	-	9	-	9	-	-
National Health Service Corps:																					
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(2)	290,000	190	295,000	248	300,000	229	283,040	219	287,370	214	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	-	-	-	-	310,000	226	288,610	225	310,000	206	310,000	206	310,000	206
GME Payments Teaching Health Centers:	H.R. 3590, Section 5508																				
P.L. 111-148 Mandatory		230,000	4	-	4	-	6	-	5	-	4	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	-	-	-	-	60,000	8	55,860	8	126,500	10	126,500	10	126,500	10
Family to Family Health Information Centers:																					

[252] FY 2018 funding level does not include supplemental hurricane appropriations ($60 million).

		FY 2011		FY 2012		FY 2013		FY 2014		FY 2015		FY 2016		FY 2017		FY 2018[252]		FY 2019		FY 2020	
Program	**Section**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**
Non-P.L. 111-148 Mandatory	H.R. 3590, Section 5507	5,000	1	5,000	1	5,000	-	5,000	1	5,000	1	5,000	1	4,655	1	6,000	1	6,000	1	6,000	1
Home Visiting Program:																					
P.L. 111-148 Mandatory	H.R. 3590, Section 2951	250,000	19	350,000	23	379,600	22	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	371,200	22	400,000	25	400,000	37	372,400	44	400,000	42	400,000	42	400,000	42
Total		**3,325,000**	**299**	**1,900,000**	**347**	**2,232,100**	**325**	**2,803,956**	**351**	**4,201,481**	**373**	**4,375,000**	**519**	**4,232,186**	**512**	**4,642,500**	**442**	**4,842,500**	**442**	**4,842,500**	**442**

Programs Proposed for Elimination

The following list shows the programs proposed for elimination in the FY 2020 Budget Request. Termination of these programs totals approximately $972.3 million in discretionary resources. Following each program is a brief summary and the rationale for its elimination.

(dollars in millions)

Program	FY 2019 Enacted
Loan Repayment/Faculty Fellowships[253]	$1.2
Centers of Excellence[253]	$23.7
Scholarships for Disadvantaged Students[2533]	$49.0
Health Career Opportunity Program[2533]	$14.2
Primary Care Training and Enhancement[2533]	$48.9
Oral Health Training Programs[2533]	$40.7
Graduate Medical Education for Health Care Professionals	$25.0
Area Health Education Centers [254]	$39.3
Geriatric Programs[2533]	$40.7
Public Health/Preventative Medicine[2533]	$17.0
Advanced Nursing Education[2533]	$74.6
Nursing Workforce Diversity[2533]	$17.3
Nurse Education, Practice and Retention[2533]	$41.9
Nurse Faculty Loan Program[2533]	$13.5
Children's Hospital Graduate Medical Education	$325.0
Autism and Other Developmental Disorders[2533]	$50.6
Sickle Cell Service Demonstrations[2533]	$4.5
James T. Walsh Universal Newborn Hearing Screening[2533]	$17.8
Emergency Medical Services for Children[2533]	$22.3
Heritable Disorders[2533]	$16.4
Pediatric Mental Health Care Access Grants	$10.0
Screening and Treatment for Maternal Depression	$5.0
National Hansen's Disease – Building and Facilities[2533]	$0.1
Rural Hospital Flexibility Grants[2533]	$53.6
State Offices of Rural Health[2533]	$10.0
Rural Residency Planning and Development	$10.0
Total Programs Proposed for Elimination	**$ 972.3**

Loan Repayment/Faculty Fellowships (-$1.2 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

[253] Proposed for elimination in the FY 2018 and FY 2019 budgets.
[254] Proposed for elimination in the FY 2017, FY 2018, and FY 2019 budgets.

Centers of Excellence (-$23.7 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Scholarships for Disadvantaged Students (-$49.0 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Health Career Opportunity Program (-$14.2 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Primary Career Training and Enhancement (-$48.9 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Oral Health Training Programs (-$40.7 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Graduate Medical Education for Health Care Professionals (-$25.0 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Area Health Education Centers (-$39.3 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Geriatric Programs (-$40.7 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Public Health/Preventative Medicine (-$17.0 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Advanced Nursing Education (-$74.6 million)
The Budget eliminates funding for Nurse training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Nursing Workforce Diversity (-$17.3 million)
The Budget eliminates funding for Nurse training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Nurse Education, Practice and Retention (-$41.9 million)
The Budget eliminates funding for Nurse training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Nurse Faculty Loan Program (-$13.5 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Children's Hospital Graduate Medical Education (-$325.0 million)
The Budget eliminates funding for training programs. The Budget prioritizes funding for health workforce activities that provide scholarships and loan repayment in exchange for service in areas of the United States where there is a shortage of health professionals.

Autism and Other Developmental Disorders (-$50.6 million)
No funding is requested for this program. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs.

Sickle Cell Service Demonstrations (-$4.5 million)
No funding is provided for this program. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs.

James T. Walsh Universal Newborn Hearing Screening (-$17.8 million)
No funding is provided for this program. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs.

Emergency Medical Services for Children (-$22.3 million)
No funding is provided for this program. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs.

Heritable Disorders (-$16.4 million)
No funding is provided for this program. The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs.

Pediatric Mental Health Care Access Grants (-$10.0 million)
In FY 2020, HRSA's previously funded Pediatric Mental Health Care Access Program awards will continue to support behavioral health integration in pediatric primary care through statewide or regional pediatric mental health care telehealth access programs.

Screening and Treatment for Maternal Depression (-$5.0 million)
The Budget prioritizes programs that support direct health care services and give states and communities the flexibility to meet local needs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

National Hansen's Disease – Building and Facilities (-$0.1 million)
No new funding is provided for buildings and facilities. There are sufficient funds available to continue the renovation and repair work on patient and clinic areas, and to complete minor renovation work on the Carville museum and cemetery.

Rural Hospital Flexibility Grants (-$53.6 million)
No funding is provided for these programs, due to a shift in program priorities that emphasize direct health care services.

State Offices of Rural Health (-$10.0 million)
No funding is provided for this program, due to a shift in program priorities that emphasize direct health care services.

Rural Residency Planning and Development (-$10.0 million)
No funding is provided for this program, due to a shift in program priorities that emphasize direct health care services.

Physicians' Comparability Allowance (PCA) Worksheet

1) Department and component:

Department of Health and Human Services, Health Resources and Services Administration

2) Explain the recruitment and retention problem(s) justifying the need for the PCA pay authority.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*
FY18 included (4) Separations of which (3) accepted other job offers and (1) retired. The average length of service for the (4) separations was 4.75 years.
In FY18, (6) vacancy announcements were posted. Quality applicants have been limited. For example, 35 applications were received for an SES vacancy, however, only (2) applicants were considered highly qualified for the position.
To date there have been (0) Accessions.

3-4) Please complete the table below with details of the PCA agreement for the following years:

	PY 2018 (Actual)	**CY 2019 (Estimates)**	**BY* 2020 (Estimates)**
3a) Number of Physicians Receiving PCAs	31	37	37
3b) Number of Physicians with One-Year PCA Agreements	2	0	0
3c) Number of Physicians with Multi-Year PCA Agreements	29	37	37
4a) Average Annual PCA Physician Pay (without PCA payment)	$158,159	$159,741	$159,741
4b) Average Annual PCA Payment	$22,129	$22,350	$22,350

*BY data will be approved during the BY Budget cycle. Please ensure each column is completed.

5) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

In FY17 there were (4) separations and (4) accessions. All (4) accessions needed PCA in addition to their base salary to meet their current salary or salary expectations.

6) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

n/a

Drug Control Budget
Health Resources and Services Administration

Resource Summary

	Budget Authority (in Millions)		
	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Drug Resources by Function			
Prevention	$104.000	$111.000	$111.000
Treatment	$540.000	$553.000	$553.000
Total Drug Resources by Function	**$644.000**	**$664.000**	**$664.000**
Drug Resources by Decision Unit			
Bureau of Primary Health Care	$544.000	$544.000	$544.000
Federal Office of Rural Health Policy	$100.000	$120.000	$120.000
Total Drug Resources by Decision Unit	**$644.000**	**$664.000**	**$664.000**

Drug Resources Personnel Summary			
Total FTEs (direct only)	-	-	-
Drug Resources as a Percent of Budget			
Total Agency Budget (in Billions)	$11.416	$11.714	$10.733
Drug Resources Percentage	5.641%	5.668%	6.187%

Program Summary

MISSION

The Health Resources and Services Administration (HRSA) is the primary Federal agency for improving access to health care for people who are geographically isolated, and economically or medically challenged.

BPHC

The Health Resources and Services Administration (HRSA) is the principal Federal agency charged with increasing access to primary health care for those who are medically underserved. For more than 50 years, HRSA-funded health centers have delivered affordable, comprehensive, high quality primary health care services by coordinating and integrating a wide range of medical, dental, mental health, substance use disorder (SUD), and patient support services. Today, nearly 1,400 health centers operate more than 11,000 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

Health centers providing SUD services play an essential role in addressing the nation's opioid epidemic. They offer a range of integrated services, including but not limited to Screening, Brief

Intervention, Referral, and Treatment (SBIRT), counseling and psychiatry, 24-hour crisis intervention, detoxification, Medication-Assisted Treatment (MAT), and recovery support.

FORHP

The Federal Office of Rural Health Policy (FORHP) is responsible for advising on rural policy issues, conducting and overseeing policy relevant research on rural health issues, and administering grant programs that focus on supporting and enhancing health care delivery in rural communities. FORHP is statutorily charged with coordinating the activities within the Department that relate to rural health care and providing information to the Secretary and others in the Department with respect to the activities, of other Federal departments and agencies, that relate to rural health care. In addition to its policy roles, FORHP also administers a range of grant programs focusing on capacity building and enhancing health care delivery at the community and state levels as well as programs aimed at leveraging the use of health information technology and telehealth to enhance access to and the quality of health care services in rural and underserved areas.

FORHP launched the Rural Communities Opioid Response Program (RCORP) in FY 2018 to support treatment and prevention of substance use disorder, including opioid abuse, in rural communities at the highest risk for substance use disorder. The program goal is to reduce the morbidity and mortality associated with opioid overdoses in rural communities through the strengthening of the organizational and infrastructural capacity of multi-sector consortiums. These consortiums address prevention, treatment, and recovery focus areas at the community, county, state, and/or regional levels. This initiative reflects the high level of interest in and continued need for rural-focused funding to build robust opioid prevention, treatment, and recovery infrastructure and capacity in rural communities. HRSA is developing performance measures to support this new large-scale initiative.

METHODOLOGY

BPHC

In FY 2016, the Health Center Program awarded approximately $94 million in a targeted supplemental funding opportunity for substance use disorder service expansion in existing health centers. The $94 million in FY 2016 substance use disorder expansion funding was awarded as ongoing annual funding, to be included in health centers' base continuation funding in subsequent fiscal years, contingent upon sufficient Health Center Program appropriations.

In FY 2017, the Health Center Program awarded approximately $200 million in an additional targeted supplemental funding opportunity for the expansion of substance use disorder and mental health services (SUD/MH) in existing health centers. Approximately $100 million of the FY 2017 SUD/MH expansion awards were provided as one-time funding, and an additional $100 million was awarded as ongoing annual funding, to be included in health centers' base continuation funding in subsequent fiscal years, contingent upon sufficient Health Center Program appropriations.

In FY 2018, the Health Center Program awarded approximately $350 million in an additional targeted supplemental funding opportunity for the expansion of SUD/MH in existing health centers. Approximately $200 million of the FY 2018 SUD/MH expansion awards were provided as one-time funding, and an additional $150 million was awarded as ongoing annual funding, to be included in health centers' base continuation funding in subsequent fiscal years, contingent upon sufficient Health Center Program appropriations.

The FY 2019, the Health Center Program projects $200 million in new SUD/MH awards, and the FY 2020 OMBJ maintains drug resources. As a result, the reported amount of drug resources for FY 2018, and those projected for FY 2019 and FY 2020, reflect the ongoing annual SUD/MH awards initiated in FY 2016 through FY 2018, and those projected in the FY 2019 President's Budget and FY 2020 OMBJ.

FORHP

The allocation of funds for the Rural Community Opioid Response Program (RCORP) is through competitive grants and cooperative agreements. The RCORP initiative is currently composed of two competitive grant programs and two cooperative agreements that provide technical assistance coordination and program evaluation.

- **RCORP-Planning** provides one year of support to rural communities to identify opioid use disorder issues in their communities and develop plans to resolve these issues. The one-year planning grant provides sufficient time and resources for communities to form partnerships with other entities, conduct needs assessments, and plan ways to address specific issues being faced by the communities.
- **RCORP-Implementation** provides multi-year support to rural communities to yield large-scale organizational and infrastructural improvements at the regional and state levels to address opioid use disorder, with a particular focus on treatment and recovery.

In FY 2019, HRSA will make grants and cooperative agreements to support the treatment for and prevention of substance use disorder in rural communities. HRSA will also develop a Rural Centers of Excellence on Substance Use Disorders program in FY 2019 that will support the dissemination of best practices related to the treatment for and prevention of substance use disorders within rural communities, with a focus on the current opioid crisis. These new opioid response activities will continue in FY 2020.

BUDGET SUMMARY

The drug control budget for the Health Resources and Services Administration for FY 2020 is $664.0 million, the same as the FY 2019 Budget level.

Bureau of Primary Health Care

FY 2020 Request: $544 million

In FY 2020, the Health Center program plans to support nearly 1,400 grantees and provide primary health care services to over 27 million patients, including access to ongoing SUD services. Health centers will continue to provide SUD services for all age groups.

Federal Office of Rural Health Policy

FY 2020 Request: $120 million

In FY 2020, the Federal Office of Rural Health Policy will continue to invest in initiatives and support evidence-based strategies that address the specific substance use disorder issues and mental health services needs in rural communities. The FY 2020 Budget request will fund additional grants and cooperative agreements for RCORP to strengthen the infrastructure and capacity within rural communities at high risk for substance abuse disorders and provide needed prevention, treatment, and recovery services to rural residents.

PERFORMANCE

Information regarding HRSA's Health Center Program's performance is based on the UDS. The table and accompanying text represent highlights of their achievements for the latest year for which data are available.

Health Resources and Services Administration		
Selected Measures of Performance	**FY 2017 Target**	**FY 2017 Achieved**
» Number of Health Center Program grantees providing SBIRT services	525	548
» Number of Health Center Program grantees providing substance abuse counseling and treatment services	425	491

HRSA is taking several approaches to improve access to high quality substance use disorder (SUD) services for medically underserved communities through the Health Center Program. General approaches include developing the infrastructure for high quality care through the adoption of health information technology (HIT) and the transformation of health centers to patient-centered medical homes (PCMH). PCMH and the meaningful use of HIT will enable enhanced access to care, better care coordination, and improved patient engagement. Transformed health centers are better positioned to partner with other addiction-related services in the community including inpatient and outpatient SUD services.

To further improve access and raise the quality of SUD services, the availability of services on-site is essential. This is to be achieved by training health center clinicians to provide high quality and expanded services for those with addiction disorders. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based process used by primary care providers in health centers to effectively detect and treat addiction. Because many communities served by health centers have a high burden of addiction disorders, many health centers have chosen to co-locate and integrate SUD specialty services reflecting efficient and effective approaches in meeting patient needs. The integration of SUD services may include the provision of enhanced services, such as medication-assisted treatments, by primary care clinicians. In addition, HRSA provides guidance to health centers on collaboration with State agencies to ensure that appropriate standards of care are implemented and that referrals are coordinated.

Screening for substance use disorders has increased 42% since 2016 with the number of patients receiving screening, brief intervention, referral and treatment (SBIRT) increasing from 716,677

in 2016 to 1,017,249 in 2017. From 2016–2017, the number of health center providers eligible to prescribe MAT increased 75% (from 1,700 in 2016 to 2,973 in 2017) and the number of patients receiving MAT increased 64% (from 39,375 in 2016 to 64,597 in 2017).

In 2017, 491 health centers provided SUD counseling and treatment services, exceeding the program 2017 target. Also in 2017, 548 health centers provided SBIRT services, exceeding the program FY 2017 target.

Significant Items TAB

SIGNIFICANT ITEMS FOR INCLUSION IN L-HHS APPROPRIATIONS COMMITTEE FY 2020 CONGRESSIONAL JUSTIFICATION

CONFERENCE REPORT 115-952 (September 13, 2018)

1. **Graduate Medical Education. —** The conferees include $25,000,000 to support colleges of medicine at public universities located in the top quintile of States projected to have a primary care provider shortage. The conferees direct HRSA to give priority to applications from universities located in States with the greatest number of Federally-recognized Tribes. The conferees direct HRSA to give priority to applications from public universities with a demonstrated public-private partnership. **(Page 7)**

   Action to be Taken
   HRSA is currently working on the Notice of Funding Opportunity (NOFO) for this new program and plans to release a competitive NOFO in 2019.

2. **Oral Health Training. —** The conferees include not less than $12,000,000 for General Dentistry Programs and not less than $12,000,000 for Pediatric Dentistry Programs. The conferees direct HRSA to provide continuation funding for predoctoral and postdoctoral training grants initially awarded in fiscal year 2015, and for section 748 Dental Faculty Loan Program grants initially awarded in fiscal years 2016, 2017, and 2018. The conferees continue to support awards with a preference for pediatric dentistry faculty supervising dental students or residents and providing clinical services in dental clinics located in dental schools, hospitals, and community-based affiliated sites. **(Page 8)**

   Action to be Taken
   In FY 2019, HRSA plans to provide continuation funding for the 25 Predoctoral Training in General, Pediatric and Public Health Dentistry and Dental Hygiene grantees initially awarded in FY 2015 and FY 2017 and the 20 Postdoctoral Training in General, Pediatric and Public Health Dentistry grantees initially awarded in FY 2015. In FY 2019, HRSA expects to provide full continuation funding for 9 Dental Faculty Loan Repayment grantees initially awarded in FY 2016, 10 grantees initially awarded in FY 2017, and 11 grantees awarded in FY 2018. HRSA is not planning any new Oral Health competitions in FY 2019.

3. **Children's Health and Development. —** The conferees include $3,500,000 within Special Projects of Regional and National Significance (SPRANS) for another year of the HRSA funded study focused on improving child health through a Statewide system of early childhood developmental screenings and interventions. **(Page 8)**

   Action to be Taken
   In FY 2018, HRSA awarded $3.5 million to the University of Mississippi Medical Center to support year two of the Early Childhood Developmental Health System Program. The project will continue with annual funding of $3.5 million per year for three years, from

September 30, 2017 to September 29, 2020, pending satisfactory performance and availability of future funds. The aim of the Early Childhood Developmental Health System Program is to improve population-level early childhood developmental health outcomes in a state with significant risk factors for poor child health status. A system of early developmental promotion, screening and interventions is being implemented. An early child development fellowship for cross-systems professionals (pediatricians, psychologists, nurses and social workers) has been established. Through this activity, HRSA aims to develop and promote best practices that can be applied to all states and communities, and particularly those with the highest rates of child poverty.

4. **Delta States Rural Development Network Grant Program. —** The conferees encourage HRSA to continue to consult with the Delta Regional Authority (DRA) on the awarding, implementing, administering, and monitoring of grants under the Delta States Network Grant Program in fiscal year 2019. In addition, of the funds provided, the conferees provide $8,000,000 to support HRSA's collaboration with the DRA to continue DRA's program to help underserved rural communities identify and better address their healthcare needs and to help small rural hospitals improve their financial and operational performance. Within 90 days from the date of enactment of this Act, the conferees direct HRSA and DRA to provide a joint briefing to the Committees on Appropriations of the House of Representatives and the Senate on the program's progress. **(Page 10)**

   Action to be Taken
   HRSA continues to collaborate with the DRA on the Delta States Network Program. In FY 2017, HRSA and DRA worked together to develop the Delta Region Community Health Systems Program, which provides technical assistance to ten hospitals located in the Delta region in the areas of financial operations, quality improvement, and telehealth. HRSA and DRA will add two additional hospitals in FY 2018 and a new cohort of 8 hospitals in FY 2019. HRSA will continue its collaboration with DRA and engage in discussions on the development of DRA's Next Health Strategic Plan and other activities to ensure that individuals in the Delta region receive high-quality health care. HRSA and DRA are preparing to jointly brief the Committee on the program's progress.

5. **Rural Communities Opioids Response. —** Within the funding provided, the conferees include an increase of $20,000,000 for the establishment of three Rural Centers of Excellence (Centers) on substance use disorders as directed by Senate Report 115-289. The Centers should provide scientific and technical assistance to county and State health departments and other entities as identified seeking guidance on how to address the substance use disorder challenges in their community. HRSA is directed to establish one such Center at an academic university, in a rural State where the U.S. Census Bureau defines over 60 percent of the population as rural. In addition, the university should be connected to an associated medical school that is already utilizing a collaborative approach to behavioral health care, with partnerships between the university and medical school, and the State has an effective, systems-wide approach to addiction treatment, such as the hub and spoke model. In addition, one Center shall be a public-private partnership between a nonprofit and an academic university to provide technical assistance and best practices on the development of recovery housing programs for

substance use disorder intervention. This Center shall serve multiple States and be based on an intervention model with a demonstrated track record, including multi-year outcomes data conducted by an academic research institution. Furthermore, the Center shall focus on best practices for successful substance use disorder intervention for low income, high-risk individuals, including those who have been involved with the criminal justice system. Finally, one Center shall be at an academic university located in a State included in the Delta Regional Authority or Appalachian Regional Commission with an overdose death rate for synthetic opioids as determined by the Centers for Disease Control and Prevention higher than a 150 percent change between 2015 and 2016. **(Page 10)**

Action to be Taken
HRSA is planning a Notice of Funding Opportunity (NOFO) to establish three Rural Centers of Excellence on substance use disorders. HRSA will issue the NOFOs in 2019 with an anticipated project start date in fall 2019. The Rural Centers of Excellence will be coordinated with HRSA's existing Substance Use Disorder resources to maximize HRSA's impact in addressing substance use disorders in rural communities.

6. **Oral Health Literacy. —** The conferees include $250,000 for the development of an oral health awareness and education campaign across relevant HRSA divisions, including the Health Centers Program, Oral Health Workforce, Maternal and Child Health, Ryan White HIV/ AIDS Program, and Rural Health. The conferees direct HRSA to identify oral health literacy strategies that are evidence-based and focused on oral healthcare prevention and education, including prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer. The conferees expect the Chief Dental Officer to play a key role in the design, monitoring, oversight, and implementation of this project. **(Page 12)**

Action to be Taken
HRSA will collaborate across relevant agency components/programs to develop evidence-based oral health literacy approaches around early detection, disease prevention, and oral health promotion. The Chief Dental Officer will be involved in the design, planning, development, and monitoring of an oral health education campaign for health center patients, people living with HIV/AIDS, pregnant women and children, and rural or underserved populations.

HOUSE REPORT 115-862 (July 23, 2018)

1. **Independent Compliance Reviews. —** HRSA will conduct independent compliance reviews, ensuring all health center access points have policies, procedures, and training to comply with all applicable Federal laws. HRSA shall submit quarterly reports to the Committees on Appropriations of the House of Representatives and the Senate containing

the results of all audits and compliance reviews of health center access points and oversight of health center project officers. **(Page 20)**

Action to be Taken
HRSA has submitted the requested reports to the Committees for the first and second quarters, and will continue to adhere to this requirement.

2. **Home Visiting. —** The Committee encourages HRSA to expand partnerships between Health Centers and evidence-based home visiting programs in high need areas in order to improve pregnancy, child health and developments, and other health outcomes, all while reducing costs. **(Page 20)**

Action to be Taken
HRSA will pursue and promote opportunities for expanded partnerships between Health Centers and evidence-based home visiting programs in high need areas in order to improve health outcomes and reduce costs.

3. **Perinatal Transmission of Hepatitis B. —** The Committee is therefore pleased that HRSA has implemented a strategy to increase the capacity of HRSA funded clinics to address perinatal hepatitis B transmission, including the use of telehealth to link experts with clinic providers around the US. The Committee requests an update on this effort in the fiscal year 2020 Congressional Justification. HRSA should include in its update information on the findings and recommendations on the effectiveness of this intervention. **(Page 21)**

Action to be Taken
In 2016, HRSA awarded a contract to the University of New Mexico's Project ECHO (Extension for Community Healthcare Outcomes) to develop and support an innovative T/TA initiative for HRSA-funded health centers to address perinatal HBV transmission in the primary care setting through an interactive, collaborative learning model. The HBV ECHO: Reducing Perinatal Transmission supported health center primary care clinicians and care teams by providing ongoing mentorship and feedback from HBV specialists with extensive experience on evidence-based intervention strategies to address and reduce perinatal HBV transmission in underserved populations. HRSA-funded health center participants presented patient cases and learned promising practices to eliminate mother-to-child transmission of HBV through routine HBV screening during prenatal care; evaluation, care management, and treatment of HBV-infected women during pregnancy; and HBV vaccination for at-risk women and infants.

TeleECHO videoconferencing sessions provided didactic learning, case-based, guided learning, and care management. Over the course of 2 years, the HBV ECHO met twice per month via videoconferencing technology, for a total of 37 teleECHO sessions, and hosted a web-based virtual learning community to provide T/TA to 21 health centers in 12 states. TeleECHO sessions contained a lecture by an expert on a topic, case presentations by participants, discussion of clarifying questions, and a recommended course of action. After each session, case presenters received written, evidence-based recommendations.

The HBV ECHO Faculty Curriculum Workgroup, consisting of national, state, and local subject matter experts, developed a curriculum that aligned with the primary care needs of underserved populations at risk for mother-to-child HBV transmission. Curriculum topic areas included HBV epidemiology, testing, and treatment; HBV care management during pregnancy; and social, cultural, and systemic barriers for high-risk populations. Technical assistance resources developed through this initiative will be made available on the HRSA website for all health centers to utilize. Primary care integration of viral hepatitis testing, vaccination, other prevention, care, and treatment can increase access and improve health outcomes for at-risk patients and patients with chronic infection.

4. **Tuberculosis. —** The Committee has previously directed the Administrator to report on coordination between health centers and State and local TB control programs to help ensure appropriate identification, treatment, and prevention of TB among vulnerable populations. The Committee requests an update in the fiscal year 2020 Congressional Justification on this topic. **(Page 21)**

   Action to be Taken
   HRSA is collaborating with the National Association for City and County Health Officials (NACCHO) to provide technical assistance to support coordination between health centers and State and local TB control programs to help ensure appropriate identification, treatment, and prevention of TB among target populations. NACCHO conducts environmental scans and reaches out to stakeholders to inform their technical assistance plan. Additionally, HRSA plans to encourage coordination between health centers and State and local TB programs in FY 2020 funding opportunities.

5. **Eating Disorders. —** The Committee encourages integration of evidence-based training for health professionals to screen, access, intervene, and refer patients to specialized treatment for the severe mental illness of eating disorders as authorized under the 21st Century Cures Act (PL 114–255). **(Page 22)**

   Action to be Taken
   HRSA plans to conduct a webinar in early May, 2019 during Mental Health Month on eating disorders in collaboration with the HRSA' Office of Women's Health. The Bureau of Health Workforce will partner with the Bureau of Primary Health Care, the Maternal and Child Health Bureau and their funded workforce award to Harvard University School of Public Health, and SAMSHA's newly funded National Center of Excellence for Eating Disorders at University of North Carolina at Chapel Hill. HRSA plans to disseminate information on the webinar widely to HRSA stakeholders. The webinar will include an overview of the incidence, prevalence and description of Eating Disorders (ED); gaps in care; the impact on health and society; potential signs, symptoms and screening options for EDs; tools to help providers refer to the right resource; common signs of EDs (anorexia nervosa, bulimia nervosa, and binge eating); available resources; and collaboration between members of the primary care provider team.

6. **Oral Health Training. —** HRSA is directed to provide continuation funding for pre-doctoral and postdoctoral training grants initially awarded in fiscal year 2015. **(Page 22)**

Action to be Taken
In FY 2019, HRSA plans to provide continuation funding for the 25 Predoctoral Training in General, Pediatric and Public Health Dentistry and Dental Hygiene grantees initially awarded in FY 2015 and FY 2017 and the 20 Postdoctoral Training in General, Pediatric and Public Health Dentistry grantees initially awarded in FY 2015. In FY 2019, HRSA expects to provide full continuation funding for 9 Dental Faculty Loan Repayment grantees initially awarded in FY 2016, 10 grantees initially awarded in FY 2017, and 11 grantees awarded in FY 2018. With increasing continuation commitments for the Dental Faculty Loan Repayment Program, HRSA is not planning any new Oral Health competitions in FY 2019.

7. **Dental Faculty Loan Repayment. —** The Committee directs HRSA to provide continuation funding for grants initially awarded in fiscal years 2016, 2017, and 2018. **(Page 23)**

Action to be Taken
In FY 2019, HRSA plans to provide continuation funding for 9 Dental Faculty Loan Repayment grantees initially awarded in FY 2016, 10 grantees initially awarded in FY 2017, and 11 grantees awarded in FY 2018.

8. **Area Health Education Centers. —** The Committee is aware that some state dental associations have already initiated programs to refer emergency room patients to dental networks. HRSA is urged to work with those programs. **(Page 23)**

Action to be Taken
In FY 2019, HRSA will continue to support Area Health Education Centers (AHEC) awards. AHEC grants were awarded in FY 2017. Several current AHEC grantees are already collaborating with community-based organizations to expand access to oral health care, including state dental associations, community health centers, and state offices of rural health. Several AHEC grantees (8 grantees) have expanded continuing education opportunities for practicing health care professionals regarding oral health topics, increased rural/underserved interprofessional experiential clinical training experiences with patient examples, and developed and implemented community health worker initiatives focused on the importance of oral health and its connection to overall health and well-being. The community health worker trainings are focused on oral disease prevention, promoting healthy behaviors, self-management goals, and improving access to diverse and underserved patient populations.

9. **Graduate Psychology Education. —** The Committee encourages HRSA to invest in programs that expand access to treatment for substance use disorders in Federally Qualified Health Centers. The Committee also encourages HRSA to invest in geropsychology training programs and to help integrate health service psychology trainees at Federally Qualified Health Centers. **(Page 23)**

Action to be Taken
In FY 2019, HRSA will continue to provide technical assistance to the current Graduate Psychology Education (GPE) grantee portfolio. In FY 2019, HRSA will provide funding to grantees to build capacity of the health psychology workforce who are trained in the prevention and clinical treatment of patients with Opioid Use Disorder (OUD) in high need and high demand areas. This includes the use of tele-behavioral health to deliver these services.

In addition, the Bureau of Health Workforce will continue to collaborate with the Bureau of Primary Health Care to facilitate activities between Federally Qualified Health Centers and academic institutions across all behavioral health programs. In FY 2019, HRSA plans to provide funding for the Opioid Workforce Expansion Program, which is designed to train behavioral health trainees to provide prevention, treatment and recovery services for Opioid Use Disorder (OUD) and Substance Use Disorders (SUD) in high need and high demand areas.

10. **Veteran's Bachelor of Science Degree in Nursing. —** The Committee supports the enacted level for these efforts and urges HRSA to continue this vital program, aimed at helping veterans transition to civilian life, removing barriers, and building our nursing workforce. HRSA should either continue to support current grantees or re-compete this program in fiscal year 2019, placing emphasis on institutions that already have a program in place to support these veterans moving to nursing careers. **(Page 24)**

Action to be Taken
In FY 2019, HRSA plans to recompete this program with a focus on supporting veterans' transition to civilian life, removing barriers, and building our primary care nursing workforce in rural and underserved communities. All the previous grantees, which are institutions that have a program in place to support these veterans moving to nursing careers, will be eligible to compete for this grant.

11. **Graduate Medical Education. —** The Committee includes bill language directing HRSA to prioritize applications from Colleges of Medicine located in States with a projected primary care provider shortage. Within the States in the top quartile of primary care provider shortage, HRSA is directed to give additional priority to applications from universities who serve a large percentage of Medicaid beneficiaries or are located in States with a significant proportion of Federally recognized Tribes. **(Page 24)**

Action to be Taken
HRSA is currently working on the Notice of Funding Opportunity (NOFO) for this new program and plans to release a competitive NOFO in 2019.

12. **Neonatal Abstinence Syndrome Effects on Maternal and Child Health. —** The Committee requests an update in the fiscal year 2020 Congressional Justification on implementation of recommendations outlined in the strategy and identification of barriers to implementation, including specifics on any areas where Congressional action is needed. **(Page 25)**

Action to be Taken

HRSA works to address neonatal exposure to opioids on several fronts. The *Protecting Our Infants Act: Final Strategy* (2017), resulting from the Protecting Our Infants Act (POIA) of 2015 (P.L. 114-91), is helping to inform HHS and HRSA's efforts to address neonatal abstinence syndrome (NAS). Further, HHS is developing an implementation plan in response to recommendations from the 2017 GAO report, *Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome*. This implementation plan is an important tool to facilitate the coordination and execution of new and ongoing HHS-wide efforts to address NAS. HHS is addressing all of the recommendations in the *Final Strategy*, and HRSA supports programs that address 29 of the 39 recommendations included in the Final strategy.

Examples of how HRSA's Maternal and Child Health Bureau (MCHB) is addressing the recommendations include:

- In 2018, HRSA's MCHB launched the Addressing Opioid Use Disorder in Pregnant Women and New Moms Challenge. This innovative competition will award $375,000 in prizes to support technological innovations to improve access to quality health care, including substance use disorder treatment, recovery, and support services for pregnant women with opioid use disorders, their infants, and families, especially those in rural and geographically isolated areas.
- Through the HRSA-supported Alliance for Innovation on Maternal Health (AIM) initiative, MCHB developed a safe maternity care protocol focused on obstetric care for women with opioid use disorder. MCHB is partnering with states to promote the use of the protocol in birthing hospitals nationwide.
- States are using Title V Maternal and Child Block Grant funds to support a range of efforts to address NAS and maternal opioid misuse. These efforts include: provider training on best practices; use of screening tools for early detection of high-risk women; and teleconsultation services for health providers treating perinatal women with psychiatric and substance use disorders. States also use Block Grant funds to address the needs of pregnant women and their babies, including care coordination; standardizing care for infants with NAS; and using Maternal Mortality Review Committees to explore the relationship between maternal mortality and substance use disorders (including opioid use).

Many barriers still exist in implementation of the recommendations. A few examples include a reluctance by pregnant women to seek treatment for fear of punishment or having children removed from their care; limited knowledge among health and social service providers about how to identify opioid use among pregnant women; and limited or lack of availability of community service providers to refer women and children affected by opioid misuse to family-friendly early intervention, treatment, and wraparound recovery support services.

HRSA will continue to work with its HHS partners, states, and other stakeholders to address NAS. The *Final Strategy* and subsequent implementation plan will help guide these efforts.

13. **Alliance for Innovation on Maternal Health. —** HRSA is encouraged to continue to support AIM with adequate funding to meet the growing desire of States and hospital systems to participate in the program. **(Page 25)**

Action to be Taken
In 2018, HRSA doubled its investment in the Alliance for Innovation on Maternal Health (AIM) initiative, expanding the program to include 18 states and more than 990 birthing hospitals to implement maternal safety bundles that address the leading causes of maternal death, such as hemorrhage and hypertension. In FY 2019, HRSA will utilize an additional $3 million in funding provided in the FY 2019 appropriation to further expand implementation of the AIM maternal safety bundles to all U.S. States, the District of Columbia, and U.S. territories, as well as tribal entities. The FY 2020 Budget proposes to continue this expanded implementation.

14. **Set-aside for Oral Health. —** The Committee includes 250,000 to continue demonstration projects to increase the implementation of integrating oral health and primary care practice. The projects should model the core clinical oral health competencies for non-dental providers that HRSA published and initially tested in its 2014 report, ''Integration of Oral Health and Primary Care Practice.'' The Committee expects the Chief Dental Officer to continue to direct the design, monitoring, oversight, and implementation of these projects. **(Page 27)**

Action to be Taken
In FY 2018, following consultation with HRSA's Chief Dental Officer, HRSA awarded $250,000 to the National Maternal and Child Center for Oral Health Systems Integration and Improvement program (National Maternal and Child COHSII). With this funding, the National Maternal and Child COHSII will provide technical assistance, training and other support for six projects that will continue demonstrating the implementation of the Inter-professional Oral Health Care Clinical Competencies (IPOHCCC) outlined in the 2014 report Integration of Oral Health and Primary Care Practice.

15. **Thalassemia. —** The Committee strongly encourages HRSA to reconstitute this program in order to ensure the continued improvement of care and treatment options for patients with this complex and debilitating blood disorder. **(Page 27)**

Action to be Taken
HRSA continues to support programs that bring lifesaving medical care to individuals with thalassemia. In FY 2018, HRSA released a notice of funding opportunity, HRSA-18-079 Thalassemia Program. Three awards were made to improve the quality of care delivered to individuals with clinically significant thalassemia, especially those who are transfusion-dependent. Through collaborative regional networks that use collective impact strategies and telehealth, grantees are (1) promoting the use of expert recommended and evidence-informed care, and (2) improving the capacity of primary and subspecialty care clinicians to manage thalassemia, particularly in remote and/or

medically underserved communities. This is a three-year program supported through May 31, 2021.

16. **Pediatric Neurodevelopmental Delivery of Care. —** The Committee encourages the Secretary of HHS to collaborate with public and private non-profit organizations with expertise in pediatric neurodevelopmental disabilities, including autism, to develop a pilot project designed to improve the delivery and coordination of care and to lower costs through integrated subspecialty outpatient service delivery models that incorporate comprehensive diagnostic services and therapeutic care for pediatric neurodevelopmental disability patients, including those with autism. The Committee requests an update on this activity in fiscal year 2020 Congressional Justification. **(Page 28)**

    Action to be Taken
    HRSA agrees with the Committee that initiatives to improve the delivery and coordination of care and lower costs of outpatient services for pediatric neurodevelopmental patients, including those with ASD, is important. HRSA was unable to fund a pilot to address this particular issue in FY 2019.

    However, HRSA continues to enhance the capacity of providers to conduct screening and diagnostic services, and provide treatment for children and youth with ASD and other developmental disabilities through the Leadership Education in Neurodevelopmental and Other Related Disabilities (LEND) and Developmental Behavioral Pediatrics (DBP) training programs. These programs address the shortage of trained professionals who can provide screening, diagnostic services, and treatment for children and youth with Autism Spectrum Disorder (ASD) and other developmental disabilities. Many of the LEND and DBP grantees expand their reach through telehealth by providing tele-consultation to providers in rural and other underserved areas to enhance their capacity to provide screening and services for children with ASD and other developmental disabilities. These grantees facilitate tele-education to include remote trainees in the longer-term training programs.

    HRSA will continue to support LEND and DBP program activities to enhance the capacity of providers to conduct screening and diagnostic services, and provide treatment for children and youth with ASD and other developmental disabilities.

17. **Newborn Screening. —** HRSA will build on that successful program by providing grants to support States with the implementation, education, and awareness of newborn screening for new conditions recently added to the Recommended Uniform Screening Panel, including Pompe, Mucopolysaccharidosis I, and X-linked adrenoleukodystrophy. The program will also disseminate national, regional, and State education and training resources for parents, families and providers. **(Page 28)**

    Action to be Taken
    HRSA is committed to supporting state efforts to screen newborns for conditions on the Recommended Uniform Screening Panel (RUSP), and developing and disseminating education and training resources. In FY 2018, HRSA funded the Newborn Screening

Data Repository and Technical Assistance Center to provide technical assistance on the implementation of state-based public health newborn screening through resource development, state education and training, policy initiatives, disorder surveillance, evidence-based data collection, evaluation, collaborative efforts with stakeholders, and technical assistance to state newborn screening programs to implement conditions added to the RUSP including Pompe, Mucopolysaccharidosis I, X-linked adrenoleukodystrophy or any new condition added to the RUSP by the Secretary. HRSA is also supporting the Newborn Screening Family Education Program to develop and deliver educational programs at appropriate literacy levels about newborn screening counseling, testing, follow-up, treatment, and specialty services to parents, families, patient advocacy and support groups, and the public. These educational programs will also include information on all conditions including the recently added conditions on the RUSP.

18. **Pediatric Hospice Care. —** The Committee encourages HRSA through the Heritable Disorders Program to work with experienced hospice providers which are not conflicted by decisions of whether to provide hospice or curative treatments in the hospital to children nearing the end of life to establish a pilot program aimed at developing best practices. **(Page 29)**

Action to be Taken

While HRSA agrees with the Committee that pediatric hospice care and grief support is an important issue, HRSA was unable to fund a pilot in FY 2019. In addition, HRSA notes that the proposed pilot program would not be consistent with the authorized purpose and activities of Section 1109-1112, 1114 and 1117 of the Public Health Service Act (PHS Act), which authorize HRSA's Heritable Disorders program. For example, the purpose statement articulated under Section 1109 of the PHS Act, "Improved Newborn and Child Screening for Heritable Disorders," is to support newborn and child screening activities for heritable disorders specifically. In addition, the eligible entities included in the Heritable Disorders authorizing statute are not the appropriate organizations to do this work. For example, eligible entities per section 1109 of the PHS Act are: a State or a political subdivision of a state; a consortium of two or more States or political subdivisions of States; a territory; a health facility or program operated or pursuant to a Indian Health Service contract/grant; or any other entity with appropriate expertise in newborn screening as determined by the HHS Secretary. Finally, the Heritable Disorders authorizing statute is limited to genetic disorders, but pediatric hospice patients can include those with non-genetic congenital disorders, neuromuscular disorders, and cancer, among other diseases, disorders, and/or conditions. Implementation of a pediatric hospice care pilot under the Heritable Disorders authorization would result in a program that is unable to address the legitimate need of hospice care for children with non-heritable disorders.

19. **National Cord Blood Inventory. —** In order to expand access to life-saving transplants, the Committee urges HRSA to fund public cord blood bank pilot demonstrations that are focused on increasing recruitment of donors and banking of cord blood units from diverse populations. In addition, the Committee encourages HRSA to support proposals for novel

pilot programs using cord blood and tissue-derived cellular therapies in regenerative therapies. **(Page 30)**

Action to be Taken
HRSA continues to fund public cord blood bank pilot demonstration projects that increase the recruitment of expectant mothers and the banking of cord blood units from diverse populations. In April 2018, HRSA engaged stakeholders from the cord blood community, including cord blood banks and transplant physicians, to gain insight into the most needed demonstration projects and special studies. HRSA plans to use the information from the field to prioritize funding decisions regarding future demonstration projects.

20. **Office of Pharmacy Affairs. —** The Committee includes an increase of $5,000,000 for additional oversight of the 340B program. An in-depth examination of the 340B program by the House Energy and Commerce Committee resulted in a report entitled ''Review of the 340B Drug Pricing Program.'' The Committee directs HRSA to use additional funds to implement recommendations contained in such report. Specifically, the Committee directs HRSA to conduct additional audits of covered entities, finalize guidance to clarify parameters of the 340B program, and complete the rulemaking process for areas where HRSA has regulatory authority. **(Page 31)**

Action to be Taken
These funds were not appropriated in FY 2019.

21. **Hansen's Disease Program. —** The Committee understands that the incidence of leprosy in some areas has been increasing. With level funding provided for this year, the Committee strongly encourages HRSA to sustain its contracts with satellite clinics to ensure that essential services are provided for these vulnerable patients and to allow treatment for patients' ongoing problems and the timely interventions for new complications and for newly diagnosed patients. **(Page 32)**

Action to be Taken
HRSA established contracts in fiscal year 2018 to ensure leprosy patients receive essential services through ambulatory care clinics. These contracts have performance periods through fiscal year 2023.

22. **Rural Hospital Flexibility Grants. —** Under the Rural Hospital Flexibility Grants, of the funds provided for section 1820(g)(6) of the Social Security Act, the Committee recommends a transition from supporting telehealth activities to other efforts to improve care for rural veterans, such as helping rural hospitals and clinics that seek to serve as access points under the Veterans Affairs (VA) Community Care Program or other VA-contracted care. **(Page 33)**

Action to be Taken
HRSA prioritizes improved and coordinated care for veterans. HRSA is coordinating with the U.S. Department of Veterans Affairs' (VA) Office of Rural Health to develop

and implement the transition to supporting other efforts to improve care for rural veterans and to ensure alignment with VA priorities.

23. **Telehealth. —** Given the rising rates of maternal mortality and severe maternal morbidity, as well as barriers to access to care in rural areas, the Committee encourages HRSA to explore the use of telemedicine for high-risk pregnant women to include, but not limited to pregnant women with chronic conditions, preeclampsia, or a need to see a maternal-fetal medicine specialist. **(Page 34)**

    Action to be Taken
    In FY 2019, HRSA is funding new State Maternal Health Innovation Grants to support state-led demonstrations to implement evidence-based interventions to address critical gaps in maternity care service delivery and reduce maternal morbidity and mortality. Included as part of the grants will be $1.0 million for the purchase and implementation of telehealth services to address access to obstetric services in rural and underserved areas.

SENATE REPORT 115-289 (June 28, 2018)

1. **Home Visiting. —** The Committee encourages HRSA to expand partnerships between health centers and evidence-based home visiting programs in high need areas to improve pregnancy, child health and development, and other health outcomes, all while reducing costs. **(Page 44)**

   Action to be Taken
   HRSA will pursue and promote opportunities for expanded partnerships between Health Centers and evidence-based home visiting programs in high need areas in order to improve health outcomes and reduce costs.

2. **Clinical Training Sites. —** The Committee directs HRSA to ensure that not less than 15 percent of funds provided for this program are used to support training of physician assistants [PAs]. **(Page 47)**

   Action to be Taken
   HRSA is currently working on the NOFO to support Physician Assistant Training in Primary Care and plans to release a competitive NOFO in early 2019. The anticipated total annual available FY 2019 funding is $2,000,000 to support an estimated number of up to seven grants. In addition, non-competing continuation funding will be provided to some existing PCTE grants. The total amount of funding to support Physician Assistant Training will be at least 15 percent of the PCTE appropriation.

3. **Clinical Training Sites. —** The Committee recommends that the Secretary leverage currently convened Advisory Committee(s), as applicable, to study clinical training site availability in primary care and mental and behavioral health for PAs. The Committee encourages the Advisory Committee(s) to develop recommendations to enhance clinical

education through inter-professional team-based education, address the shortage in preceptors willing to provide clinical site training, and explore reimbursement incentives to increase the number of available clinical training sites. **(Page 47)**

Action to be Taken
In FY 2019, HRSA plans to collaborate with the Federally Designated Officials for the Advisory Committees to study clinical training site availability in primary care and mental and behavioral health for PAs. HRSA will also encourage the Advisory Committees to develop recommendations to enhance clinical education to address the shortage of preceptors.

4. **Clinical Training Sites. —** The Committee also urges the integration of evidence-based trainings for health professionals to screen, access, intervene, and refer patients to specialized treatment for the severe mental illness of eating disorders as authorized under section 13006 of the 21st Century Cures Act (Public Law 114–255). **(Page 47)**

   Action to be Taken
   HRSA plans to conduct a webinar on eating disorders in collaboration with the HRSA Office of Women's Health. The webinar may be part of the BHW Grand Rounds series.

5. **Training in Oral Health Care. —** The agency is directed to provide continuation funding for predoctoral and postdoctoral training grants initially awarded in fiscal year 2015, and for Section 748 Dental Faculty Loan Program grants initially awarded in fiscal year 2016 with preference for pediatric dentistry faculty supervising dental students or residents and providing clinical services in dental clinics located in dental schools, hospitals, and community-based affiliated sites. **(Page 47)**

   Action to be Taken
   In FY 2019, HRSA plans to provide continuation funding for the 25 Predoctoral Training in General, Pediatric and Public Health Dentistry and Dental Hygiene grantees initially awarded in FY 2015 and FY 2017 and the 20 Postdoctoral Training in General, Pediatric and Public Health Dentistry grantees initially awarded in FY 2015. In FY 2019, HRSA expects to provide full continuation funding for 9 Dental Faculty Loan Repayment grantees initially awarded in FY 2016, 10 grantees initially awarded in FY 2017, and 11 grantees awarded in FY 2018. With increasing continuation commitments for the Dental Faculty Loan Repayment Program, HRSA is not planning any new Oral Health competitions in FY 2019.

6. **Behavioral Health Workforce Education and Training Program. —** The Committee continues to direct HRSA to take steps in the solicitation process and the timing of it to ensure that the grant competition results in program funding being distributed relatively equally among the participating health professions. **(Page 48)**

   Action to be Taken
   In order to ensure funding to both professional and paraprofessional applicants within the FY 2017 BHWET Program, HRSA used a separate rank order list for each track. HRSA

also aimed for a proportionate distribution of awards across the disciplines based on the number of eligible applications received and recommended for funding by the review panel for each discipline.

7. **Graduate Psychology Education Program. —** The Committee urges HRSA to explore evidence-based approaches to leverage workforce capacity through this program (including through geropsychology training programs). The Committee encourages HRSA to help integrate health services psychology trainees at FQHCs. The Committee also urges HRSA to utilize cost-effective methods, such as Project ECHO, to help train and support health service psychologists across the country. **(Page 49)**

   Action to be Taken
   In FY 2019, HRSA will continue to provide technical assistance to the current Graduate Psychology Education (GPE) grantee portfolio. In FY 2019, HRSA will provide funding to grantees to build capacity of the health psychology workforce who are trained in the prevention and clinical treatment of patients with Opioid Use Disorder (OUD) in high need and high demand areas. This includes training to deliver behavioral health and substance use services via tele-behavioral health similar to Project ECHO.

   In addition, the Bureau of Health Workforce will continue to collaborate with the Bureau of Primary Health Care to facilitate activities between Federally Qualified Health Centers and academic institutions across all behavioral health programs.

8. **Nursing Workforce Development Programs. —** The Committee encourages HRSA to consider the successful past practice of entities that have received funding from the Veterans to BSN program in making new awards. **(Page 49)**

   Action to be Taken
   In FY 2019, HRSA plans to recompete this program with a focus on supporting veterans' transition to civilian life, removing barriers, and building our primary care nursing workforce in rural and underserved communities. All the previous grantees, which are institutions that already have a program in place to support these veterans moving to nursing careers, will be eligible to compete for this grant.

9. **Children's Health and Development. —** Therefore, the Committee provides $3,500,000 within the Special Projects of Regional and National Significance program for the HRSA-funded study focused on improving child health through a statewide system of early childhood developmental screenings and interventions. This funding shall be used to extend the currently funded project for another year. **(Page 51)**

   Action to be Taken
   In FY 2018, HRSA awarded $3.5 million to the University of Mississippi Medical Center to support year two of the Early Childhood Developmental Health System Program. The project will continue with annual funding of $3.5 million per year for three years, from September 30, 2017 to September 29, 2020, pending satisfactory performance and availability of future funds. The aim of the Early Childhood Developmental Health

System Program is to improve population-level early childhood developmental health outcomes in a state with significant risk factors for poor child health status. A system of early developmental promotion, screening and interventions is being implemented. An early child development fellowship for cross-systems professionals (pediatricians, psychologists, nurses and social workers) has been established. Through this activity, HRSA aims to develop and promote best practices that can be applied to all states and communities, and particularly those with the highest rates of child poverty.

10. **Maternal, Infant and Early Childhood Home Visiting Program. —** The Committee encourages HRSA and ACF to continue their collaboration and partnerships to improve health and development outcomes for at-risk pregnant women, parents, and young children through evidence-based home visiting programs. **(Page 51)**

    Action to be Taken
    HRSA will continue the Maternal, Infant and Early Childhood Home Visiting Program in partnership with the Administration for Children and Families in FY 2020, in accordance with the mandatory appropriations for the program.

11. **Maternal Mortality. —** HRSA is encouraged to work with States to collect comprehensive data associated with all pregnancy-associated and pregnancy-related deaths, regardless of the outcome of the pregnancy. **(Page 51)**

    Action to be Taken
    Addressing maternal morbidity and mortality, as well as the disparities that may contribute to them, is among HRSA's top priorities. HRSA addresses maternal mortality through a variety of programs that improve women's health across the lifespan, promote innovation and quality improvement to improve health care delivery for pregnant women, and strengthen data collection and analysis related to maternal mortality and severe maternal morbidity in partnership with CDC. With the additional funding provided in FY 2019, HRSA will expand implementation of the Alliance for Innovation on Maternal Health Initiative's maternal safety bundles to all U.S. States, the District of Columbia, and U.S. territories, as well as tribal entities. In addition, HRSA will utilize the $23 million in new funding for State Maternal Health Innovation Grants to support state-led demonstrations to implement evidence-based interventions to address critical gaps in maternity care service delivery and reduce maternal mortality. The demonstrations will be representative of the demographic and geographic composition of communities most affected by maternal mortality. State demonstrations could include activities to support surveillance, analysis and reporting of maternal health data.

    HRSA also will continue to support states in their effort to collect and analyze data related to maternal mortality. This includes establishing priorities and measures to drive improvement and demonstrate impact. For example, through the State Maternal and Child Health (MCH) Block Grant, HRSA has constructed two National Outcome Measures that address maternal mortality and severe maternal morbidity. State-selected Maternal and Child Health performance measures become the guiding priorities for state

programming efforts. Performance measures related to women's health include the well woman visit, preventing low risk cesarean deliveries, and reducing smoking/drinking.

HRSA's State MCH Block Grant also supports tracking of severe maternal morbidity and individual maternal mortality cases as essential ways to identify the causes of maternal morbidity and death. For example, the State MCH Block Grant is often used to support Maternal Mortality Review Committees within states to identify and review deaths of women who die due to pregnancy, and develop recommendations for preventing future deaths. This information helps to identify priority areas for interventions in maternal care, focus quality improvement where it will make the most difference, and determine if interventions are effective.

12. **Autism and Other Developmental Disorders. —** The Committee encourages HRSA to enhance current efforts to determine whether a parent-centered approach to providing care for ASD children can be an effective intervention in a rural care setting. **(Page 52)**

Action to be Taken

HRSA has supported a research study to compare the efficacy of a telehealth parent training intervention, ImPACT Online, delivered in a self-directed or therapist-assisted format. The study examined the comparative efficacy of the two telehealth intervention models on parent fidelity, parent self-efficacy, and child language at follow-up. The study found that for both formats, program engagement was significantly associated with gains in parent intervention knowledge, and that therapist assistance increased parent engagement. Other HRSA-supported studies are examining different approaches to parent-centered strategies of care for children with ASD.

HRSA's field-initiated research program supports research to advance the evidence base on effective interventions to improve the health and well-being of children and adolescents with ASD and other developmental disabilities. Applicants submit research proposals including parent-centered approaches to providing care for children with ASD that address the needs of underserved populations, such as individuals who have limited access to services including those in rural communities, low-income, racial/ethnic minorities, and other underserved populations.

HRSA will continue to support field-initiated research to advance the evidence base on effective interventions including parent-centered approaches to providing care for children with ASD in rural and other underserved areas.

13. **Maternal Mortality. —** Clinical staff will provide direct access to well-woman care and maternity care services to reduce barriers in access to maternity care and help address maternal health disparities among high-risk and underserved women. Clinical staff will also support health educators by conducting training on maternal early warning signs. **(Page 53)**

Action to be Taken
HRSA anticipates awarding a total of $12,000,000 to approximately 100 Healthy Start (HS) grant recipients in FY 2019 to hire clinical service providers (directly or through a contract). These clinical staff will provide direct access to well-woman care and maternity care services within each HS program site nationwide. The clinical service providers include, but are not limited to, nurse practitioners, certified nurse midwives, physician assistants, and other maternal-child advance practice health professionals.

14. **Screening and Treatment for Maternal Depression. —** HRSA is directed to make grants to States to establish, improve, or maintain programs to train professionals to screen, assess, and treat for maternal depression in women who are pregnant or who have given birth within the preceding 12 months. **(Page 54)**

Action to be Taken
HRSA awarded a total of approximately $5 million in FY 2018 through cooperative agreements to seven states (Florida, Kansas, Louisiana, Montana, North Carolina, Rhode Island and Vermont) to establish, improve, or maintain programs to train professionals to screen, assess, and treat for maternal depression in women who are pregnant or who have given birth within the preceding 12 months.

15. **National Cord Blood Inventory. —** The Committee urges the agency to consider establishing a mechanism for reallocation of NCBI contract funds to cord blood banks that have reached their specified goals for bankable units from cord blood banks that are unable or unlikely to meet such specified goals during the contract period. **(Page 56)**

Action to be Taken
HRSA currently has contractor performance monitoring mechanisms in place that impact funding decisions and identify contractors that are unable or unlikely to meet their proposed goals during the contract periods. HRSA remains committed to exploring mechanisms to best allocate appropriated funds to support the legislative aims of the NCBI.

16. **Rural Communities Opioids Response. —** Within the funding provided, the Committee also includes $20,000,000 for the establishment of three Rural Centers of Excellence on Substance Use Disorders that will support the dissemination of best practices related to the treatment for and prevention of substance use disorders within rural communities, with a focus on the current opioid crisis and developing methods to address future substance use disorder epidemics. **(Page 58)**

Action to be Taken
HRSA is planning a Notice of Funding Opportunity (NOFO) to establish three Rural Centers of Excellence on substance use disorders. HRSA will issue the NOFOs in 2019 with an anticipated project start date in fall 2019. The Rural Centers of Excellence will be coordinated with HRSA's existing Substance Use Disorder resources to maximize HRSA's impact in addressing substance use disorders in rural communities.

17. **Delta States Rural Development Network Grant Program. —** The Committee encourages HRSA to continue to consult with the Delta Regional Authority [DRA] on the awarding, implementing, administering, and monitoring grants under the Delta States Network Grant Program in fiscal year 2018. The Committee continues to encourage HRSA to align its awards as closely as possible with the DRA's strategic plan and with DRA economic and community development plans. In addition, of the funds provided, the Committee provides $8,000,000 to support HRSA's collaboration with the DRA to continue DRA's program to help underserved rural communities identify and better address their health care needs and to help small rural hospitals improve their financial and operational performance. Within 90 days of enactment of this act, the Committee directs HRSA and DRA to jointly brief the Committee on this program's progress. **(Page 59)**

Action to be Taken

HRSA continues to collaborate with the DRA on the Delta States Network Program. In FY 2017, HRSA and DRA worked together to develop the Delta Region Community Health Systems Program, which provides technical assistance to ten hospitals located in the Delta region in the areas of financial operations, quality improvement, and telehealth. HRSA and DRA will add two additional hospitals in FY 2018 and a new cohort of 8 hospitals in FY 2019. HRSA will continue its collaboration with DRA and engage in discussions on the development of DRA's Next Health Strategic Plan and other activities to ensure that individuals in the Delta region receive high-quality health care. HRSA and DRA are preparing to jointly brief the Committee on the program's progress.

18. **Rural Outreach Grants. —** The Committee directs HRSA to review the criteria for rural healthcare services outreach grants and similar opportunities to ensure that rural health centers may engage in collaborative partnerships with health centers in non-rural locations. **(Page 59)**

Action to be Taken

The Rural Health Care Services Outreach Grants (Section 330A of the Public Health Service Act) provides flexibility for partnerships with entities that are not necessarily located in rural areas. Under the current statute, the eligibility for applicants notes that an applicant:

- shall be a rural public or rural nonprofit private entity;
- shall represent a consortium composed of members that include 3 or more health care providers; and
- may be nonprofit or for profit entities.

Within that authority, HRSA Office of General Counsel determined that the lead applicant has to be from a rural area. However, the two (or more) other entities that make up the consortia can include an urban entity as long as the services are delivered in a rural area and are focused on a rural population. HRSA understands the prior concerns raised on the eligibility issue and will continue to work with potential applicants to better understand the role that urban entities can play in these grants.

19. **Rural Hospital Flexibility Grants. —** The Committee continues to recognize the importance of supporting hospitals located in rural or underserved communities and recommends HRSA give preference in grant awards to Critical Access Hospitals serving rural communities that create community health teams to better coordinate care among rural populations to create better outcomes in chronic disease management. **(Page 59)**

    Action to be Taken
    The Medicare Rural Hospital Flexibility Grants authorizes HRSA to provide grants to states to fund activities to meet the needs of Critical Access Hospitals to increase quality, financial, and performance improvements and the provision of rural Emergency Medical Services. The program is competitive in FY 2019 and includes specific recommendations for states to include activities related to chronic disease management and population health.

20. **Black Lung Clinics. —** The Committee continues to direct the Secretary to evaluate funding levels for applicants based on the needs of the populations those applicants will serve and the ability of those applicants to provide health care services to miners with respiratory illnesses, with preference given to State agency applications over other applicants in that State, without regard to the funding tiers and overall per-applicant funding cap established by the Secretary in fiscal year 2014. **(Page 60)**

    Action to be Taken
    The Black Lung Program is not competitive in FY 2019 and will be competitive in FY 2020. The FY 2017 Black Lung Notice of Funding Opportunity removed the funding tiers and cap on individual applicants.

21. **Telehealth Network Grant Program. —** The Committee encourages HRSA to continue telehealth initiatives in school-based clinics, substance abuse treatment, and behavioral health treatment in the Telehealth Network Grant Program. **(Page 61)**

    Action to be Taken
    The FY 2019 cohorts of Telehealth Network Grant Program (13.2 TNGP) grantees focus on school-based health, behavioral health treatment, and substance abuse treatment. HRSA will also assess the effectiveness of the School-Based Telehealth Network Pilot Program, which will end in the last quarter of FY 2019.

22. **Rural Communities. —** The Committee encourages the Secretary to ensure that rural concerns and challenges are adequately represented in the Department's policies, programs, and activities, including policies related to the opioid epidemic. The Committee requests that the Secretary include a status of these activities in the fiscal year 2020 CJ. **(Page 168)**

    Action to be Taken
    HRSA addresses the status of various activities planned through the Rural Communities Opioid Response Program (RCORP) in the FY 2020 CJ. These initiatives are designed to

strengthen the infrastructure and capacity within rural communities at high risk for substance abuse disorders and provide needed prevention, treatment, and recovery services to rural residents.

Vaccine Injury Compensation Program

TAB

Vaccine Injury Compensation Program

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Appropriation Language

VACCINE INJURY COMPENSATION PROGRAM TRUST FUND

For payments from the Vaccine Injury Compensation Program Trust Fund (the ‘‘Trust Fund’’), such sums as may be necessary for claims associated with vaccine-related injury or death with respect to vaccines administered after September 30, 1988, pursuant to subtitle 2 of title XXI of the PHS Act, to remain available until expended: Provided, That for necessary administrative expenses, not to exceed [$9,200,000] *$11,200,000* shall be available from the Trust Fund to the Secretary.

Amounts Available for Obligation

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Discretionary Appropriation:	$27,430,000	$27,430,000	$33,312,000
Transfer to Other Accounts	-$9,200,000		
Transfer from Other Accounts	$9,200,000		
Subtotal, adjusted Discretionary Appropriation	**$27,430,000**	**$27,430,000**	**$33,312,000**
Mandatory Appropriation	$227,082,600	$280,000,000	$285,600,000
Transfer to Other Accounts	-$227,082,600		
Transfer from Other Accounts	$227,082,600		
Subtotal, adjusted Mandatory Appropriation	**$227,082,600**	**$280,000,000**	**$285,600,000**
Spending Auth Offsets	$310,677		
Administrative Expenses	27,430,000	27,430,000	33,312,000
Total HRSA Claims	227,082,600	280,000,000	285,600,000
Total New Obligations	**254,512,600**	**307,430,000**	**318,912,000**

Budget Authority by Activity

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
Trust Fund Obligations: Post-10/1/88 claims	$227,083,000	$280,000,000	$285,600,000
Administrative Expenses: HRSA Direct Operations	$9,200,000	$9,200,000	$11,200,000
Total Obligations	$236,283,000	$289,200,000	$296,800,000

Budget Authority by Object

	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
Insurance claims and indemnities	$280,000,000	$285,600,000	+$5,600,000
Salaries & Expenses/Other Services	$9,200,000	$11,200,000	+$2,000,000
Total	$289,200,000	$296,800,000	+$7,600,000

Authorizing Legislation

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget
(a) PHS Act, Title XXI, Subtitle 2, Parts A and D:			
Pre-FY 1989 Claims	---	---	---
Post-FY 1989 Claims	$227,083,000	$280,000,000	$285,600,000
(b) Sec. 6601 (r)d ORBA of 1989 (P.L. 101-239):			
HRSA Operations	$9,200,000	$9,200,000	$11,200,000

Appropriation History Table
(Pre-1988 Claims Appropriation)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1996	110,000,000	110,000,000	110,000,000	110,000,000
1997	110,000,000	110,000,000	110,000,000	110,000,000
1998	---	---	---	---
1999	---	---	100,000,000	100,000,000
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2020	---	---	---	---

Vaccine Injury Compensation Program

	FY 2018 Final	FY 2019 Enacted	FY 2020 President's Budget	FY 2020 +/- FY 2019
Claims BA	$227,083,000	$280,000,000	$285,600,000	+$5,600,000
Admin BA	$9,200,000	$9,200,000	$11,200,000	+$2,000,000
Total BA	$236,283,000	$289,200,000	$296,800,000	+$7,600,000
FTE	18	18	24	+6

Authorizing Legislation – Public Health Service Act, Title XXI, Subtitle 2, Parts A and D, Sections 2110-19 and 2131-34, as amended by Public Law 114-255, Section 3093(c).

FY 2020 Authorization ..... .Indefinite

Allocation Method ..... Other

Program Description and Accomplishments

Serving as an alternative to the traditional tort system, the National Vaccine Injury Compensation Program (VICP) compensates individuals, or families of individuals, who have been injured by vaccines recommended by the Centers for Disease Control and Prevention (CDC) for routine administration to children or pregnant women. HRSA administers the VICP, and the Department of Justice (DOJ) represents HHS in the U.S. Court of Federal Claims (Court), which ultimately decides to provide compensation or dismiss claims.

HRSA receives claims requesting compensation for vaccine injuries or deaths, which the petitioner has served against the HHS Secretary and filed with the Court. HRSA medical officers with special expertise in pediatrics and adult medicine review these claims along with supporting documentation. HRSA also contracts with health care professionals for claim reviews and with other medical specialists to provide independent claim reviews and to testify in Court. HRSA medical officers develop preliminary recommendations regarding petitioner eligibility for compensation, based on medical reviews that DOJ incorporates in its Rule 4(b) report submitted to the Court. Lastly, HRSA processes payments to petitioners and their attorneys based on judgments entered by the Court.

HRSA also publishes notices in the Federal Register listing each claim received and promulgates regulations to modify the Vaccine Injury Table that lists injuries and/or conditions associated with covered vaccines. HRSA provides administrative support to the Advisory Commission on Childhood Vaccines (ACCV), which is responsible for advising the HHS Secretary on issues related to VICP operations. The ACCV is composed of nine voting members, including HHS officials, healthcare professionals, attorneys, and parents or legal representatives of children who have suffered vaccine-related injuries or death.

Vaccine Injury Compensation Trust Fund

With a current balance of over $3.8 billion, the Vaccine Injury Compensation Trust Fund (Trust Fund) provides funding for VICP administration and for compensating vaccine-related injury or death claims for covered vaccines administered on or after October 1, 1988. The Department of Treasury maintains the Trust Fund through a $0.75 excise tax on vaccines recommended by the CDC for routine administration to children or pregnant women. The excise tax applies to each disease prevented per vaccine dose. For example, influenza vaccine is taxed $0.75 because it prevents one disease while measles-mumps-rubella vaccine, which prevents three diseases, is taxed $2.25. The Department of Treasury collects the excise taxes and manages Trust Fund investments.

Petitioners include individuals, parents, or legal representatives applying on behalf of others. The number of petitioners receiving compensation nearly doubled from 365 in FY 2014 to 706 in FY 2017. The data in Table 1 reveals a steady rise in the number of petitioners and Court-ordered compensation through FY 2017. Table 1 also shows that the Court did not adjudicate as many claims in FY 2018 as in previous fiscal years.

Table 1. Growth in Families and Individuals Receiving Compensation

Fiscal Year	No. of Petitioners	Compensation ($ in millions)
2014	365	$214
2015	508	$226
2016	689	$253
2017	706	$282
2018	522	$227

VICP Administration

The number of claims filed has approximately doubled from 633 claims filed in FY 2014 to 1,238 claims filed in FY 2018, primarily due to the increase in the number of seasonal influenza vaccine claims filed. With the CDC recommending an annual influenza vaccine for adults in addition to children, many more people receive influenza vaccines each year. Alleged injuries after receipt of the influenza vaccine account for approximately 60 percent of claims filed annually.

HRSA anticipates 1,720 claims filed in FY 2019, a nearly 40 percent increase over the FY 2018 level of 1,238 claims filed. The Final Rule modifying the Vaccine Injury Table (Table) was published on March 21, 2017, and petitioners have two years from the effective date of Table changes to file claims for injuries or deaths that occurred up to eight years preceding the Table modification date. The FY 2019 claims filed increase is based on a projected bolus of claims filed by March 21, 2019, the deadline for filing claims related to specific changes to the Table.

While the number of claims filed approximately doubled from FY 2014 to FY 2018, administrative funding increased by 42 percent over the same period, as shown in Table 2. In FY

2017, the VICP initiated a backlog of claims because the increased number of claims filed exceeded the resources that were available to conduct medical reviews. Claims are averaging a wait of nine months for review, resulting in delays in compensating petitioners. The cumulative backlog of claims awaiting review was 640 claims at the end of FY 2018 and is expected to grow to 1,370 by the end of FY 2019. With the anticipated growth in claims filed, HRSA expects the backlog will continue. HRSA anticipates the claims backlog could exceed 1,500 claims by the end of FY 2020.

Table 2. Five-Year Trend in Number of Claims Filed and Administrative Costs

Fiscal Year (FY)	No. of Claims Filed	Administrative Funding *($ in millions)*
2014	633	$6.46
2015	803	$7.50
2016	1,120	$7.50
2017	1,243	$7.75
2018	1,238	$9.20

Funding History – VICP Claims Compensation

FY	Amount
FY 2016	$252,884,049
FY 2017	$282,945,120
FY 2018	$227,082,600
FY 2019	$280,000,000
FY 2020	$285,600,000

Funding History – VICP Administration

FY	Amount
FY 2016	$7,500,000
FY 2017	$7,750,000
FY 2018	$9,200,000
FY 2019	$9,200,000
FY 2020	$11,200,000

Budget Request

VICP Claims Compensation - The FY 2020 Budget request for VICP claims compensation is $285.6 million, which is $5.6 million above the FY 2019 Enacted level. The FY 2020 Budget request will ensure adequate funds are available to compensate petitioners and pay their attorneys' fees and costs. These funds will also allow the VICP to continue to meet its zero percent target for the percentage of eligible claimants who opt to reject awards and elect to

pursue civil action. Prior to the existence of the VICP, civil actions against vaccine manufacturers threatened to cause vaccine shortages and reduce vaccination rates.

VICP Administration - The FY 2020 Budget request for VICP administration is $11.2 million, which is $2.0 million above the FY 2019 Enacted level. This funding level will support administrative expenses to process claims filed, including costs associated with medical expert reviews and expert testimony to the Court. The FY 2020 funding increase will allow HRSA to hire additional contractors to conduct initial medical reviews and full-time medical officers to review the contractors' work. At the $11.2 million level, HRSA plans to review about 1,200 vaccine injury claims in FY 2020, which is approximately 200 more claims than it expects to review in FY 2019 at the $9.2 million level.

In addition, the VICP will continue to provide professional and administrative support to the ACCV, process compensation awards, maintain necessary records securely, and inform the public of the availability of the VICP. The funding request also covers costs associated with the claims award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
26.II.A.1: Percentage of cases in which judgment awarding compensation is rejected and an election to pursue a civil action is filed. *(Outcome)*	FY 2018: 0% Target: 0% (Target Met)	0%	0%	Maintain
26.II.A.4: Average time settlements are approved from the date of receipt of the DOJ settlement proposal. *(Outcome)*	FY 2018: 6.1 days Target: 10 days (Target Exceeded)	10 days	10 days	Maintain
26.II.A.5: Average time that lump sum only awards are paid from the receipt of all required documentation to make a payment. *(Outcome)*	FY 2018: 1.9 days Target: 7 days (Target Exceeded)	4 days	4 days	Maintain

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 +/- FY 2019
26.II.A.6: Percentage of cases in which court-ordered annuities are funded within the carrier's established underwriting deadline. *(Outcome)*	FY 2018: 98% Target: 98% (Target Met)	98%	98%	Maintain
26.II.A.7: Percentage of medical reports that are completed within 90 days of receipt of any medical records. *(Outcome)*	FY 2017: 90% (Baseline)	75%	75%	Maintain
26.II.A.8 Percentage of FY 2017 and subsequently filed claims with any medical records assigned for medical review within 4 months of receipt from the Court.	FY 2017: 57% (Baseline)	65%	65%	Maintain